

Health Promotion for Older People in Europe

Health promoters and their activities

Knowledge for training

Health Promotion for Older People in Europe

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Co-funded by
the Health Programme
of the European Union

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Scientific editon
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Warsaw 2017

Cover by Katarzyna Juras

Proofreading by Glen Cullen

On the cover Pro-Health65+ project logo designed by Jan Gandziarowski was used.

Organisation of work – Andrzej Kropiwnicki

Illustrated by VisuAll Works Ryszard Popiołek, Shutterstock



Co-funded by
the Health Programme
of the European Union

This publication arises from the project Pro-Health 65+ which has received funding from the European Union, in the framework of the Health Programme (2008-2013). The content of this publication represents the views of the authors and it is their sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or the Executive Agency for Health and Consumers or any other body of the European Union. The European Commission and/or the Executive Agency do(es) not accept responsibility for any use that may be made of the information it contains.

Publication co-financed from funds for science in the years 2015-2017 allocated for implementation of an international co-financed project.

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ISBN 978-83-7383-906-9

doi 10.7366/9788373839069

Preparation:

Scholar Publishing House Ltd.

ul. Wiślana 8, 00-317 Warszawa

e-mail: info@scholar.com.pl

www.scholar.com.pl

First edition

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Introduction to the book

This handbook on health promotion addressed to older people, which is written for readers in European countries, should function as **a training programme guideline for health promoters**. The authors are aware that it is an excessively ambitious task in light of the relatively poor scientific state of affairs in the field of health promotion. This ambition may be justified to some extent by the experience of the writing team, who acquired a considerable capital of knowledge as a result of '*Pro health 65+*' – the European project on health promotion addressed to elderly people and prevention of chronic diseases, which was carried out as a part of the second Health Programme of the European Union.

Health promotion has been present in serious documents and reports by the World Health Organization (WHO) for only 30 years (from the moment of announcing the Ottawa Charter in 1986). These documents and reports have become a guidebook for development of international and domestic actions aimed at health protection before diagnosis is made and before a disease is treated through use of medical knowledge, technology and professional staff.

Health promotion has become the main focus of actions taken by modern public health organisations, constituting – as it is called nowadays – the core of public health. It is also said that presently we deal with new public health, which is oriented not only at prevention of contagious illnesses but also at changing lifestyles and avoiding the risk of non-contagious chronic illnesses since these illnesses constitute the main threat to the health and life of the population. This mainly concerns prosperous countries where societies have begun to get considerably older, achieving impressive indexes of significantly longer life.

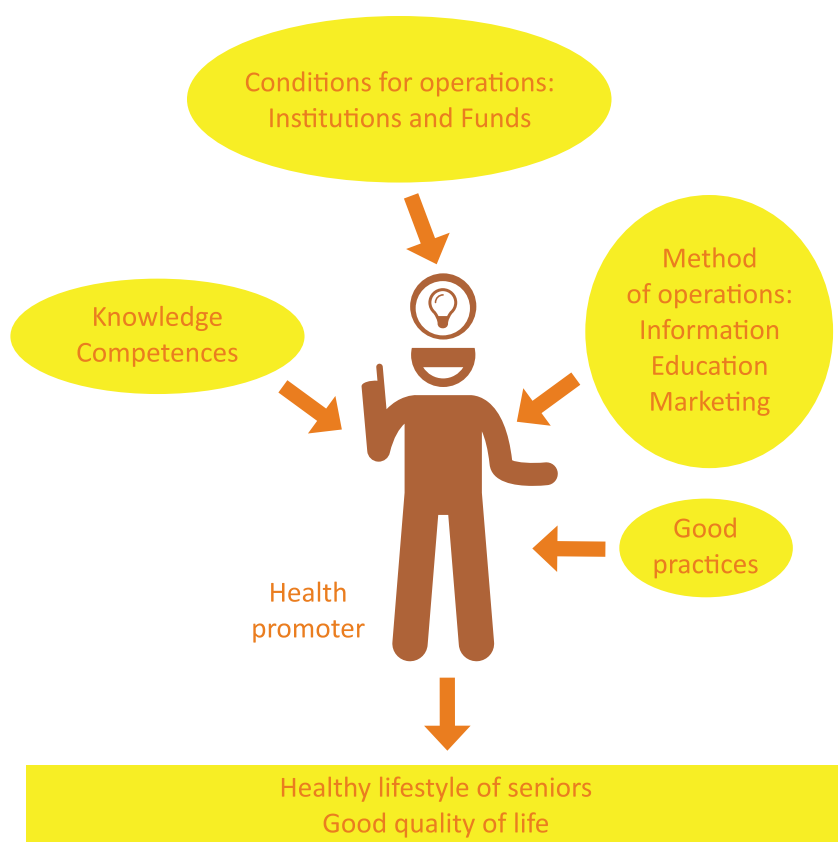
However, a longer life is not always accompanied by good health. Health condition rather deteriorates with age, initially slowly but dramatically more quickly at the end of life.

An unavoidable increase in the use of health and care services in ageing societies may be alleviated by publically organised, efficient, cost effective and professionally carried out health promotion addressed to the older population.

Health promotion, as practiced in European countries (and also in other world regions), does not only take place in the health sector, where it is usually clearly

demarcated by legal restrictions and actions taken by institutions. It is also carried out in other sectors and by other institutions as a part of various professionals' work. Health promoters may be doctors (particularly of primary health care), nurses (especially environmental ones), public health specialists, physiotherapists, dieticians, social workers, environmental health officers and relevantly trained teachers, in particular biology and physical education teachers.

Figure 1 Health promoter as a key actor in actions for healthy ageing



Source: author's own figure.

The expectations of a health promoter are presently great. This must be a professional who will convince people to change their behaviour, who will influence a permanent modification of a lifestyle, who will become a partner of the authorities responsible for health and who can be influential in the media to change the proportion between advertising products (particularly drugs) and the promotion of a healthy lifestyle, also at an older age. To do so, they must have strong foundations of

knowledge concerning efficient promotion and prevention methods and must utilise that knowledge systematically. Moreover, they need to be skilled in taking action and impacting others and must comply with the principles of public health ethics: to search for scientific evidence, know the health needs of beneficiaries, induce change by talking rather than forcing and encourage social participation. However, in practice there is no profession of health promoter and the representatives of medical and para-medical professions in which health promotion actions are undertaken cannot sufficiently carry out health promotion tasks in addition to their demanding medical duties. On the contrary, in many countries there is a deficiency of such staff. This is also true with regard to health care (treatment), which constitutes the biggest area of competition in employing people with the qualifications of health promoters. Figure 1 presents factors which help give shape to a health promoter's activity, aimed at improvement of seniors' quality of life.

Population ageing noticeably increases the demand for health promotion services. The authorities of many countries provide relevant funds for this purpose and create conditions for health promoters' work. They are supported by international organisations, mainly the WHO, and relevant departments of the European Commission through provided information, examples and guidebooks for operation. As a result, the health promoter's profile is taking shape; requirements and suggestions are being formulated.

We address this book to a health promoter for whom either this is their primary work or it is a part of other tasks carried out for the older population.

After three years of scientific work in a few European countries¹ the team of authors now provides examples of actions concerning health promotion addressed to elderly people, particularly those indicated as good practices. This does not mean that they have to be immediately applied in any country. They may require many conditions which need time for reform and education. Analysis and methodologically determined assessment of good practices constitute a basis for practices to be selected to be used in conditions other than those in which they were originally successfully undertaken. Being designated good practices is also significant evidence of the sense and effectiveness of the undertaken actions concerning health promotion as there is not always direct evidence from a population-based survey, which requires considerable expenditure and time.

¹ An extended survey was carried out in 10 European countries: in two wealthy countries of continental Europe, the Netherlands and Germany; in three countries from Southern Europe, Italy, Portugal and Greece, where lifestyle and climate conditions favour longevity; and in five countries of Central and Eastern Europe, Poland, the Czech Republic, Hungary, Bulgaria and Lithuania, i.e. in the post-communist countries with the biggest problems with regard to longer and healthy living. Reports on the institutional dimension of health promotion addressed to older people in those countries have been published in the first Issue of the 2017 Journal, *Zeszyty Naukowe Ochrony Zdrowia. Zdrowie Publiczne i Zarządzanie* [Scientific Issues on Health Protection. Public Health and Governance].

This book is also addressed to *policy makers* to make them understand the challenges facing the health protection system under the conditions of high ageing dynamics in European countries, in particular those of the Central and Eastern European region, and to incite them to undertake and support relevant actions to meet them. Longevity is undoubtedly an achievement of mankind and may be a social asset (not a burden) if health and social policy is oriented at creating conditions for activity and maintaining health and a good quality of life for the growing senior population. The role of professionally prepared health promoters is invaluable.

This handbook is a result of the teamwork of Polish, Italian, German and Dutch participants of the European project '*Pro health 65+*'. Stanisława Golinowska was the scientific editor of the book and co-author of the included chapters. The following people were the main authors and contributors of the respective chapters of this book: Stanisława Golinowska, Walter Ricciardi and Andrea Poscia with Andreia Jorge Silva da Costa (introduction, chapter 1 and 2), Agnieszka Sowa and Agnese Callamati (chapter 3), Maria Rogaczewska, Giovanni Capelli, Andrea Poscia, Milena Pavlova and Wim Groot (chapter 4), Stojgniew Sitko, Maria Rogaczewska Kai Huter, Andrea Poscia, Walter Ricciardi and Nicola Magnavita (chapter 5), Iwona Kowalska-Bobko, Walter Ricciardi, Andrea Poscia, Nicola Magnavita and Christoph Sowada (chapter 6), Alicja Domagała, Jelena Arsenijevic and Andrea Poscia (chapter 7), Maciej Rogala, Kai Huter and Agnese Collamati (chapter 8), Marzena Tambor and Nicola Magnavita (chapter 9).

We wish to thank all participants and experts of the '*Pro health 65+*' project from all Country Partners: the Netherlands, Italy, Germany, Portugal, Greece, Hungary, the Czech Republic, Bulgaria, Lithuania and Poland as well for inspiration, sharing knowledge and the support of our editorial efforts. Thanks to them, the authors of this handbook felt stronger and more convinced of their mission in the field of health promotion addressed to older people – a group which is sometimes disrespected as it becomes less independent with age.

We also wish to thank the reviewers and first readers of the handbook.

AGEING. ACTIVE AND HEALTHY

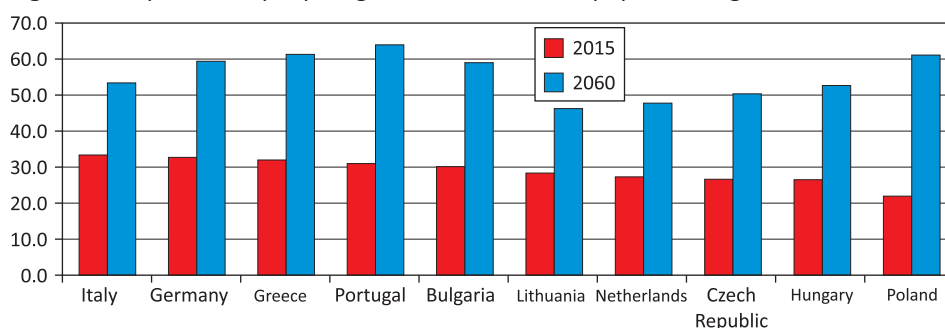


Ageing. European strategies of active and healthy ageing

The process of population ageing is *de facto* a demographic revolution of modern times. Presently it constitutes the highest challenge for mankind apart from climate change. This process initially concerned mainly the population of prosperous countries but now the ageing trend can be also found in countries where incomes are average and in some cases also low. According to experts dealing with the global dimension of ageing (as a part of the project titled “Program on The Global Demography of Aging”, <http://www.hsph.harvard.edu/pgda/working>), ageing in developing countries, contrary to wealthy ones, means a longer life for their residents in poor conditions since those countries have not yet achieved a sufficient welfare level and their population is now living considerably longer than in the recent past.

In European countries the index of *participation* of elderly people in the economically active population (15-64) and the ageing rate (65 and over in the entire population) are similarly high regardless of the level of prosperity. In one regard, Italy and Germany are leading, and in the other – Hungary and Poland are. Population projections indicate that post-communist countries, including Poland, will be leaders among the countries with the highest participation of elderly people (Figure 2).

Figure 2 Proportion of people aged 65+ in relation to population aged 15–64



Note: Data for the European countries participating in the “Pro health 65+” project.

Source: Eurostat 2016 Online.

A demographic revolution called a silent revolution, expressed by longer living of not only single persons but also considerable groups of the population, has already started (Rowland 2012). What will it mean for the mankind? What should our reaction be?

The questions yield various responses, sometimes more or less pessimistic (with regard to threats) and sometimes very optimistic (concerning assets). Each of them is supported by studies and forecasts of the impact of the demographic structural change on various spheres of human life. The answers are formulated mainly by circles of international experts in the form of requested strategies and programmes as a part of the operation of global organisations such as the United Nations (or its agency, the WHO) and in Europe as a part of planning work of the European Commission. In some countries responsible politicians supported by local experts also undertake specific actions aimed not only at relieving the effects of the ageing population but also sometimes at taking advantage of the economic and social benefits thereof.

The answers are related both to economic as well as social and health policy. In economic policy, methods of economic development are searched for despite the impact force of demographic factors which weaken the general work performance. Questions are posed concerning economic growth factors in the so-called silver economy which will include and stimulate the consumption needs of the older generation. Social policy considers such methods of ensuring the financial security of the elderly population that enable maintaining an inter-generation balance of financial redistribution systems. On one hand health policy analyses opportunities to ensure health care for the elderly population, whose health condition naturally deteriorates, and on the other hand considers how to alleviate the health effects of ageing so that elderly people are fit and independent as long as possible.

In this book we will focus on responses formulated in the concepts of active living in old age (active ageing) and healthy ageing since they support the health promotion and disease prevention of older people.

Active ageing strategy

The concept of active ageing was formulated by the WHO in 2002 in the form of the Madrid International Plan of Action on Ageing (MIPAA), which emphasises an equal right of elderly people to active living: work, social and political activity, participation in culture, etc.

The concept of active ageing assumes (and also demands) that elderly people will still be productive, professionally active, will learn and will be active socially and in their families according to their abilities and needs. Thus, they will be independent for a longer time, will sustain relations with others (in social integration), will count


on mutual help and get greater satisfaction from life. Simultaneously, policies will be carried out which enable this activity from the institutional and infrastructural perspective and will favour the removal of social barriers in further activity of elderly people.

The concept of active ageing has become the basis for many actions in the European Commission. Trends and basic content of active policies and drafts of operational programmes have been proposed (e.g. AGE Platform Europe 2011). The European Union announced 2012 the *European Year for Active Ageing and Solidarity between Generations* by initiation of favourable operations for seniors (ECORYS 2014). As a part of scientific research funded by the European Commission a research project devoted to analysis of assets of longer living was carried out (*Mobilising the Potential of Active Ageing*, MOPACT). It proved the existence of a considerable potential of individual and social benefits when a longer life is active and of good quality.

A list of indices of active ageing has been prepared (Table 1). It includes four domains: (1) further work; (2) participation in social life; (3) independent and secured life with access to health services; (4) environmental opportunities for active living. For each of them indices were selected and defined with reference to which results of relevant research carried out in the EU were presented (LFS, EQLS, EU-SILC).




Ranking of the active ageing index places post-communist countries, including Poland, in the lowest group of the EU countries². Taking into consideration the high dynamic of population ageing, this constitutes a great challenge for them.

Table 1 Active Ageing Index (AAI), 2015

Domain and its weight (total 100%)	Indexes	Indexes for analysed countries
Further work 35% 	Employment rate 55–74	Poland 22.4 Italy 23.0 Germany 34.4 Netherlands 33.9 EU-28 27.8

² As early as in the 80s a network of countries was formed at the global level, which have initiated legislation concerning support of the older population – Help Age International. They developed the Global Age Watch Index as a part of their operation, in which four domains of living conditions and capabilities (income security, health status, individual development capabilities, and access to environmental resources) were selected for assessment and described by 13 indices. Out of 96 monitored states from around the world divided into five groups on account of index value, Germany and Holland are in the first group and the second group consists of the remaining countries which participate in the ‘Pro-Health 65+’ project, except for Greece. This country is in the fourth group – in the 79th position.

Table 1 – continued

Participation in social life 35% 	(1) Volunteering, (2) Care for elderly, (3) Care for children and grandchildren, (4) Participation in political and social life	Poland 12.1 Italy 24.1 Germany 13.6 Netherlands 22.4 EU- 28 17.7
Independent and secure life with access to health services 10% 	(1) Physical activity, (2) Access to health care, (3) Independent life at the age of 75, (4) Financial security, (5) Safety in the place of living, (6) Further organized learning – LLL	Poland 64.9 Italy 69.0 Germany 74.7 Netherlands 78.9 EU-28 78.9
Environmental opportunities of active life 20% 	(1) Average life expectancy (LE) at the age of 55, (2) Share of average healthy life years (HLY) in the average LE at the age of 55, (3) Mental well-being (4) Use of ICT, (5) social connectedness, (6) Educational attainment – share of people aged 55–74 with tertiary or secondary education	Poland 47.9 Italy 53.4 Germany 55.8 Netherlands 61.8 EU-28 54.1

Source: according to UNECE and European Commission (2015).

Strategy of healthy ageing

Good health is a precondition for activity in longer life. At the same time activity favours health. Thus healthy ageing is strongly correlated with activity and this means that it may influence health condition by mobilising activity factors.

Numerous definitions of healthy ageing are currently in use. Some of them include a more medical perspective (maintaining balanced physical and mental health and fitness), others prefer a psychosocial approach, namely the possibility of exercising social functions in older age, which influences the quality of life³. Moreover, some definitions attract attention to prolongation of the length of professional activity as the main source of motivation for educational activity and care for health. In a European project carried out by The Swedish National Institute of Public Health in 2006 a definition of healthy ageing (or ageing and health) extensively includes the participation perspective. (*“Healthy ageing is the process of optimising opportunities for physical, social and mental health to enable*

³ Numerous definitions of healthy ageing were collected and analysed in the project “Pro health 65+” by Beata Tobiasz-Adamczyk. The selected examples and conclusions were presented in the article by A. Sowa et al., 2016

older people to take an active part in society without discrimination and to enjoy an independent and good quality of life”) (p.16)

In the report by the WHO on ageing and health (2015) healthy ageing is defined in a simpler and more individual way: it is a process of developing and maintaining abilities to function, which enables well-being in older age (*Healthy Ageing as the process of developing and maintaining the functional ability that enables well-being in older age*) (p.28).

In order to define the *well-being* of elderly people an attempt was made to create an index with analogical method as in case of active ageing⁴.

If we divide the life cycle into three periods (growing, adulthood and old age) then initial signs of ageing may present as early as the beginning of the second period. In the third period, the ageing process speeds up. There may be some exceptions to this path in individual cases; biological youth may be long or biological old age may start very early. From the point of view of the population which is in the third period of life, the concept of healthy ageing is interpreted as the possibility of continuing one's mental, physical, social and economic life even if the body is weaker and is limiting this process. The principal aspects involved in healthy ageing in older people are frailty, multimorbidity (that is the coexistence of many chronic illnesses), the loss of independence and social isolation.

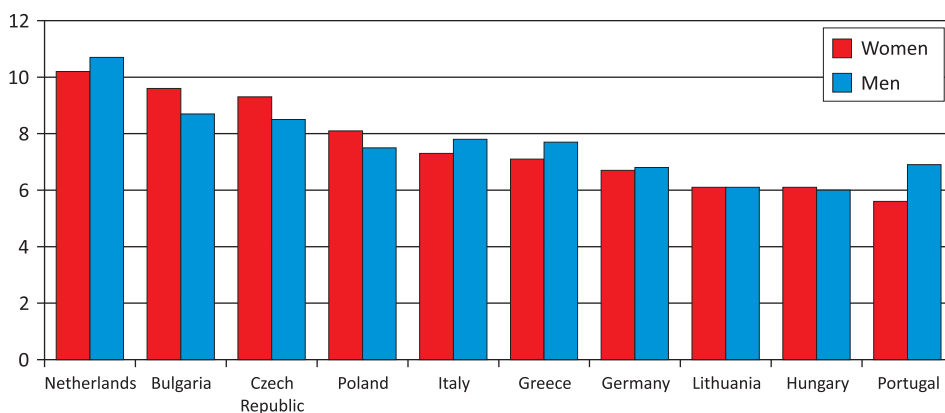
The following three groups of factors influence healthy ageing: the first one comprises internal factors embodied in a human being – the genes. The impact of genes is the object of intensive research, although results are not clear (Sanders et al. 2014). The second group consists of factors that characterise biological and social status: sex, ethnic group, origin, education, profession, financial status and lifestyle. The third group includes natural, social and environment factors. It also comprises institutional solutions carried out by health systems, both in the direction of supporting healthy ageing or not. To some extent these factors may replace each other. Losses in one group may be compensated for by factors from another group. This elasticity is the basis for the selective optimisation with compensation theory (SOC) (Baltes and Baltes 1990; Baltes 1993). This is based on the assumption that each individual at various stages of life aims at a balance between a selection of life aims, adjusting methods for their pursuit and replacing them in situations when the present methods are not suitable. Achieving a satisfactory life balance is more and more difficult in older age but, also, older people have the potential to

⁴ The index of wellbeing of elderly people called WILL (wellbeing in later life) was assessed for Great Britain in 2016 (<http://www.ageuk.org.uk/professional-resources-home/research/reports/health-wellbeing/wellbeing-research/> access date 9.01.2017). The indices which have the highest positive impact on wellbeing are participation in cultural life (social sphere) and physical activity (health sphere). The strongest negative impact is in case of health related indices: failure to diagnose a health condition, chronic illnesses and disability. Loneliness and financial instability have a negative impact too, but to a smaller extent.

cope with new situations and requirements *strengthened by learning and support of their environment*. Thus, there is a justified basis for action for the benefit of healthy ageing through “ignition” of proper factors.

An average duration of healthy life was assumed as a basic indicator of healthy ageing in the European Commission (European Commission 2007; Figure 3). An increase by two healthy life years (*healthy life years*, HLY) – without disability – has become an operational aim of the health policy in the European Strategy “Europe 2020”.

Figure 3 Indicator of average healthy life years (HLY) at the age 65.



Note: Data for the European countries participating in the “Pro health 65+” project.

Source: Eurostat 2016 Online.

Average healthy life years for a person aged 65+ in the analysed countries is 6–10 years as presented in Figure 3. In Bulgaria, the Czech Republic and Poland the period of healthy life (in well-being and without disabilities) is usually longer for women than men. In the remaining analysed countries, men have HLY indices the same as women or higher.

Achieving the healthy ageing strategy through social and health policy is a very ambitious aim for Poland and other countries of the region. It seems impossible to achieve it easily. Politicians, health promoters and the rising population of older people face a great challenge.

Conclusions

Ageing is a revolutionary change of the demographic structure which is occurring both in prospering countries and developing ones. The pace of this change will be particularly high in the coming years in the countries of Central and Eastern

Europe. The ageing process constitutes a challenge for social and health policy as well as economic policy.

Experts from the WHO and the European Commission have formulated strategies for coping with the population ageing process: strategies of active and healthy ageing, which are often combined. Both are oriented at the increased activity of the population in the second part of the life cycle (50+) when phenomena related to leaving the work market, limitations in efficient functioning in everyday activity and an increase of chronic illnesses occur.

Active ageing strategy emphasises conditions which favour professional work, social activity and independence in life, as well as environmental preconditions which support social participation and integration. An active ageing index (AAI), which enables supervision of the effects of actions taken in European Union countries, was suggested. The collected data and analyses (for three periods: 2012, 2013, 2014) locate Poland in the lowest group of countries which take actions for the benefit of active ageing. On the other hand, the Netherlands is a leader in the AAI ranking.

Taking into consideration the fact that older people inevitably lose their health potential, healthy ageing strategy emphasises actions in two directions: delaying health loss (i.e. health promotion and disease prevention) and improving health quality by combatting chronic illnesses and disabilities (health promotion, rehabilitation and support). The healthy ageing index has been proposed in particular countries to evaluate the realisation of this strategy. The increase of average life years by two years was identified as an indicator for realisation of the healthy ageing strategy. Is it achievable.

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HEALTH PROMOTION



Chapter 2

Health promotion generally and addressed to older people

Healthy ageing strategy emphasises the need to shift health policy more towards public health than health care (treatment), assuming that greater care for the health of the society will help avoid many burdensome illnesses and improve the quality of life during the biological ageing of the human body.

Health promotion and disease prevention are the core of modern public health. The main elements of health promotion were defined at a conference in Canada in 1986 when the Ottawa Charter for Health Promotion, also called the Ottawa Charter, was signed. It provides that the objective of health promotion is *enabling people to increase control over and improve their health*. Therefore, we should indicate and support actions which enable **control over individual health** – to maintain and improve it. For this purpose, we should provide information regarding the things that are good for and support health, advice, including motivation and support to acquire skills that help apply this knowledge in life, and support in undertaking related actions and pushing others (including politicians and the media) to do the same. According to what was assumed in Ottawa, health promotion has an equally (or even more) significant meaning for achieving health as other services of the health protection sector.

Health promotion is based on four assumptions which, according to John Kemm (2015), constitute its ideology. First, health is a positive value; second, protection of individual and group health is possible by means of relevant actions undertaken in a local environment and a change of lifestyle; third, measures and assessment of health may be applied in actions aimed at its protection; and fourth, health factors are equally distributed.

The assumed thesis is that health promotion and prevention of the main illnesses in the population constitute an alternative to the increasing costs of health care in longer human life. A second assumption is contained therein, stating that when undertaking actions concerning health promotion we base our choice of actions on scientific evidence of their favourable impact on health. At the same time we

can compare programmes which have similar effects in terms of their required expenditures and can select those which are most cost effective.

Actions concerning health promotion are based on knowledge which comes from many disciplines: psychology, sociology, communication and management, social marketing and medicine (Tzenalis and Sotiriadou 2010). They require a complex knowledge of many areas of individual human behaviour (cognitive, motivating), group behaviour (influencing and being influenced, mobilisation), institutions, legal possibilities and restrictions, public duties, orders and prohibitions.

The 10 Essential Public Health Operations

WHO Europe listed the 10 Essential Public Health Operations (EPHO) that define the field of modern public health for Member States in the WHO European Region.

EPHO 1 – Surveillance of population health and wellbeing

EPHO 2 – Monitoring and response to health hazards and emergencies

EPHO 3 – Health protection including environmental, occupational, food safety and others

EPHO 4 – Health Promotion including action to address social determinants and health inequity

EPHO 5 – Disease prevention, including early detection of illness

EPHO 6 – Assuring governance for health and wellbeing

EPHO 7 – Assuring a sufficient and competent public health workforce

EPHO 8 – Assuring sustainable organisational structures and financing

EPHO 9 – Advocacy communication and social mobilisation for health

EPHO 10- Advancing public health research to inform policy and practice

Source: WHO 2011.

Despite the fact that a complex scope of knowledge is applied, health promotion is subject to sceptical opinions concerning its effectiveness, particularly in the medical environment. This could be one of the reasons why public health in general, and especially health promotion, has long been weak and under-funded (Hemenway 2010). Overcoming this scepticism requires extensive population-based research over an extended period, numerous observations and comparisons. Collecting scientific evidence of the efficiency of promotion, prevention and analysis of the cost effectiveness of health programmes has become the focus of more and more valuable actions in the health protection system in recent years. An important example has arisen from the WHO “*Best-buy*” list that summarises the most cost-effective and feasible interventions (i.e. enforcing bans on alcohol advertising or promoting public awareness about diet) that allow countries of all income levels to reduce their non-communicable disease burden (Zarocostas 2011).

At the same time, investigations have developed and conclusions have been made as to the impact of social factors on health (social health determinants), which indicate the negative impact of bad conditions and an unhealthy lifestyle – prevalent in mass culture – on health. Michael Marmot and Richard Wilkinson (2003) collected wide knowledge on the health risks present in our lives, social pre-conditions and behaviour, and introduced it to the public health field. This provides the basis for promoting actions which aim at risk limitation, improvement of conditions and lifestyle change. It also suggested a more flexible approach to the requirements of establishing scientific evidence of the effectiveness of operations with regard to health promotion. A debate on this subject (e.g. Nutbeam 1999, Raphael 2000) leads to the conclusion that evaluation of health promotion actions should mainly include health problems in a particular environment and place.

Reference to such a good practice, where one can find similar resources and conditions but also similar values and a tendency to respect healthy lifestyle, proves the proper functioning of a health promotion programme. This does not mean that so-called scientific evidence is less important. It is always the most important of the applied criteria. However, programmes must be understandable and able to be adopted to have a real impact on individual behaviour. They are such when they respond to specific needs of specific people in a given place.

Various classifications are used in the operative determination of health promotion's scope. First of all, functions are specified (sometimes called health promotion methods). Secondly, types of pro-health activities and interventions are registered. Thirdly, places where people live, places where care for conditions enables achievement of better health, and institutions which are responsible for creation and efficient realisation of health programmes are indicated.

Methods (functions) of health promotion

The basis for health promotion consists of **information on health and diseases of the population and their determinants**, including how that information is formed. Health examinations, registration of diseases, epidemiology research, research on the health effects of environmental pollution and on risky health behaviour and lifestyles are used for this purpose. This information is then made available in the form of reports, media information and announcements. Presently, the packet of activities called e-health, which is available due to information technology, fulfils a significant informative function.

Screenings are sometimes included in the informative function of health promotion. On account of their diagnostic nature in treating diseases they are considered separately. Their results are addressed both to the tested persons as well as doctors and policy makers of the health sector in order to establish health policy with regard to allocation of health funds with reference to the screened group.

Health education constitutes another function (method) of health promotion. The education process deals with sharing knowledge on behaviour which favours (or harms) health as well as shaping and raising health awareness in society – which is fundamental. It results in health competencies in wider groups of society, defined as *health literacy*. In the process of education we usually have a teacher and a student. Health promoters are active in health promotion. They have knowledge about health and its prerequisite factors and they share it with people. In the next chapter of this book, the authors explain who is and who may become a health promoter.

Primary prevention consists in preventive steps taken to mitigate the risk of specific diseases, usually arranged by the health sector as they require some resource of medical knowledge. Primary prevention includes vaccination against infectious diseases and, with reference to chronic diseases, specific recommendations concerning the recognised risk of incidence (e.g. of ischemic heart disease or diabetes) are formulated. Along with development of population-based research more and more evidence has been emerging that strengthens the justification of such actions as beneficial not only for individuals but also for the society by reducing alternative costs which occur when sick people must be treated.

Advocacy regards influencing society (families, employers, media) and policy makers through advising, counselling, support and lobbying in order to raise the profile of health and healthy lifestyle in the society. As a result of these activities it is possible to create conditions (environmental, infrastructural and institutional) which favour health and eliminate threats and barriers to a healthy lifestyle. The need to propagate health results from the fact that various aims compete – both in political and private life. The first WHO documents devoted to health promotion (1986) raised the need of political engagement in health issues, showing health problems and threats, and indicating health pre-conditions and irregularities in health in order to intervene more precisely and effectively.

Social marketing is quite a new category which refers to the commercial product market, where a seller and client meet. However, in the case of health promotion selling the product is not an issue (although vaccinations may be an exemption) but rather, the focus is on ‘advertising’ the multilevel favourable effects of changes in behaviour and social campaigns regarding a specific health risk (Cheng, Kotler and Lee 2009).

There are **good practices** of new and innovative health promotion methods which carry out an active and healthy ageing strategy. Specific activities of health promotion and prevention of chronic diseases do not always find sufficient confirmation which complies with the required standard of medical research based on evidence. Systematic literature reviews and meta-analyses on the effectiveness of intervention with regard to health promotion addressed to older people as well as primary prevention of diseases prevalent in old age, carried out as a part of the ‘Pro health 65+’ project (Duplaga, Grysztar and Rodzinka 2016), indicate that the

amount of confirmed scientific evidence is still low but increasing. The insufficient amount of research on health promotion and disease prevention results from the fact that studies are usually population-based surveys which require a long period of repeatable observation of large groups. When there is a deficiency of such studies, other evidence is searched for, among which good practices are successfully identified, namely indication of executed actions, being undertaken currently, which bring favourable health effects for participants and often for the social surrounding. Defining good practices does not require scrupulous scientific evidence according to strictly determined standards with reference to each participant. However, it is required that these positive actions are repeatable, transferable to other places and cost effective (European Commission 2015). They should serve as an example of action in a given field for others. The European Commission supported the initiative of scaling good practices with regard to active and healthy ageing. In 2012 the European Innovation Partnership on Active and Healthy Ageing EIP AHA was founded. It creates a data bank of good practices and develops strategies of their implementation. In chapter 7 of this book selected examples of good practices, including some selected by EIP AHA, are presented.

Types of pro-health activities and avoiding the risk of a disease

Progress in epidemiological studies and the health of various populations over a long period of time and in various life cycles enables indication of the types of activities which are favourable for maintenance of health. The list gets longer and more precise. The following fixed behaviours, which comprise lifestyle, are the most effective areas to focus on with regard to health:

- physical activity;
- healthy eating;
- vaccinations;
- avoiding health risks, in particular smoking, excessive alcohol drinking, being overweight and falls;
- avoiding stress, developing emotional intelligence and intellectual activity, maintaining and developing social bonds and social integration to protect mental health;
- care for sexual health to avoid sexually-transmitted diseases.

Physical activity is the most significant kind of health promotion activity. Numerous reports of the WHO and scientific articles have proven the significance of physical activity and explained threats related to its deficiency (Warburton, Nicol and Bredin 2006). Mobility and physical exercises (which should not be mistaken with playing sports) are indispensable for correct development of the body and maintaining it in good condition (without being overweight) and fitness. A lack of systematic physical activity means a risk of cardiovascular system diseases and cancers, i.e. the

most dangerous chronic diseases. Development of the proper infrastructure in public places and in schools, work places, or houses where a group of people co-habitate is a precondition for regular physical activity for groups of people of various ages.

Healthy eating is another precondition of good health. Knowledge of proper diet for a group of people of varied ages, with various illnesses, is very extensive. The profession of a dietician, who supervises and advises on healthy eating, has been created. There are many scientific and popular journals on healthy eating. Moreover, information is available in health sector institutions. Despite that, a healthy diet is not popular. Bad eating habits on one hand and food producers' interests on the other, result in bad eating from the point of view of health. Industrial production of food, transport and storing which require suitable chemical substances cause that not only the manner of eating but also food itself can be a threat to human health. However, consumer interest has resulted in regulations concerning the obligation to inspect food and provide information on the composition of products and their shelf life being passed in the EU. However, this information is not always understandable and readable for consumers, in particular for older people. Thus, knowledge on the composition and quality of food products has become the subject of health education.

Excessive drinking, particularly of spirits, is a life threat. A fight against this habit is difficult because of the social role of alcohol and because treating alcoholism and its social effects is very expensive. WHO experts have developed a system for controlling alcohol abuse, *Global Information System on Alcohol and Health* (WHO 2014). Within this system, Europe is subjected to thorough observation and control, in particular of heavy drinking and evaluation of the efficiency of programmes that limit it since alcohol consumption is the highest in Europe and the effects for somatic and mental health are socially very burdensome.

Other bad habits, **especially smoking cigarettes**, which is the main cause of ischemic heart disease and lung cancers, threaten human health. Fighting with nicotineism and promotion of non-smoking have become flagship actions in health promotion. The EU drafted a frame convention on limiting tobacco use (*Framework Convention on Tobacco Control*, FCTC), which was then signed by all member states and became effective in 2005. The way it is applied falls under control, which is also carried out as a part of the second Health Programme of the EU.

Smoking cessation – an example from Poland

Smoking is considerably higher in the Central and Eastern Europe countries than in Western Europe. According to Eurostat, in Bulgaria, Romania and Poland smokers constitute 42%-52% (in Germany and Netherlands it is approximately 30%) of men aged 45–54 – which is the period where men smoke the most often in their life cycle. Seniors smoke less, but still it is from $\frac{1}{3}$ to $\frac{1}{4}$ of the male population aged 65+ (women 10%) (*Eurostat online*).

Diseases which result from smoking decimate men in their best years and cause their premature death. Thus, counteracting smoking is the main task of public health in the region of Central and Eastern Europe. In Poland, this task was initially undertaken not only by public authorities, but also by non-governmental authorities. **They are led by the “Health Promotion” Foundation which was founded in December 1991 in Warsaw by the initiative of Witold Zatoński – a professor of medical science.**

The foundation focuses on two types of operations: trainings and social campaigns. Thousands of health protection employees were trained in primary prevention of lung cancer and diagnosis and treatment of tobacco dependence syndrome. All training programmes carried out by the foundation are based on scientific evidence (*evidence and science-based trainings*) and prepared in cooperation with domestic and foreign experts.

The most popular social campaign of the foundation is **“Stop smoking with us”** which has its culmination each year in May (the World No Tobacco Day) and in November (Don’t Smoke Day).

The fact that millions of Poles have quit smoking is a measurable effect of all actions taken by the foundation as a result of the campaign. The incidence of lung cancer among middle-aged men has dropped by half since 1982.

Source: relation (expertise) from Witold Zatonski prepared for the project “Pro-Health 65+”.

Vaccinations protect against some infectious diseases. In the case of elderly people, they are mainly addressed with flu vaccinations. Each year, the flu is a serious threat to the health and even lives of elderly people. Flu vaccinations generally are not obligatory and in many countries they are paid for by the health system. Vaccination programmes constitute in practice one of the main prevention methods addressed at seniors.

Vaccination of older people – an example of inter-sectoral cooperation from Italy

Italy is one of the European Countries with the widest offer of vaccinations free at the point of use for its population and the recommended vaccinations for older people represent an early and interesting example of healthy ageing and inter-sectoral cooperation in this field. Since the 1999/2000 season, the Ministry of Health has provided an official recommendation for flu prevention, which has the objective to vaccinate almost 75% of the target cohort over 64 years old.

The vaccine campaign is performed every year from October to December. The vaccine coverage passed from 40.7% in the 1999/2000 season to 48.6% in the 2014/2015 season, with a peak in the 2005/2006 season, when 68.3% of citizens over 64 years old were vaccinated. Furthermore, since 2012, a collaborative project of several scientific societies (the Italian Society of Hygiene, Prevention Medicine

and Public Health (SITI), the Italian Federation of Family Paediatricians (FIMP), and the Italian Federation of GPs (FIMMG) realised the first edition of the “vaccination calendar for life”, which represents a first attempt to introduce a life-long approach to vaccine preventable diseases. The life-long calendar approach has been included in the National Immunisation Plan 2017–2019 and, starting from 2017 every person over 64 years could be freely immunised against influenza (yearly), invasive pneumococcal disease, herpes zoster, diphtheria, tetanus and pertussis (one dose each ten years).

The main actors of this kind of primary prevention at the local level are the health personnel within the departments of prevention, which directly or indirectly are accountable for vaccinations, and the general practitioners within the Italian health districts, which could vaccinate their patients in their practices. But it should be mentioned that the shift towards the above-mentioned life-course immunisation schedule was driven not only by health professionals and their scientific societies, but also by a strong partnership between politicians, governmental and academic institutions and non-government organizations. Among the latter, the “Happy Ageing” Alliance should be mentioned because it represents a collaborative effort across seven organisations, ranging from health professionals [the Italian Society of Hygiene (SITI), the Italian Society of rehabilitation (SIMFER), the Italian Society of gerontology and geriatrics (SIGG) and the Federation of local health authorities and municipalities (Federsanità-ANCI) to trade unions (elderly sections of the CISL, CGIL, UIL, ACLI], with a strong commitment towards the promotion of policies and initiatives targeted at the health and wellbeing of older people. Furthermore, this alliance plays an important role in the citizens’ awareness and empowerment, realising several communication campaigns to promote healthy ageing with an innovative and appealing approach. For example, the yearly immunisation campaign for influenza has been carried out putting together a famous showman and a very popular jingle, both very known and appreciated among the older people.

Other than advocating for the protection of older people against vaccine preventable diseases, “happy ageing” is also actively involved in the promotion of physical activity and healthy eating among the elderly according to the holistic active ageing approach.

Source: Poscia et al 2016 and 2017.

Prevention of falls and accidents constitutes a considerable group of actions concerning health promotion towards the elderly. At the age when so-called body fragility occurs, falls cause bodily injuries, which require hospitalisation and serious medical interventions. Many times, they result in death. Statistical data on falls among elderly people indicate an almost “epidemic” of this phenomenon (WHO 2007; Eurosafe 2015), although there are countries (e.g. of Southern Europe: Portugal, Spain, Greece) in which this problem is not dramatic. Accidents happen

most often at home or around the house and are related both to faulty or unadjusted devices of the closest surrounding as well as unsafe behaviour or an underestimated weakness of the senses and low energy (bad eyesight, bad hearing, lack of balance or the ability to lift). They happen more often in residential care institutions and women suffer more often from health problems as a result of falls. A list of actions concerning fall prevention has been determined and recommended and undertaken programmes and interventions have given good results. Firstly, they include physical activity aimed at strengthening muscles and maintaining balance. Supervision of medicines taken, supplementation with vitamin D, good glasses and hearing aids are crucial. Adjusting an apartment for a weaker body or movement to a safer place is the next essential step in preventing falls and accidents. Providing supervision and ongoing care to an older individual is also invaluable. In the EU, fall prevention programmes, which constitute a considerable amount of activity, are carried out by the above mentioned European Innovation Partnership on Active and Healthy Ageing, EIP AHA (European Commission 2015).

Health promotion programmes for older people more often include **programmes which aim at mental health protection and maintaining intellectual capacities**. The mental dimension of health strongly depends on society: on difficult living conditions (poverty and homelessness), a low level of education, loneliness, lack of family and friendship bonds, bad relations in the work environment and personal dramatic experiences. Elderly people suffer many losses not only related to health. They lose their peers and partners. They suffer pain as a result of many diseases, they more often become victims of violence, get depressed when society rejects them and they withdraw. Depression and dementia diseases including Alzheimer's disease represent the dark side of longevity and they are becoming a mass problem of ageing. Therefore, it is not strange that they are a subject of health promotion and disease prevention despite considerable difficulties in clearly indicating successful prevention methods. However, mental health protection programmes in the general aspect and addressed to older people specifically are being developed and carried out at both the global (WHO 2000; 2004), and the European levels (Jané-Llopis and Anderson 2005; European Union 2016) and in many individual countries (e.g. the Netherlands and Finland). On account of the wide scope of the pre-conditions of mental health, mental health promotion programmes and programmes preventing mental disorders are carried out not only by professionals of the health sector, namely by doctors of Public Health Care and health visitors or psychiatry specialists or clinical psychologists but also by many actors and stakeholders in peoples' lives: public administration institutions in the place of living, religious and social organisations, professional associations and business environments. Actions for the benefit of mental health require not only medical professionalism but also psycho-social sensitivity and the existence of social capital in the places where people live. According to experts (WHO, 2004) mental health promotion includes actions which consist of:

- activating people to participate in cultural and educational events, engaging them in the operation of local organisations and activating members of those organisations to give support;
- help and support in arranging friendship networks which are oriented at similar hobbies, experiences and occupational interests;
- supervision and interventions in the case of limited freedom and violence;
- organising economic support through improvement of employment possibilities and help in employment or in finding a place to live, improving living conditions;
- improving access to relevant help and care and the possibility of calling psychological help in emergency situations;
- arranging specific informative and educational actions which concern physical and mental help.

The international environment has recently strengthened appeals and pressure related to care for mental health. The World Health Organization developed an action plan for 2013–2020 (WHO 2013) and in 2015, the first world conference with ministers of health of the countries which are members of the United Nations was organised to oblige them to undertake more specific actions (WHO 2015). They focused on indication of relevant institutions (governmental and non-governmental), preparation of necessary data and carrying out suitable scientific research and determination of indispensable financial and staff resources. An appeal for actions related not only to suitable treatment of mental diseases and the quality of life of sick people and their families, but also to research indicating the risk of mental diseases as well as undertaking counteracting programmes was a significant element of the conclusions from the global meeting.

Nutrition in Alzheimer's Disease – an example from Portugal

Within the scope of the National Programme for the Promotion of Healthy Eating, the Directorate-General of Health in partnership with the Virtual Center on Aging created a manual that addresses the role of nutrition and a healthy lifestyle in the prevention and progress of Alzheimer's disease. The manual titled "*Nutrition in Alzheimer's Disease*" aims to compile and organise what is known about the influence of nutrition in the prevention and progression of Alzheimer's disease. The authors address the most appropriate nutrients and eating patterns (Mediterranean diet and MIND diet), provide information regarding the scientific evidence of the preventive role played by the consumption of fish, vegetables, fruits and legumes. They give special importance to the consumption of complex B Vitamins (B2, B6, B12 and folic acid), A, C, D, K and E Vitamins, Selenium, Homocysteine and omega 3 fatty acids, as well as the prevention of the consumption of copper or aluminum contaminated foods, as they seem to promote the appearance and progression of Alzheimer's disease.

The role of caregivers is highlighted in this manual and advice is given on practical care to be taken when feeding Alzheimer's patients.

Source: Sousa 2014.

Health promotion in the place of living

Current analyses and postulates presented mainly by the WHO raise the problem of promotion and the requirements of good conditions for health in popular and everyday settings. This idea has born fruit with the concept of health promotion based on the place of living (*settings based approach* – SBA) and as a result, with numerous health programmes such as: 'healthy city', 'healthy school', 'healthy university', 'healthy company' or 'healthy hospital'. The concept of implementation of health promotion principles in settings (schools or work places) has earned recognition, although more often these are places with a smaller scale (schools or workplaces) rather than the space of the entire city.

Setting based health promotion programmes, more and more popular in many countries and regions, include such elements as:

- health promotion in the workplace and prevention of professional diseases;
- health protection in health care ("healthy hospital") and social ("senior's healthy home") institutions and prevention of infections resulting from living in group residential institutions;
- health protection in the place of living (e.g. movements like "healthy cities");
- presence of healthy life values in each community (*community health*);
- healthy home;
- healthy media (propagation of a healthy lifestyle and not advertisement of medical or quasi-medical products).

The conditions in which people live everyday depend on them to a limited degree and more often depend on owners and managers of such places. Can ensuring healthy conditions of stay be considered a guideline for actions? Certainly, some standards concerning hygiene are known and maintained (checked by sanitary inspection services), while more efficient health promotion actions consist in accurate indication of the entities which are authorised and are competent to use suitable programmes and which are responsible for their performance. This approach, which may be called the *sector based approach*, answers the question of who can start, finance and implement a programme. Such an institutional approach has been used in the analyses of the 'Pro health 65+' project on which this handbook was based (Golinowska 2016).

Health promotion addressed to older people

Many papers and reports pay attention to the fact that health promotion should be carried out from the youngest age. The earlier people understand what influences their health, what behaviour is health-risky and learn to control it, the more complete the outcome will be. A well-known American handbook on health promotion throughout the life span (Edelman, Mandle, Kudzma 2014) which has been published in eight editions, does not omit older people but it is mainly devoted to promotion and prevention in the first years of life starting in the prenatal period. Therefore, is it not too late for health promotion addressed to older people? The main factors of chronic diseases and disability risk among this population may have occurred in earlier stages of life but when they are still present in older age, chances for healthy ageing are limited. The reasons for undertaking health promotion programmes addressed to older people are complex and are not restricted to ethical and bio-ethical standards and those that derive from human rights. There are many serious reasons that the undertaken programmes for this group of people bring proven health effects. However, the younger the target group is, the less visible the effects are. Simultaneously, arguments related to the needs and choices of older people are indicated. Seniors are becoming more aware of their health and its deterioration with age. Thus, they have greater motivation to undertake preventive measures and request health services which will stop deterioration of the quality of life due to diseases and limited fitness.

The need to maintain independence is an additional motivation for older people to participate in health promotion programmes. For this reason, the desire to know how to cope with many chronic diseases is greater than in a younger population which is short-sighted in this regard. The aim of maintaining independence in older age is strengthened by the practice of seniors participating in the decision-making process concerning health policy. This requires *empowering* older people politically and in some papers empowerment is considered almost as an ethical method of health promotion e.g. in the texts by Per-Anders Tenglanda (2007, 2012) and also in the WHO reports (e.g. Wallerstein 2006). When older people are given a voice they will accept such solutions which are understandable and acceptable for them. Forcing them to change behaviour or even just intensive pressure causes mental discomfort and is much less efficient while, at the same time, it does not meet the ethical standards of the health promoter (doctor, teacher)-patient relationship.

Conclusions

Health promotion is a modern field of public health which focuses on both individual behaviour as well as on creation of general possibilities and health

favouring conditions in communities and certain settings. Actions related to health promotion are undertaken professionally both in the health sector and outside it. Effective health promotion programmes require activities in the local environment and defining institutional responsibility for their initiation and execution.

Along with progress in population-based research, there is more and more scientific evidence of the health effects of health promotion and the possibility of preventing diseases as a result of healthy living. These effects may be obtained at various levels of expenditures. Assessment of the efficiency of health promotion programmes is the next step for health promotion actions. Their operations are the subject of evaluation with regard to their cost efficiency. Health promotion and primary disease prevention, to a significant extent, constitute an alternative to health care services i.e. treating diseases.

In health promotion, both traditional (information and health education) as well as modern (e.g. social marketing) methods are applied. Good practices, collected in information banks and developed methods of their replication in other places are indicated.

Among many universal types of activities concerning health promotion and disease prevention, such as physical activity, healthy eating, avoiding excessive alcohol drinking and smoking cessation, there are special actions addressed to older people which are more and more often related to mental health protection and prevention of falls and accidents.

Health promotion addressed to older people is rationally and ethically justified. It is socially advantageous and desired by older people.

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OLDER PEOPLE AND THEIR HEALTH



Older people and their health status

Older people, suffering from chronic diseases more frequently than their younger counterparts, are in this book the main target group for health promotion and chronic disease prevention activities. When we say “older people” we are aware that this group is very heterogeneous, both in terms of age, living conditions and health. At the same time, the older people are, the worse are their conditions. The ageing process also varies in its dynamics. For some people it is gradual and gentle, for others it is almost unnoticeable until their health status rapidly worsens. Professors of medicine from Stanford University formulated a morbidity compression theory in 1980 which states that life expectancy in good health increases faster than life expectancy itself, moving the period of the burden of chronic diseases to the final years of life (Fries 1980).

Defining demographically different groups of older people requires, while introducing the subject, an indication of the period in which older age begins. An age after which we consider people older is a convention which can change, and is related to demographic and social processes, especially with increasing healthy life expectancy, increasing needs of social participation of older people, and changes in the perception of their social roles. Peter Laslett (1991), who divided human life into three large periods, devoted his analysis to the emergence of the third age, which is the oldest age. He related it to economic activity and productivity. Based on longitudinal data, Laslett showed that the period of ceasing economic activity is shifting upwards. Following that, the border of older age was shifted in official demographic statistics. Until recently in its statistics and demographic reports the UN assumed the age of 60 as the beginning of older age (sometimes the UN still uses this convention). Nowadays it is rather the age of 65 that has become broadly accepted by the European Commission.

The next step in defining differentiation of longer life in old age is related to isolating the so called fourth age (Rowland 2012). This is in many cases a period of dependency, in which a person requires care. This period is short on average, although it varies between countries.

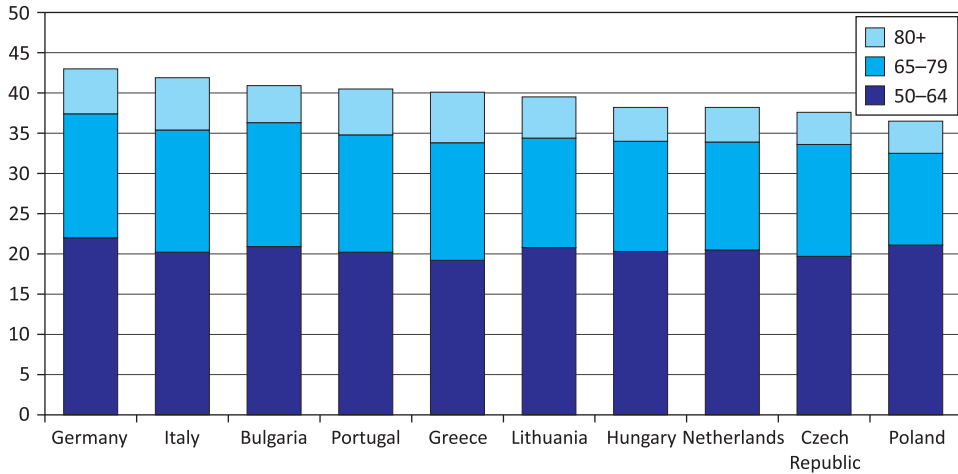
Demographic and social structure of the older population

In the Pro-Health 65+ Project, the results of which constitute the basis for this workbook, three groups of people in older age have been distinguished.

- The first group comprises **people who are only entering the period of older age, at the age of 55–67**. These people are usually still professionally and socially active (in pre-retirement age). At this age the first more serious health conditions occur, and are often chronic. Therefore health promotion and disease prevention, especially regarding chronic diseases as well as occupational risks, is very important. Activities in the area of health promotion and disease prevention directed to this age group are usually conducted individually in the context of occupational medicine or primary care, but in many countries cardiovascular diseases and cancer screening programmes are also implemented at the community level.
- The second group comprises **people aged 67–80/85**. These people have entered retirement and are typically inactive in the labour market, although they are still active socially and in their families. Activity in this age group is inevitably related to better physical and mental health. In this period of life, health promotion and disease prevention is organised in the framework of multiple programmes and interventions, mainly in the local community, aimed at maintaining physical, social and cultural activity, health education and information as well as education in other spheres of life. The type of intervention depends on local conditions and the individual characteristics of older people: their level of education, capabilities stemming from health status, life style and family situation.
- The last group is composed of the oldest people, **above 80/85 years**. These are people with a far worse health status, among whom care needs are rising. Health promotion in this age group, although it still might bring positive health effects, is often conducted indirectly, in cooperation with family and care providers. Actions and interventions in this age group should account for individual health and living conditions: living at home, using day care or living in an institution.

People in these three age groups account for 40% of the European population. About half of this group are people aged 50–64 who will enter the ageing phase in the years to come. People aged 67–79 constitute from 11% (Poland) to over 15% (Germany) of the population. The oldest people, above the age of 80, constitute from 4% (Poland) to over 6% (Italy, Greece) of the population (Figure 4).

Figure 4 The share of mature, older and oldest old in the population of European countries



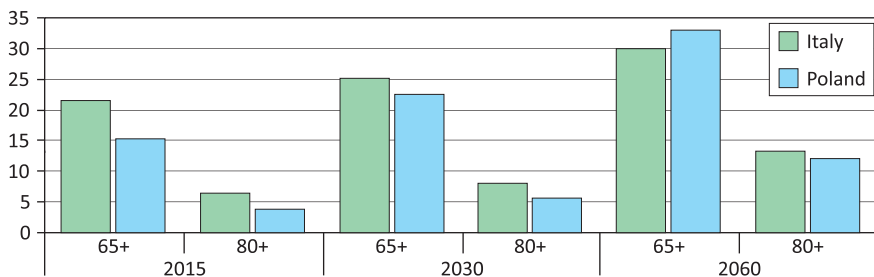
Note: Data for the European countries participating in the "Pro health 65+" project.

Source: Eurostat 2016.

Changes in the demographic structure of the older population in Italy and Poland

The structure of the population will substantially change in the coming decades, with an increasing proportion of older people. At the moment, Italy is the most aged society in Europe, while Poland is only entering the ageing phase. The share of people aged 65 or more will increase from 22% to 30% in Italy and from 15% to 32% in Poland between 2015 and 2060. The share of the oldest old, aged 80 or more, will double (increase from 6% to 13%) in Italy and triple (increase from 4% to 12%) in Poland (Figure 5).

Figure 5 Projection of changes in the proportion of the older people in the total population in Italy and Poland, 2015–2060



Source: Eurostat [proj13_ndbims].

In response to the growing older cohorts central and local governments are undertaking various initiatives aimed at addressing the ageing phenomenon by monitoring demographic and health changes, promoting healthy and active ageing or addressing growing care needs⁵.

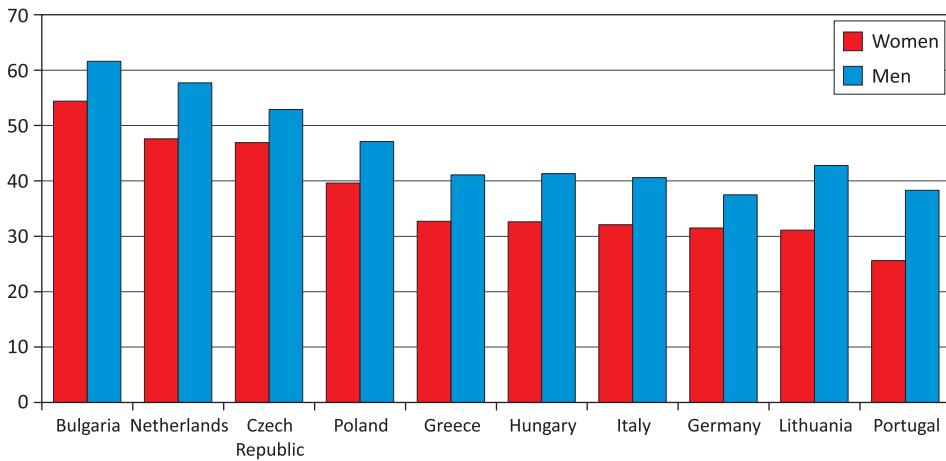
Differentiation of the life expectancy of older people in European countries

The average life expectancy in European countries is substantially growing. In 1990 it did not exceed 77 years in any European country. Today, Italians, whose average life expectancy amounts to 83.2 years, are among the longest living Europeans. The Dutch, on average, live 81.8 years and Germans 81.2 years (data from the Eurostat database, 2014). The average life expectancy in the countries of Central and Eastern Europe is also increasing, but remains lower than in Western European countries. On average, the highest life expectancy in Eastern Europe is in the Czech Republic – 78.9 years and Poland – 77.8 years. In Hungary life expectancy is slightly lower – 76 years. It is worth noting a huge change that has taken place over the past 25 years, during which the average life expectancy in Poland and in the Czech Republic has increased by 8 years. Marek Okólski (2005) points out that the increase in average life expectancy can be attributable to a decrease in mortality due to circulatory system diseases resulting from a healthier lifestyle (i.e. smoking cessation, enriching diet with fruits and vegetables available throughout the year, not only seasonally, a decrease in consumption of animal fats) and increased access to medical care and technologies allowing for quick, life saving interventions, which is particularly important in regards to cardiovascular system diseases. In the countries of Central and Eastern Europe a decrease in environmental pollution has also been important for health status improvement. According to the analysis of the National Institute of Public Health – the National Institute of Hygiene (2012) the increase in the average life expectancy of Polish males results from a decrease in excessive mortality before the age of 65, while among females a decrease in mortality was especially present in the older population (above the age of 65). Still, the difference in life expectancy of men and women is high. In Western Europe women live on average 4 years longer than men, whilst in Central and Eastern European countries it is 6 to 8 years longer. It is worth remembering that, while women enjoy longer life, they have a greater risk than men of chronic diseases, especially circulatory system diseases, diabetes and musculoskeletal diseases.

⁵ In Portugal for example the “International Day of Older Persons” was celebrated with the theme “*Leaving No One Behind: Promoting a Society for All*”, the Directorate-General of Health launched the report “*Portugal. Older Ages in Numbers*” to give a special focus to the population group aged 65 or over, following the launch of the annual reports of the “*Health Priority Programmes*”.

An increase in average life expectancy means extension of life in older age. According to the Eurostat database, the average life expectancy at the age of 65 in Italy amounts to 21.2 years, in the Netherlands to 20.1 years and in Germany to 19.9 years. In Central and Eastern Europe life expectancy at the age of 65 is lower. In 2014 in Poland it amounted to 18.4 years, in the Czech Republic to 18.1 years and in Hungary to 16.9 years. On average, older women live 3 years longer than men in Western Europe and in the Czech Republic. In Poland this gap is larger, reaching 5 years.

Figure 6 The share of healthy life years (HLY) in the average life expectancy at the age of 65 (%)



Note: Data for the European countries participating in the "Pro health 65+" project.

Source: Eurostat 2016.

According to the Eurostat data, inhabitants of the Netherlands enjoy the longest period of living in good health and without disability in older age. The healthy life years (HLY) are estimated in this country at 10.2 years for women, which constitutes 54% of their lives at the age of 65, and 10.7 years for men, which constitutes about 62% of their lives at the age of 65. The shortest period of life in good health in older age is observed in Portugal and Lithuania. In Lithuania healthy life years at the age of 65 are estimated at 6.3 years for women, which constitutes only 32.7% of their lives, and 5.9 years for men, which amounts to about 42.1% of their lives at the age of 65. The HLY indicator, although important in European policy, should be interpreted with some caution in cross-country comparisons. It is estimated based on mortality on the one hand and subjective health status assessment on the other. In the case of the older population it is vulnerable to overestimating the mortality of the younger (productive age) population and subjective valuation

and perception of respondents' own health and abilities, which could be culturally driven and different across countries.

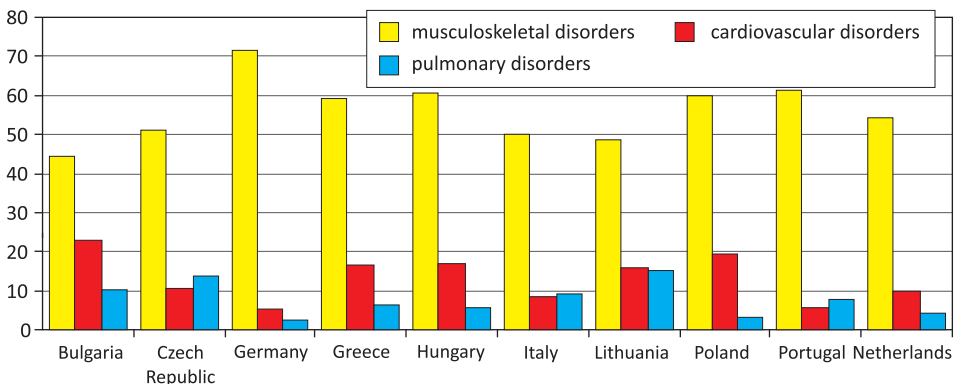
Health problems increasing with age

Life in older age, especially after the age of 60, is characterised by occurrence of health problems, worsening over time, which often become chronic, lasting 6 months or longer and in many cases coexisting (Poscia et al, 2015). The phenomenon of living with two, three or a higher number of chronic conditions is referred to as multimorbidity. According to various estimates, this condition affects 50, 60 or even 80% of the older population and increases with age.

Chronic conditions result from the natural and progressing ageing of the body and its organs. Eurostat data (2016) show that, at the age of 50–64, approximately 30% of Italians and 50% of Poles are already suffering from some type of chronic illness.

Considering the increase in the duration of working life (from 32.4 to 34.1 years on average in the 10 selected European Countries between 2004 and 2013) and the increase in the average employment rate of workers between 55 and 64 years (25.8% between 2005 and 2014), the disease prevalence in this age group has serious implications for their professional activity (i.e. the opportunity to stay longer in the labour market) (Magnavita 2017). The existing significant differences in the prevalence of work-related health problems of older workers, as shown in Figure 7, call for the implementation of effective health promotion strategies, which should be integrated with the work safety and environmental programmes and policies with the common aim of improving and maintaining the health of older workers (Poscia 2016).

Figure 7 The share of European older workers (55-64 years of age) reporting different work-related disorders (%)



Note: Data for the European countries participating in the "Pro health 65+" project.

Source: Eurostat LFS 2007.

The share of people suffering from chronic conditions in the population increases with age. Analysis of the health status of older Europeans shows that chronic illnesses occur in about 65% of the population older than 65 (Onder et al. 2015) and reach around 85% in Italians older than 75 (ISTAT 2014). From this perspective, comorbidities, particularly chronic illnesses, are an immanent element of life in older age and a challenge for healthcare systems and long-term care. Coexistence of multiple chronic conditions is the most frequently reported by inhabitants of Central and Eastern European countries (Eurostat 2016). In Poland, Slovakia and Hungary 75–80% of people aged 65 or more complain about these diseases. In Germany and Italy it is about 65% and in the Netherlands it is 50%. Less frequent declarations regarding chronic diseases might indicate better health of the older population as well as better conditions for preventing and dealing with diseases thanks to access to healthcare services and new technologies. Moreover, societies of Western European countries are on average wealthier, they spend more on healthcare and their population entering older age live, on average, in better conditions than the population of the post-communist countries of Central and Eastern Europe. At the same time, regardless of location or declared level, chronic conditions are more frequent among women than men.

Data on the existence of illnesses typical for old age usually comes from surveys and often covers different sets of diseases or different aged cohorts. Nevertheless, it makes it possible to shine a light on the actual health status of older people and to make careful comparisons. Cardiovascular diseases are among the most common in the population older than 65. They are also the main causes of mortality, especially in Bulgaria and Hungary where they constitute over 50% of deaths in older age (WHO 2016). Survey research conducted in Germany points out that circulatory system diseases are reported by 21% of women and 31% of men aged 56–74. In Poland, according to the PolSenior survey, hypertension is observed in more than 70% of men and 75% of women aged 65 or more (Mossakowska et al. 2012).

Illnesses of the musculoskeletal system are a typical health problem in older age, largely contributing to functional limitations. According to a Hungarian study, rheumatic diseases, arthritis, osteoporosis and other illnesses of the bones are reported by approximately half of the population aged 60 to 70 (Daróczy 2005).

In older age the risk of diabetes also increases. It is estimated that 40% of the Polish population aged 65 or more has diabetes, but in about half of the cases this condition is not medically recognised or adequately treated. Most importantly, untreated diabetes leads to various complications and even premature death. The costs of treatment of diabetes is very high. According to the International Diabetes Federation, Diabetes costs around 9% of total health expenditure for people 20–79 years of age (International Diabetes Federation 2016).

With age, the functioning of the senses – hearing and vision – deteriorates. The Polish study PolSenior (Mossakowska et al. 2012) showed that about 50% of people

aged 65 or above have vision problems and 30% report hearing impairment. In Hungary the situation is similar. Problems with vision and hearing deterioration are reported by 10% of the population between 60 and 70 years of age.

Chronic diseases are common in the so-called fourth age (above the age of 80) and are reported by 85% of the population (Onder et al. 2015). Similarly to the population aged 65–79, the most common health problems include musculoskeletal illnesses and circulatory system diseases. In Germany 64% of women and 46% of men above the age of 75 declare illnesses of bones and joints, 35% of women and 40% of men report circulatory system diseases (Robert Koch Institute 2015). In Poland almost 80% of people above the age of 80 suffer from circulatory system diseases (Mossakowska et al. 2012). Diminished functioning of the senses affects about half of the population.

Health problems, especially above the age of 80 are often related to cognitive decline. The first symptoms may occur as early as in the fifth decade of life and are related to ongoing neurodegenerative processes. The severity of limitations resulting from cognitive function decline depends on a combination of individual (genetic) factors and social factors related to education, professional activity, social environment and lifestyle (Poscia et al. 2015). A certain percentage of older people develop dementia, which is a group of symptoms affecting memory, leading to a cognitive and social decline and decreasing independence. Data on diagnosed dementia show that the problem affects about 2% of the Italian and German populations, 1.5% of the Dutch population and about 1.3% of the Czech and Polish populations (Alzheimer Europe 2016). According to the estimates of the OECD and the European Commission (2016), the problem of dementia affects 1.5–2% of the population aged 65–74, 12% of the population above the age of 80 and even 40% of the population above the age of 90. The problem of dementia will intensify with the continued ageing of the population.

It is worth noting that the above listed health problems significantly contribute to decreased quality of life in older age. Older people often complain about a reduced life satisfaction, distraction, difficulties in performing everyday activities and rituals. They face sleep disorders and excessive fatigue (Křížová et al. 2010). These symptoms contribute to mental health deterioration, and in some cases, especially in combination with loneliness and social exclusion, may lead to depression.

Main risk factors of poor health in older age

The health status of older people depends on various factors: social position, income, type and intensity of professional activity throughout life, family situation, environment, living conditions, access to medical care and rehabilitation and pro-health activities undertaken throughout life.

Among the main risk factors increasing the probability of illnesses and disability in older age there are a lack of physical activity, an inadequate diet, smoking cigarettes or using other tobacco products and alcohol abuse.

Lack of physical activity is one of the most important causes of health status deterioration, but in many cases it is also a result of poor health in older age. Research conducted in Germany shows that less than one in five people aged 60–69 is regularly physically active. In Italy the lifestyle of 44% of older people is sedentary and, according to the PASSI D'ARGENTO surveillance system, older age, being female, facing depression symptoms, economic difficulties, being overweight or obese, suffering from social isolation, vision or hearing problems and carrying 3 or more chronic non-communicable diseases are independent risk factors for physical inactivity (Cristofori 2014). The lack of physical activity in combination with a diet rich in fats and poor in fruits and vegetables often results in obesity, which becomes a common problem in older age, contributing to the development of cardiovascular system diseases or diabetes. Recently, growing literature is suggesting that diet, together with physical inactivity, could have an impact on sarcopenia (Marzetti et al. 2017). An international study “SPRINTT” (Sarcopenia and physical frailty in older people: multi-component treatment strategies) is one of the largest clinical trials aimed at frailty prevention by multi-component interventions, including physical activity, nutritional advice and supplements together with the use of innovative technologies (Martone et al. 2017).

Obesity is becoming a common problem for European societies. According to the European Health Interview Survey (EHIS) data published by the Central Statistical Office in Poland (GUS), 28% of people aged 60–69 are obese (BMI – Body Mass Index – equal or higher than 30). Similar obesity indices are observed in the Czech Republic where about 30% of people aged 60–69 are obese, while in Germany it concerns 23% of people aged 65–74 (Robert Koch Institute 2015).

Obesity is less frequent among the oldest old, above the age of 80 (11% in the Czech Republic, 18% in Poland and Germany), while frailty becomes a significant health problem since it reduces functional abilities and increases the risk of falls and injuries. Falls are the leading cause of hospital admissions in older patients. According to hospital statistical data in almost half of all cases falls result in bone fractures, in every fourth case in bruises and in 5% of cases in serious head injuries (Eurosafes 2015).

Despite the widespread knowledge of the dangers related to smoking cigarettes and using other tobacco products, smoking is still frequent among older people. Every fourth older person in Poland, every fifth in the Czech Republic and every tenth in Germany smokes. The smoking incidence, however, decreases with age and the number of smokers above the age of 80 is substantially lower. In Poland it is then only 5% of the older population. When health problems occur, these persons

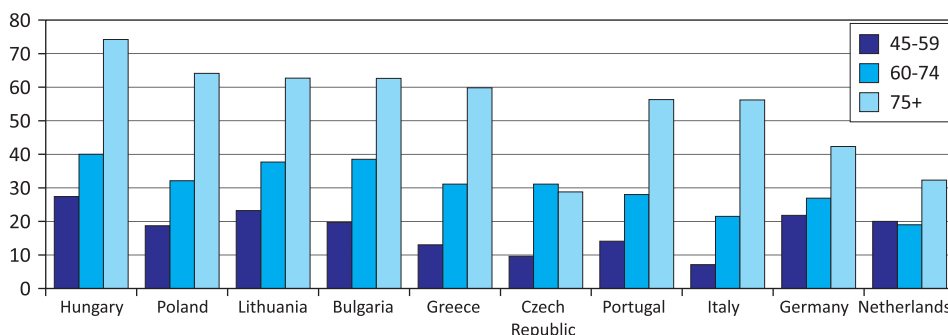
typically decide to quit. As shown in Central Statistical Office studies (GUS 2016), healthy people smoke more frequently.

Similar tendencies are observed in the excessive use of alcohol, especially for binge drinking, which is particularly health damaging. On average, every fifth adult in European countries drinks excessively and more frequently these are men. Although risky drinking is more common in the younger population (20-30 years of age) and represents a source of concern in the workplace environment (Magnavita et al. 2014; Venturelli et al. 2017), it might also become a problem above the age of 60. Every fourth older person in Germany and the Czech Republic declares binge drinking. In Poland 10% of people aged 60–69 and about 5% of people aged 70 or above declare binge drinking (drinking more than 6 standard portions of alcohol at a sitting) once a month (GUS 2016).

Functional limitations in the everyday activities of older people

Chronic diseases contribute to functional limitations in everyday activities. The onset of functional limitations depends on several factors including types and sequence of chronic conditions, social context and lifestyle. Particularly, dementia, diabetes and falls resulting in disability contribute to the occurrence of functional limitations. Functional limitations are more common among women than men and increase with age. According to the European Survey of Health and Social Inclusion of 2012, at the age of 50 about 20–30% of the population declares some limitations in everyday activity resulting from health. At the age of 60–74 this share in most of the countries increases to 30–40% (except Italy and the Netherlands where it is lower) and above the age of 70 it reaches 50–75%. Among the selected countries, disability and functional limitations are more frequent in Hungary, Poland and Lithuania and less frequent in Italy, Germany and the Netherlands (Figure 8).

Figure 8 Disability and functional limitations in selected European countries, 2012



Note: Data for the European countries participating in the "Pro health 65+" project.

Source: Eurostat, European Health and Social Integration Survey, (EHSIS) data [hlth_dpeh005].

Potential for activity and good health in older age

Despite health problems and frequent functional limitations, older people remain active, although the level of activity gradually declines and depends on individual capabilities and social environment: economic status, education or access to adequate infrastructure supporting activity. People aged 50–64 are typically mobile and ready to be professionally and socially active. They are involved in family life, often becoming carers of their grandchildren, spouses or other dependent relatives. They often engage in volunteering, social work and activities of religious organisations. In more traditional countries like Poland religious organisations are in fact centres of not only the religious, but also the social activity of older people (Rogaczewska 2015).

Although engagement in social life decreases with age and is lower among persons with poorer health status, adequate stimulators might encourage them to undertake social activities, especially activities that are health beneficial (Galenkamp, Deeg 2016).

Awareness and acceptance of prevention and health promotion among older people is increasing. Vaccinations together with a healthy lifestyle contribute to a decreased risk of diseases or their severity and lesser limitations caused by diseases. Analysis undertaken in the *Pro-Health 65+* project (Sowa et al. 2016) shows that older people undertaking health beneficial activities: physical activity, regularly consuming healthy food, drinking adequate amounts of liquids and not smoking, more frequently enjoy better physical and mental health. A healthy lifestyle, even above the age of 80 is beneficial for health and quality of life. Obviously the level of activity has to be adjusted to individual capabilities and expectations of seniors.

The beneficial effects of a healthy lifestyle are visible not only in the population living at home, but also among people living in residential care institutions. In the *Pro-Health 65+* project we observed that institutionalised people who are – accordingly to their capabilities – physically active and who lead a healthy lifestyle face a lower mortality risk (Collamati et al. 2016).

Conclusions

In a dynamically ageing society older people become as important a target group for health promotion and prevention as younger cohorts. The older population, however, is heterogeneous. A long period conventionally defined as “older age” can be divided into subperiods (subgroups of older people) based on criteria of health status and functional abilities.

In the pre-retirement period we deal primarily with older workers. These people are prone to occupational risks. Compared to the younger population, the prevalence of musculoskeletal system disorders, circulatory system diseases and

pulmonary system diseases increases. At the same time employers are not always responsive to the needs of older employees and do not invest in improvement of working conditions to adjust work places to the decreasing capabilities of older workers due to poorer health status and occurrence of diseases. Age management strategies are not commonly applied by European entrepreneurs (Magnavita et al. 2016, Poscia et al. 2016).

After entering retirement, which is typically after the age of 60, a large portion of the older population is still active, also professionally. Health status gradually worsens, but it allows for continuation of previous activities and involvement in new ones related to postponed dreams and plans (i.e. travelling, learning in new fields, gardening, pets) or new family and social challenges (i.e. caring for grandchildren, voluntary work). Students of third age universities, social activists and patients of SPA treatment often recruit from this group. At the same time health status in the third age worsens: osteoarticular diseases and cardiovascular diseases become more frequent. The risk of diabetes increases; sight and hearing deteriorate. However, this group can still be affected by health promotion and disease prevention.

The fourth age, after the age of 80, is a period of rapid health deterioration when restrictions in functional abilities become more significant. Illnesses of bones and joints and cardiovascular diseases are common in this group. Mental health also deteriorates, with an increasing risk of depression, anxiety and dementia. Due to the progression of diseases, social involvement decreases and the need for nursing and care increases. Nonetheless, a satisfactory quality of life can be achieved in this period of life as well by motivating people to be active and supporting them in their activity.

Knowledge on disease specifics in different periods of life constitutes a backbone of formulating adequate strategies of health promotion and disease prevention. Good sources of knowledge on health status, morbidity and limitations, but also on the needs of the older population are national (i.e., in Poland, PolSenior, PASSI D'ARGENTO surveillance) and international survey research. Reliance on reliable research and using it to formulate adequate prevention and promotion actions is a prerequisite for their efficiency, both in social and cost terms, especially when we address the period of older age, when the severity of diseases progresses.

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HEALTH PROMOTERS



Chapter 4

Health promoters

The present chapter discusses efforts to shape the profession of health promoters and to establish the competencies necessary to carry out professional health promotion. The chapter is based on a literature review and results of research conducted within the project *Pro-Health 65+*, particularly an overview of practical solutions gathered as part of the collection and analysis of best practices in health promotion, as presented in chapter 7.

Profession of health promoter

The profession of health promoter does not yet exist in a regulated form. However, in parallel with the development of the new field of public health, where health promotion plays a particular role, the competencies of a health promoter have been being defined and consolidated for a number of decades.

A health promoter is a general label for a constantly expanding group of professionals and experts who promote health through their work in a broad and positive sense, help to develop and maintain the optimal psycho-physical condition of the population and focus on disease prevention. According to the wording proposed by Anastasios Tzenalis and Chrisanthi Sotiriadou (2010), health promoters are representatives of an ever more vivid profession whose mission is, in particular, to ensure concrete, practical implementation of strategies and public health policies and the recommendations of international agencies (such as the WHO) and government bodies. They carry out these strategies and recommendations by: (1) empowering individuals and their families; (2) working towards social responsibility and public accountability for the health of citizens (e.g. on the part of public authorities and businesses); working towards the creation of health-oriented institutions and communities (e.g. schools engaging in health promotion, health-promoting municipalities etc.); (3) effective leadership; (4) building partnerships and networks (*ibidem*: 54).

Health promoters may operate at one level or at two or three levels in parallel: the individual level (one-to-one contacts), the social/community level⁶ as well as the institutional level (health promotion in primary health care, at the workplace, in nursing homes, etc.). Regardless of the scale of their work, health promoters are constantly developing their competencies in accordance with the principle of lifelong learning, in order to strengthen their professional and ethical legitimacy among all other professionals working in the health care sector.

The health promoter profession and the accompanying professional ethics procedures, mission and standardised set of competencies are developing along three parallel tracks.

(1) On the one hand, efforts are being taken to incorporate knowledge, skills, attitudes and values related to effective health promotion into existing professions, primarily medical ones (Kemppainen, Tossavainen and Turunen 2012). The idea is that medical professionals should be more involved in comprehensive health education targeted at different population groups. The majority of doctors and nurses undertake a number of steps related to health promotion and they do it individually, often on their own initiative. The box below provides examples of such activities undertaken by nurses.

Examples of health promotion tasks incorporated in the occupation of a nurse

- Individually helping patients and their families in making decisions conducive to health
- Informing patients and their families about the various possibilities associated with a healthy lifestyle
- Interacting with patients, actively communicating with patients, listening actively, encouraging patients to assume greater responsibility for their own health (patients' empowerment)
- Volunteering in local communities (e.g. working in clinics for the poor)
- Cooperating with other institutions and sectors (e.g. the social work sector)
- Taking measures to prevent chronic diseases and lifestyle diseases (e.g. encouraging patients to abandon bad habits, to quit smoking, etc.)
- Health education targeted at various groups
- Getting involved in specific interventions aimed at changing the behaviour of individuals or their families.

Source: Kemppainen et al. 2012.

Anyway, this idea is well established in the history of the medical education, since the Hippocratic Oath requires new physicians to swear they will prevent disease.

⁶ See, e.g. an interesting concept of health equity zones, developed in urban communities in the USA: <http://www.health.ri.gov/projects/healthequityzones/> accessed on 10 Dec. 2016

The current Italian version stresses the importance of health promotion and health education in several clauses – see box below (FNOMCEO 2014). Furthermore, also other health professionals, i.e. midwives or environmental health professionals, also receive specific public health and health promotion training during their academic courses.

**Extract of the Italian version of the Hippocratic Oath
related with health promotion**

Art. 3. General Duties and competencies of a physician.

- In order to protect individual and collective health, the physician practices skill-based activities [...]

Art. 5. Promoting health, the environment and global health

- The physician, considering the living and working environment and the levels of education and social equity as key determinants of individual and collective health, cooperates in the implementation of appropriate education policies and of preventive and counteracting actions to health inequalities. Furthermore he promotes the adoption of healthy lifestyles, informing about the main risk factors. Based on available knowledge, the physician will undertake relevant communication on exposure and vulnerability to environmental risk factors and promote proper use of natural resources for a balanced ecosystem which will be liveable for future generations.

Art. 13. On prescriptions regarding prevention, diagnosis, cure and rehabilitation.

Art. 42. Information on sexual health, reproduction and contraception

In order to protect individual and collective health and conscious and responsible procreation, the physician provides individuals and couples with all relevant information on sexuality, reproduction and contraception.

Art. 55. Health Information.

- The physician promotes and implements accessible, transparent, rigorous and prudent medical information based on acquired scientific knowledge. He does not spread information that arouses unfounded expectations or fears or, in any case, that could undermine the public interest.
- The physician, in collaboration with public institutions or private individuals in the field of health information and health education, avoids direct or indirect advertising of his own professional activity or services.

Art. 75. Prevention, care and cure of physical or mental dependencies

The physician is committed to the prevention, care, clinical recovery and social reintegration of the person suffering from any form of physical or mental dependence. He respects the rights of the person and cooperates with families as well as, public or private social and health institutions or associations.

Source: FNOMCEO 2012.

Nevertheless, the educational path of both doctors and nurses is focused on illness and health problems in the body, their diagnosis and treatment, limiting the acquisition of competencies in health promotion, unless they attend dedicated public health courses (Hemenway 2010).

Recently, it should be highlighted that several institutions are trying to overcome this limitation, reshaping the curricula of medical students by introducing the concept of population medicine (George 2015; Ivory 2013; Dysinger 2011; Ornt 2008) or creating dedicated post-graduate courses (Mello 2015). Population medicine, is not a new specialty, but is rather an epidemiological approach to the management of clinical services, which has been developed under the awareness that clinicians in the 21st century have a responsibility to the population they serve and to the patients they never see, as well as to the patients who have been consulted with or referred. Clinicians practising population medicine are required to use their charismatic and sapiential authority to promote health and prevent disease and to encourage sustainable care, getting the best balance of benefit to harm (Gray 2013).

(2) On the other hand, efforts are being made to provide an accurate description and standardisation of the competencies of the health promoter as a separate profession, with its own educational path, procedures, standards and continuing education path. This is the case, for instance, in Australia, as described in the document issued by the Australian Health Promotion Association (AHPA 2009). In New Zealand health promotion exists as a job.

Health promoter – description of the job in New Zealand

Health promoters may do some or all of the following:

- develop policies, strategies and programmes for improving health
- work with other agencies to co-ordinate health promotion programmes
- advocate and lobby for health promotion causes
- work alongside schools and community groups to identify health issues and solutions
- manage health promotion programmes
- establish networks in the community
- develop promotional and educational material for publication.

Health promoters need to have skills:

- an understanding of different cultural approaches to health
- knowledge of the health system and political environment
- knowledge of the Treaty of Waitangi and the Ottawa Charter of Health
- evaluation skills, for assessing how effective their programmes are
- facilitation and negotiation skills.

Working conditions of health promoters

- usually work regular business hours, but have to work evenings and weekends to attend community meetings or events
- work from offices but also in the community at places like schools, rest homes

Source: Kaitoko Hauora: <https://www.careers.govt.nz/jobs-database/health-and-community/health/health-promoter/> [accessed 2.06.2017]

In Europe, the professional status of people working in health promotion is quite heterogeneous, according to national laws, traditions, and power relationships and systems, but usually, people working exclusively on health promotion are extremely rare. Only a few examples can be added.

Health Education and Promotion teaching programmes in the Netherlands

In the Netherlands, the Masters' programmes of Health Education and Promotion focus on training professionals in systematic development, evaluation and implementation of health interventions. Candidates are directly admissible to these programmes if they have a bachelor's or master's degree from a university programme in a relevant domain (not necessarily the health education and promotion domain). Relevant university domains are: Communication Sciences; European Public Health; Health and Life; Health and Society; Health Sciences; Medicine; Movement Sciences; Nursing Sciences; Nutrition and Health; Psychology; Sociology. During the programme, students not only learn why health education and promotion programmes are or are not effective, but also how to formulate communication strategies and effectively develop health interventions based on a theoretical and practical toolset. Students learn, for example, how to: (1) analyse positive or negative effects of behavioural and environmental factors on the quality of life; (2) formulate specific and testable objectives for intervention; (3) design effective, scientific health promoting interventions; (4) formulate plans for the diffusion and implementation of these interventions; (5) test, evaluate and refine those interventions; (6) develop communication strategies to disseminate programmes to various audiences. Graduates from the Master's programmes of Health Education and Promotion are experts familiar with the different aspects of health education and knowledgeable about topics such as psychology, communication, epidemiology, biomedicine, sociology, political science and statistics. Therefore, the Health Education and Promotion programmes are multidisciplinary, and include those subjects in their courses.

Graduates of the Master's programmes of Health Education and Promotion rapidly find good jobs, sometimes even before graduation. The following career paths are observed:

- Health institutes: At regional, national and international health institutes, Health Education and Promotion graduates can be found working on both preventive

- and awareness campaigns. But they also work on intervention development and help evaluate health education strategies.
- Consultancy: At consultancies, graduates provide national and international organisations with advice on how to develop health interventions or improve health education strategies.
- Governments: Some Health Education and Promotion graduates opt for a career working for a local or national government where they work on a broad range of health initiatives, ranging from the prevention of infectious diseases to healthy diets and exercise promotion campaigns.

Source: Maastricht University (<https://www.maastrichtuniversity.nl/education/master/master-health-education-and-promotion>).

Health promotion consultant in the Netherlands

In the case of the Netherlands, there is an occupation strictly related to health promotion, namely the **GVO-Consulent** (*Gezondheidsvoorlichting en Opvoeding*). The occupation title literally means: *Health Information and Education Consultant*. A GVO-Consulent usually works as an information officer at a health service agency (regional or municipal). This specialist can work in social care, home care or in many other places where health information about healthy lifestyle is provided directly to people. She or he usually encounters different audiences, from seniors to children. A GVO-Consulent may work alone but usually stays in regular contact with colleagues and experts (also in multi-disciplinary teams). The provision of health information may have many different forms: preparing brochures and other publishing materials, but also open lectures, co-operation with the media, targeted workshops, direct conversations, family counselling. It requires very high level communication and social skills and sound knowledge about health promotion targeted at various population groups.

Source: <https://www.roc.nl/default.php?fr=beroep&beroepsid=1360> [accessed 12.06.2017].

(3) A health promoter is often described as a specialist in the public health workforce. Training and practice of health promoters are deeply interwoven in public health (Mereu et al. 2015). In some countries the position of *public health practitioner* exists. In the UK about 10,000 public health specialists work in various areas of public health: in the public, private and voluntary and community sectors (NHS England website). Specialists should possess the set of intellectual (knowledge) as well as practical (skills) competencies stated in ASPHER's comprehensive list of public health core competences for Essential Public Health Operations (EPHOs), in particular the EPHO 4, namely "*Health promotion, including action to address social determinants and health inequity*" (Foldspang 2015; WHO 2011).

Some studies offer a very important contribution to the discussion on the optimal set of competencies in the profession of public health. Those studies analyse employers' demand for specific skills to be demonstrated by graduates of public health study programmes. In Poland such pioneering studies were undertaken, among others, by a team headed by Katarzyna Czabanowska under a Leonardo da Vinci project. The team explored the expectations of: central and local government units as potential employers for public health specialists, service providers, payer institutions, representatives of NGOs and employers from the social assistance sector, as well as the career-related expectations of public health graduates employed in public institutions which implement health policies (Czabanowska and Włodarczyk 2004).

Marielle Jambroes (2015) has presented how the development of the public health workforce in the Netherlands was stimulated by demand factors. The analysis is based on 7 specific reports (documents) published between 2003 and 2010. She claims that the need to gain insight into the public health workforce (and their competencies) and what the future demand of public health professionals will be, has increased considerably over the last 10 years. This has resulted in the production of many inventories, each from different parts of public health, for example a specific professional group such as health promotion specialists, or a specific organisation, e.g. the municipal health service. The study examines whether these inventories, when combined, provide sufficient insight into the size and composition of the public health workforce.

Estimation of the public health workforce in the Netherlands

The registries researched by Marielle Jambroes (2012) indicated 40 different roles and occupations. The lack of proper registration of occupations and roles in public health care is a barrier to proper sizing of the public health workforce. A compulsory register is only available for physicians, public health physicians and so-called profile physicians of the Royal Dutch Medical Association (KNMG). She estimated the total size of the Dutch public health workforce at 12,000 (934 public health physicians) in comparison to 11,870 registered general practitioners.

Marielle Jambroes concludes that in the Netherlands there is still limited insight into the size and composition of the public health workforce. Also, the definitions of persons working on health promotion activities (meaning, for example the development and performance of campaigns, improvement of expertise or research in the field of health promotion etc.) are still too different among many institutions.

Source: Jambroes 2015.

Competencies of a health promoter

As health promoters are becoming an increasingly visible professional group, engaged in their mission and vocation, and as their education and career paths are described in ever greater detail,⁷ one can increasingly move health promotion from the sphere of aspirations, expectations, projects and ideals to the sphere of concrete actions, constantly and devotedly undertaken by engaged and educated people working in many different institutions in parallel: clinics, hospitals, nursing homes, local government units or in non-governmental and community organisations.

The formulation of a universal entry-level set of competencies for health promoters (each time taking the national context into account) is needed for many reasons. With such a set of competencies, the following objectives can be achieved (after AHPA 2009):

- 1) Health promoters do not only have sufficient theoretical knowledge (knowledge of health promotion rules) but also know how to apply specific health promotion principles (for instance, ways of exerting effective influence on people based on psychosocial mechanisms and ways of influencing people's behaviours including behavioural economics or choice architecture); they have the ability to select specific targets and appropriate action instruments (see also Bik and Przewoźniak 2005).
- 2) Employers and managers in the health sector and in local government units are able to formulate precise job descriptions for health promoters and have more understanding of and appreciation for their unique role.
- 3) Passionate young people, driven by a sense of mission for public health and equal opportunities in health, have better chances of planning their educational path and career (Ashoka, the most prestigious organisation of social innovators, claims that a sense of mission alone is not enough to become a social innovator or a public health innovator; for this, one needs a very complex set of competencies; see Wagner 2012).
- 4) Health promoters, as well as people fulfilling a variety of professional roles in the health sector, are able to plan their continuing education and improvement and to include the component of ongoing education and constant growth into their daily work routine.
- 5) Education and training institutions in sectors other than health care (e.g. in the area of social work, physical education, sanatoria, etc.) are able to plan their

⁷ The historical evolution of the profession of health educators and health promoters was extensively described in a book by Barbara Bik and Lucyna Przewoźniak entitled *Historia profesji promotora (edukatora) zdrowia* [The history of the profession of the health promoter (educator)] (2005). The authors, citing a number of key documents (including the Lalonde Report, the Ottawa Charter, the Jakarta Declaration), point to the interdependence of gradual development of the discipline of health promotion and new professional roles: health promoter/health educator.

- curricula and training programmes in order to help professionals from other fields to complement their knowledge and skills in the field of health promotion.
- 6) Thanks to a shared matrix of concepts and a common understanding of key concepts, procedures and practices in health promotion, it is possible to set up multidisciplinary teams as well as partnerships and cross-sectoral cooperation.
 - 7) Thanks to the existence of **living, positive personal examples of the profession** (i.e. award-winning, publicly distinguished professional health promoters who can demonstrate concrete achievements) the role of health promotion is more appreciated in the public sphere and thus the public is ready for a debate about allocating more taxpayer money not only to health protection but also to health promotion).

**Entry level competencies for a health promotion practitioner:
The Australian example**

- A higher education diploma in medicine (social medicine), public health, health promotion, social sciences, education, local development, management or social communication
- Ability to work in an interdisciplinary team
- Competencies related to project planning, implementation, project management and evaluation (incl. desk research and analysis of best practices, studying and diagnosing the needs of target groups, evidence-based strategy planning)
- Cross-sectoral partnership building and maintaining competencies (given their importance for health promotion, establishing and developing partnerships is among the crucial tasks of an educator and/or a health promotion practitioner)
- Communication and report writing competencies
- Technology competencies (support for people and communities using e-health and mobile medicine apps/solutions, awareness of healthy lifestyle apps, e.g. those counting body parameters, counting calories, measuring exercise levels etc.)

Source: AHPA 2009.

Following many authors, such as John Kemm (2015: 140), it is worth noting the complexity and subtlety of the competencies of a health promoter. A health promoter must help the individual and the family to get rid of extremely harmful and unhealthy habits such as smoking (the author writes about smoking cessation specialists) or encourage them to get more exercise. Those competencies must be rooted in psychology, motivation, organisation, management, communication, mediation and negotiation. In addition, health promoters must be able to cope with setbacks and difficulties, their own and those of their clients (this is characteristic, for instance, of community leaders).

A health promotion practitioner is able to:

- be rooted in a belief in **ethical values**, especially equity and social justice, as well as respect for the autonomy and choice of both individuals and groups, and collaborative work;
- draw on a multidisciplinary **knowledge base** of the core concepts, principles, theory, and research of health promotion and its application in practice;
- **enable change** with individuals, groups, communities and organisations to build capacity for health promotion action to improve health and reduce health inequities;
- **advocate for health** with, and on behalf of, individuals, communities and organisations to improve health and wellbeing and build capacity for health promotion action;
- **mediate through partnership** working collaboratively across disciplines, sectors, and with partners to enhance the impact and sustainability of health promotion action.
- **communicate** health promotion effectively, using appropriate techniques and technologies for diverse audiences;
- contribute to **leadership** with the development of a shared vision and strategic direction for health promotion action;
- conduct **assessment of needs and assets** in partnership with stakeholders, in the context of the political, economic, social, cultural, environmental, behavioural, and biological determinants that promote or compromise health;
- develop **planning**, with measurable health promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders;
- **implement** effective and efficient, culturally sensitive, and ethical health promotion action, in partnership with stakeholders;
- use appropriate **evaluation and research** methods, in partnership with stakeholders, to determine the reach, impact, and effectiveness of health promotion actions.

Source: Association of Schools of Public Health in the European Region (ASPHER). <http://aspher.org/>

A more detailed list of competencies for a health promoter has originated as a result of the CompHP (Competencies in Health Promotion) project, that, after a long participative process launched by Health Promotion Accreditation System (IUHPE) and other partners, led to the European Health Promotion Accreditation System (Mereu et al. 2015).

Who performs the role of a health promoter?

Health promoters for older people may come from a range of existing occupations.

Potentially, the European Union offers a very broad pool of personnel that could perform health promotion functions among the elderly. It is a good idea to look at some general quantitative data that reflect this fact (after Schulz 2013). In 2011, over 23 million people were employed in the entire sector of health and social welfare in EU countries, representing more than 10% of the total work force in the labour market. At the same time, the share of the health care sector in the gross domestic product (GDP) was well over 10%. The upward trend in employment in the health sector has been very clear, even despite the economic crisis and the related decline in employment in many industries. And, of course, it is strongly linked to the ageing of the EU population, and thus, to the need to increase spending on health and welfare services for the elderly.

At the same time, there are considerable disparities between EU countries in terms of the percentage of health care workers in total employment (obviously, the lower the percentage, the more likely it is that health and social services are to remain in the hands of families, volunteers and communities rather than salaried professionals). The highest percentage of people employed in health services and social assistance can be found in Denmark (19%), with Germany having a relatively high share as well (over 12%), whereas a low level of employment is characteristic of countries such as Italy (7.4%), Slovakia (6.8%) and Cyprus (under 4%). Unfortunately, Poland does not perform very well in this respect, with only 5.7% of employees working in health care.

According to 2008 NACE 2 (*Nomenclature statistique des Activités économiques dans la Communauté Européenne* – the statistical classification of economic activities in the European Union), this entire group of employees could be divided into those who work in the health sector – human health activities (Q86), residential care activities such as nursing homes and similar facilities (Q87) and social work activities without accommodation (Q88). The share of health care workers (employed in hospitals, clinics and other healthcare facilities) exceeds 58%, whereas the share of employees in the long-term care sector is 20%, i.e. almost the same as the share of social workers (over 21%). It should be noted that in all these areas we are witnessing a slow yet steady growth in employment in most EU countries, although some countries have seen declines, especially in the health care sector, for example the United Kingdom, Latvia or Slovenia.

The health care sector is highly feminised. In 2011, women accounted for as many as 78% of all employees of that sector. The share of women is even higher in the residential care subsector (81%), as well as in social work (83%) (Schulz 2013). The feminisation of this sector is very clear in the context of the entire EU labour market, where women are still a minority (45% of all those employed). However,

the sectors of health and social work are chosen especially frequently by women as a career. More than 18% of all employed women work in these sectors, compared with only 4% of all employed men (most of whom, i.e. over 3%, are physicians and people working in the management of health care institutions).

Another challenge associated with the personnel working in health care and social work is related to the relatively advanced age of their employees. According to Erika Schulz (*ibidem*), one third of people employed in the health sector are over 50. Those people will leave their jobs over the next 15 years. Meanwhile, given the declining numbers of young workers, filling a large share of those jobs might be problematic.

Since 2010, agencies such as Eurostat, the OECD and the WHO have been collecting data on workforce resources in the health sector as well as its material and technical condition. These data concern doctors (including specialists and GPs), dentists, pharmacists, physiotherapists, nurses and employees of community health care in the broad sense. The definition of 'health personnel' in those data sets is not consistent and varies from country to country, as stressed by Erika Schulz in her analyses (project *NeuJobs 2013*).

People working in a large number of occupations can perform functions related to health promotion among the elderly. Based on the International Standard Classification of Occupations, developed by the ILO (International Labour Organization), one can identify the following occupations which can engage in this kind of health promotion (Table 2).

Table 2 Occupations which engage or may engage in health promotion for the elderly according to the International Standard Classification of Occupations, ILO

22 Health Professionals
221 Medical Doctors
2211 Generalist Medical Practitioners
2212 Specialist Medical Practitioners
222 Nursing and Midwifery Professionals
223 Traditional and Complementary Medicine Professionals
224 Paramedical Practitioners
226 Other Health Care Professionals
2261 Dentists
2262 Pharmacists
2263 Environmental and Occupational Health and Hygiene Professionals
2264 Physiotherapists
2265 Dieticians and Nutritionists
2266 Audiologists and Speech Therapists
2267 Optometrists and Ophthalmic Opticians

Table 2 – continued

2269 Health Professionals Not Elsewhere Classified (e.g. movement and dance therapists, art therapists, balneotherapists)
2635 Social Work and Counselling Professionals (e.g. social workers, community workers, addiction counsellors, family counsellors)
3412 Social Work Associate Professionals (e.g. local activity centre organisers, local life organisers, organisers of activities for senior citizens, social project co-ordinators, assistants to local senior citizens' councils, assistants to disabled citizens, family assistants, life skills instructors)
342 Sports and Fitness Workers
3422 Sports Coaches, Instructors and Officials (e.g. a swimming or Nordic walking instructor for older people)
3423 Fitness and Recreation Instructors, personal trainers, sport facility organisers
532 Personal Care Workers in Health Services
1343 Age Care Services Managers
3253 Community Health Workers

Source: International Standard Classification of Occupations, ILO 2012: http://www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_172572.pdf [accessed 10.12.2016].

Collaboration as the essence of a health promoter's work

Street-level health promoters must work with multiple communities, organisations and institutions. Health promotion calls for relationships, partnerships, cooperation, building an 'open system', i.e. bridges between many sectors and institutions (see Borkowska and Zielinska 2014) or, in other words, for conscious efforts to build social capital for health. It also requires leadership based on open dialogue in the community, broad coalition-building capabilities, openness to different organisational cultures (the fundamental role of leadership in the context of health promotion is discussed, among others, by Walter Ricciardi (2010) and Katarzyna Czabanowska (2013)).

If performed well, the function of a health promoter helps to produce a special kind of social glue (common language, trust, a sense of mission to improve people's health situation). This is conducive to wise cooperation among various institutions.

It is essential to make efforts to institutionalise cross-sectoral cooperation in the field of health promotion to make sure it is not only based on informal relationships and arrangements. If health promotion for the elderly is considered to be a kind of innovative, cross-sectoral public policy, then its implementation requires, firstly, institutional motivators (incentives to cooperate, i.e. increased funding for partner projects for health promotion among the elderly) and, secondly, the mobilisation of many sectors and different types of personnel working in those sectors.

Systemic deficits are conducive to innovation – the Polish paradox?

In countries such as Poland, where very few institutional and financial motivators exist to promote the health of the elderly, there is a lot of room for innovation in this area for non-governmental actors such as NGOs, social entrepreneurs and companies engaging in such activities as part of their CSR efforts (*corporate social responsibility*). The examples collected in the course of research for the *Pro-Health 65+* project indicate that impulses for innovative actions in the public system often come from non-public actors (e.g. non-governmental organisations).

see <http://www.seniorzywakcji.pl/?p=14>. [accessed 10.12.2016]

Dilemmas related to the professionalisation of health promoters and leveraging the potential of this profession

Researchers who study the history of professions and professionals (see Evetts 2013) have noted that professionals were clearly distinguished from blue collar workers in the past in that they were more empowered as employees and their work involved a great deal of autonomy. Unlike ordinary workers, they were not subject to continuous supervision and micromanagement. They were able to make most decisions by themselves. This situation changed when corporations with their organisation style became more widespread around the world.

An increasing number of professionals, including physicians, who were once independent and autonomous, are now part of the corporate machinery. Moreover, the boundaries between employment in the private vs. public sectors as well as public and non-governmental sectors are becoming blurred (an increasing number of projects are hybrid in nature). This also applies to the health sector. As noted by Anastasios Tzenalis and Chrisanthi Sotiriadou (2010), the blurring boundaries between the private, public and non-governmental sectors mean that the role of a health promoter must be multi-professional and multidisciplinary at its core. According to those authors, a health promoter increasingly operates outside the narrow field of medical and clinical services and engages in community work in places where people actually live, work, raise children, spend their free time, learn, develop and acquire new skills.

In practice, health promoters may play such diverse roles as advisers, consultants, researchers, trainers, project leaders and social innovation leaders, coordinators of health partnerships, officials responsible for the implementation of health-oriented strategies and policies, mediators and advocates of excluded groups suffering from health inequality. Nevertheless, the experience gathered during the *Pro-Health 65+* project has uncovered some examples, such as in Italy, where the local health authority is the starting point and the coordinator of a wide

and successful workplace health promotion programme implemented in deep cooperation with other sectors and institutions, such as the employers, trade unions and occupational health physicians.

Another aspect of the work of professionals is that they deal with 'professional risk management', i.e. they help clients to estimate and manage different types of risk, thus reducing their sense of uncertainty and confusion, so ubiquitous in today's 'risk society'. Professionals' work is based on trust. People must trust doctors, lawyers or plumbers before they approach them with any task or request. On the other hand, professionals must go a long way to acquire knowledge that is not accessible to all and is protected from the uninitiated. What professionals have in common is the shared experience, the same perspective, tacit knowledge, educational background, many shared habits and communication styles, as well as membership in professional associations guarding their professional identity and culture, as well as a system of values pertaining to the profession.

This raises an important question: on which basis can people trust health promoters and what may be the sources of their professional legitimisation?

The types of risks associated with the professionalisation (and legitimacy) of the profession of health promoter/educator are discussed by Alan Cribb and Peter Duncan (1999). Based on Daryl Koehn's work (1994) on professional ethics, those authors claim that the essence of any profession lies in a kind of public pledge, whereby the professional will act in the best interest of the client/patient, using the best of their knowledge in order to meet a well-defined and clear need (e.g. to cure a disease, to provide defence in a lawsuit, to conduct effective psychotherapy etc.). In the case of health promoters, the ability to fulfill the public pledge (i.e. to improve the health and quality of life) is quite problematic. This is due to the fact that this public pledge is dependent on too many factors, often unpredictable, going beyond the good will of the health promoter. Moreover, 'complete health' is not an entirely undisputed concept and it is not desired by all people to the same extent. There might be people who attach more importance to the sensations derived from the use of psychoactive substances than to sobriety, even though the latter is objectively better for their health (see discussion on this topic in Kemm 2015).

In practice, health promotion is much more often addressed to wider population groups and has a population-wide dimension (e.g. preventive screening, vaccinations, social campaigns and programmes devoted to health promotion) rather than an individual focus. Therefore, health promoters do not have the same relationship with their patients as doctors do. Nevertheless, it is increasingly more common for health promoters (e.g. physical therapists) to possess unique psychological skills (active listening, influencing methods, persuasion, motivating dialogue) that can change an elderly person's behaviour.

In addition to the challenge of the ethical and professional legitimisation of the profession, there is also the problem of space (legal, institutional, economic and

cultural) for the development of the profession in Poland and other EU countries. As for the legal space, it definitely exists and enables the professional development of health promoters, both as an extra role for strictly medical personnel and as a new profession, with a separate path to learn and acquire competencies. Based on national and professional regulations, the majority of countries are transferring several tasks normally performed by physicians to health professionals with a different or lower level of education and training (task shifting). In the field of health promotion several experiences involving community pharmacists in cancer screenings (Havlicek et al. 2016) or in cardiovascular health and diabetes prevention programmes (Silenzi et al. 2016), as well as midwives in health promotion and education regarding vaccine preventable diseases (Pearce et al. 2008), seem promising.

An economist might ask, however, whether it is economically reasonable to single out a new profession of health promoter since there is often a shortage of primary care physicians, specialists and nurses (especially in the Polish health care system). In this situation, who will pay for the various activities carried out by this role and what kind of funding should be used? Can the separation of this profession change anything in the sphere of public health policies? Thus, the financing of health promotion is one of the greatest challenges.

However, this problem has deeper roots, i.e. the highly uneven distribution of knowledge resources concerning health. This knowledge remains the domain of a narrow group of experts, health professionals and doctors. In short, the level of public awareness or shared knowledge about the health of older people and about costs for the individual, the family and the community and about efficient models of health promotion is very low (we elaborate on this in Chapter 6). This also applies to the officials responsible for allocating public resources to health promotion programmes. Therefore, the challenge is that the entire society should have a chance to develop health literacy and knowledge resources for health. This certainly requires knowledge brokering (see Olejniczak and Haber 2014), i.e. the transfer of knowledge to the people who make many concrete decisions in their daily practice (political, social, public, community-related decisions). Such a transfer should be carried out using modern education methods.

Desirable knowledge and skills for health promoters working with older people

In addition to theoretical knowledge (specific health information) and the above-mentioned results of the project CompHP (Competencies in Health Promotion), the knowledge base related to the health needs of the elderly also comprises a good understanding of cultural, economic and social conditions, awareness of the risk associated with individual behaviours and their social costs, and the impact of the spread of negative health behaviours. These resources also comprise self-control

and self-care and coping skills, both in health and in illness. Those skills are the ones people have themselves as well as ones they can pass on to others (competencies that make up health literacy). There are also negotiation skills and communication skills, skills in using health care services (awareness of structures and procedures, use of institutions, use of technology, i.e. e-health), and a pro-active mind set, i.e. the use of health knowledge to change fatalistic perceptions of health problems or, conversely, to ignore threats.

Source: Author's work based on Bik and Przewoźniak 2005 and Mereu et al. 2015.

In post-communist countries, efforts to build the knowledge base on health (which also opens up ever more space for health promoters) are delayed and slow. Educational institutions (schools, universities) are slow to introduce innovations and cutting-edge knowledge on health promotion. Another problem is that the intellectual capital related to health is often a source of income for the professions which serve as experts in this field (medical experts, auditors, consultants etc.), and this may be a reason for them to lobby against the full development of those new professionals.

In order to explore the barriers to building the knowledge base for health, an exploratory quality research was conducted in 2016 as part of Work Package 9 under the *ProHealth 65+* project. The conclusions from that study concerning the deficits of knowledge among health promoters are described in the next chapter. Here, we will only note that the majority of the respondents, i.e. current and potential health promoters, have no regular access to the knowledge of good practices and do not undergo training in this respect. They perceive this knowledge as 'expert knowledge, reserved for specialists, clinicians and scientists.' This knowledge costs too much and they cannot afford to purchase it. Therefore, they rely on intuitions, habits and prejudices rather than on documented knowledge. Anyway, that requires special attention to avoid the risk that misconceptions concerning science and false myths or beliefs might spread instead of evidence-based knowledge (Scudellari 2015), because it could be even more dangerous when a credible professional speaks in favour of these kinds of wrong messages (Di Pietro 2017).

Moreover, in the context of some analysed countries there is a huge gap in terms of power, prestige and knowledge between doctors and medicine-related professions as well as a pronounced scepticism among doctors as to the effectiveness of health promotion. The strengthening of so-called "population medicine" could ameliorate the acceptance of the importance of prevention and health promotion in the current practice of the physicians (Grey 2013).

Conclusions

The occupation of health promoter does not yet exist in a regulated form. For several decades, however, it has been being dynamically shaped. The competencies of health promoters have been defined and reinforced in parallel with the development of the new public health system, which has a particular role for health promotion.

The set of competencies included in the occupational role of the health promoter may evolve differently in the two occupational groups. One group will consist of “traditional” health care professionals: doctors, nurses, dentists and physiotherapists. Most of them have a long lasting tradition in the field of health promotion training and practice, but, in the real world, they are usually too occupied with all the activities related to patient care and, consequently, may devote only a limited amount of time to health promotion activities. The second group may include people who engage in health promotion not only because of their formal education but also because they are driven by a sense of mission and a willingness to make a difference that motivates them to pursue further/ongoing education, even at later stages of their career, gaining interdisciplinary knowledge, especially in the field of public health and health promotion. It is important to make a clear distinction between these two groups, as the difference lies primarily in their knowledge about health.

The former group (health workers and health professionals) has constantly updated, evidence-based, up to date scientific knowledge on diseases and the human body. The latter group has practical knowledge, often as well as intuitive or tacit knowledge, about the health promotion practices which work well in specific contexts and in specific population groups. A practical opportunity is represented by grassroots sport, namely “the physical leisure activity, organised and non-organised, practised regularly at the non-professional level for health, educational or social purposes” (EC 2016). In many cases, those employees are familiar with the behavioural approach, aimed at changing the attitudes and behaviours of older people, as described in, among other sources, the 2015 World Bank report and a book by Richard Thaler and Cass Sunstein entitled *Nudge* (2012). The essence of the behavioural approach (and the skills to apply it) means that an effective health promoter does not need to have a huge financial base, his/her own institution, prestige or significant authority. However, above all, health promoters should have in-depth knowledge of cognitive and behavioural mechanisms operating in human minds in the social context, and the ability to inspire the elderly, their families and social networks, and to nudge them to engage in proper behaviours.

The discussed professional groups can perform a variety of functions. They can operate at the individual level, engaging in mentoring, counselling or one-on-one interactions with an elderly person. They can also work at the social and institutional levels, acting as educators and in-house trainers in institutions, as well as managers

of projects of varied scales (a single institution, a local community, a region or a city). They can also work together to create partnerships and cross-sectoral alliance, because efforts towards HP4E cannot be separate from with the health sector. In this sense, it is important to highlight the essential role of public health, which in most of the analysed countries has a prominent role in the planning, organising, delivering and evaluation of health services, including health promotion that, in time of resources shortages, should be more than ever based on available evidence (Evidence Based Prevention).

Theoretically, we have a very large group of educated people across Europe who have the necessary qualifications and could perform health promotion tasks for the elderly. Their potential actions are legally defined in legal acts on specific occupations and acts on public health. However, the real possibility to perform health promotion functions remains limited.

The inhibiting factors, particularly in the context of post-communist countries, primarily include gaps in social knowledge about health resources, organisational culture and financial resources; a reluctance to learn and a preference for routine behaviours; the scarcity of resources (mainly financial ones); the lack of institutional motivators; time deficiencies; gaps in communication skills and organisational skills.

However, as health promoters are becoming an increasingly highlighted professional group, engaged in their mission and vocation, and as their career path and educational path are consistently being better outlined, health promotion can be increasingly shifted from the sphere of aspirations, expectations, projects and ideals to the sphere of concrete actions. Such actions are constantly and devotedly taken by engaged and educated people working simultaneously in a number of different institutions (as diverse as hospitals, clinics, nursing homes, local government units, non-governmental organisations, social organisations, etc.)

The success of proven and cost-effective health promotion definitely demands that the figure of the health promoter should be strengthened as a representative of a special profession which can be practiced both by health sector professionals and personnel related to social assistance. Most of these activities could be performed by non-medical health professionals (i.e. dieticians), involving efforts made to ensure an effective and safe task shifting, and partly also by other professional groups, trained volunteers, NGO workers, community workers and social organisers as well as elderly people who engage in initiatives for their peers.

The diversity and richness of the competencies and skills mentioned above mean that a health promoter in the local community is the opposite of a bureaucrat. Rather than reinforcing the status quo, health promoters may (if, of course, they have the required competencies) become a kind of innovator in the field of health enhancement for the elderly and contribute to many positive changes, such as the empowerment of groups previously excluded for health reasons that suffered inequalities in access

to knowledge about health, or resolution of a well-described and diagnosed problem (most often a deficit, e.g. in terms of a healthy diet, exercise, proper post-hospital care, fall prevention, etc.). To make this all possible, health promoters need to be trained according to a well-defined training programme in public health, at least in the field in which they are directly involved (i.e. health habits), to acquire a well-described set of essential competencies (WHO 2011; Mereu et al. 2015). Furthermore, to ensure a well-balanced allocation of economic resources, a well-defined evaluation of their activity should be considered as in all public health activities.

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EDUCATING HEALTH PROMOTERS



Educating health promoters

Introduction

Education, classically speaking, is the process of conveying knowledge, skills and information in the form of formal education at all levels. In recent years, the education process has begun to encompass learning outside the classroom, lifelong learning (LLL) and, sometimes, self-learning, the results of which can be determined.

The outcome of the learning process is obtaining qualifications, which in practice can be determined by type and measurable level. Formal qualifications are regarded by economists as life-capital, also called human capital.⁸ It is through the use of this capital that people increase and improve their life achievements: productivity at work, material standard of living, social status and general well-being.

The broad understanding of the term ‘education’ creates a clear distinction between formal education, non-formal education, self-education (informal) and incidental learning. The lifecycle differentiates the importance of particular types of education, though formal education is considered the most important. This applies not only to children and adolescents but also to adults, including older people, who are the target group of the “students” in this textbook.

Gaining qualifications (credentials) has always mattered, but today it is the most important imperative of human endeavour. This is due to the accelerated pace of change: the emergence and prevalence of new technologies, economic growth on a global scale and people’s personal ambitions. Around the world, to participate in the process of change and to gain from its effects, learning is a must. This includes everyone in the lifecycle, every organisation and all of its employees: at every age and in every position (Senge 1990 a and b; Mayo and Lank 1994). There is

⁸ Garry Becker, winner of the Nobel Prize in economics in 1992, greatly contributed to the understanding and dissemination of the concept of human capital and Jozef Dietl (1804-1878), physician, professor and rector of the Jagiellonian University, wrote as early as the nineteenth century: “What is spent on education is not given, but loaned, because education is the most reliable debtor.”

a well-known statement in business circles: “change or die” (Drucker 2009) which can be interpreted as “learn or perish.”

In the field of health care – as in other sectors of the economy – there is a rise in the importance of possessing knowledge, which stems from the need to apply new technologies and effectively adapt to comprehensive and complex changes.

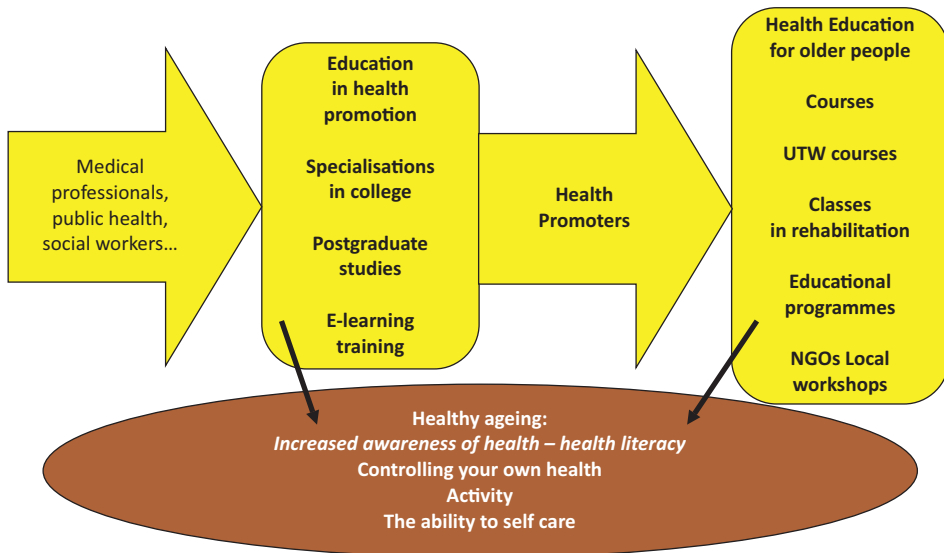
There is an increased importance in the health sector, in having not only biological and medical knowledge but also pedagogical and psychological knowledge, resulting from the specificity of the service provided – which demands highly qualified educational and relational service providers. The service provider is in fact the “product” – *uno actu*. This applies to health care, meaning the treatment of patients, as well as to health promotion and disease prevention, which is to mean the early phase, at which time an indication of possible health risks can be made and steps can be taken to limit or even completely eliminate ensuing health implications.

In the field of health promotion, educational activities are less defined, and more widely dispersed than in the provision of medical services. As mentioned in Chapter 4, health promoters do not constitute a separate vocational group and their educational path is carried out in practice by other professional groups, still imprecise and not fully regulated, although in many countries, there is formal education in the form of postgraduate studies in medical and medically-related fields that train health promotion specialists.

On the basis of the experience gained through the realisation of the European Project *ProHealth 65+* we are attempting to present the main findings related to the education of health promoters. We are working on the assumption that education is the primary method (and function) of health promotion (Wojnarowska 2013). In the case of this textbook, however, we are not strictly concerned with the overall education of health promoters, but our focus is on specialised education, aimed at maintaining the health of older people.

When considering education in the field of health promotion addressed to older people, it is worth noting that we are, in fact, dealing with two types of education. One type is the education of health promoters, a heterogeneous group in terms of education level and specialisation, but nevertheless, basically competent (see Chapter 4) and determined to become promoters of health. The second type is the education of older people, taught by qualified health promoters (Figure 9).

The first type of education – training of health promoters – requires discerning the educational needs of this group, which is not easy because of its diversity. An initial step was to choose one group of health promoters, in our case – those who are active in the local community (*street level health promoters*). Identifying their educational needs (knowledge deficits) regarding health promotion targeted at older people was the next key step in establishing the programme of their training. This was achieved, among other ways, by conducting a study of knowledge deficits of the people carrying out tasks within health promotion, presented in the figure below.

Figure 9 Education for health promotion targeted to older people

Source: developed independently.

Health promoters need epidemiological knowledge about the risk factors of unsafe health behaviours, prevention of major diseases and the consequences of failing to respect a doctor's instructions. Also they need psychological knowledge about effective methods of influencing changes of behaviour. A report prepared by experts from the World Bank Group, (World Bank Group 2015), which compiled overviews of numerous psychological research studies conducted in many countries about the difficulty of achieving intended objectives in health care, draws attention to the fact that human behaviour is fairly routine (automatic) and strongly conditioned socially. Providing people with information on how to improve their health is rarely enough to change their behaviour (*providing information is not sufficient to get people to change behaviours that undermine health* – *ibid*, p. 155). What is needed is sometimes the introduction of real incentives (rewards/penalties) – and not just promises and intimidation – referring to the behavioural patterns of popular individuals and role models, as well as the implementation of certain standards of healthy behaviour, which can be widely accepted and become lasting or sustainable behaviour.

The second type of education is the education of older people organised by health promoters. The assumption is that this falls within the scope of formal education, which is conducted for different groups of older people in the form of training and courses within universities of the third age, seniors club activities, rehabilitation packages, support groups and activities associated with therapy and care.

Education in health promotion

The term “health promoters” applies to a large and diverse group of people whose tasks, in varying degrees, include undertakings in health promotion which can be carried out both directly in contact with the target addressees, as well as indirectly – through the organisation and management of institutions and/or creation of health policies. The first of these categories, as discussed in Chapter 4, consists of “frontline health promoters” directly in contact with a target recipient of promotion – a patient, a person in need of care, an older person. These are medical professionals, mainly doctors of primary health care (PHC), but also specialists (including – occupational and environmental), dentists, nurses, physiotherapists, therapists, pharmacists and nutritionists as well. In this category, a vital role is also played by social workers, as well as numerous experts in various fields related to health, including: organisers of local centres, project coordinators, trainers/instructors of physical activity/recreation, people assisting/helping those with disabilities, caretakers of the sick and older people (ILO 2012). Other people also promote health, even though it is not clearly defined in the scope of their job duties. This category includes, for example, beauticians, massage therapists or diet counsellors and general support staff, both medical and non-medical. Teachers of adult education – including universities of the third age, community or folk universities – may, after obtaining the relevant competencies, also play a role in direct contact with the target addressee.

A separate and important group consists of people who work for organisations at different levels: local, regional, national, European or even global – creating appropriate institutional working conditions for “health promoters of first contact.” Though their input is crucial to the shaping of the system and functioning of health promotion, they are not the subject of this part of the textbook.

Even though medical professionals have thorough preparation and knowledge in the field of health promotion, it is also known that the working conditions for doctors, nurses or physiotherapists are not always conducive to its effective implementation⁹. Focusing on the diagnostic and therapeutic aspects of health frequently puts issues dealing with health promotion on the back burner.

On the other hand, people who do not have a comprehensive, educational background in medicine but have more time to spend with an older person, have a unique opportunity to effectively and positively influence someone's health: by encouraging, instructing, persuading and demonstrating examples.

The main subject in educating health promoters is scientifically confirmed knowledge about effective measures in the field of health promotion and disease prevention (evidence-based knowledge). Credibility is guaranteed by articles in

⁹ For example in Polish circumstances (probably valid in some other countries too) there is a lack of time, hypertrophy of bureaucratic requirements and often under-funding of procedures - these are just some of the barriers that hinder this task.

peer-reviewed, domestic and international journals. The titles of the main scientific journals in the field of health promotion addressed to older people are given in the last Chapter.

Information based on scientific evidence

Relying on trustworthy and up-to-date scientific information in public health, referred to as evidence-based public health, EBPH), is based on the same practice in medicine (evidence-based medicine, EBM). In relation to health promotion, the concept of EBPH is a relatively new approach. It is about searching for and attaining the best available scientific knowledge on effective methods to impact health, aimed at the identified health needs of the population.

The EBPH approach was first developed and implemented in the United States and Canada, whereas in Europe, particularly in the countries of Central and Eastern Europe, the scientific approach to the development of public health, followed by attempts to implement the principles of applying scientific information is still evolving.

Source: developed on the basis of Jenicek 1997, Brownson 1999, Kohatsu 2004.

Figure 10 Educating health promoters



Source: developed independently.

In many European universities, usually in the context of medical schools and schools of public health, one can find studies in the field of health promotion at the undergraduate (bachelor) or master's degree and postgraduate levels. These education programmes are increasingly being carried out through a variety of methods within the realm of remote learning, often referred to as e-learning. In

some cases even the whole learning cycle is carried out via the internet without the students' physical presence at a college or university.

Education in the field of health promotion and prevention in Germany.

In Germany, as in most European countries, there is no a separate profession (position) of a health promoter. In practice, the functions of health promotion are performed within many medical as well as social, pedagogical and other health-related professions. Yet, for the last twenty years education has been developing in the fields of public health, health promotion and prevention at the bachelor level and, more and more often, the master level, at general universities and at universities of applied sciences specific to health. Moreover, health promotion can be studied combined with studies in sports or nutrition sciences. In 2015, 13 bachelor and 25 master studies which directly concerned public health and health promotion were registered in Germany. Besides the system of formal education, there are other systems of education for adults in the area of health promotion. Some are of a specialist nature such as post-graduate studies, other constitute an element of professional development in life-long-learning. Private organisations also conduct such forms of learnings.

Due to the multitude of possibilities of education and gaining qualifications in the area of public health and health promotion, which may seem unclear and not transparent for the interested people, attempts at standardisation have been made in Germany within the framework of professional training (Fachqualifikationsrahmen – FQR) at the university level. These are using the Dublin descriptors (as part of the European Qualifications Framework and the Public Health Action Cycle) to describe the content of the courses and the desired skills of the graduate. For now, however, these are only guidelines; universities are not obliged to use them, but they are widely accepted.

The German statutory health insurance that finances health promotion interventions on different levels (1. individual measures, 2. workplace health promotion, 3. interventions in specific settings [i.e. schools, day care centres, nursing homes], defines qualifications that are necessary to provide refundable health promotion interventions on the individual level. This implies a state-recognised vocational qualification or academic degree for the specific field of activity and mostly an acknowledged additional qualification that depends on the specific intervention (GKV-Spitzenverband 2017). For the implementation of workplace or setting-oriented health promotion interventions additional qualifications concerning organisational development, organisational consulting, process and project management are required

Source: Blaettner, Hartmann, Baumgarten 2015, GKV-Spitzenverband 2014a, 2014b and 2017.

The beginnings of education in the field of health promotion at the Jagiellonian University

In the Krakow School of Public Health, the first school of its kind in the region of Central and Eastern Europe (founded in 1991 as an interdisciplinary unit of the Medical Academy and later – the Jagiellonian University), the concept of post-graduate studies in the field of health promotion was launched as a part of the EU pre-accession projects (TEMPUS). The three-year programme began in 1992. In 1995 the Annual Postgraduate Health Promotion course for professionals responsible for planning and evaluating health programmes in central and local government and at the public insurance organisations was opened. The course was also offered to people involved in health education in the departments of health inspection, hospitals and superintendents. Up until 2012, participants in this course of study, together with lecturers – developed more than 100 individual and collective health promotion projects with a practical value. Projects have been designed to be implemented in specific locales with regard to their existing capabilities and resources. The concept of the programme and coordination remain in the hands of Barbara Bik and Lucyna Przewoźniak.

Source: Bik, Przewoźniak., Szczerbińska 1996 and information from the Institute of Public Health in Krakow.

Education in the field of health promotion and prevention in Italy.

Health promotion in Italy is deeply intertwined with other activities carried out by several health care professionals, especially in the field of public health. Indeed, the role of health promoter is not defined as a separate profession and most the health promotion activities are carried out by physicians and other health professionals together with social workers or teachers, which are often engaged in programmes of projects to improve the health of the population.

Almost all the graduate work in medicine and health sciences and post-graduate training activities e.g. specialisation in public health and health promotion and PhD studies have to be performed by universities. Even if the faculty of medicine, usually within public health institutes, provides the majority of the professional training, health promotion is highly considered also in other faculties, especially within studies in sports or social sciences.

Other post-graduate courses are realised by national, regional and local organisations, scientific organisations, academic bodies only if accredited by the Ministry of Health through the mechanism of Continuous Education in Medicine (ECM), which is compulsory and requires each doctor and nurse to attend yearly post graduate training.

Source: Poscia, Silenzi, Ricciardi 2017.

Life-long learning in health promotion

“Continuing Education” is a term often used interchangeably with the terms “lifelong learning” and “learning for life” (life-long learning, LLL). It is a systematic process of expanding knowledge, using new information and acquiring new professional and life skills. Lifelong learning is generally voluntary, although it is often stimulated by employers’ needs and determined by the situation in the labour market¹⁰. According to Paul Lengrand (1995), *“the former division of human life into a period of learning and a period of professional activity and social activity is becoming obsolete. The era of continuous and comprehensive learning has arrived.”*

Lifelong learning is a requirement of modern times

Among the 21 principles set forth in the landmark report by UNESCO, entitled *Learning to be. The world of education today and tomorrow*, the following theses can be found:

- It is necessary to de-formalise institutions; educating should be carried out with the help of various methods; the most important thing should be what a person has learned and what he/she knows; the choice of means and methods of education must be free and should take into account the end result of education since all the roads leading to education should be treated as valuable.
- The most important issue in educational strategy should be adult education.
- Self-directed study has irreplaceable advantages. There should be institutions that support self-study.
- New playback and communication techniques should be introduced to modernise teaching technologies – to meet this principle it is necessary that a movement be started that would seek the implementation of these methods.
- Education of teachers should prepare them for the role of educators; (...) the distinction between professional and non-professional educators is becoming important; there needs to be an increase in the number of voluntary or partially paid assistants in the educational process.
- The mode of teaching should be adapted to the student. It is to be the focal point of any educational activity.
- The students’ internal processes of active participation in the learning process should be stimulated, and students should have the opportunity to take responsibility for their learning.

Source: developed on the basis of Faure 1975.

¹⁰ To understand the crucial role of education in social development, the term “learning society” was used in the report produced by the International Commission for the Development of Education UNESCO, edited by Edgar Faure of 1972. (*Learning to be. The world of education today and tomorrow*).

The continuation of UNESCO's position – Education. *In it is a hidden treasure* – includes:

- Learning to know – one should get familiar with the tools for learning/knowledge acquisition.
- Teaching and learning requires concentration skills, use of existing knowledge and thinking.
- The purpose of learning is to achieve the joy of understanding, discovery and possession of knowledge.
- Learn to act – have the ability to use knowledge in practice, teach cooperation and communication so that one can cope with unexpected situations, work in teams and creatively shape the future.
- Learn to be – the main aim is the comprehensive development of the individual.
- Education should prepare and develop independent thought, ability of critical judgment, feelings and fantasies. Without that the world is at risk of becoming de-humanised.

Source: Delors 1996 – a continuation of the UNESCO report of 1972.

Life-long-learning in health promotion – an example from Italy

- Medical professionals in Italy have the obligation to attend yearly a post-graduate training. Within this general framework, some universities, local authorities or scientific societies carries out a special project on health promotion and education, for example:
- The Italian Society for the health promotion has the mission to promote the culture of health promotion in the institutional, social, political, scientific and professional arena. Furthermore, the Italian Society of Hygiene (SIItI), has a dedicated working group on health promotion, which carries out scientific initiatives, such as seminars at the national and regional levels and several publications. Purposely devoted to health promotion for older people, the Regional Lazio Section of the SIItI has recently organised a working group on active ageing.
- Within the University of Perugia, the Experimental Centre for Health Promotion and Health Education (CeSPES) produces research, working and professional training patterns in public health, being a permanent laboratory of ideas and practices about prevention, education and health promotion. The CeSPES organised the 1st level master in planning, management and evaluation of integrated actions of health promotion for the community, which is accredited by the International Union for Health Promotion and Education (IUHPE) within the European Health Promotion Accreditation System.
- The Regional Centre for Health Promotion Documentation in the Piedmont Region (DoRS) supports health promotion policies at the regional and local levels, through a knowledge transfer and exchange approach, to review evidence, policies and good practices as well as developing programmes in community settings.

- A multidisciplinary team of 27 professionals in health promotion, psychology, education, documentation, communication, biology and chemistry works at the DoRS carrying out several activities such as the translation into Italian of scientific articles and documents on disease prevention, health promotion and social marketing, the organisation of courses and workshops as well as the training and assistance to implement local, regional and national plans and projects

Sources: <http://www.sipsalute.it>; http://cespes.unipg.it/index_htm_files/master%202015-2016%20uken.pdf; http://www.dors.it/pagina_singola.php?idpagina=8.

Research on the knowledge deficits of street-level health promoters

Health promoters involved in health programmes focused on older people use a lot of so-called “tacit knowledge” (Polanyi 1964) on a daily basis. They use their common sense, intuition or routine procedures; they also have some random data and some good practices to work from. They try to be practical and rarely devote their time and resources to examining the scientific evidence for their common-sense practices and ideas.

To assess the training needs of street level health promoters, special research was conducted in Poland. It can be compared to many similar qualitative studies focused on knowledge deficits and training needs of various groups of employers in the health and social care sector. Some examples of such studies focused on the competencies in the field of care service can be found in Hendry, Williams, Wilkinson 2008 and Gaspard & Yang 2016.

Empirical research on training needs assessment for health promoters from Poland

The aim of the empirical research was to explore the problem of knowledge deficits of health promoters for older people and identify any major training needs in relation to health promotion. This study was not a goal in itself but was mostly instrumental in designing the best training programme for health promoters (trainings-for-trainers).

The research has been completed with the use of two research methods:

- 1) on-line questionnaire targeted at purposefully selected respondents from 4 sectors: health; social; NGO; central government and local self-governments
 - 2) additional 10 qualitative in-depth interviews with experts in the field (experts were taken from 4 sectors as well) + some elements of institutional ethnography.
- We used a method of purposive sampling because there is a limited number of respondents that have expertise in the area being researched. Qualitative interviews have been designed to discuss and deepen the conclusions drawn from the results of the on-line questionnaire.

The questionnaire has been filled in by 58 respondents from all over Poland (big cities, towns and villages), representing many various institutions and organisations: Universities of Third Age, social service centres, local government bodies, local health centres, NGOs focused on services for older people. Among the experts chosen for in-depth individual interviews there were: the leaders of expert NGOs focused on services for seniors; the director of the Institute for the Development of Social Services (IRSS); the head of the regional branch of the General Practitioners Union; representatives of regional departments of public health; a representative of the centre of psychiatry for seniors.

The results of this study are summarised below.

- The first question of the questionnaire was about the main functions of health promotion implemented by particular institutions. Most of them (over 80% of respondents) focus on providing general information about health determinants, health risks and health education for better health literacy, including motivating people towards a healthier life. Only one third of respondents declared that they perform functions such as primary prevention, screening and diagnostics, lobbying on various levels for the health of seniors and giving voice to grass-roots health promoters. As for practical initiatives undertaken at the community level, the most popular is organising physical activity for seniors and social activities (integration). Less popular are initiatives focused on healthy eating (less than half of the respondents), prevention of obesity, immunisation (organised only at the regional, not the local level), prevention of falls, prevention of addiction to alcohol and smoking. Only one among all respondents declared that they organise initiatives focused on the sexual health of older people.
- Questions concerning the access to trainings and continuing education in the fields of health promotion for seniors were asked. Only 21% of respondents declared that they take part in such trainings, while almost 60% do it very rarely or never. Another query concerned the access to knowledge databases for seniors: how that kind of knowledge is managed and stored in an organisation and how good practices are used and collected. 68% of respondents declared that they do not collect such information or good practices; only 10% do it regularly. As for the sources of knowledge, the respondents mostly use their own intuition, experience (75%) and the Internet and accessible books/articles (50%). Not more than 20% complete their own local diagnosis/needs assessment or do their own desk-research.

Training needs were reported on 4 levels:

- individual level (initiatives for improvement of individuals health condition: rehabilitation, nutrition, physical activity);
- infrastructure level (initiatives for improvement of home conditions, heating, recreational space, access to public services);
- institutional level (modernisation of health institutions, access to public, private and non-profit institutional services, inter-sector co-operation) and fund-raising;
- local community level (social bonds in the local environment, local mobilisation, community support, community programmes for health, such as health equity zones).

In most cases, and on all the above-mentioned levels, the most desired knowledge concerns financing, fund-raising and the financial sustainability of the initiatives for seniors (over 90%). So this kind of knowledge is desperately needed. Also, knowledge about good practices from other countries is very much desired as is knowledge about designing and inventing such projects from scratch. The least desired type of knowledge concerns validation, evaluation and impact assessment of such projects. This last result probably means that the respondents underestimate the importance of evaluation in good planning.

Source: research conducted within the project Pro-Health 65+ by Maria Rogaczewska.

More general conclusions were drawn from the presented research

- The majority of health promotion initiatives undertaken by respondents are generally not based on scientific knowledge (gerontology, geriatrics, psycho-geriatrics etc.), but it is not their personal fault. The major barriers in access to evidence-based practices and knowledge are context-dependent: lack of finance; deficit of time; deficit of accessible training. The majority of respondents would like to get access to such knowledge to support their initiatives.
- The most preferred channels for communicating knowledge are: special web portals; seminars & trainings; networking among different sectors; activists and experts joint meetings. The least preferred would be e-learning and webinars.
- The following strategic goals of respondents' organisations could be reached if knowledge was delivered to them: increased health literacy of seniors themselves; engaging all generations in community projects; synergy and partnerships; financially sustainable initiatives; more support from local government and policy makers¹¹.
- A huge part of the problem is also the fact that responsibilities of various institutions focused on health promotion are dispersed and vaguely defined. In effect, what is done are usually very selective, small scale, and short-term interventions (mostly using physical activity and community engagement), based on common-sense knowledge about what is good for health.
- Another significant part of the problem is also the phenomenon of *syndemics* among older people – e.g. synergy of multiple health, economic and social problems characteristic for numerous groups of seniors (economic shock of retirement; social isolation; behavioural addictions, like over-consumption of pharmaceuticals; obesity; depression and mood disorders; the necessity to

¹¹ One of the respondents of the in-depth interviews used an interesting metaphor to describe the current situation. She compared scientific knowledge about health promotion to a genuine "Prada" bag. She said: *"It is a luxury – only the richest institutions can afford to buy it from experts, actualise it, engage actively in knowledge retention and knowledge management. Most organisations are too involved in basic fund-raising to survive to be able to afford it."*

take care of their terminally ill parents who are over 80, while they are also ill). These problems are not addressed properly as there is very little knowledge about how to deal with them.

- A much more optimistic conclusion consists in the fact that street-level health promoters are very eager to gain new knowledge, to share it with their colleagues and to use it in their activity planning. They are also able to enumerate many possible advantages of using this knowledge for seniors' well-being and to increase health-literacy among them and their families.

Modern forms and methods of adult education

Just as in all other fields of human activity, education is in need of interesting methods which can make the learning process more attractive. This does not need to be an absolute innovation. Making use of even familiar solutions, employed elsewhere, but in new social, cultural or organisational conditions can be innovative.

The dynamic development of information technology and the spread of internet access via computer or mobile phone are conducive to the development of different techniques for the remote transmission of information to support activities in the field of health (e-health) as well as distance learning (e-learning). The European Union has strongly begun promoting the development of e-health, and the Commission encourages Member States to prepare the concept and implementation of applications of information and communication technologies in health care (Duplaga 2007). Telemedicine and electronic methods of recording and transmitting medical records are revolutionising the organisation of health care. They are also being introduced to the system of patient care (Bujanowska-Fedak and Pirogowicz 2014). The question arises of whether this applies to training personnel – including health promotion personnel. E-learning undoubtedly helps promoters of health information. This is exemplified through the widely available high-quality educational materials which are presented here below:

Health *e-learning* for older workers: e-CAPACIT8

In the years 2013–2016, the Nofer Institute of Occupational Medicine (IMP) in Lodz headed a European project in the field of public health. Its aim was to develop educational materials specifically concerning the health of older workers and the creation of an e-learning platform through which these materials would be made available for a wide range of educators throughout Europe: occupational physicians, nurses, psychologists, ergonomists and other health professionals concerned with the health care of workers. Providing educational materials on this e-learning platform served to enhance information and increase the competence of health educators working with older workers, which can contribute to improving

the health of this part of the working population. Educational materials were developed in several languages and are available free of charge to all interested parties. More information can be found on the project's website, on which there is also access to the e-learning platform.

Source: Strengthening occupational health professionals' capacities to improve the health of ageing workforces, www.e-capacit8.eu [access: 20.12.2016].

Elements of innovative education may consist of products such as curricula with new content and methods of education, attractive textbooks and other educational materials.

Ways of transferring knowledge and the organisation of teaching can be innovative: e.g. the hiring of interns, learning by example, learning through research, including case studies, problem solving and design method (Dumont, Instance and Benavides 2013). Below, there is a brief overview of some of the teaching methods used in health promotion which activate students/trainees, help reduce learning barriers, make teaching more attractive, easier and more effective. They usually require working in groups and can – through the appropriate selection of educators – integrate various specialists of health promotion¹².

Case study is a method commonly used in various disciplines [relatively often in biology and medicine (Herreid 1994, Bonney 2015)] and at various levels in education. It is based on the analysis of a specific case described in detail, which takes into account different points of view on the basis of which conclusions can be drawn that can be partially or fully applied to other similar situations, and even used to create an action model for that particular category of cases.

A way to use a case description

The subject of the discussion may touch on a number of aspects of the case, e.g. a completed project on health promotion, or only its description/plan, such as the legitimacy of the venture, the significance of the problem, the reliability of the analysis prior making a decision, the adequacy of resources and means to accomplish tasks, evaluation of results, effectiveness (and even efficiency – if there is probable cause for doing so).

Demonstrations of realistic examples (“a good example is worth a 1000 words”) works best when supported by the participation of those who contributed to their

¹² This “inclusive education” is considered to be one of the key factors in effective collaboration of various professionals in achieving the objectives of health, including health promotion (see. e.g. WHO 2010).

implementation or took part in them. Participants should be given the opportunity to accurately read the presented example and there should be enough time for questions as well as discussion. The person(s) presenting should be convincing. Materials containing the main data from the presented examples need to be prepared in advance.

Analysis of good practices consists of becoming familiarised with noteworthy undertakings in the field of health promotion which have been the subject of evaluation and indicating their positive health effect on the target group. Through reflection this might be an inspiration for the adaptation (if necessary) and transferring of such a good practice to another place or other populations of recipients. More information about this is provided in Chapter 7.

Preparing a project for a new venture. The description of the project includes the following elements: its purpose, concept and plan, method of implementation and monitoring, evaluation and the method of ensuring the sustainability of results. Preparing projects in health promotion in small groups of participants is not only a dynamic way of educating, but it also serves the future practice of health promoters. To carry this out properly, information about the form of the project and what is necessary to organise and realise it needs to be prepared for participants in advance.

Use of project-based learning

Sample elements of a project description prepared by the participants of the training are: introduction, purpose, method and implementation, risks and factors that contribute to success, results, evaluation, discussion, prospects for continuation and development.

Work is conducted in groups, preferably in several stages (at least two) to allow for proper selection of teams, a preliminary decision on the topic of the project and familiarisation with the rules of the project's preparation. Consultation is necessary, given by the teacher, and the final stage is the presentation of projects by the teams (done according to the previously prepared scheme).

Source: developed based on TeachThought in 2016.

Role playing in health promotion involves taking on the role of older people, patients or those in need of care (recipients of health promotion) and staging real situations that occur in the educational process. Both sides are engaged in the staging, allowing them to better understand the problems of the trainees and "teachers". This method triggers spontaneity (because there is no exact scenario), it enables the discovery of unnoticed aspects of the problem, allows participants to practice communication and reactions in difficult and unexpected situations.

It helps to re-evaluate existing points of view and ways of behaving. The method of role-play is most effective in small groups (four to six knowledgeable people). Warning: people should not be engaged in roles that may be difficult for them psychologically.

**Simulation of physical and mental handicaps,
which older people are subject to**

This teaching method involves the simulation of the functional limitations of older people and the disabled, as in the following examples:

- putting a physically able person in a wheelchair and requesting that he/she move around the building or perform simple physical exercises;
- role playing the part of an older woman who had hip surgery two months earlier and describing her daily activities;
- obstructing a healthy person's ears and/or wearing glasses which hinder vision to see how he/she receives certain information;
- giving oral instructions concerning the use of a complex device or a chemical process (which the listener has no prior knowledge of) and then checking how much he/she has comprehended given the highly complex content;
- restricting people's ability to move – in a manner typically experienced by older people (students of the AgeLab at the Massachusetts Institute of Technology created a special suit for the purpose of limiting movement).

Source: developed based on AgeLab-MIT.

Staging (drama) is an expanded version of the role-play exercise, realised with the simultaneous involvement of many people ("actors") and according to a pre-planned scenario. Though it requires more preparation and time, it is useful in simulations of situations that involve many participants. It can be used in groups consisting of representatives of various kinds of health promoters, which contributes to a better understanding of the complementarity of their roles. This technique succeeds when the scenario is relatively simple, there is adequate space and if there is a possibility of discussion immediately following the staging.

Preparation of information materials tailored to the specific needs and capabilities of older people requires teamwork (in small artistic groups). Attention should be paid to the use of larger letters, simple texts, referring to symbols, people and events of prior periods (to the time of the recipients' youth and middle age). The making of posters, flyers, short information brochures, and audio or video materials is much desired.

Presentation of professional successes/achievements enables (activates) listeners. The idea is to encourage the preparation of short presentations showing examples of successful ventures in the field of health promotion for older people

which have been drawn from professional experience. An alternative to this might be the preparation of such presentations based on appropriate examples found in the literature. It is advisable to specify the format of presentation, i.e. the duration of the presentation and the information which it is to include, as well as to highlight the conclusions/lessons to take from the example, and to provide time for group discussion after the presentations. Competition between groups and prizes for the best ideas and presentations enhance the quality of teaching.

Meetings with representatives of institutions involved in health promotion bring participants closer to practice. Inviting representatives of specific institutions creates opportunities for learning and discussing the problems that these institutions confront and allows for an exchange of practical experiences with the audience. It is possible to discuss problems that need to be solved, and even to formulate indications to improve the operations of the institution. An extension of such meetings may be for small groups of students to visit the institutions, especially those which the students do not know from personal experience, which further promotes familiarisation with their practical functioning.

Continuation of contact with the participants of the training consolidates the acquired knowledge. This applies, admittedly, to the period following the completion of the training, but it is an important element of “sustaining” learning outcomes.

There is a change in the teacher-student relationship taking place in education at present. The role of the teacher as the “instructor” and “controller” of students’ knowledge and behaviour – is no longer sufficient. The teacher is now becoming more of a mentor, coach and partner of the individuals he/she works with. A mentor is understood as being a teacher transmitting reliable knowledge, but also – just as importantly – an assistant in solving the educational problems of the health promoter, a guide through the system and institutions of health care, the middleman who shares his/her network of contacts and a counsellor that draws attention to important issues, as well as the guardian sharing in the responsibility for some specified decisions made in the teaching process (Miller 2010).

The specificity of health education addressed to older people

Older people comprise a specific and heterogeneous population. Its diversity in terms of demography and health condition is presented in Chapter 3. On account of this differentiation there is a need to use different forms of education. Older people who are still present in the workforce are generally oriented towards lifelong learning (LLL), which is connected to the maintenance, replenishment and improvement of professional qualifications. Retired seniors are the main recipients of voluntary health education, while people over 85 years of age generally require

the linking of the care they receive with both health promotion and prevention (e.g. falls), and often with medical care as well. Educational activities in this case are addressed more to the caregivers and families of the older people rather than exclusively to the seniors themselves.

Education of older people is very diverse in terms of form and content. Formal education is usually more prevalent and is organised by an institutional entity. The idea behind this is to “pull” the older person out of the house, to meet with others. This extraction from the house is very stimulating. It promotes social integration and is an important factor in the prevention of mental disorders (Golinowska et al. 2016). The integrational aspect of education is emphasised by UNESCO (2009) under the concept of inclusive education¹³.

Formal education is of particular importance in health promotion addressed to older people. There is a guarantee that the knowledge and the information passed on by the health promoter in classes for seniors is adequate and reliable; whereas the advice seniors receive from friends and acquaintances (other seniors) is often conflicting.

Although with age, activity generally decreases and health problems usually begin to increase, there is usually a considerable crowd of activists and volunteers, within the group of seniors, who act *de facto* as health promoters, organising the social life of the local community. In Poland, this does not happen in quite the way that it does in Scandinavian countries, the Netherlands and Italy, but there is evidence of an increasing trend in this direction (Principi et al. 2016).

What fosters people’s ability to learn health promotion effectively?

- Learning refers to the problems they experience themselves or to goals they have set out to achieve.
- They see the relevance and value of what they are learning.
- They have an impact on the actual learning process.
- They are engaged in learning on a voluntary basis.
- They are valued and their experiences matter.
- They can speak freely and without fear of criticism.
- They are, along with other learners, actively engaged in the learning process.
- They can make mistakes and apply the method of trial and error without fear of stigma.
- Learning objectives are clear and understandable and the process of learning is divided into achievable stages.

¹³ Inclusive education is a process of “strengthening the capacity of the education system to reach out to all learners ...” As an overall principle, it should guide all education policies and practices, starting from the fact that education is a basic human right and the foundation for a more just and equal society.

- The methods and ways of teaching are varied and tailored to the learners and subject matter.
- They are encouraged to use their knowledge and skills in ways which are known to them, as well as in new contexts.
- They have the opportunity to ask questions, obtain clarifications and express their points of view in a way that shows that they are being heard and understood.

Source: Keleher et al. 2003.

Older people can be difficult recipients of education if particular characteristics of their condition (health potential) and attitude to education are not properly taken into account. They often have trouble absorbing content quickly, have problems with hearing, tend to be impatient and excitable; or the opposite – their reactions might be slow. They suffer from a variety of somatic and psychological ailments which influence their perception and learning capabilities. Older people filter transmitted information by comparing it with their own larger, richer set of life experiences, more than the typical recipient. At times, they can be very critical in their evaluation of the content, form, and – very importantly – the teacher. It is more difficult to convince them to accept reasoning other than their own. Despite this, the period of “late adulthood” is starting to be treated not as a period of loss, but as an opportunity for new challenges (Zielazny, Biedrowski and Mucha 2013) and there are already a number of practical recommendations aimed at facilitating learning at this age (see e.g. *A guide to coaching the older people*, – Kurantowicz, Nizińska and Czubak-Koch 2013).

Health education of seniors requires particularly **good communication** between the health promoter and the older person. In addition, the information directed to the senior should be properly adapted to him/her. How this can be achieved can be seen in commercial marketing campaigns which use very persuasive arguments to convince consumers to purchase the featured products. Health promoters should be equally convincing to change the behaviour or even the lifestyle of an older person.

Information should therefore be given with special care, under appropriate conditions, and also in an individualised manner. There are several key factors that lead to successful communication:

- **form of communication** – works best if it is through direct personal contact under conditions that are conducive to a quiet conversation; conversations over the phone can be used to support and supplement prior direct contact; leaflets or brochures can be supportive but should not be a substitute for real personal contact;
- **language** – should be easy to understand, without unnecessary medical jargon, and the rate of transmission of information should be tailored to the recipient's cognitive skills;

- **approach** – should be based on partnership; it should be empathetic and involve not only reliable transmission of information, but also conscious listening, observing the reactions of the recipient and giving continued support.

For the relatively small percentage of older people who use computers and the internet it is possible to conduct e-learning on health. American studies have shown that health awareness and respect for doctor's recommendations significantly improve when an adapted system of distance learning is put into place, regardless of whether the recipients are individuals or groups (Xie 2011).

Older people are able to learn effectively, if they do so with joy, at their own pace in a manner appropriate to their abilities, which at the same time is not drastically revolutionary or life altering. While forcing them to carry out specific changes, even the most legitimate pro-health behaviours will not yield positive effects if they are far removed from the recipients' routine and are unpleasant. There is therefore a need to adjust health promotion to each specific kind of recipient, in this case to seniors. Examples of effective methods of informing and educating older people used in health promotion are included in the box below.

Examples of teaching methods used towards older people in health education

- **Motor activities:** (themed) excursions, walks – aimed at learning about interesting places, and even the collection of data for the development of documents and studies concerning e.g. management of residential areas for the purpose of adapting them to the needs and capabilities of older people, Nordic walking, water aerobics, classes in parks
- **Games** – involving both the mind and body: requiring physical movement, memory training, playing board games and mind games and mental, individual and team competitions
- **Film screenings**, going out to the theatre, discussion clubs, interest groups, preparing performances or cabarets, all with content related to healthy lifestyles
- **Classes with music** (the best choice of music for this is that which is known to the participants), both for entertainment (physical exercises, dancing in pairs and in a circle), and classical, relaxation sessions
- **Art classes** focused on topics concerning lifestyle and health; preparing posters, sculptures, decorations, and even advertisements
- **Maintaining interests** and developing all kinds of hobbies, for example, gardening, healthy cooking, caring for animals
- **Recreational trips**, rehabilitation, thematic picnics, senior games containing elements related to health promotion
- **Self-study groups, intergenerational workshops** for younger people led by seniors, the organisation of thematic meetings, courses
- **Support groups**, networks of friends and neighbours: learning by example, mutual exchange of experience and help in achieving the goals of education,

health education, – babysitting, visits to nursing homes or in the homes of individuals, including senior volunteering

- **Providing possibilities of expression**, discussion: meetings, focus groups, moderated (by health promoters) discussions, joint preparation of documents, opinions, petitions, group projects, involving the development of analyses and giving the recipients substantial weight in decision-making
- **Inclusion in the preparation of projects** on issues relevant to older people and their communities, activating the participation of older workers.

Source: own comparison.

A health promoter should be a source of motivation for leading a healthy lifestyle. He/she should set an example of good health and be a role model to follow. For an older person, an especially appropriate form of promoting health is through a concept called ‘friendship professional mentoring’ (Clutterbuck 2004) – it is friendly, that is to say, it puts emphasis on partnership, empathy and sympathy shown by the health promoter/teacher in relation to the older student. This approach reinforces trust and promotes the efficiency of the process of knowledge transfer: achieving success with the “student”, but also giving the mentor job satisfaction.

A good mentor in health promotion should be: willing, available, responsive and attentive, self-conscious, discreet, ready to learn, non-judgmental, patient, positive, empathetic, respectful, tolerant, understanding, able to listen, polite, open, motivating and enthusiastic (Miller 2002; Megginson et al. 2006; Brigden 2000).

Setting a good personal example by the educator is always the best form of motivation for achieving good results in education. A person who is physically fit, who does some type of exercise, preferably of a kind that a senior could also take part in, and has a cheerful personality, likes to smile, has a positive attitude and leads an interesting life is more likely to be an effective promoter of health than a person with addictions or who never exercises. An important aspect in health promotion is the educator’s personal mobilisation to shape attitudes and attributes that show respect for the principles of health promotion. In addition, people who approach their profession with a high degree of conviction and passion, who treat it as a mission, are not only more successful, but also derive more joy from their work. Young volunteers often possess these characteristics. On the one hand, their work helps to successfully achieve the objectives of promoting health in older people, while their enthusiasm and dedication – on the other hand – can be a very good example for other promoters.

Every type of education – including health education – can be said to be effective when, as a result, people modify or completely change their behaviour, leading to improved health and/or the cessation of negative processes related to the deterioration of one’s health. A commonly used indicator of a given education project’s

range is the number of persons whom it reached, e.g. the size of the population to which relevant health-related information was communicated. A much more important indicator, however, is the level of knowledge that recipients gained as a result of the education they received; and the key element here is to assess how a particular type or method of education has affected their health. Assessment of health promotion campaigns uses the following criteria of effectiveness of influence (World Bank Group, 2015):

- Clearly communicated information about how a specific action/behaviour will change one's state of health;
- Presentation of examples and specification of procedures/proceedings
- Identification of and taking steps to reduce/eliminate barriers that impede the implementation of healthy change;
- Creation of a support system for people who choose a desired change in behaviour (e.g. quitting smoking and/or alcohol);
- Providing the materials needed for the implementation/execution of change;
- Providing direct (personal) contact and/or making contact with the help of the internet in order to provide further information.

Conclusions

Health education is a fundamental method of health promotion both in general and specifically addressed to older people. In the health education process the main group of educators (teachers) are promoters of health. This professional group is not yet defined with specific work standards. Health promotion activities are realised by various professional groups. These include medical professionals and specialists working in the social, education and sport sectors, as well as social activists (often volunteers) who have varying levels of preparation and qualifications.

Investing in the staff development of health promoters and expanding their competence in the field of health and prevention of chronic diseases is an urgent challenge for the current health policy aimed at developing a strategy for the healthy ageing of the population.

Training health promoters takes place at both the undergraduate and specialisation levels, within the framework of specialised postgraduate studies, as well as in various forms of lifelong learning.

There are a number of indications, methods and good examples of how to conduct modern training of health promoters. For this aim, it is helpful to take developed and tested (often in other countries) training methods and to adapt them to the institutional conditions of a specific country. An important factor in modern education is the use of knowledge of specialists educated in various disciplines or coming from different educational backgrounds, which is an important element needed for building interdisciplinary, inter-institutional and inter-sectorial bridges.

In contemporary education, teaching methods are interactive, such that the teacher is more a mentor, partner and advisor rather than an instructor who provides certain content to be remembered or learned. Modern education usually requires group work and active participation in the performance of tasks by designing, producing, presenting and partaking in evaluation. Preparing to become a health promoter requires an understanding of the fact that this is a special mission. It also requires the possession of a strong sense of authority and an ability to be a broker of knowledge in the field of health sciences.

In their work addressed to older people, health promoters have to perform a more difficult task of teaching compared to those who teach the younger population. Seniors are more difficult recipients of knowledge and information about what promotes health and what constitutes a risk to health. They are also less likely to change their lifestyles. Meanwhile, health promoters have to effectively raise the health awareness of older people. The prestige of the profession of doctor, nurse, therapist or dietitian¹⁴ – just to name a few, whose representatives undertake tasks in the field of health promotion every day – is undoubtedly a major factor in the positive attitude of the seniors towards health information, but it is not enough to achieve sufficient effects. In carrying out this important function it is helpful to master and implement appropriate methods of communication in daily practice and to use especially active and practical training methods, taking into account the limitations of perception and adroitness of older people. This field is already relatively rich in resources, knowledge and experience from a range of countries (including best practices), much of which can be found in this handbook.

Health promoters often play the role of advocates, promoting health (*health advocacy*). They work in order to gain political and social acceptance and systematic support for specific goals and desired health programmes (WHO 1998). Because health professionals enjoy considerable prestige in society, their voices and public involvement are factors which should not be underestimated for they play a significant role in persuading individuals towards favourable health behaviour and encouraging institutional activities which are conducive to the protection of health.

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¹⁴ Medical professionals, including doctors and nurses consistently rank at the forefront of professions who are most trusted by society in Poland (Gesellschaft für Konsumforschung – GfK 2016). They therefore have a very important asset that can and should be used properly for health.

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INSTITUTIONS AND FUNDING OF HEALTH PROMOTION



Institutions and funding of health promotion for older people

Introduction

Any organised activity, including health promotion, is realised within the framework of institutions and through institutions. This sentence shows just how broad the meaning of the term ‘institution’ can be. On the one hand, these include norms and other rules of operation, while on the other hand they are formal organisations that are operating within the rules set by those institutions. In the past thirty years, the institutional dimension of human activity has seen an expansion of research in fields such as economics, sociology and political science. Douglas North, who received the Nobel Prize in Economics in 1993 for explaining and proving the importance of institutions in the realm of human activity, put emphasis on the rules concerning that activity, both informal (often of a cultural nature), as well as formal, designated by law, agreements or codes. Oliver Williamson, however, considered organisations to be an important element of the institutional approach to economic analysis. Polish readers can find the clearly presented fundamentals of institutionalism in the works of Jerzy Wilkin, especially in that of 2016. (Wilkin 2016).

Every organised activity also requires resources for its inception: financial capital and human capital. Both types of resources are equally important. We need both money and qualified people who are capable of managing effectively as well as in accordance with set goals.

The present chapter deals with both institutions of health promotion and the finances supporting their activities. Considerations are made for older people, according to the definition set out in Chapter 4.

The institutional infrastructure of health promotion is dispersed and in certain European countries which have been analysed it has been found to vary significantly. In some countries, it is more regulated and situated in the healthcare sector. Whereas in other countries, it is rather the result of bottom-up

initiatives, institutionalised within the NGO sector. In the 80s the importance of measures taken by the State to promote health increased and new types of planned, implemented and monitored health programmes were developed with a rise in the number of professionals who were educated and focused on health promotion and prevention of chronic diseases.

The aim of this chapter is to present the activities of recognised institutions and organisations of health promotion (in general as well as specifically for older people), to clarify the rules pertaining to their activities and to give an indication of the necessary resources which enable them. In this chapter we will present the strategic-planning institutions as well as payment institutions and those carrying out particular activities - the so-called operational institutions. We will draw attention to the diversity of the functioning of state institutions – centralised and decentralised – as well as the role and position of non-governmental organisations and the media. We will distinguish institutions in the health, sport, recreation and social sectors which are relevant to health promotion. We will also take into account the role of employers in health promotion and disease prevention in the workplace, especially with regard to older workers.

After reading this chapter the reader should be able to answer the following questions: what organisations are engaged in health promotion addressed to the elderly, what activities do they undertake, within the framework of what rules, what methods do they use and with what resources do they carry out implementation?

Regulations in the area of health promotion

The regulatory sphere (strategies, national programmes, laws) in the area of health promotion for older people in European countries varies considerably despite being subjected to the rules of convergence resulting from participation in the European Union (EU). Existing regulations do not always directly relate to health promotion addressed to older people. More often they refer to certain fields of health policy or public health and health promotion in general, by defining the priorities of the state in terms of prevention and health policies addressed to a specific group of the population or determination of the responsibility of decentralised power structures.

EU countries distinguish between diversified legal acts dedicated to health promotion. The fundamental legal act regarding health care in the context of guaranteeing access to health services, including prevention, within the framework of public finances, is the constitution.

Health promotion and disease prevention are considered the main currents of the regulated activities of the State in the realm of public health, which primarily include laws on public health (e.g. Poland, the Netherlands, Sweden, the Czech Republic) and laws on the prevention of diseases (e.g. the Netherlands, Germany).

Health promotion is also governed by social laws (e.g. The Netherlands, Germany, Poland), laws of health – mainly insurance (the Netherlands, Germany, Poland) and safety at work (most EU countries) (Arsenijević and Groot 2017; Sowada et al. 2017; Golinowska et al. 2017; Sowa and Szetela 2017).

The laws on public health adopted in the 1990s (Sweden) and in recent years (2015 – Poland) define the responsibilities of mainly central and local authorities in the planning, implementation, monitoring, evaluation and financing of health promotion. This legislation determines that the most operative level in health promotion is the local level, that of the community. The law on prevention in public health regulates the responsibility and financing of local governments to promote health enhancing activities in this area. Social acts are addressed to people with disabilities, the older population, etc. and protect these groups against social exclusion through activities that promote health.

Countries in the EU have laws on public health. However, more specific regulations are rare, like those that would deal only with health promotion and prevention. The exception is Germany, which in the year 2015, passed a law strengthening health promotion and prevention (Preventive Health Care Act, PHCA; Gesetz zur Stärkung Gesundheitsförderung und der Prävention) (Golinowska et al. 2017). The main objective of the act is the commitment of many different actors to work together for health, and particularly for its promotion and the prevention of modern diseases of the ageing population.

Furthermore, EU countries have adopted long-term strategies and plans, which include activities in health promotion and disease prevention, including those targeting older people. National health programmes do not always emphasise the health needs of the older population. Sometimes targeting the elderly takes place in a separate integrated programme of health promotion. The main objectives of these programmes are: promoting healthy ageing, identifying the needs of older people, promoting a sustainable environment and the independent living of older people through prevention of injuries and accidents, prevention of mental illness and social exclusion, fighting addiction, promoting physical activity, healthy eating and oral health, as well as access to a high quality of health care, including long-term care (Table 3). These objectives are interdisciplinary; their implementation is primarily the responsibility of local authorities and providers – especially family doctors, nurses, dietitians, physiotherapists. Not all EU countries have national health promotion documents addressed to older people.

Legal regulations concerning health promotion for older people are also created at regional levels of administration, especially in countries with a significant regional autonomy of the local government. This is exemplified by the Regional Agreement for Health in Italy, and in Poland – with Regional Programmes of Public Health.

Table 3 National priorities in health promotion, with a particular focus on older people in selected EU countries

National Health Programmes (NHP)	Priorities	National health programmes addressed to older people	Priorities
The Netherlands National Programme of Prevention (NPP) 2014– 2016	Cooperation of actors involved, such as local authorities, promoters and health care providers (doctors, nurses, physiotherapists, nutritionists), sports clubs, insurers, schools, NGO's. The most important goals of health promotion are: the prevention of obesity, the fight against addictions (tobacco and alcohol), increased physical activity, rational antibiotic therapy. Website: "Alles is gezondheid".	Many national documents integrated into Nationaal Programma Ouderenzorg.	Prevention of injuries and accidents, prevention of mental health, social inclusion. Particular attention is paid to selected minorities among the elderly population: migrants and homosexuals.
Germany National Health targets (since 2000) National Recommendations for Health, Promotion and Prevention by the National Prevention Conference (February 2016)	120 organisations and institutions cooperate for the development of the national health targets. National health targets are: Reducing the risk of the incidence of type 2 diabetes, breast cancer, mental illness. Reducing the consumption of alcohol and tobacco, strengthening the sovereignty of the patient, healthy ageing and health before and after birth. The National Recommendations on Prevention established in 2016 declare 3 main goals: growing up healthy, healthy living and working conditions, health in old age.	Healthy Ageing– has been a national health target since 2012.	Health promotion and disease prevention – to increase the social participation of older people, physical activity, promoting a balanced diet and oral health. Access to high-quality health care (medical, psychological, and nursing). Special challenges: disability, long-term care, psychiatric care.
Italy National Health Programme Pact for Health – National/ Regional Agreement for Health	The most important goals of health promotion are: fighting against addictions (alcohol, cigarettes), proper nutrition, increasing physical activity, promoting healthy lifestyles, prevention of injuries and accidents.	Programme for the Health of Older People (1992) <i>Tutela della salute degli anziani</i> Currently, the National Prevention Plan. No document dedicated.	Ensuring access to high quality health and social care, supervision and control of communicable and noncommunicable diseases, increasing physical activity, reducing inequalities, the integration of health and social care.

Table 3 – continued

National Health Programmes (NHP)	Priorities	National health programmes addressed to older people	Priorities
Portugal National Health Programme 2016–2020	Supervision and control of communicable and non-communicable diseases, health promotion, fighting addictions (tobacco, alcohol), increased physical activity, healthy eating.	National Health Programme for Older People.	Promoting the idea of healthy ageing, access to the corresponding needs of the elderly health care, promotion and development of a sustainable environment.
Poland NHP 2007–2015 NHP 2016–2020	The need for inter-sectoral actions. The most important goals of health promotion are the fight against addictions (alcohol, cigarettes), proper nutrition, increasing physical activity, promoting healthy lifestyles, prevention of injuries and accidents, access to high quality health care.	There is no single document. National policy is dispersed into multiple documents, strategies and programmes.	Prevention of injuries and accidents, promotion of mental health, social inclusion, the fight against addictions (alcohol, tobacco, drugs), healthy eating, increasing physical activity.
Hungary Changing the National Health Programme, The strategic document “Healthy Hungary 2014–2020”	Supervision and control of communicable and non-communicable diseases, health promotion, increased physical activity, healthy eating, fighting addictions.	The National Ageing Strategy for the years 2009–2034	Main goals – long-term care, extending healthy life, mental health, ensuring the viability of the pension fund, social integration, the harmonisation of different kinds of services: medical, social, educational, cultural.

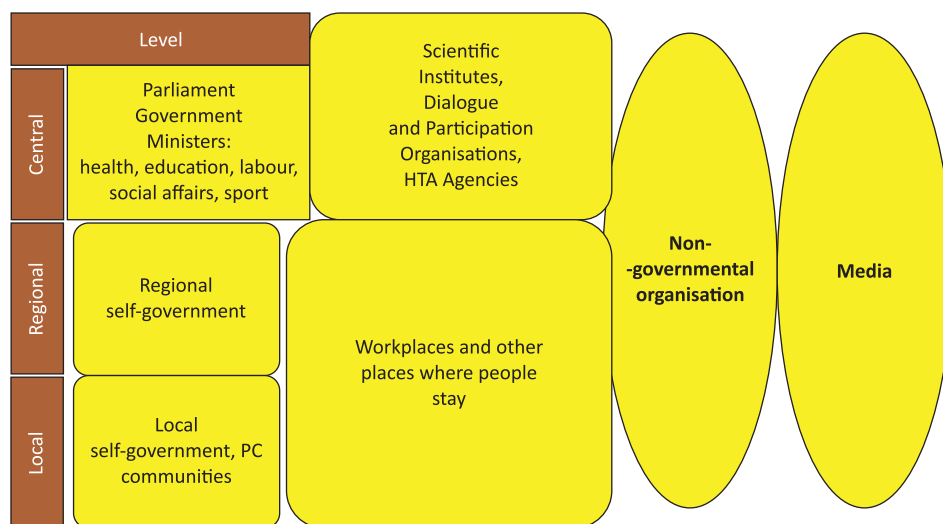
Source: own comparison based on: Arsenijevic and Groot 2017; Falvo et al. 2017; Tambor et al. 2017; Golinowska et al. 2017, Sowada et al. 2017; Pavlova et al. 2017; Poscia et al. 2017; Sowa and Szetela 2017.

Sectors and the institutions functioning within them

Health issues require institutional support, sometimes mandatory support, even though each person is free to make decisions about his or her lifestyle and behaviour. Health promotion as an institutionalised activity is performed within the framework of a number of sectors and organisational structures, both public and private, governmental and non-governmental, at the central and local levels and in many different locations: schools, workplaces, clinics and hospitals. Health promotion can be addressed to the entire population or selectively to certain groups of the population.

Determining what makes sectors and the institutions situated within them particularly active in health promotion for older people depends on the institutional specificity of the country. Experts involved in the *Pro Health 65+* project (Sitko et al. 2016) have found, on the basis of their studies, that the institutions most committed to health promotion for the elderly in the 10 analysed European countries operate within: the health sector of the territorial self-government (regional and local) and the so-called third sector (non-governmental organisations, NGOs). In Germany, for example, outside of the health sector and local government, the sports and education sector is considered important. In the Czech Republic – the social sector is also of importance, and in Italy – the social sector and the workplace and its occupational medicine within it. The diagram in Figure 11 reflects the image of sectors and their main institutions carrying out activities in the field of health promotion addressed to the elderly.

Figure 11 The sectors and institutions carrying out activities in the field of health promotion and prevention of chronic diseases



Source: own study.

The institutional image of health promotion is much more diverse than health care, which to a large extent has defined boundaries and is standardised, with the option of the universally applied standards of medical procedures (Golinowska 2016). In European countries, the differences in the regulatory mandate, structure, size, operating principles, competence, scope of activity of functions and rules of financing institutions dealing with sectoral health promotion are large (Table 4).

Table 4 Sectoral activities and functions in the field of Health Promotion for Older People

Sectors	Function	Activities	Target groups
Central Government National Health Institute	Regulation function: legislative initiative to establish public health/health promotion and disease prevention law Preparing strategic documents Knowledge building on healthy lifestyle (research, scientific studies)	Conducting policy, the creation of strategies and programmes, conducting research activities undertaken by specific professionals Programmes, research, policy/strategy	Entire population
Regional and local government	Information Motivation and encouragement Advocacy Knowledge building and dissemination Education Organising primary and secondary prevention and health promotion	Strategies and policies on the local level, activities undertaken by particular professionals and health promotion promotes on the local level (e.g. initiatives)	Residents of a given region and community
Health Sector MH Payer/insurance body Primary care	Primary and secondary prevention delivery Information and Education	Within service financing – prevention per se: increasing physical activity, proper diet and posture, prevention of lifestyle diseases, such as cardiovascular diseases, and vaccination, e.g. flu vaccine for people 65+ Within service delivery – oriented on health conservation, improvement, postponing worsening health condition, promotion of expected life style (improving health – diet/ physical activity recommendation)	Patients – ill people
Workplace sector	Prevention of occupational risks Health Promotion Information Motivation and encouragement Advocacy Knowledge building and dissemination Education	Regular checking of workers, diagnostics and other services within occupational medicine service and professionals Ergonomics Programmes/ training organised at the workplace	Entire workforce, in some companies also workplace health promotion specifically target to older workers
Non-governmental organisations (NGO's)	Information Motivation and encouragement Advocacy Knowledge building and dissemination Education Social inclusion and participation	Actions of different kinds addressed to the older population in need in different settings (determined by the NGO type and mission)	Selected groups

Table 4 – continued

Sectors	Function	Activities	Target groups
Social Sector	Information Motivation and encouragement Education	Accompanying social service delivery, direct contact with professionals (advocacy for life style/habit change, personal support)	The vulnerable population
Sport and Leisure	Motivation and encouragement Advocacy Education	Promoting physical activity and sport (e.g. aerobics, Nordic walking, soccer, swimming, volleyball, dance)	The population generally and seniors particularly
Media	Information Motivation and encouragement Knowledge building and dissemination Education	Creating health programmes (physical activity, healthy nutrition, prevention of chronic diseases) addressed to the older population.	The population generally and seniors particularly

Source: Own study based on the WP6 research of the Project Pro Health 65+ (Golinowska 2016).

A Canadian researcher in the field of public health, Dennis Raphael points out that the presence of activities in the field of health promotion in the health sector depends on many factors, such as the development of public institutions in the country, the model of health care, the level of decentralisation of power or civic activity to solve people's personal affairs. For example, in countries with a centralised model of public institutions, health promotion is carried out by government agencies; the National Institutes of Public Health, the Ministry of Health, the Ministry of Labour and Social Policy, and public media as the main activity of public health. In countries that are more decentralised, health promotion is conducted through delegation (outsourcing) and also grass-roots' activities, independent of the central level.

The World Health Organization (WHO) developed the concept of promoting and enforcing good conditions for health in general and in permanent places of human habitation. In this way the concept of health promotion based on where one lives was created (the settings based approach, SBA), which in turn has resulted in numerous health programmes in many places (Table 5). These include programmes such as: healthy city, healthy schools, healthy university, healthy company, healthy home and healthy hospital. The concept of implementing the principles of health promotion in places occupied by people has gained a lot of recognition, although it applies more to less designated places (schools or workplaces) rather than to larger areas (the whole city) (Dooris 2009).

Table 5 Who undertakes activities in the sphere of health promotion for older people?

Sector	Main sectoral institutions	Place of setting	Health promoters
Health	Ministry of Health, GP/ Primary care organisations, Outpatient specialist Care, Insurers and others	Health centres/ units Patient's homes	GPs, Nurses, Public health organisations, different specialists and professionals, Physiotherapists Occupational therapists, Dieticians, Exercise counsellors Pharmacists, Opticians/ optometrists Speech and language therapists
Public Authority	Different Ministries (e.g. Ministry of Health, Ministry of Social Policy) National public health agencies/ organs/bodies Regional/local public health departments, special healthy ageing units e.g. senior councils	Different settings (depending on the particular activity)	Public health professionals Epidemiologists Teachers, Community workers Social workers Environmental health officers
Sport and Leisure	Sports organisations/clubs/ associations	Sport clubs, Sport centres	Teachers, pedagogy specialists, sport trainers, physiotherapists
Social Sector	Social Services	Nursing homes, Different settings (depending on the particular activity)	Social workers, therapists, environmental nurses
Workplace	Governmental Institutions (i.e. Ministries, Local authorities, Inspectorates)	Mainly workplaces, but in some instances also different settings (gyms, gardens)	Occupational Physician/ Occupational health services (Psychologist, Nurse) Employer (or dedicated staff/ Internal safety committees) Employees' representatives or organisations (i.e. Network of workers or Trade Unions) Health Insurance Companies (insurance systems) Research organisations (Academic/University)
NGO/ Voluntary	Social and civic organisations – NGOs	Different settings (depending on the particular NGO and particular activity)	NGO activists Public health professionals Pressure groups Health Educators
Media	Media organisations (TV, radio, press, Internet)	Different media (press, audio and TV programmes, internet)	Journalists – Health correspondents

Source: as above.

Government sector

Governments in many countries, besides having departmental (ministerial) institutions, also have their own separate government institutions, usually performing functions that involve strategic-planning to deal with comprehensive, general problems and coordination of shared ministerial responsibility for affairs in various fields. Also with regard to the territorial structures, which can be more or less autonomous, governments have their institutions at the territorial levels. The division of responsibility and its structure within the government are specific to the country, connected to the tradition of the formation of the state administration, undertaken reforms and the influence of international structures.

Health issues generally fall under the domain of the ministries and responsibility for them falls under the Ministry of Health, although public health problems tend to be dealt with at the government level. Governments have difficulty coordinating issues that fall under ministries. A portrayal of these problems is the postulate – a slogan calling for unified action for health: “health in all policies”. Matters of health promotion and prevention of chronic diseases are also present in the departments of labour and social policy, education, science and sport, as well as agriculture, transport and construction.

Both the government institutions’ and government-department institutions’ primary functions are the preparation of strategies and action plans; they initiate a number of legal acts, developing and indicating methods of operation.

Democratic governance in European countries has led to the development of dialogue and social participation in many major political and social issues. As ageing is one of the biggest challenges at present, many countries have created special councils or committees to deal with issues concerning older people’s needs at the central level. For example, Italy has a parliamentary group called *Active ageing*, representing the interests of senior citizens in creating policies of active and healthy ageing (Poscia et al. 2017), in the Czech Republic there is a Government Council for Older People and the Ageing population (Owl and Szetela 2017), and in Hungary there is a Committee for Ageing (Tambor et al. 2017).

The central level mainly deals with surveillance activities and control of communicable diseases, health promotion and health education (e.g. screening programmes, prevention).

Governance in any field requires the development of facilities for research, information and analysis. Most EU countries have established research institutes which operate at the national level examining and monitoring the health of the population, gathering expertise and cooperating with other centres in order to rationalise the decision-making process in public health and health promotion. These are usually National Institutes of Health (or public health). Examples are provided in the frame below.

Examples of National institutes of Health and other institutes related to the public health in selected countries.

- National Institute of Public Health (Rijksinstituut voor Volksgezondheid en Milieu RIVM) and the Netherlands Institute for Research and Development in Public Health (Nederlandse organisatie voor gezondheidsonderzoek en zorginnovatie, ZonMw) in the Netherlands
- The Robert Koch Institute in Germany
- The National Institute of Health and the National Centre for Disease Prevention and Control (CCM) in Italy
- National Institute of Public Health (PZH) and the National Institute of Occupational Medicine in Poland

Because they are national institutes, they often have statutory mandates, and work together with decision makers (e.g. concerning the laws on public health). Their tasks include conducting research. The work of health institutes is also comprised of defining national health goals and strengthening health promotion activities and prevention aimed at different age groups, including older people. There are units within the internal structures of these institutes which are responsible for people's health at any given age, as shown in the examples of the Netherlands and Germany. In the Netherlands, there are also other institutes related to health promotion, such as the Institute of Mental Health, the Dutch Institute for Sport and Physical Activity (Nederlands Instituut voor Sport en Bewegen, NISB) and local public health institutes (GGDs – Gemeentelijk Gezondheidsdienst). In addition, activities connected to health promotion are also carried out by Centres of Academic Cooperation, responsible for transferring fact based knowledge to a specific practical activity.

Table 6 The National Institutes of Public Health – the characteristics

Country	Name of the Institute and its characteristics
The Netherlands	National Institute of Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu – RIVM) is the main scientific institute in the field of public health, environment and nutrition in the Netherlands. The Institute has been promoting public health and safeguarding environmental quality in the Netherlands for over 100 years. RIVM has expanded to become a knowledge institute at the center of Dutch society, advising on health and the environment. The work of the Institute is primarily commissioned by Dutch ministries, but inspectorates and projects are also undertaken within international frameworks, such as the European Union and United Nations. RIVM works to prevent and control outbreaks of infectious diseases, collects knowledge and information from various sources, both national and international. Each year, RIVM produces numerous reports on all aspects of public health, nutrition and diet, health care, disaster management, nature and the environment. The main

Table 6 – continued

Country	Name of the Institute and its characteristic
	tasks and responsibilities are policy support, national coordination, prevention and intervention programmes, provision of information to professionals and the general public, knowledge development and research as well as crisis management and response. RIVM has a joint responsibility in a number of national crisis situations, such as an outbreak of an infectious disease, a food safety incident or an environmental accident.
Germany	Robert-Koch-Institute (RKI) is a federal institution that is concerned with public health, health monitoring and the detection, prevention and control of diseases. It assesses, analyses and investigates diseases that are highly dangerous, very widespread or of great significance in terms of the public or health policy. The RKI additionally performs statutory and scientific tasks in the fields of genetic engineering and biological safety. The RKI acts as an advisor for the federal government, state and local health authorities and medical specialists. The RKI conducts research on different aspects of healthy ageing. As part of the general health monitoring it conducts several regular representative health surveys in which information on the health status of the older population as well as on risk factors and resources from childhood to senior age are gathered. In its research it explores relevant factors for healthy ageing and how they change over time. Health related behavior, the social context and living conditions that are influencing factors for chronic diseases, as well as physical and functional disabilities in older age are assessed as well. The health monitoring is complemented by analyses on the prevalence of cancer and on the provision of health care for older people with manifest diseases and disabilities, with a special focus on supply structures with GPs and care for multimorbid conditions. Another important part of the RKI's activities in the field of health prevention for older people is its research on vaccines against influenza and pneumococci.
Italy	The National Institute of Health (Istituto Superiore di Sanità – ISS) , is the leading technical-scientific body of the SSN. It started its activity in 1934 with the law of 11th January 1934, which defines its status and functions: The Institute of Public Health is established in Rome, in the service of Home Affairs, as a centre for investigations, research and verifications, pertaining to public health services and for the specialisation of the personnel of the said services in the kingdom. Since 1958 the Institute falls within the remit of the newly established Ministry of Health. The Presidential decree No 70/2001 modifies the legal status of the Institute, which became a public corporation and the technical and scientific body of the Servizio Sanitario Nazionale (National Health Service) aimed at carrying out research, clinical trials, control, consultation, documentation and training in public health. It is headed by the President, the General Director, a Scientific Committee and the board of auditors.
Poland	National Institute of Public Health – National Institute of Hygiene (NIZP-PZH) called previously the National Institute of Hygiene (Polish acronym: PZH) was established at the time Poland obtained its independence in 1918. Three years later – thanks to the support of the Rockefeller Foundation – Poland established Europe's first National School of Hygiene. Trained doctors and medical staff (called the 'Rockefellers') became the backbone of public health personnel in the country. The National School of Hygiene's activities were initially dominated by issues concerning the prevention of infectious diseases; production of serums and vaccines, the organisation of vaccinations and the control of food and sanitary conditions. Alongside these undertakings, scientific research, epidemiological studies and information and publishing activities were also given room to grow. The National School of Hygiene

Table 6 – continued

Country	Name of the Institute and its characteristic
	(PZH) carried out activities to combat major epidemics during the Second World War and for a few years after. Over time the PZH, which was transformed in 1952 into a scientific unit, developed activities in the field of monitoring health threats, health promotion and primary prevention of non-communicable diseases as well. It did not, however, discontinue its activities in the field of vaccinations. In recent years (along with the name change to the National Institute of Public Health with the addition of the PZH) there has been an increase in advocacy in the field of population health. The institute has created its first long-term health programmes adopted by the authorities of the country as a basis for health policy. This almost century-old institution tells the story of the medical and social community's great concern for the health of the population, finding wide recognition within society.

Source: based on information from the country experts of the "Pro-Health 65+" project: Jelena Arsenijevic, Kai Huter, Andrea Poscia and posted on www.pzh.gov.pl, <http://www.bzga.de/?id=Seite5138>, <http://www.rki.de>, http://www.rivm.nl/en/About_RIVM.

It has been shown that in most European Union countries there are national public health institutes of a scientific nature. They carry out extensive epidemiological research as well as conducting activities related to environmental health, nutrition, promotion and disease prevention. They often perform information functions for health ministries and government agencies, obtaining research reports and expertise. It is worth noting, however, that apart from such research institutes, government health centres with advisory and educational functions may also be set up at the central level, with the aims of creating guidelines in the government's public health policy and the development of public health plans and programmes focused on health promotion and disease prevention. In some cases such centres coordinate the implementation of health programmes at the regional (e.g. Italy) and local levels. Well-known examples of such institutions are Bundeszentrale für gesundheitliche Aufklärung (BZgA) (the Federal Center for Health Education) in Germany or The National Centre for Disease Prevention and Control (Comitato Collaborazione Medica CCM) in Italy.

**Bundeszentrale für gesundheitliche Aufklärung (BZgA)
(Federal Centre for Health Education)**

The BZgA is a German federal authority under the oversight of the Federal Ministry of Health. It was established in 1967. Its main tasks as defined in 1967 are

- The elaboration of principles and guidelines relating to the content and methods of practical health education
- Vocational training and continuing education of persons working in the field of health education

- Coordination and intensification of health education in Germany
- International collaboration

Over the years the scope of activities has been extended to cover now health promotion and prevention in general. The BZgA contributes to the development of national action plans and programmes concerning the prevention of infectious diseases, the prevention of drug use and health promotion and prevention in general. It provides education on organ and tissue donation, blood and plasma donation as well as sex education and family planning (statutory tasks). Furthermore the BZgA performs national joint tasks that are necessary to implement key aspects of health promotion and health education like evaluation and quality assurance, and it supports and coordinates cooperation of other actors and institutions in the field of health and health promotion.

Health of the Elderly is one of the key topics of the BZgA. Important activities in this field are the programme “Gesund und aktiv älter werden” (Ageing healthy and active”) and the prevention programme “Älter werden in Balance” (“Ageing in balance”). “Gesund und aktiv älter werden” includes regular national and regional conferences in all federal states on healthy ageing and support for cooperation between national associations and universities. The programme offers an internet portal and a newsletter. Both provide information on new data, projects, activities and publications (www.gesund-aktiv-aelter-werden.de).

“Älter werden in Balance” is focussed on communal strategies to promote health for older people with a strong focus on physical activities, general well-being and social integration. As part of this programme the BZgA initiated a national competition series in 2015 “Healthy ageing in the municipality – physically active and mobile” to honour good practice projects in communal settings that promote physical activity and mobility for older people (www.aelter-werden-in-balance.de). The BZgA also issues numerous publications on the health of older people. These include scientific reports as well as brochures with practical tips addressing older people.

Sources: <http://www.bzga.de/home/bzga/tasks-and-goals/> [accessed 31.05.2017]; <http://www.bzga.de/themenschwerpunkte/gesundheitsaelterermenschen/> [accessed 31.05.2017].

Comitato Collaborazione Medica – CCM **National Centre for Disease Prevention and Control in Italy**

The main task of the CCM is to liaise between the Ministry of Health on the one side, and regional governments on the other as regards surveillance, prevention and promptly responding to emergencies. The CCM was established in 2004. Over the years, the CCM has acquired a specific identity which makes it unique within the framework of Italian public health. The CCM is attached to the General Directorate for health prevention of the Ministry of Health, whose offices

guarantee operational support as regards project implementation. The mission of this Centre is: more prevention nationwide and in the national health service practice through strategies and interventions whose efficiency can be demonstrated by solid scientific data. Its main goals is to optimise the plans and priority actions in terms of public health nationwide. The Centre is a bridge between the world of research and health facilities on the one hand, and the best practices and entities being developed on the other, by activating institutional partnerships and professional collaborations: its aim is to build an Italian prevention network.

Source: <http://www.ccm-network.it/pagina.jsp?id=node/282&lingua=english> [accessed 7.06.2017].

Education and research in public health and health promotion, with particular emphasis on the older population, is also conducted by main academic centres, such as e.g. Charles University in Prague and Masaryk University in Brno, Jagiellonian University's Medical College in Krakow, Università Cattolica del Sacro Cuore in Italy and the University of Maastricht. There are also numerous research institutes which focus on specific health problems concerning older people, e.g. long-term care, health status, quality of life and nutrition for the older population. Some examples include the International Longevity Centre and the International Clinical Research Centre at the Hospital of St. Anne in Brno and the National Institute for Rest and Care of Elders (IRCCS-INRCA)

The Health Sector

The greatest expectations in relation to health promotion for older people are directed at the health sector, within which are included the Ministry of Health and its agencies, primary health care (PHC) and outpatient specialist care (AOS), institutions of health and social insurance, as well as private insurance companies. In European countries, the health sector is not uniform, and the existing differences depend on the model of the health system and its financing methods, the system of government and the adaptation of the concept of public health.

Although programmes of health promotion and prevention of chronic diseases are carried out for the most part within the health sector, other sectors also benefit from the resources of the health sector, and above all the competence of the medical staff and paramedics. Motivating and encouraging doctors, nurses and other medical professionals, including therapists, physiotherapists and nutritionists to take up preventive measures in relation to the elderly is one of the biggest challenges not only of health promotion, but of public health in general, as discussed in chapter 3.

The essential expectations for health promotion in the health sector are addressed at PHC institutions, and within them to family doctors and community nurses. They have direct contact with elderly people who turn to them with different health needs, not exclusive to those requiring treatment. These interactions help form relationships of trust, on the basis of which information about access to prevention and staying active in the context of health promotion can be disseminated and encouragement to improve one's lifestyle gives good results. Activities in the area of health promotion for older people carried out by family doctors (though they do not always have the time) are assessed as effective, and home visits for prevention and psychological support are often indicated as being good practices of health promotion (Duplaga et al. 2016).

Health insurance institutions play an important role in health promotion within the health sector. Obvious examples are the health insurance funds in Germany and Austria. German health insurance funds are legally obliged to spend 7 euros for each insured person on health promotion and primary prevention (Golinowska et al. 2017). This goes beyond general services of the health insurance funds as with influenza vaccinations that are generally covered by the health insurance for people over 60 years of age. In Poland, the National Health Fund finances the influenza vaccination for people over 65 years of age.

Example of a hospital network specifically devoted to geriatrics and gerontology in Italy.

The National Institute for Rest and Care of Elders (IRCCS-INRCA) is the only institute aimed at scientific development specialised in geriatrics and gerontology in Italy. The headquarters is in Ancona, in the Marche Region, but the IRCCS-INRCA consists of several (5) specialised clinics, three in the Marche Region, one in the Lombardia Region and one in the Calabria Region. The IRCCS-INRCA, as a Scientific Institute, conducts research and assistance. The latter is strongly characterised by a model focused on the relationship between multimorbidity and disability, promoting the patient's independence and social integration through a multidisciplinary and multi-specialist approach. Specific assistance is provided in the fields of rehabilitation, senile bronchopulmonary disease, and pain management. A peculiarity of the IRCCS-INRCA relies on the integration of the comprehensive care, based on the multidimensional evaluation of the patient (medical, functional, psychological and social) followed by an integrated multidisciplinary intervention (doctors, nurses, therapists, psychologists, social workers), with the geriatric research, which is aimed at studying the determinants of disability and loss of autonomy and at measuring the effects of treatments.

The social sector is sometimes integrated into the health sector, mainly at the regional and local level in connection with the implementation of specific promotional and preventive activities that require joint intervention of social and health services. *Nota bene* integration of the health and social sectors is currently one of the major demands/concerns of international experts.

Local and regional authorities

In countries of the EU, decentralised public authorities also take part in health promotion initiatives in a differentiated manner. Tasks in the field of health promotion for older people are conducted for the most part at the level of the regional government, which is sometimes equipped with a feature for planning and coordination. In some countries, the region is quite autonomous in the organisation of tasks in health care (e.g. Italian regionalism).

The local level (municipality or local health authorities) is responsible for the implementation of many programmes of health promotion. This applies particularly to the prevention of communicable and non-communicable diseases, sexual health, vaccination programmes, and assistance in the event of disasters and catastrophes. The local level also implements programmes in the field of environmental health, mental health and health education. Many of them are addressed specifically to the older population (Kowalska-Bobko and Domagała 2016).

The undertaken health programmes for older people that function at the local level in EU countries usually focus primarily on preventing mental illness, preventing loneliness, promoting physical activity, preventing injuries and accidents, promoting healthy nutrition and the fight against addiction.

If local programmes are financed from public funds, they are often assessed for their appropriateness and effectiveness. Evaluation is typically performed by institutions of health technology assessment or specific public agencies.

In some countries, i.e. in the Netherlands, at the decentralised level there are local institutions of public health, responsible for the planning, implementation, monitoring and evaluation of health programmes for older people. Another example, found in Poland, is the special Senior Council, whose job it is to work with local authorities to more effectively identify the needs of older people and to influence the decision-making process in terms of their planning and implementation. Measures for health promotion at the local level are undertaken in collaboration with health care providers (mainly Primary Care (PC) and NGOs).

Since the effectiveness of health promotion is measured by changes in individual behaviours of the population (lifestyle changes) to more healthy ones, it is this kind of favourable impact of institutions that is particularly important. It is more credible and persuasive, and situated closer to the community in which people live,

learn, work and spend time together. This sense of community, as described in texts from various social disciplines (especially sociology, in which the community is the central object of research studies), consists of identifying with the group, respecting values which are more or less shared, accepting and observing a certain standard of behaviour deemed appropriate.

The importance of the community for health and a healthy lifestyle is often emphasised. The development and strengthening of political communities in regard to health promotion has been added by the WHO to the recommendations contained in the Charter for Health Promotion from Bangkok (The Bangkok Charter for Health Promotion – WHO 2007).

Non-governmental organisations

The non-governmental sector, also called the voluntary sector, covers many different organisations, such as foundations, associations, unions, clubs and partnerships.

These organisations are more or less formalised. Presently, within health promotion there are also social movements and local initiatives that deal with not only the proclamation of the need for a healthy life, but also the organising of leisure time in an active way, e.g. arranging marathons as a way to promote running as fashionable, giving instruction in Nordic walking or organising fairs and shows on healthy food preparation and healthy eating. It is not just doctors and nurses who should become involved in these initiatives, it is foremost for social activists from various disciplines with proper training. Despite the fact that for some time there has been a tendency to de-medicalise health promotion, there is, it seems, a need for some caution in this regard. Diversified health status and the prevalence of multimorbidity require individualised supervision by a doctor. At the same time, however, limiting oneself to strictly medical services is insufficient to sustain health.

The non-governmental sector is, additionally, comprised of associations and professional chambers. In every European country there are associations of medical professionals, who undertake activities to promote health. Associations of geriatricians and gerontologists, as well as cardiologists, oncologists, and endocrinologists take into account, within the scope of their activities, the primary prevention of the very diseases which they treat.

When taking action in the field of health promotion, the non-governmental sector frequently takes on the role of the executor or co-contractor of programmes organised by others in this field. NGOs usually collaborate with local authorities, but also with regional and central authorities. Some NGOs organise their activities independently, others join forces and lead health promotion for elderly people through different networks or more formal associations (syndicates, federations).

They may also form umbrella organisations and then link up with other organisations with similar objectives, often from different countries.

The tasks of non-governmental organisations in the area of health promotion are related to the specifics of the country (region), e.g. based on the level of development, culture and traditions, political systems, resources and needs.

Non-governmental organisations for the promotion of health in Poland

In Poland there are about three thousand associations and foundations whose main function(activity) is health care, which accounts for 4-7% of the NGO sector. According to nationwide research about one third of these organisations declare that they deal with prevention, promotion and health education (Petrovich and Cianciara 2013). Many of them work on a very small scale, a microscale. They are limited by finances, a lack of qualified staff and access to innovation to facilitate their performance.

On the initiative of the Institute for Patients' Rights and Health Education in 2015, a project was founded, called "Network for health." Its purpose is to exchange information about important initiatives and events related to the protection/promotion of health in Poland and in the European Union.

Source: based on Michal Zabdyr-Jamroz report prepared for the project "Pro-Health 65+".

Institutions in the NGO sector perform a number of functions to promote health for older people. These include: monitoring the health situation, production and transfer of health information, educating and conducting health marketing and prevention of diseases. Activities undertaken by NGOs to promote the health of older people include, above all, the propagation of physical activity, healthy diet, social integration, support for the older population (financial, psychological), activation, including professional activation of older people, prevention of diseases, accidents and injuries, mental health, lifelong learning, access to healthcare (long-term care, primary health care, professional services, social care).

Health promotion and prevention in the workplace

The main responsibility for health promotion and prevention of occupational diseases in the workplace lies with the doctors of occupational medicine and managers of these entities, as well as with employers who are responsible for organising and financing health programmes (Magnavita 2016).

Measures being addressed in the workplace right now are not only aimed at the prevention of occupational diseases. Quite simply, healthy lifestyles are increasingly

being promoted. As part of the health programmes targeting employees, actions are being taken to encourage healthy eating by offering appropriate menus in staff canteens, prohibiting smoking and drinking alcohol in the workplace, organising classes of physical activity in suitably prepared areas (Dobras, Sakowski and Fries-Tersch 2016). Increasingly, attention is paid to good work relations between management and employees (workplace harassment is generally considered a crime) and the forming of friendly connections (Poscia et al. 2016).

The situation of older workers at the workplace is the subject of specific undertakings embodied in the concept of age management, which is treated as an element of human resource management, and more specifically part of diversity management. This involves the implementation of various activities that allow for a more rational and efficient use of human resources in companies by taking into account the needs and opportunities of workers of all ages. In the next 10–20 years employers will have to deal with a reduction in the number of job candidates. It is worth keeping in mind that in most of the “old” EU countries the share of employment by persons aged 55–64 has long exceeded 50% (in Sweden it is more than 70%), while in Poland it has reached only 31.6% (European Commission 2009).

The current exceptional epidemiological and social transition calls for up-to-date knowledge to deal with a new type of “worker” and a joint effort to target the negative aspects of ageing at work. Italian analysis of experiences in EU countries showed that successful development and implementation of workplace health promotion (WHP) for older workers depends largely on involving both employees and management in the development and implementation of these programs. Ageing is a highly complex phenomenon, which requires a multi-level approach involving the collaboration of different institutions in order to effectively manage the health of an ageing workforce. Activities undertaken as part of a wide-ranging strategy and implemented by large parent companies or local authorities are more likely to be sustained over time, and the presence of external consultants can offer valuable technical experience and expertise (Magnavita, 2016). In this sense, an interesting experience arises from the Italian National Prevention Plan 2014–2018, which identifies the workplace as one of the most effective settings for health promotion.

Workplace health promotion in the province of Modena in Italy

The Local Health Authority (AUSL) of Modena has realised a good example of a WHP programme in 2013, before the National Prevention Plan had introduced WHP in the health prevention field. The project originates from the strong local awareness of the WPH's strategic value, especially when it is linked to the reduction of additive or synergistic effects on the health risks related to lifestyle and occupational risk from the perspective of the inevitable ageing of employees. Thus,

WHP also represents a tool which can be used within active ageing strategies. The project was introduced after a careful analysis of the adult population's behaviour, especially based on the PASSI and PASSI D'Argento surveillance (the national monitoring specific to people older than 64).

The AUSL Modena project was developed on the basis of their territorial activities, which are mainly characterised by small and medium-sized companies, and therefore foresees two levels of intervention.

The first level is defined by individual and collective actions (i.e. environmental) which are simple to perform, such as:

- a bulletin health board comprising posters, billboards, and other illustrative material;
- provision of information materials on issues related to lifestyle;
- actions performed by the occupational physician during occupational health check up that go beyond the prevention of possible consequences caused by professional risks.

A second level of WPH intervention is more comprehensive; it has the purpose of changing workers' inappropriate health behaviours and habits through collective promotion actions, such as:

- the identification of business strategies (i.e. changes in menu of the company canteen, and/or dispensers of healthy food such as fruit and vegetables);
- specific company rules regarding the respect of an absolute smoking ban;
- implementation of dedicated programmes of education/training for workers, managers, supervisors, worker's representatives for health and safety;
- counselling with experienced professionals, organising lectures for workers aimed at improving their knowledge on health issues, and counselling regarding collective health promotion action;
- agreements with gyms and/or swimming pools or organisation of specific activities aimed at promoting physical activity among workers.

The central role of the OH in the project is one of the main characteristics of the Modena approach. The OH is not only a performer, but also a promoter of WHP both for the employers and the workers, thanks to the confiding relation established between them. Due to personal organisational issues, it often occurs that the OH is the only physician the workers can refer to.

Therefore, the Department of Public Health (DSP) of AUSL Modena has launched a continuous education programme (ECM) for all OHs which includes, in addition to the description of the project and its instruments, the motivational approach from the transtheoretical model of behaviour change according to Prochaska and Di Clemente.

The Modena project was afterwards adopted by the PRP 2015–2018 of the Emilia-Romagna Region, which pointed it out as an example for other Local Health Authorities (AUSLs). During 2015, which was the first year of formal implementation of the tool, 48 companies have officially joined the project, including 1,698 workers.

Source: Poscia et al. 2017, Carrozzi et al. 2016.

Sport and Leisure

Active people not only live longer, but also have a better chance to live longer in good health and independence (King 2010). This thesis applies to both physical as well as intellectual activity. This paragraph will deal with physical activity.

Physical activity falls within the scope of the sport and recreation sector. With respect to seniors it is also present in the sectors of health, education, non-governmental organisations and local government. In most of them, however, there is a lack of specialised institutions/bodies responsible for sports. This causes the overlapping of various sectoral obligations and entitlements (rights), resulting in multiple, often unrelated plans and programmes.

Recognition of institutional solutions for the physical activity of seniors requires the identification of at least three types of physical activity. Firstly, there is a sport activity (field sports). The nature of the activities of this type is highly institutionalised. Physical activity is organised by sports clubs, sports federations, managed by sport faculties/departments of local governments or non-governmental organisations. The second type of physical activity is understood as recreation and leisure. In this case it is very often non-institutionalised or commercialised. The third type of physical activity refers to work and is organised by the employer, who is concerned with the effectiveness of the its employees (Goldys 2016). As far as health promotion of the elderly is concerned, rehabilitation is also an important factor in the prevention of numerous diseases.

The sport and recreation sector is, for the most part, operated by professionals from the field of physical activity. These are sports instructors, overseeing various forms of physical activity of seniors, such as aerobics, jogging, swimming, dancing, football, volleyball and handball, but also include physiotherapists, responsible for rehabilitation. Primary care physicians are also part of the scheme recommending physical activity to their patients, e.g. doctors prescribing specific forms of physical activity for their patients in Germany and in Italy. Furthermore, in Italy general practitioners play an active role in spreading good practices, such as the “group for walk” or to engage their patients in physical activity (Peliti 2015).

In some EU countries there are special national institutes dealing with sports; for example, the Dutch Institute for Sport and Physical Activity (Nisba), which is the main Dutch institution engaged in health promotion for the elderly in the sports sector. In most countries, institutes of sport cooperate with local governments and non-governmental organisations.

Social sector

The definition of the social sector depends on the criterion of the scope and types of social benefits. In a broader sense it includes all income redistribution aimed

at the achievement of social goals. In a narrower sense it is a sector that supports so-called vulnerable groups, sensitive to deprivation and social exclusion. These groups are supported by various types of social benefits; in cash and in kind (Sowa et al. 2017). The social sector, due to differences in the organisation of social security systems, health systems, social policy models and intergenerational cooperation models, is organised differently depending on the individual EU country.

Health promotion in social institutions is carried out by both medical professionals (doctors, nurses, physiotherapists and nutritionists), as well as social workers in the patient's home and in stationary facilities: social welfare homes or nursing homes. The addressees of these measures are the most elderly, often over 80 years of age. Although the oldest old are not an obvious target for health promotion, a healthy lifestyle even above the age of 80 is beneficial for health and wellbeing. The beneficial effects of a healthy lifestyle are visible not only in the population living at home, but also among people living in residential care institutions, decreasing the risk of mortality and increasing a better quality of life.

Nursing homes have great potential, which can be directed to optimise resources, directing them not only to care for older people, but also to promote, maintain and improve health. This concept requires the reorganisation of health care beyond the provision of care services, treatment or hospital care.

There is reason to believe (e.g. new legislation, research projects, websites, conferences, publications) that integrating various public services is becoming a priority in European countries. This process usually consists of integrating social assistance with health services. Experience shows that for working together to be effective in the fields of social assistance and health care, a good deal of time is required. However, traditional divisions that exist between the two kind of services can be overcome with appropriate "incentives", e.g. if local authorities do not have a nursing home for an older person ready to leave the hospital. In Denmark, the local authority has to pay a "penalty" for each extra day that a cured patient stays in the hospital. At the same time service contracts stipulate that relevant departments at the local level must be informed several days in advance of the upcoming release from the hospital of a patient in need of further care (Munday 2005). In the Netherlands and Italy, the social sector is involved in health promotion for the elderly through local authorities, cooperating in this respect with primary health care.

Cooperation in fighting social isolation in Italy

Viva gli anziani (Long Live the Elderly!) is a Community-based Active Monitoring Programme (CAMP) promoted and organised by the Community of Sant'Egidio, in cooperation with the Italian Ministry of Health and the municipality of Rome, which aims at fighting the social isolation of the elderly by creating a network

among older people to prevent critical events. The mission of the project is to guarantee and to protect the right of older people to stay in their own living quarters and to maintain their own sense of identity. To do this the project offers phone monitoring, and home visits in to strengthen the social network around frail individuals to improve elderly people's quality of life as a whole and to reduce hospitalisation and institutionalisation. Furthermore, the project promotes several initiatives to raise public awareness of the importance of the quality of life of the oldest seniors such as the collection of signatures for "Maria's Letter" or for "Anna's Letter". These letters told the story of Maria, a 75 year old woman, who is asking to remain at home, surrounded by her own things, and to avoid the institutionalisation and Anna, 82 years old, who launched the so called initiative "an hour of time" for persons (elderly or not) who want to spend time with elderly people who are alone. More than 500,000 persons throughout Europe have already signed Maria's letter. "*Viva gli anziani*" also has a research topic, which is related to measurement, prevention and management of community-dwelling older frail adults, defined as a multidimensional issue, made up of psycho-physical conditions as well as the lack of socio-economic resources, that is able to determine the progressive decline of older people.

The targets of the programme are the over-80 older adults that all live in the urban zone where the programme operates according to the so-called "universal approach". However the programme potentially involves all the residents who want to collaborate to support the older adults, especially seniors up to 80 years old and vendors (like pharmacists, the food markets etc. ...) who can operate as volunteers.

Sources: <http://www.santegidio.org/en/vivaglianziani/> [accessed 9.05.2017]; Liotta 2016.

The media

Mass media encompasses both traditional media such as television and radio, newspapers, magazines and books as well as social media, available through the Internet.

Modern media is now one of the main sources of information, including information relating to health, making it one of the most important pillars of health education. Research shows that the average person spends about three and a half hours each day on various forms of media. It is, therefore, in third place after work and sleep in the daily time budget (Szymczuk et al. 2011).

Health information is transmitted in different ways, e.g. in thematic programmes (regular television programmes, sporting events, etc.) or in advertising products considered to be healthy such that actors popularise healthy lifestyles.

Most of the research (Slater and Rouner 2002; Bandura 2004) on the educational role of the media is focused on television series and serial dramas. This research shows that the greatest impact on the health behaviour of a society lies in the scope of TV series, shaping the audience's views and pro-health attitudes (Turbiarz 2010). The stories presented in them show protagonists who are worthy of imitation and antagonists who face some form of well-deserved punishment. The way in which the stories are presented encourages their recipients to change their behaviours and make lifestyle changes. Research studies (Green and Brock 2000; Slater and Rouner 2002 de Wied, Zillmann, and Ordman 1994; Hall and Bracken 2011) also prove that a viewer who is engaged in the message presented in film is easily persuaded to change his or her views or behaviour because it seems less critical; also viewers identify with the presented story and its characters. Knowing this, the creators of television series deliberately incorporate important health issues into scripts such as, e.g. prevention of prostate cancer and breast cancer (an example of this is the Polish TV series *Clan*, or *For Better or Worse*) or treating alcoholism or drug addiction.

The British Centre for History in Public Health (CHiPH) provides and promotes television series and films on the subject of health. For example, the movies *Saturday Night* and *Pool*, made in 1978, deal with problems of addiction, mainly alcohol. Another interesting example is the documentary *Lessons for the Living* (1987), about the attempt to implement a health promotion programme in Sheffield, based on the assumptions of the Finnish North Karelia project. The Centre's catalogues contain documentaries and feature films touching on subjects such as addiction (tobacco, drugs), food hygiene, obesity, infectious diseases (Spanish Flu, malaria), sexual health, and many others (<http://history.lsh.ac.uk/>).

Another suggestion is a series called *Western Medical Centre* (*Medisch Centrum West*) shown once a week from 1988–1994 by the Dutch TV TROS (2). Against the backdrop of the lives of the main characters, who were doctors and nurses, the show presented important medical cases (Bouman Leos and Kok, 1998). It was watched by 2.5 million viewers weekly.

Many of the presented television programmes are addressed to the whole population and while the problems they address may interest older viewers, they are rarely intended to be the sole recipients of these programmes. Of course, this does not mean that such programmes do not exist. They are implemented in the form of documentary films or (educational) programmes usually broadcast on public regional TV or the internet rather than on the national channels. Certainly, programmes addressed to the elderly in the field of health promotion are more prevalent on the radio, in newspapers or on the Internet.

Many research findings also point to the limitations of the media in as far as health promotion is concerned, which include: one-sided communication between the sender and the recipient and the lack of repetition, supplementation and customisation to the individual needs of the given message, which can lead to

the fact that the information communicated spurs concerns, anxiety and confusion. This statement implies that in order to properly utilise the media to promote health, it is necessary to identify the group to which the programme is addressed, determine its needs, and then select the information content and frequency of broadcasting the message encompassed in the programme. The messages should also show the benefits of the proposed actions, while combining education with entertainment, through the use of sporting events, concerts, etc. A perfect example of this combination is the global campaign “Movember”, the name of which is an amalgamation of the words moustache and November. It is an annual, month long campaign which consists of growing a moustache in November. Its aim is to raise public awareness about the health problems of men, especially in the field of prostate cancer. The campaign’s main promoters are athletes (football players, volleyball players, hockey players or rugby, etc.) and sports commentators.

Thanks to its attractiveness, the media enables the process of acquiring knowledge, modelling behaviour and shaping social and moral attitudes in a pleasant and efficient way. The media’s power to influence is reliant on strengthening and modifying existing beliefs and converting attitudes.

The media can affect the recipient in both the short-term and long-term. The short-term effect of its impact is for the most part provided by news programmes. According to research, viewers understand and remember 5–30% of the information they receive for at least one day (Mrozowski 2001). It has been found, however, that the media is an effective tool of persuasion. Classic examples of this are advertising campaigns or simple programmes for health promotion. In 2005, Polish television channels aired a campaign called *Reality Quitting* “I quit, because I stuck on NiQuitin.” The same campaign was carried out in the UK in 2004 and became a huge success, encouraging thousands of people to decide to quit smoking.

It is worth keeping in mind, however, that the media can also have a negative impact on health, as exemplified by commercials advertising medicinal products (drugs, dietary supplements), which can have a negative impact on health if assumed without professional medical advice and supervision. Furthermore, the commercials usually played during TV and Radio programmes, without strong regulation, could explicitly or implicitly recommend unhealthy habits, such as the use of sweet and sparkling beverages, or risky behaviours, such as hazardous play.

Social media also plays an important role in this subject matter. Internet portals can effectively shape healthy attitudes through their interactive nature, including participation in the exchange of views, experiences, ideas and content creation. Functional diversity, multimedia and the lack of barriers of time and space create a completely different model of education, much different from its traditional counterpart. In this sense, media could also play an important role in avoiding one of the most dangerous barriers to active and healthy ageing for older people: social isolation (Stojanovic et al. 2017).

Sources and methods of financing health promotion

The activities in the field of health promotion, including those dedicated to older people, are conducted both within the broad public scope as well as individually. As a result, individual benefits are created, so-called internal effects and there are also social benefits, called external effects. The groups which benefit from internal effects are those who directly take part in health promotion programmes, private entities which make contributions from their own resources for altruistic reasons and companies that finance these programmes in the workplace in order to improve the physical and mental condition of their employees as functional ability in old age may be related to work ability. Social benefits are expressed in terms of the overall improvement of the health of the population, in the rise of a sense of security, and in the possibility of shifting part of the restorative medicine funds to other important social objectives. Workplace health promotion is known to enhance workplace productivity and performance and could benefit both the workforce and employers by improving the long-term well-being of workers and their families, and by reducing pressure on health and social security systems. The coexistence of the internal and external effects justifies the universal use of the two main sources of financing all human activity, i.e. public and private funds. The proportion to which public and private funds ultimately participate in the financing of health promotion, vary from country to country. The selection and shape of the tools for financing health promotion depend on both the existing general principles of organisation and financing of healthcare (the model of the National Health Service or the model of Social Health Insurance) and the adopted state model (the ratio of the central government to the local government), as well as to the level of economic development and the level of society's institutional development.

Sources of funding for health promotion

Financial documents published in various countries usually do not distinguish or account for spending on health promotion as such. Much less do they distinguish spending on health promotion for the elderly. The primary source of financial information gathered according to a uniform methodology – National Health Accounts – is generally limited to the aggregate category called prevention and public health expenditure, with a possible indication of the purposes for which funds are allocated (e.g. school medicine, occupational medicine and disease prevention), but does not specify the type of activities it entails (e.g. health promotion). Only in a few cases are expenditures on health promotion by source of funding explicitly singled out (e.g. in the aggregate of the German Federal Statistical Office). In other cases, tracing the source of funding is only possible on the basis of the analysis of

documents related to specific projects and initiatives. However, given their diversity and number (in Europe, health promotion is dealt with by thousands of different kinds of institutions), drawing up a full list, which would provide comprehensive information on the financing of health promotion, is not possible. A general (though incomplete) overview of the various activities in the area of health promotion for the elderly in 27 European countries (Arsenijević et al. 2016) suggests that, in seven of these countries (Denmark, Germany, the Netherlands, Norway, Slovenia, Switzerland and the United Kingdom) alongside public funds, a significant role is played by private funds. In many countries (e.g. Austria, Bulgaria, Croatia, Estonia, Poland, Lithuania, Slovakia, Slovenia), institutions that deliver health promotion programmes also make use of other sources of financing, in particular foreign resources, including those that come from EU budgets.

The primary source of funding for health promotion in all of the countries covered by the review remains, however, public funds. These include funds collected in the form of taxes, contributions and administrative fees. Taxes and fees feed the state budget and the budgets of local governments, while contributions supply the budgets of social health insurance. In countries where health systems were built on the foundation of the Beveridge model – the National Health Service, (mainly Scandinavia, southern European countries and the United Kingdom), budgetary financing dominates, and in some, the majority of funding comes from the central tax (e.g. in Great Britain, Italy and Spain), while in other countries funding comes from local taxes (e.g. in Sweden and Finland). In several European countries (e.g. Belgium, France and Iceland), but also in Australia, activities in the field of health promotion are financed through the allocation of a predetermined portion of revenues from excise taxes on drugs (alcohol and cigarettes).

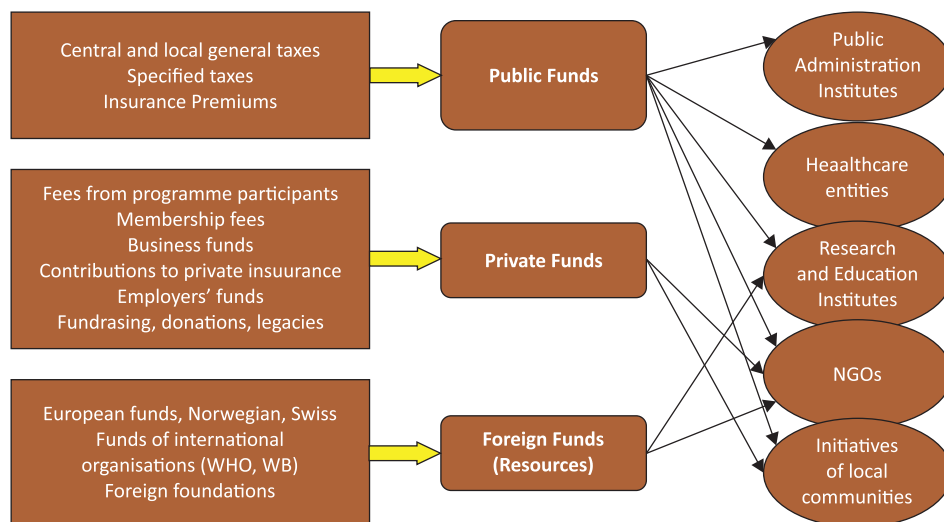
But budgetary financing also appears in the countries where the organisation and financing of health care rely on the Bismarck-type of social insurance (e.g. Germany, Austria, France, Slovenia, Switzerland and Poland). In their case, part of the funding (often a significant portion) for measures in the field of health promotion are secured by Insurance Funds: public, such as the Sickness Funds in Germany and Austria, or private insurance companies, managing public contributions, as in countries such as the Netherlands and Switzerland. Contributions to social health insurance can at the same time take the form of contributions from income (payroll tax, which is the case in Poland, France and Germany) or independent of individual risk premiums per capita as in Switzerland and the Netherlands. The involvement of social health insurance in financing activities in the field of disease prevention and health promotion is growing, even in those countries where insurance has traditionally focused on financially securing access to healthcare, (in many countries, insurance even bears the name of the sickness insurance while their institutions are called Sickness Funds). Institutions of social health insurance followed suit because private insurers have already noticed that preventing the development of disease

and maintaining their customers in good health for as long as possible is not only advantageous for the insured, but also for themselves. Increasingly, all insurers will need to face the costly effects of demographic, epidemiological and technological changes that are taking place in the world, as well as rising expectations on the part of the insured.

Among private funds for the financing of health promotion, there is one in particular that deserves to be mentioned in the first place – direct expenditure: fees and membership contributions from people using specific health promotion programmes or from people who are members of organisations implementing such programmes. Charging fees is all the more justified, the greater the direct personal benefit, not necessarily only in the form of improving one's health in the future, but also due to improving quality of life thanks to fuller social integration. Private funds also include private donations, legacies and offerings provided to institutions implementing different programmes or just collecting funds to finance them. Other private funds come from premiums paid to private health insurance, if they participate in the financing of health promotion, from collections organised by non-governmental organisations, churches and religious associations, from grants submitted by employers or business spheres (including foundations of different companies and banks) and also from the commercial activity of institutions involved in the implementation of tasks in the area of health promotion (e.g. publishing activities, organisation of festivals, sale of services).

Part of the funding used to finance health promotion programmes (including those for older people) comes from international sources like European structural funds, funds of international organisations (such as the World Health Organization and the World Bank), Norwegian and Swiss funds, international associations (e.g. the Network of Healthy Cities) or foundations (e.g. the Polish-American Freedom Foundation). European funds support, in particular, cross-border programmes implemented in many countries at the same time. An important example is represented by the pan-European initiative “European year of Active Ageing and solidarity between generations”. As an example, during the European Year of Active Ageing in 2012, the Italian Department for Family Policies, which was in charge of coordinating all the initiatives regarding this issue, funded with 1.5 million euro 47 projects to spread greater knowledge on issues related to the active ageing strategy in Italy.

International sources are relatively more frequently used by countries of Central and Eastern Europe. However, beneficiaries from richer countries can also count on the support of positively evaluated initiatives (Figure 12).

Figure 12 Financing of health promotion for older people

Source: own material.

Methods of financing institutions implementing health promotion programmes

In each country the methods of financing specific projects and initiatives depend largely on: the existing regulations related to the internal structure of the government (especially the executive government), various models for assigning public tasks to be carried out by non-public institutions and the level of the society's development, expressed through, among other things, the existence and acceptance of non-state initiatives (including formal non-governmental organisations).

In some European countries (e.g. Poland, Norway, Austria and Finland), health promotion programmes are organised and implemented directly by local governments. Their funding is taken directly from the budgets of the public administration (e.g. the ministries or local government bodies). Public research and educational institutions dealing with problems of health promotion often benefit from direct budgetary financing, although they often apply for grants from abroad as well. However, for the most part, public authorities outsource entire programmes or specific parts thereof to third parties (institutions of health insurance or managers of public funds in the system of the National Health Service contract, for example, certain services related to health promotion from service providers: family doctors, doctors working in specialist outpatient care and hospitals [e.g. Poland, Germany, Austria, Italy, Sweden and the UK]), providing them with resources either in the form of flat rate charges (per capita, for example, capitation rates in Poland or Italy),

and/or in the form of payment for specifically made provisions (fee for service), such as in Italy for the vaccination of older people.

Due to the usually non-medical nature of benefits in the area of health promotion, the implementation of most programmes therefore takes place outside the medical sector. NGOs play a special role here for, in addition to their own capital (from tax deductions, collections, private donations, grants from employers, membership fees and charges from programme participants), they can obtain public funding, e.g. in the form of subsidies or grants for the implementation of specific tasks, or foreign resources. Public funds are transferred to NGOs usually directly by their dispatcher (e.g. the central government or local government unit). Another possibility is to create an additional special purpose fund. In Austria, for example, a large part of public funds allocated for the development of health promotion goes first to a special public fund *Fonds Gesundes Österreich*, which then subsidises various initiatives. This kind of concentration and flow of resources allows for rational spending. A strong fund has more effective instruments of control and greater expertise which is necessary for proper verification of grant applications.

Less formalised initiatives of local communities find resources for their activities mainly from private sponsors (e.g. local employers), organising meetings and festivities, during which they sell various goods and services, or charge membership fees as long as they have been officially registered. In many countries, however, (e.g. in Poland and Germany), they can also apply for public funding.

Conclusions

The scope and intensity of activities in the field of health promotion depends on the development of public institutions in the country, the model of decentralisation, the model of the health care system and the level of social participation. In countries with more centralised models of social policy, health promotion is carried out at the central level by government institutions and government ministries: such as the ministries of health, labour and social policy, education and sport. National institutes of public health and institutions of social dialogue, monitoring and control also conduct their work at the central level. In countries with a more decentralised system, health promotion initiatives are carried out primarily by regional and local institutions, which are often autonomous and politically independent.

Sources of financing health promotion, including that for the elderly, are varied and much less stable than those allocated to healthcare, or even traditional public health services such as sanitary control. Funds earmarked for promotion are dependent on access to various programmes that are offered periodically and are not always continued.

Activities in the areas of health promotion are governed by a wide variety of acts, from constitutional laws through regulations, policies, programmes and national,

regional and local plans. They are dedicated to many different activities in both public health and health promotion.

Programmes (projects) in the field of health promotion are conducted in many sectors and by different institutions, appearing in the role of entities which both form/finance them as well as those which implement them through cooperation with specific communities or groups. The responsibility of institutions that create these programmes is to provide access to the so-called infrastructure of health promotion, to the development of infrastructure bases, i.e. to facilities intended for physical activity and rehabilitation, health services, information and education. There are also responsibilities pertaining to the monitoring of the society and providing healthy food, clean air and clean water.

Sectors have their own national, organisational, institutional and professional specifics. They are addressed to different groups of older recipients: beginning with working seniors (the sector of occupational medicine) to seniors who are over 80 years old (mostly the social sector). They perform their own functions and activities to promote health and generate different working practices. Recognition of the institutional diversity of health promotion enables the organisation of cross-sectoral activities in the form of modern trade unions: networks, partnerships or consortiums. This makes them effective through the use a number of potential actions and helps reduce unnecessary undertakings, which in turn facilitates the implementation of the strategy of “*health in all policies*,” and we could add – “*health everywhere*.”

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GOOD PRACTICES IN HEALTH PROMOTION FOR SENIORS



Good practices in health promotion for older people

This chapter describes selected good practices of health promotion targeted at the elderly. Describing and sharing information on good practices in a particular domain and place may form a reference or inspiration to other organisations, and for the authorities, a basis for recommendation and motivation to broaden the implementation of such practices. All the actions described herein have been put into practice and evaluated. Evaluation results led to the conclusion that the actions were efficient, the projected aims fulfilled, and the benefits grounds for sharing the experience.

A **good practice** in health promotion can be widely understood as an intervention, programme, or action (activity) carried out in order to achieve a positive change in relation to the health of a particular population or place. With respect to research works, it is recommended to use *good practice* instead of *best practice*, although it is still hard to determine and assess how *good* a specific activity is. Synonyms of good practice, such as *efficient solution*, *promising practice*, or *innovative practice*, are also in use. Good practices are well-described programmes of an efficacy proven under a solid evaluation, while **promising or innovative practices** are still in an early stage of development, even though signals indicating their possible long-term efficacy are present.

Good practice in health promotion covers scientifically proven and practically evaluated:

- interventions,
- programmes,
- actions,

which rendered change in behaviours/lifestyle beneficial to the health of the individuals and/or environment to which they were addressed.

A good practice in public health and health promotion is yet not clearly defined, and literature review reveals multiple definitions. The most frequently quoted

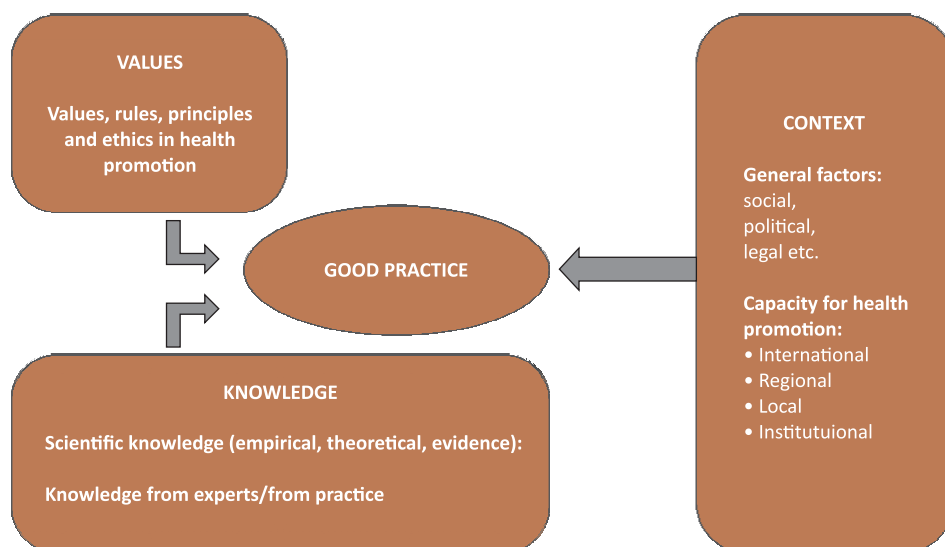
definition is the one developed by the Food and Agriculture Organization of the United Nations (FAO):

A good practice is not only a practice that is good, but a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, which has been repeated and deserves to be shared so that a greater number of people can adopt it.

Therefore, a good practice is an activity that has rendered a healthy change of behaviours under specific conditions, and it is probable that the activity will prove its effectiveness in other setting as well. According to the WHO, a good practice informs about particularities proven to work in the real world, and not under investigational circumstances. It is focused mostly on preconditions and their interconnections (e.g., available resources, political engagement, support of key stakeholders, social factors) and issues related to its implementation, e.g. possible barriers and limitation, success factors (WHO, 2008).

According to Broesskamp-Stone and Ackerman's concepts (2010), an analysis of good practices should include three main domains: value, knowledge, and context (Figure 13).

Figure 13 Good practice dimensions



Source: Broesskamp-Stone and Ackerman 2010.

Kahan, Goodstadt and Rajkumar (1999) believe that *the essence of a good practice in health promotion comes down to exposing effectiveness or positive results under specific, real conditions with relation to the adopted objectives of a programme.*

The authors point out that a good practice may become an educational tool for other organisations and countries. And this very aspect of the mutual exchange of experiences through collecting and disseminating good practices was also observed by the European Commission, which initiated the platform *The European Innovation Partnership on Active and Healthy Ageing* in 2012.

In recent years, national and local governments of the member states, as well as other entities involved in the issue of population ageing have initiated and implemented a number of valuable actions for healthy and active ageing. Even so, these actions have not yet been widely disseminated, and no complex database presenting good practices in an ordered and indexed manner is available. Therefore, the European Commission has developed the *European Scaling-up*¹⁵ *Strategy in Active and Healthy Ageing*. The scaling-up process consists of five steps:

- **step 1** – building a database of good practices
- **step 2** – assessment of the viability of good practices for scaling-up
- **step 3** – classification of good practices for replication
- **step 4** – facilitating partnerships for scaling-up
- **step 5** – implementation: key success factors and lessons learned.

A European on-line data base, containing information on innovative actions considered to be good practices, and inspirational for entities in other regions and countries, is currently being developed. Activities under this strategy are carried out by identifying so-called reference sites and good practices. Reference sites are regions, municipalities or local societies where complex and innovative actions for obtaining a favourable environment for active and healthy ageing are being undertaken. The highest numbers of such reference sites were identified in Spain, the Netherlands, Italy, and the United Kingdom (European Commission, Reference Sites 2013).

Identification and evaluation of good practices is carried out by dedicated workgroups for the following six areas: (1) adherence to prescription; (2) falls prevention; (3) functional decline and frailty; (4) integrated care; (5) independent living solutions and (6) age-friendly environments (European Commission 2015).

The significance of good practices in health promotion

Conclusions arising from population research studies are more and more commonly applied to activities in the public health area. However, actions are not always adequately developed. Practical confirmation, drawn from real programmes, is becoming equally valuable as inspiration for public health programmes and

¹⁵ *Scaling-up is a deliberate effort to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis* (WHO 2009).

their management. A selection of good practices from amongst the implemented and evaluated programmes is one of the methods for revealing such confirmation. However, this approach is not always accepted indiscriminately. The applicability of practices considered good is limited as there is no agreement as to the criteria of such a classification. Despite taking into account those limitations, we assume that a methodically organised analysis of good practices forms a basis for their acknowledgement and promotion.

The role of good practices in health promotion is to reveal the real outcome and health effects for a particular population and its environment, which, in the case of evident benefits (found upon evaluation), renders the practices credible and promotion- and replication-worthy. Also, so-called success factors can be identified upon analysis of good practices. They are factors promoting efficient implementation and achievement of expected benefits (e.g. organisational model, managing system, communication system with stakeholders).

Identification of good practices in their already widespread evaluations allows for special databases to be created. They offer information on already implemented and evaluated programmes, which facilitates dissemination of already applied actions, giving a chance to strengthen them and improve their applicability under different conditions. Identification of good practices also allows for creation of professional networks for health promotion, including those for older people.

Due to the relatively high freedom in defining and adopting criteria, various sources utilise proprietary definitions. For example, the WHO *Age-Friendly in practice* database uses a definition according to which age-friendly practices are “concrete measures aimed at creating more supportive and accessible environments to enable older people to actively participate in community life and to maintain their autonomy and independence”.

Databases of good practices make it possible to present inspiring, bottom-up initiatives for active and healthy ageing. Such databases are initiated on both national (e.g. the Pro.Sa Italian database, collecting examples of Italian health programmes considered to be good practices) and international (e.g. the *HealthProElderly* or *JA-CHRODIS* databases created within European programmes) levels. Also, databases dedicated to specific problems in health promotion of older people, such as prevention of falls (ProFouND) or prevention of alcohol abuse by the elderly (Best Practices – Vintage Project), have been created.

Details about sources of information on good practices in health promotion of older people are provided in the last chapter of this guidebook.

Criteria for considering an activity to be a good practice — what practice is good?

A good practice should meet the requirements of the evaluation criteria such as: relevance, community participation, stakeholder collaboration, ethical soundness, replicability, effectiveness, efficiency and sustainability (Ng and de Colombani 2015).

In order to sort out problems with defining and adopting criteria for good practices in public health, a leading American scientific centre, the Centers for Disease Control and Prevention (CDC), established a special workgroup for good practices.¹⁶ The main objective of the group was to develop a definition of good/best practice, and criteria and ways of classifying diverse actions in relationship to best practices (CDC 2010). The group assumed that good practices are *practices subjected to a detailed verification and assessment, proving the effectiveness in enhancing health effects, usually proven in systematic reviews*. Upon evaluation of good practices, particular weight was applied to evaluation of the impact on public health and quality of scientific evidence. On that basis, four categories of good practices were proposed (Spencer et al. 2013):

- **Emerging practices** – practices combining values, nature and indicators of other positive or efficient interventions in the area of public health. They are based on guidelines, protocols, standards or recommended practical models, which lead to the expected effects in public health. They also take into account the constant quality enhancement process and programme results evaluation plan. However, there is still no data available to prove the effectiveness of emerging practices or the positive impact of their results.
- **Promising practices** – programmes, activities or strategies which during early implementation stages present a potential to improve to become best practices with a long-lasting, sustainable impact. A promising practice must be supported by evidence in order to prove its potential for replication among different organisations.
- **Leading practices** – programmes and activities which work efficiently and provide expected results, and which are supported by evidence and a growing quantity of objective source data.
- **Best practices** – have emerged from a solid assessment and evaluation process, which indicates their effectiveness in obtaining set goals in public health improvement within a selected target group. The practices have been verified and confirmed by experts in line with the current standard of empirical studies. They can be replicated in various environments and settings, providing the

¹⁶ CDC Best Practices was created as a part of the Office for State, Tribal, Local and Territorial Support, Centers for Disease Control and Prevention.

expected results. Best practices are obtained when their direct influence on positive results, as well as a lack of impact of external factors, can be proven.

Assessment of scientific evidence is carried out using a four-stage quantity and quality scale for the evidence collected: weak, moderate, strong and rigorous, depending on the collected, evaluated and published evidence of effectiveness.

Review of literature and databases of good practices in public health and health promotion (including that for older people) confirms that the key criteria taken into consideration by experts evaluating good practices are: effectiveness, impact, feasibility, sustainability, transferability, social participation, engagement and cooperation of numerous stakeholders and the evaluation process (WHO 2001; Baker et al. 2008; Ng and de Colombani 2015; Windsor 2015).

Table 7 lists questions assessing good practices in terms of the five key criteria. The questions are not universal, and some of them may not apply to all practices. However obtaining answers to them may significantly facilitate the evaluation of a specific activity as a good practice.

Table 7 Good Practice's evaluation criteria

Good Practice Criteria	Validating/verifying questions
EFFECTIVENESS Extent to which the practice achieves the planned outcomes	<ul style="list-style-type: none"> • What are the practice's desired outcomes? • How consistent is the evidence? • What is the magnitude of the effect, including efficiency or effectiveness? • What is the significance to public health, systems, or organisational outcomes? • What are the benefits or risks for adverse outcomes? • In considering benefits or risks for adverse outcomes, does the practice promote health equity? • To what extent does the practice achieve the desired outcomes?
REACH Extent to which the practice affects the target group(s)	<ul style="list-style-type: none"> • What is the practice's intended and critical target population? • What beneficiaries are affected? • What is the proportion of the eligible population affected by the practice? • How much of the population could ultimately be affected (potential reach)? • How representative are the groups that are currently affected compared with groups ultimately affected by the problem? • In considering representation, does the practice promote health equity? • To what extent does the practice affect the intended and critical target population(s)?
FEASIBILITY Extent to which the practice can be implemented	<ul style="list-style-type: none"> • What are the barriers to implementing this practice? • What are the facilitators to implementing this practice? • What resources are necessary to fully implement the practice? • Does the practice streamline or add complexity to existing procedures or processes? • What is the cost-effectiveness and what are the available resources to implement the practice?

Table 7 – continued

SUSTAINABILITY Extent to which the practice can be maintained and achieve desired outcomes over time	<ul style="list-style-type: none"> • How is the practice designed to integrate with existing programmes or processes or both? • How is it designed to integrate with existing networks and partnerships? • What level of resources is required to sustain the practice over time? • What long-term effects or maintenance or improvement of effects over time can be achieved? • How has the practice been maintained to achieve its desired outcomes over time?
TRANSFERABILITY Extent to which the practice can be applied to or adapted for various contexts	<ul style="list-style-type: none"> • How has the practice been replicated in similar contexts, and did it achieve its intended outcomes? • Was adaptation required in different contexts? • How has the practice been adapted? • What is the impact of varying political, organisational, geographic, social, and economic contexts? • Has the practice been proven to be effective in different settings? • To what extent has the practice been applied to or adapted for a variety of contexts?

Source: Definitions for Elements of Public Health Impact and Examples of Questions to Consider Related to the Elements, Spencer et al. 2013.

For presentation purposes of European health promotion practices for older people and prevention of chronic diseases, the guidebook for health promoters contains only a limited number of practices (16 examples). Upon selection, only evaluated practices available in European or national databases of good practices were considered.

The selected practices are those which:

- implement health promotion activities promoting healthy ageing;
- relate to actions of proven effectiveness confirmed by scientific evidence;
- are directed to the target group as defined under the *ProHealth 65+* project;
- relate to activities that may be implemented into practice;
- have been evaluated;
- are implemented with the involvement and cooperation of many stakeholders;
- allow for the long-term sustainability of the results obtained;
- can be applied in/adopted to various circumstances.

Selected examples of good practices. How effectively do others do it?

The below described examples of actions considered to be good practices in health promotion for older people relate to the activities in health promotion described in chapter 2. When selecting good practices for the purposes of this guidebook, we focused primarily on interventions whose effectiveness was confirmed by analysis conducted within the *ProHealth 65+* project. Most evidence confirming the effectiveness of interventions in health promotion for older people

was identified in the case of physical activity. Other interventions of confirmed effectiveness are, amongst others, those taking place in homes of the elderly, those run by different health professionals, those pertaining to education and consultation about physical fitness and those actions aimed at increasing independence and self-reliance, prevention of falls and healthy diet. Other programmes implemented in the context of social actions, covering for example dancing or other activities performed by a group of seniors, also exhibited vast effectiveness and a positive impact on the quality of life, cognitive functions, mental health and the maintaining of physical activity (Duplaga, Grysztar and Rodzinka 2016).

Country Profiles developed under the *ProHealth 65+* project, available on the project web page, were an important source of information about the good practices listed below.

Descriptions of each programme have been made with special attention given to identifying the organisation responsible for its implementation (type of organisation, sector), and cooperating entities. Groups of recipients and places of action implementation, as well as health promoters are defined. Key objectives and activities of the programme are presented, along with the results and benefits brought about by the implemented actions. Information on programme evaluation and funding sources is also provided. At the end, we provide a link to a web page containing further, detailed information on the programme described. Additional literature describing the presented programmes is listed at the end of the chapter.

I. Physical activity

Project name/title	Physical activity on prescription <i>Bewegen op recept</i>
Implementing organisation	NISB (Netherlands Institute for Sport and Physical Activity) Different NGOs such as STIOM (a foundation that takes care of health for people living in deprived neighbourhoods) General practitioners (GPs) Type of organisation: NISB is a public institute and is mainly financed by the Ministry of Health. It can also receive donations from third parties such as NGOs.
Target group	Country: The Netherlands Group: Older adults with a sedentary life-style, obese older adults and older adults with chronic diseases like diabetes or cardio-vascular diseases
Settings/Place of implementation	The intervention is conducted in local leisure facility centres. The intervention has a nationwide character – it is implemented all over the Netherlands
Health promoters	Health care professionals: GPs, physiotherapist, sport advisor

Key objectives	The main objective is to increase the level of physical activity among older adults. The intervention also addresses different target groups: separate programmes are available for older female migrants or for obese older adults. This intervention is also part of the broader programme – “BeweegKuur”. In this intervention older adults with a sedentary lifestyle and lifestyle related diseases receive a prescription from their GP to become engaged in physical activity. Together with health professionals (physiotherapist or sport advisor), the older adult makes a tailor-made plan of physical activities that she/he will perform. Also, the groups of older adults are matched based on their physical status but also based on their social –demographic characteristics (for example, older Turkish women prefer only females in the group).
Main activities	The main activities are different types of sports such as swimming, gymnastics, cardio-fitness or dancing. The duration of intervention is between 18 and 20 weeks, two times per week.
Effects and benefits	The intervention has been shown to have moderate benefits. It is shown that benefits depend on the target group – older migrants and people with diabetes show more improvement in physical activity than obese older adults.
Evaluation	Evaluation studies are usually focused on the effects that physical activity on prescription has on different population groups (Schmidt et al., 2008). There is an ongoing evaluation of this intervention within the project “BeweegKuur” (Berendsen et al., 2011). This evaluation is based on an effect and process evaluation. It will also give insight into the cost-effectiveness of the intervention.
Source of funding	The intervention is funded through NISB. Participants also pay small co-payments (€22 euros for 20 weeks). If they participate in more than 80% of all activities, they will get €10 back.
Further information	http://international.nisb.nl

Comments and remarks: A similar programme of prescribed physical activity (*Rezept für Bewegung*) is already being implemented in numerous German regions and municipalities based on the cooperation between health and sport institutions. Also in Italy, several regions (i.e. Piemonte, Lombardia, Veneto) are going to approve regional laws to allow their patients, especially people with diabetes and/or cardiovascular diseases, free access to “health gyms” (gyms accredited with the regional health system).

Project name/title	Fit until 100 <i>Fit für 100</i>
Implementing organisation	Name: German Sport University Cologne <i>Deutsche Sporthochschule Köln</i> Type of organisation: public Sector: education and sport Cooperating institutions: territorial government, residential homes
Target group	Country: Germany Region: North Rhine-Westphalia Group: older people, in particular >80 years of age, and seniors with dementia

Settings/ Place of implementation	Nursing homes, residential centres in various cities of the region
Health promoters	Adequately trained and certified trainers/instructors
Key objectives	The main objective of the project is to implement an efficient physical activity programme directed at the oldest group of seniors (>80 years of age). In order to promote physical health and to prevent falls occurring frequently in this age group a special set of exercises to improve balance was developed. Through strengthening muscles and improving balance, the project aims at enhancing the sense of security, independence and mobility of older people and improving their quality of life.
Main activities	Activities under the programme relate to the following three areas of physical activity: <ul style="list-style-type: none"> • weight lifting exercises; • balance exercises; • exercises in daily life activities. The set of exercises has been carefully selected for the needs and abilities of this age group. Notably, the programme provides for exercises directed at persons with reduced mobility, including wheelchair users. Each training session lasts 45–60 minutes and takes place twice a week. Exercise instructions are also broadcast through media such as radio, television and the press, thus increasing the group of potential recipients.
Effects and benefits	Evaluation results show that the actions under the programme enhance the mental and physical condition of its participants, who confirm increased physical fitness and ability to cope with daily activities, easier contact initiation and increased general life satisfaction. The programme is cost-effective and brings considerable cost savings due to the reduction of hospitalisation related to falls.
Evaluation	Evaluation was undertaken with regard to testing the cognitive and sensorimotor skills, such as: coordination ability, muscle strength, cognitive skills, the ability to perform everyday life activities independently and enhancement of general health and well-being.
Source of funding	Ministry of Labour, Health and Social Affairs North Rhine-Westphalia
Further information	www.ff100.de

Project name/title	GALM – Groningen Active Living Model
Implementing organisation	Name: GALM foundation Sector: non-governmental organisation Cooperating organisations: University of Groningen, governmental agencies, territorial government, sport centres, residential homes, local societies
Target group	Country: The Netherlands Region: initially 7 communities, later on, popularisation at the national level Group: people aged 55–85
Place of implementation	Local societies, sport centres, residential homes

Health promoters	Licensed instructors/ trainers of physical exercises, additionally trained in a special 3-day GALM training
Key objectives	<ul style="list-style-type: none"> • Increase in physical activity of seniors and change of dietary habits to promote health. • Offering a comprehensive programme of exercises, adapted to individual needs and preferences (on the basis of the results of a special motor skills test, performed before joining the programme). • Mobilising the programme participants to continue exercising in order to obtain a lasting change towards a more active lifestyle.
Main activities	<p>The GALM project was developed by the Dutch Sport and Physical Activity Institute, and initially was addressed to less active people of 55–65 years of age in order to encourage them to live a more active and pro-health lifestyle through participation in exercising classes taking place in their areas. Each exercise session lasts 60 minutes and ends with a brief coffee meeting, arranged with the intention of building good neighbourly relations.</p> <p>The popularity of the programme, satisfaction of the attendees and proven benefits helped popularise and develop the programme. Programme modifications, addressed to particular groups of seniors, have been designed and implemented:</p> <ul style="list-style-type: none"> • GALM-COACH — life coaching for less active people; • GALM 65+ — for people of over 65 years of age; • SCALA — for older people with chronic diseases; • SMALL — for municipalities with up to 20,000 inhabitants; • AKTOR — for lone seniors; • GALUM — for immigrants aged 45–65.
Effects and benefits	Participation in GALM results in a visibly enhanced physical activity, improvement of physical skills and intensified social relationships. Evaluation of the programme has proven that participation is beneficial for general fitness, stamina of the legs, dynamic balance, strength of the arms, BMI, and nutritional habits. The GALM programme is efficient in encouraging non-active seniors to commence and continue performing activities, thus leading to the improvement of their general well-being.
Evaluation	The effects of the programme were closely evaluated in reference to the general health condition, maintaining physical activity and lifestyle. The study was performed in three Dutch municipalities with the participation of control groups, and was repeated after 6, 12, and 18 months.
Source of funding	Half of the costs are paid by the government, and the remainder – by the local government, the elderly people foundation and other organisations interested in participating in the project. Cost for the attendee amounts to 1–3 euros.
Further information	www.galm.nl

Comments and remarks: A number of interesting programmes, considered to be good practises, have been implemented in the realm of physical activity, e.g. the national German programme *IM FORM*, the Italian programme *Colori in Movimento* (Colours in Movement), introduced in the Abruzzo region, or *Anziani in Cammino* (Seniors on the Way), established in Umbria.

In the case of such programmes, paying attention to efficient encouragement and engagement of seniors in physical exercises and maintaining their interest

in physical activity is of the utmost importance. Physical exercises for the elderly should be arranged in a manner which provides satisfaction for the participant, while simultaneously accounting for their individual abilities. Moreover, they should take place in the area of residence. Practical guidelines in this regard are collected in a handbook entitled *Recruiting Older Adults into Your Physical Activity Programmes* (Centre for Healthy Ageing, 2006).

II. Healthy nutrition

Project name/title	Delicious Life <i>Chutný život</i>
Implementing organisation	Name: National Institute of Public Health <i>Státní zdravotní ústav</i> Type of organisation: public Sector: central administration Cooperating organisations: Ministry of Health, regional public health institutions, elderly care homes, territorial government, NGOs
Target group	Country: The Czech Republic Region: Prague and the following regions: Pardubický, Královéhradecký, Liberecký, North-Bohemia, Moravskoslezský, Zlínský, Jižní Morava, Olomoucký. Group: elderly people
Settings/Place of implementation	Elderly care homes, local society
Health promoters	Dieticians, NGO volunteers
Key objectives	<ul style="list-style-type: none"> The main objective of the project is to provide more knowledge and enhance cooking abilities amongst the elderly in order to encourage them to healthy eating, enhance their physical activity, and motivate them to follow a healthy lifestyle. As part of the programme, <i>Tasty Wednesday</i>, meetings are organised, during which, after a short gymnastics session, educational lectures on healthy eating in the main cuisines of the world (e.g., Greek, Italian, French, Asian) are provided, followed by tastings. The lecturers are both nutritional specialists and seniors themselves. Interactive participation of elderly people enables their active involvement — they select recipes and prepare and taste the dishes together. Moreover, participants of the programme helped in creating a special calendar, containing the most successful recipes, tips and guidelines for promoting health in older adults. Improvement in motivation and skills of persons responsible for public health in the field of health promotion directed to older people.
Main activities	<ul style="list-style-type: none"> A series of lectures and interactive meetings, along with preparation and tasting of healthy foods from main cuisines around the globe. A brisk warm-up exercise session, preceding the culinary portion, was an integral part of each meeting. Preparation and publication of informative materials, with active participation of seniors. Preparation and production of a training movie, with active participation of seniors.

Effects and benefits	<ul style="list-style-type: none"> • 94% of the attendees were satisfied with the programme. • More than 95% of participants were highly satisfied with the atmosphere and socialising during the culinary meetings. • Around 46% of the entrants declared a change in their diet. • Approximately 40% of persons attending declared enhanced physical activity. • Employees of regional public health institutions became more active in promoting health amongst the elderly (by developing programmes and building cooperatives). • Some of the recipes created during the programme were used in the kitchens of elderly care homes.
Evaluation	Evaluation of the effects involved assessment of satisfaction and change in behavioural habits of the project participants when compared to non-participants.
Source of funding	The Ministry of Health (as a part of the national health programme) Social welfare centres and territorial government
Further information	http://www.szu.cz/tema/podpora-zdravi/projekt-podpory-zdravi-chutny-zivot?lang=1

Comments and remarks: A similar, interesting programme is the German campaign *Fit im Alter – Gesund essen, besser leben* (Prepare for Adulthood – Eat Healthy, Live Better); further details are provided on www.fitimalter.de.

Also, two Italian programmes are worth noting: which promote healthy eating habits along with physical activity, the *Colori in Movimento* programme, implemented in the Abruzzo region, and a programme for improving nutrition of the elderly in nursing homes, taking place in the Piedmont region.

III. Primary prevention

Project name/title	Keep Well This Winter
Implementing organisation	Name: Welsh Government Type of organisation: public Sector: governmental Cooperating organisations: National Public Health Service, local health entities, and Charity Age Cymru
Target group	Country: Great Britain Region: Wales (Cymru) Group: inhabitants of over 65 years of age
Settings/Place of implementation	Health care centres, the media
Health promoters	Physicians of local health care centres (for vaccinations) Volunteers of Charity Age Cymru, a Welsh organisation for seniors
Key objectives	<ul style="list-style-type: none"> • Fighting flu by vaccinations provided free of charge • Development and implementation of a broad campaign directed at the senior inhabitants of Wales in terms of information and guidelines about maintaining good health condition during the winter months

Main activities	<ul style="list-style-type: none"> • Free flu vaccination campaigns for people over 65 years of age • Broad campaign in various media outlets about the benefits of vaccination, preparation for winter months, including information and educational programmes on healthy eating, maintaining physical activity, home living ergonomics (how to decrease power and gas bills, perform maintenance and repairs), being safe at home, avoiding slips and falls.
Effects and benefits	<ul style="list-style-type: none"> • Increase in flu vaccination coverage • Improving seniors' knowledge on diet, choice of clothes, and staying active during the winter • Enhancement of knowledge on maintaining heat in homes amongst the elderly.
Evaluation	The issued evaluation questionnaire was aimed at collecting opinions about the programme from the health entities performing vaccinations, and from entities participating in preparation of the media campaign.
Source of funding	Welsh Government
Further information	www.ageuk.org.uk/cymru/health--wellbeing/keep_well_this_winter/

Comments and remarks: Interesting examples of actions for vaccinations of older people can be found in Italy, where the Ministry of Health has published annual official recommendations for a flu prophylaxis programme since 1999. It is planned that eventually 75% of persons aged 65 and more will receive vaccinations. The vaccination campaign takes place every year, from October to December. Vaccination coverage increases every year, e.g. in 1999/2000 it amounted to 40.7%, while in 2005/2006 — it was up to 68.3%. Family doctors play an important informative and educational role in this programme. Moreover, Italy has implemented a special bonus system (fee for service model) rewarding family doctors for vaccinating older people.

Project name/title	Happy Ageing – the Italian alliance for active ageing
Implementing organisation	<p>Name: Happy Ageing Type of organisation: Non-profit association Sector: NGOs</p> <p>The alliance is composed of scientific societies (the Italian Society of Hygiene (SITI), the Italian Society of rehabilitation (SIMFER), the Italian Society of gerontology and geriatrics (SIGG) and the Federation of local health authorities and municipalities (Federsanità-ANCI) and several trade unions (elderly sections of the CISL, CGIL, UIL, ACLI).</p>
Target group	<p>Country: Italy Group: inhabitants of over 65 years of age</p>
Settings/Place of implementation	Institutions mentioned above, the media (website)
Health promoters	<p>Stakeholders and decision makers from several organisations with different roles in HP4OP Famous showman/VIPs appreciated by older people</p>
Key objectives	<p>The aims of the Happy Ageing alliance are advocacy for HP4OP at the national level and the collection of all the best practices in the field of elderly wellness. The alliance is mainly focused on 5 thematic areas regarding the health of older people: immunisation, eating, physical activity, drugs and screening.</p>

Main activities	<ul style="list-style-type: none"> • Awareness regarding the importance of flu vaccination for people over 65 years of age and the other thematic areas. • Broad campaign in different setting (scientific meeting, information and educational programmes, flyers, etc). • To advocate at institutional level policies and initiatives targeted at the health and wellness of older people
Effects and benefits	<ul style="list-style-type: none"> • Increase in flu vaccination coverage • Increase in the healthy literacy of older people • Development of policies and initiatives targeted at the health and wellness of older people
Evaluation	Not yet performed. For the influenza vaccination, the effectiveness of the campaign could be evaluated using the national immunisation coverage collected yearly and published by Italian local health authorities (ASLs) and the Ministry of Health.
Further information	http://www.happyageing.it/category/area-media/

Project name/title	National Operative Plan Against Sudden Excessive Heat "Ondate di Calore"
Implementing organisation	Italian Ministry of Health in collaboration with the Centre for Prevention and Control of Diseases (CCM) and the Department of Epidemiology of the Roma (ex RomaE) Local Health Authority
Target group	Elderly , especially frail older people with chronic conditions Country: Italy
Settings/Place of implementation	This is a community based programme coordinated by the Italian local health authorities (ASLs) and implemented by general practitioners, with the collaboration of the National Civil Protection (Protezione Civile) and several non-for profit organisations
Key objectives	The main objective of this yearly plan is to prepare elderly people, especially those with limited thermoregulation capacity or who are frail, to face excessive heat and high environmental temperatures.
Main activities	<ul style="list-style-type: none"> • Identify frail elderly citizens • Provide proper information and education regarding the risk of excessive heat exposure • Predict in advance the arrival of the heat waves and communicate the risks in a timely manner
Effects and benefits	Avoidance or reduction of heat exposure Reduction of the mortality and hospitalisation rates in the frail population Establishment of collaborative mechanisms between bodies and institutions, including monitoring and alert systems
Evaluation	The effectiveness of this programme could be monitored using the Italian and European Mortality Monitoring systems (i.e. Euromomo)
Source of funding	Public. The first project has been funded by the CCM. The annual activities are carried out within the budget of the National Health Service
Further information	http://www.ccm-network.it/pagina.jsp?id=node/2039

Comments and remarks: This plan started in Italy in 2005, following the 2003 summer in which excessive heat caused an increase in hospital admissions and deaths, particularly among the elderly. Similar strategies have been developed also in most countries and the European Commission has realised public health responses to heat waves within the wider strategies to prevent the negative effects of the climate change.

Project name/ title	Dutch spin-off of the Coping With Depression (CWD) course <i>In de put, uit de put 55+</i>
Implementing organisation	TRIMBOS Institute (Netherlands Institute of Mental Health and Addiction), Utrecht, The Netherlands GGZ Nederland (Dutch Association of mental health and addiction care), Amersfoort, The Netherlands Type of organisation: TRIMBOS Institute is a public organisation. GGZ Nederland is a sector organisation that organises employers of mental health care providers.
Target group	Country: The Netherlands Group: Adults older than 55 with subclinical depression and those with major depressive disorder. People with psychotic episodes or with suicidal ideas are not eligible for this intervention. Also, migrants are considered non-eligible. A separate course has been developed for Turkish and Moroccan immigrants (<i>Lichte dagen, donkere dagen. Light days, dark days</i>).
Settings/Place of implementation	The intervention is conducted in mental health care (GGZ) or community centres related to prevention of mental health problems.
Health promoters	Medical professionals (physicians, psychologists)
Key objectives	The main goal of this intervention is to cure or to prevent (in the case of subclinical depression) the symptoms related to depression. The intervention has several objectives: to give a theoretical background on what depression is, to help older adults with depression to stand up for themselves (assertiveness), to teach them how to relax, how to engage in more pleasant activities and how to maintain treatment achievements.
Main activities	This intervention is a Dutch adaptation of Lewinsohn's CWD (Coping with depression) course (Lewinsohn et al., 1984). The main activities include relaxation techniques, examples of how to increase pleasant activities, workshops and techniques related to constructive thinking and techniques related to improving social skills. The intervention is group based and the number of participants can vary from 6 to 13. The intervention consists of 10 meetings (each meeting once per week) with a duration of 2 hours. Several materials are also used. For participants, a course book has been developed. There are also flyers and posters in GP's offices. For health professionals involved in the intervention, a handbook has also been developed.
Effects and benefits	The intervention is beneficial for participants with mild and severe depression. This is consistent with results from three evaluation studies. There is no evidence (for the Netherlands) on the cost-effectiveness of the intervention.
Evaluation	Three studies have evaluated the intervention and all three have used randomised control trial as a design. The first study addressed the effectiveness of the intervention on older adults with subclinical depression (Allart-van Dam et al., 2007). The second study was also focused on subclinical depression, but compared the "In de put, uit de put 55+" with an internet-based intervention (Spek et al., 2007). The third evaluation study is focused on people with subclinical depression but also on people who have already been diagnosed with depression. This intervention has been approved by the Dutch Institute of Public Health (RIVM).
Source of funding	The intervention is funded through regular mental health care funding. Based on several Dutch laws (Wmo and Zvw) community centres receive the money for health promotion activities based on the number of patients taking the course. Professionals included in the intervention had a two day preparation course that cost €550 per participant. The cost for the handbook was approximately €40. The participants pay €27.50 for the course book.
Further information	www.loketgezondleven.nl/interventies/i-database

Project name/title	Do we actually need so many medicines when we get older? <i>Ali v zrelih letih res potrebujemo toliko zdravil?</i>
Implementing organisation	University of the Third Age in Ljubljana <i>Univerza za tretje življenjsko obdobje Ljubljana</i> Sector: non-governmental organisations Cooperating organisations: family doctors, territorial government, the Health Insurance Institute
Target group	Country: Slovenia Region/city: Ljubljana Group: elderly patients
Settings/Place of implementation	Family doctors' offices and the University of the Third Age
Health promoters	Family doctors
Key objectives	The main objective of the programme is to support elderly people in adjusting the medicines they take to their actual needs. The programme is aimed at individual interventions to check and verify the list and dosages of medicines taken by elderly patients. Studies revealed that people over 65 years of age take several times more medicines than people from other age groups. Some of the medicines used can lead to unwanted interactions with other drugs. This particularly applies to over-the-counter medicines, which can be more detrimental than beneficial. Besides, seniors often do not pay attention to the shelf life of medicines.
Main activities	<ul style="list-style-type: none"> Discussions/interviews with individual elderly patients about medicines taken in the previous three weeks. On that basis, an assessment of the type and dosage of recommended medicines is made. Organisation of lectures devoted to issues related to medication. Particular attention is paid to the following drug types: painkillers, tranquillisers, antidepressants, antibiotics, antihypertensives, antidiabetics and laxatives.
Effects and benefits	<ul style="list-style-type: none"> The implemented programme and its long-term evaluation (the programme has been active since 2005) have shown that the elderly people included in the project-related actions are more cautious with taking medicines and have reduced the number of preparations taken. The educational actions provided are of huge significance for particular individuals, helping them prepare a list of medicines taken. A rational approach to taking medicines by elderly people saves money spent on medicines (both in general and by individual patients).
Evaluation	The planned support model was evaluated by the target recipients before it was further disseminated. The project is still being continued and monitored.
Source of funding	The Health Insurance Institute of Slovenia
Further information	www.seniorji.info/Ali_res_potrebujemo_toliko_zdravil_

Comments and remarks: Good practices from this area are also collected under the European Innovation Partnership on Active and Healthy Ageing: Prescription and Adherence to Medical Plans (Action Group A1).

Project name/title	Udine: an “Age Friendly City”
Implementing organisation	Name: Municipality of Udine Type of organisation: public
Target group	Country: Italy Region/city: Udine Group: elderly patients (but also the general population)
Settings/Place of implementation	City of Udine
Health promoters	Several stakeholders
Key objectives	This project is within the wider “WHO Global Network for Age-friendly Cities and Communities”, which aims to develop and implement policies, services, settings and structures to support and enable people to age actively within their cities
Main activities	<ul style="list-style-type: none"> • Matching the distribution of the elderly in the city to the provision of public, health and social services offered at the local level; • Recording the experiences and needs of older people through a consultative process with citizens, caregivers and providers of services to discover the existing “age-friendly” urban features as well as the barriers to active ageing; • Promoting opportunities for older people to remain physically, mentally and socially active through activities at the local level (i.e. groups for walking); • Cycle of seminars and cooking workshops; • Creating occasions for socialisation and gathering people of different ages.
Effects and benefits	<ul style="list-style-type: none"> • Creation of new opportunities for intersectoral and inter-generational work; • Involvement of the elderly community in social activities; • Implementation of food and mobility policies oriented towards the elderly
Evaluation	The network is a platform to exchange good practices. The citizens are involved in the evaluation process through a participative approach to the project.
Source of funding	The Municipality of Udine
Further information	WHO, Global Age Friendly Cities. A guide. 2008, www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf ;

Comments and remarks: The WHO Global Network for Age-friendly Cities and Communities includes 400 cities and communities in 37 countries all around the world (covering over 146 million people), with the collaboration of governmental, nongovernmental and academic groups.

IV. Avoiding health risks

Project name/title	Good health into older age – VINTAGE
Implementing organisation	National Institute of Health, Roma, Italia <i>Istituto Superiore di Sanità</i> Project Coordinator
Target group	International project Country: European countries Group: older people

Settings/Place of implementation	Projects partners: Faculty of Health, Medicine and Life Sciences, Maastricht University, the Netherlands Department of Health, Programme on Substance Abuse, Government of Catalonia, Spain Institute of Alcohol Studies, the United Kingdom National Institute of Public Health, the Czech Republic Research Centre, Institute of Public Health, Slovenia National Institute for Health and Welfare, Finland And 12 collaborating institutions from different European countries (Germany, Norway, the Netherlands, Spain, Italy), and the WHO Collaborating Centre for Research & Health Promotion on Alcohol and Alcohol-Related Health Problems
Key objectives	The main objective of VINTAGE was to build capacity at the European, country and local levels by providing the evidence base and collecting best practices to prevent the harmful use of alcohol amongst older people, including the transition from work to retirement.
Main activities	<ul style="list-style-type: none"> • To identify, document and summarise the existing scientific and grey literature on the impact of alcohol on the health and well-being of older people • To collect best practices, laws and infrastructures to prevent harmful alcohol use by older people in different European countries at different levels • To ensure wide dissemination of the main findings of the project (project reports, good practices, relevant laws and infrastructures) with relevant key findings and implications for policy and programme development, to those responsible for alcohol policy and programme development in order to build capacity and knowledge and support evidence-based decisions.
Effects and benefits	<ul style="list-style-type: none"> • The main conclusions presented in the final project reports are: • Alcohol and ageing is a subject for a strategic framework of action and prevention; • Alcohol strategies should ensure an ageing perspective, and should include alcohol issues into healthy ageing strategies; • Older people should be made more aware about alcohol-related consequences on their health and safety; • Alcohol consumption guidelines dealing with alcohol and older people should be an appropriate way of drawing attention to this neglected target of health planning and prevention; • Alcohol in older people should be a major health policy issue for tackling mental health in older people
Evaluation	The project was the subject of external and internal evaluation including the assessment of scientific reliability and utility.
Source of funding	European Commission within the Second Programme of Community Action in the Field of Health 2008–2013
Further information	www.epicentro.iss.it/vintage/project.asp

Comments and remarks: *Guadagnare Salute (Gain Health)* is an Italian programme from the area of health risk avoidance which merits recognition. It aims at modifying major risk factors to decrease chronic disease burden, including: change of lifestyle and eating habits, e.g. increased intake of fruits and vegetables, reduced intake of salt, sugar and fat with foodstuffs, elimination of calorie-rich foods from the diet, fight against tobacco and alcohol addiction.

Project name/title	Dance as therapy with an effect on health and quality of life of nursing home residents <i>Vliv tanecní terapie na zdravotní stav a kvalitu života seniorů zijících v institucích</i>
Implementing organisation	Name: Gerontology Centre <i>Gerontologické centrum</i> Type of organisation: public Sector: social welfare Cooperating organisations: Ministry of Health, elderly care homes
Target group	Country: the Czech Republic Region: Prague Group: elderly people, particularly those with dementia (47% of the group)
Settings/Place of implementation	Elderly care homes
Health promoters	Adequately trained dance instructors Employees of elderly care homes
Key objectives	<ul style="list-style-type: none"> • Development of a dance therapy programme, which could be easily implemented in elderly care homes • Inclusion and activation of seniors with dementia • Improving the quality of life of nursing home residents by improving their functional states and preventing injuries and falls • Increase in motivation and self-awareness, prevention of depression • Provision of scientific evidence of the positive effect of dance therapy on general health, quality of life, communication between seniors and employees, and health service utilisation
Main activities	<ul style="list-style-type: none"> • Dance therapy is a motion-involving method to improve emotional, cognitive, social, and physical skills. The priority is to stimulate non-verbal communication and improve mental health. • Activities carried out as part of the programme include: • development of a dance therapy programme for older people; • training of employees and collaborators; • providing dance therapy classes in seven nursing homes in Prague; • preparation of methodological tools to test empirical evidence to confirm the effectiveness of the programme; • data collection and analysis to verify the programme; • publication of an informative flyer and preparation of a training recording.
Effects and benefits	<ul style="list-style-type: none"> • Dance therapy brought about a statistically significant, beneficial impact on the seniors' condition and functioning, particularly with regard to lower limb function, balance and dexterity, which in turn improves prevention of falls and injuries. • Participants rated the programme highly and received it with satisfaction. • The programme facilitated integration amongst seniors with dementia, elderly wheelchair users, and people over 90 years old. • There was also a positive psychological effect observed which involved improved communication, expressions of contentment and joy by the seniors and their increased involvement. • The programme helps improve mental health (depression prevention, emotional support), and aids deepened interpersonal ties.

Evaluation	Qualitative and quantitative methods were used in programme evaluation. The programme was evaluated by an interdisciplinary team (geriatrist, professional dancer and choreographer, health-care personnel specialised in caring for people with dementia) and additionally during discussions with employees of retirement homes. The evaluation of results was performed as a randomised control study (covariates: health condition, functional condition, and quality of life). Also, participants' satisfaction with being in the programme was assessed.
Source of funding	Ministry of Health
Further information	www.gerontocentrum.cz

Project name/title	View on balance <i>Zicht op evenwicht</i>
Implementing organisation	<ul style="list-style-type: none"> • Trimbos Institute, Utrecht, The Netherlands (Netherlands Institute of Mental Health and Addiction) • Maastricht University, Maastricht, The Netherlands • ZonMw (The Netherlands Organisation for Health Research and Development)
Target group	Country: The Netherlands Group: Self-reliant older people age 65 and older who reported at least some fear of falling
Settings/Place of implementation	The intervention is designed as a multicomponent cognitive behavioural intervention aimed at reducing the fear of falling and reducing activity avoidance among older adults who live in the community. The intervention is carried out in local community centres – free transport is organised for participants (in case they need it). Although the intervention is community based, it is also possible to conduct the intervention on an individual basis – at the home of an older person. This is done in cases when older adults prefer a home setting.
Health promoters	Six trained geriatric nurses conducted the intervention. The script-book was developed in order to help them during implementation.
Key objectives	The primary goal of the intervention is to reduce the fear of falling among older adults. The secondary goal is to prevent older adults from non-participation in activities that might lead to falling. The intervention consists of four strategies namely: restructuring the view regarding the fear of falling, promoting the view that fear is controllable, setting realistic goals for increasing physical activity in a safe manner, changing the home environment to reduce fall risk, promoting physical activities to increase strength and balance.
Main activities	Different techniques are used for each component: lectures, videos, group discussions, mutual problem solving and assertiveness training. Physical activity is used, primarily in the form of stretching, flexing and strength exercises. The intervention also included signing individual behavioural contracts – where each person set his/her own goals. In order to promote the intervention among older adults several materials have been developed such as DVDs, CDs with movies, brochures and flyers available at GP's offices.
Effects and benefits	The intervention has shown moderate effects in reducing the fear of falling. It has also been shown that the intervention can reduce anxiety and depression among older adults.

Evaluation	Three independent studies have been done in order to evaluate this intervention. Their results are consistent – the intervention has medium sized effects on the primary goal (reducing the fear of falling). The first evaluation is based on a longitudinal randomised control trial (RCT) with several follow ups. It is based on an effect, process and cost evaluation. For all three issues, findings are positive (Zijlstra et al., 2009). The second evaluation is based on attitudes of participants and instructors (Haastregt et al, 2013). The third evaluation is focused on the individual intervention and it has also found positive effects (Dorresteijn et al., 2011). Since the relation between the effects and the costs of intervention are positive in all three evaluations, the intervention is now part of regular (basic) care. Those evaluations have been done by Maastricht University. The RIVM (Dutch Institute of Public Health) has also evaluated the intervention positively.
Source of funding	Funding is provided by Dutch Ministry of Health, ZonMw and since the intervention is also part of regular (basic) care, funding is also obtained from insurance premiums paid by citizens.
Further information	www.zichtopevenwicht.nl www.loketgezondleven.nl

Comments and remarks: Prevention of falls in elderly people is given special attention. A particular, international network for sharing good practices in the field, The Prevention of Falls Network for Dissemination (ProFouND), was founded. Further details are available on: <http://profound.eu.com/best-practices-2>.

Good practices from this area are also collected under the European Innovation Partnership on Active and Healthy Ageing – Personalised Health Management and Falls Prevention (Action Group A2).

V. Maintaining and developing social networks and social integration

Project name/title	Ujbuda 60+ Budapest
Implementing organisation	Name: Ujbuda – one of the largest districts in Budapest Type of organisation: public Sector: territorial government Cooperating organisations: NGOs, Ministry of Health, senior clubs, sport clubs
Target group	citizens 60+ of Ujbuda
Settings/Place of implementation	Seniors clubs, municipality infrastructure and sport clubs
Health promoters	Volunteers of local non-for profit organisations
Key objectives	The main objective is raising the quality of life with the instruments of the self-government and achieving results in: loneliness reduction, eliminating the generation gap, ensuring and providing life-long learning, maintaining health and an active lifestyle, ensuring a safe environment and maintaining the independence, activity and dignity of older people as long as possible. Feedback from users is collected and the project is updated.

Main activities	<ul style="list-style-type: none"> • This innovative and complex programme is in line with the principles of the Hungarian Chart of Elderly People and adapting them to practice at the local level. It is based on the real needs of older people and provides about 280 programmes and services monthly that improve the quality of life of the target group and helps maintain their activity. The key elements of the programme are as follows: • Building communities to develop human relations and communicate information. These tasks are organised and run by 106 trained volunteers on the different points, e.g. visiting/shopping/guiding; teaching English/German, painting etc. • Sports and Health: outstanding programmes (physiotherapy, hiking, nordic walking) and other programmes (gymnastic, yoga, dancing, swimming and aquagymnastics, playing chess and cards). • Healthcare: education (e.g. healthy diet), screening and prevention; services in mental hygiene (e.g. relaxation courses), alternative health care programmes. • Ujbuda 60+CARD (symbol for the community of older people), which entitles the elderly to take part in centrally organised programmes/courses at a low cost or free of charge. • Communication precisely for older people (a dedicated district newspaper, the internet webpage, newsletters informing about the events, programmes). Information is provided in the Ujbuda 60+ Programme Centre in person and on the phone every working day. • Culture – several dozens of programmes from hand crafts to instrumental music. • Senior Academy Ujbuda – lectures and courses: Internet, English/German courses with more than 2000 participants, crossword puzzles, banking matters etc. • Crime prevention programme – to make people to feel safer; this programme cooperates with the staff of the National and Local Police Organisation, e.g. crime prevention.
Effects and benefits	<ul style="list-style-type: none"> • In 2009 and 2013 Ujbuda won the prize of the Elderly – for Friendly Municipality. • It became the largest and well-known programme in Hungary in the issue of healthy ageing • Many successful actions, innovations, programmes and conferences (providing trainings for other municipalities) and increasing local activities in healthy ageing • Since September 2015 Programme Ujbuda 60+ has been part of the Educational Programme of Physiotherapists and Dietitians
Evaluation	Evaluation is constantly conducted in the form of a satisfaction survey of programme participants.
Source of funding	Project Ujbuda 60+ is financed by Ujbuda Self-Government, but they are searching for EU funds (Q-Ageing; Senior Capital Project). Human resources are employed as volunteers.
Further information	www.ujbuda.hu/ujbuda/sokan-voltak-a-60-gyaloglo-program-elso-setajan

Project name/title	Long Live the Elderly! <i>Viva gli anziani</i>
Implementing organisation	Name: Community of Sant'Egidio Type of organisation: Non-profit organisation Sector: NGOs Cooperating organisations: Ministry of Health, Municipality of Rome, Local Health Authorities
Target group	Country: Italy Region: Lazio Group: inhabitants of a district of Rome 80+
Settings/Place of implementation	Home of elderly and the community around them (General practitioner, pharmacists, shopkeepers, caretakers, etc)
Health promoters	Social assistants, ad hoc trained operators (trained to perform home visits, administer the GFE questionnaire, assess basic physical condition, manage administrative tasks related to the relation of the client with the public administration) Formal services and/or informal carers who voluntarily make themselves available for performing one or more tasks
Key objectives	Fighting the different components of social isolation of the elderly by creating a network among older people and between older people and formal and informal carers to prevent critical events. The general aim is to increase the social capital of both the community and the individual.
Main activities	<ul style="list-style-type: none"> • Temporarily intensifying the support around the isolated individual during physical, mental, socio-economic or environmental crisis • A dedicated phone number active from 9.00 to 17.00, Monday to Friday that can be reached for specific requests • Frailty evaluation by means of the Geriatric Functional Evaluation—GFE questionnaire • Periodic phone calls (at least two times per year and during each environmental emergency, such as a heat or cold wave) to the older adults included in this Community-based pro-Active Monitoring Programme (CAMP) • Support to specific requests directly or indirectly involving available formal and/or informal resources • Strengthening of formal and informal carers' network. • Development of networks among public and private partners
Effects and benefits	<ul style="list-style-type: none"> • Avoiding the hospitalisation and costs related with residential health care assistance • Improving access to the community services dedicated to the elderly • Involving older adults in good conditions as well who voluntarily make themselves available to help other peers.
Evaluation	In 2015, Marazzi et al. showed its capacity to reduce the over-74 hospitalisation rate, the use of Long Term Care and the cost of services used by the studied population
Source of funding	private and public funds
Further information	http://www.vivaglianziani.it/programma-viva-gli-anziani/ www.longlivetheelderly.org

Project name/title	Alzheimer Cafe – a community space for people coping with dementia and Alzheimer’s disease
Implementing organisation	Name: Alzheimer Cafe Type of organisation: public/private Sector: NGOs Cooperating organisations: local NGO, local health authorities, municipalities
Target group	Seniors suffering from dementia or Alzheimer’s disease and their families
Settings/Place of implementation	A café adapted to the needs of older people
Health promoters	Volunteers from local NGOs dedicated to seniors, experts in the field of dementia and Alzheimer’s.
Key objectives	The main aim of this project is to decrease these people’s isolation and to gather a group of people facing similar challenges.
Main activities	Café Alzheimer is a real café, where patients and their families can drink and eat something together and meanwhile caregivers organise simple activities for them (e.g. relaxation exercises, guided walks). Special meetings are also organised by the caregivers: helping families and the patients themselves to cope with the problems they face, music therapy, physical activities, etc. Special trainings given by experts are offered to caregivers. Café Alzheimer is not a rehabilitation centre, but a special nice place for meetings, mutual support and complex information dedicated to dementia and Alzheimer’s.
Effects and benefits	Increased quality of life of the target group, new interactions between the community members and experts, better access of the elderly to suitable services, efficient informal modes of learning in a nice atmosphere, effective help for those families who live together with seniors suffering from dementia or Alzheimer’s disease.
Evaluation	In 2012 the Unicredit Foundation published a scientific report based on the activity of 7 Alzheimer Caffès (Cesena, Cremona, Sesto Fiorentino, Roma, Saronno, Oderzo, Treviso), which highlights relevant improvements both for patients and for caregivers.
Source of funding	Both public (i.e. municipalities, Provinces, local health authorities, etc.) and private funding (i.e. a private foundation) are supporting the start up and support of the Alzheimer Cafés)
Further information	Alzheimer Caffè: la ricchezza di una esperienza. 2012 https://www.unicreditfoundation.org/content/dam/ucfoundation/documents/publications/Alzheimer_Caffe.pdf

Comments and remarks: Loneliness and social isolation are some of the most difficult life issues amongst older people. Therefore, actions taken in order to maintain and develop social ties and to integrate with society are of an utmost practical importance.

The “Alzheimer Cafés” is an initiative started in The Netherlands in 1997 that has spread throughout all of Europe. In Italy in 2014 there are more than 100 independent “Alzheimer Cafés”, some of them with a specific name (i.e. Café Oz in Genoa, Amarcord al Caffè in Cesena, etc.)

An interesting British initiative aimed at prevention of loneliness and the isolation of seniors is the *Ageing Well UK Network*. The network includes more

than 170 local centres providing active support to elderly people. Further details are available on: www.ageuk.org.uk.

Conclusions

A good practice in health promotion is an intervention, programme or specific action carried out in order to obtain a positive health change within the entire population or its group(s), which brings positive outcomes.

Good health promotion practices addressed to older people constitute a convincing source of information and motivation, particularly for health promoters and policy makers in health care, providing practical evidence to confirm the effectiveness of the implemented health programmes.

Examples of good health promotion practices are the grounds for indications, demands and programmes for healthy ageing strategies which have been developed in many countries.

Creation of information databases on good practices aids in promoting the sustainability of already implemented actions and enhances their applicability under different conditions.

The European countries in which many actions for older peoples' health are being undertaken, which are considered by experts to be good practices, are mainly the Netherlands, Italy, Germany, the United Kingdom and Spain.

In order to facilitate access to information on good practices for older peoples' health, with the support of the European Committee, an experience sharing platform was created and is now a source of knowledge and inspiration about innovative and effective actions.

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SOURCES OF KNOWLEDGE AND INFORMATION



Sources of knowledge and information for health promoters

Introduction

Systematic enrichment of professional competencies is a requirement in all professions. The concept of life-long learning (LLL), as described in chapter 5, has been developed for this reason. The requirement to supply knowledge systematically is especially important for the profession of a health promoter. Health promotion is a young branch of science where facts are often of a conventional character and are supported by developing scientific research. However, progress has been significant.

The supplementation of knowledge does not need to have the character of formal training, although this kind of education should also be developed. Self-education is the most common and is dependent on access to sources of knowledge and information.

In the last chapter of this book we present the sources of knowledge and information most useful for health promotion professionals. As the turn of the 20th and 21st centuries has brought an information revolution, there is now the possibility to access the plenitude and variety of information which is available on the global scale and to use that information for educational and communication purposes. At the same time, there is also now a risk of choosing unreliable, undependable, or even deliberately falsified information.

The principle of using scientifically confirmed or evidence based sources is a method of selecting information and knowledge. Like representatives of other professions of public trust, health promoters use elaborations or papers published in scientific journals which guarantee reliability. A review of the sources of information and knowledge which are useful or necessary in the work of health promoters begins with scientific literature based on the principle of the application of evidence obtained through research.

We are also presenting sources found in the media. It is more and more difficult nowadays to make an unequivocal assessment of media sources. The division into

the traditional media, i.e. television, radio, the press, and the modern media, i.e. the Internet, is not clear. Once obvious and clear, the boundaries between these two kinds of media are now wearing thin. These changes are also deepened by the exceptionally fast development of IT technologies such that it is now difficult to talk strictly about, for example, a radio station when each station's web site contains texts for reading, something which used to be attributed to the press only, as well as video clips which would indicate a visual perception which used to be present in television only. Present day newspapers have also moved to the Internet and they frequently use audio-visual forms, which used to be present in the radio and television only.

Scientific literature

Scientific literature, like books or publications in scientific journals constitutes the main source of reliable information about effective programmes and interventions in health promotion.

First, we want to indicate the most respected titles of scientific journals (Table 8) in both general health promotion and promotion for older people.

The articles found in Polish or foreign reviewed journals are guaranteed of reliability. Some scientific journals, although still rather few, share their reviewed articles on the Internet in the full version, with access to their contents (open access).

Table 8 A list of scientific journals dedicated to public health, health promotion, older people and ageing

Journal title	Publisher	Comments
<i>Age and Ageing</i>	Oxford University Press http://ageing.oxfordjournals.org/	An international journal of geriatrics and gerontology.
<i>American Journal of Health Promotion</i>	Michael P. O'Donnell, President and Editor in Chief of AJHP http://www.healthpromotionjournal.com/	An American journal dedicated to contemporary problems of health promotion, scientific research and its practical application
<i>BMC Health Services Research</i>	BioMed Central (BMC) – Springer Nature http://bmchealthservres.biomedcentral.com/	Subjects discussed in this journal include the issues of health care, an evaluation of health needs, organisation of health care, comparative analyses of health care systems, the economics and policy of health.
<i>BMC Public Health</i>	BioMed Central (BMC) – Springer Nature www.biomedcentral.com	A journal publishing articles which comprise issues from the fields of epidemiology and public health.
<i>European Journal of Public Health</i>	Oxford University Press https://academic.oup.com/eurpub	A journal publishing articles which comprise issues from the fields of epidemiology and public health.

Table 8 – continued

Journal title	Publisher	Comments
<i>European Journal of Ageing</i>	Springer http://link.springer.com/journal/10433	An interdisciplinary journal dedicated to the social, behavioural and biological aspects of ageing.
<i>Health Promotion International</i>	Oxford Journal http://heapro.oxfordjournals.org/	An international journal which presents the main trends of innovation in health promotion.
<i>International Journal of Health Promotion and Education</i>	The Institute of Health Promotion and Education http://www.tandfonline.com/toc/rhpe20/current%20ation	A journal addressed to promoters and educators in public health, health sciences, nursing, medical sociology and administration of the health sector.
<i>Journal of Community Health – The Publication for Health Promotion and Disease Prevention</i>	Springer http://link.springer.com/journal/10900	This journal publishes articles about health promotion and disease prevention, focusing on health issues of local communities.
<i>Health Education & Behavior</i>	Society for Public Health Education (SOPHE) http://journals.sagepub.com/home/heb	This journal deals with issues of healthy behaviour and behavioural strategies.
<i>The Global Journal of Health Education and Promotion (GJHEP)</i>	Sagamore Publishing http://js.sagamorepub.com/gjhep	This journal describes international programmes and initiatives on health education and promotion.
<i>Global Health Promotion</i>	International Union for Health Promotion and Education (IUHPE) http://journals.sagepub.com/home/ped	This journal publishes academic texts on health promotion which include issues of the theory of public health and health education.
<i>Public Health Ethics</i>	Oxford University Press http://phe.oxfordjournals.org/	This international journal publishes articles on ethics in public health.
<i>Journal of Gerontology</i>	Oxford University Press https://biomedgerontology.oxfordjournals.org/	A journal dedicated to biological and social problems of ageing and issues of clinical epidemiology.
<i>Healthy Aging Magazine</i>	Healthy Aging® – CWI Productions, Inc., http://healthyaging.net/	An American magazine which provides information and counselling about healthy ageing.
<i>Epidemiology, Biostatistics and Public Health</i>	http://ebph.it	A multidisciplinary journal aimed at strengthening the evidences on effective preventive interventions.
<i>Zeszyty Naukowe Ochrony Zdrowia Zdrowie Publiczne i Zarządzanie</i>	Wydawnictwo Uniwersytetu Jagiellońskiego http://www.ejournals.eu/Zdrowie-Publiczne-i-Zarzadzanie/	This Polish magazine publishes texts on public health, management and economics in health care.
<i>Zdrowie Publiczne Polish Journal of Public Health</i>	Uniwersytet Medyczny w Lublinie www.pjph.eu	The oldest Polish magazine on public health, originally called <i>Zdrowie (Health)</i>

Table 8 – continued

Journal title	Publisher	Comments
<i>Public Health Forum</i>	Czasopismo Polskiego Towarzystwa Zdrowia Publicznego http://phf.edu.pl/	This journal deals with public health in general.
<i>Promocja Zdrowia i Ekologia</i>	Krakowska Wyższa Szkoła Promocji Zdrowia http://www.kwspz.pl/uczelnia/wydawnictwa/	A Polish magazine (a half-yearly) dedicated to health promotion and the environment.
<i>Health Policy in Non Communicable Diseases</i>	http://hpncd.it/index.html	An Italian Journal dealing with policy in the field of chronic diseases (with a special issue regarding active ageing).

Source: the authors' own sources based on information from the journals presented in the table.

Recommended literature

The realisation of the *ProHealth 65+* Project, during which several systematic reviews of literature have been made and many articles have been published in scientific journals, allows us to recommend useful literature to health promoters, which may also help them continue their self-education. The presented list of literature includes literature chosen in accordance with the subject structure of the book (Table 9).

Table 9 Useful literature for health promoters

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Independent library literature review

In the Internet age, access to information, including scientific information, enables people to develop self-education on a much bigger scale than before. The ability to search for specific information independently is very useful. In the field

of health promotion it can be done by means of such search engines as Medline, Google Scholar or PubMed. In order to make the search effective, at the beginning it is necessary to establish the basic categories which will make it possible to find the needed sources. The categories defined by functions (methods) of health promotion, accepted within the *Pro-Health 65+* Project (see Chapter 2), may be helpful for health promoters. These categories include: health advocacy, primary prevention, health screening or health education. Information source searches might also be based on selected health promotion activities, such as healthy nutrition, rehabilitation and fall prevention.

The radio and television

Although the television and radio are quite traditional and popular, rather than professional, sources of knowledge and information, health promoters who in their work focus on older people include television and radio as a place to promote healthy lifestyle, warn of health risks and encourage the prevention of chronic diseases.

In the countries which participated in the *Pro-Health 65+* project, there are radio programmes and channels as well as TV broadcasts which focus on the general problems of senior citizens, where health is the most commonly discussed subject.

The radio

On their Internet portal, the Polish Radio broadcasts a series of audio or text programmes for senior citizens. Radio.pl-senior informs seniors about free medicine for people over 75 years of age, about medical packages, senior activation programmes, the principles of a healthy diet, the influence of physical activity on health condition or about the health of elderly people in Poland and other European countries. Examples of the interesting activities of regional radio stations come, among others, from Germany and Poland. Radio Darmstadt, for example, from Germany transmits “Magazin für junge Alte” – a periodical programme dedicated to the elderly focused on the health problems of falls and diseases – prevention, symptoms, treatment and a healthy style of life. Radio Blau from Germany (Leipzig) presents a series of programmes called “Seniorenradio 50plus” with a variety of issues corresponding to the active and healthy ageing of seniors including the health problems. Polish Radio Katowice transmits a series of programmes called “A Health Guide” dedicated to different aspects of health, including healthy lifestyle and disease prevention and treatment. It is aimed at various groups of listeners, including senior citizens (with programmes about the treatment of seniors, cancer and heart disease prophylaxis, the treatment of diabetes or a healthy, balanced diet). In Polish Radio

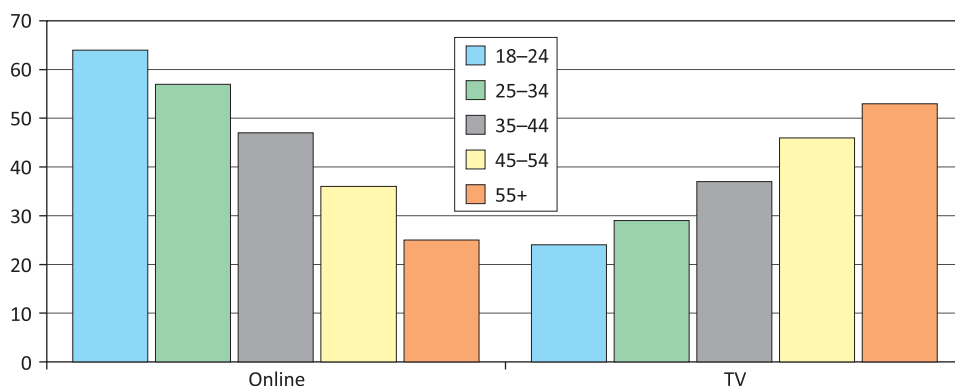
Rzeszów seniors can listen to a series of programmes called “Let’s Talk about Health” which, includes, among others, information about blood glucose and the treatment of diabetes, flu vaccinations for senior citizens, the role of screening tests and interviews with experts about the symptoms, consequences and treatment of selected ailments.

Radio stations available on the Internet are also increasingly popular and among those examples Radioklinika.pl in Poland and on-line radio NDR Niedersachsen in Germany have been identified. Radioklinika.pl is an on-line radio station which presents a variety of information about both rare and common civilisation diseases. It broadcasts interviews with specialists about medical rehabilitation, diet and obesity, information about the role of fitness, the methods of fighting cancer, diabetes, hypertension and heart disease, depression and mental diseases. On on-line radio NDR Niedersachsen in “Gesundheitsmagazin” programmes focused on health issues and promotion of a healthy style of life are presented.

Television

The analysis of the viewers who use television as the main source of information, indicates that age is the main factor in this aspect. For older people television is still the main medium. For them it is not only a source of information but also a way of spending their free time and “participating” in social life. In young adults (below 34) the tendency to watch television is decreasing at a stable rate, or even falling rapidly, as observed in Sweden or Denmark in the last few years. This has been proven by a 2016 report of the Reuters Institute in Oxford, the data of which is presented in the graph below (Figure 14).

Figure 14 The use of television and the Internet as the source of information depending on age. Attention: the presented data represent an average of 26 European and non-European countries, members of OECD.



Source: Report of the Reuters Institute for the Study of Journalism 2016, <https://reutersinstitute.politics.ox.ac.uk/sites/default/files/Digital-News-Report-2016.pdf> [accessed: 3.01.2017].

Older people are the most loyal viewers of television programmes, from which they obtain not only information but also behaviour patterns. A health promoter focused on the elderly population might treat television as his/her best ally in the promotion of a healthy life style. However, health is not a topic led by health specialists on television. This topic is dominated by commercials of pharmaceutical companies and food or drink producers and ageing in good health is not always their main priority.

In several European countries the activity and health of older people have become the subject of popular programmes of national television stations. In Holland, for example, there is a TV series for families and older people, called *Nederland in beweging*, which is dedicated to the promotion of physical activity at home. In Italy (Tuscany) and Greece (Thessaloniki and Athens) an innovative international project, Television T-Seniority, has been prepared for seniors, connecting new digital interactive TV technologies on TV channels, which use interactive TV solutions including personalised care e-services: TV assistance, communication and tele-monitoring for seniors. The main aims of the TV is enhanced information about primary-care, availability of care structures, monitoring of health care parameters, management of alerts and emergencies and services for older people with disabilities.

In Poland, health programmes for a general audience, with no age differentiation, are shown on special TV channels (e.g. TV Meteo Active) or as part of regular programmes of state television including: *Po prostu zdrowie*, *Panie Doktorze*, *Ostry Dyżur Jedyńki*, *Sposób na zdrowie*, *Pora na doktora*, *Zdrowo z jedyńką czy Recepty Jedyńki* (*Just Health; Doctor, Doctor; Accidents and Emergency; How to be healthy; Live a Healthy Life with Channel 1 or The Channel 1 Prescriptions*).

The table below shows examples of combinations of traditional television with an internet option for older people.

TV channels and programmes for an older audience in European countries:

- The Netherlands: NPO – Netherlands Public Broadcasting programme called “Nederland in beweging” (the Netherlands is moving). Periodical programme transmitted by national television dedicated to seniors about healthy style of life through different physical activities directed to different age groups including the elderly
- The Netherlands: Cocoon TV – private television channel; programme: *Mijn leven mijn gezondheid* (My Life, My Health) which presents a periodical magazine focused on health issues available online and on RTL television in the Netherlands, directed at different age groups including elderly people. Content of the programme is concentrated on health information and education of healthy and active style of life.

- Germany: DGF Deutsches Gesundheit Fernsehen – television channel (private). A television channel transmitted via cable and satellite focused on health, medical knowledge in a practical context and nutrition. DGF is also available on an on-line portal. DGF is a private TV station, directed to different age groups including elderly.
- Germany: Ihre-Gesundheit.de – a television portal available on the internet, focused on health. One of the areas is aimed at health issues of seniors (prevention, diagnostics, symptoms and treatment of diseases, explanation of health problems, (interviews with experts, health education and information
- Italy: RAI-Radiotelevisione Italiana Spa (on television channel TG 2) a programme called “TG Medicina 33.” This is a periodical programme on national television – broadcast daily – dedicated to the topic of health. Each episode is focused on a chosen issue connected with health. The programme is directed at different age groups including older people.

Sources: based on information obtained from RAI-Radiotelevisione Italiana Spa, Cocoon TV, DGF Deutsches Gesundheit Fernsehen, Ihre-Gesundheit.de, and NPO – Netherlands Public Broadcasting, worked out by the authors.

The press

As was mentioned at the beginning of this chapter, the combination of paper and on-line press is becoming more and more common in the media, which is also true in the case of press for the elderly. In the table below we present 2 examples of such actions, which are supported by non-government organisations with the cooperation and co-funding of public institutions.

Examples of magazines and newspapers for older readers:

Germany: Magazine – “Senioren Zeitschrift” (Senior Magazine)

Senioren Zeitschrift (Senior Magazine) – a magazine dedicated to elderly people undertaking health issues. One of the important topics is healthy life (Gesundes Leben). The magazine is published in written and online form. The main aims and activities are: building a awareness and knowledge, information, interviews, activities (yoga, brain-gym, theatre, dance). The magazine is edited in Frankfurt am Main.

Germany: Magazine – “Senioren Magazin Hamburg”

Senioren Magazin Hamburg – a magazine published in written and online form and dedicated to seniors’ important issues including healthy ageing: the role of physical activities, information increasing knowledge and awareness about health, healthy food and diet, and interviews with experts.

Poland: Magazine and on-line portal – “The Voice of Seniors”

“The Voice of Seniors” is present in three types of media: a paper magazine published by the “Manko” Association in Krakow and distributed all over Poland, a television programme, “The Voice of Seniors” and an on-line portal for and about seniors. The project is co-financed from the ministry funds within the Government Programme for the Social Activation of Elderly People from 2014–2020. Its actions include informing senior citizens about health programmes as part of the promotion of a healthy ageing strategy. These programmes contain education, promotion, counselling and support of, for example, physical activity for the disabled or care of people with chronic diseases, including diseases of the circulatory system.

Poland: Newspaper – Senior

Senior – a newspaper published in both paper and on-line versions. It has been published in paper form since 2011. It has regional versions (Poznan, Wroclaw) and is published all over the country. It deals mainly with health advice, health education, the role of primary and secondary prevention or various forms of medical and psychological support for seniors

Sources: based on the information obtained from the “Senioren Magazin”, “Senioren Magazin Hamburg”, the “Manko” Association and “Senior”.

The Internet

In spite of the common access to the Internet, its use is very different in various age groups. Older people do not use the Internet as often as the young. The Internet is also used for various reasons. It is frequently used as a post office (sending and answering e-mails), and more and more commonly to buy goods and services. It is less commonly used as a source of good information. Generally speaking, the trends of internet use are similar, but the level of its use by elderly people in various European countries differs significantly. (Table 10).

An interesting observation about Internet use has been made that in those countries where the Internet enjoys the greatest popularity among seniors, such as the Netherlands or Germany, it is less frequently used to read press than in the other countries. In the post-communist countries, the Internet is used for reading press publications to a relatively greater degree.

Thanks to the Internet, there is broad and reliable enough access to the sources called grey literature. Most frequently, these are different unreviewed research papers, such as reports, analyses, opinions, surveys, policy descriptions, project results, publications by unknown publishers and post-conference publications, etc. These types of sources of information have a significant information value. Reports and documents of such organisations as the WHO and its agencies, institutions

of the European Union, OECD or government agencies are usually prepared by well-known, respected experts of various fields.

Table 10 Internet users, aged 65–74 in EU countries

Countries	Older internet users (aged 65–74) % of population	% of older users who use the Internet only for the following reasons				
		e-mail	Information about goods and services	Reading on-line press	On-line shopping	Participation in a social network
UE-28 average	42	86	79	60	42	23
The Netherlands	76	94	83	52	35	30
Germany	53	91	86	63	49	11
The Czech Republic	37	86	79	85	17	15
Hungary	28	89	84	89	11	51
Portugal	23	78	75	66	15	44
Poland	21	65	69	74	18	23
Lithuania	21	62	76	93	6	18
Italy	20	79	51	62	14	24
Greece	14	63	69	87	17	29
Bulgaria	10	51	53	67	2	30

Note: countries participated in the “ProHealth65+” Project.

Source: Eurostat 2014 research – Accessed within the last three months.

The Internet provides a new form of communication with other people. Social media plays a particular role here. Active use of the most popular networks, such as Facebook or Twitter as well as other less populous local networks is replacing traditional contact and mutual exchange of news and information. The level of participation of older people in Poland on social networks is average in comparison to other countries of the EU.

The Internet is becoming a source of information downloaded from on-line portals and websites. Table 11 presents some of the portals and websites focused on health promotion among older people in project 65+ partner countries.

Table 11 A list of selected Internet portals focused on health promotion among older people

Country	The type of medium	Name	A description of activity
Germany	Internet portal	<i>Senioren Ratgeber – Gesundheit und Fitness fuer active Menschen</i> http://www.senioren-ratgeber.de/	It is mainly dedicated to active life and the health of seniors, the role of physical activity, primary and secondary disease prevention, counselling and health education. Registering enables seniors to receive a newsletter.
Germany	Internet portal	<i>Projekt Im Alter IN FORM – Potenziale in Kommunen aktivieren</i> http://projekte.bagso.de/fit-im-alter/startseite.html	It has been created by BAGSO (Bundesarbeitsgemeinschaft der Senioren-Organisationen), focused on health prophylaxis, health education and information (especially about diet).
Italy	Internet portal	<i>Happy ageing.it</i> http://www.happyageing.it/	It is dedicated to the most important problems of seniors, including health promotion (physical activity, spreading the latest medical knowledge and research findings, information about medication and the role of vaccinations).
Italy	Internet portal	<i>Viva gli Anziani</i> http://www.vivaglianziani.it/	Portal for seniors where health is one of the key issues. It presents information about the health of seniors (vaccinations, selected ailments, physical activity, the role of elder care).
The Netherlands	Internet portal	<i>Plusser.nl</i> (Plusonline magazine, Senioren.nl, Vijftigplus.nl) http://plusser.nl/	The largest portal for elderly people in this country, called <i>Plusonline Magazine</i> , which publishes on-line magazines dedicated to the problems of older people. The above mentioned media is used for health promotion addressed to elderly people and is focused on counselling on health issues, information about pro-health campaigns and healthy lifestyle (diet, physical and sexual activity).
The Czech Republic	Internet portal	<i>Tretivek.cz</i> http://www.tretivek.cz/	Web portal dedicated to seniors where the main subject is health of seniors and problems connected with maintaining a healthy life (health food, physical activities, questions to health experts with answers, useful information about causes and symptoms of diseases).

Table 11 – continued

Country	The type of medium	Name	A description of activity
Hungary	Internet portal	50plusz.net http://www.50plusz.net/	Forum of the Hungarian IT Organisations for Information Society to make the internet and the digital world a familiar place for people over 50. Health promotion is one portal topic. The web portal is focused on important issues for seniors including physical activities, psychological conditions; describing symptoms, treatment, complications of most common diseases.

Note: countries analysed in Project “ProHealth 65+”.

Source: based on the contents of the internet portals listed above.

Examples of social profiles and blogs:

- *50plusnet.nl* – Dutch profile-based internet community to expand social networking, engage in activities with people who belong to the same age group, and learn from each other
- *Bildung ab 50 blog* – a social blog in Germany as a part of Bildung ab 50
- *Senioren Ratgeben* – social profile in Germany on facebook as a part of the internet portal and newspaper “Senioren Ratgeben”
- *Zdrowysenior.org* – a social profile in Poland run on Facebook under the zdrowysenior.org service about the advantages of lifestyle change and much more
- *Senior Cafe Club* – a social blog run under the Senior.pl portal in Poland

Networks and partnerships of experts and health promotion organisations for older people

International and domestic networks which connect institutions, organisations and expert teams from various countries, regions and cities are a significant source of knowledge about different health promotion campaigns. In table 12 selected network initiatives of this type have been presented. The leading subjects of these initiatives are health promotion and disease prevention in a general sense as well as addressed to seniors.

Table 12 A list of international web networks, platforms and partnerships dedicated to seniors and health promotion for older people

The name of network/platform	Aims	Partners
The WHO European Healthy Cities Network http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network	A network created in order to promote health in all policies and locations. One of its elements is participation in the decision making process and inter-sector cooperation.	The network connects nearly 100 cities and towns from 30 countries.
European Innovation Partnership on Active and Healthy Ageing – EIP AHA Partnership http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing	An international partnership for innovation, beneficial for active ageing in good health and activities which aim at the improvement of the effectiveness and duration of social and health care systems.	3,000 partners comprising 339 chief organisations which act and create consortia and coalitions in all EU countries.
The WHO Global Network of Age-friendly Cities and Communities http://www.who.int/ageing/projects/age_friendly_cities_network/en/	A global network connecting cities, communities and organisations in order to enhance the full participation of elderly people as part of healthy and active ageing.	The network currently connects 314 cities and communities in 35 countries, 124 million people all over the world.
AGE Platform Europe http://www.age-platform.eu/	An international network of non-profit organisations which act for people over 50 years of age through the promotion of their interests and creation of specific policies for elderly people and pensioners including the health aspect.	Non-profit organisations from all over the EU which focus on older people.
BAGSO – German National Association of Senior Citizen's Organisations http://www.bagso.de/bagso-german-national-association-of-senior-citizens-organisations.html	An organisation which works for older people in Germany and lobbies for the problems of senior citizens. It organises courses and conferences about ageing in good health.	It connects 110 active member organisations and represents over 13 million older people in Germany.
EPIC – Elderly Network on Ageing and Health http://www.nut.uoa.gr/EpicElderlyNAH/	A network created within an EU programme focused on the improvement of information and knowledge about morbidity and mortality in Europe as well as the policies of healthy ageing.	NKUA – National and Kapodistrian University of Athens (as project leader) and several cooperating organisations and academic and research institutions in various EU countries.
The Prevention of Falls Network for Dissemination (ProFouND) http://profound.eu.com/	A network which deals with popularisation and implementation of best practices in fall prevention in Europe.	The network comprises 21 partners from 11 countries and an extra 10 cooperating members.

Table 12 – continued

The name of network/platform	Aims	Partners
EuroHealthNet http://eurohealthnet.eu/	Members of this international group work for healthy ageing and health equality by collecting knowledge and experience and aiding in the realisation of EU projects. The following projects have been realised within this network: The New European Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (CHRODIS-JA), The Intersectoral Health and Environment Research for Innovation (INHERIT).	Members of this network are national and regional institutes, academic and research centres and national and regional authorities.
AEQUIPA: Körperliche Aktivität, Gerechtigkeit und Gesundheit: Primärprävention für gesundes Altern http://www.aequipa.de/ueber-aequipa.html	The main objectives of this platform are various pro-health, prophylactic activities among older people through the promotion of healthy life style and physical activity.	This platform connects six universities and two research institutes in the north-western part of Germany.
International Union for Health Promotion and Education (IUPHE) http://www.iuhpe.org/index.php/en/	An international union which connects individual people and organisations working for improvement of the quality of health through education and health promotion on the global scale, common actions in the communities and the development of health policy.	The union connects member organisations (local and regional institutions and universities) and individual people (students, pensioners, honorary members) to improve the quality of life in good health. It works on a few continents.
Healthy Ageing Supported by Internet and the Community (HASIC) http://www.hasicproject.eu/en	An international project which focuses on strengthening people over 65 years of age through cooperation among local health care providers and healthy life style education.	Academic centres from Finland, Estonia, Hungary, Germany, Holland, Spain and Norway.
The International Network of Health Promotion Foundations http://www.who.int/healthpromotion/areas/foundations/en/	An international network which works under the aegis of the WHO to promote health at the population level through the establishment of innovative and long-lasting mechanisms of financing these types of projects on the national and lower levels.	The network comprises organisations from different parts of the world which work for the promotion of health.
The Norwegian Network for Research and Education in Health Promotion Research https://www.ntnu.edu/chpr/network	An organisation which works for research and education in health promotion.	It comprises 17 member institutions in Norway.

Sources: based on information about the networks listed above.

GLOSSARY



Glossary of terms related to health promotion for older people

Introduction

A manual for health promoters, who represent various disciplines of knowledge and qualifications, requires the preparation of a terminological dictionary – a glossary. The glossary presented in this chapter, initially, was a working glossary prepared to facilitate the communication in the international and multidisciplinary *ProHealth 65+* project team. Today, we offer it as an educational tool for health promoters.

The glossary includes a list of terms, along with their definitions, related to health promotion for older people. We present a normative meaning of the terms applied in health promotion, rather than their possible meanings. The references that served as a basis for the definitions are also provided.

The terms and their definitions are presented in thematic order. The terms are divided into six thematic groups. We start with the general terms related to the concept of health and its institutions. The next block includes terms describing the methods and activities of health promotion. The third group includes terms related to older people and ageing. Further, we present the terms used in health economics. The terms related to health policy are included in the fifth block. We close with the ethical issues which should be known and understood by health promoters.

HEALTH AND HEALTH-RELATED INSTITUTIONS

Health

According to the WHO definition, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

In line with this definition, health can be seen as both an individual capacity to adapt (physically, psychologically and socially) to the conditions of daily life and the ability to meet new challenges, as well as the human capital which guarantees a population's favourable development.

Source: WHO 1946; Golinowska 2015b.

Functional health

The ability of the individual to autonomously function in his/her environment. The assessment of functional health is important especially in the context of the elderly, whose impairments in terms of physical and mental health often lead to limitations in everyday functioning.

An example of a tool used to assess functional health is the Activity of Daily Living scale (Katz ADL), which measures the ability to independently perform basic activities (self-feeding, washing, dressing, toilet, transferring), or the Instrumental Activities of Daily Living scale which is used to assess more complex skills necessary for independent functioning in a community (e.g. shopping, handling transportation, managing finances, preparing meals).

Source: based on WHO 2001; Kocot 2015.

Health system

A set of elements: organisations, institutions, resources and their interrelationships, aimed at achieving a common goal, which is the health of the population.

A health system consists of various structural components. On the one hand there are patients/consumers and providers as well as manufacturers and suppliers of medical devices. On the other hand, there are the entities organising the system: regulatory bodies (Parliament, the Ministry of Health and its agencies), funding bodies, the institutions supervising and managing the resources.

Source: based on WHO 2000; Golinowska 2015b.

Health sector

A set of organisations/institutions operating within a given legal framework, often within one government unit (e.g. a ministry), whose main task is to promote, restore and maintain health.

Source: Golinowska 2015b.

Public health

The art and science of preventing disease, prolonging life and promoting health through the organised efforts of society.

Public health tasks include:

- surveillance and monitoring of population health and health hazards;
- disease prevention (vaccination, monitoring living conditions, monitoring the quality and safety of health services);
- health promotion;
- creating the conditions for public health actions (advancing public health research, developing the policies and regulations for health, ensuring public funds for public health, increasing social mobilisation for health, educating the public health workforce, analysing the quality and efficiency of health services).

Source: definition adopted by WHO, after: Acheson 1988; Golinowska 2015b.

Health promotion

The actions undertaken in order to enable people to increase control over and to improve their health.

Health promotion includes:

- creating and providing information about health, population health status and its determinants;
- screenings;
- health education;
- primary prevention aimed at preventing the onset of disease;
- health advocacy;
- social marketing.

Health promotion activities are mainly focused on:

- physical activity;
- healthy nutrition;
- avoiding health risks (smoking, excessive alcohol drinking, obesity and falls);
- vaccinations;
- avoiding stress, developing emotional intelligence and intellectual capacity, developing and maintaining social relationships and social integration in order to protect mental health;
- caring for sexual health.

Source: WHO 1986; a concept developed under the *Pro-Health 65+* project.

Healthy settings (settings-based health promotion)

The concept of promotion and enforcement of good conditions for health in places where people commonly engage in daily activities (e.g. schools, work sites, hospitals, villages and cities).

This is a holistic and multi-disciplinary approach which integrates action across many risk factors. This concept has its roots in the Ottawa Charter (1986), which noted that ‘health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love.’

Source: based on Scriven & Hodgins 2012; WHO 2016f.

Evidence-based health promotion

Similarly as in evidence-based medicine, this is an approach to practice which relies on the best available scientific evidence regarding health impact in the context of the identified health needs of the population. For this purpose, the information derived from formal research and systematic investigation is used to identify the causes of and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations (good practices).

Source: based on Smith, Tang & Nutbeam 2006.

Health care

The main part of the health system, which largely includes diagnosis and treatment of diseases and the management of health care delivery.

Health care includes some preventive services (secondary and tertiary prevention), usually provided by medical professionals and other specialists closely associated with medicine.

Source: Golinowska 2015b.

Primary health care

The first level of care, which determines (through the referral system) further treatment in specialised care, if required. It is based on the principle of universality and equity.

Primary health care aims to ensure continuous and comprehensive care for a given population, using resources efficiently, which is possible due to a better recognition of health and its determinants, and the reduction of unnecessary use of specialist care through gate-keeping.

Source: based on WHO 1978; Golinowska 2015b.

Population medicine

It represents an epidemiological approach to the management of clinical services, which would complement the epidemiological approach to the consultation, generally known as evidence-based medicine.

Source: Gray 2013, Gray 2010.

Rehabilitation

A set of coordinated medical, nursing, social and educational activities to maintain and/or restore functions (lost due to illness or injury) to bring about the highest possible level of independence, physically, psychologically, socially and economically.

Source: based on WHO 2004.

Long-term care

A range of services, medical (performed by medical professionals such as physicians and nurses) as well as care services (assistance in daily functioning, e.g. feeding, personal care, mobility, shopping), provided to individuals who, due to frailty or level of physical or intellectual disability, are no longer able to live independently.

Source: based on WHO 2004; Golinowska & Tambor 2015.

E-health

The use of information and communication technologies (ICT) for health, e.g. for diagnosing and treating patients, conducting research, educating the health workforce, tracking diseases and monitoring patient health status.

Source: WHO 2016c.

HEALTH PROMOTION METHODS AND ACTIVITIES

Disease prevention

Measures aimed at precluding the occurrence of disease and/or avoiding or slowing down its consequences in persons in whom disease has occurred.

Source: WHO 1998.

Primary prevention

Measures undertaken in order to prevent the onset of disease i.e. to reduce the probability of disease. Examples include vaccinations or changes in lifestyle (healthy nutrition, physical activity).

Source: based on WHO 1998.

Secondary prevention

Measures undertaken in order to detect a disease in its earliest stages, and intervene to slow or stop its progression. This includes the use of screening tests or other suitable procedures to detect disease as early as possible. These activities are typically targeted at populations at high risk of disease.

Source: based on WHO 1998.

Screening

A diagnostic procedure with the use of simple tests, performed on a large scale (in the entire population or a high-risk population) to determine whether apparently well persons have a disease or are at high risk of acquiring a disease.

Source: based on Modeste & Tamayose 2004.

Health education

All evidence-based activities and processes, aimed at improving health literacy, including building knowledge, developing attitudes and life skills which are conducive to individual and community health. Through health education, people understand the importance of caring for their own health and the health of others.

Source: based on WHO 1998.

Health literacy

The cognitive skills and motivation of an individual to gain access to, and use information to promote and maintain good health.

This includes knowledge and skills on how and where to seek health information and the ability to understand this information and communicate with the person handling this information, as well as the ability to critically evaluate information in order to make the right health choices for realising one's health potential.

Source: based on WHO 2004.

Social marketing

The adaptation of commercial marketing technologies to planning, implementing and assessing programmes designed to influence voluntary behaviour (e.g. health behaviour) of targeted population groups, in order to improve their personal welfare and that of the society of which they are a part.

Source: Andreassen 1995.

Advocacy for health

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme. The strategic aim is to increase the overall value of health in society.

Source: based on WHO 1998.

Information brokering

The process of identifying needs and gaps in knowledge, obtaining reliable information and effectively transferring this information to users.

The purpose of knowledge brokers is to help policy makers, planners of health programmes and public managers to obtain and use reliable information for better designing and implementing public policies and programmes.

Source: Ward, House & Hamer 2009; Olejniczak, Kupiec & Raimondo 2014.

Health promoter

A person conducting health promotion activities (e.g. health sector professionals, those working in the social sector or the voluntary sector), who possesses knowledge on health and health determinants, as well as the skills to effectively transfer this knowledge to people in order to change their attitudes and motivate them to adopt more healthy behaviour.

Source: definition developed under Pro-Health 65+project (Chapter 3).

Lifestyle

A way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions.

Source: based on WHO 1998.

Healthy lifestyle

A lifestyle characterised by undertaking behaviours that reduce the risk of disease. Such behaviours include: undertaking moderate or vigorous physical activity, adequate nutrition, non-smoking and avoidance of binge drinking, adequate sleep, good hygiene and safe sexual behaviour as well as suitable stress-coping strategies.

Incorporation of such a lifestyle is positively related to health outcomes at any stage of life, even if healthy behaviours are undertaken in older age.

Source: based on WHO 1998.

Risk factors

Social, economic, biological, behavioural and environmental factors that contribute to the occurrence of a specific disease, ill-health or injury.

Source: based on WHO 1998.

Body Mass Index (BMI)

Index commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m^2)

Classification of adults according to BMI:

< 18.50	underweight
18.50–24.99	normal range
25.00–29.99	overweight
≥ 30.00	obese

Source: based on WHO 2000a.

Healthy nutrition

A balanced consumption of food products of an appropriate quality (safe), in line with the body's dietary needs, depending on age and living conditions. An adequate well-balanced diet protects against both malnutrition in all its forms and obesity, which is a risk factor for many chronic non-communicable diseases.

Source: based on WHO 2016b & d.

Physical activity

Any bodily movement produced by skeletal muscles that requires energy expenditure.

Regular moderately intensive physical activity has significant benefits for health, e.g. improving cardiorespiratory and muscular fitness, bone and functional health and reducing the risk of non-communicable diseases, depression and cognitive decline.

Source: WHO 2016e.

Good practice

An intervention which was applied in specific real-life conditions (not under experimental conditions), has been proven to work well and produce good results (e.g. health results for a specific population group) and it is likely to also be effective in a different environment. Consequently, this practice, after a prior evaluation according to specific criteria, is advised and recommended as a model for use by others.

Source: definition developed under Pro-Health 65+ project.

AGEING AND OLDER PEOPLE

Life cycle

The entire course of a person's life – from infancy to old age.

The human life cycle is divided into the following periods: infancy, early childhood, play age, school age, adolescence, young adulthood, adulthood, the third age and the fourth age.

The family life cycle includes: independent life in youth and early adulthood, starting a family, living with small children, living with teenagers, adult children leaving the family (empty nest period), living with a partner or alone, and life requiring care.

Source: WHO 2004; the stages of the life cycle based on the psychological approach of Erikson and socio-demographic statistics (e.g. Polish statistics).

Older people

There is no general agreement on the age at which a person becomes old and the definition varies between countries and over time. In most developed countries, the chronological age of 60 or 65 years is used in the statistics to define an older person.

Considering social and economic factors, three subgroups in older age can be distinguished:

- persons entering into a period of ageing, usually still professionally and socially active (age: 55–67 years);
- persons in retirement age, usually professionally inactive but still socially active (age 67–80/85 years);
- persons dependent in self-care, requiring care and nursing (age > 80/85 years).

Source: the concept developed under 'Pro-Health 65+.'

Ageing

The lifelong process of growing older at a cellular, organ or whole-body level throughout the life span. Ageing is associated with the gradual accumulation of a wide variety of molecular and cellular damage which leads to a gradual decrease in physiological reserves, an increased risk of many diseases, and a general decline in the capacities of the individual.

Source: based on WHO 2004; WHO 2015.

Population ageing

The increase over time in the proportion of the older population. This usually results from decreasing fertility rates and/or increasing life expectancy.

Source: WHO 2015.

Healthy ageing

The process of developing and maintaining the functional abilities that enable well-being in older age.

This includes measures delaying health deterioration (health promotion and prevention), as well as measures to keep older people active, despite the prevalence of chronic disease and disability. Their aim is to improve the wellbeing of the elderly.

Source: based on WHO 2015.

Active ageing

The process of optimising opportunities for active life in older age (i.e. working, learning, social, cultural and political participation) in order to improve quality of life for older people, and ensure that older persons remain a resource to their families, communities and economy.

Active ageing strategy focuses on reducing costs resulting from the ageing of the population, mainly through longer participation of older people in the labour market and remaining active in retirement.

Source: based on European Commission 2002.

Successful ageing

According to the traditional definition, successful ageing means a low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life (Rowe & Kahn 1998).

A more recent approach also takes into account one's mental attitude to ageing: optimism, resistance to adverse factors (e.g. stressful experiences in life), a willingness to remain active.

Source: based on Rowe & Kahn 1998; Minkler & Fadem 2002; Oxley 2009.

Active Ageing Index

A tool to measure the untapped potential of older people for active and healthy ageing across countries. The index has been constructed in the framework of the 2012 European Year for Active Ageing and Solidarity between Generations (EY2012).

Using 22 individual indicators, it measures the level to which older people 1) participate in paid employment; 2) participate in social activities; 3) live independent healthy and secure lives and 4) their capacity and degree of enabling environments for active ageing.

Source: UNECE 2015.

Disability

According to the concept applied in the new classification of disease and disability (International Classification of Functioning, Disability and Health, ICF), the term covers: damage to the organs of the body and impaired mental and physiological functions and limited ability to perform activities of daily living, as well as further consequences such as reduced possibility for social participation due to barriers (e.g. technical, cultural, legal, etc.) in the environment.

Source: based on WHO 2001; Golinowska 2012.

Functional disability

Long-lasting functional limitations resulting from health problems or conditions, i.e. a limited capacity to perform basic activities of daily living (grooming, feeding and toileting etc.) and to live independently, i.e. to perform basic household duties and participate in social life.

Source: based on WHO 2001; Golinowska 2012.

Chronic diseases

Long-lasting (min. 6 months) non-communicable diseases, including circulatory system diseases, cancer, diabetes, respiratory system diseases, bone and joint diseases, mental diseases and dementia.

The probability of occurrence of these diseases increases with age and results from gradual accumulation of a wide variety of molecular and cellular damage. Chronic conditions are the leading cause of disability and death in the world population.

Source: based on WHO 2016g.

Multimorbidity

The occurrence and co-existence of more than one disease simultaneously.

This is more frequent in older people. The estimates of the occurrence of multimorbidity depend on the measurement applied (specifically on the number of diseases concerned: two or more, three or more). In European countries, it is estimated that approximately 50% of people aged 65+ and 80% of people aged 80+ suffer from two or more diseases. Multimorbidity in old age is associated with higher rates of death, disability and a generally lower quality of life.

Source: based on Marengoni et al. 2011.

Frailty

A geriatric syndrome characterised by age-associated declines in physiologic reserve and function across multi-organ systems, leading to increased vulnerability for adverse health outcomes (diseases and disability). Clinical diagnostic criteria include: weight loss, weakness, exhaustion, slowness, reduced physical activity.

Frailty is also seen as a multidimensional syndrome which includes physical and mental health, functional status, lack of social and economic resources. This operative definition of frailty relates to the risk of adverse healthcare outcomes (disability, hospitalisation, institutionalisation and death) to which the individual is exposed given the association between frailty level and risk.

Source: Chen, Mao & Leng 2014; Liotta 2016.

Sarcopenia

Sarcopenia is a syndrome characterised by progressive and generalised loss of skeletal muscle mass and strength with a risk of adverse outcomes such as physical disability, poor quality of life and death.

The EWGSOP definition of sarcopenia, the most widely accepted and used in research and clinical practice, recommends using the presence of both low muscle mass and low muscle function (strength or performance) for the diagnosis of sarcopenia.

Source: Cruz-Jentoft et al. 2010.

Comprehensive geriatric assessment

A multidimensional interdisciplinary diagnostic process to assess physical, mental and functional health of an older person, along with social and environmental conditions.

This enables determination of the ability of the older person to function independently in his/her environment and identify the older person's health and social needs, in order to develop a coordinated and integrated plan to meet the unmet needs.

Source: based on Krzemieniecki 2009.

Workplace Health Promotion

The combined efforts of employers, employees and society to improve the health and wellbeing of people at work.

It comprises: improvements in work organisation and working environment, promoting active participation and encouraging personal development.

Source: European Commission 2007.

Occupational safety and health

The science of the anticipation, recognition, evaluation and control of hazards arising in or from the workplace that could impair the health and well-being of workers, taking into account the possible impact on the surrounding communities and the general environment.

Source: Alli 2008.

HEALTH ECONOMICS CATEGORIES

Methods of funding health care

The methods of collecting funds for health. There are public methods (taxation, social health insurance) and private methods (household out-of-pocket payments, private health insurance, medical savings account).

In most developed countries, the public methods of health care funding dominate. By relying on obligatory participation and solidarity, they are intended to ensure equal and universal access to health care.

Source: Golinowska & Tambor 2015.

Health expenditure

Expenditure on all goods and services related to health and health care. This includes spending by public sources (central government and territorial governments, the social

health insurer), private sources (households, private health insurance companies, employers, NGOs) and external sources (international organisations, foreign governments, etc.).

Source: Golinowska 2015b.

National Health Accounts

A systematic, comprehensive and consistent system of monitoring the flow of funds in a country's health system for a given period. It reflects the main functions of health care financing, such as resource mobilisation, pooling and allocation as well as purchasing health services.

National Health Accounts have been developed using the System of Health Accounts (SHA), proposed by the OECD (2000). They provide a wide range of information on the structure of financial resources and expenditures in the health system, both at the national and international levels.

Source: Poullier et al. 2002.

Efficiency

Efficiency is the ratio of the output /outcome to the input (resources used).

Improving efficiency is to maximise output from given input used, or to minimise input for a given level of output.

Source: based on Golinowska 2015a.

Effectiveness

The extent to which a desired effect is achieved, without considering resources used or cost incurred.

Source: based on Golinowska 2015a.

Health Technology Assessment (HTA)

An interdisciplinary field of knowledge to facilitate evidence-based decision making in health care, combining knowledge from different fields: medicine, epidemiology, biostatistics, economics, law and ethics.

This is a systematic and transparent evaluation, conducted according to generally accepted principles, aimed at summarising available evidence on health, economic, social and ethical aspects of medical technologies.

Source: based on AOTMiT 2016.

Economic evaluation

Economic evaluation is a comparative analysis of alternative courses of action in terms of both costs and consequences. The basic tasks of any economic evaluation are, therefore, to identify, measure, value and compare the costs and consequences of the alternatives under consideration.

A full economic evaluation compares at least two alternatives and examines costs and consequences of both of them.

Source: Drummond et al. 2005.

QALY (Quality Adjusted Life Year)

An index that measures health gains as a combination of the duration of life and the health-related quality of life. The life years that are gained are weighted with the quality of life they are spent in.

The quality of life is measured on a scale of 0 (equivalent to death) to 1 (equivalent to full health). Thus, one year spent in perfect health has the same value as two years of life spent with a quality of life that is valued with 0.5

Source: Drummond et al. 2005.

Healthy Life Years (HLY)

An indicator that measures the number of remaining years that a person of a certain age is still expected to live without disability (also called disability-free life expectancy).

The importance of this indicator has been stressed in the Lisbon Strategy. The “Healthy Life Years” indicator is a part of the core set of the European Structural Indicators.

Source: European Commission 2016b.

Silver economy

The economic opportunities arising from an ageing population and meeting the specific needs of that older age population.

Within the concept of the silver economy, ageing is perceived not only as a burden for the economy (due to diminishing labour resources and increasing social cost), but also as an opportunity for generating new jobs (e.g. for carers of older people), creating new technologies tailored to the needs of the elderly, and increasing older people's activity and participation in social life.

Source: Golinowska 2011.

HEALTH POLICY CATEGORIES

Health policy

A purposeful activity of the state (central and territorial governments) targeted at health and health care issues. This defines goals, priorities and the parameters for action in response to health needs, taking into account available resources and other contextual factors, e.g. stakeholders' expectations.

Source: based on WHO 1998; Wojtczak 2009.

Health programme

Planned and organised series of activities in order to carry out specific tasks and achieve health-related goals.

Source: WHO 2004.

EU health programme

The main instrument the European Commission used to implement the EU health strategy. This specifies the health-related objectives to be achieved and priority issues to be addressed.

There have been three health programmes implemented so far: Community action in the field of health 2003–2007, the 2nd Community action in the field of health 2008–2013, the 3rd Union's action in the field of health 2014–2020.

Source: European Commission 2016a.

Health in all policies

An approach to public policies across sectors that systematically takes into account the health and health system implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity.

This relies on a long-understood fact that health is largely created by factors outside health care services and various non-health sectors need to be involved in actions on the social, economic and environmental determinants of health. The term was coined in the late 1990s, and explored in depth during the second Finnish EU Presidency in 2006.

Source: Leppo et al. 2013.

Health Impact Assessment

A system of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.

An HIA provides decision-makers and other stakeholders with relevant information which can help to maximise the positive health effects of a proposal and minimise its negative effects.

Source: based on European Centre for Health Policy 1999; WHO 2016a.

Age management

The various dimensions by which human resources are managed within organisations with an explicit focus on ageing. In general terms, age management refers to the overall management of the workforce ageing via public policy or collective bargaining

Source: Walker 1997.

ETHICS AND HEALTH

Quality of life

A multidimensional concept that covers physical (somatic), mental, spiritual, social and environmental dimensions of human life. This usually takes into account both objective and subjective perspectives.

In medical science, the concept of quality of life is used to assess a patient's condition, and is focused on physiological aspects. To assess health-related quality of life, general or disease-specific questionnaires are used. A commonly used tool is EuroQol 5D which evaluates quality of life in five dimensions: mobility, self-care, usual activities, pain/discomfort, anxiety/depression

In social sciences, the social and environmental aspects are more closely considered when assessing quality of life.

Source: based on Stiglitz, Sen & Fitoussi 2009; Balestroni & Bertolotti 2012; Wnuk et al. 2013.

Wellbeing

Self-perceived quality of life, i.e. subjective assessment of the extent to which individual needs and expectations are met. This includes satisfaction with life and its various aspects, feeling positive emotions, a sense of accomplishment and belonging.

Source: based on Diener & Seligman 2004; GUS 2013.

Inequity in health

The presence of systematic differences in health status between people belonging to different groups (demographic, social, economic, geographical), which are unnecessary, avoidable, unfair or unjust.

Source: based on Whitehead 1992.

Ageism

Negative stereotyping and discrimination against individuals or groups because of their age, in particular against older people.

This phenomenon can manifest at the micro (individual/family), the meso (organisation/community) and the macro (government/society) levels. For example, older people might be seen as less efficient and thus, are less willingly employed. Also, the policy of the state imposing an obligation to retire at a certain age (usually 65 years), regardless of health and ability to work, can be seen as an example of discrimination against the elderly.

Source: based on Butler 1975; Palmore 1999.

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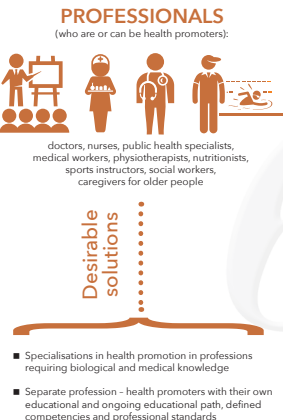
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HEALTH PROMOTION FOR OLDER PEOPLE

HEALTH PROMOTER



FAVOURABLE EXTERNAL CONDITIONS

- Adequate regulations
- Support of governments and territorial self-governments
- Public and private funds
- Educational offer
- Active society
- Professional media

DESIRABLE COMPETENCIES

- Basic biological, medical and psychological knowledge
- Diagnosing health needs
- Ability to design and evaluate actions
- Emotional intelligence
- Communication skills (motivating dialogue)
- Negotiation skills
- Organisational skills
- Ability to create partnerships

EVIDENCE FOR HEALTH PROMOTION

Effectiveness and Cost-Effectiveness Analysis

Good practices
Criteria for good practices: effectiveness, reach, feasibility, sustainability, transferability
→ selection of practices



SENIOR ADULTS

AGE GROUPS



HEALTHY LIFESTYLE GOOD QUALITY OF LIFE



Co-funded by
the Health Programme
of the European Union

<http://www.pro-health65plus.eu>

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