European Commission

OPTIONS TO FOSTER HEALTH PROMOTING HEALTH SYSTEMS

Report of the

Expert Panel on effective ways of investing in Health (EXPH)

Health

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EXPERT PANEL ON EFFECTIVE WAYS OF INVESTING IN HEALTH

(EXPH)

Opinion on
Options to Foster Health Promoting Health Systems

The EXPH adopted this opinion at its 18th plenary on 7 November 2019
after public hearing on 23 October 2019

About the Expert Panel on effective ways of investing in Health (EXPH)

Sound and timely scientific advice is an essential requirement for the Commission to pursue modern, responsive and sustainable health systems. To this end, the Commission has set up a multidisciplinary and independent Expert Panel which provides advice on effective ways of investing in health (Commission Decision 2012/C 198/06).

The core element of the Expert Panel's mission is to provide the Commission with sound and independent advice in the form of opinions in response to questions (mandates) submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability. The advice does not bind the Commission.

The areas of competence of the Expert Panel include, and are not limited to, primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities, etc.

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EXECUTIVE SUMMARY

Health promotion has a critical role to play in improving the health and wellbeing of current and future generations of EU citizens. Based upon a socio-ecological model of health, health promotion has been defined by the WHO (1986) as *"the process of enabling people to increase control over, and improve, their health".* Health promotion moves the focus from individuals at risk of developing illness to systems and environments that shape the development of good health at a population level. As such, it is an essential component of modern health systems in order to ensure that all human beings can have healthy lives, can maximise their health potential and that no one is left behind. Cost-effective and feasible health promotion interventions have been shown to make a real difference in improving population health, reducing risks for non-communicable diseases, improving mental health, increasing health literacy, and addressing the social determinants of health and health equity. However, the level of infrastructure and capacity to support health promotion action varies considerably across EU countries. The concept of health promotion is often poorly understood and there is a limited appreciation of the infrastructure, resources, knowledge and skills that are required to translate health promotion into action. As a result, there are significant gaps in implementation in many countries, particularly in terms of mainstreaming health promotion within health services, and there is a lack of investment in developing the necessary health promotion systems for substantive progress to be made.

Embracing a health promotion framework requires a significant shift in focus from illness to health and calls for intersectoral action and partnership working as an integral aspect of health promotion practice. Health promotion embraces a new and broader understanding of health and its determinants and calls for a new base of multidisciplinary knowledge, skills and competencies that extend beyond the traditional healthcare approach. While successive EU health policies and strategies have endorsed the need to invest in health promotion, and some countries have made good progress in developing health promotion capacity, political commitment to implementing health promotion is lacking in many countries. Health policies and budgets remain focused primarily on curative interventions. Balancing the prioritization of treating and preventing diseases against the promotion of longer-term health improvement is a difficult trade-off when funding and resources for health systems are under pressure.

This Opinion considers what progress has been made in implementing health promotion within the EU region, and considers what mechanisms can be used for strengthening the integration of health promotion within health systems. Current conceptual and policy frameworks for health promotion are outlined, and the rationale for the development of health promotion and its continued relevance within the context of current policy objectives, including the Sustainable Development Goals, is considered. A critical reflection is

undertaken of current enablers and barriers to progress including the need for: advocacy and high-level political leadership and support; enabling governance structures and processes for implementation; sustainable funding mechanisms and incentives; organizational and workforce capacity development. Building on this reflection, a number of enabling mechanisms are outlined and practical examples provided including: policy structures and processes for the implementation of a Health in All Policies (HiAP) approach; the integration of health promotion within health services, with a particular focus on strengthening health promotion within primary care; sustainable financing for health promotion; and mobilising wider community participation and engagement.

Health promotion is an essential strategy for improving health equity and a key action underpinning the reform of health systems in Europe. Applying the principles of the European Pillar of Social Rights and the competences of the EU treaties for the promotion of wellbeing and protection of health across all EU policies, we recommend that a range of policy measures and financial mechanisms at the European level are applied to support the implementation of transformative health promotion policies and practices in EU Member States. This shift in focus from disease to health can be considered 'a disruptive innovation' due to the need to transform existing organisational structures, workforce, and services. More specifically, the following actions are recommended for implementation at the EU level in cooperation with key partners, citizens and national governments in Member States:

- ***Advocate for the importance of health promotion***
    - *Develop effective advocacy for health promotion* to increase the visibility and relevance of health promotion and ensure that its contribution to human, social and economic development in Europe is recognised across the political spectrum and in communications for public health, especially for vulnerable and underserved population groups.
    - *Advance political commitment to effective health promotion policies and action plans* through the formulation of specific health promotion goals and the development of feasible and evidence-informed policy options for health promotion action in Europe and among high-level policymakers, including those from the non-health sector.

- ***Provide strategic leadership for health promotion at EU level***
    - *Provide leadership and coordination at EU level in ensuring the implementation of a HiAP approach* in EU Member States and the integration of health promotion as a priority within European and national policies by supporting Members States in developing the required organisational

structures and processes for innovative intersectoral health promotion actions and strengthening capacity development in different country contexts.

- *Promote the integration of health promotion within health services, especially in primary care* to ensure universal access to health promotion programmes thereby improving the scope and range of services to health service users, reaching out to the most vulnerable groups in society to ensure better health for all.
- *Invest in developing a dedicated workforce for health promotion in Europe*, through leadership in advancing recognition of the need for a dedicated health promotion workforce with the necessary skills and competencies for quality professional practice and the inclusion of health promotion in the educational curricula of health professionals.

- ***Protect and promote sustainable financing mechanisms for health promotion***
  - *Invest in the development of robust health promotion policies and programmes at EU level* by ensuring sustained investment for the implementation of comprehensive health promotion strategies in EU Member States.
  - *Apply EU funding and investment mechanisms* to ensure that health promotion is included in EU, national and regional programming priorities, thereby protecting funding for capacity development.
  - *Explore the use of EU financial instruments* such as the ESIF, and co-financing mechanisms, to support the re-orientation of health systems to health promotion.
  - *Support Member States in reviewing current health budgets* and exploring new ways of balancing spending towards health promotion and developing mechanisms and incentives for ensuring its sustainability.

- ***Develop the capacity to implement health promoting health systems at EU level and in Member States***
  - *Apply the EU Semester process and other available policy mechanisms to enable countries to establish the system requirements for health promotion* policy and programme development, including high-level leadership and political responsibility at a country level for the implementation of health promotion policies and programmes.
  - *Provide technical guidance on implementing health promotion in practice* through the setting of European norms and standards for best practices and

evidence-based priority interventions to be delivered at all levels of the health system.

- *Support the assessment of health promotion capacity in Member States* through the development of tools for assessing and benchmarking infrastructure capacity and performance for core health promotion action.

- ***Invest in health promotion research in Europe***
  - *Support the development of interdisciplinary and innovative health promotion research* through the EU framework programmes for research, development and innovation, with a particular focus on: monitoring of positive indicators of population health and wellbeing status across the social gradient at a country level; the comprehensive evaluation of complex upstream and multilevel health promotion interventions; multi-country implementation trials of evidence-based approaches; economic analyses to determine the cost-benefit and cost-effectiveness of health promotion strategies; health equity impact assessments of policy making across sectors; and the dissemination of feasible evidence-based strategies.
  - *Develop knowledge translation mechanisms for health promotion in the EU region* by developing a network of dedicated health promotion knowledge translation centres to promote the timely use of scientific research and knowledge to strengthen health promotion practices and policies.

- ***Strengthen health promotion partnerships at EU level***
  - *Support sustained partnerships for health promotion* through active collaboration with dedicated health promotion foundations, NGOs such as IUHPE and EuroHealthNet, academic partners and national focal points with a health promotion remit.
  - *Support effective and sustainable multi-level partnerships across diverse sectors* in order to progress implementation of HiAP and to meet the targets set by the SDGs.

- ***Support social mobilisation strategies***
  - *Invest in improved consultation processes and community engagement strategies* to actively engage European citizens in creating a greater demand for health promotion in Europe and advocating for the implementation of policy decisions that impact on population health and wellbeing.

BACKGROUND

Health promotion emerged in the 1980's as a dynamic force within public health, aimed at addressing the social determinants of health and thus contributing to the positive development of health at a population level. Based upon a socio-ecological model of health, health promotion has been defined by the WHO (1986) as *"the process of enabling people to increase control over, and improve, their health".* Health promotion moved the focus from individuals at risk of developing illness to systems and environments that could shape the development of good health at a population level.

Health Promotion has a critical role to play in improving the health and wellbeing of current and future generations of EU citizens. Good health for individuals, families and communities is essential to reduce inequities and achieve population health, wellbeing and sustainable development. While traditional healthcare approaches have focused primarily on treating ill-health, it is increasingly recognised that treatment approaches alone are not sufficient to address the growing global burden of disease and to bring about improvements in health and wellbeing at a population level. A comprehensive approach is needed which calls for a focus on health promotion and prevention alongside treatment and rehabilitation. This means investing in policies that provide a mandate for action on health promotion at a population level, putting in place structures and delivery mechanisms for policy implementation, and ensuring that the systems tasked with implementation have the resources and training necessary for effective action.

While successive EU health policies and strategies have endorsed the need to invest in health promotion, and there is general agreement as to the merits of promoting good health at a population level, political commitment to implementing health promotion is lacking in many countries. The level of capacity and infrastructure to support health promotion action varies considerably across EU countries with significant gaps in implementation of health promotion policies and a lack of sustainable funding in most countries (Barnfield et al., 2018). While the case for investing in health promotion has been made at the EU level (SG ECFIN/EPC report, 2016; 2017 Companion report on the State of Health in the EU cycle), the focus in health budgets remains focused on curative interventions with a lack of investment in developing the necessary health promotion and primary prevention systems that are needed for substantive progress to be made.

The Ottawa Charter for Health Promotion (WHO, 1986) presented a re-framing of health and its determinants and outlined concrete actions that can be taken to promote good health at a population level. However, the systematic integration of health promotion into health policies and its implementation in practice has been slow to realise in many countries. Despite global acknowledgment of the importance of good health and policy endorsement of

the importance of promotion and prevention as part of a comprehensive public health approach, there is a lack of political priority given to health promotion. Health promotion does not attract the same sense of urgency as treating illness. Balancing the prioritization of treating and preventing diseases against the promotion of longer-term health improvement is a difficult trade-off when funding and resources for health systems are scarce. However, it is recognized that the combined efforts of population-wide health promotion, prevention and effective treatment is needed to achieve the greatest health gains. For example, to make progress in tackling non-communicable and chronic diseases, it is clear that population-wide approaches are needed in order to address the causes rather than the consequences of chronic diseases and to address the health equity gap (WHO, 2011; Commission on the Social Determinants of Health (CSDH), 2008). This requires a **fundamental shift in our understanding of health and the factors that determine good health**. However, the concept of health promotion is often poorly understood and there is a limited appreciation of the infrastructure, resources, knowledge and skills that are required to translate health promotion into action. Even when health promotion does feature in national health policies and action plans, implementation is fragmented and there is frequently a narrow interpretation of health promotion interventions with a predominant focus on individual behaviour change. This is a classic case of 'lifestyle drift' (Popay, Whitehead & Hunter, 2010), which refers to the tendency for policy to start by acknowledging the need for action on upstream social determinants of health but to drift downstream and focus largely on individual lifestyle factors, leading to a failure to address the broader structural determinants of health. For progress to be made, there is a need to strengthen political commitment and capacity development for the implementation of health promotion policies and evidence-informed actions. This means investing in leadership and technical capacity at a policy level, providing sustainable funding for practice, research, education and training, and investing in the development of organizational capacity and implementation structures at national and local levels.

Current global policy frameworks provide a new impetus for action. The implementation of the United Nations 2030 Agenda for Sustainable Development (United Nations, 2015), and in particular the delivery of universal health coverage, calls for concerted action at EU level, working in partnership with Member States, international organizations, and different sectors at all levels of government and civil society, to invest in developing and scaling-up transformative health promotion actions that will deliver on population health improvement, reduce health inequities, and enhance wellbeing and sustainable development. Meeting the ambitious targets of the UN Sustainable Development Goals (SDGs) means moving beyond a focus on secondary and tertiary levels of health care to also embrace health promotion and primary prevention interventions that will address the broader determinants of health ("the causes of the causes") and place empowered citizens at the centre of their own health and

wellbeing. Investment in innovative health promotion approaches has the potential to bring transformational change in how population health is understood and the range of mechanisms and strategies that can be used to promote health and wellbeing and reduce health inequities. An integrated policy approach is integral to effective action, entailing multisectoral action across government, civic society and international organizations.

In this Opinion we consider how further progress can be made in effectively implementing health promotion within the EU and consider what policy and investment mechanisms can be applied to support transformative health promotion action.

2 TERMS OF REFERENCE

The Expert Panel is requested to provide its analysis and recommendations on the following points:

(a) What are the mechanisms for strengthening the implementation of health promotion within health systems, how can health systems incorporate, integrate and foster health promotion efforts and paradigms, and what policies need to be in place to make this happen from a health-in-all policies perspective?

(b) As public health services and primary health care are operating in an increasingly integrated way, how can this joint approach contribute to action and implementation of health promotion and improved health literacy and how could this development be linked to social care?

(c) What could be the success factors for further integration from a conceptual, organisational and financing point of view? And what are the main obstacles and challenges to address?

3 OPINION

3.1 Promoting population health and wellbeing: conceptual and policy frameworks

Health promotion is a multidisciplinary area of practice that represents *a paradigm change in thinking about health* (WHO, 1986). Health Promotion reframes the challenge of improving population health by seeking to address the questions of where is health created and how can the greatest health gain be achieved for the greatest number of people (Kickbusch, 1996). By bringing a clear focus on promoting population health and wellbeing, health promotion shifted the centre of gravity from a deficit model of illness, focused on treating and preventing disease, to the promotion of good health and optimising the health potential of the whole population in their everyday settings. A socio-ecological model of health replaced a biomedical model, and perspectives from the social, political, and environmental sciences brought a fresh perspective on addressing health challenges (McQueen and Jones, 2007). This transdisciplinary approach brought new players and innovative strategies from the non-health sector into the health field to create systems that keep people healthy as opposed to health systems that treat ill-health.

Health promotion embraces a positive definition of health and seeks to place empowered citizens at the centre of their own health (WHO, 1986). A positive concept of health was introduced in the World Health Organization Constitution of 1946, which defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or injury. Subsequent definitions have gone on to describe health as a resource for living and as a positive concept emphasizing social and personal resources, as well as physical capacities (WHO,1986). The WHO (1981) 'Health For All' strategy created a revolution in long-term thinking about health, embracing a broader conceptualisation of health and its determinants, based on principles of equity, social justice, participation and empowerment. Adopting a human rights framework, the strategy advocated that people have a right to the highest attainable standard of health, and health was conceptualised as being central to human development. This approach called for a fundamental shift in health service orientation, with a move from biomedical and individual lifestyle approaches to broader socio-environmental and policy strategies.

This shift was supported by a growing recognition that the major causes of disease lay beyond the biomedical model of health and that in order to promote the health of populations, consideration must be given to the environment, individual behaviours and lifestyles in addition to health services and medical science. The seminal Lalonde Report (1974) on 'New Perspectives on the Health of Canadians' clearly articulated the limitations of

traditional health services that focused on curative care, " ... for the environmental and behavioural threats to health, the organised health care system can do little more than serve as a catchment net for the victims..." There was, therefore, a recognition that the changing nature of new and old complex health problems required new approaches that extended beyond traditional vertical-based health care focused on controlling and treating illness. Health promotion was, therefore, introduced by WHO, as a comprehensive and innovative approach to bring about the social changes needed for improved health at a population level.

The global strategies for 'Health for All by the Year 2000' (WHO, 1981) and the Alma-Ata Declaration (WHO, 1978) laid the foundations for the development of the Ottawa Charter for Health Promotion (1986), which has provided the blueprint for health promotion action since its inception. The basic concepts and principles of health promotion were outlined in the Ottawa Charter for Health Promotion (WHO, 1986) and subsequent WHO directives (e.g., WHO, 2005, 2013, 2016). The Ottawa Charter moved the focus from an individual, disease prevention approach towards the health actions and wider social determinants that keep people healthy.

The Ottawa Charter (WHO, 1986) adopted a systems approach to health and its development and outlined five concrete areas for action including; interventions that will build **healthy public policy** to make the healthier choice the easier choice, to **create supportive environments** for health, **strengthen community action** to achieve better health, **develop personal skills** to enable more control over health, and **reorient health services** beyond clinical and curative services to the pursuit of health promotion. Therefore, a new suite of strategies were identified for improving health ranging from the use of public policy mechanisms (e.g., regulation, legislation and taxation) to intersectoral engagement (working with other sectors that influence population health such as education, employment, agriculture, welfare, urban planning, local communities), to organizational change (e.g., in creating health promoting environments in communities, cities, workplaces, and schools), developing individual skills through health education and health literacy, and re-orienting health services to integrate a focus on promotion and primary prevention, including the use of new technologies (e.g., the online delivery of behaviour change and health literacy interventions) for improving health. A number of prerequisites for health were also identified including enabling change, advocacy, and mediation of intersectoral interests. The five key actions and principles for health promotion that were set out were further developed and elaborated on through a series of international conferences, statements and declarations. The health promotion agenda shifted the centre of gravity to a population wide systems-based perspective on health and wellbeing, which was also carried forward into 'Health for All in the 21st Century' (WHO, 1998a).

The traditional approaches of health education and disease prevention were extended in the Ottawa Charter to underscore the importance of synergistic action across different levels highlighting the need for top-down policy and bottom-up community and individual action working together to achieve common goals. The most effective health promotion interventions have been shown to employ comprehensive strategies that operate at multiple levels - structural, community/social group and individual level - and include a combination of integrated actions to support each strategy (Jackson et al., 2006; Mittelmark et al., 2005; McQueen and Jones, 2007).

Box 1 Principles of Health Promotion

Health promotion:

- involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases;
- is directed towards action on the determinants or causes of health;
- combines diverse, but complementary, methods or approaches;
- aims particularly at effective and concrete public participation; and
- health professionals, particularly in primary health care, have an important role in nurturing and enabling health promotion

Source: WHO, 2009

3.1.1 Understanding why a health promotion framework is needed

The rationale for developing health promotion in the 1970s/80s was based on the need to respond to changing patterns of disease and disability and to develop new approaches that could bring about substantive improvements in population health and wellbeing. A number of trends led to the development of health promotion, which are still relevant to this day. These include: a shift from infectious diseases to growing non-communicable and long-term chronic diseases including mental ill-health; a lengthening of the lifespan in many countries, often accompanied by longer periods of poorer health and multiple chronic conditions; growing inequities between rich and poor and across the social gradient within and between countries; the need for cost containment of health service delivery with increasing demands for improved and more expensive clinical treatments and health care; a shift from hospital to community-based health services seeking to place greater emphasis on primary health care. These changing patterns were accompanied by an increasing recognition that environmental,

social and behavioural factors play a critical role in the origin, prevention and treatment of diseases and a realisation that these factors are potentially modifiable and as such the majority of chronic diseases are preventable.

These trends made a strong case for a new approach to traditional health services in order for transformational changes in population health to be achieved. This led to a new focus on developing strategies for protecting and promoting good health and preventing diseases alongside the provision of treatment and rehabilitation services. These developments were accompanied by a broadening of our understanding of health and its determinants, and of the importance of underlying structural determinants of health, such as the social, political, economic and environmental factors, that shape our living and working conditions and ultimately influence people's health.

From a societal perspective, it is recognised that people value health, health is a global public good that is of intrinsic value and a core 'capability' required for human wellbeing and flourishing (Sen, 1999). In addition, health is essential for social and economic development, as good health leads to more economically productive and cohesive societies (WHO, 2005) and reduces costs due to illness, loss of productivity and reduced demand for public services. Health inequities are both the consequence of, and a key contributor to, social and economic inequities. Health inequities limit people's potential and the risk of poor health is consistently shown to be greatest for those who are deprived and marginalised and at the bottom of the socio-economic gradient (Marmot, 2005; Marmot and Wilkinson, 2006; Marmot Review Team, 2010). Addressing such inequities is critical for social cohesion (Wilkinson and Pickett 2009) and a prerequisite for social justice. A focus on health promotion and disease prevention is also critical to make our health systems more sustainable (Wanless, 2002, 2004). There is growing pressure on health systems due to rising levels of disease and multi-morbidity, with increasing health care costs and a demand for better and improved health services. By keeping people healthier and for longer, this reduces the need for expensive clinical treatments and healthcare and also reduces pressure and costs in other public services support systems (Hochlaf, Quliter-Pinner and Kibasi, 2019).

Health systems have been defined as: "..the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (WHO Regional Office for Europe, 2008). Health systems are, therefore, more than healthcare and include disease prevention, health promotion and efforts to address health in other sectors. Health promoting health systems can, therefore,

be defined as health systems where health promotion is integrated across all system functions and levels as a core component of delivery. In accordance with the Nairobi Call to Action for Closing the Implementation Gap in Health Promotion (WHO, 2009), this entails systematically integrating health promotion across the full spectrum of services, ranging from a specialist health promotion function with overall co-ordination responsibilities across diverse sectors and settings, to health promotion services mainstreamed within disease prevention, primary, secondary and tertiary care services, and rehabilitation and community outreach services.

The increasing costs of tertiary level curative and clinical services is a concern in many countries and health promotion is an important vehicle to reorient investment so that health systems are more sustainable. However, the percentage of the health budget that is allocated to public and primary health efforts in many countries is less than 3-4% (Wanless, 2002, 2004) and the proportion dedicated to health promotion is even less. The Wanless reports, based on a an independent review of the NHS in Britain, endorsed the need for health systems to scale up action on evidence-based health promotion and cost-effective interventions in disease and injury prevention and in addressing the wider determinants of health, in order to be sustainable in the future. It is also recognised that that access to wider services and supports beyond traditional healthcare is needed to achieve improved population health (McGovern et al., 2014). This includes improved interventions and supports for early years and parenting and school-based initiatives, for which there is robust evidence as to their impact in improving long-term health outcomes in multiple domains, as will be highlighted later in this report.

The rationale for the initial development of health promotion remains equally valid today, if not more so, in view of the global threat of complex health problems, including infectious and chronic diseases, rising rates of poor mental health, injury and violence, health impacts of climate change, population displacements and natural diasters, which affect disproportionally the poorest and most vulnerable populations. Studies show that over half the burden of illness in developed countries is attributable to a cluster of unhealthy behaviours; smoking, excessive alcohol consumption, poor diet and low levels of physical activity (Buck and Frosini, 2012). While there was a decline in the number of disability-adjusted life years (DALYs) associated with smoking and dietary risks from the period 1990 – 2010, Buck and Frosini report that earlier improvements have stalled and that since 2010 there has been a reversal of the decrease in some areas such as dietary and metabolic risk and those related to smoking are declining at a lower rate. To reverse the trend in these unhealthy behaviours, however, requires a focus on their determinants, the so-called 'causes of the causes'. This entails addressing the social, commercial, political and environmental

factors that shape people's health behaviours and lead to a clustering of unhealthy behaviours among those who are poorer and are exposed to environmental, socio-economic pressures and stress. Poverty, deprivation and inequality have all been found to be strongly associated with higher rates of smoking, unhealthy diets, inactivity, alcohol and drug abuse, poor mental health and higher levels of obesity (Baker, 2018; ONS, 2018, Pickett and Wilkinson, 2010; CSDH, 2008; Marmot, 2005). The Commission on the Social Determinants of Health (CSDH, 2008) clearly advocated for the need to improve daily living conditions and ensure access to resources to address such health inequities.

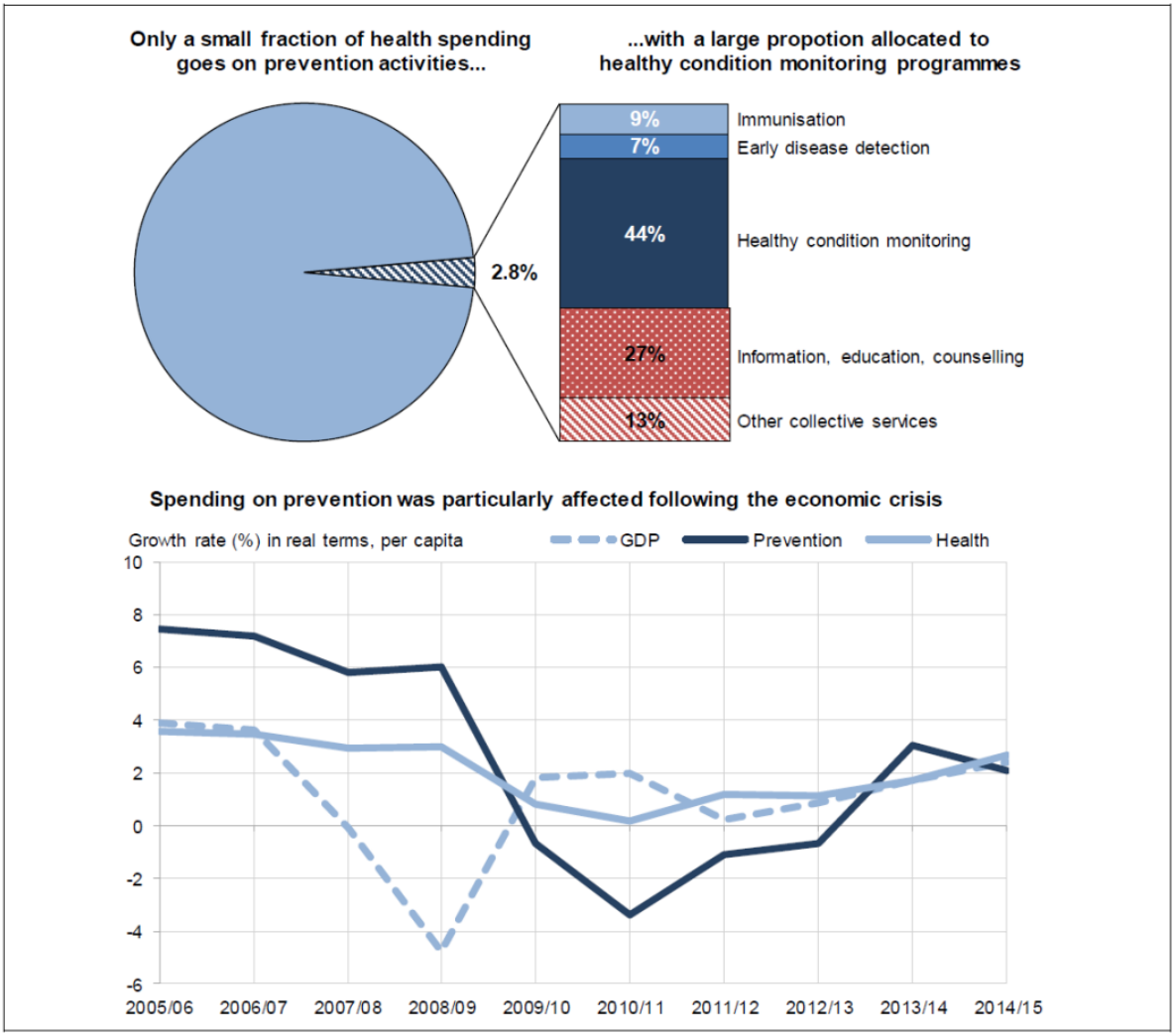
While there has been good progress in the European Region in meeting the Health 2020 targets (WHO, 2012), with improved life expectancy, reduced infant mortality and mortality from major NCDs for adults aged 30-69, progress is uneven and significant inequalities remain within and across countries (WHO, 2018a). Some countries, such as the UK, have witnessed a stalling of progress and a reversal in trends in recent years (Holchaf et al., 2019). Further progress on achieving improved population health and wellbeing will require a focus on all the determinants of health, including political, commercial, social, environmental, genetic, systemic, cultural and ecological. This can only be achieved through coordinated multisectoral action, with a clear focus on health promotion and prevention, as exemplified by a health in all policies approach.

3.1.2 The economic case for investing in health promotion

A clear economic case for investing more in health promotion can also be made. To date, health promotion and prevention appear to receive only a small proportion of total health care spending across the globe.[1] A recent OECD study indicates that less than 3% of total health care expenditures are spent on prevention and health promotion. While the growth rate of this spending outpaced that of overall expenditures for a while, alarmingly, during the recent economic crisis spending on health promotion and prevention was especially seen to drop. This decline in spending is problematic, as there are good reasons to argue that a shift from curative care to prevention and health promotion would be beneficial, also from an economic perspective. This shift is even more desirable in light of the developments in health and health care, with an increase in lifestyle related illnesses (including the increase in obesity rates) and non-communicable diseases, which increase the importance of enabling people to take control over their own health, not only in terms of health promotion and prevention but also in terms of managing (multiple) diseases they may suffer from.

[1] https://www.oecd-ilibrary.org/social-issues-migration-health/how-much-do-oecd-countries-spend-on-prevention_f19e803c-en

Figure 1 Spending on prevention in OECD countries



Note: Data refer to the OECD average for 2015 (top panel) and 2006-2015 (bottom panel).

Source: OECD Health Statistics 2017.

Source: Adapted from OECD Health Working Paper NO. 101 (Gmeinder et al., 2017)

Here we only highlight two main reasons, relating to two main goals of health care systems: (i) efficiency and (ii) equity.

Efficiency

Typically, health care systems strive to allocate scarce resources optimally. Efficiency, for instance expressed as how much health is produced in the population with the available resources, should then be considered. Governments should attempt (all else equal) to fund and implement those interventions in their health care systems that would produce most health per invested euro, in line with the goal of maximizing population health, given the available resoruces. Efficiency can be promoted by improving the functioning of the health care system (e.g. by minimizing waste and providing incentives for productivity), but also by

selecting to fund and implement activities that contribute most to population health in relation to their costs.

A common way of expressing the efficiency of interventions is in terms of their cost-effectiveness. This expresses how much health (often expressed in terms of quality-adjusted life-years, QALYs, or Disability-Adjusted Life-Years, DALYs, both outcome measures combining changes in length and quality of life) is gained per invested euro through some intervention (in comparison to current care). By selecting those interventions with most favourable cost-effectiveness ratios, governments can contribute to the efficiency of the health care system and to maximizing population health with the available budget. It has been demonstrated repeatedly that a number of health promotion and prevention interventions, if executed well and with the right populations, can result in (very) favourable cost-effectiveness outcomes. Some interventions in relation to improving health behaviours (such as reducing smoking and excessive drinking) have been shown to be very cost-effective. These interventions range from regulating prices and access to unhealthy products, such as increasing taxes on cigarettes (e.g. Van Baal et al., 2007) and reducing the number of points where these can be purchased (and consumed), to programmes that assist people in smoking cessation (Hoogendoorn et al., 2010). Such interventions can improve health at relatively low costs, also in comparison to many curative interventions. In the context of nutrition interventions, introducing a tax on soft drinks with high sugar content or junk food with high caloric content or high salt concentration can help to divert consumption from unhealthy foods and thus improve health. The increased tax revenues could be re-invested to subsidize healthy foods (such as fruit and vegetables) thus supporting low-income groups who are more likely to be affected by a tax on high-caloric but cheaper food. These interventions do not necessarily require additional resources (although they may directly or indirectly lead to costs), and might even reduce (certain) costs, and can be designed to be budget neutral from a government perspective, but again there may be political costs associated with their implementation.

It is important to stress once more that health promotion can be a very cost-effective means of increasing population health, even if one acknowledges that successful health promotion may lead to additional (future) health care costs due to increased longevity. These additional costs may offset possible savings in avoided diseases that were related to the unhealthy behaviours and lifestyles (Russel, 2007; Van Baal et al., 2008; Rappange al., 2009). Including such costs is required to provide a sound estimate of cost-effectiveness (Van Baal et al., 2011). Even when these costs are taken into account, health promotion interventions can still produce health at relatively low costs, implying that further investment in health promotion would result in more health from available resources.

Moreover, it is important to stress that requiring health promotion or preventive interventions to be cost saving is unreasonable and not in line with the overall goal of a health care system of maximizing health with available resources (Rappange et al., 2010) As Bonneux and colleagues (1998) put it: "*The aim of health care is not to save money but to save people from preventable suffering and death. … Any potential savings on healthcare costs would be icing on that cake.*" This is true for curative and preventative interventions. Sometimes stating the obvious is necessary. Activities should be cost-effective, not necessarily cost saving – and to use different standards for different types of care is inconsistent. Hence, health promotion activities should be high on the priority list whenever they have shown to produce health at relatively low costs. That they can, even when including costs incurred in gained life years and due to competing diseases may be seen in table below (taken from Rappange et al., 2010).

Table 1 Cost effectiveness ratios (costs per QALY)

Risk factor	*Preventive intervention*	*True CE ratio*	*CE ratio (excluding costs unrelated medical care)*
Obesity	Low calorie diet[47]	€17 900 or $24 340	€12 100 or $16 460
	Intensive lifestyle program[48]	€7 400 or $10 060	Cost saving
Smoking	Tobacco taxes increase[49]	€2500 or $3400	Cost saving
	Minimal counseling by GP (or GP assistant) in combination with nicotine replacement[17]	€4400 or $5980	€1500 or $2040

Costs discounted at 4% and effects discounted at 1.5%. Dollar price level 2009 (07/01/09: 1 euro = 1.36 dollars).

The highlighted interventions, targeted at smoking and obesity prevention, all show (very) favorable cost-effectiveness ratios in comparison to other interventions and commonly used thresholds for cost-effectiveness.

Other examples of policy interventions with varying degree of cost-effectiveness (from very effective to medium effectiveness) include smoking bans in public places, enforcing drink driving laws, banning and regulating advertising, introducing warning labels and food labelling. Ekwaru and colleagues, for instance, investigated the cost-effectiveness of a school-based health promotion programme in Canada and conclude, given common thresholds for costs-per QALY in Canada, that it is a cost-effective intervention for obesity prevention and reduction of chronic disease risk over the lifetime (Ekwaru et al., 2017). Economic analyses of early childhood interventions, including home visiting, parenting ad preschool programmes also demonstrate their cost-effectiveness, especially for the most vulnerable families (McDaid and Park, 2011). Mass media campaigns can also be (cost-) effective, if well designed and combined with other focused interventions. As Cecchini et al. (2010) write: "*Several population-based prevention policies can be expected to generate substantial health gains while entirely or largely paying for themselves through future*

reductions of health-care expenditures. These strategies include health information and communication strategies that improve population awareness about the benefits of healthy eating and physical activity; fiscal measures that increase the price of unhealthy food content or reduce the cost of healthy foods rich in fibre; and regulatory measures that improve nutritional information or restrict the marketing of unhealthy foods to children. A package of measures for the prevention of chronic diseases would deliver substantial health gains, with a very favourable cost-effectiveness profile." This highlights the numerous potential routes to improve public health through health promotion and prevention, in cost-effective ways. This implies that spending more on (well selected) health promotion activities could improve overall population health.

Equity

Health care systems are not only concerned with maximizing the health of the population with available resources, but also to promote health equity. An equitable distribution of health and health care are typically among the most prominent health policy goals. Despite this, socio-economic health disparities have remained large. For instance, in a country like The Netherlands, the difference in life-expectancy between high and low socio-economic status is about 7 years. The difference in time expected to live in good health is even larger: 18 years. Such differences in life expectancy and health expectancy between different socio-economic groups also relate to aspects such as lifestyle and health literacy, in which health promotion could especially be effective. Smoking, excessive alcohol use and obesity are more prevalent among the lower socio-economic groups, which significantly reduces their life expectancy and health expectancy and increases the inequity in health within populations. Moreover, considering a broader array of social and environmental factors such as air pollution (in particular areas), housing circumstances, employment and social protection could add to these differences.

Hence, more spending on health promotion, targeted at enhancing protective factors and reducing risk factors, especially for those population groups that are currently worst off, could have a significant impact on reducing health inequities. Implementing Health in all Policies strategies could improve this even further.

3.1.3 Adopting a health promotion framework: transforming how we think about health and improving it for the population as a whole

Health promotion as a concept and multidisciplinary area of practice is often poorly understood, which leads to an overly narrow interpretation of its core purpose and of its implementation in policy and practice. In public discourse, health is largely understood as relating to illness and health services are predominantly illness services concerned with treating and caring for ill-health. While there is a general understating of the nature and

importance of prevention, in that 'prevention is better than cure', the concept of health promotion tends to remain more elusive.

In this respect, it is important to make a distinction between health promotion and disease prevention. Disease prevention is primarily concerned with measures to prevent diseases or injury rather than with curing them or treating the symptoms. Prevention is conceptualised as working at three levels; (i) primary prevention focuses on preventing diseases before they occur through enhancing protective factors and controlling exposure to risk factors (e.g., tobacco legislation), (ii) secondary prevention intervenes as early as possible after an illness or risk factors have already been diagnosed (e.g., screening for those with known risk factors), (iii) tertiary prevention efforts seek to minimise the impact of an established disease on an affected person (e.g., cardiac rehabilitation).

From the above it can be seen that health promotion and prevention overlap to some extent, especially in relation to primary prevention, however, prevention starts from the position of seeking to prevent disease and related risk factors, while health promotion seeks to promote health and to enhance the factors that create and protect good health. Therefore, the starting points and loci for action of these two approaches differ, as do the health outcomes that are being targeted (i.e., increasing protective factors for health versus reducing risk factors for illness). Likewise, health promotion has a distinct set of underlying principles and values that guide effective action, embracing a participatory, empowering and collaborative approach with prerequisites for health based on equity, and social justice.

The relationship between health promotion and public health is also the source of some contention and debate, with some viewing health promotion as being a part of, or a process of public health, while others view health promotion as being complementary to and more wide ranging than public health, especially in those countries where public health is synonymous with public health medicine. Whether health promotion is viewed as being separate to, or part of, multidisciplinary public health, it is recognised that there is a distinctive body of knowledge, skills and expertise that underpins its practice (Barry et al., 2012a,b) and that specific capacities are needed to develop and implement health promotion actions that will promote health at a population level.

Embracing a health promotion framework requires a significant shift in focus from illness to health and calls for intersectoral action and partnership working as an integral aspect of health promotion practice. To some extent, health promotion could be seen as a challenge to conventional approaches to health care and its delivery and to the health professionals who are primarily trained in illness diagnosis and treatment. As outlined later in this Opinion, adopting a health promotion approach calls for a new base of multidisciplinary knowledge,

skills and competencies that extend beyond the traditional healthcare approach and requires a broader understanding of health and its determinants.

Health is more than the absence of disease: Broadening our understanding of health and its determinants

Health promotion is rooted in a salutogenic view of health (Antonovsky, 1996) and is aimed at whole populations across the life course (Halfon et al., 2018) and across settings (Poland et al., 2000). The salutogenic view means strengthening people's health potential. Health promotion not only focuses at the level of the individual but also on groups, communities, the settings where people live their lives, and on entire populations. As described by Kickbusch (2003), the Ottawa Charter initiated a re-definition and re-positioning of actors at the 'health' end of the disease-health continuum. This re-orientation shifts the focus from the modification of individual risk factors or risk behaviours to addressing the context and meaning of health action and the protective factors that keep people healthy. Health promotion addresses the critical question of where and how health is created and what strategies are needed to create the greatest health gains for the greatest number of people.

Adopting a socio-ecological or systems-based approach, health promotion emphasises that health is created within the settings where people live their lives and as such these everyday contexts or settings, such as the home, school, workplace, community, is where health can be promoted. The challenge of improving population health is, therefore, reframed to focus on the health potential of people and their everyday settings for living. The inextricable link between people and their environments forms the basis of this socio-ecological approach to health (McLeroy et al., 1988) and provides a conceptual framework for practice. This is exemplified through a settings-based approach to health promotion (Poland et al., 2000), which emphasises the influence of whole systems and the interlinked nature of people and their everyday environments. The settings approach has led to a number of successful and innovative health promotion initiatives such as health promoting schools, health promoting cities and communities, islands, workplaces and hospitals, which have been successfully implemented in a number of countries in Europe and beyond.

The WHO Healthy Cities and Communities movement, which aims to develop healthy sustainable cities by integrating health considerations into development and planning processes at the local level, provides many examples of how intersectoral partnerships and community participation are used in mobilising resources for building healthier and resilient communities (de Leeuw, 2009; Heritage and Dooris, 2009), including creating greener and healthier living environments and advancing policies that create co-benefits between health and wellbeing and other city policies. With regard to promoting health in the workplace, the WHO Healthy Workplace Framework and Model (WHO and Burton, 2010) provides a global

framework for action, with practical evidence-based guidance, which has been adapted for different workplaces in Europe. The European Network for Workplace Health Promotion (ENWHP) has promoted workplace health promotion in Europe, undertaking a series of initiatives to advance practice, including the use of legislation, regulations and organizational-level changes in the workplace.

Likewise, an array of approaches to delivering school-based health promotion have been employed ranging from universal curriculum-based interventions through to whole school approaches. The Health Promoting Schools Framework (WHO, 1998b) resulted in a shift from a focus on curriculum and knowledge-based approaches to more comprehensive strategies that seek to promote students' health through curriculum teaching in combination with a supportive and healthy school environment and a sense of connectedness with family, community and the broader social context (Samdal and Rowling, 2013). A whole school approach embraces changes to the school environment, its ethos and policies, as well as to the curriculum, and actively engages parents, families and external supports in the community. The Schools for Health in Europe Network Foundation (SHE) is a network of professionals that supports the development and implementation of a health promoting schools approach through national and regional coordinators in over 33 countries in Europe and Central Asia.

A life course approach to health promotion takes into account the differential exposure to risk and protective factors throughout life and calls for actions to improve the conditions in which people are born, grow, live, work and age (CSDH, 2008; WHO and Calouste Gulbenkian Foundation, 2014). The CSDH (2008) report argues that policy making at all levels of governance and across sectors can make a positive difference to health outcomes and advocates for actions and public policies that are universal and inclusive, yet proportionate to need, in order to address existing inequalities. The principle of proportionate universalism, as put forward in this report, posits that focussing only on the most disadvantaged will not reduce inequities and that universal action, calibrated proportionately to the level of disadvantage, is required to address the steepness in the social gradient. In order to reduce health inequities, action needs to be taken to improve everyday living conditions, beginning before birth and progressing into early childhood, adolescence, adulthood and old age (WHO and Calouste Gulbenkian Foundation, 2014). Systematic reviews show that integrating health promotion within routine pre-natal and post-natal care services, including home visiting parenting programmes, lead to improved child development and parenting skills, reduced behavioural problems and improved maternal health and social functioning (Barlow et al., 2014; Britto et al., 2017; Kendrick et al., 2013; Stewart-Brown and Schrader-McMillan, 2011). Antenatal screening and targeted prevention interventions lead to improved detection and management of postnatal

depression for women at risk of depression and intimate partner violence (NICE, 2018; Shaw et al., 2006). The effects of early years interventions are especially evident for the most vulnerable families, including those living in poverty, war torn areas and mothers with depression (Baker- Henningham and Lopez Boo, 2010; Nores and Barnett, 2010; Dybdahl, 2001). Economic analyses of several childhood interventions demonstrate that effective interventions can repay their initial investment with savings to the government and benefits to society, with those at risk making the most gains (Karoly et al., 2005; Galinsky, 2006; McDaid and Park, 2011; Knapp et al., 2011).

A number of EU countries have implemented early years strategies in order to give children a healthy start in life and address the barriers to positive development for children and their families from disadvanatged backgrounds (see for example, the Early Years Scotland Strategy 2017-2020 (https://earlyyearsscotland.org/Media/Docs/What%27s%20New/Strategic%20Plan.pdf).

Adopting a health promotion framework calls for integrated multilevel action across the life course. While the risk reduction model begins with a focus on reducing risks for ill health, the health promotion approach focuses on enhancing positive health and wellbeing. This approach signals a shift from an individual-centred, deficit-focussed approach to one embracing an emphasis on health assets, psychosocial strengths, resources, and supportive environments. The goal, therefore, becomes enhancing potential and wellbeing rather than focussing solely on reducing illness. This perspective is the basic tenet of health promotion which was clearly articulated as; *"Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases"* (p.6, WHO, 1985).

Mental health promotion offers a good illustration of how adopting a health promotion perspective can reframe the challenge of improving population mental health and wellbeing. The need to address mental health as a positive resource and an integral part of improving overall health and wellbeing is clearly endorsed in the global WHO Mental Health Action Plan 2013-2020 (WHO, 2013a) and is also explicitly referenced in the SDGs (United Nations, 2015). Strategies focused on curing mental ill health alone will not necessarily deliver on improved mental health at a population level (WHO, 2013a). Mental health promotion and prevention strategies have been introduced in many countries globally as the most sustainable method of reducing the increasing burden of mental disorders and improving overall health and wellbeing. The Lancet Commission on global mental health and sustainable development (Patel et al., 2018) also called for a reframing of the global mental health agenda to embrace the improvement of mental health for whole populations, given its relevance to sustainable development globally.

Options to foster health promoting health systems

A health promotion approach to mental health underscores the universal relevance of mental health for the general population and identifies the need for strategies that can be applied across the life course for diverse population groups and settings. These strategies range from promoting social and emotional skills development, to creating supportive living environments, to enhancing protective factors and reducing the risk of developing mental health problems (see Box 2). Mental health promotion practice intervenes at the level of strengthening individuals, strengthening communities, reorienting health services and promoting intersectoral policy and programmes to remove the structural barriers to mental health at a societal level (Barry, 2009). Mental health promotion offers a distinctive framework for promoting population mental health and reducing mental health inequities, based on the underpinning principles of health promotion and intersectoral actions addressing the social determinants of mental health across the life course (Barry and Jenkins, 2007; Herrman, Saxena and Moodie, 2005; Hermann and Jané-Llopis, 2012; Jané-Llopis et al., 2005; WHO, 2002). The body of knowledge on the effective implementation of mental health promotion policy and practice has grown considerably and the strength of the evidence base makes a strong case for investment (Knapp et al., 2011).

Box 2 Adopting a health promotion approach to improving population mental health and wellbeing

Mental health promotion is concerned with strengthening protective factors for good mental health and enabling access to resources and supportive environments that will foster the mental health and wellbeing of individuals and populations (Barry et al., 2019). There is compelling evidence from high-quality studies that mental health promotion interventions, when implemented effectively, can reduce risk factors for mental disorders, enhance protective factors for good mental and physical health, and lead to lasting positive effects on a range of social and economic outcomes (Petersen et al., 2015; Barry et al., 2013). Drawing on this international evidence from high-, middle- and low-income countries, a number of effective and sustainable interventions have been identified, which can be implemented with population groups across the life course in key settings such as the home, school, workplace, community, primary care health services. These include the following priority actions:

- Promote infant (0-3 years) and maternal mental health through integrating mental health promotion and prevention into routine pre and postnatal care services and home visiting programmes.
- Promote early child mental health development (3-6 years) through pre-school education
- Provide parenting and family strengthening programmes for school-going children (3-16 years)
- Promote young people's (6-18 years) life skills and resilience through school-based interventions in primary and post-primary schools
- Promote the mental health and social wellbeing of adolescents and young people (12-18 years +) through out-of-school multicomponent interventions
- Deliver community empowerment interventions to promote mental health and reduce the risk of mental disorders for families in poverty and debt
- Train primary health care providers in opportunistic mental health promotion and

prevention interventions for adults and older people
- Advocate for workplace policies and programmes that will improve the mental health of working adults
- Advocate for the implementation of policies and regulations on alcohol consumption
- Implement regulations restricting access to commonly used lethal means of suicide.

Source: Adapted from Barry et al., 2015

Recognising that health promotion is an essential strategy for addressing health inequities and the social determinants of health

In order to reduce inequities in health the full range of modifiable factors influencing health, including those at the broad social, organisational and structural levels, need to be addressed. Addressing the social determinants of health calls for change at the level of social policies and systems in order to reduce poverty and improve equity in access to education and good living and working conditions. Similarly, the negative impact of social exclusion, racism, sexism, discrimination and bullying also requires policy interventions alongside changes in social norms and values at a societal level. This requires different sectors and actors (civil rights, employment, education, housing, planning, media etc.) to work together in order to create more supportive environments for positive health through policy, organisational and societal level change.

The social determinants of health have been conceptualised as stemming from unequal distribution of opportunity in society, including inequity in resources, money, power, voice, and choices at the level of the structure of society (CSDH, 2008). The unequal distribution of opportunity is driven by public policies and social norms, and Compton and Shim (2015) argue, for example, that the social determinants of mental health are, therefore, best addressed by working at the upstream levels of the environmental and social factors that shape the more proximal risk and protective factors. This is also referred to as addressing 'the causes of the causes' (Marmot, 2005). Interventions addressing the proximal risk and protective factors do not necessarily address the underlying causes of those risk and protective factors which may be shaped by society, culture, social policies and social norms. It gives an important perspective to examine social determinants through the lens of social justice so that they can then be best addressed through advocacy, political will and policy interventions (Marmot, 2005; Marmot and Wilkinson, 2006).

A striking case in point is the documented increases in suicides in Europe related to changing economic and employment conditions. Stuckler et al. (2009) report that there was a 0.79% increase in suicides for those aged under 65 years of age related to every 1% increase in unemployment based on analysis of data from 26 EU countries over the period 1970-2007. Following the sharp increase in unemployment during the economic crisis in Europe post 2008, unemployment rates rose sharply in EU Member States and the downward trend in

suicide rates evident prior to 2007 began to reverse (Stucker et al., 2011). Based on an analysis at country level, Stuckler et al. (2009) also report that strong social protection policies, with investment in active labour markets, can have a protective effect in such circumstances.

Policy making at all levels across sectors can make a critical difference to improving population health, supporting the view that, a 'Health in All Polices' approach is needed to effectively improve population health and reduce health inequities. Social policies in education, social protection, justice, trade, employment, housing and support services can have a major impact on life experiences and can empower individuals and groups in optimising the potential for positive health and wellbeing in everyday life. Understanding population health as being influenced by these upstream determinants places the responsibility for improving health and reducing inequity within the sphere of policies, politics and governance and calls for a whole-of-government and whole-of-society approach (WHO, 2014a). Cross-sectoral policies and actions are, therefore, a critical component of effective health promotion action at international, national and local levels.

The essential role of health promotion in addressing global threats to health

Many diseases are preventable and the prevention and control of infectious and chronic diseases requires changes in social policy as much as in health services. Chronic non-communicable diseases, injury and poor mental health have overtaken infectious diseases as the leading cause of morbidity, disability and mortality and are one of the leading challenges for global development. The UN Political Declaration on NCDs (2011) advocated for prevention approaches to be the cornerstone of the global response to the rising tide of these diseases, the root causes of which reside in non-health sectors. Intersectoral action for health promotion and disease prevention is, therefore, critical to addressing these diseases and stemming the tide. The increasing costs of advanced treatment and care for diseases such as cancer, heart disease and diabetes can put these services out of the reach of many people, even in the high-income countries. Mental disorders account for 5 of the 10 leading causes of disability worldwide and constitute a major burden and source of personal and social costs. There is, therefore, a strong economic argument for investing in health promotion and disease prevention, which is elaborated on in this Opinion.

In this century, improved living conditions are not necessarily being followed by improved health status and in many countries the progress has started to reverse. The Institute for Health Metrics and Evaluation report (2019) shows that between 1990 and 2012, the number of disability-adjusted life years (DALYs), where a preventable risk factor was an underlying cause, fell from 7.7 million to 5.6 million. By 2017, however, this had risen to 5.9 million. In many countries, economic growth is creating the conditions that favour the rise

of NCDs, due to changes in lifestyle patterns in relation to diet, exercise, alcohol, tobacco, and stress. Global trends in modernization, urbanization, trade and planetary sustainability have facilitated the creation of unhealthy living environments and related unhealthy behaviours and living patterns. Coupled with this, the burden of chronic diseases is inequitably distributed globally and within societies. Health inequities have increased rather than decreased over the last 50 years and the rise of chronic diseases threatens to widen this gap even further. Economic crises and austerity policies have lead to a worsening of health outcomes, especially for the most vulnerable populations (Horton, 2017; Stuckler et al., 2017). The Rockefeller/Lancet Foundation's Report on Planetary Health (Haines, 2017) highlighted the urgent challenge of promoting planetary health to address the negative health impacts posed by environmental threats such as climate change, loss of biodiversity, depletion of land resources and ocean acidification. A systems-based eco-social approach to population health promotion, that can address the ecological and social determinants of health, is needed to counter these global health threats (Hancock, 2015).

As may be seen from this brief overview, addressing the broad and complex nature of global health threats requires a strenghtening and transformation of health systems. Comprehensive population-wide approaches are needed to bring about the scale and scope of social changes needed for improved health at a population level. This calls for supportive policy measures focused on strengthening health promoting health systems in order to ensure effective actions across government and society that will lead to more equitable health outcomes.

3.1.4 Policy frameworks for health promotion

Current policy frameworks for health and wellbeing clearly endorse the central role of intersectoral actions across government and society in creating the conditions that will protect and promote people's health and wellbeing, reduce exposure to risk factors, and empower individuals, families and communities in maximising their health and wellbeing across the life course, and reduce inequities (WHO, 2012: WHO, 2013b; WHO, 2019). With the realisation that many of the determinants of health and health inequities lie outside of the health sector, the potential health impact on population health of public policies and decisions made in all sectors and at different levels of governance has been brought to the forefront in recent policy frameworks, which endorse intersectoral action and healthy public policy as integral elements of health promotion for achieving population health and health equity (WHO, 1986; WHO, 2011; United Nations, 2011a; 2011b).

The WHO Helsinki Statement on Health in All Policies (HiAP) outlined HiAP as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful impacts in order to improve population

health and health equity" (WHO, 2014a). As a concept HiAP reflects the principles of participation and collaboration across sectors and levels of government, recognising that public policies in all sectors have a significant impact on population health. The significant influence of sectors outside of health on the determinants of health calls for coordinated policy action from sectors such as welfare and social services, childcare, education, employment, trade, housing and urban planning, media, public finance and debt management, human rights, leisure and culture. A HiAP approach recognises the need for upstream policy interventions to address the social determinants of health such as healthy living and working conditions, access to education, life opportunities, housing and safe communities and to reduce inequities caused by the structural determinants such as poverty, racism, gender inequality, social marginalization and discrimination of minority groups.

A HiAP approach is clearly reflected in the EU health strategy and the WHO Health 2020 European policy framework for health and wellbeing, which call for actions across whole of government and whole of society that will "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality" (Health 2020). The full range of EU and national public policy mechanisms are required to effectively promote population health, including legislation, regulation and a broad range of fiscal, socio-economic and environmental policies to ensure that the conditions that create and support population health and wellbeing are accessible to all. As a shared competence for the protection of public is included in Article 9 of the Lisbon Treaty, this provides a strong mandate for putting improved population health and wellbeing and reducing health inequities at the centre of all EU policy and implementation measures.

The challenge of implementing a whole-of-government and whole-of-society approach

As reflected in the Health 2020 European health policy framework, a HiAP approach calls for a whole-of-government and whole-of-society approach to health, which broadens the frame of reference for action well beyond traditional healthcare services with a predominant focus on curative care. This approach requires a greater awareness of how social, economic, cultural and physical environments impact on health throughout the life course, and a greater appreciation of the need for health promotion to be incorporated across policy sectors and their role in shaping population health and wellbeing through parenting, child care, schools, workplaces, communities, employment, social protection, trade, financial, cultural, environmental, and social care settings. Policy coherence is a major consideration in supporting the implementation of integrated whole-of-government policy approaches and remains a significant challenge. Lack of coherence across policies, e.g., in relation to health and education, social protection and employment etc., can lead to greater inequities. Policy

coherence and alignment between different levels and mechanisms of governance is critical for effective whole-of-government approaches. This calls for the use of intersectoral policy analysis and the application of tools such as health impact assessment for systematically monitoring and accounting for the health implications of policy decisions in other sectors. Political commitment and inter-departmental governmental structures are critically important in supporting effective intersectoral policy development and implementation, as is creating a culture of collaboration and capacity for effective intersectoral partnership working (Jenkins and Minoletti, 2013; Corbin et al., 2016).

Effectively implementing cross-sectoral actions involves building partnerships not only across governmental departments at a policy level but also with a wide range of nongovernmental and civil society actors, agencies, organisations and community groups. Adopting a whole-of-society approach seeks to engage a broad range of actors who can play an important role in influencing the health potential of everyday settings and environments e.g., through culture, recreation and creative arts, sports, youth services, citizen wellbeing, and at the level of local authorities, municipalities and local communities. Facilitating the participation of the wider community, including marginalised and vulnerable groups such as migrants, minorities and disadvantaged people, is a critically important challenge in enabling a wider set of actors to contribute and have a meaningful role in creating the conditions for positive health and wellbeing at a whole-of-society level.

New models of intersectoral working are required including effective leadership, participatory processes and partnership working in implementing a whole-of-society approach that will lead to creating a flourishing and healthy society. Engaging partners from other sectors, identifying opportunities for intersectoral collaboration, negotiating agendas, mediating different sectoral interests and promoting synergy to facilitate effective partnership working across sectors, are all core elements of implementing a whole-of-society approach. Adopting a whole-of-government and whole-of-society approach to population health, therefore, entails integrated action implemented across upstream policy approaches and bottom-up community action with vertical and horizontal integration through intersectoral partnerships and participatory processes. The practice of health promotion, therefore, requires the necessary knowledge and skills that can embrace this broader cross-sectoral population approach.

Few of our health professionals receive training in intersectoral partnership working currently and few of our policy and decision-makers in health systems have a broad appreciation of how such an approach can be implemented in practice and what skills are required. This issue will be addressed more fully later in this Opinion, when we draw on the lessons learned

from the practical implementation of HiAP in countries and what structures, processes and governance tools are required to ensure effective action and policy coherence.

Health Promotion within the framework of the Sustainable Development Goals

Population health and wellbeing is recognised as a critical element of sustainable development. The overall aim of the 17 goals in the Agenda 2030 for Sustainable Development (United Nations, 2015) is "to ensure that all human beings can fulfil their potential in dignity and equality in a healthy environment". Goal 3 is to "Ensure healthy lives and promote well-being for all at all ages" and states as part of its fourth target: "By 2030, reduce by one third premature mortality from non-communicable disease (NCDs) through prevention and treatment and promote mental health and wellbeing" (Target 3.4). Many of the other SDGs also have implications for health. Progress on the goals related to poverty reduction, gender equality, economic development and reducing social inequities will contribute greatly to health promotion as health is strongly influenced by levels of poverty, financial hardship and debt, education and low productivity. The interlinked nature of the SGDs requires action across multiple sectors to ensure healthy lives and to promote mental health and wellbeing. The SDGs place health at the centre of the global development agenda, thereby acknowledging that improving population health will lead to a broad range of socio-economic and development outcomes (Scorza et al., 2018).

It is also notable that mental health has for the first time been included explicitly as an essential component of the global development agenda, with Goal 3 directly addressing mental health as part of Target 3.4. Aspects of mental health are also included in Target 3.5; "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol". Both mental disorders and substance misuse contribute to premature mortality from NCDs, partly from suicide, non-suicidal trauma and accidents, and comorbidity between mental ill-health, physical illness and substance misuse. Thus SDG 3.4 and 3.5 requires policy attention to the promotion of mental health and the prevention and treatment of mental disorders. The Lancet Commission on global mental health and sustainable development (Patel et al., 2018) supports broadening and reframing the global mental health agenda within the sustainable development framework from a focus on reducing the treatment gap for mental disorders to the improvement of mental health for whole populations based on the recognition that mental health is global public good and is relevant to sustainable development globally.

The Shanghai Declaration on Promoting Health in the 2030 Agenda for Sustainable Development (WHO, 2016a) clearly underscores that health and wellbeing are essential to achieving sustainable development and reaffirms health as a universal right, an essential resource for everyday living, a shared goal, and a political priority for all countries. The Shanghai Declaration endorsed a renewed focus on the healthy settings approach (e.g.,

health promoting schools, hospital, workplaces and cities), and the Shanghai Consensus on Healthy Cities (WHO, 2016) outlined priority actions for cities to achieve SDG 3 and SDG 11 to make cities and human settlements inclusive, safe, resilient and sustainable.

The focus on universal health coverage (UHC) within the SDGs, and the UN Political Declaration on UHC (United Nations, 2019), also reflects the need to prioritize universal access to promotion and prevention for population health improvement. The WHO advocates for universal health coverage so that all people and communities can have equitable and affordable access to the full range of quality health services, including universal population health promotion and disease prevention alongside curative, rehabilitative and palliative health services, without being exposed to financial hardship. Such initiatives afford an opportunity to place health promotion squarely at the centre of the global health agenda. To enable progress on universal health coverage, health promotion needs to be integrated into health and broader social and development policies. It is clear that since health has an impact on numerous interconnected social and economic areas of life, government policy needs to integrate health promotion strategies not only into health, but also into sectors such as education, social protection, employment, trade, transport, agriculture, and community development policy. Therefore, developing and implementing an intersectoral approach to health promotion policy, is crucial for the achievement of these broader health and development agendas.

As highlighted in the Roadmap to Implement the 2030 Agenda for Sustainable development, building on Health 2020 (WHO Europe, 2017 - Regional Committee for Europe, 67th Session, 11-14 September, 2017), the SDGs present a major opportunity to adopt a determinants of health approach and bring a central focus on the social, economic, commercial, cultural and environmental determinants of health in policy making across all sectors and to engage a wide range of stakeholders beyond the health sector. The SDGs present an opportunity to engage in intersectoral action to tackle complex health problems and issues. However, for this to be achieved investment is required including developing institutional and human resources, and strategic leadership at national and local levels, to develop regulatory frameworks and the co-creation of policies and strategies outside the health sector. Such intersectoral approaches are essential for the delivery of health promotion that will benefit population health and wellbeing by addressing the interconnected multi-level determinants of health and wellbeing. Advocacy and effective communication are needed to raise awareness and encourage ownership of health promotion at various levels within the health system and across government and civic society. Partnership working across sectors is also critical to this endeavour, drawing on the diverse skills and knowledge of stakeholders from sectors in food, energy, transport, agriculture, architecture, environment, security, social protection and others. Governance structures from inter-governmental and intersectoral

action will need to be created to implement a whole-of-government and whole-of-society HiAP approach. This is critically important in tackling the global burden of disease and global health threats from environmental exposures, climate change, food systems, risk factors for NCDs and mental health, emergencies, communicable diseases and to strengthen the factors that promote social protection and empower people through education, community action, health literacy and active participation in shaping the conditions that will promote good health and wellbeing for all. The reform of health and social programmes in the EU provides an important opportunity to apply existing policy mechanisms and tools, including those linked to the European Semester and implementation of the European Pillar of Social Rights, to support the adoption of a HiAP within all policy actions and to develop capacity and resources for strengthening health promoting health systems in EU countries.

3.2 What progress has been made in implementing a health promotion approach?

The Ottawa Charter was a charter for action that put health promotion on the policy agenda of governments and health agencies in many regions and countries (Catford, 2011). A number of efforts have been made to assess what progress has been in implementing health promotion policy and practice since the publication of the Ottawa Charter in 1986 (McQueen and Salazar, 2011; Potvin and Jones, 2016; Kickbusch and Nutbeam, 2017; Thompson, Watson and Tilford, 2018). There have also been attempts to update the Charter, while endorsing its core concepts and principles at a global (Bangkok Charter for Health Promotion in a Globalized World, WHO 2005) and European level (the Vienna Declaration, McKee et al., 2016), and frameworks have been developed to rejuvenate health promotion approaches within the context of the UN 2030 Agenda for Sustainable Development (EuroHealthNet, 2016). In assessing progress, a number of commentators have pointed to the lack of political commitment in implementing health promotion policies and the challenges posed by the changing global health context over the last 30 plus years.

Among the factors identified as impeding progress are; rapid demographic and epidemiological changes in the patterns of disease with new and emerging health challenges, increasing urbanization, technological developments and globalization of trade, travel, values and ideas, combined with ongoing widespread absolute and relative poverty and growing health inequities in many countries. The global environmental threats to health due to climate change and unsustainable development have also created obstacles to achieving the health targets set by the Millennium Development Goals, and are also relevant for the current UN Sustainable Development Goals (SDGs) in the UN 2030 Agenda. There is a recognition that achieving intersectoral action for health is challenging and requires a different approach to policy development and health governance. Political will together with coordinated action and resources are needed to advance the health promotion agenda and

implement the principles and strategies of the Ottawa Charter and subsequent declarations at regional and country level. Some EU countries have made significant strides in this respect, establishing dedicated health promotion functions and embracing a social determinants of health approach to population health improvement. For example, in Ireland a national infrastructure was established following publication of the Ottawa Charter (WHO, 1986), with the creation of a Health Promotion Policy Unit within the Ministry of Health and a health promotion service established across the regional health boards. A dedicated university academic centre was also established with support from the Ministry to provide the research, education and training base to support this new multidisciplinary area of practice. There are currently over 200 specialist health promotion posts, master's and PhD level programmes in health promotion, a national professional organisation with voluntary registration for practitioners, and a Ministerial post with specific responsibility for health promotion at government level. However, coordinated action and political leadership for health promotion have been lacking in many countries.

While the Ottawa Charter advocated an integrated multi-level approach to action, the emphasis on certain strategies over others in implementing health promotion has varied considerably. In many countries the focus has remained primarily on encouraging individuals to take responsibility for their own health by engaging in health behaviour change. This phenomenon of 'lifestyle drift' is often manifested in efforts to promote individual-based approaches for increased physical activity, dietary and other lifestyle changes. This contrasts with a more determinants of health approach with a focus on healthy public policy and government strategies to create more healthy environments for people, and encourage government and wider societal responsibility for population health.

In their review on progress in implementing the Ottawa Charter, Thompson et al. (2018) comment on the fact that in many countries health promotion policies and practices within schools, workplaces and communities, have focused mainly on discrete packaged interventions addressing specific elements within settings, rather than adopting a whole-organisational or settings approach that seeks to bring about change at the level of the whole system, which is clearly more difficult to achieve. A classic example is focusing on implementing strategies for stress management in the workplace, while failing to address the underlying causes of workplace stress through more organizational and policy level approaches. Coordinated intersectoral action is needed for the settings approach to fulfil its promise, however, in many countries the rhetoric of health promotion is not backed up by a commitment to action (Raphael, 2013a, 2013b). While health promotion may be viewed as everyone's business, there is a need for a dedicated and well-resourced cadre of health promotion workers to take this forward and to lead and support action across sectors.

Of all the actions outlined in the Ottawa Charter for Health Promotion, re-orienting the health services is identified as the one where progress on implementation has been most difficult (Wise and Nutbeam, 2007; Ziglio et al., 2011). The focus on health systems remains on curative care and treatment, with negligible budgets being allocated to health promotion actions. The redistribution of funding and resources to health promotion and primary prevention has not occurred in most countries. While health promotion was framed as an investment strategy, periods of economic recession and austerity in Europe have led to major cuts in health budgets, with areas such as health promotion and public health being hit the hardest. In the face of such challenges, there is a need for improved mechanisms for governance and sustainable funding at a regional and national level. Thompson et al. (2018) argue that governments need to take a long-term strategic approach to promoting population health, focusing not only on individuals but also on creating supportive environments. Significant challenges remain in implementing and integrating health promotion policy and practice as a core plank of modern health systems. Capacity needs to be strengthened for effective implementation within complex and changing policy and political environments and this calls for effective leadership, advocacy and technical expertise, combined with supportive implementation structures and delivery mechanisms and effective partnership working across sectors.

Utilising wider policy levers: progress in developing healthy public policy

An innovative aspect of the health promotion framework, as articulated in the Ottawa Charter (WHO, 1986), was the inclusion wider policy mechanisms to promote population health and wellbeing, extending the earlier focus on more traditional health education approaches. The implementation of healthy public policy can be seen most notably with the use of new policy mechanisms for tackling smoking as the major preventable cause of disease and mortality. As highlighted in a previous Opinion by the Expert Panel on Disruptive Innovations (EXPH, 2016), the use of legislation and regulatory frameworks for controlling tobacco use, heralded the use of innovative approaches for protecting and promoting population health and addressing the leading preventable causes of mortality and disease. The WHO Framework Convention on Tobacco Control (WHO FCTC, 2003), was the first international legal instrument for public health, asserting the responsibility and right of governments to protect public health and the right of all people to the highest standard of health. The WHO FCTC represented a paradigm shift in developing a global regulatory framework for implementing public health measures and introduced a suite of innovative strategies for addressing tobacco control including supply, demand and harm reduction strategies (WHO FCTC, 2003). Building on the scientific evidence on the harm caused by tobacco, the WHO FCTC addressed the global threat posed by transnational tobacco advertising, promotion and sponsorship, advocated measures to tackle illicit trade in tobacco, and supported the need for cooperative international action to address these

problems. The implementation of the treaty globally has had a significant impact on the public health landscape and has been followed up with the introduction of further legislative mechanisms at local, national and regional levels, including the protection of children and workers from tobacco related harm and the introduction of standardized packaging for tobacco products.

Through exemplifying how an international regulatory framework can be implemented in response to a global public health threat, i.e., the globalization of the tobacco epidemic, the WHO FCTC opened a new phase in global health policy and demonstrated the importance of global health governance. This approach has since been further developed through actions on health inequity and the social determinants of health (CSDH, 2008; Rio Political Declaration on Social Determinant of Health, 2011), the Political Declaration on the Prevention and Control of Non-communicable Diseases (United Nations, 2011b) and the WHO Global NCD Action Plan 2013-2020, which provided a menu of policy options and cross-sectoral actions for health equity, health gain and the reduction of premature mortality from non-communicable diseases.

The introduction of these new health promotion approaches signalled a transformational change in how population health is understood and the range of mechanisms and strategies that can be used to promote health and wellbeing and reduce health inequities. An integrated policy approach is now integral to effective action on health promotion, entailing multisectoral action across government, civic society and international organizations. The potential application of this approach is very broad, e.g., in relation to healthy public policy on food systems, alcohol use, improved housing, sustainable environment, the introduction of health taxes on the consumption of unhealthy products such as fat, sugar, sweetened drinks etc., thereby, utilising new entry points and innovative policy strategies for health promotion. However, political commitment to implementing such approaches has been far from guranteed and progress is slow in the face of implementation failures and opposition from vested interests. Chan (2014) highlighted the need for political will to address these challenges, in particular, the threat posed by health policies being distorted by commercial and vested interests. These include court challenges to governments who introduce measures to protect the health of their citizens, and efforts by industry to shape the public health policies that that affect their products.

In response, a new area of scholarship and advocacy has grown up, termed the commercial or corporate determinants of health (McKee & Stuckler, 2018). From its origins studying the tobacco industry, an activity facilitated by the release of vast quantities of industry documents following litigation in the USA, this has extended to other areas, including food, beverages, alcohol, exposure to toxic substances, and gambling. This has revealed that

these industries frequently use the same strategies, e.g., seeking to control the narrative about their products and public health responses to them. Thus, problems are portrayed as being "complex" and solutions as elusive. They also a focus on largely ineffective individual measures, such as education about harms, while undermining efforts to adopt policies that work, mostly involving action on price, availability, and marketing. They fund research that diverts attention away from policies that would harm their interests, while seeking to influence how research is interpreted, for example by undermining the precautionary principle and promoting standards for establishing harm that are impossible, in practice, to meet (Diethelm & McKee, 2009). Where possible, these industries seek to influence policy processes, for example by membership of policy bodies or technical committees, including the use of "revolving.doors", where they hold out offers of lucrative future employment to government officials. Often, this involves working through front organisations, many of whom refuse to disclose their funding. Increasingly, they combine their efforts (McCambridge et al, 2019). Given that the influence that they exert is often designed to be concealed, it can be challenging to detect it, although there is now a growing armoury of tools, including analysis of language, network analysis, and research on internal documents. There are also a growing number of resources, including libraries of these documents and websites revealing connections, such as https://www.tobaccotactics.org/. In the present context, however, the most important implication is the importance of complete transparency, linked to constant vigilance, for example to avoid some recent situations where public health bodies have engaged in collaborations with industry-funded organisations that, while portraying themselves as part of the solution, are promoting messages that resemble those of their funders (Maani Hessari et al., 2019).

3.2.1 Addressing the barriers and enablers to progress

A number of strategic initiatives have been supported at EU level to support the integration of health promotion within health and wider social care systems. Funding under the EU Health Programmes has led to the establishment of EU platforms and alliances and the development of Joint Action plans on issues such as healthy ageing, physical activity, mental health and well-being, health equity and chronic diseases among others. A Steering Group on Health Promotion, Disease Prevention and Management of Non- Communicable Diseases has been established by the Commission to support countries in reaching the SDG targets. Including representation from Member Stares, the Steering Group provides advice on developing and implementing health promotion actions and supporting the transfer and scale-up of best practices by EU countries. As part of this remit, knowledge resources for practitioners and policymakers have been developed including the online Best Practice Portal on health promotion, disease prevention and management of non-communciable disease (https://webgate.ec.europa.eu/dyna/bp-portal/) and the Health Promotion and Disease

Prevention Knowledge Gateway (https://ec.europa.eu/jrc/en/health-knowledge-gateway). The Steering Group has an important role to play in engaging with EU policy and funding mechanisms that could support the implementation of health promotion health systems in Member States. This includes opportunities to advance the implementation of policy recommendations relevant to health and health systems through the European Semester process, the recently published Country Specific Recommendations, and specific instruments within the next Multiannual Financial Framework (the Structural Reform Support Service, the European Social Fund +, and Horizon Europe), in order to assist Member States in maximising the benefits these instruments may bring to advance their national health priorities and strengthen the creation of health promoting health systems.

While some countries have made significant progress in advancing health promotion, the integration of health promotion within health systems has been very mixed across Member States. In view of the compelling rationale and arguments for health promotion, it is worth considering why a greater focus on health promotion is not more evident within European health systems, and why is there a consistent lack of progress in implementing comprehensive health promotion actions and what are the factors that are impeding real progress.

We will now examine possible reasons as to why current efforts have not been successful and seek to explore some of the main barriers to, and enablers of, progress in strengthening health promotion policy and programmes. For progress to be made, a more sophisticated understanding is needed of the barriers to progress as well as renewed efforts to address these barriers. This entails addressing current and past implementation failures and accelerating progress in integrating health promotion more effectively into health systems. For this to be achieved political commitment will need to be galvanised, with the creation of enabling structures and processes for the comprehensive and sustained implementation of health promotion policies and actions at EU and country level.

Current gaps and needs

Further progress is needed in implementing health promotion in Europe and while policies endorse the language and rhetoric of health promotion, this is rarely backed up with action. The Joint Action CHRODIS Plus report (Barnfield et al., 2018) highlights a number of key gaps and needs in health promotion systems in EU countries. A review of EU country reports identifies a lack of adequate funding and capacity for implementing health promotion and translating policy and evidence into action. Appropriate levels of funding for health promotion is identified as a key challenge across countries, as is the lack of strategic leadership, evaluation and research. The country reports also call for a greater focus on the social determinants of health to encourage a move away from the contested biomedical model of health. The development and implementation of structures and approaches in

countries to promote HiAP was also identified as representing a major step in the right direction.

Capacity building is identified as a means of addressing the limited resources, knowledge base, education and training, and leadership available for health promotion across EU member states. The report also draws attention to the importance of where and how health promotion is positioned within the health system and within the perspectives of governments. The report identifies improving the uptake of HiAP approaches, using the determinants of health as the basis for health policy, and partnership working across sectors as the best examples of working in a collaborative way for health across Europe. Support for capacity development for health promotion, including implementing good practices, intersectoral collaboration, better informed and sustainable investment in health promotion and primary prevention, is identified as an attainable goal that could lead to significant improvements in population health and wellbeing in Europe.

3.2.2 Critical reflection on the barriers and enablers for fostering health promoting health systems

In considering the barriers and enablers for strengthening the health promoting potential of health systems, it is important to reflect on the factors that may be critical in facilitating or blocking progress. Drawing on discussions by members of the Expert Panel and selected literature on policy change in population health and health promotion (Baker et al., 2018; Béland & Katapally, 2018; IUHPE, 2018; McGovern et al., 2014) we first consider the conceptual, political, policy and implementation challenges involved in strengthening health promotion and integrating its essential functions within current health systems. This is then followed by consideration of the enablers and systems requirements for comprehensive health promotion initiatives that can reorient current health systems.

Barriers to fostering health promoting health systems

Conceptual barriers:

- *Framing the concept of health promotion*

The terminology of health promotion is poorly understood both within the health sector and in society more generally. The concept of health promotion is often viewed as a contested one, with a plethora of related terms being used, such as the oxymoron of 'preventive health' or 'lifestyle medicine' being preferred by health sector personnel. As outlined earlier in this Opinion, the distinction between promotion and prevention is often blurred and there is a lack of understanding of where health promotion sits in relation to public health and health services more generally. From a policy perspective, this presents

as a challenge as clear framing of issues is required to justify resource allocation for the implementation of health promotion policies and programmes. The framing of health promotion is, therefore, strategically important from a policy and political perspective as there is a need to clearly articulate its essential functions and how it contributes to achieving the ultimate goal of health systems in improving population health and reducing health inequities.

- *Visibility of health promotion*

Health promotion has low visibility and there may be a low demand for health promotion among the general public, media and politicians. The health agenda is more likely to be dominated by a focus on illness, waiting lists, and hospital beds, and it may, therefore, be more difficult to mobilize a strong base of support among the public, interest groups and opinion leaders in shaping a health promoting agenda. As a result, health promotion becomes overshadowed by the immediacy of addressing the dominant illnesses (e.g. cancers and cardiovascular diseases) and health emergencies (pandemics, infectious diseases) that pre-occupy the public discourse on health. Health promotion requires a more long-term commitment and a longer range vision for embedding change at a wider societal and population level over time. Therefore, increasing the visibility of, and importance of, health promotion and sustaining interest in its implementation and longer-term development through the use of effective advocacy methods, emerges as a clear challenge in this context.

- *Ethics of health promotion*

Some health promotion strategies can be construed as being ethically problematic as they raise concerns about 'health imperialism' and the legitimacy of state interference in influencing and shaping individuals' choices regarding health behaviours. This is especially the case for strategies that are viewed as restricting personal and lifestyle choices (e.g. regulations and legislations regarding smoking, alcohol, diet, etc.). There is a view in liberal societies that lifestyle behaviour choices should be left to individuals. However, it is also understood that governments have a right and an obligation to protect the health of the public and therefore, may be justified in limiting people's autonomy when it infringes on other people's health e.g., banning drink driving, legislation on passive smoking. Strategies such as nudging and social marketing campaigns, while often framed as noncoercive and informational, have also been criticised for encroaching on individual's autonomy and as being coercive rather than enabling for those that are targeted, who may often be from low-income population groups (Gardner, 2014; Carter et al., 2011). Some social marketing campaigns have been found to involve manipulation of preferences and coercion, (in exposing people to

fear about new or unidentified risks, especially for those at low risk e.g., weight control of children and risk of obesity), leading to guilt and stigmatization for those involved (Carter et al., 2011). However, given the predominance of commercial marketing of harmful and unhealthy products in society, it could be argued that that social marketing campaigns conducted to promote public health are more 'counter-manipulative' as individuals are exposed to a lot of sophisticated marketing and branding that shape their behaviour and lifestyle choices from an early age. Health promotion policy measures that seek to address the commercial, social and environmental determinants of health behaviours need to 'make the healthy choice the easier choice' by creating more supportive environments for health and not opting only for strategies that target individual behaviour change. In this way, in keeping with the principles of health promotion, health promotion strategies will enhance and create greater autonomy regarding health rather than opt for more paternalistic and ethically questionable strategies.

Policy and political barriers:

- *Institutional norms and practices*

Health policy has predominantly focused on health care (illness treatment) rather than on health creation (promoting health and wellbeing), and this has resulted in a lack of emphasis on health promotion and prevention, despite recognition of their importance for health systems in maximising the greatest health gain at a population-wide level (Wanless, 2002, 2004). Existing decision-making systems and policy processes can either shape opportunities for, or create obstacles to, policy change. Theories of the policy process indicate that dominant belief systems and practices of policy-making institutions can act as a barrier to new ideas and new actors entering the policy space (Béland and Katapally, 2018). When policy is primarily oriented to hospitals and healthcare services, there is resistance to addressing more comprehensive approaches required to address the social determinants of health and the 'causes of the causes' of health problems (Baker et al., 2018). This results in a drift towards topic-specific and narrower behaviour-change initiatives with less of an appetite for more comprehensive inter-sectoral approaches, that are more complex and more difficult to coordinate and evaluate. In addition, dominant political ideologies may also influence which ideas and types of evidence are taken-up and which policies and programmes are prioritised for implementation.

- *The institutionalisation of a medical model of health*

The presence of a medicalised culture within health systems can also act as a powerful institutional barrier. The predominance of the biomedical paradigm and of the medical profession within health systems, reinforces a focus on the 'immediacy of illness' and on acute health care within the health services. This creates a cultural barrier as clinicians tend not to see health promotion as being part of their role and, therefore, its relevance is reduced. Health promotion may be seen as a less important practice and less worthy of investment when viewed in comparison with clinically focused health services. As a result, it becomes more difficult to align health promotion with existing health policy priorities focused on health crises, illness and curative services and health promotion can become side lined as a low priority issue for health policy and practice.

- *The competing role of vested interests*

As health promotion advocates for regulation of products and substances that are harmful to public health, this puts it in direct conflict with a number of powerful commercial interests, including the tobacco, alcohol, food and beverage industries. Addressing the commercial determinants of health is a politically charged activity and can prove quite challenging when securing support from political representatives and policymakers due to interference from hostile industries. In addition, health promotion strategies do not align with the powerful interests of the biomedical and pharma industry, and therefore, do not have access to the same level of resources when engaging in advocacy and lobbying for non-medical health improvement interventions.

- *Broad scope of health promotion and diffusion of responsibility*

Health promotion is a multidisciplinary area of practice that encompasses a number of disciplines (spanning the behavioural, medical, social and political sciences), and a broad range of actors working across different sectors and levels. Health promotion actions are primarily focused outside the health sector (e.g. in schools, communities, workplaces etc.) requiring coordinated actions across sectors within and outside government. This makes it a complex endeavour with a very broad scope. The implementation of health promotion requires policymakers to work across sectors and settings and at different levels (e.g., national, regional and local levels). This can result in a diffusion of responsibility and accountability across a range of stakeholders, as it is difficult to pinpoint who is responsible for such broad population health outcomes. This leads to a lack of institutional ownership of health promotion. The perceived complexity and broad scope of health promotion can result in shifting the focus away from health promotion policy when viewed against more established and streamlined acute care and curative health services.

- *Lack of institutional structures and processes*

As health promotion is not seen as being core to health systems and services, in many countries there is an absence of institutional structures to ensure its delivery and to sustain the issue on the policy and political agenda. Institutional structures with a clear health promotion mandate are needed, such as the establishment of new divisions within the existing government departments of health and health services (e.g. health promotion units and divisions), technical bodies that can provide expert input, mechanisms for local community input, and dedicated training and research infrastructures. These structures are critical for generating demands for action, providing leadership, advocating and supporting policy, formulating evidence and developing interventions, and building organizational capacity and workforce competencies for implementation in practice.

Comprehensive health promotion action calls for systematic processes of working intersectorally, including engaging high-level government actors and policymakers, and mobilizing public participation and wider community engagement. However, there is not an established tradition of working outside of the health sector within institutional health systems and cross-sectoral coordinating mechanisms and processes may not exist. At a policy level there is need for consultation, planning and decision-making processes that will facilitate effective intersectoral policies and programmes based on partnership working and collaboration across ministries, sectors and settings. As such, this involves a complex network of actors working in partnership and calls for policy-makers and practitioners that can bridge different policy and practice circles and lead to the establishment of cohesive mechanisms and processes for promoting and implementing cross-cutting health promotion policies and programmes.

- *Lack of implementation mechanisms and capacity development*

Mechanisms to ensure the implementation of health promotion are either lacking or poorly developed in many EU countries, especially when it comes to inter-sectoral actions. From a broader health systems perspective, health promotion remains under-developed and health promotion strategies have not been fully implemented or brought to scale in many countries. Where health promotion has been implemented, it remains fragmented with a tendency to focus on more discrete behavioural change interventions, rather than more comprehensive upstream approaches employing healthy public policies, which are more difficult and complex to implement. However, the implementation of a broader set of integrated cost-effective actions is recognised as being necessary to achieve better health outcomes (Morgan et al., 2014). Mechanisms for integrating cross-

sectoral actions are needed that can address the social determinants of health and health equity, and are critical to implementing a HiAP approach.

Making health promotion a reality requires the development of organisational capacity with technical expertise and competent practice skills to deliver effective action on the ground. Alongside policy champions and technical experts, this requires a trained workforce with the necessary skills in leadership, advocacy, partnership working, programme planning, implementation and evaluation, and effective communication and research skills. Local implementation mechanisms are crucial to support the delivery and mainstreaming of health promotion through existing health service structures and cross-sectoral coordination mechanisms.

- *Funding mechanisms and incentives*

A number of economic arguments that may help to explain the lack of investment in health promotion need mentioning. A first important one is that in many jurisdictions, health promotion does not have earmarked funding and health promotion activities are often not seen and safeguarded as entitlements, unlike curative interventions. Moreover, it is not always clear who is exactly responsible for promoting, funding, and implementing such activities, especially when these are intersectoral. This means that improved funding mechanisms, entitlements, and responsibilities may be a way forward, as we will explain later in this report. Health promotion may also be lower on the priority list in many countries, due to a number of important characteristics of many health promotion activities. We highlight a few. (Note that these may serve as *explanations* for why health promotion receives less priority than it deserves, but not as *justifications*).

Delayed rewards. People normally favour immediate positive and delayed negative consequences, which is called time preference, leading to discounting future events in decision making. For health promotion, the time between the investment and reward can be long. This diminishes the attractiveness of such investments, both at a governmental and individual level. One may, with Pigou (1920), argue that even though time preference may be relevant for individuals, the government '*should protect the interests of the future in some degree against the effects of our irrational discounting*…'. Indeed, one may observe in some other areas (like for pensions) that the government also tries to protect our future selves. Delayed rewards also imply that reducing expenditures on health promotion does not lead to immediate health losses, but to future ones. This may make reducing spending on health promotion relatively 'easy'.

Uncertainty. The effects of health promotion can be uncertain (also because of the delay and broader developments). This makes assessing the effectiveness of interventions challenging

(which may require modelling longer-term effects from shorter-term observed, intermediate effects). "Highest level evidence" obtained through RCTs may not always be feasible to collect. Concerns about the sustained effectiveness (e.g. maintaining lower weight after losing it) can add to the resulting uncertainty, as well as how to translate observed intermediate outcomes (weight loss) into relevant health outcomes (such as QALYs or DALYs). More uncertainty about the effects of an intervention can reduce the spending preparedness of policymakers. At an individual level the uncertainty about the health rewards are typically even larger and less easily observed. This can lead to reduced efforts in health promotion.

Necessity of intervention. People who are currently in poor health are typically seen as most 'in need' of treatment. The 'rule of rescue' can provide an example of this. In some countries, like the Netherlands, such necessity considerations play an explicit role in selecting interventions for reimbursement in the basic benefits package (Rappange and Brouwer, 2012). Health promotion is relatively often targeted at people who are not (yet) ill, which can lower the perceived necessity for intervention. Again, given that these people may present as future patients with high need, this raises the issue of whether perceived current need should be the leading concern in these matters, especially in prioritizing government intervention.

Own responsibility. Part of health promotion actions may be targeted at changing people's behaviours. People may consider some interventions (like increasing taxes or banning access to unhealthy products) as being paternalistic and interfering with individual (sovereign) choices. Moreover, in the context of collectively financed health care, people may feel that interventions designed for improving individuals' lifestyles should not be a collective but an individual responsibility (as long as people are not yet ill). Such sentiments may result in resistance to collective spending on health promotion. Moreover, they may lead to striking discrepancies in 'treating' people before and after they become ill and sometimes deny that addictions and behaviours can qualify as diseases themselves.

Intersectoral impacts. Health promotion can give rise to costs and benefits in different sectors. Moreover, health effects can occur due to actions in many different sectors (e.g. housing, education, road and food safety, etc.). This can complicate optimal decision making. For instance, when costs and benefits to some extent fall on other sectors/budgets, a decision maker may not (fully) take them into account. Moreover, decision-makers may not be held accountable (positively or negatively) for such external effects. Some interventions may indeed require action/initiation outside the health care sector, even though improved health outcomes may be the main objective. An example is increasing

taxation on particular products, which is not normally undertaken soley by a Ministry of Health. Another example are school-based programmes that may require additional efforts from the education sector.

Incentives. Many health care systems are targeted at treating people who are ill, not preventing people from becoming ill. Incentives for health care suppliers are often aligned with this, making investing in health promotion and prevention unattractive (as it might even reduce revenues/incomes). Other actors, such as health insurance companies, may also lack direct incentives to invest in health promotion, for instance, when insured individuals may switch to another insurer later. Moreover, in some countries (like The Netherlands) insurance companies cover individual care rather than collective health promotion. This can also lead to less clear entitlements regarding health promotion. This clarity may be further reduced both in terms of what is covered and may be expected, from whom coverage, delivery or initiation may be expected and for whom the interventions are intended. It also deserves noting that incentives for health promotion for actors like insurance companies may depend on issues such as the way in which enrollment is regulated and whether and how they are compensated for risk factors of those they insure (e.g. Kanters et al., 2013).

Seemingly, factors like the ones above, which allude to responsibility for financing, and the perceived importance of health promotion, affect the level of investment in health promotion and the failure to protect this low level of investment in times of economic crisis. This is the case, inspite of the evidence that health promotion can be highly cost-effective (McDaid, 2018). This knowledge does not sufficiently translate into policy action and therefore, further investment is needed.

3.2.3 Enablers for Health Promoting Health Systems

Next we consider what strategies are needed to strengthen health promotion within health systems. To address the barriers already outlined, we draw on the key systems requirements for health promotion that have been identified by the International Union for Health Promotion and Education (IUHPE, 2018). The IUHPE position paper (see Box 3) argues for leadership at the highest political level and intersectoral governance in adopting robust policies and action plans and ensuring that the necessary institutional capacity, funding and resources are made available for effective and sustained implementation of health promotion actions. Systems requirements are also outlined at the level of creating enabling implementation structures and delivery mechanisms. These include creating the necessary organizational capacity within the health system and beyond, partnership working

across sectors, technical expertise and the training and recruitment of a competent and skilled health promotion workforce. Each of these enablers will be addressed in turn.

Box 3 IUHPE Position Statement on the System Requirements for Health Promotion and the Primary Prevention of NCDs

1. In each country, establish a ministerial and head-of-state-level political commitment to health promotion, health equity and NCD prevention.

2. Develop transparent and robust national action plans to prevent non-communicable disease and address health inequity with clear accountabilities and specific objectives.

3. Allocate sustainable financing for programme implementation, research and evaluation for prevention and health promotion.

4. Strengthen or build dedicated health promotion institutions at national and sub-national levels.

5. Assure mechanisms for cross-sector collaboration and co-benefits.

6. Appoint high level health promotion leaders in the public service.

7. Build and strengthen health promotion workforce competency.

8. Implement comprehensive health promotion and prevention plans that emphasise policies and environment changes which address social, environmental and commercial determinants of health.

9. Partner with non-state actors and communities.

10. Invest in evidence generation, guidelines, evaluation and monitoring to ensure quality and accountability.

Source: Adapted from the IUHPE (2018)

- *Effective health promotion advocacy*

To address the conceptual barriers outlined earlier, there is a need for effective health promotion advocacy approaches that can communicate clearly the key purpose and role of health promotion, raise its visibility, and justify resource allocation and policy implementation. In essence, this means effectively promoting a better understanding of what health promotion is, and framing key health promotion messages for different policy, practice and public audiences. Advocacy has been defined by the WHO as " 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 WHO Health Promotion Glossary, WHO 1998c). While advocacy is recognized as a core competency for health promotion (Barry et al., 2012a), it is also an underutilized strategy. Shilton (2016) identifies different types of advocacy strategies; political, media, professional mobilization, community mobilization and advocacy from within organisations. Shilton argues that advocacy should be employed when the evidence for health promotion action

exceeds political commitment to action. Effective advocacy means understanding the existing health systems, the policy environment, and the wider health context and socio-political environment. Organized advocacy methods are critical for articulating clearly the core purpose of health promotion (what it is and why it is needed), and translating its key concepts, evidence and strategies into persuasive language that will convince key stakeholders and target audiences, thereby raising the profile of health promotion and creating a demand for action. In essence this involves effective message framing for different audiences to enable policy and systems change for advancing health promotion.

Shilton (2008, 2016) describes an advocacy model that has been applied across a range of health promotion areas in different countries. This model outlines six imperatives for success as follows:

- Evidence: what evidence is there to support your change and present it as urgent?
- Policy Fit: What are the key policies that are most relevant and how may these need to change?
- Solutions: What are the specific solutions or actions, e.g. a five point plan that can advance your issue?
- Partnerships/Coalitions: What agencies will you work with to advocate this issue?
- The Advocacy Strategy: What advocacy actions will help achieve change?
- Persuasive Communication: What persuasive messages best capture your issue? Translating the evidence through persuasive framing, adding qualitative elements such as perseverance, passion, creativity, personality and media savvy.

Political and policy requirements:

- *Establish high-level political commitment to health promotion*

Mobilising political commitment is key to addressing institutional barriers, as outlined earlier, to advancing health promotion at a policy and political level. Strategies for strengthening the position of health promotion need to be targeted at the highest level of government in order to deliver the changes needed in health policies, systems and environments and to bring a clear focus on the promotion of population health and health equity. Political commitment and leadership should ideally be at the level of head of state or equivalent, together with a dedicated Minister assigned responsibility for a health promotion portfolio, and a dedicated policy division for health promotion within the Department of Health. This is not the case currently in the majority of EU countries. In Ireland, for example, a Minister for Health Promotion is appointed within the Ministry of Health with a mandate to lead on the national Healthy Ireland framework for improved health and wellbeing (Department of Health, 2013).

Having such a position ensures commitment to health promotion within the political and policy system, and addresses the need for clear responsibility and accountability for delivering on health promotion at a national level.

- *Establish institutional structures and processes for health promotion*

A clear governance structure for health promotion is required in order to ensure delivery on priority strategies across different sectors and government departments. Institutional structures with a clear mandate for health promotion policy development, research and programme implementation are needed to strengthen health promotion at the national and regional levels. Dedicated institutions, such as health promotion institutes, foundations, government departments and service provision arms, need to be established and appropriately resourced at a country level. These structures are vital to providing national leadership in health promotion implementation and advancing the development of dedicated health promotion research and practice functions.

With regard to institutional processes, mechanisms for cross-sectoral collaboration are needed to address the social determinants of health and to implement a HiAP approach. This involves mechanisms for inter-governmental policy development, including health impact assessments of public policies and cross-sectoral decision-making and planning processes to ensure policy coherence. These mechanisms will be elaborated on later in respect of HiAP, but suffice to say at this point that they are critical for delivering on comprehensive health promotion actions and the goals of high-level international strategies such as NCD prevention and control and implementation of the SDGs.

Policy entrepreneurs and champions for health promotion are needed to successfully navigate the policy landscape and to shape opportunities for cross-sectoral policy change processes, engaging a broad spectrum of key actors and stakeholders. To counteract entrenched institutional and systemic barriers there is a need for policy entrepreneurs to work closely with existing stakeholders in population health – advocates, networks of researchers, policymakers, activists and NGOs - to promote specific health promoting policy solutions. A commitment to robust cross-sectoral policy and national action plans has been advocated by the UN Political Declaration on NCDs (United Nations, 2011b) among others, and is identified as a fundamental building block for developing national approaches to health promotion (IUHPE, 2018). The development of national action plans is crucial for ensuring implementation of priority actions, based on clear and specific objectives and specified accountabilities within the health system for promoting health and equity.

- *Develop capacity and strengthen delivery mechanisms for health promotion*

To ensure effective intervention delivery it is necessary to put in place mechanisms for quality implementation and health promotion capacity development. Infrastructures to support effective implementation are needed both within the health system and across sectors. In keeping with a HiAP approach, health promotion strategies need to be embedded across a range of sectors. This requires skilful coordination and effective partnership working where community members, health professionals, governmental and non-governmental agencies work together in promoting health and well-being. The delivery components include sustainable mechanisms for embedding health promotion practice into mainstream health and social service delivery and effective actions across a wide range of sectors such as education, employment, social protection, agriculture, transport, trade, urban planning etc. This entails investing in human, technical, financial and organisational resources needed to achieve priority actions and outcomes. Mainstreaming the delivery of health promotion within the health system calls for the development of organisational capacity to deliver on health promotion at the local level and a dedicated workforce with a clear mandate for action.

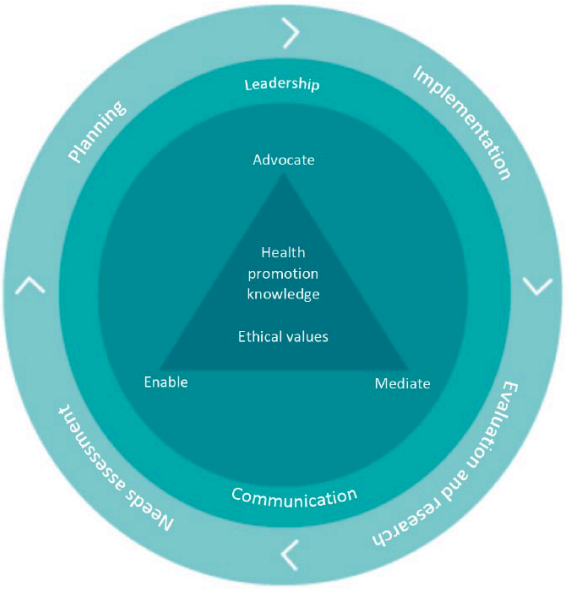
Capacity development is needed to enable practitioners to implement evidence-based interventions and engage successfully with the complex processes involved in intersectoral working. This can be supported by the provision of technical support, knowledge translation strategies and practice guidelines for effective implementation of feasible and sustainable interventions in the local context. A cadre of health promotion specialists are required, with the necessary training and competencies to implement effective programmes and policies and work with the wider workforce (other health professionals, teachers, community workers) to ensure sustainable action.

- *Develop workforce capacity*

A skilled and trained health promotion workforce with the necessary skill-mix and competencies to work at the levels of policy, population groups, communities and individuals is recognised as being critical to effective implementation. Intersectoral working calls for high-level expertise in order to engage and facilitate the participation of diverse sectors and mobilise and mediate diverse interests to deliver on effective health promotion interventions (Corbin et al., 2016). Workforce capacity needs to be developed to ensure health promotion practitioners are equipped with the required competencies to implement current knowledge, research and best practice in health promotion. Building the capacity of the workforce through education and training, including continuing professional development, is fundamental to advancing and sustaining health promotion action.

International developments lead by IUHPE have identified core competencies for health promotion (Allegrante et al., 2009; Barry et al., 2009). Building on this, the CompHP Core Competencies Framework for Health Promotion, which was based on an consensus-building development process funded by the EU Health Programme, provides a comprehensive framework for informing workforce development and training in health promotion in Europe (Barry et al., 2012a,b, 2013). As shown in Box 4 , this framework identifies 11 domains of core competency, each of which are elaborated on in further detail, and presents a common language and a shared understanding of what constitutes health promotion practice. Competencies are defined as " a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion" (Barry et al. 2012a, p. 64). These domains provide a solid basis for quality assurance of health promotion practice, education and training. This framework now also provides the basis for an international competency-based Accreditation System run by IUHPE, which accredits individual health promotion practitioners and postgraduate level educational programmes globally (Battel-Kirk et al., 2014). A core curriculum for postgraduate level training in health promotion, based on the CompHP core competencies, and earlier initiatives such as the European Masters in Health Promotion programme (EUMAHP) (Davies et al., 2000), have been implemented in a number of countries in Europe, and in Australia, Canada and New Zealand. Further investment is required in health promotion training and workforce development, including for specialists, generalists, managers and the wider health workforce.

Figure 2 CompHP Core Competencies Framework for Health Promotion



Source: Adapted from Barry et al., 2012b

Box 4 CompHP Core Competency Domains for Health Promotion

- **Ethical Values Underpinning Health Promotion Core Competencies**: Ethical values and principles for health promotion include a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups, and collaborative and consultative ways of working.
- **Knowledge Base Underpinning Health Promotion Core Competencies:** The core competencies require that a health promotion practitioner draws on a multidisciplinary knowledge base of the core concepts, principles, theory and research of health promotion and its application in practice.
- **Enable Change:** Enable individuals, groups, communities and organisations to build capacity for health promotion action to improve health and reduce health inequities.
- **Advocate for Health:** Advocate with, and on behalf, of individuals, communities and organisations to improve health and well-being and build capacity for health promotion action.
- **Mediate through Partnership:** Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion action.
- **Communication:** Communicate health promotion action effectively, using appropriate techniques and technologies for diverse audiences.
- **Leadership:** Contribute to the development of a shared vision and strategic direction for health promotion action.
- **Assessment:** 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.
- **Planning:** Develop measurable health promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders.
- **Implementation:** Implement effective and efficient, culturally sensitive, and ethical health promotion action in partnership with stakeholders.
- **Evaluation and Research:** Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of health promotion action.

Source: Adapted from Barry et al. (2012a,b)

- *Invest in health promotion research and evaluation*

Investment in research and evaluation is critical to building a strong evidence base for health promotion and ensuring that evidence is translated into policy and practice. Multidisciplinary research methods are needed for intervention research and evidence synthesis to support effective strategies for the promotion of population health and wellbeing. Epidemiological research is also required for monitoring population health status, including the positive indicators of mental and physical health and social wellbeing, in order to improve our understanding of the determinants of good health and changes in patterns among population groups across the social gradient and over time. Evaluation research on

the process, impacts, outcomes and costs of health promotion interventions is critical to ensuring the successful adoption of evidence-based interventions and their transferability across diverse socio-cultural contexts and settings. Innovative implementation and translational research is also needed to inform the scaling-up and sustainability of interventions especially in low-resource settings. The complexity and breadth of health promotion practice requires a wide spectrum of research methods including innovative interdisciplinary methods and systems methodologies that can capture the systemic impact of upstream and multilevel intervention approaches. Methodologies to undertake the systematic analysis and assessment of the health equity impact of policy making across sectors are also needed to support policymakers and health professionals in implementing and monitoring a HiAP approach.

The development of knowledge translation for health promotion is especially important to promote the more effective use of evidence in policy and practice. However, knowledge translation strategies have been relatively underdeveloped in the European region in comparison to countries such as Canada (for example, the Canadian Institutes of Health Research and the National Collaborating Centres for Public Health) and Australia (e.g. the Sax Institute).

- *Provide sustainable financing*

Health promotion activities require adequate funding. While some actors may be intrinsically (or extrinsically but non-financially) motivated to contribute to health promotion, in general adequate funding and payment mechanisms are required to ensure that desired health promotion activities are performed. This has several dimensions. First of all, the financing of health promotion needs to be adequate in terms of the overall amount of the budget. This requires the political will to increase the overall level of financing for health promotion. Second, the budget needs to be 'protected'. As highlighted above, the current budgets can be considered low but also vulnerable to further reductions in times of poor economic growth. Protection (e.g. through setting target levels or percentages of total expenditure or clearly earmarking the funding for health promotion) is, therefore, required. Third, the budget needs to be transformed into activities that optimally contribute to health and an equitable distribution of health. Fourth, the financing systems used need to reward quantity, quality and outcomes of health promotion activities. In other words, it is not sufficient to spend the money on health promotion, but the money needs to be well-spent. Without sustainable financing and incentives to spend the available resources optimally, the quest for more health promotion may fail.

3.3 Mechanisms for strengthening the implementation of health promotion within health systems

In this section we will consider what mechanisms are available to foster and strengthen health promotion within health policy and to ensure that health promotion is a central plank of health systems within the European region. We examine examples of health promotion structures, processes and mechanisms that have been implemented and present as feasible and viable options for fostering health promoting healthy systems in Europe.

3.3.1 Enabling policy structures and processes: Implementing a Health in All Policies approach

Mechanisms for strengthening the incorporation of the health consideration in policymaking across sectors (government departments) for better policy coherence

The ultimate aim of Health in All Policies (HiAP) approach is to promote coherent policy which enhances the health and well-being and equity of people. To achieve this aim, the work across sectors within the government needs to be systematic and sustainable. This will be realized only if there are 1) permanent structures which enable sectors to meet each other on a regular basis and 2) systematic process and mechanisms which make all sectors aware of other sectors' initiatives, policies and decisions in a way that allows for intervening early enough and proposing/negotiating the possible changes needed for these initiatives, policies and decisions.

HiAP is defined in the WHO Helsinki Statement on Health in All Policies (HiAP) as; "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful impacts in order to improve population health and health equity" (WHO, 2014a). In practice, HiAP is a way of working, not a project or programme. As an approach, it moves beyond the traditional definition of "health systems" by reaching all sectors of the government that typically are not "*mandated to improve, maintain or restore health*" (see WHO Regional Office for Europe, 2008).

The role of the health sector in implementing HiAP is crucial since it needs to advocate for HiAP and have the necessary competence to arrive at a good understanding of the objectives and policies of other sectors that are relevant to the health of the population. This competence and knowledge is needed also for prioritisation purposes. When resources are scarce, which is the case in many ministries of health, they need to be used effectively. This is the case especially if there is not a tradition of engaging in systematic work across sectors within the government and where the structures and processes are not yet in place.

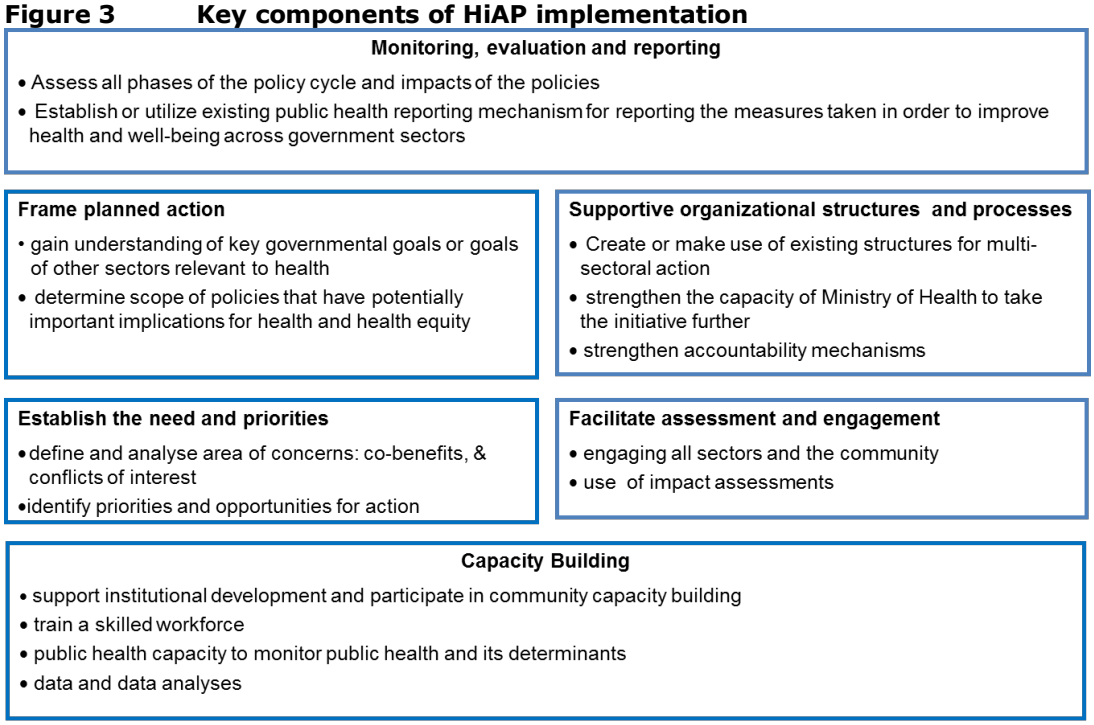
This section reviews the capacity and competence needed within health systems in order to implement HiAP. In addition, the structures and processes needed for the successful

implementation of HiAP are reviewed. These key components are based on the WHO Framework for Health and Health Equity across Sectors (WHO, 2015a). Examples and experiences from Finland and other countries are also presented (Ståhl, 2018; Government of South Australia & WHO, 2017).

Key elements for implementing Health in All Policies

The WHO Framework for Health and Health Equity across sectors (WHO, 2015a) was adopted by the World Health Assembly in 2016. It is based on the HiAP Framework for Country Action for Health and Health Equity developed by 8th Global Conference on Health Promotion held in Helsinki, Finland in 2013 (WHO, 2014a). This framework provides concrete guidance for building the necessary structures, processes and mechanisms for working across sectors (see Figure 3).

Figure 3 Key components of HiAP implementation



Source: Ståhl 2018, Based on Health in All Policies Framework for Country Action, WHO 2013

The framework is written from the health sector perspective, giving guidance for health professionals on what to do in order to implement HiAP. This can be seen especially in "frame planned action", "establish the need and priorities", "monitoring, evaluation and reporting" and "capacity building" components that emphasise the role of the health sector and the expertise required. For example, there is a need to have a comprehensive understanding of the goals and competence (and determination) of the government and other key sectors to analyse and prioritize key areas of concern when starting this work. While the role of the health sector is crucial in these HiAP implementation elements, the role

of other sectors is also significant in the structures, processes, assessment and engagement components that should be jointly implemented by all sectors.

If the principles of HiAP are understood, adopted and adapted by sectors other than health, they may start to work similarly. For example, in Finland the Ministry of Education and Culture (responsible for sport, exercise and physical activity) is advocating physical activity in all policies. Recently, the National Sports Council (expert body for the Ministry of Education and Culture) launched a report which considers from a ministry perspective; a) ministry's objectives in relation to physical activity, b) key activities for physical activity promotion, c) indicators that are used to follow the progress, d) estimation of the resources used for physical activity promotion, e) legislation in relation to physical activity, and f) future development areas. In total, eleven ministries and the Prime Minister's Office provided the necessary information (Finnish National Sports Council, 2019).

Next, the contents of "Frame planned action", "Establish the need and priorities", and "capacity building" components are reviewed, especially from the health sector perspective – what is expected from health sector and what kind of capacity and competence does it need to have in order to implement HiAP? Examples of "Organization structures and processes" and "Assessment and engagement tools" that enable HiAP are presented.

Capacity and competence needed in health sector for HiAP implementation

The health sector's role is important in initiating and advocating the implementation of HiAP. In order to implement HiAP, the health sector needs to have an understanding of the following:

1) the government's and other sectors' goals and their relevance to health and health equity
2) sectors and policies which matter for health, health systems functioning, health protection, health promotion and social determinants of health
3) which policy areas offer opportunities for change through public policies
4) what kind of distributional issues are relevant and how policies relate to the social distribution of health, tackling health inequalities and access to universal health care.

In order to get this understanding, the health sector needs to have: 1) a critical mass of capacities, expertise, and experts who will have the time, resources and sufficient knowledge of policies in other sectors to engage in a dialogue, 2) awareness of its own health priorities and how these fit with the priorities of other sectors, 3) awareness of where potential co-benefits (win-win situations) could be gained with other policies and where the possible conflicts of interest lie. This can best be done if both individual and institutional capacities and competences are available.

The experts need to have knowledge and skills for; a) analysing the implications of decisions, policies and initiatives from a legal and regulatory perspective, b) engaging with other sectors to raise attention to health issues and creating an understanding of the potential influence of the policies on health and health equity, and d) communicating the findings effectively to policymakers and community. Diplomacy, negotiation and communication skills are important in engaging with other sectors (WHO, 2015b).

Institutional capacities are needed for the systematic collection and analysis of health data and for policy analysis. There needs to be sufficient capacity that the health sector can provide assistance to other sectors when needed. The institutional capacity can lie, for example, in public health institutes.

Prioritization and establishment of needs

The need for HiAP can be established, for example, by raising awareness of the interconnectedness of health and health equity with social and economic development or building a case for action across sectors – demonstrating to other sectors the benefits of working with the health sector, and communicating the costs of inaction.

Due to limited resources that the health sector often has, the actions need to be prioritized. This can be done in relation to the significance of the issue for health or health equity, the alignment with government priorities, the existence of feasible and evidence-based solutions, the availability of resources, or those that are most amenable to intersectoral action.

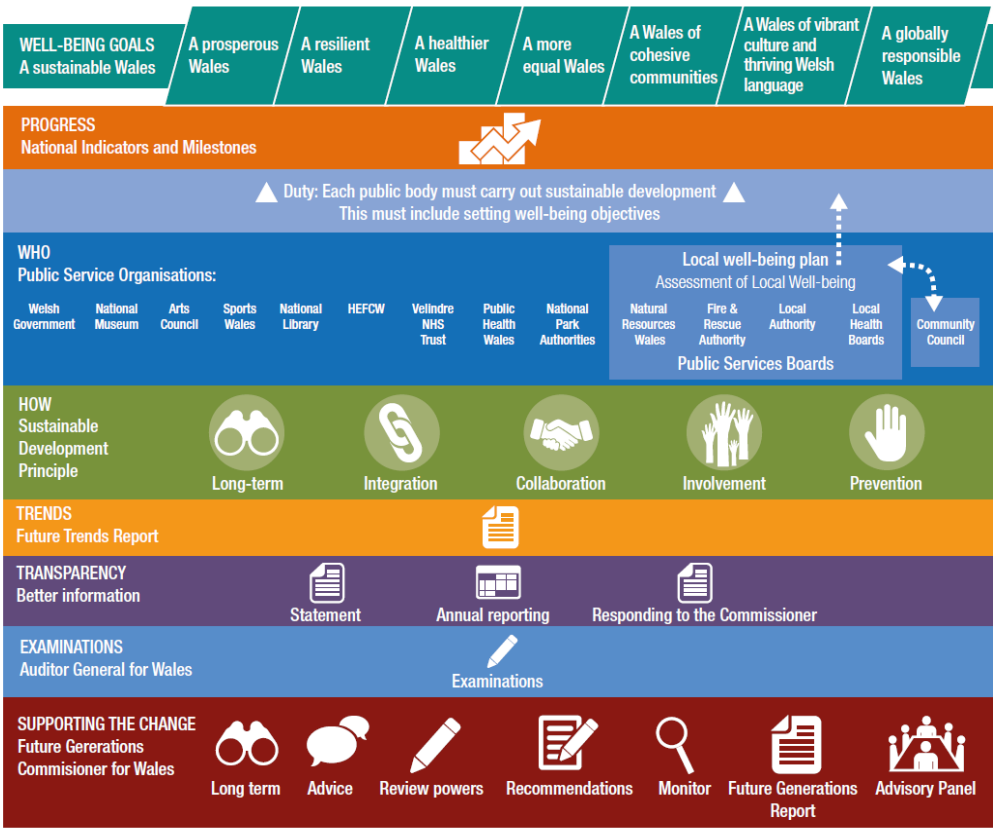
Structures that enable sustained work

To ensure that HiAP work is sustained, there needs to be permanent structures established which bring different sectors together on a regular basis. These collaborative arrangements can lead to a longer term view of tackling complexity and be resilient when other changes (in personnel or politics) take place. HiAP cannot solely rely on the interest of enthusiastic individuals in ministries. In Wales, the Well-being of Future Generations (Wales) Act gives a sound legislative framework for implementing HiAP both by defining 'health' and enabling an understanding and ownership towards tackling the determinants of health and wellbeing (Box 5).

Box 5 The Well-being of Future Generations Act (2015)

The Act provides an enabling framework to support public bodies in Wales to work coherently as described in the figure below. The public bodies need to work on achieving the well-being goals, and must use the sustainable development principle, the "five ways of working" to shape what they do, how they do it, and how it is communicated. Monitoring and accountability structures, for example an independent Future Generations Commissioner, as well as reporting requirements for tracking the progress are also built into the legislation. For more information, see Weatherup et al. (2017).

Figure 3. The Architecture of the Well-being of Future Generations Act



The first task is to review the existing structures. New structures should be established only if there are no applicable structures available. Sometimes, structures are available but they are not working well or the health sector is not represented in them. In those cases, the health sector needs to make sure that it will get representation and that health related issues are considered in those structures.

Intersectoral committees are a basic organisational structure for intersectoral action. These can be formed as; a) general committees within the administration for coordinating intersectoral issues as these relate to health or, b) with a more health-specific focus, such as nutrition, child health, or ageing, or c) as a specific and more multisectoral committee including representatives from nongovernmental and private sectors. For example, in Finland the National Nutrition Council is run by the Ministry of Agriculture and Forestry and has

members from all relevant ministries, NGOs, and the research community (Ståhl, 2018). In Iceland, there is a Ministerial Council on Public Health led by the Prime Minister. Other members of the Council are the Minister of Health, the Minister of Education and Culture and the Minister of Social Affairs and Housing plus representatives from their ministries. A Public Health Committee, which works under the authority of the Minister of Health, involves stakeholders from a wide range of sectors; sectors represented in the Ministerial Council, and representatives from unions, public health centres, universities and associations. (WHO, 2018b). In Austria, intersectoral working groups are formed around the 10 national health targets that were defined in a broad, participatory process involving stakeholders across government and civil society. The intersectoral groups are responsible for the implementation of the health targets. (Bundesministerium für Arbeit, Soziales, Gesundheit un Konsumentenschutz, 2019) There are many other examples available in the literature (see, e.g. McQueen et al., 2012; WHO, 2015a; Government of South Australia & WHO 2017; WHO, 2018b). In addition, the health sector also needs to be ready to d) engage with processes directed by other sectors and e) engage with broader-based intersectoral or multisectoral committee work that is not directed on the basis of health needs.

Processes and mechanisms for systematic work

It is not enough to have structures, as capacity and competence for HiAP is also required if the work is to be undertaken systematically. There needs to be mechanisms and processes that guarantee that sectors are aware of the initiatives, draft policies and decisions of other sectors. However, awareness is not enough and there needs to be processes in place that give access to, and the possibility to influence, the action under preparation.

Such processes are for example, formal consultation on legislation drafts, impact assessment of all legislative proposals (see Box 6), intersectoral preparation for, and the implementation of, the government programme (Government of South Australia and WHO, 2017; Ståhl, 2018; WHO, 2018b). In Finland, consultations on draft legislation, policies, and programmes are widely used and are a well-established practice in Finnish national policymaking. Consultations are not limited to ministries alone, but also with NGOs, trade unions, the research community, the private sector, and municipalities. Citizens can comment on the draft legislation through an online website available in Finnish or Swedish (Ståhl, 2018).

Box 6 Mandatory impact assessment of legislative proposals

In Finland, every legislative proposal by every ministry needs to include an assessment of the potential impacts of the legislation under consideration. There is a joint guideline by Ministry of Justice for all ministries to follow in order to conduct the prospective impact assessment. The guidelines set the procedures for the assessment and the impacts to be assessed (Ministry of Justice, 2008). Health impacts are considered within the social impacts.
In order to improve and ensure the quality of the impact assessment for the proposed legislation, the Legislation Assessment Council was appointed in December 2015. The council is an independent and impartial body attached to the Prime Minister's Office. The role and tasks of the council are defined in the decree ordered in 2015 (Ståhl, 2018).

Lessons learned

Implementation of HiAP is a challenging task that needs long-term commitment and vision. Public health capacity and expertise for advocacy are needed. It is important that data on health and health determinants and analyses of the links between health outcomes, health determinants and policies are available. Health literacy among the public, policymakers, media and civil servants in all sectors creates an understanding of the importance of health and health equity and builds that understanding so that it forms the foundation for a fair, safe and productive society. Intersectoral structures, processes and tools are needed for the identification of problems and solutions, decisions and implementation across sectors. These include parliamentary and/or intersectoral committees and working groups, hearings, impact assessments, public health reports etc. In many countries legislation enables and sets the backbone for sustained and systematic work across sectors for population health and health equity.

3.3.2 Health promoting health services

The Ottawa Charter emphasised the need to reorient health services toward promoting health, as part of a broad package of policies including healthy public policies. However, as outlined earlier, over 30 years later, it is widely acknowledged that progress has been limited. There is little evidence that health systems have reframed, repositioned or renewed their efforts to prioritize health promotion. A clear example is anti-tobacco policy, where there has been substantial progress in many countries in enacting policies tackling price, availability, and marketing, and especially the creation of 'smoke free' environments (Ziglio, Simpson, & Tsouros, 2011). Yet, far too few patients are even asked whether they smoke and even fewer are offered help to quit. Only a relatively short while ago, health authorities in the UK were proposing to install smoking rooms in new hospitals (McKee, Gilmore, & Novotny, 2003).

The goals of health systems include better health outcomes and delivery of services responsive to service user expectations, with universal access to care. In reality, however, at least half the world's population still do not have full coverage of essential services and this is almost certainly a factor in the weakness of health promoting aspects of health services. Recognition of the consequences of this problem stimulated the governments of the world to commit, at the United Nations General Assembly in 2015, to the Sustainable Development Goals (SDGs), within which they agreed to 'ensure healthy lives and promote well-being for all at all ages' in Goal 3, where the achievement of universal health coverage is recognized as a unifying platform to achieve progress. To that end, in goal 3.8, governments have also committed to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". More recently, the UHC2030, a movement that aims to strengthen health systems for universal health coverage, reformalised the UHC movement as a set of 6 key asks (UHC2030, n.d.), that include:

1) Ensuring political leadership beyond health
2) Leaving no one behind
3) Regulating and legislating
4) Upholding quality of care
5) Investing more and better
6) Moving together and harnessing key opportunities for multi-stakeholder engagement

The 16 other SDGs address a wide range of interdependent social determinants, many important for health, but it is important to recognize that a well-functioning health system not only ensures equitable and universal access to essential primary and preventive services but also advocates for better social and environmental conditions so as to enable people to increase control over, and to improve, their health. UHC should enable everyone to access services to address the most significant causes of disease and death, which should include the causes of the causes. While health promotion may not explicitly be included in universal healthcare packages, it has enormous potential to deliver both health and economic gains equitably, when provided alongside curative treatments, rehabilitation and palliative care. Strengthening health promoting health systems can, therefore, provide an opportunity to improve health and promote financial fairness (Wanless, 2002, 2004). In this way, it has a potentially transformative role to play in altering the economic, environmental, and social contexts that ultimately determine health and can help to deliver the key asks described above. As progress towards UHC progresses, it is also important to consider what is sustainable, especially for health systems with resource constraints. Where there is an excessive emphasis on tertiary level curative services, delivering increasingly expensive treatments, investment in health promotion can be an important means to promote not only equitable coverage of healthcare but also sustainability. Consequently, policy documents in countries like the UK, Sweden, Canada, and the Netherlands are now advocating greater

investment in and integration of health promotion as a means to achieve high-performing health systems (Wise & Nutbeam, 2007). Their experiences offer a valuable model for other less well-resourced health systems. These benefits may be further realised by new approaches to health promotion, that now involve the development of multilevel interventions that combine healthy environments, reoriented health services, and promotion of well-being and healthy choices based on community involvement, healthy public policies, and strengthening individual capacity to control the determinants of health (Edington, Schultz, Pitts, & Camilleri, 2016; Whitelaw et al., 2001). Health systems that prioritize locally determined actions across a range of social determinants and balance their investments in curative services with prevention and promotion, have greater potential to promote health equity (Gilson, Doherty, Loewenson, & Francis, 2007). This is because individuals at the greatest risk of ill health are often those living in poverty, who are homeless or in sub-standard accommodation, experience unsafe working conditions, and have insecurity of income and employment, while also having poor diets and being more likely to smoke. Yet these groups often have minimal access to curative and preventative healthcare (Dahlgren & Whitehead, 2007; WHO Regional Office for Europe, 2010). When implemented equitably, health promotion can, therefore, also help health systems to address poverty reduction as a fundamental determinant of health.

3.3.2.1 Re-orienting health services to health promotion

There are several reasons why progress in reorienting health services has been limited. Wise and Nutbeam (Wise & Nutbeam, 2007) suggest that these may include a historic tendency to overstate the contribution of tackling social determinants, in contrast to the minimal effort that has gone into highlighting the contribution that health systems can make. They also note how those working in tertiary services still dominate the policy dialogue on health systems and related areas, which tends to under-emphasise and reduce resources for promotion and prevention. Within tertiary services, interventions have also become more complex and costly, requiring health services to demonstrate both clinical and cost-effectiveness, an area that has perhaps been less effectively communicated for health promotion. There is also an issue of ownership, with the onus placed on those in the health promotion field rather than the entire health workforce to demonstrate a commitment to promoting health alongside their role in treating illness.

Reorganisation of health systems as vehicles to promote health requires a political commitment to reposition health promotion from the margins to the mainstream. This involves advocating for greater investment of resources, both financial and human by governments. In practice, this may mean diverting resources away from hospitals and instead into provision of community-based services, which is no easy task, given ageing

populations with increasing levels of multimorbidity that are accompanied by increased rates of costly emergency admissions. Confronting the challenges that this approach is likely to provoke, will involve reframing the existing discourse on the role of the social determinants of health, to avoid propagating the message that health systems themselves cannot contribute to health promotion, and instead advocating for and celebrating the evidence supporting the health benefits of health promotion initiatives. There is also a great need to improve engagement among health professionals working within the health sector to advocate for better resourcing of health promotion and prevention. Strategically, reorienting health systems to promote health rather than only treat disease must be accompanied by an intersectoral, whole systems approach, addressing the entire life course. Practically, it means providing the requisite resources to redress the balance between prevention and promotion on the one hand and curative services on the other. Operationally, there is a fundamental need to extend the mandate of 'multi-disciplinary teams' providing healthcare, to embrace intersectoral partnerships for promotion of health and prevention of disease. This might include, for example the education sector, where improved school retention rates can reduce skills inequalities in later life and improve health outcomes. Whilst these changes were alluded to in the Ottawa Charter, they have not, for the most part, been fully realized. It is, however, critical to note that the five action domains of health promotion in the Ottawa Charter are interdependent and should be interpreted on the assumption that a range of approaches are required, simultaneously to create supportive environments that enable people to better promote their health as well as educating people about healthy behaviours.

The Global Commission on Social Determinants of Health (CSDH, 2008) and the World Health Assembly (WHA) resolution (World Health Assembly, 2009) also emphasised that health systems are a vital determinant of health and an important area for action to improve health equity. Ziglio and colleagues (Ziglio et al., 2011) summarised the recommendations for health-system actions that evolved from this approach, which included:

- Building health systems based on principles of equity, disease prevention, and health promotion and ensuring that health system financing is equitable.
- Developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being.
- Building and strengthening the health workforce and expanding capabilities to act on the social determinants of health.
- Developing and implementing goals and strategies to improve public health with a focus on health inequities.
- Ensuring dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies and enhancing intersectoral action.

These recommendations are all centred on health promotion and reorientation of the health system, which is defined broadly, as described earlier, as including all the activities whose primary purpose is to promote, restore, or maintain health.

There are numerous examples of the effectiveness of lifestyle and environmental health promotion interventions in a wide range of contexts outside of the health system, including, for example, through Health-Promoting Schools and Healthy Cities initiatives (Buijs, 2009; WHO Regional Office for Europe, 2019). The success of such initiatives has also been important in the development of health promotion skills in other sectors, which could now be used to help health systems increase their contribution to tackling the social determinants of health. These might be directed, to improving, for example unhealthy living conditions and environments as well as reducing the drivers of unhealthy behaviours (NICE, 2007).

In many European countries, local governments play a considerable role in providing public health services, primary and community-based healthcare. The Verona Initiative (now known as the Investment for Health initiative), pioneered a strategic approach to investing for health and development. This begins with an initial appraisal of resource use to identify the critical issues determining health and wellbeing. This approach emphasises the importance of considering social and economic benefits at a societal level, rather than focussing on the health or environment sector alone and is an example of good practice in the pursuit of reorienting health systems (Bertinato, 2000; WHO Regional Office For Europe, 2002).

A second example is Programme MURA, from Slovenia, which is also based on the investment for health approach (Buzeti & Zakotnik, 2008). This programme aims to integrate health into regional development in the Pomurje region, prioritising improving healthy lifestyles, healthy food production and distribution, developing tourism products that are healthier, and reducing ecological burden, among other things. A related activity is the 'Let's Live Healthily' health promotion programme, which includes activities to promote healthy lifestyles among adults in rural communities but also extends to creating a consortium of fruit and vegetable producers to improve access to fresh fruit and vegetables in an effort to address both the causes of ill health and their underlying determinants within a single, integrated programme.

By distributing health improvement initiatives more equitably, we can improve the likelihood that people who access health services leave them with a greater sense of empowerment and the ability to self-care, protect, and promote their own health more effectively. There are many opportunities to achieve this, and it is important that health systems first 'get their own house in order' to better advocate, enable, and mediate for health. This means changes in policy, legislation, and other measures to ensure that environments are health-promoting both in the wider sense and within the health service itself.

Examples of these sorts of transitions are slowly beginning to take form in England for example, where the implementation of Sustainable Transformation Partnerships require local areas to demonstrate commitments to creating intersectoral partnerships dedicated to (among other things) improving the health and wellbeing of their populations, including through prevention. The housing sector is an obvious target (Buck & Gregory, 2018), given that housing is a critical determinant of health (Marmot, 2010) with around 10% of excess winter deaths deemed to be attributable to fuel poverty (Hills, 2012). An example of this is the Housing First Model, which aims to provide vulnerable individuals with suitable housing in an effort to minimise the impacts of poverty on health and social outcomes. This has more recently been implemented and tested in various projects in Australia (Wood et al., 2019), Canada, and the USA (Baxter, Tweed, Katikireddi & Thomson, 2019), where these initiatives have been associated with significant reductions in hospitalisations and use of emergency care.

Advances in knowledge, technology and pharmaceuticals have contributed to increased life expectancy over the last 40 years, but this has been accompanied by increasing numbers of people with multimorbidity and disability, posing challenges to those delivering effective and efficient care. Hospitals remain at the heart of the health system, receiving a disproportionate share of health budgets. Hospitals have traditionally been defined as organisations that provide 'beds, meals and constant nursing care' (Miller, 1997), but in reality are diverse and complex institutions that are often structurally and culturally resistant to the changes demanded of them. The contribution that health systems and hospitals can make to population health have been described previously (McKee, 1999), but much could be gained from extending this to include intersectoral policies to address health promotion and prevention.

Box 7 The Health Promoting Hospital initiative

The Health Promoting Hospital initiative (Health Promoting Hospitals; WHO Regional Office for Europe, 2007) is an example of how hospitals can effectively implement health promotion activities. This WHO-led initiative aims to change the culture of hospital care towards interdisciplinary working and transparent decision-making with active involvement of patients and partners; Now comprising an international network of about 600 hospitals and health services worldwide, this initiative has agreed a set of standards and indicators for health promotion, which can be used to inform an evaluation, which can ultimately contribute to the evidence base in this area. Based upon this model, future efforts can provide leadership into how to translate these findings into existing quality management systems to reframe norms and standards both at the local and the national levels. The Health Promoting Hospitals Network also includes an internationally validated data model, which can be used practically during clinical assessment to document the health promotion service needs of patients. The tool itself consists of 9 simple questions that cover the 5 main risk factors (smoking, risky drinking, overweight/obesity, malnutrition and physical inactivity). This tool is then supplemented with systematic recording of the health promotion services the patient has received. It is easy to use and understand and has been particularly successful in hospitals that also invest in the capacities required to implement it (Röthlin, Schmied and Dietscher, 2015). The Health Promoting Hospitals initiatives also aims to improve the ability of health workers to provide health promotion in hospital settings. This includes both increasing numbers of workers to enable a larger population (of patients, personnel and relatives) to access the service. They have also set standards to be used when monitoring implementation. This approach could also be diversified to influence professional practice in other facilities and with other social groups, while their comprehensive approach includes reducing environmental pollution through improved hospital waste management practices, increasing energy efficiency, reducing the environmental impact of travel to hospitals by staff and patients, and promoting consumption and production of healthy food and other commodities.(WHO Regional office for Europe, 2004; WHO Regional Office for Europe, 2011)

Box 8 Baby-Friendly Hospital Initiatives

A second example of initiatives delivered at the hospital level include the Baby-friendly Hospital initiative (World Health Organization, 2018), which was launched by WHO and UNICEF in 1991, following the Innocenti Declaration, which reinforced the importance and the role of breastfeeding in promoting a healthy start to life and improving later health outcomes. This initiative, which now involves more than 20,000 facilities in 152 countries aims to strengthen the role of maternity services to enable mothers to breastfeed babies. It also endeavours to improve the care of pregnant women, mothers and newborns health facilities providing maternity services by protecting, promoting and supporting breastfeeding. The initiative has measurable and proven impact, increasing the likelihood of babies being exclusively breastfed for the first six months. Baby-friendly Hospitals have been enabled through the provision of different tools and materials, developed and field tested specifically for this purpose and a range of appraisal and evaluation tools.

3.3.2.2 Health promotion services for older people

The aforementioned Sustainable Transformation Plans in the UK are an example of how top-down policy changes can support better integration between health and social care. This has never been more necessary than now in the face of ageing populations and unprecedented numbers of people with disability, frailty and dementia. As health services struggle to provide an acceptable level of care within predominantly acute settings, social services are also at risk of being overwhelmed. The failure of both sectors to collaborate effectively, both financially and operationally has contributed to increased rates of loneliness, falls and emergency admissions in the elderly, with the result being that neither individuals nor health or social services can cope. There are numerous initiatives (British Geriatrics Society, 2014; British Geriatrics Society & Royal College of General Practitioners, 2016) that have been designed to counteract this issue, including frailty units in hospitals, which aim to minimise the well-documented detrimental effects of hospitalisation on individuals with cognitive impairment. These units and allied comprehensive geriatric assessments by community geriatricians aim to facilitate early assessment of people's social care needs, ideally before the first admission (which often tips patients into a spiral of ill health (Clegg et al., 2013), so that they can receive early integrated health and social services in the community to enable older people to age well and also to prevent further decline. Although there is little literature on existing innovations within nursing homes and long-term care facilities in the health systems literature, novel examples exist in several parts of Europe, include the design and development of elderly care villages. For example, Hogewey (Godwin, 2015; Hogeweyk, n.d.), which lies on the outskirts of Amsterdam is locally known as 'Dementia Village'; a cutting-edge elderly care facility where residents benefit from environmental adaptations that allow them to live apparently normal lives, without the constraints presented by the

environment in conventional communities. Like any normal town, Hogewey is equipped with its own town square, theatre, garden, and post office. The notable differences are that it also has cameras, which monitor patients at all hours of the day, with non-uniformed caretakers and a well-designed security system. Hogewey residents are reported to require fewer medications, eat better, live longer, enjoy greater independence and appear happier than those in standard elderly-care facilities. There are similar examples of 'pensioner villages' in Spain, including Pescueza (BBC News, n.d.), a collaboration between the voluntary and private sectors equipped with railings in its streets to support the mobility of its residents, preventing falls and promoting independence. These examples have yet to gain traction as publicly run initiatives and are a promising model from which to enhance the existing Healthy Cities initiatives.

3.3.2.3 Integrating health promotion within acute health care services

Acknowledging the difficulties faced by health systems in implementing health promotion policies within the constraints of clinical practice (Keyworth et al., 2018; Lowson et al., 2015), the Making Every Contact Count (MECC) campaign is a National Health Service policy in England that aims to opportunistically encourage individuals to make behavioural changes like stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption through contacts inside and outside the health service. Based on recognised behaviour change theory (Michie, van Stralen, & West, 2011), MECC utilises the opportunities provided by day-to-day interactions that healthcare workers and organisations, such as fire, police and housing services have with other people to encourage changes in behaviour and direct them to local services that can support them. MECC has been developed with a diverse range of partner organisations, including local authorities, Public Health England, the Royal Society for Public Health, the Care Quality Commission and NICE. Through these collaborations, MECC is expected to have a positive impact on the health and wellbeing of individuals, communities and populations. The policy has now been written into the standard NHS contract for commissioning and health service delivery, which now requires healthcare providers to develop and maintain an organisational plan to deliver MECC activities. As a minimum standard, all healthcare professionals in direct contact with patients are encouraged to "raise awareness, motivate and signpost people to help them improve their health and wellbeing" (Public Health England, 2016). Evaluations of the programme based on qualitative interviews show that key stakeholders are engaged and supportive and welcome the opportunity to fill a recognised gap in public health knowledge in the health and allied workforce and the impetus to create essential cross-sector partnerships (Nelson et al., 2013). There is, however, considerable disparity in the take-up of the initiative in different organisations, with cultural resistance cited more frequently within the health service. The numbers also support this (Keyworth et al., 2018) and show

that among 1,387 health professionals, only 31.4% had heard of the MECC policy. Nonetheless, in at least half of their consultations, they felt that there was a need for opportunistic behaviour change interventions, but reported that only half of those who might benefit actually received them. This suggests that there is great potential to overcome the barriers presented by the health system itself, in which there appears to be a disconnect between perceived need and delivery, which might be improved through greater awareness and collaboration with established MECC programmes and a more effective use of existing resources.

3.3.2.4 Health promotion education and training for health professionals

As outlined above, a wide range of health professionals, alongside health promotion specialists, have a key role to play in promoting population health and wellbeing. This includes; nurses, medical doctors, psychologists, community pharmacists, occupational therapists, speech and language therapists, physiotherapists, together with social care and community workers, among others. In 1988, in the Edinburgh Declaration (World Federation for Medical Education, 1988), the World Federation of Medical Education published a set of recommendations for reform of medical education, one of which was to 'complement instruction about the management of patients with increased emphasis on promotion of health and prevention of disease'. A recent review has assessed progress since then (Hays, 2018). It found limited evidence of change in undergraduate training, except that health promotion now featured in the standards for medical graduates set out by some professional regulators. It found more progress in postgraduate training, especially in primary care. A literature review, conducted as part of the study, found little evidence that the inclusion of health promotion impacted on graduate outcomes or subsequent medical practice, although it did suggest that those who had been introduced to health promotion concepts may have gone on to play a role in advocacy and other public health strategies. Finally, it questioned whether earlier changes had gone as far as they were likely to, as the discourse on population-based practice had moved on to concepts like global and planetary health.

In view of the important health promoting role of health professionals, health promotion should be included in the core curriculum of training for health professionals in Europe, both at undergraduate and postgraduate level, ideally with a greater focus on interprofessional learning.

3.3.3 Strengthening health promotion within primary care

The role of health promotion within primary care is well established, dating back to the Alma Ata Declaration (WHO, 1978) where the importance of engaging in health promotion in order to build strong Primary Health Care (PHC) was clearly stated: "The *promotion* and protection

of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace". The declaration also formulated the broader societal ambition of 'better quality of life and world peace' on the forefront, indicating that health promotion should put its aspirations in a broader context. In 2008, the Commission on Social Determinants of Health, in its final report : "Closing the gap in a generation" (CSDH, 2008) emphasized the need to "build health-care systems based on principles of equity, disease prevention and *health promotion* and health care services with universal coverage focusing on PHC" (p. 12). In the same year the World Health Report: "Primary Health Care: Now more than ever" (WHO, 2008), WHO operationalized the importance of health promotion in providing person-centered primary care. In order to understand what matters to people, "simply asking patients how they feel about their illness, how it affects their lives, rather than focusing only on the disease, results in measurably increased trust and compliance that allows patient and provider to find a common ground on clinical management, and facilitates the integration of prevention and *health promotion* in the therapeutic response". Here WHO makes clear that health promotion is an integrated part of good patient care: " A comprehensive spectrum of care maximizes opportunities for preventive care and *health promotion* while reducing unnecessary reliance on specialized or hospital care" (WHO, 2008). The 2008 World Health Report suggests organizing Primary Care Networks, that offer services including prevention and *promotion* as well as efforts to tackle determinants of ill-health locally. A direct and enduring relationship between the provider and the people in the community served is essential to be able to take into account the personal and social context of patients and their families". On 25 October 2018, the Declaration of the Global Conference on PHC in Astana (WHO, 2018c) explicitly referenced health promotion twice: " We can no longer underemphasize the crucial importance of *health promotion* and disease prevention, nor tolerate fragmented, unsafe or poor-quality care" and "We will prioritize disease prevention and *health promotion* and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care". This emphasis is also reflected in the UN Political Declaration on Universal Health Coverage (United Nations, 2019) where health promotion is identified as a critical component of UHC's goal of ensuring that all human beings can have healthy lives and can maximise their health potential. Finally, in the Opinion: "Definition of a frame of reference in relation to Primary Care with a special emphasis on Financing Systems and Referral Systems" (EXPH, 2014) EXPH emphasizes that: "*Primary care is the first level of a health system where people present their health problems and where the majority of the population's curative health needs, health promotion and preventive health needs are satisfied. Effective primary care not only prevents diseases at early stages, but also stimulates people to take up healthier behaviours*".

3.3.3.1 The contribution of primary care to improving health literacy

Health literacy is a critical determinant of health, which can empower individuals and lead to engagement in health promotion, disease prevention and the management of illness (WHO, 2016a; Sørensen et al., 2015). The promotion of health literacy is also recognized as a key action in in reducing health inequalities as low health literacy tends to be concentrated among people with poor health status, high healthcare use, low socio-economic status, lower education and older people (HLS-EU Consortium, 2012). Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services (Institute of Medicine, 2004). More recent definitions have broadened the concept of health literacy as being "linked to literacy and entails peoples' knowledge, motivation and competencies to access, understand, appraise, and apply health information in order to make judgements and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course" (Sørensen et al., 2012). The wide range of skills that comprise health literacy and influence a patient's ability to navigate the health care system and make appropriate decisions about his or her health include writing, reading, numeracy, communication, and, increasingly, the use of electronic technology (Kutner, 2006). Available European data for 18 countries shows that in two-thirds of these countries more than half of individuals have poor levels of health literacy (OECD, 2018). Limited health literacy has a huge impact on health system utilization, personal health care and health outcomes, as summarized in Table 2 (Hersh, Salzman and Snyderman, 2015).

Table 2 Impact of limited health literacy

Implications	*Research findings*
Health system utilization	
Access to care	Mixed results for association with number of physician visits
Access to insurance	Low parental health literacy associated with no health insurance for children
Emergency care and hospitalization	Increased use of emergency care, increased hospitalization rates
Health care costs	Studies have mixed results regarding differences in costs of health care by health literacy level
Personal health care	
Adherence to care recommendations	Studies have mixed results depending on adherence measure and disease state
Adherence to healthy lifestyle	Studies have mixed results
Interpreting health information	Difficulty understanding nutrition labels or a standard appointment slip
Medication use	Difficulty identifying medications, interpreting dosing, and administering medications correctly; higher risk of misunderstanding medication labels/directions
Preventive services	Decreased rates of mammography, influenza vaccination, and screening for cervical and colon cancers
Health outcomes	
Chronic disease outcomes	Studies have mixed results for chronic disease in general and for specific chronic diseases
Health status	Lower overall health status among older adults
Mental health outcomes	Higher rates of depression
Mortality	Higher mortality rates in older adults

Source: Adapted from Hersh et al., 2015

Services delivered in primary care have great potential to improve the health literacy skills of patients, and the way health care services are being provided and communicated. Primary care providers and practices can enhance health literacy by investing in action geared towards: 1) the organisational level of primary care, 2) the accessibility of primary care for all levels of health literacy, 3) health information provision, and 4) communication and shared decision-making (Heijmans et al., 2016).

Creating health literate primary care organisations

'Health literate' health organisations target both the individual and the practice environment through a user-friendly design, making it easy for people to navigate their way through the delivery of services and to understand and apply the health information received (Brach et al., 2012). The American Institute of Medicine identified ten key attributes for establishing health literate organisations (Brach et al., 2012). Each attribute is found of particular importance to primary care (see Box 9).

Box 9 Ten preconditions for health care literate organisation

1. Make health literacy integral to the mission, structure and operations of primary care.
2. Health literacy is fully integrated into planning, implementation and monitoring.
3. A competent, health literacy-promoting primary care workforce
4. Populations served are included in the design, implementation and evaluation of health information and services.
5. Services and information are accessible to a wide range of health literacy levels while also avoiding stigmatization
6. Health literacy strategies are used in interpersonal communications and to confirm understanding at all points of contact.
7. Health and service information is made easily accessible to help patients navigate the system.
8. Invest in the design and dissemination of information (print, audio-visual, and social media content).
9. Address health literacy in high-risk situations, including care transitions and communication about medicines.
10. Clearly communicate what services are covered and what people are expected to pay.

Source: Adapted from Brach et al. (2012)

Acting upon these attributes in practice demands changes at every level of the health system and the wide engagement of actors, including in particular facility management, practitioners and the target population.

Ensuring the accessibility of information in primary care for all levels of health literacy

Ensuring the accessibility of information in primary care ranges from the signage in facilities and print resources provided, to information available by phone or on a practice website, and a patient's medication and treatment plan. In primary care, attention should be given at a minimum to three key considerations: information needs and health literacy levels of target populations; accessibility of service laws or regulations; and accessible facility-specific information. In working to improve access to health information on primary care services to the population-at-large and priority population groups, key considerations signalled in reviews include the following (Heijmans et al., 2016):

- create support within the entire organisation;
- conduct an information needs assessment of the target population;
- involve the target group in the development and evaluation of content; and
- ensure regulatory and procedural material is transparent, simplified and supported by opportunities to ask questions to make information accessible.

Provide understandable health information in a transparent way

Services delivery is information-intensive. It involves written information provided to or by patients, tests that may be paper-based or electronic, discussions that may take place in practices, by phone or videoconferencing. There are a number techniques and approaches available to improve the reach of information to a wide range of health literacy levels. These includes for example developing dedicated public websites (Mammarosa, 2019); using technologies for translation and editing (SkritSwap, 2019); accessing personalized patient portals (WHO Regional Office for Europe, 2016); or by applying visual (language independent) resources (drawings, images, videos).

Enhance communication and shared decision-making through provider education and use of shared decision-making tools

Patients with low health literacy levels more frequently have difficulty in communicating with their health care providers (Wynia and Osborn, 2010) and can face barriers to participation in shared decision-making, which exacerbates disparities in decision quality (Grabinski et al., 2018; Brabers et al., 2017). There are a number of strategies to adapt communication styles to health literacy levels and activate patients to participate in decision-making. It is important that primary care providers are made aware of communication techniques and are culturally competent (ethno-sensitivity) (Sorensen et al., 2017). It should be part of the curriculum of medical training to train primary care providers to communicate by gaining attention, providing clear and memorable explanations (Hong et al., 2013). Providers need to apply a 'universal precautions approach' that entails the use of plain language to all patients, while using tools or techniques to test comprehension of information and identify the need for additional information (Koh et al., 2013). An example of such a technique is the 'teach-back' approach that works by combining health literacy principles of plain language and asking patients to explain in their own words the information they were given (Teach-back Toolkit, 2019). The knowledge and motivation level of patients to participate in consultations and decision-making should determine the communication techniques used by providers. This requires active listening and an explicit discussion on the preferred level and method of shared decision-making. Various decision aids have been developed to help health professionals support patients in understanding complex information and the corresponding treatment options, adapted to different health literacy levels 14-17 (Li et al., 2013; Barton et al., 2016; Holmes-Rovner et al., 1996) (e.g. the Ottawa Personal Decision Guide; the SHARE Approach of the Agency for Healthcare Research and Quality; and tools developed by the Mayo Clinic Shared Decision Making National Research Centre) (The Ottawa Hospital, 2018; Agency for Healthcare Research and Quality, 2014; Mayo Clinic, 2018).

3.3.3.2 Health promotion related to life-style interventions in primary care

A variety of health promotion interventions in primary care settings have been advocated for in the literature. However, the findings from systematic reviews challenge the impact of these general approaches. A systematic review on lifestyle counselling interventions (with regard to cardio-vascular risk factors) delivered by primary care providers in primary care settings to patients at low risk (primary prevention) appeared to be of marginal benefit. The authors conclude that resources and time in primary care might be better spent on patients at higher risk of cardiovascular disease, such as those with existing heart disease or diabetes (Fleming and Godwin, 2008). An overview of systematic reviews on the clinical impact in different settings of lifestyle interventions for the prevention of diabetes (mostly focusing on diet and physical activity), concluded that relatively long-duration lifestyle interventions can limit or delay progression to diabetes under trial conditions. However, outcomes from more time-limited interventions, and those applied in routine clinical settings, appear more variable, in keeping with the findings of recent pragmatic trials. There is little evidence of intervention impact on vascular outcomes or mortality endpoints in any context. 'Real-world' implementation of lifestyle interventions for diabetes prevention may be expected to lead to modest outcomes (Howells et al., 2016). In a quasi-experimental study in real world, a life-style team was introduced in multi-professional primary care centers in Sweden, in order to facilitate healthy lifestyle promotion. Intervention centers did not show higher rates than control centers on reach of patients or adoption among staff. All intervention centers struggled to implement working referral structures for lifestyle promotion. However, intervention centers were more positive on effectiveness outcomes, attitudes and competency among staff (Thomas et al., 2015). In efforts to increase evidence-based practice and lighten the burden of clinicians in primary care, decision and policymakers are introducing digital tools for healthy lifestyles. As outlined in the Opinion of the Expert Panel on Assessing the Impact of Digital Transformation of Health Services (EXPH, 2018), while some digital health services may have the potential to strengthen health promotion and reduce health inequities for hard-to-reach groups, others such as mobile and eHealth technologies may result in a further widening of the gap in health outcomes due to varying technical and literacy skills between different socio-economic and socio-demographic groups. It will, therefore, be important to explicitly define the role of digital health literacy tools as complements to face-to-face encounters in order to contribute to maintaining meaningfulness in the patient-clinician encounter, when digital tools are added to facilitate patient behaviour change of unhealthy lifestyle behaviours (Berman et al., 2018).

In conclusion, there is actually not much evidence for advocating the implementation of health promotion lifestyle interventions in primary care practices, certainly not for patients at low risk. Also the introduction of specific lifestyle teams in primary care does not seem to help. The place of digital tools for health promotion in primary care has to be assessed

carefully. For sustainable changes in population health, however, there is a need to move beyond a focus on individual lifestyles to also address the broader factors that shape people's lives and determine their health.

3.3.3.3 Community Oriented Primary Care (COPC): an integrated approach to health promotion and the social determinants of health in Primary Care

The findings from a realist review on taking action on the social determinants of health in clinical practice, advocates, amongst other approaches, for the implementation of Community-Oriented Primary Care (COPC) as an approach that integrates health promotion strategies in tackling the social determinants of health (Andermann et al., 2016):
"*Community-Oriented Primary Care is defined as the systematic assessment of health care needs in a practice population, identification of community health problems, implementation of systematic interventions involving target population (e.g. modification of practice procedures, improvement of living conditions) and monitoring the effect of changes to ensure that health services are improved and congruent with community needs. Community-Oriented Primary Care teams design specific interventions to address priority health problems. The team, consisting of primary care workers and community members, assesses resources and develops strategic plans to deal with problems that have been identified. Community-Oriented Primary Care integrates individual and population-based care, blending clinical skills of practitioners with epidemiology, preventive medicine, and health promotion, minimizing the separation between public health and individual health care*" (Rhyne et al., 1998).

The importance of the community one lives in for health and well-being has been acknowledged since Hippocrates (5th century BCE). In the 20th century, various initiatives started working with communities using health promotion to improve health. Samuel and Emily Kark were the first to design a structured model which they implemented in the 1930s and 40s in a rural South African setting (the Pholela Health Centre). Their approach started from a health center which takes responsibility for a given area. To guide their actions, they laid the emphasis on data-gathering and community research. This approach proved successful to address nutritional deficits and infectious diseases. The model spread to other parts of the world, mainly documented in the United States of America (Dobbie et al., 2006). The method can provide tools to approach problems encountered by healthcare workers in the community but that only can be addressed on a higher level than the individual patient-healthcare worker contact. There seems to be no widespread implementation of the strategy since the first account in 1952 (Kark, 1952), but when COPC is used as a broader label to describe all efforts by healthcare teams working "in and with" the community, many more examples can be given (Iliffe and Lenihan, 2003).

The primary care practice is considered by many as the "pivotal element" in any COPC process. A COPC team consists of a varying group of primary care health/welfare workers and community members. The first step is to define the community on which the efforts will be focused. The community can be the population of a certain area (neighborhood, city, school, district), the patient list of a practice, or a cultural group. Secondly, the community's health problems need to be identified. A combination of primary care knowledge and accessible public health data and socioeconomic and demographic data present a comprehensive image of the health needs of a community. The list of problems a community faces, along with its strengths, defines the "community diagnosis". According to the available resources and priorities, an intervention strategy can be developed. Essential to any process is a thorough cost-utility analysis: is the intervention worth the effort? Therefore the last principal element in any COPC cycle is evaluating the impact of the intervention, allowing the COPC team to adjust. Whether dealing with substance abuse in an inner-city neighborhood, or with inter-sectoral HIV/AIDS approach in a rural area, the seventy year old principles of COPC strategy are the same, even though practical implementation, methods and context may vary widely (Gaede, 2005).

A related practice to COPC is the use of social prescribing, which operates alongside traditional treatments in primary care and provides practitioners with a non-medical referral option to community services and programmes. Social prescribing recognises the social, economic and environmental determinants of people’s health and the need for a holistic approach to health care that empowers service users to be more in control of their health and wellbeing. It may involve practical advice and linking a person to a number of community resources and activities (such as gardening groups, befriending programmes, sports activities, art programmes, education etc.) that can assist with social issues such as poverty and abuse, as well as programmes that are health promoting such as parenting and exercise programmes. People who may benefit from social prescribing include those who are socially isolated and/or have mental health problems, as well as socio-economically disadvantaged groups (Bickerdike et al., 2017). While the evidence base on the effectiveness of social prescribing on improving health and wellbeing is still in its infancy, with a recent systematic review highlighting that most of the existing evidence is of low-quality (Bickerdiek et al., 2017), promising evidence is emerging and social prescribing is being implemented in primary care settings in countries such as the UK and Ireland.

Box 10 COPC at Work: Two Practice Examples from Belgium

The Belgian primary care system is characterised by a single-handed fee for service practices. Recently, more primary care physicians have formed group practices, sometimes multidisciplinary teams and Community Health Centres, gradually creating a more COPC-friendly environment. The Community Health Centers (CHC) in Ghent have tried for many years to implement aspects of COPC in their activities, with a special emphasis on health promotion.

The CHC "Nieuw Gent" (www.wgcnieuwgent.be) started in 2000. An interprofessional team delivers integrated primary care and social care for 4300 patients in a deprived neighbourhood that is characterised by social inequalities in health. These inequalities stimulated the team to explore the health needs and the social determinants of health in the community. Health needs assessment documented a high prevalence of locomotor problems (e.g. low back pain), chronic conditions (e.g. obesity, sleeping disorders), and higher cardiovascular risk factors for those at a younger age (such as smoking, hypertension, diabetes, and others related to lifestyle). Interviews with the patients and the population revealed the need for accessible physical activity, the lack of spaces for meeting each other and the lack of green spaces. These data informed a 'community diagnosis' leading to the following health promotion interventions: the design of a 'cardiovascular route'(see picture) in the neighbourhood, with increased spaces for meeting (e.g. the 'neighborhood garden'). The infrastructure for this 'route' was made by volunteers and local 'social arts projects'. The physiotherapists of the CHC developed the exercises that can be performed at different stops on the route. Feedback from participants suggested proposals for improvement. People were referred to the 'cardiovascular route' by health care providers, by social care workers and by informal caregivers. This project is coordinated by the health promoter of the CHC, and supported by the local authorities of the city of Ghent. Creating a healthier living environment through accessible infrastructure for improved physical activity addresses the determinants of health and contributes to social cohesion, thereby reducing the social gradient.

In the Community Health Center "Botermarkt" in Ledeberg (www.wgcbotermarkt.be), there was an "epidemic" of teenage pregnancies, especially with young poor women living alone. The reason for this epidemic was unclear to the local healthcare workers. In most of the cases, there was no father who wanted to commit himself to the child, and many of these teenagers had been placed in institutions for a large part of their youth, and none of them had clear occupational plans for the future. In order to define the problem adequately, all girls living in the local communities between 14 and 18 years received an anonymous questionnaire exploring their knowledge, behaviour and attitudes with respect to sexuality, contraception and relations[1] .The response rate to the survey was 64.5% and showed that accurate knowledge of sexuality decreased with social class. As far as contraception was concerned, more girls from the lower social class used unsafe methods. We checked the knowledge of the teenage mothers from the "epidemic-group", but there seemed to be no lack of knowledge. By using group discussions, it became clear that pregnancy was a well-decided choice for these girls: they felt they had failed in so many domains of their life (relations, work, education, family). They wanted to succeed in their fundamental human right to become pregnant and to become a mother. If the hypothesis of "lack of knowledge" had not been discussed with the community of young mothers, the more fundamental cause of the epidemic would have remained unknown. To simply try to increase knowledge on sexuality would not have worked. Instead, a project was designed to help the girls to be successful in their new role as mothers. This case highlights that health promotion should take as a starting point a thorough analysis of the upstream causes of the actual problem as perceived by the people involved.

COPC is nowadays more and more integrated in (inter-professional) undergraduate training of health professionals (Art et al., 2008) and may contribute to innovative approaches in health promotion and more integration in the field between primary car and public health.

'The cardiovascular route' in Nieuw Gent (picture: CHC)

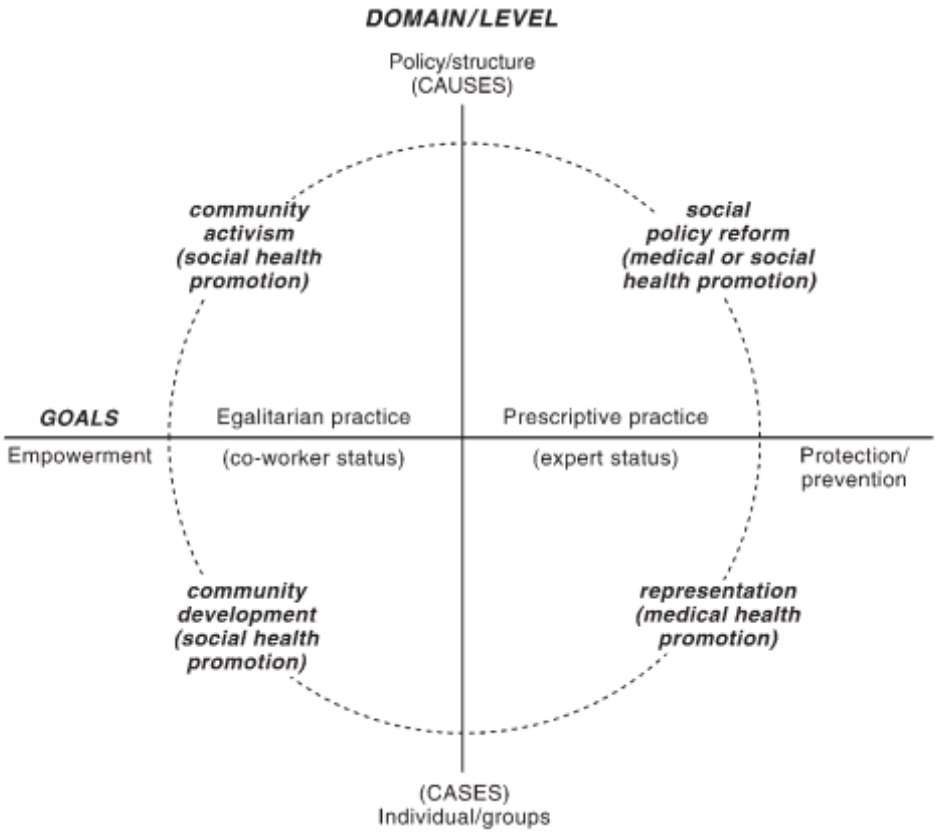
3.3.3.4 Advocacy and political action for health in primary care

The Ottawa Charter for Health Promotion (WHO,1986) underscores the importance of advocacy as a health promotion strategy: "*Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioral and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health*" (WHO, 1986). Rees (1991) defines advocacy in terms of the activities it encompasses: for example, the representation of under-privileged groups, such as those who are disadvantaged or sick, with the aim of promoting their rights and/or redressing imbalances in power. He names this: *'case' advocacy* (Rees, 1991). Advocacy is also seen as a lobbying activity, that has become increasingly common within the health promotion literature. This approach acknowledges that barriers to health can lie beyond the control of individuals, and that structural factors need to be addressed if health inequalities are to be reduced. This has been characterized as *'cause' advocacy* .

Carlisle developed a conceptual framework that provides a more explicit way of locating advocacy practice in health promotion (Figure 4). "Four different types of advocacy are identified. It is suggested that these are shaped by the domain within which health promotion advocacy takes place (case or cause); the goals and philosophy of the practitioner; and the freedoms and constraints associated with their professional role. Advocacy work will also be influenced by the particular conceptualization of health inequalities being used. The axes of the matrix are best regarded as continua along which practice can be located, rather than mutually exclusive and oppositional poles: depending on context, it is possible that one form of practice may shade into another. The right-hand half

of the matrix relates to representational types of advocacy: the left to facilitating types." (Carlisle, 2000).

Figure 4 A conceptual framework for advocacy in health promotion



Some examples may illustrate this framework:

- Medical health promotion advocacy: health care providers advocating for healthier lifestyle ('quit smoking') of poor people, in order to reduce health inequalities.
- Social health promotion advocacy (community development): psychologists voicing the needs of their mental patients in a local meeting on priority setting for increasing supply.
- Social health promotion (social policy reform): care providers challenge the government policy on reducing allowances for the poor, in a public debate.
- Social health promotion advocacy (community activism): participation in the action of relatives of victims from the opioid epidemic that start a juridical procedure against the company that produces the drug.

Actually, there is a very limited body of research in the field of advocacy. Taking into account that 'civil society organisations' become more and more active in the field of health (care), the 'advocacy' domain may require more exploration.

3.3.3.5 Integration of health promotion in the framework of better structured primary health care

Opportunities arise for a new positioning of health promotion within health services, especially in countries and regions that implement a more decentralized approach to the organization of health care. Indeed, the integration of primary care and public health locally, introduces the concept of 'population health' in primary care: practices are no longer accountable for their reactive care only, they are stimulated to develop a pro-active health oriented strategy, where 'everybody counts' and 'no one should be left behind'.

An integrated multi-stakeholder approach is required, with input from primary care professionals such as general practitioners/family doctors, practice nurses and community pharmacists, working with public health professionals, social care workers and community services and supports. Evidence supports the impact and cost-effectiveness of a range of community-based approaches for population health promotion including, for example, enhanced services delivered by community nurses (Randall et al., 2017; Tan et al., 2019) and community pharmacists (Sabatar-Hernández et al., 2016; Dawoud et al., 2019).

The model of 'Primary Care Zones' (PCZ) as developed, for example, in Estonia (De Maeseneer, 2016) and in Flanders[2] (Belgium), provides a useful framework to implement such a more integrated strategy.

For Estonia, the following functions of such a PCZ were, amongst others, proposed [2]:

- Provide support at the micro level by ensuring organisation and mentorship between different disciplines including family doctors and stimulating multidisciplinary and intersectoral cooperation, including the most needed integration of health and social care.
- Implement national programmes for health promotion, disease prevention, curative services, care and rehabilitation, in an integrated manner in order to provide universal access to those programmes.
- Serve as the operational level for the initiative of the National Institute for Health Development, e.g. making the health promotion professional operational at the level of PCZs.
- Implement the provision of human resources for health care (recruitment and retention).
- Facilitate different forms of citizen participation.

In Flanders (Belgium), PCZs take care of 75,000 to 125,000 inhabitants.

[2] Flemish Community. Conference Primary Care: Re-organisation of Primary Care in Flanders: towards integrated primary care. Brussels, 16.02.2017. Available at: https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/CELZ%20beleidstekst%20hervorming%20eerstelijnszorg.pdf (in Dutch).

Within a primary care zone, public health services and primary care centres can facilitate concerted health promotion activities, aiming at the same population, using an integrated interprofessional electronic health record. According to Luke Allen, public health teams and primary care teams, working together "are well positioned to identify the local drivers of morbidity and mortality, including transport, the food environment, pollution, poverty, early years education, housing, road safety, exercise spaces, and the availability and affordability of alcohol and tobacco. Primary care teams see these local social determinants at work every day and have overlapping moral, professional, and (where they are paid by capitation) financial interests in tackling them. Through collaboration with public health, social care, and other community organisations, primary care professionals are uniquely placed to translate their insights into priorities for community level prevention. Primary care teams have detailed patient datasets and a unique ecobiopsychosocial perspective, and they often develop a high stock of community trust and a rich ethnographic understanding of the local population (Allen et al., 2018).

Primary care teams, integrated with public health teams, can increase the coverage for immunization, the participation in health promotion activities, reaching out to the most vulnerable groups in society and so increasing impact. In order to address the social determinants of health, integration of primary and public health, with social care may be the way forward. However, in most of the countries, there is still a (long) way to go to make this happen.

3.3.4 Sustainable financing for health promotion

As already highlighted, the level of spending on health promotion is typically low, and is reduced even further in times of economic crises, in spite of the fact that it has the potential of improving (long-term) population health in a cost-effective way. The existence of evidence highlighting cost-effectiveness clearly is not sufficient to ensure continued funding for health promotion. Thus, producing compelling evidence on the economic advantages of health promotion is a necessary but not sufficient condition to ensure continued (protected) funding for health promotion. A complete analysis of the economic context of health promotion has to go beyond the cost-effectiveness argument to invest in this area. The challenge of sustainable funding for health promotion actions needs a more complete understanding of the key elements in funding decisions. Some of the potential reasons for this (e.g. cutting expenditures on health promotion does not lead to immediate health damage) and entitlements for health promotion were highlighted earlier in this report. Timing and uncertainty are identified as two major aspects driving the explanation of this. The effects of health promotion take time to materialize, measured in years and often decades into the future. The time horizon in which effects are produced is farther in the future than the relevant time horizon for decision-makers that have to allocate scarce

resources to competing uses. From the population perspective, myopia over the long-term future may be present. It means that decision-makers will not be judged by their performance on whatever decisions they take regarding health promotion. For both "demand" and "supply" of health promotion interventions, there is a bias against investing that arise from long-term effects. The second element is uncertainty, which is also to some extent linked to the nature of the long-term effects of health promotion. From an individual perspective, it is not obvious or simple to perceive the (future) benefits from health promotion. Many other elements will contribute to the future health of each individual, some under the control and decision of the individual, some completely external and random. The lack of a clear and visible link from health promotion interventions to improved individual health may lead to health promotion receiving less attention from individuals. While these arguments are intuitive and compelling, other areas of economic activity deal with similar issues. Sometimes, strong public sector intervention is observed, with the pension system (which in most countries is either a public system or has heavy regulation) being a good example. It may be helpful to consider what makes the pension system different from health promotion activities in order to identify the key elements that would protect funding for health promotion.

A first feature is the link between the public sector intervention (by design of the pension or by design of the rules) and a future "right", or claim, that people will have. The causal nexus is easily perceived: someone contributing more to the pension system today expects to receive a higher pension in the future. There is a tangible asset to be received. This contrasts with the promise of better health (which is difficult to measure in a way as objective as the monetary value of a pension) and with the perceived (and sometimes, actual) vague relationship between health promotion actions today and improved health in 20 or 30 years into the future. This comparison suggests that an important element of any payment mechanism for health promotion will be a permanent attention to the dissemination of information to the population on the results being achieved. There is a need to build a clear sense of the causal relationship between health promotion actions and improved health. At first, it will have to be mainly short-term evidence, that will grow over time in a more systematic way. A simple example illustrates this idea. An intervention based on nutrition and meal preparation may be an important element in avoiding future cases of diabetes. At a population level, a score for future cases of diabetes can be set based on current circumstances (including other drivers), and each future year can see actual numbers compared to a prediction of new diabetes cases in the absence of intervention.
There will be uncertainty regarding this impact at the individual level, but reporting every year this information and promoting its discussion will help to build awareness of health promotion effects.

The second element is more subtle and related to individual entitlement. By making a mandatory contribution to social security, an individual feels an entitlement to receive a payment in the future (the pension). Some entity, public or private according to the particular social security system of each country, will have the responsibility of paying the future pension. If this payment does not take place, it will be noticed (and most likely will lead to strong protest). In health promotion interventions, if there is a cut in the budget, very few individuals feel a loss in entitlement. The lesson from this observation is that a payment system that protects funding for health promotion should create some sort of entitlement. This will make the population "champions" of health promotion funding or, at least, should reduce the bias favouring budget reductions in health promotion when compared with other areas in the health sector. Another difference between pensions and health promotion is the difficulty in making "payment by results" in health promotion. This is generally difficiult in health care delivery, but more difficult in health promotion due to the time lag of effects. Consequently, health promotion is usually paid by process (fund the use of resources) rather than by results. The payment system needs to deal with these features in a way that funding is protected. Protection of funding here has the meaning of explicit or implicit commitment to not change decisions on the funding of health promotion later on, in the near future. Or, at least, do not reduce funding proportionately more than in other areas of health spending.

A sustainable financing model of health promotion needs to be built with a two-step approach. In the first step, there is the decision as to the level of funding, based on the available evidence and with the contribution of cost-effectiveness analyses to set priorities. The second step is the definition and application of a payment mechanism that inherently "protects" the funding decision, leading to continuation of an optimal level of funding in future decisions. That is, protection means that future decision-makers should find it optimal from their point of view to keep the assigned funding of health promotion. This is done by increasing, or by creating, costs of reverting the decision on the level of funding.

Some mechanisms to create this protection are formal. It may be possible to set a law defining that health promotion funding will be at a certain value for a number of future years. But laws can be changed or have "doors" that allow funding to be reduced in "exceptional" conditions. Given the widespread view that health promotion is underfunded in many countries and for several years (if not decades), it is reasonable to conjecture that a formal protection, by law enactment, will likely not be enough. Other mechanisms must be associated with the payment system, creating greater visibility for health promotion and defining entitlements that will lead to a reaction from the wider population if decreased.

Payment by results in health promotion will not be undertaken at the individual level. The emphasis should be on information being periodically released and publicly presented at the population level to ensure visibility and create a "soft pressure" to not decrease the funding. Thus, payment of health promotion needs to be accompanied by explicit reporting contracts by the entities implementing the intervention. A yearly report, publicly deposited and discussed at Parliament level or any other high-level visible body, is one example of these reporting duties. Given that both governments and individuals may prefer short-term situations of underspending on health promotion, providing information does not necessarily guarantue that the government will keep up expenditure levels. The way in which the information is reported may, therefore, require attention. For example, by highlighting the expected future health gains produced by spending (perhaps per group of beneficiaries, and eventually highlighting how each individual's health will likely benefit) the health losses due to reduced spending become clear as well, which may be more persuasive in nudging people to prefer and demand higher levels of spending. An additional element, therefore, can be the creation of a visible "endowment" to people regarding health promotion, in the sense that cuts to spending in health promotion are felt as reduction in future health opportunities. Suppose that an intervention for a specific population group involves a yearly consultation with a nutrition specialist. A possibility for a payment system that creates an entitlement with the population is to issue, at the start of each year, a voucher for that visit, informing the citizen, the nutrition specialist and the GP that follows the patient (if applicable) of that entitlement. Preferably, a precise appointment date should be given, as specifics will provide more emphasis to the entitlement. Of course, the details should be thought carefully in each case. The point here is not to have good management of health services (which should be aimed for anyway). The point is to make the citizen aware of the right to have this intervention, so that cutting it feels like a loss to the citizen. If budget cuts or redeployment of resources cause the intervention to be suspended, cancelled or delayed, there will be a political cost to the decision-maker due to pressure from people who are losing their entitlement.

At the macro level of the health system, the bias against spending on health promotion and in favour of short-term, more immediate impact, interventions should be countered by the appointment of officials that have the single objective of health promotion. The trade-off between types of spending in health care should be made more visible by public actions and the positions of decision-makers and with the duty (and interest) of pursuing health promotion interventions. Institutions are more likely to have a long-term vision than individuals.

Funding for health promotion interventions could have the form of medium-term contracts between the funder (a health promotion agency) and health care providers (e.g. a primary care, secondary care or community care providers), based on population-level results. As an illustrative hypothetical example, a hospital and a dedicated health promotion official body could set fixed-term contracts (say, five years) by which some funding of health promotion interventions is secured by the hospital, with end-of-period assessment of impact taking place. This final assessment brings in an element of payment-by-results at the population level, which can be from the hospital to the health promotion body, or from a third-party payer (government or public-sector payer, in some countries, health insurers or sickness funds in other countries). Either at the individual citizen level or at the macro level, the payment mechanism needs to do more than state the amount of funding. It is required that other conditions and elements are included in the "contract" in a way that makes the benefits of health promotion more visible and also makes it clear who owns those benefits. Although the specific elements of the payment model may change from country to country, or from programme to programme, reflecting the particular context of each health system, the broad principles are common to all health systems. In several countries, the effort to secure sustainable and adequate funding for health promotion may require additional institutional design, with the creation of specific bodies or institutions together with new modes of paying for health promotion. The definition of the payment model must include, whenever an element of performance is included, a detailed definition of objectives to be achieved, the associated metrics, the sources of information to be used for the computation of metrics, and the structure of the payment mechanism.[3] The suggestion of particular agencies taking up health promotion as their main task has been used in several countries already, with mixed views about their role (Schang et al., 2011). Boswell et al. (2019) draw on the experience of Australia, New Zealand and England, to conclude that institutional building of these new agencies takes a toll in terms of quick progress. None of the examples reviewed mention the building of entitlements to citizens as part of the payment system.

Sources of funding

The sources of funding for health promotion vary across countries. Some countries have looked at non-traditional sources, like taxation of "sin" consumptions. The choice of source of funding is less relevant than it may seem on a cursory look. Some options that look attractive at first impression may actually be detrimental. Using sources of funds that have a strong pro-cyclical nature leads to unwarranted variation in the availability of funds over time. Avoiding decision-makers' choices over uses of more standard sources of funding does not necessarily contribute to stability in health promotion funding. The use of dedicated

[3] Cashin et al. (2014) provide a useful discussion of the details to be considered.

taxes to fund health promotion is only able to secure stable funds for health promotion depending on the tax base that is considered. Taxing a "sin" consumption is politically attractive but success in reducing the underlying consumption reduces the available funding, and if consumption is stable, then the burden of funding health promotion falls only on those groups of the population with no behaviour changes. In such cases, using an ineffective instrument (in terms of changing behaviour) to transfer money from people with a particular behaviour to all other people needs a clear justification. A careful monitoring of behaviour changes (or not) is required, as how people react to policy interventions may often have unexpected elements in light of the initial expectations of decision-makers.
Securing a fraction of total funds for health expenditure can make it more stable, though at the cost of making explicit the competition within the health sector for available funds with other health interventions.

A series of options to fund multisectoral actions of health promotion is reviewed in McDaid and Park (2016). These options are worthy of consideration, even in the absence of partners from other sectors. The suggested financing mechanisms are earmarked funding, delegated financing and budgeting schemes. They also highlight the relevance of "routine effective monitoring". As mentioned previously, earmarked funding does not guarantee its duration and stability and it does not solve the issue of protection funding for health promotion in the medium term. There is a need to complement these approaches with mechanisms that make it costly for decisions-makers to cut health promotion funding. A possible line of action is to build an explicit entitlement to health promotion interventions, which is recognized as such by the population, and that provides a tangible and visible benefit from the funding initially committed. A recent publication on "Financing Health Promoting Services – An Information Guide" (Barnfield et al., 2019) provides examples of how investment can be mobilised and existing gaps met through innovative sources and financing mechanisms at EU level. In that report, new ways of financing beyond traditional models and budgets are considered including: increasing health promotion funding through smarter taxation and fiscal measures, use of health insurance funds, innovative multi-sector solutions and co-financing mechanisms, and new investments models such as public investment banks, social impact bonds and social outcomes contracting. Applying the principles of the European Pillar of Social Rights and Invest EU programme, and particularly the Social Investment and Skills Window, this guide endorses the need to invest in health as an asset for sustainable social and economic development and wellbeing in the European region.

3.3.5 Mobilising community participation and engagement

Health promotion, like other public health approaches, focuses on populations and sub-populations or communities, not just individuals. By affecting large groups, even small improvements can bring considerable health gains. At the same time, significant benefits could come from health improvements in relatively small albeit vulnerable groups of population. Intersectorality and social participation together are recognized as key strategies for addressing health inequities (Fiorati et al., 2018). However, a particular form of supportive and sophisticated "architecture" (Carey, 2015) is needed for intersectorality to overcome structural, cultural and political barriers. Thus, both collaborative activities and structures should be taken into consideration to translate intentions into practice. At the same time, a lack of awareness within policy networks on the social determinants of population health, and a tendency of health actors to neglect investing in other sectors' complex problems, should be recognized (Breton, 2016).

The need for intersectoral collaboration has already been considered under the more comprehensive HIAP approach, presenting a set of institutional arrangements and a broad variety of operational frameworks for HIAP implementation. Among widely applied approaches frameworks with an emphasis on involved governmental systems (Shankardass et al., 2018) could facilitate the progress in the field (see Figure 5).

Figure 5 A systems framework for HIAP implementation

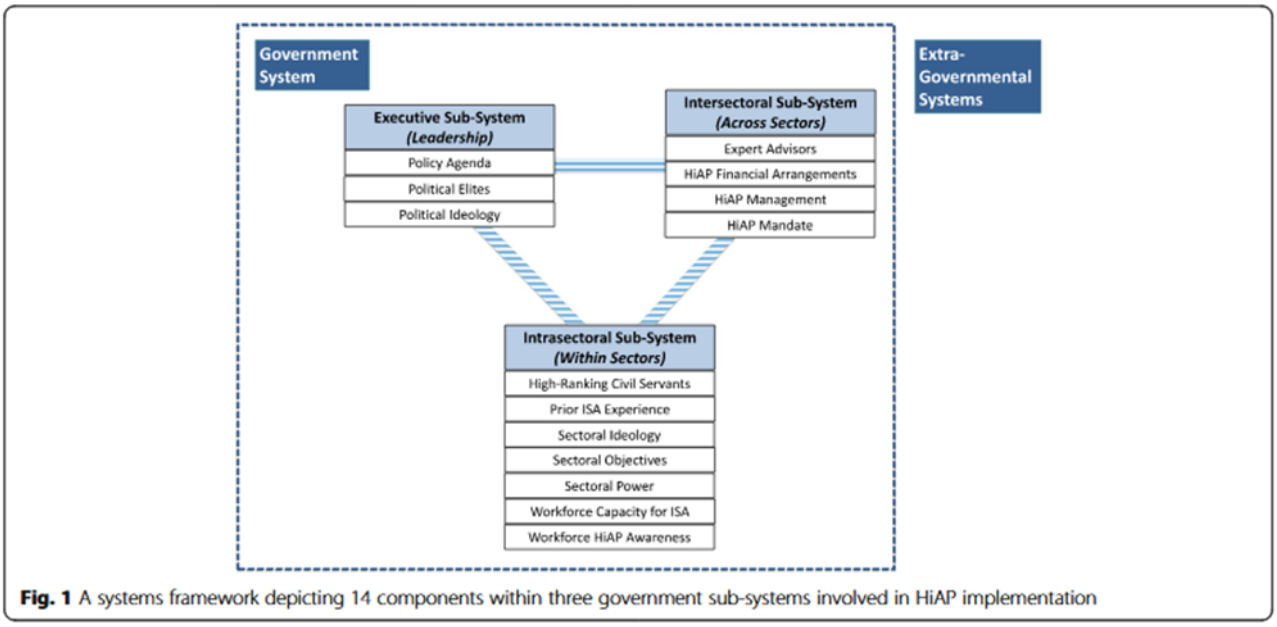


Fig. 1 A systems framework depicting 14 components within three government sub-systems involved in HiAP implementation

Source: Adapted from Shankardass et al. (2018)

Together with the government, civil society organisations have a key role to play in implementing HiAP. Not surprisingly, the WHO 2016 Framework (WHO, 2016b) is devoted to interaction between state and non-state actors, and progress to improve the participation of civil society is a long-term process. Increasing the role of civil society is also a challenge due to the inevitable tensions that arise if actual changes are taking/have taken place in the balance of power. As Mikkonen states, many of the experiences of the past 30 years can be classified in effect as non-participation or tokenism (Mikkonen, 2018).

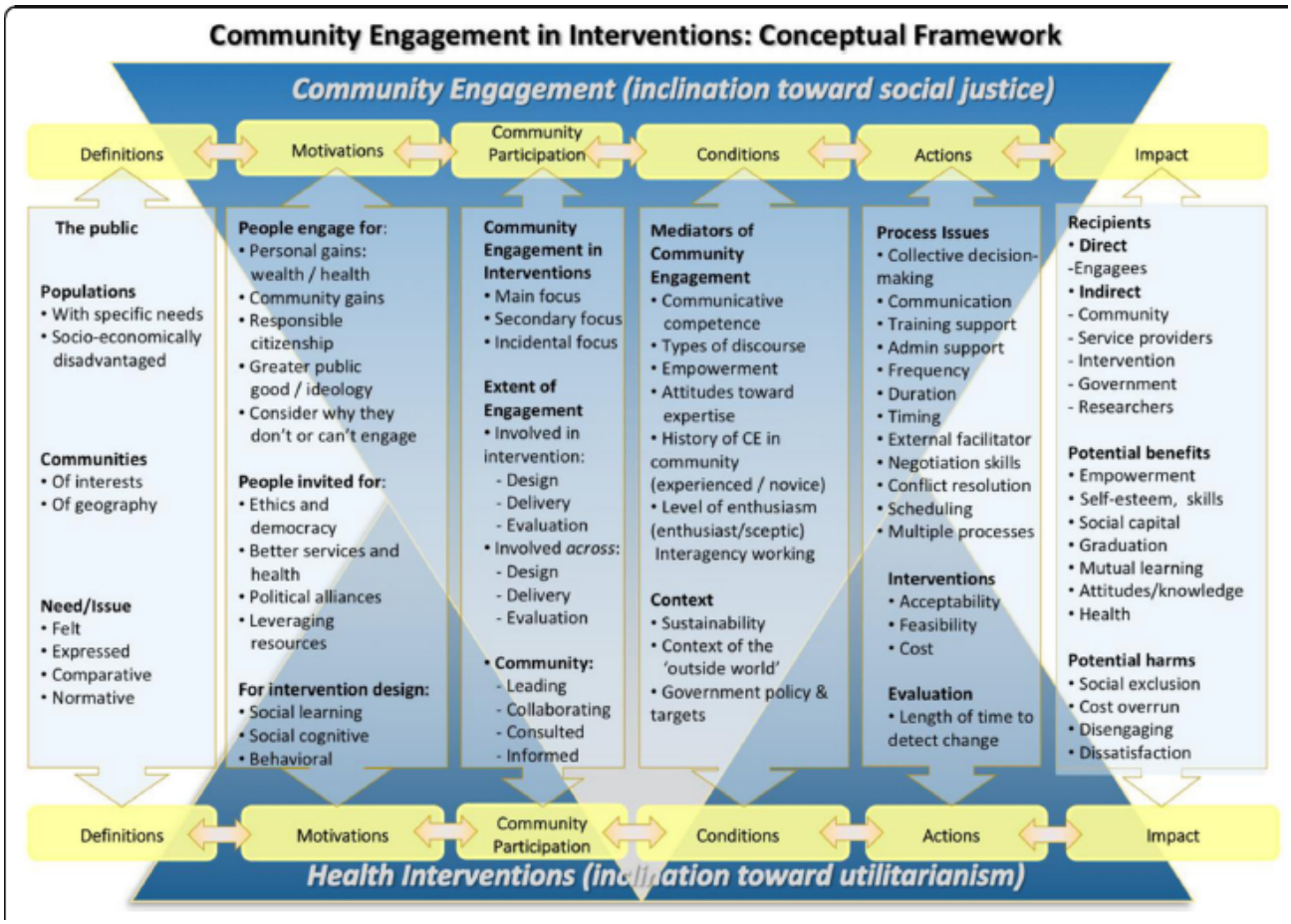
The UN and EU provide strong international support for civil society involvement. For instance, civil society organisations (CSO) have joined the movement towards UHC through the UN Civil Society Engagement Mechanism (CSEM). CSEM systematically contributes to the "Leaving no one behind" approach by influencing policy design and implementation, lobbying for participatory and inclusive policy development and implementation processes, strengthening citizen-led social accountability mechanisms, promoting coordination between CSO platforms and networks working on health-related issues at the national, regional and global levels, enabling civil society to have a voice in the UHC2030 movement[4]. To support progress towards UHC, the EU suggests particular tools for member states, namely, a multi-stakeholders' platform joining 60 countries, almost 20 agencies, institutions and organisations, and the UHC Partnership - a thematic fund providing resources for 45 partners and countries seeking to join[5].

From an ecological perspective, community engagement is at the heart of public health interventions, particularly for mitigating health inequities. There is robust evidence that "public health interventions using community engagement strategies for disadvantaged groups are effective in terms of health behaviours, health consequences, health behaviour self-efficacy, and perceived social support (O'Mara-Eves et al., 2015). At the same time a lack of community engagement like 'tokenistic' community involvement is identified as a key factor of potential unintended harm in the settings-based approach to health promotion (Mittelmark, 2014).

In brief, community engagement can be defined as approaches to involve communities in decisions that affect them (Marmot et al., 2010). At the community level, social norms and networks, as well as legislation, regulation and informal structures, are particularly important. Conceptual frameworks of community engagement, such as that outlined by Brunton et al. (2017) in Figure 6 below, present both the models, the mechanisms and contexts.

[4] https://www.uhc2030.org/what-we-do/civil-society-engagement/

Figure 6 Community engagement in interventions: a conceptual framework



Source: Adapted from Brunton et al. (2017)

Actual progress in community engagement requires critical consciousness and relevance, systematic issue selection, building community capacity, participation and empowerment (US Department of Health and Human Services, 2005). In this context, participation refers to equal partnership of all members of the community, while empowerment relates to people gaining control over their own lives and that of the community. However, while people may know what they want, they are often less certain about the means to achieve it, especially how to gain access to political influence and resources. Under such situations, people are motivated to empower themselves in order to achieve what they need and want. Becoming empowered involves a process by which people gain more control over the decisions and resources that influence their lives and health. Community empowerment builds from the individual to the group to a wider collective and embodies the intention, as does health activism, to bring about social, political and economic change for improvements in people's lives. Health activism is a growing area of interest for many who work to improve health at

[5] https://europa.eu/capacity4dev/articles/how-eu-supports-partner-countries-achieving-universal-health-coverage

both national and international levels because it offers a more direct approach to achieve lasting social and political change. Activism is action on behalf of a cause, action that goes beyond what is conventional or routine. What constitutes activism depends, therefore, on what is 'conventional' as any action is relative to others used by individuals, groups and organisations in society (Laverack, 2013).

Community participation and empowerment are core principles at the heart of the WHO approach to health promotion. On one hand, empowerment could be considered as a goal and, correspondingly, an outcome for conducting health promotion interventions or programmes. On the other hand, empowerment could be viewed as a process. From the latter perspective, community interventions encouraging community members to actively shape the future of their community, as in the social action approach and health activism, are underscored. Adopting an empowerment approach represents a way forward from interventions with a dominant focus on "working in communities" where community members are granted a passive role by professionals. In other words, community development and asset-based approaches to working with communities and neighbourhoods support a shift from "intervention-driven" to a "people-centred" perspective, from a within-settings approach to a system-wide approach (South, 2014). With reference to cultural competence, an analysis of the main forms of community engagement, i.e., Community Engagement Continuum, Diffusion of Innovations, and the most commonly used Community-Based Participatory Research (CBPR), show that key community engagement components that affect health outcomes include real power-sharing, collaborative partnerships, incorporating the voice and agency of beneficiary communities, and, where relevant, bidirectional learning, and using bicultural health workers for intervention delivery (Cyril et al., 2015). These components are especially important in ensuring meaningful engagement and participation by vulnerable groups, including those living in conditions of deprivation such as poverty with inadequate access to education, health and other services; lack of political influence, civil liberties and human rights; geographic isolation; environmental exposure, racism or historical trauma; disruption of social capital and social isolation; exposure to wars and conflicts; alienation or powerlessness.

Active engagement of young people also requires considered facilitation. This includes the use of youth participatory methods, including the use of social media as the most common platform for engaging young people in mutual activities and in the promotion of key messages, goods and services. New technologies such as social media marketing are a powerful tool for use across all age groups in tailoring information and empowering different audiences to engage in health promotion. Given the rapid increase in internet use for effective health communication, health practitioners also need to be able to identify and mobilize active users of online health information across various web-based technologies and

digital health programmes. Emerging trends include the engagement of "influencers", by definition a person with the ability to influence others by promoting or recommending items on social media. The concept of 'health e-mavens' has also emerged to characterize individuals actively engaged in online health information seeking and sharing activities. Drawing on the concept of 'mavens' from the marketing literature, this has been identified as a potentially useful construct for health promotion in the age of new media technologies (Sun et al., 2016). A range of effective and innovative community engagement strategies are therefore, needed to enable and empower people in their ability to influence decisions and to participate fully in the health systems and wider social, economic, political and cultural systems that affect their lives.

The most significant facilitators of community engagement, such as collaborative decision-making, agreement of objectives and goals, local planning and action, effective leadership, building and maintaining trust, availability of resources, a dynamic approach, a realistic time-frame, and trained and knowledgeable staff, are well-recognized and acknowledged by international guidelines. As in whole-of-government approaches, both political and operational dimensions are of crucial importance. However, operational frameworks to narrow the gap in knowledge-based practice are often lacking at the local level (Weiss et al. 2016), and research reports that local policymakers are challenged by balancing instrumental and communicative HiAP planning approaches (Synnevåg Strom et al., 2017). There is, therefore, a need to strengthen local structures and capacity to effectively mobilise local communities in engaging in health promotion strategies that will address the determinants of health at the community and national level.

3.4 Conclusions and Recommendations

There is a solid case for investing in health promotion on the grounds of improving population health and wellbeing, reducing social and health inequities, improving health systems efficiency and development, protecting human rights, and ensuring sustainable development (WHO 2011, 2013, 2019). Building on the delivery of the health mandate in European Treaties and across EU policies, the implementation of the SDGs in Europe presents a major opportunity to bring a central focus on health promotion as a core element of delivering on sustainable health development and universal health coverage. The goal of ensuring that all human beings can have healthy lives and can maximise their health potential calls for concerted action on health promotion and primary prevention as integral components of modern health systems.

Health policies which embrace a health promotion perspective, focussing on promoting health and wellbeing at a population level, have been introduced in many countries as the

most sustainable method of reducing the increasing burden of NCDs and mental disorders and improving overall health and wellbeing. However, the level of infrastructure and capacity to support health promotion action varies considerably across countries. Progress has been slow in many EU countries, particularly in terms of implementing a HiAP approach and mainstreaming health promotion within health services, and there is a lack of investment in developing the necessary health promotion systems for substantive progress to be made.

There is a need to move beyond the rhetoric of health promotion towards concrete action and strengthening the capacity of EU countries to implement health promotion at a political, policy and service delivery level. Cost-effective and feasible health promotion interventions have been shown to make a real difference in improving population health, reducing risks for NCDs, improving mental health, increasing health literacy, and addressing the social determinants of health and health equity. However, implementation gaps exist in policy, practice, governance and political will, resulting in a failure to realise the full potential of health promotion. This represent a lost opportunity with consequences that can be measured in avoidable illness and suffering as well as broader social and economic impacts. The practical implementation of health promotion is needed to improve the performance of health systems and to strengthen their capacity to improve population health and reduce health inequities, both of which are key to realisation of human rights and the EU Pillar of Social Rights. In view of the common challenges faced by EU Member States in enhancing the resilience of health systems and improving health equity, there is a strong case for putting improved population health and wellbeing at the centre of the EU policy and development agenda and making health promotion practices and actions integral to EU health and social reform implementation measures.

Reviewing current progress, it is clear that integrating health promotion more effectively within health systems requires a strengthening of the health promotion function at a broader political and policy level as advocated by a HiAP approach. Based on a critical reflection of the barriers and enablers for fostering health promoting health systems in this Opinion, a number of recommendations for action are made that can be supported through EU policy mechanisms and investment agendas.

3.4.1 Recommendations for action:

As health promotion is an essential strategy for improving health equity and the broader determinants of physical and mental health, health promotion needs to be prioritised as a key action underpinning the reform of health systems in Europe. **We recommend that a range of policy and financial mechanisms at the European level are applied to**

support the implementation of transformative health promotion policies and practices in EU Member States. This shift in focus from disease to health can be considered 'a disruptive innovation' due to the need to transform existing organisational structures, workforce, and services.

Applying the principles of the European Pillar of Social Rights and the competences of the EU treaties for the promotion of wellbeing and protection of health across all EU policies, the promotion of population health and wellbeing needs to be placed at the centre of EU policy and implementation measures. The EU Semester yearly cycle of policy coordination provides an important means of progressing the reform of health systems in EU Member States, ensuring greater access, efficiency, equity and the financial sustainability of health systems. The further development and financial sustainability of health promoting health systems could be supported as a key part of this transformative process, advancing political commitments in EU Member States on the implementation of a HiAP approach and making country-specific recommendations on the further development and integration of health promotion within health systems. Reforms in areas such as social protection, employment, social inclusion, research and innovations also have a key role in addressing the wider determinants of population health and thereby reducing health inequities. The European Structural and Investment Funds (ESIF) and related investment packages for growth and cohesion could also make a significant contribution through supporting the development and implementation of innovative health promotion programmes and measures on the social determinants of health inequity such as poverty and social exclusion. The Structural Reform Programme and the EU's future investment programmes have also been identified as important potential sources of support for transforming health promoting health systems in Europe (Barnfield et al., 2019). Harnessing the range of EU policy tools and financial instruments, including the budget provisions in the next Multiannual Financial Framework (2021-2027), constitute important sources of investment for advancing progress.

The following specific actions are recommended for implementation at the EU level in cooperation with key partners, citizens and national governments in Member States:

- ***Advocate for the importance of health promotion***
    - *Develop effective advocacy for health promotion* to increase the visibility and relevance of health promotion and ensure that its contribution to sustainable health systems and human, social and economic development in Europe is recognised across the political spectrum and in communications for public health. Specific attention is needed to develop appropriate health promotion advocacy for vulnerable and underserved groups, including those who are

poor, homeless, migrants, refugees, and minorities, avoiding the 'blaming the victim' pitfall and ensuring comprehensive contextual analysis based on a determinants of health approach.

- *Advance political commitment to effective health promotion policies and action plans* through the formulation of specific health promotion goals and the development of feasible and evidence-informed policy options for health promotion action on the social determinants of health and health inequities, so that the relevance of health promotion is understood and advocated for across the public health function in Europe and among high-level policymakers, including those from the non-health sector.

- ***Provide strategic leadership for health promotion at EU level***
  - *Provide leadership and coordination at EU level in ensuring the implementation of a HiAP approach* in EU Member States and the integration of health promotion as a priority within European and national policies. Apply EU and national mechanisms, including structural reforms and EU funds, to support Members States in developing the required organisational structures and processes for planning, implementing and sustaining innovative intersectoral health promotion actions and strengthening capacity development in different country contexts. This includes appointing high-level political leaders for health promotion and the provision of guidance and resources for the implementation of whole-of-government and whole-of-society approaches that will promote health and reduce inequities and enable countries to meet the targets of the SDGs.
  - *Promote the integration of health promotion within health services, especially in primary care* to ensure universal access to health promotion programmes thereby improving the scope and range of services to health service users, reaching out to the most vulnerable groups in society to ensure better health for all.
  - *Invest in developing a dedicated workforce for health promotion in Europe*, ensuring they have the necessary, knowledge, skills and competencies to strengthen their role in the health system and promote their professional identify and responsibility. Leadership at the EU level is critical in advancing recognition of a dedicated health promotion workforce with the key competencies required for quality professional practice. This entails supporting the education, training, and professional development of health promotion through dedicated academic (e.g. at undergraduate and postgraduate levels)

and CPD programmes, as well as the inclusion of health promotion components in the educational curricula of health professionals.

- ***Protect and promote sustainable financing mechanisms for health promotion***
  - *Invest in the development of robust health promotion policies and programmes at EU level* by ensuring sustained investment beyond once-off projects and stand-alone initiatives in order that the implementation of comprehensive health promotion strategies can be realised and sustained in EU Member States. This entails ensuring better allocation of dedicated resources and ring-fenced finances for health promotion actions to enable the health promoting component of health systems to be realized.
  - *Apply EU funding and investment mechanisms* to ensure that health promotion is included in EU, national and regional programming priorities, thereby protecting funding for capacity development and effective implementation of actions that can be supported at the national and regional level.
  - *Explore the use of EU financial instruments* such as the ESIF, and co-financing mechanisms, to support the re-orientation of health systems to health promotion, implementing innovative actions and intersectoral partnerships for health, and establishing good practices.
  - *Support Member States in reviewing current health budgets* and spending across the spectrum of health services and tracking resources aimed at funding health promotion and explore new ways of balancing spending towards health promotion, and developing mechanisms and incentives for ensuring its sustainability.

- ***Develop the capacity to implement health promoting health systems at EU level and in Member States***
  - *Apply the EU Semester process and other available policy mechanisms to enable countries to establish the system requirements for health promotion* policy and programme development. This includes providing health system guidelines and standards regarding the governance structures and processes that need to be established, including high-level leadership and political responsibility at a country level, for the implementation of evidence-based health promotion policies and programmes.
  - *Provide technical guidance on implementing health promotion in practice* to support countries in strengthening the quality of health promotion practice

through the setting of European norms and standards for best practices and evidence-based priority interventions and strategies to be delivered at all levels of the health system.

- *Support the assessment of health promotion capacity in Member States* through national assessments and audits to determine if the required policy and implementation structures are in place and how they can be strengthened. Invest in the development of tools for assessing and benchmarking infrastructure capacity and performance for core health promotion action.

- ***Invest in health promotion research in Europe***
  - *Support the development of interdisciplinary and innovative health promotion research* through the EU framework programmes for research, development and innovation, including the new Horizon Europe and related programmes, with a particular focus on the following areas:
    - the monitoring of positive indicators of population health and wellbeing status across the social gradient at a country level
    - the comprehensive evaluation of complex multilevel health promotion interventions, providing evidence on the impact of upstream interventions addressing system-wide determinants of health
    - multi-country implementation trials to test the transferability and scaling-up of evidence-based approaches across countries and contexts
    - economic analyses to determine the cost-benefit and cost-effectiveness of health promotion strategies
    - health equity impact assessments of policy making across sectors
    - the dissemination of evidence and examples of evidence-based strategies
  - *Develop knowledge translation mechanisms for health promotion in the EU region* by developing a network of dedicated health promotion knowledge translation centres to promote and improve the timely uptake and use of scientific research and knowledge to strengthen health promotion practices and policies. Such a dedicated network could foster knowledge sharing and provide a range of evidence-based tools, methods and knowledge translation services to support best practice and policy across EU Member States, with a particular emphasis on reducing health disparities.

- ***Strengthen health promotion partnerships at EU level***

- *Support sustained partnerships for health promotion* through active collaboration with dedicated health promotion foundations, NGOs such as IUHPE and EuroHealthNet, academic partners and national focal points with a health promotion remit, to support health promotion capacity development at the EU level through networks and platforms for education and training, accreditation and professional development and the establishment of specialist health promotion research and education centres.
- *Support effective and sustainable multi-level partnerships across diverse sectors,* both within and between countries, in order to progress implementation of HiAP and to meet the targets set by the SDGs.

- ***Support social mobilisation strategies***
  - *Invest in improved consultation processes and community engagement strategies* to actively engage European citizens in creating a greater demand for health promotion in Europe and advocating for the implementation of policy decisions that impact on health and wellbeing. Effective community engagement is a critical strategy for achieving improved population health and wellbeing, social cohesion and socio-economic development by generating a better public understanding of the importance of positive mental, physical and social health for sustainable human development, and the need for greater accountability for its development at a country and EU level.

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