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Health promotion policies for elderly—Some comparisons across Germany, Italy, the Netherlands and Poland

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ABSTRACT

Objective: The aim of this study is to compare health promotion policies (HPP) for older adults in four European countries: Germany, Italy, the Netherlands and Poland. We focus on the design, regulations and implementation of policies in these countries.
Method: As policy relevant information is mostly available in national languages we have approached experts in each country. They filled in a specially designed questionnaire on the design, regulation and implementation of health promotion policies. To analyze the data collected via questionnaires, we use framework analyses. For each subject we define several themes.
Results: Regarding regulations, Poland and Italy have a top-down regulation system for health promotion policy. Germany and Netherlands have a mixed system of regulation. Regarding the scope of the policy, in all four countries both health promotion and prevention are included. Activities include promotion of a healthy life style and social inclusion measures. In Poland and Italy the implementation plans for policy measures are not clearly defined. Clear implementation plans and budgeting are available in Germany and the Netherlands
Conclusions: In all four countries there is no document that exclusively addresses health promotion policies for older adults. We also found that HPP for older adults appears to be gradually disappearing from the national agenda in all four countries.

1. Introduction

Since the international conference in Ottawa in 1986 health promotion is an important and inseparable part of public health policy [1]. At that time it was thought that clear regulation of health promotion activities contained in policy would secure better health outcomes and prevent an unnecessary burden of disease [2]. To achieve this, the concept of "Healthy Public Policy" was introduced. This was later changed into "Health in All Policies" [1]. One specific domain are health promotion policies for older adults. Health promotion policies (HPP) for older adults include a wide range of programs from programs to increase physical activity for seniors, programs to alleviate loneliness and increase social participation, inter-generational activities in which older adults help young children to programs to acquaint elderly with new technologies like free of charge e-health applications for people older than 55. The importance of health promotion policies for older adults has also been emphasized by the WHO and the European Commission [2,3]. In the document entitled: "Healthy ageing: A challenge for Europe" in 2003, the European Commission emphasizes that health promotion policies should be based not only on improving physical health of older adults but also on long-term education, working longer and retiring gradually, and being involved in society. These documents also provide some examples of existing health promotion policies in EU countries. The document itself promotes cooperation between different sectors in the community in order to achieve active aging [3]. The WHO strategy entitled "The global strategy and action plan on ageing and health" published in 2015, emphasizes the importance of evidence-based health promotion policies. This document states that health promotion policies should be designed and implemented in accordance with evidence based findings and taking in account specific social contexts [4]. Despite these intentions and actions to stimulate health in all policies, it has proven difficult to

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design and implement health promotion and prevention policies in practice [6]. One of the reasons for this is the concept and the position of policy within the health care system. HPP are broader than health care policies in general and include many other aspects of life and society like schools, the physical environment, the way the public space is designed, the working environment, infrastructure and neighborhoods [7]. In this way health promotion policies are complex and usually saturated with political decisions [8]. Also individual policy measures on health promotion only rarely have a noticeable or observable impact and it is frequently a combination of health promotion interventions (and other interventions) that lead to noticeable change. This raises another obstacle as each new policy measure has its own pros and cons.

Previous studies have shown that key points of the success of health promotion policies are their design, implementation and regulations [9]. Regarding regulation, two types exist and they also influence the design and implementation of policies. One is known as top-down regulation - where the health promotion policy is a part of a national public health policy and its design and implementation is mostly defined at a national level [10]. The other approach is known as decentralized policies where local and regional authorities are directly involved in the design and implementation of health policy [5]. Some countries have a mixed system of regulation – the design of health promotion policy is determined by a national public health policy while the implementation and execution is done by local authorities. Sometimes these local authorities have quite a lot of discretion and autonomy in how to implement and execute these policies, so in practices these policies are more determined at the local than at the central level. For this type of regulation, national juridical acts are used as an umbrella to define broader measures and to provide some measure of coherence between local policies, while local and regional authorities are responsible for the design and implementation of more specific policy measures.

The top - down type of regulation is hierarchical and generally considered as inefficient. Since it usually does not have clear implementation plan, it might be neglected by local authorities. Furthermore, these policies usually do not account for local diversities and local needs [6]. The second type of regulation known as decentralized policies relies on the fact that local and regional authorities are better able to recognize the needs of the population and are more eager and able to implement health promotion policies that cater to the needs of the local population [11]. However, decentralized policy regulation is very often narrow and do not capture all the needs of the target population. For example, local authorities might underestimate the increase of chronic diseases at the national level if there are no currently registered cases within their local population. Another problem might be that local authorities are more likely and able to shift the costs to other parties, like neighboring communities or the central government level. Finally, the bottom-up approach leads to differences in policies between local communities, and consequently to differences in entitlements and in the availability of health promotion interventions between local communities. In the extreme, this may lead to differences in health outcomes between people living in different communities.

Besides regulation, the design and implementation of health promotion policies are also important. Regarding the policy design, the scope of the policies plays an important role. This include questions like what health promotion policies should address: only health promotion or also health prevention, do they need to describe regulation related to the fields that health promotion addresses (lifestyle or chronic diseases) or should they also focus on regulations related to health promotion interventions and their implementation [12]? Most of the existing research does not give clear answers to those questions and very often the scope of health promotion policies depend on the country specific context and are historically determined [1].

All three points, design, regulations and implementation are important for the impact that health promotion policies might have on health outcomes. Previous studies have shown that two main types of research to assess the impact of health promotion policies can be distinguished: the first focusses on the effectiveness of policies while the second focusses on the policy process [1]. The latter includes process evaluations of regulations (laws, who are the main stakeholders and what is the scope of the policy), the design (scope of policy) and implementation (who is responsible, the existence of an implementation plan and where the funding comes from). Although health promotion policies are recognized as an important part of "Healthy in All Policy" that can help to achieve both equity and efficiency in health care, there are still few studies that have addressed both the policy effectiveness and the policy process [5]. Most of the previous studies are from North European countries, Canada, Australia and US [5,8,11,13]. Studies from other European countries are still rare. Furthermore, most of the existing health promotions policies are focused on specific population groups like young adults and/or working adults. The number of health promotion policies that particularly focus on specific population groups such as older adults is unknown. With the ageing of the population all over Europe, assessing the existing health promotion policies for older adults provides insight that may help to improve the implementation of health promotion activities.

With the ageing of the population, policies to promote health among the elderly are becoming increasingly important. Healthy ageing is an ambition in many health policies. The aim of this study is therefore to examine the existing health promotion policies targeting older adults focusing on the policy process (design, regulations and implementation). For this purpose, we use data collected via a structured questionnaire filled in by experts in four European countries: Germany, Italy, the Netherlands and Poland. The organization and funding of their health care systems differ between these four countries. The same holds for the attention being paid to and the focus of the health promotion policies for elderly. Furthermore, those four countries also differ in their cultural and historical background, which also affects their health promotion policies.

2. Method

For the purpose of this study, we developed an open-ended questionnaire which was send to public health experts in four countries, one per country, so in total four experts were consulted. We have asked the experts from these countries about the existing health promotion policies for older adults since there are no academic publications that have described those policies in detail. Most of the policy documents are written in national languages and issued as internal documents among policy makers and other responsible stakeholders. The experts we rely on are selected for their academic knowledge, publications in the field of health promotion and willingness to participate in this study. The questionnaire was developed focusing on different aspects of the policy process for health promotion for older adults: the design, regulation and implementation of health promotion policies. We have asked the experts in the four countries to choose three main policy measures that represent best practices on health promotion policies for elderly in their country. Furthermore, we have encouraged the experts to consult experts from the government and the public health sector. For each of these policies we have asked them to describe the three main policy processes: how the policy is designed, what are the regulations and how the implementation is arranged. The questionnaire can be found in Appendix 1. We have

Table 1
Health promotion policies in four European countries.

Country	Type of health care system funding	Is there a specific regulation act related to health promotion policies for older adults	Who is responsible for regulation acts	Type of regulation
Italy	Tax-based	There is no specific regulation related to HP for older adults. Existing policy measures are part of broader documents related to public health and social security system	National institutions such as Ministry of Health and Ministry of Social Affairs are responsible for regulations	Top-down regulation
Germany	Insurance based	The regulation of HP for older adults is part of broader public health policy	16 federal governments but also social insurance fund	Mixed- model
The Netherlands	Insurance based	HPP for older adults are defined under the public health law, but also through the specific regulation acts developed by municipalities	Local municipalities	Mixed-model
Poland	Insurance based			Top -down

analyzed the data using the framework of thematic analyses. Based on the filled in questionnaires, we have defined themes for each of the aspects of the policy process. Within the design, we distinguish the following themes: what types of health promotion activities does the policy cover (prevention, primary, secondary or tertiary health promotion), to whom is the policy targeted (healthy older adults, older adults with some diseases etc.). Within the regulation part we have focused on the existence of a law or regulation towards health promotion policies for older adults, the responsible stakeholders, and the type of regulation (top-down, bottom up and mixed approach) [6]. Themes related to the implementation include: the existence of an implementation plan, the budget for implementation, the stakeholders relevant for implementation and the existence of an evaluation plan (including process, effect and economic evaluation) [1]. Those themes are chosen based on the existing literature. We use the results of the framework analyses to give a brief comparison of the four European countries regarding their health promotion policy for older adults.

3. Results

Table 1 shows that in two countries (Poland and Italy), HPP for older adults are top-down regulated, while in the two others (Germany and the Netherlands) mixed models prevail. This is in accordance with the regulation of HPP in general. If we compare the funding of health care systems, Poland has an insurance based system developed after the fall of communism, while Italy has a tax-based system. In both countries HP activities are perceived as a common good that should be delivered for free. HPP for older adults in these countries are top-down regulated by the central government that also has the responsibility for its financing. In Germany and the Netherlands, on the other side, HPP for older adults is regulated by a mixed – model characterized by a decentralized health care system and a combination of public and private financing. In the Netherlands and Germany there is a clear involvement of the private sector and NGOs in the design and implementation of the HPP. Both countries have shifted the responsibility for policy execution and evaluation to the local (the Netherlands) or the regional (Germany) authorities.

Table 2 shows in more detail the three main policy measures related to HP for older adults in the four countries. We present results for each theme per country.

In Italy, the three main policies for older adults (National Prevention Plan, Mission 24 and Solidarity Initiative) [14–16] are part of broader policy measures developed by the national government and the ministry of health or social affairs. This reflects the top – down regulation system towards health promotion policy in Italy. It is also visible that there is no policy measure that specifically targets older adults. The scope of the policies varies from primary to tertiary prevention. The responsibility for the implementation and funding mostly depends on the scope: the ministry of health is funding policy measures related to the prevention of chronic diseases while the ministry of social affairs is responsible for policy measures related to poverty. Most of the funding comes from general taxation which is in accordance with the funding of the Italian health care system. Only the last policy measure ("Awards for initiatives to promote active aging and solidarity between generations") which is rather an initiative than a policy measure is funded by the European Commission. This initiative is important as it is the only policy measure in Italy that directly addresses health promotion for older adults.

In Germany the health care system is insurance based (a combination of social and private insurance) and it is decentralized. As a part of public health policy, health promotion policies for older adults also reflect this decentralized system. This means that responsibility for health promotion policy in general and also for older adults is shared among the 16 federal states. The federal states also define the priorities in the scope of the policy measures. The decentralization of the health care system is also reflected in decentralized policy measures. This is the case with the National Action Plan ÏN FORM - the German national initiative to promote a healthy diet and physical activity". Although developed as a national initiative, the responsibility to implement and evaluate IN FORM is given to the 16 federal states. In this way the federal governments can develop implementation plans that cater to the needs of their citizens. They can also emphasize certain outcome measures if this better fits with the local context. This helps in developing an appropriate evaluation plan. Another successful example is the cooperation between the state level and the 16 federal states in Germany. It is reflected through the cooperation between the Federal Centre for Health Education (BZgA), a subordinate authority of the federal health ministry that has developed the policy for healthy and active ageing that is disseminated in cooperation with 16 federal states (regional level) [17,18]. On the other side, decentralization can also lead to a lack of an implementation plan – since every federal government might develop an implementation plan ad hoc and by itself during the health promotion intervention. An important stakeholder in the regulation, implementation and evaluation of health promotion policy in Germany is the social insurance fund. The main goal of Act to Strengthen Health Promotion and Preventive Health Care (July 2015) is not only intended to strengthen the position of health promotion in obtaining funding within social insurance fund, but also to strengthen the cooperation between the social insurance fund and the 16 federal governments in designing and implementing the health promotion policy [19]. The regulation of health promotion policies can be described as a mixed – model – most of the regulation comes from the 16 federal governments (comparable with regional level) but other stakeholders at the national level such as the social insurance fund are also involved. Furthermore, there are also some financial incentives from private insurance companies – people engaged in health promotion activities might have lower insurance premiums. In the Appendix we present some additional health promotion and

prevention strategies in Germany such as National Health Target "Healthy Ageing" (2012) [17,18].

In the Netherlands, the regulation of HP policy can be described as a mixed model. Although local municipalities are responsible for the design and implementation of the policy, the national government defines the general framework of the policy. Also, some funding is allocated from the national government to local municipalities for implementation. Besides the local municipalities, different NGOs (non-governmental organizations) and private organizations are also actively involved in the design, implementation and evaluation of HPP. In this study we describe three main HPP for older adults: the Nationaal Programma Preventie (National program on prevention, NPP), Samen tegen eenzaamheid (together against loneliness) and the Nationaal Programma Ouderenzorg (National program elderly care, NPO). The NPP is initially launched by the Dutch ministry of health but implementation of the program is done by the municipalities. This policy includes different health aspects from physical activity to decreasing depression for among older adults. Samen tegen eenzaamheid is the policy that addresses loneliness among older adults. It is initially launched by NGO's and implemented by municipalities. All these policies are based on a mixed-model – they are all conducted in cooperation with different stakeholders.

In Poland, regulation of HPP for older adults is top-down, with the national government as the main stakeholder. It is also observed that HPP for older adults do not exist as a separate policy. The three main programs related to older adults are: Assumptions of the Long-Term Senior Policy in Poland for 2014–2020, Government Program Stimulating Social Activity of Seniors 2014–2020 (ASOS) and The Programme "Senior +" (Senior – Wigor) [20]. All three programs are initiated and implemented by the government. It is also interesting that the Polish government pays special attention to the economic status of older adults and to social inclusion. In recent years, there has been more involvement of EU stakeholders through EU funded projects. Also, there are national policy measures that try to engage more NGOs and private stakeholders in the execution of HP activities for elderly. In most of HPP measures there is no clear implementation plan or clear budgeting.

4. Discussion

The goal of this paper is to examine the health promotion policies for older adults in four European countries. In order to get better insight in the policies in the four countries, we have used expert opinions. We focus on the design, implementation and regulation of HPP for older adults. The main conclusion is that in all four countries there is no document that exclusively addresses health promotion policies for older adults. In all four countries, HPP for older adults is part of the general public health policy while in some countries (Italy, Poland, Germany) it is also a part of social policy.

It is found that HPP within a general policy act (such as public health policy regulation) that clearly targets older adults, the chances for better implementation are higher. This is the case in Germany, where HPP for older adults are part of national policy measures that address the general population but with clear targeting of activities for older adults. On the other side, in Italy, general national documents do not specify activities for older adults. Consequently, in this case not all policy measures proposed are implemented.

In all four countries, we observe a shift in the scope of HPP: traditional health related topics such as prevention of chronic diseases are not very dominant in policy documents. Instead, HPP address topics such as prevention or promotion activities at work, better social inclusion of older adults and measures to decrease poverty among older adults. This is in accordance with the needs of older adults in society where most of them cope successfully with the risk of chronic diseases. Furthermore, they also prefer to participate actively in society – by working until or after age 65 and by engaging in social activities.

Our results show that regulation of HPP is related to the organization of the health care system. In countries such as Germany and the Netherlands, the health care system is decentralized and HPP are regulated by local/regional authorities in cooperation with the national government. This mixed-model allows different stakeholders to be involved. Furthermore, in those countries implementation and evaluation of HPP for older adults have clear pathways. On the other side, the top-down regulation that is present in Poland and Italy seems to undergo some changes. In those countries national governments are the main regulators when it comes to HPP. However, in recent years there is involvement of EU institutions – through EU projects and EU regulations (this is observed in Italy, where an EU project that started in 2012 addressed problems in HPP measures related to older adults). Also, there is growing involvement of NGOs in the execution of promotion activities in both Italy and Poland.

Our results show that the high expectations of HPP for older adults related to public health topics (primary, secondary and tertiary prevention) is disappearing from the national agenda in all four countries. The successful HPP that continue to exist include cooperation of different (private and public) stakeholders, require decentralized health and social systems and focus on social topics such as better social inclusion of older adults.

Limitations: In this study we have used expert opinions to analyze policy measures related to older adults. We are aware that this might lead to biased conclusions: experts focus on HPP that they deem most important for their field of interest. However, we consider that describing and analyzing HPP for older adults in four countries and the inclusion of national documents, contribute to a better understanding of HPP measures for academic and policy purposes.

Declaration of Competing Interest

None.

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Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.healthpol.2020.01.013.

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