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Health Promotion and Primary Prevention in 21 European Countries

A Comparative Overview of Key Policies, Approaches, Examples of Good Practice, and Gaps and Needs

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EXECUTIVE SUMMARY

This summary report presents an overview of the information presented in twenty-one new and updated country reports developed by representatives of organisations participating in the EU Joint Action CHRODIS PLUS: Implementing good practices for chronic diseases.

The Joint Action CHRODIS PLUS is a three-year initiative (2017-2020) funded by the European Commission and the participating organisations. Altogether 17 policy dialogues and 25 pilot implementations form the core of the CHRODIS PLUS. The policy dialogues (15 at national level and 2 at EU level) raise awareness and acceptance amongst decision makers on improved actions to combat chronic diseases. The pilot projects focus on the following areas: Health promotion and primary prevention, Integrated Multimorbidity care model, Fostering quality of care for people with chronic diseases, ICT based patient empowerment, and Employment and chronic diseases.

Europe is paying a heavy price for chronic diseases. It has been estimated that chronic diseases cost EU economies €115 billion or 0.8% of GDP annually. Approximately 70% to 80% of health care budgets across the EU are spent on treating chronic diseases. Reducing the burden of chronic diseases like diabetes, cardiovascular disease, cancer and mental disorders is a priority of EU Member States and at the EU Policy level, since they affect 8 out of 10 people aged over 65 in Europe. There is a wealth of knowledge within EU Member States on effective and efficient ways to prevent and manage cardiovascular disease, stroke and diabetes type-2. There is great potential to reduce the burden of chronic disease by making better use of this knowledge.

JA CHRODIS PLUS will contribute to the reduction of this burden by promoting the implementation of policies and practices with demonstrated success. The development and exchange of these tested policies and projects across EU countries is the core idea driving this action. JA CHRODIS PLUS raises awareness that in a health-promoting Europe – with considerably lower levels of preventable chronic diseases, premature death and avoidable disability – initiatives on chronic diseases should build on four cornerstones:

- health promotion and primary prevention as a way to reduce the burden of chronic diseases
- patient empowerment
- tackling functional decline and quality of life as the main consequences of chronic diseases
- making health systems sustainable and responsive to the ageing of our populations associated with the epidemiological transition

Forty-five CHRODIS PLUS partners from twenty-one European countries are involved in JA CHRODIS PLUS work on health promotion and primary prevention. It is been acknowledged the majority of 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. This report builds on a baseline understanding that was developed as part of JA CHRODIS of what European countries are currently doing in health promotion. Partner organisations from Bulgaria, Croatia, Cyprus (collaborating partner), Estonia, Germany, Greece, Denmark, Finland, Hungary, Iceland, Ireland, Italy, Lithuania, Norway (collaborating partner), Poland, Portugal, Serbia, Slovenia, Spain, Netherlands, and the UK (collaborating partner) have

completed a questionnaire that asked them to analyse their health promotion and primary prevention 'landscapes' and contexts. The questionnaire also asked partner countries to give examples of good practice and identify what they felt were gaps and needs in their countries to develop and maintain effective and efficient policy, programmes and practices. The individual questionnaires form the basis for this Country Overview Report.

This overview report presents a synthesised analysis of the key findings in the individual partner country reports, including:

1. All countries have national health plans:

The country reports indicate that all partner countries have National Health Plans. In addition, there other health and health related policies and programmes referenced across the reports. In general a national ministry of health is responsible for the initiation and development of national health policy in partner countries. Implementation of such policies is most frequently undertaken at regional or at local level. The country reports reveal that there is a diversity of systems and structures in relation to health promotion and prevention policies, programmes and practice. This includes centralised approaches in a majority of countries to divergent levels of decentralisation and localisation in other countries.

2. Health promotion receives limited attention from policy makers:

Levels of development in relation to health promotion and prevention capacity vary across partner countries. Prevention measures are not at the forefront of health services or current thinking throughout governments. Interconnected working is essential. In addition, the need to develop and sustain workforce capacity for health promotion and disease prevention is referred to in the reports from the majority of partner countries. This refers to increasing workforce numbers and levels of competence.

3. There is a division between medical and social approaches to health – HiAP needs to be fully implemented in more countries in Europe:

The models of health which underpin health promotion and primary prevention polices and practice differ across partner countries. The reports indicate that the majority of countries have adopted (at least in part) the social determinants of health while other countries tend to focus on medical or disease based approaches. Relatedly, the country reports highlight that a partnership approach is used in relation to health promotion and prevention which includes the involvement of ministries other than health (with limited reference to the adoption of Health in All Policies) and of nongovernmental organisations. The country reports further reveal that there is an urgent need for more structured and coordinated approaches in order to develop and maintain effective and sustainable partnerships.

4. There is not enough funding for Health Promotion:

An issue that is shared among all country reports is that funding for health promotion and disease prevention is inadequate and represents a minor proportion of overall health budgets. The country reports reveal that the majority of partner countries health promotion and disease prevention activities are funded by national taxation systems. The new and updated reports indicate several new funding measures. Most notably the Prevention Act in Germany and Sugar Taxes on soft drinks in Ireland and the UK. The reports include a few

references to funding from the private sector. However, references are made to accessing funding from the European Structural Funds and other EU sources in more country reports.

5. Health promotion needs further operationalisation so it is easier to monitor and value (e.g. economically):

The country reports reveal that there is divergence between partner countries in terms of evaluating and monitoring health promotion programmes and targets. Some partner countries report examples of evaluation and monitoring of policy and programme implementation. However, there are frequent references to the need for agreed criteria, more coordinated and structural approaches to monitoring and evaluation, dedicated funding for evaluation, and better dissemination and use of findings. The need to operationalise will help to strictly define variables into measurable factors. The process would allow health promotion policies and programmes then to be measured empirically and quantitatively providing policy makers more evidence relating to existing good practices.

6. There is an urgent need for more evidenced based good practices and an organised way of implementing them:

A minority of country reports indicate that they have a database of examples of good practice and have developed frameworks for identifying and selecting such examples. It would be beneficial for comparison and to build capacity to have a universal method of collecting and analysing good practices across Europe. This would require the development of universal agreed criteria as well as a mechanism for distribution. The criteria would need to be able to capture and evaluate process, qualitative, quantitative, and formal research. In addition, the country reports demonstrate that projects are easier to describe and support than putting health promotion into laws and regulations. Especially embedding them within all sectors. However, it is more effective to have health promotion within these structures and not just in ad-hoc projects.

7. The gaps and needs in relation to health promotion and primary prevention identified across partner countries falls under nine categories.

The gaps and needs that have been identified most frequently in the country questionnaires are: a lack of adequate, consistent, and dedicated funding for health promotion and primary prevention; a lack of evaluation, monitoring, and research to assess the quality and disseminate health promotion implementation findings; and a lack of utilising approaches that incorporate the social determinants of health, health equity, and are attentive to the needs of vulnerable groups.

➢ Monitoring and Evaluation
➢ Capacity/Capacity and Knowledge Development
➢ Partnerships/Participation/Health in all Policies
➢ Funding
➢ Approaches/Social Determinants
➢ Communication and Coordination
➢ Leadership and Strategic Vision
➢ Reorientation of Health Services
➢ Quality Assurance

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INTRODUCTION

JA CHRODIS PLUS

Chronic diseases, also known as Non-communicable diseases (NCDs), are not passed from person to person. They are of long duration and generally slow progression. They generally cannot be prevented by vaccines or cured by medication. The four main types of chronic diseases are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. In Europe chronic diseases are responsible for 86% of all deaths in the region. They affect 8 out of 10 people aged over 65 in Europe, and 70% to 80% of healthcare budgets are spent on chronic diseases. Thus, Europe is paying a heavy price for chronic diseases. It has been estimated that chronic diseases cost EU economies €115 billion or 0.8% of GDP annually; and this figure does not include the additional loss in terms of lower employment rates and productivity of people living with chronic health problems. The challenge of chronic disease is immense but health promotion and disease prevention programmes are the answer. Health promotion engages and empowers individuals and communities to share in healthy behaviours, and to make changes that reduce the risk of developing chronic diseases.

The Joint Action CHRODIS PLUS is a three-year initiative (2017-2020) funded by the European Commission and the participating organizations, that involve a total of forty-five beneficiaries representing twenty-one European countries. The overarching goal of JA CHRODIS PLUS is to support Member States through cross-national initiatives identified in JA CHRODIS to reduce the burden of chronic disease, increase the sustainability of health systems, and develop human capital. The focus is on tangible trans-national activities with a potential to trigger health and chronic disease policies in Member States with the potential to improve health outcomes. In specific terms, the aim of JA CHRODIS PLUS is to promote the implementation in several countries of innovative policies and practices for patient empowerment, health promotion and prevention, and fostering quality management of chronic disease and multi-morbidity as well as for improving the adaptation of the employment sector to chronic patients. JA CHRODIS PLUS will promote the implementation of pilot actions that are based on the collection started in JA CHRODIS.

As part of the effort of JA CHRODIS PLUS we have asked partner countries to update their country reports from JA CHRODIS. In addition, we have new partner countries completing reports. This work will complement the existing country reports to assess the state of development of policies on health promotion and disease prevention within countries not yet covered in JA CHRODIS (i.e. Croatia, Denmark, Finland, Hungary, Poland, and Serbia). The country reports will provide policy makers, practitioners, and stakeholders with a quick idea of the situation and key actors in the respective countries. They will also provide an understanding of what is needed in terms of health and other relevant policies and strategies (physical education, anti-smoking laws, employment policies, etc.) and in terms of implementation of good practices for those target groups. As many good practices are implemented outside the healthcare sector this will also give an overview of inter-sectoral collaboration of several actors. The reports provide a helpful baseline for more efficient cross-national learning. In addition, and from an EU perspective, the reports link with other work that map health systems and increase the insights into broader health systems organisation. These country reports are unique as they are the only ones that address organisation and policies in the field of public health and health promotion. These issues only receive minimal attention in other health system country reports.

This report provides a comparative overview of the information included in the twenty-one new and updated country reports. This information can provide insight into further steps that Member States can undertake to support one another and strengthen their health promotion and primary prevention policies and practices. Given the wealth and complexity of information provided in the individual country reports, this overview will only highlight key areas and issues. Unfortunately, we also have three country reports that couldn't be updated due to resource constraints. Thus, the original country reports from Estonia, Greece, and Norway have been included to enable a comparison with the new and updated country reports.

The conclusions drawn are based on the information provided in the country reports and on comparisons of findings from individual reports undertaken by some of the participating countries. The overview outlines and discusses the commonalities and differences across the country reports 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

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. This is also related to the organisation that completed the questionnaire which can influence the priorities or focus. Comparisons between partner countries in relation to levels of capacity, funding, and levels of activity in health promotion and primary prevention presented in this overview 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 this overview report. Where examples of policies, processes, or good practice 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.

HEALTH PROMOTION AND PRIMARY PREVENTION LANDSCAPE

POLICY CONTEXTS AND CAPACITY IN RELATION TO HEALTH PROMOTION AND DISEASE 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.

The new and updated country reports show a continued diversity in political and policy systems relating to health. This ranges from mainly centralised (e.g. Cyprus, Greece, and Lithuania) to complex devolved systems (e.g. Denmark, Spain, and UK). There has only been modest change in the countries who have updated their reports. However, the addition of the new reports follow a similar pattern with centralised systems (e.g. Croatia and Serbia) and complex localised and devolved systems (e.g. Denmark and Finland). Overall, the addition of the new and updated country reports indicate the continued complexity that there still is within the health promotion landscape in Europe. They also highlight that there is still some distance to go before health promotion occupies a central position in politicians, policy makers, and stakeholder's perspectives.

The increased number of countries participating in the country review process is promising and helps to enhance the knowledge base on the health promotion landscape within Europe. But, as with the previous overview, the varying level of detail included in the reports means that 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. However, it is clear from the country reports that health promotion still receives limited attention from policy makers and funding from governments. Interestingly, the country reports reveal the increased focus placed upon nurses (and specialised nurses) within health promotion policies (e.g. Denmark, Hungary, Italy, Poland, and Slovenia).

The country reports show that all partner countries have a National Health Plan and other health specific laws and policies. Some countries (e.g. Denmark, Finland, Germany, UK, and 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, Hungary, Poland, Lithuania, and Serbia) the emphasis appeared to focus more on the epidemiological, disease, or medical model. In addition, there are several examples of specifically targeted health promotion policies. The first is the Prevention Act in Germany which obliges insurers to ring fence €7 per insured person for a specific prevention fund. The second is the Sugar Tax in the UK which places a tax on the percentage of sugar in soft drinks above a certain level with the proceeds being spent on physical activity programmes for school children. Ireland has also brought in a Sugar-Sweetened Drink Tax which aims to reduce obesity and raise revenue by taxing the sugar in soft drinks.

Several partner country reports specifically referred to evidence based policy development (e.g. Denmark, Finland, Italy, UK, Netherlands and Ireland). The majority of countries made implicit reference to ethical dimensions in their reports (e.g. in relation to equity). Health in All Policies (HiAP) was specifically expressed by several countries across Europe (e.g. Croatia, Denmark, and Finland). The emphasis on HiAP was strongest

in Finland where legislation requires all sectors of the government take health and wellbeing into account. It also sets specific tasks and obligations to municipalities for implementing HiAP. It is clear from the partner country reviews that there is still an urgent need for strong and clear political leadership for health promotion.

An overview of National Health Plans, related laws and policies, and good practice databases as detailed in the individual reports is provided in Tables 1 and 2.

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

Country	National Health policy / Strategy	Other Health Policy / Strategy	Other Relevant Policies / Strategies
Bulgaria	National Program for Prevention of Chronic Non-Communicable Diseases 2014-2020	National Strategy for Poverty Reduction and Social Inclusion Promotion 2020 National Program to Improve Maternal and Child Health 2014-2020 National Strategy for Long-Term Care (2014)	National Strategy for Demographic Development in the Republic of Bulgaria - Update (2012-2030) National Strategy for Physical Education and Sports Development of the Republic of Bulgaria 2012 – 2022 National Strategy of the Republic of Bulgaria on Roma Integration (2012 - 2020) National Plan to Promote Active Aging among Elderly in Bulgaria (2012-2030)
Croatia	National Health Strategy 2012-2020 Strategic Action Plan for the Development of Public Health 2013-2015	The National Programme 'Living Healthy' National Healthcare programme for persons with diabetes 2015-2020 Strategic Action plan for the reduction of excessive salt intake in Croatia 2015-2019 National Strategy for Prevention of Harmful Use of Alcohol and Alcohol related diseases 2011-2016 Start your heart-save your life program Action Plan for strengthening Tobacco control 2013-2016	Act on the Restriction of the Use of Tobacco Products National Roma Plan
Cyprus	Strategic Health Strategy of the Ministry of Health	National Diabetes Strategy 2016	

		Health Promotion in the Communities	
Estonia	National Health Plan 2009-2020	Public Health Act Regulation on health protection for catering facilities in preschool institutions and schools 2008 Alcohol Act paper 2019 Tobacco Act 2016	Strategic Plan for Sport for All Plan for Primary Care 2009-2015
Germany	Preventive Health Care Act (Prevention Act 2015)	National Health Target Process National Health Targets National Action Plan to Prevent the Lack of Physical Activity and Malnutrition	National Strategy on Drug and Addiction Policy Environmental Health Action Programme E-Health Law
Greece	National Strategy Action Plan for Health 2011-2013 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
Denmark	Together for the Future 2015	Health Agreements 2015-2018 Cancer Plan 2017-2020	National Board of Health 11 Prevention Packages (2013)
Finland	Health Care Act (2010)	National Obesity Program 2016–2018. On the move – national strategy for physical activity promoting health and wellbeing 2020.	Finish Constitution (section 19, 1999) Local Government Act (2015) 'Health in All Policies' (2006) Land Use and Building Act (2000)

Hungary	Health Hungary Strategy 2014-2020	Health Hungary Strategy 2014-2020 National Strategy (2007-2032) on "Better for children" National Strategy (2009-2034) on elderly people Edict of 2013/71 by the Ministry of Human Capacities Edict of 2014/34 by the Ministry of Human Capacities	National Sustainable Development Strategy (frame) 2013-2018 National strategy (2013-2020) on drugs
Iceland	National Health Policy 2020 National Health Policy 2022 (*in progress*)	National eHealth Strategy 2016-2020 Policy on alcohol and drug prevention 2020 Public policy on tobacco control Regulation on the Maximum Levels for Trans-Fatty Acids in Foods Public health policy and action plan for health promoting community	Media Act The national transport policy Legislative Act on Sports Law and regulation concerning Environmental Impact Assessment and Nature Conservation
Ireland	Healthy Ireland – A Framework for Improved Health and Wellbeing (2013) Sláintecare Report (2017) Public Health (Alcohol) Bill 2015	The National Physical Activity Plan: Get Ireland Active (2016) National Positive Ageing Strategy (2013) A Healthy Weight for Ireland – An obesity policy and action plan (2016) National Sexual Healthy Strategy 2015-2020 (2015) Get Ireland Walking (2017)	Framework for Reform of the Health Service 2012-2015 Sugar-Sweetened Drink Tax 2018 Tobacco Free Ireland 2013 National Men's Health Action Plan Healthy Ireland 2017-2021 National Strategy for Women and Girls 2017-

		National Drugs Strategy (2017-2025) Health Service Breastfeeding Action Plan (2016-2021) Better Outcomes, Brighter Futures – the National Policy Framework for Children and Young People (2014-2020)	2020: creating a better society for all (2017) 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 (2014 - 2018) The National Platform for Gaining Health (2017)	National Guidelines on nutritional quality of canteen menus at school Lombardy Workplace Health Promotion Network
Lithuania	Lithuanian Health Strategy for 2014-2025 National Public Health Development Program for 2016-2023	Action Plan for Reducing Health Inequalities in Lithuania for 2014-2023 Action Plan to Ensure Healthy Ageing in Lithuania for 2014-2023 National Cancer Prevention and Control Program for 2014-2025	Procedure for strengthening health of persons who are at high cardiovascular and diabetes mellitus risk Procedure to identify and intervene with patients whose alcohol use is hazardous or harmful to their health and wellbeing
Norway	National Health Strategy	Public Health Act 2011 Health and Care Services Act 2012	Coordination Reform 2008-2009 Public Health Report: Good Health Shared

		Equal heath and care services National Strategy for Immigrant Health 2013-2017 NCD Strategy 2013-2017	Responsibility 2012-2013 Strategy to reduce Social Inequalities in Health 2007 Elderly over 65 in Norway – fact sheet
Poland	National Health Program 2016-2020	The Public Health Act 2015 Program for Treatment and Prevention of Cardiovascular Diseases – POLKARD (2017-2020) National Program for Cerebrovascular Disease Prevention (2017-2020)	Program for Supporting Outpatient Treatment of Diabetic Foot Syndrome (2016-2018) National Program for Transplant Medicine Development (2011-2020) National Cancer Prevention Program (2016-2024)
Portugal	National Health Plan extension to 2020	National Programme for Cardio-Cerebrovascular Diseases National Programme for Diabetes National HIV/AIDS and Tuberculosis Programme National Mental Health Programme National Programme for Respiratory Diseases	National Programme for the Promotion of Healthy Eating National Programme for Smoking Prevention and Tobacco Control (PNPCT) National Program for the Promotion of Physical Activity
Serbia	Law on Public Health (2016)	Law on Patients' Rights Strategy on the Suppression of Drug Abuse for the Period 2014-2021 National Programme Serbia against Cancer National Programme for the Promotion of Early Childhood Development	Law on Health Insurance Strategy for Social Inclusion of Roma population in the Republic of Serbia for the period from 2016 to 2025 National Strategy for Gender Equality

			National Programme for prevention of harmful alcohol use and alcohol disorders in the Republic of Serbia
Slovenia	National Health Plan 2016-2025 "Together for a society of Health"	National Action Plan on Nutrition and Physical Activity 2015-2025 National Diabetes Prevention and Care Development Programme; Development Strategy 2010-2020 National programme on primary prevention of cardiovascular diseases (2002) Restriction on the Use of Tobacco and Related Products Act	Health in All Policies: Inter-sectoral cooperation in Slovenia is regulated by Article 10 of the Rules of Procedure of the Government of the Republic of Slovenia
Spain	Spanish National Strategy on health promotion and prevention	National recommendations advancing on the reduction of salt, sugar and fats are also being developed Cohesion and Quality at the NHS Act Public Health Act	Guide for the Local Implementation of Spanish Strategy on Health Promotion and Prevention Operational Plan 2018-2020 within the National Roma Integration Strategy in Spain
Netherlands	Public Health Act National Prevention Programme 2014 - 2016	Youth Act 2015 Exception Medical Expenses Act Social Support Act Health Insurance Act	Healthy Nutrition from Beginning to End Good Nutrition Guidelines of the Health Council
UK	The Public Health England Strategic Plan: better outcomes by 2020 Health and Social Care Act 2012	Soft Drinks Industry Levy 2018 NHS 5 Year Forward View	NHS Health Check Programme

		Department of Health: Shared Delivery Plan	

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

Country	National Health policy	Good Practice Database - Examples	
Bulgaria	X		
Croatia	X		
Cyprus	X		
Estonia	X	X	X
Germany	X	X	X
Greece	X		X
Denmark	X	X	X
Finland	X	X	X
Hungary	X		
Iceland	X	X	X
Ireland	X		X
Italy	X	X	X
Lithuania	X		
Norway	X		
Poland	X		
Portugal	X	X	X
Serbia	X		
Slovenia	X	X	X
Spain	X	X	X
Netherlands	X	X	X
UK	X	X	X

IMPLEMENTATION AND EVALUATION

The partner country reports reveal that the majority of initiation and development of health promotion and primary prevention policies occurs at a national level. They then continue to be implemented at regional/local level. In some of the countries the development is centralised with local regions only responsible for the local operations, in this case national policy is reported to inform and forms the basis for local policy development and implementation (e.g. Croatia, Lithuania, and Serbia). In other countries the implementation stage is managed through formal agreements between the national health department and the regional or local administrations. Denmark offers a good example of a localised approach whereby the health system operates on a concept that relies on inter-sector collaboration between regions and municipalities.

The country reports indicate that there is a mixture of monitoring and evaluation strategies in partner countries. In some of the partner countries there is a clear and distinct monitoring and evaluation strategy for policy implementation which is coordinated at national level. In these countries it is connected to established national health promotion and prevention strategies (e.g. Portugal, Germany, and Finland). In other partner countries, evaluation of policy implementation is reported as either occurring at other levels or not at all. An overall finding from JA CHRODIS country reports was that monitoring and evaluation were areas that were not well developed. This finding has been replicated in this overview report. Monitoring and evaluation remains under-developed and uncoordinated across the continent and are not implemented at a structural level.

The gaps and needs section (page 38) demonstrate that this is a recognised area that requires improvement. The country reports also reveal a recognition by partner countries of the need to establish strong and communal criteria as the foundation for monitoring and evaluation of health promotion and primary prevention policies, programmes and practice across Europe. This is connected to the frequent reporting of inadequate distribution of findings from evaluation and monitoring between countries as well as improving levels of exchange of good practices. The need to establish a mechanism to facilitate the dissemination of findings and their application to improve health promotion and prevention policy is recognised in all of the country reports.

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	National Planning Agency
Transport Authority	Environment Agency
Transport, Tourism and Sport	Commissioner of Policies
Environment Community and Local Government	Local Authorities/Regional Governments
Jobs enterprise and innovation/ Social Welfare and Employment /Labour and Social Policy	National health Insurance Fund
	Regional health Insurance Fund
Country ministries (e.g.UK)	Centres of Healthy Living
Justice and equity	Environmental Protection Agency
Interior Ministry	Health and Safety Authority Welfare
Youth and Sport	Primary Health Service/Groups of Primary Care centres
Education, Science and Culture	
Ministry of Education and Science	Municipalities
Agriculture Food and Medicine	Public Health Units/Directorates at different level
Children and youth Affairs	
Communication Energy and National Resources	National Support Network for Elderly
Economic Affairs	Service for Interventions on Addictive behaviours
Ministry for Education and Skills	
Ministry of Social Affairs and Health	Organisation for Health Research and Development
Ministry of Human Capacities	
	Health Promotion Institutes
	Boards of Health Supervisor/Health Inspectorates
	National Organisation for Health Care
	Central Statistics offices

Table 4. Institutions with public health roles which inform, influence public health or undertake related tasks

Country	Organisation	Main Role
Bulgaria	National centre for Public Health and Analysis	Protecting public health and preventing diseases, providing information for health care management
Bulgaria	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.
Croatia	Croatian Institute of Public Health	Deals with public health, health promotion and education, disease prevention, environmental health, school medicine, mental health care and addiction prevention. Main tasks are to plan, promote and implement measures for the enhancement of population health and reduction of health problems.
Cyprus	X	X
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
Germany	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
Greece	Centre for control and Prevention of disease	Control of NCDs and AIDs
Greece	Organisation against drugs	Planning and implementation of policies for perverting and combating drug addiction
Greece	National centre for diabetes mellitus	Monitoring, prevention and treatment of diabetes
Greece	National school of Public	Postgraduate/ further education, research in public health, health promotion and prevention
Greece	Health 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.
Denmark	Danish Society for Public Health	Promotes public health, prevent diseases and reduce the impact of diseases as well as to reduce

		health inequalities between different groups of the Danish society
Denmark	The Council on Health and Disease Prevention	A knowledge sharing and policy suggesting entity working in a wide range of fields; communicable diseases as well as non-communicable, economics, nutrition, exercise, sports,
Denmark	The Danish Committee for Health Education	Covering all public health organisations to produce health information materials and promote health via direct intervention or information projects.
Finland	The National Institute for Health and Welfare	Studies and develops the promotion of wellbeing and health and coordinates networks and supports municipalities and regions by providing latest information and tools for the management, planning, implementation and evaluation of health promotion.
Finland	Finnish Federation for Social Affairs and Health	A national umbrella organisation that gathers together 200 social and health NGO's and dozens of other partner members to influence social and health policy and other relevant sectors of societal policy;
Hungary	National Public Health Institute	Only the occupational health supervision and the coordination of ongoing EU projects remained at the central institute, along with nationwide epidemic surveillance system.
Hungary	Health Professional's College, Preventive Medicine and Public Health department	The main task of the organization is to articulate and communicate opinions on various topics related to healthcare, also provide professional guidance and advice on the topic of public health strategy.
Iceland	Directorate of Health	Among a wide remit, it 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
Ireland	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

Italy	National Health council	Support for national health planning, hygiene, public health, pharmacology and pharmaco-epidemiology, continuous medical training for health care professionals, and information systems.
Italy	Agency for Regional Health services	Conducting comparative effectiveness analysis
Italy	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
Lithuania	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.
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.
Norway	The Norwegian Institute of Public Health (NIPH)	The main source of medical information and advice
Poland	National Research Institutes (National Institute of Public Health – National Institute of Hygiene)	Public health research institute and the reference centre for the national network of sanitary epidemiological service. It cooperates with public health centres at provincial level and other medical research institutes and institutions in Poland
Portugal	National institute of Health	Aims to increase gains in the public health sector
Portugal	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
Serbia	Institute of Public Health of Serbia "Dr Milan Jovanović Batut" and network of 24 Public Health Institutes	Conduct health promotion activities centred on community health, health education, and health care of socially vulnerable groups
Slovenia	National Institute of Public Health of the Republic of Slovenia	A government agency accountable and responsible for public health promotion at the national level.

Slovenia	The Health Education Centre Network	A key structure for ensuring community health promotion activities and health education for adult population at local level
Spain	The National Institute of Heath Carlos III	Research body attached to the Ministry of Science and Innovation, whose basic goal and responsibility is to promote and asses biomedical and health research
Spain	The National School of Public Health of Spain	A public research institution in the field of Public Health and Health administration. Specialises in Public Health research and education
Netherlands	Health Promotion Institutes	Action on specific themes (e.g. nutrition/physical activity/ migrant health/mental health)
Netherlands	National institute of Public Health and the environment	Health, disease and care surveillance and public health reporting
Netherlands	Centre for Healthy living	Promotes the use of appropriate lifestyle interventions based on evidence.
Netherlands	Council for Public Health and Health Care	An independent advisory body which advises the government on public health and care.
UK	Public Health England	Brings together public health specialists from more than 70 organisations into a single public health service.
UK	King's Fund	Shapes public health and social care policy and practice, provides NHS leadership development, and health care analysis

Vignette 1: Intra-sectorial collaboration, Denmark

Fostering collaboration is a key challenge in developing health promotion activities and implementing recognised good practices in different contexts. The country review questionnaires asked for information ***on the*** *decision-making mechanisms for policy development and implementation. A good example of how intra-sectoral collaboration can be coordinated throughout the decision-making and policy implementation process comes from Denmark. The essence of the idea is to enable strong collaboration between regions and municipalities. This aims to broker connections between health promotion and healthcare for all citizens. This is achieved by dividing responsibilities via health agreements into two broad inter-locking spheres of health and healthcare that the municipalities and regions take forward together.*

Municipalities and Regions

In Denmark, the structural reforms of 2007 sought to distinguish between healthcare and health promotion. Health promotion and disease prevention became the responsibility of the 98 municipalities while healthcare treatments was placed under the remit of the 5 regions. This division means that the regions are responsible for running and developing the Danish hospital system and includes municipally placed GPs and healthcare treatment services for the citizens of the municipalities in each region. The payment for these services are partly the obligation of the municipalities. The intertwined responsibilities and obligations have been designed to foster close cooperation between the municipalities and the regions.

The two different aspects -- health promotion and healthcare -- are funded via taxation with the regions adopting an economic service model paid by state taxes whereas the municipalities raise money through municipal taxes. This system is thought to doubly incentivize the municipalities to run and continuously develop prevention initiatives to maintain health *and* to maintain local budgets. The municipalities are in charge of most health promotion and disease prevention, but also provide disability and social care, including the citizens with severe postoperative or chronic care needs.

This separation of tasks and obligations between different organizational levels is central to the current formation of the Danish healthcare system. This also gives both municipalities and regions incentives and roles to play in initiating and developing health care policies to constantly optimize the overall performance – both relying upon the performance of their counterpart. The mutually beneficial aspect requires both sides to take longer term positions on funding prevention programmes and allocating resources. This collaboration is underpinned by *Health Agreements* that sets priorities and targets.

Health Agreements

Every four years the 5 Danish regions must establish *Health Agreements* between the region and the municipalities to set political goals and specific ambitions. The agreements include the clear separation of the tasks and the terms of specific economical, health, or service levels between the hospitals, GPs, and the health promotion and disease prevention efforts of the municipality. The *Health Agreements* are then approved the National Board of Health.

The *Health Agreements* 2015-2018 covered four priorities: Prevention; Treatment and Care; Rehabilitation; and Health-IT and Digitalization. Across these four pillars, the regions and municipalities had five ambitions that covered: better collaboration; stronger coordination; empowerment of patients and relatives; equal

access; and better research, quality, and patient safety. As of February 2018 the Ministry of Health unveiled a new structure for the forthcoming *Health Agreements*. The ambition is to reduce administration and strengthen cross-sectorial collaboration to improve overall treatment quality, speed, and communication. The ambition to transform local policies into binding, measurable commitments between region and municipality is still central to future planning.

FUNDING

The new and updated country reports show a disparity in the levels of detail of how funding systems operate and the funding mechanisms for health promotion. As expected, partner countries recorded that the main source of income is through national government budgets. However, there are some subtle 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. In Denmark, regions and municipalities cover healthcare costs via taxes, the regions via an economic service model paid by the state taxes, the municipalities via municipal taxes. This includes certain exceptions. For example, in relation to dental care for working adults and certain types of physiotherapy. Portugal again reported that over 90% of health funding is from taxation while public and private health insurance systems make up the remainder. In Lithuania the national health insurance fund is the main health system's financing agent, accounting for about 60% of the total expenditure on health care.

There has been little change in relation to the sources of funding reported in the JA Chrodis country reports. Partner countries again reported that the focus has remained within health budgets on curative interventions and that there is a significant lack of funding for health promotion and primary prevention. For example, the proportion of GDP spent on health by the Croatian government has grown steadily since the early 2000s. In 2014, Croatia spent 7.5% of its GDP on health. However, it spends only 0.2-0.3% of GDP a year on programmes, planning, and regulation of public health. In Poland, public expenditure covers around 70% of all health care expenses but only 3% (€19.24 per capita) was spent on public health and promotion. In the UK, the National Health Service (NHS) in England spends around 4% on prevention. The amounts spent on prevention and promotion roughly correspond to the World Health Organisation average of around 3% of national health sector budgets being spent on public health and prevention. The Ireland country report included the recent commitments by the government to expand health and wellbeing funding by increasing the budget to €233M over ten years. They also committed to developing a universal child health and wellbeing service that will cost €41M over the first five years. The 2018 Irish health budget of €14.5 billion represents an overall increase of €608 million (4.4%) which is a considerable increase in the level of funding.

The government of Finland offers grants for health promotion projects annually. The state budget allocates a portion for health promotion and for the prevention and reduction of drug use and tobacco smoking. In addition, projects can focus on healthy nutrition, physical exercise, mental health, promoting participation and accessibility, sexual health, violence and injury prevention. Projects should develop health promotion methods and structures to strengthen approaches, enhance cooperation, and include targets to narrow health inequalities. Projects normally last for 1-3 years. In 2018 the total amount for grants was €2,176,794. The average grant was €200,000 per project. In addition, partner countries again reported examples of national and statutory health insurance funds (e.g. Lithuania, Poland, and Germany). There was limited reference in the reports to private sector funding. Mention was made of small amounts of funding from commercial parties such as the food industry and public-private partnerships in the Netherlands. 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 taxes on alcohol, the wholesale of tobacco, and different types of processed foods (e.g. Iceland, Ireland, and Finland).

In some partner countries funding for health promotion and primary prevention was also reported as coming from other stakeholders such as NGOs, municipalities, and regional governments. This funding is described as normally being specific to action on health promotion and prevention in given geographic areas, to population groups, activities (such as sport) and named diseases 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.

As reported in the JA CHRODIS summary report there is evidence of different levels of funding for health promotion and prevention across partner countries. Again, all country reports indicate an overall lack of funding and the need for consistent, dedicated funding to support sustainable and effective health promotion and primary prevention.

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

Organisation Type	Name
Patients organisations/Patients' rights	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; Active travel campaigns
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; Nursing Associations
Networks (including international networks)	Healthy Cities; Elderly Friendly Cities; Health Promoting Schools/Kindergartens; Healthy Work Place Charter; EuroHealthNet; European Workplace Health Promotion
Other	Ethnic Minority Communities/Groups; Social enterprise to promote the health of the population; Industry e.g. Food Industry.

Table 6. Examples of how stakeholder input is managed

Country	Process
Cyprus	National workshop through which stakeholders inform policy development.
Finland	National processes to support the implementation of HiAP Consultations on draft legislation, policies, and programmes are widely used and well-established practice in Finnish national policymaking. Consultations are not limited to ministries alone, but also with NGOs, trade unions, the research community, the private sector, and municipalities. Citizens can comment on the draft legislation through an online website available in Finnish or Swedish
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.
Hungary	Health Promotion Offices (HPO) - a network at community level, identifying the stakeholders most influential in the health behaviour of the community, and forming constructive relationships with them.
Iceland	One of the rules for participation in National Health programmes is the appointment of a steering group, involving stakeholders from different sectors.
Netherlands	The Partnership Overweight Netherlands is a cooperation of several stakeholders, including the Ministry of Health, Welfare and Sport, the Healthy Weight Covenant, local authorities which are taking part in its JOGG programme (based on EPODE), the Health Care Insurance Board, the Dutch Care Institute, the Netherlands Diabetes Federation and the Vital Blood Vessels platform, an alliance of 25 organisations concerned with cardiovascular health.
Poland	Associations and foundations organizing nationwide actions supporting healthcare and health education of the society (such as Polish Red Cross, Caritas, Great Orchestra of Christmas Charity).
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.
UK	Primary prevention and health promotion are the responsibility of a specific policy team within the Scottish Government. Policies are developed by policy makers in collaboration with stakeholders. Analytical services within government and Health Scotland provide the evidence base if it is a national policy. Some programmes and policies will be national, others local.

EXAMPLES OF GOOD PRACTICE

The country reports indicate a diverse range of examples of good practice in health promotion and disease prevention. This includes initiatives, projects, and interventions as well as other elements of policy, programmes, and practice that are beneficial examples. For example, how stakeholder involvement is managed in different countries (e.g. Cyprus, Germany, and Hungary), how health services are localised in a decentralised system (e.g. Denmark), and how 'Health in All Policies' is implemented (e.g. in Iceland and Finland). Other examples assembled 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.
- The Danish Prevention Foundation that dispersed 70 million Euro to explore and implement best practice prevention with and for Danish workplaces. The foundation established a rigorous procedure for selection and funded only proven methods for health promotion and disease prevention.
- The Preventive Health Care Act (Prevention Act 2015) in Germany has established a fund paid for by insurers that will focus exclusively on prevention initiatives.
- Implementation of HiAP in Finland is via legislation which obligates all sectors of the government to take health and wellbeing into account. It also sets specific tasks and obligations for municipalities to implement HiAP.

The country reports demonstrate that there is a vast amount of knowledge that can be shared by countries with greater experience in health promotion and disease prevention in relation to developing and sharing models of health promotion that focus on the social determinants of health and health equity. The need to share such information is intertwined with the need to establish agreed criteria on what constitutes good practices for health promotion. Examples of established procedures to identify and disseminate good practice used in partner countries include:

- In Portugal the 'Health Literacy Repository' selectively collects, analyses, selects and disseminates projects and instruments that establish good practices in education, literacy and self-care. A partnership has been established to support, facilitate, and take advantage of the development of this repository articulating an 'intelligent network for promoting health literacy'.
- The BZgA, in Germany, in cooperation with other stakeholders in the field of health promotion, has developed tools and toolkits to evaluate interventions in various settings. A structured overview on the existing methods of quality assurance in health promotion is provided through a web portal10. In 2004/2005 the BZgA-led nation-wide Cooperation Network 'Equity in Health' which developed twelve criteria of good practice.
- The National Center for Nutritional Education in Poland operates a portal that spreads knowledge about nutrition and a healthy lifestyle. It includes verified information regarding basics of nutrition, healthy weight loss or choosing appropriate diet in relation to various types of diseases.
- In Italy the Health Promotion Documentation Centre has established a procedure and framework to identify good practice at national level http://www.dors.it http://www.retepromozionesalute.it
- An electronic database for health promotion activities in Estonia includes recommendations on interventions on Type 2 Diabetes, low income groups, chronic diseases, the elderly, community, obesity, addiction, mental health, and school based interventions

As was reported in the summary report for JA CHRODIS, there is considerable divergence in the number and type of examples that the partner countries have identified. The majority of the country reports indicate that they have well populated databases of good practice. Most of the partner countries have supplied examples of good practice and reported various national guidelines and local instructions for all those working across the field of public health. However, the reports do illustrate variances in the focus, type, and methodologies of the differing examples of good practice. While some partner countries reported examples of actual practice activities and processes (e.g. Italy and the Netherlands), some countries described results or outputs of policies and programmes. Partner countries also reported an increase in online repositories for good practices within their countries (e.g. Denmark, Estonia, and Italy).

The examination and collection of good practices is a valuable exercise for the partner countries. However, a real issue for the partner countries is the divergent classifications of what constitutes a good practice. This is an important issue for countries who are less experienced and would like to learn from more experienced countries, and for the more experienced countries to learn about the latest developments and innovations in good practices. A finding of this report is the urgent need to develop and establish an agreed mechanism for sharing evidenced based information on good practices for health promotion and disease prevention. The debate will be subjective and depends upon which model of health the countries adopt to underpin their health promotion system. It will also depend on the different characteristics that are deemed to be the most important and what method of evaluation is agreed.

The countries that favour the medical model will likely stress the importance of measurements focused on changing individual behaviour and on risk specific measurements. The countries that adopt a social model will tend to focus on upstream changes that influence the determinants of health. The updated Ireland report again raised concern over 'lifestyle drift'. This is described as when a policy starts off by recognising the need for 'upstream' work on health determinants only to drift 'downstream' where the focus is once again on individual lifestyle and disease in the implementation and evaluation stages. This is a warning that should be heeded by all policy makers and evaluators when considering what constitutes evidence of good practice in health promotion and prevention at all stages of planning, implementation, and evaluation.

The specific examples of good practice identified in the country reports are outlined in Table 7.

Table 7. Examples of good practice

Country	Database	Identification Procedures	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.gesundheitlich echancengleichheit.de/engl ish/	Preventive Health Care Act (Prevention Act 2015)
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	National Health Register Health and well-being of Icelanders		The Public Health Fund 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 20082011 Weight management Treatment Algorithms Obesity Campaigns National Guidelines on Physical Activity

			Health Promoting Schools
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 organisation
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	
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
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.
UK	NICE guidelines on best practice including; Lifestyle and wellbeing; Diabetes and other endocrinal, nutritional and metabolic;	NICE criteria	Raising healthcare workers and the public's awareness of the link between Atrial Fibrillation and Stroke and preventing Stroke from this cause.

	conditions; Cardiovascular conditions; Health Inequality; Cardiovascular assessment and modification of blood lipids National-level best practice Guidance on Cardiovascular conditions		
Portugal	Health Statistics Portal (https://www.dgs.pt/portal-da-estatistica-da-saude.aspx) PDS Platform - Health Data Platform (http://spms.min-saude.pt/2013/11/pds-plataforma-de-dados-da-saude/) RSE – Electronic Health Record (http://spms.min-saude.pt/product/area-cidadao/) Bank for Innovation in Health (http://www.ihealthbank.eu)		"Health Literacy Repository" that selectively collects, analyses, selects and disseminates projects and instruments that establish good practices in education, literacy and self-care, as well as partnerships that support, facilitate and take advantage of the development of this repository articulating a “Intelligent network for promoting health literacy".
Finland	Innovillage.fi is a joint effort by SOSTE Finnish Federation for Social and Health, the Association of Finnish Local and Regional Authorities and the National Institute for Health and Welfare (THL).	Current Care Guidelines are independent, evidence-based clinical practice guidelines. These national guidelines cover important issues related to Finnish health, medical treatment as well as prevention of diseases. The guidelines are intended as a basis for treatment decisions, and can be used by physicians,	

	Liikuntahankkeet.fi offers current information on projects and good practices in the field of physical activity and sports. The web portal also publishes news and articles and baseline information of the project funding in Finland. It is maintained by the Finnish Society of Sports Sciences. Muutostaliikkeella.fi site brings together actions and actors that promote a physically active lifestyle. Best Practices is an open service maintained by the Finnish National Board of Education. Anyone working in the world of education may propose a best practice for publication on the service. Tepsivät teot brings together good practices concerning occupational well-being. Kasvun tuki is a resource for professionals of evidence-based interventions to support children and families. Early	healthcare professionals and citizens. The guidelines are developed by the Finnish Medical Society Duodecim in association with various medical specialist societies. The Current Care editorial team are responsible for the production of the guidelines. The guidelines are produced with public funding.	

	Intervention is designed to disseminate information and promote awareness interventions and their effectiveness. The inclusion criteria is psychosocial support for children and adolescents.		
Denmark	In 2015 the National Health Data Board was established to support the MoH with IT-services and the entire healthcare system with database services. Among these are: The Danish Patients Registry provides data on most common diseases. The database encompasses data for all citizens since 1977 containing all contact with the healthcare system including information about name, gender, address, visits to GP, admittances, diagnoses, treatments and operations. https://sundhedsdatastyrelsen.dk/da/registre-og-services/om-de-nationale-sundhedsregistre/sygedomme-laegemidler-og-behandlinger/landspatientregisteret	In 2010 the then Minister for Employment launched a special government foundation "The Prevention Foundation" with almost 70 million euro to explore and implement best practice prevention with and for Danish workplaces. The foundation established a rigorous procedure for selection and funding only best and proven methods for health promotion and disease prevention in the workplace. This is an exception to the rule for Denmark. The foundation spent its remaining funds in 2016.	The National Institute for Public Health continuously monitors and surveys developments in the Danish healthcare system. The Danish Committee for Health Education has produced the Guideline for Good Hygiene in Day-care as a comprehensive collection of issues and advice concerning disease prevention in day-care. The Council for Better Hygiene has produced a series of Good Advice on best practice in homes, workplaces, food safety, and daily lives regarding the use of hygiene as tool to prevent infections. The Danish Cancer Society has listed a series of key advice to schools and municipalities to tackle tobacco use.

	The Danish Diabetes Association extracted data from the Danish Patients Registry from 2007-2012 to form a special Danish Diabetes Registry https://diabetes.dk/presse/diabetes-i-tal/det-nationale-diabetesregister.aspx The Cancer Registry contains data about every diagnosed Danish cancer patient since 1943 https://sundhedsdatastyrelsen.dk/da/registre-og-services/om-de-nationale-sundhedsregistre/sygedomme-laegemidler-og-behandlinger/cancerregisteret The Rehabilitation Registry contains data about rehabilitation treatments performed by the hospitals since 2004, and by the municipalities since 2007. https://sundhedsdatastyrelsen.dk/da/registre-og-services/om-de-nationale-sundhedsregistre/sygedomme-laegemidler-og-behandlinger/genoptraening		

Poland			National Center for Nutritional Education. A portal that spreads knowledge about nutrition and a healthy lifestyle. It includes verified information regarding basics of nutrition, healthy weight loss or choosing appropriate diet in relation to various types of diseases. http://ncez.pl/
Serbia			In order to increase visibility of projects, and foster sharing experience and lessons learned as well as communication between organisations, database for mapping of projects/programmes was piloted (www.prevencija.rs) However, at this moment, only small number of projects are currently registered

Vignette 2: Health in all Policies, Finland

To encourage health promotion and health equity through the decision making process a Health in All Policies (HiAP) approach is widely seen as the most effective way to ensure that health is embedded throughout all fields of government. HiAP is an approach to public policy that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. The country review questionnaires asked for information on what kind of inter-sectoral structures are in each country at different levels taking into account the Health in All Policies approach. A good example came from Finland. The essence of their approach is to have legislation that obligates all sectors of the government to take health and wellbeing into account.

The Finish Way

The concept HiAP was introduced by Finland in 2006 during its EU Presidency. However, work to incorporate a HiAP approach had started much earlier in Finland. A more systematic development of intersectoral action had already started in 1972, when the Economic Council of Finland, chaired by the Prime Minister launched a 'Report of the working group exploring the goals of health'. The working group summarized the key findings by stating that, "most of the measures required by the comprehensive preventive health policy are actually to be implemented in the areas of other sectors of society: economic policy, labour policy, housing policy, social welfare, social security, agriculture policy, traffic policy, trade policy and so on".

Since this report, a more systematic approach across all sectors for health and health equity has been an enduring effort in Finnish health policy. For example, to help support HiAP consultations on draft legislation, policies, and programmes are widely used and well-established practice in Finnish national policymaking. Consultations are not limited to ministries. They include NGOs, trade unions, the research community, the private sector, and municipalities. Citizens can also comment on the draft legislation through an online website available in Finnish or Swedish (www.lausuntopalvelu.fi).

National structures to support the implementation of HiAP

To support HiAP on a national level Finland has established a broad range of multi-disciplinary committees with a strong health focus that are led by different ministries. For example, the National Nutrition Council is run by the Ministry of Agriculture and Forestry and the National Committee on Health-enhancing Physical Activity is run by the Ministry of Education and Culture. Typically, these committees have members from all relevant ministries, NGOs, trade unions, the research community, the private sector, and municipalities. The purpose of the multi-disciplinary committees is to include health in though and decision making processes across different departments and levels of government.

To support national level work Finland has policies concerning health promotion and primary prevention that are implemented at local, regional, and national level. At the local level the municipalities and locally functioning non-governmental organizations implement the policies, whereas at the regional level health care districts lead implementation. Regional State Administrative Agencies have the role of monitoring implementation and offer educative seminars to municipalities and health care districts. These systems help to guide policy and the relationships between different sectors throughout the implementation stages.

To strengthen the presence of health throughout Finish law an integrated impact assessment (IA) of a proposal by the government to the Parliament is mandatory in Finland. The Ministry of Justice has published Common Guidelines for all the ministries to follow that define the procedures for the assessment and the impacts to be assessed. Health impacts are are a fundamental concern and are assessed as a part of social impacts. In addition to these assessments, there are mandatory impact assessments that also have a health component, for example, in legislation that is covered by environmental impact assessment (1994) and the Land Use and Building Act (2000). The role of these impact assessments is to mainstream the idea of health and health equity in all policies.

The Future…

The Finish Government is currently exploring whether there are new ways of working across sectors and how these could replace current working structures. A way of working across sectors is connected to the current Finish Government Programme. The sub-project 'Confirming cross-sectoral structures to take into account health, wellbeing and equity in all sectors early enough' started in 2015. This sub-project aims to develop a new model for cross-sectorial work and recommendations for action. The core of the new model consists of a description of how all sectors of government can best take into account the potential impacts of their decisions and actions on health, wellbeing, and inequality, and how they can promote health, wellbeing and equity in their work for all citizens.

GAPS AND NEEDS

The new and updated country reports again asked partner countries to identify what they felt were their gaps and needs in relation to health promotion. When considering the gaps and needs identified in the 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. 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, as expected there is slight variation between partner countries and this is related to the different ways health and health systems are organised, planned, and managed.

As explained in the previous section on funding, a major issue identified in the country reports was the lack of adequate funding for health in general and health promotion specifically. This is a major concern across Europe and was clearly experienced in partner countries. Appropriate levels of funding for health promotion is a key challenge. It is also linked to the need for strategic leadership that was reported by the majority of partner countries. The need for clear and strong strategic leadership on health promotion was reported in different ways by partner countries in the gaps and needs section. This includes a need for stronger emphasis on evaluation and monitoring mechanisms and procedures to achieve these improvements. It also entails a greater focus on the social determinates of health as a framework for health promotion to encourage a move away from the contested medical model of health. The development and implementation of structures and approaches in countries to promote health in all policies would be a big step in the right direction.

The main themes emerging from the analysis of gaps and needs identified in the partner country reports are outlined in Table 8.

Table 8. Key gaps and needs - themes by country

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, multidisciplinarity*	**Funding** *including inadequate funding/ lack of consistency/ dedicated funding.*	**leadership/strategic vision** *including political commitment, shifting priority/focus to prevention, leaders*
Bulgaria Croatia Cyprus Greece Estonia Hungary Iceland Ireland Italy Lithuania Poland Portugal Serbia Slovenia Spain Netherlands	Bulgaria Croatia Cyprus Denmark Estonia Greece Ireland Lithuania Norway Poland Serbia Slovenia Spain	Bulgaria Cyprus Greece Hungary Ireland Italy Lithuania Poland Portugal Serbia Spain	Bulgaria Croatia Denmark Estonia Finland Germany Greece Hungary Iceland Ireland Italy Lithuania Poland Norway Portugal Netherlands Serbia Slovenia UK	Bulgaria Croatia Denmark Finland Greece Hungary Ireland Netherlands Serbia Slovenia UK

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*
Cyprus Croatia Denmark Estonia Finland Greece Hungary Ireland Italy Lithuania Poland Serbia Slovenia Spain UK	Bulgaria Croatia Denmark Finland Greece Hungary Lithuania Poland Serbia Slovenia Spain	Greece Croatia Denmark Hungary Iceland Lithuania Serbia Slovenia Spain UK	Bulgaria Cyprus Hungary Lithuania Norway Poland Serbia Slovenia

DISCUSSION

The new and updated reports that have been compiled by the partner countries for JA CHRODIS PLUS offer an informed insight into the current health promotion and primary prevention landscapes, contexts, and capacity in their respective countries. The reports provide an overview of the different policies, processes, funding systems, examples of good practices, stakeholder management, and the gaps and needs in relation to health promotion and primary prevention. As the JA CHRODIS report summarised, there are differences in terms of health systems, structures, and promotion strategies between the partner countries. In addition, there are also differences in terms of capacity levels, funding for health promotion, and in the models and approaches underpinning their systems, structures, and policies in the partner countries.

The country reports indicate that in partner countries there is a mixture of centralised and de-centralised systems, where more powers are given to municipalities and cities. This is in accordance with partner countries reporting different overall approaches to health and health promotion. Some reports indicated the use of the social model of health including an emphasis on the social determinants of health as the foundation for policies. Other reports highlighted the continued use of epidemiological or medical models. As in the JA CHRODIS summary report these differences are reflected across the country reports including: policymaking, stakeholder involvement, and examples of good practice (i.e. process vs. outcomes/data).

Across the partner countries differences persist in policy development, implementation, monitoring and evaluation. Again, in accordance with the previous summary report the initial and development stages is still mostly a centralised process occurring within Ministries of Health at national levels. There a few notable exceptions. In Denmark, for example, the health system is based on a more decentralised model that relies on inter-sector collaboration between regions and municipalities. However, implementation is frequently devolved to local, municipal, and regional levels across partner countries.

A further area where partner countries reported differences is in the participation of stakeholders. This again, has changed little from the summary report in JA CHRODIS. Some countries have incorporated stakeholders and organisations into all the stages of development, implementation, and evaluation. Other countries have left stakeholders with a more restricted role. As with the previous summary report this means that stakeholder engagement ranges from little or none to active and structured engagement using recognised partnership approaches. A further difference in the partner countries relates to the extend to which Health in All Policies guidelines and approaches have been developed and applied to policy making. A notable example here is Finland where Health in All Policies is integral to the Finish Governments policy making technique.

The differences that were reported by partner countries are varied and diverse. The country reports reveal that countries do have similar processes, policies, and activities with others. Therefore, there is potential for countries to work closely together as they strive to adapt their health systems to meet the challenges of the present and future. The country reports also reveal many similarities and convergence between countries in terms of gaps and needs with regard to health promotion and prevention activities. The areas of funding, strategic leadership, and evaluation and research have been identified in the majority of country reports. All countries reported a lack of adequate funding as a need and this is corroborated with the amounts spent on

health promotion in partner countries. It is connected to the lack of political leadership and the limited attention health promotion receives.

The new and updated country reports asked partner countries to asses if and how the social determinants of health are used in policy and decision making. The reports do indicate an increased awareness of the social determinants of health within the health sector. However, this has not percolated through to the political arena in the majority of countries. As in the JA CHRODIS summary report, many countries identified capacity and capacity building as a key means of developing knowledge, competency, and skills. The country reports identified limited resources, knowledge base, education and training, and leadership as areas that require improvement. A clear theme that emerges from the country reports is the role of health promotion and how it is situated within either the chosen health model or system and within the perspective of governments, ministries, and departments throughout partner countries. The needs and gaps section that was compiled by country experts in their reports is an excellent mechanism to examine and develop the systems, policies, and practices in health promotion. As the JA CHRODIS country summary report concluded, the identification of the gaps and need will help countries to improve their health promotion offering and to encourage improvements between countries and regions in Europe.

An issue that persists from the JA CHRODIS summary report is the type, quality, and methodology used by the partner counties in their examples of good practices for health promotion. The differences range from actual practices, processes, or procedures to countries offering examples of programme or policy outcomes. As stated in the JA CHRODIS summary report, these all undoubtedly provide rich and important information. However, it would be beneficial for comparison and to build capacity to have a universal method to collect and analyse good practices across Europe. This would require the development of universal agreed criteria as well as a mechanism for distribution. The criteria would need to be able to capture and evaluate process, qualitative, quantitative, and formal research. This work was started in JA CHRODIS and is part of JA CHRODIS PLUS with a particular focus in inter- and intra-sectoral collaboration in good practices for health promotion.

Overall, the county reports demonstrate a wealth of good practices and an increased level of endeavour by partner countries. However, the country reports also highlight the partner countries are each working on health promotion in their own way, and that there is a lack of coordination between them. Therefore, the need for a linked up approach across the EU to tackle the complex issue of chronic diseases is urgent. Partner countries need to share knowledge and evidence of what works, where, and for whom, to stop them from replicating the same mistakes and to replicate successes. A central objective of JA CHRODIS PLUS is to use identified good practices from JA CHRODIS and see how they can be implemented in different social, cultural, and political contexts. The country reports will help in this work and in health promotion across Europe as they offer policy makers, researchers, and practitioners a first glimpse of what their country is doing and how this compares to other countries across the continent.

CONCLUSION

The complexity of chronic disease necessitates a multifaceted response. The country summary report from JA CHRODIS explained that while socio-economic development, 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. It is essential that we adopt an approach that guarantees that people remain a dynamic force in society for longer and we act to restrain rising healthcare costs. The best way to do this is to invest more money, focus, and energy in effective health promotion and primary prevention strategies that are proven to defer the commencement of chronic disease across the life-cycle.

The findings of this overview report as part of JA CHRODIS PLUS, as with the previous summary report in JA CHRODIS, indicate that despite the fact that a considerable amount of endeavour has been engaged in across Europe, there is still a crucial requirement to increase investment in health promotion and disease prevention. This is revealed by the low levels of expenditure across all partner countries. In addition, there is the urgent need to identify the most effective approaches to promoting health and addressing risk factors. This is an opportunity for European countries to work together to make advances in reducing the burden of chronic diseases. This needs strong, clear, and decisive political will. Strategic leadership is needed to encourage countries to work together on the basis of shared goals, concepts, and information in order to support and develop efforts in this complex field.

The country reports reveal clear divergence between countries with regard to the organisations and structures of health systems. This includes decentralised and centralised approaches to health and health care. However, there is strong evidence of commonalities with regard to the needs and gaps in health promotion and primary prevention. The country reports also reveal a rich array of new and good practices in relation to policies, programmes, and initiatives established within countries that have been developed at European levels. Improving the development and uptake of Health in All Policies approaches, using the determinants of health as the basis for health policy, and partnership working with nongovernmental organisations continues to be the best example of the benefits of working in a collaborative way across Europe.

The need to develop mechanisms to share information, examples of good practice, and support for capacity development in health promotion and primary prevention has been found to be a shared goal of the partner countries. It is a goal that is attainable and one that can lead to significant improvements in the quality of life of Europeans if achieved. The Joint Action CHRODIS PLUS will lead the effort in implementing good practices, exploring inter- and intra-sectoral collaboration, and encouraging resilient and better informed investment in health promotion and primary prevention.

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