

Health promotion for older people by sectors and settings. Comparative perspective

Stanisława Golinowska ⁽¹⁾, Iwona Kowalska-Bobko ⁽¹⁾, Walter Ricciardi ⁽²⁾, Andrea Poscia ⁽²⁾, Nicola Magnavita ⁽²⁾

(1) Full Professor at the Jagiellonian University Medical College in Krakow and at the Institute for Labour and Social Studies (IPISS) in Warsaw, Poland

(2) Institute of Public Health, Università Cattolica del Sacro Cuore of Rome, Rome, Italy

CORRESPONDING AUTHOR: Andrea Poscia, Institute of Public Health, Università Cattolica del Sacro Cuore of Rome, Rome, Italy;
Email: andrea.poscia@unicatt.it

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Although everybody decides individually about their behaviour and lifestyle, in health-related matters we tend to accept others' influence and surrender to it. We are also led by institutions, sometimes obligatorily. Who has the right and is able to lead health promotion, having the necessary knowledge; and in what way, applying proper methods? The answers to these questions may be of a normative character (who should do it) or of an investigative character (who in fact does it). In the "Pro-Health 65+" project, an investigative answer was sought.

Health promotion as an institutionalised activity is conducted by many entities, both public and private, both governmental and non-governmental, both on central and local levels, aimed at the whole population and selectively, at chosen groups within the population. The institutionalised picture of health promotion is much more varied than that of healthcare, which to a large degree has defined limits and is standardised, due to universally applied standards of medical procedures.

The vast majority of health promotion campaigns are conducted in the public sphere. The scope of these campaigns depends on the development of public institutions in a given country, the model of healthcare system (Raphael 2011), and the level of public participation in making life (and health) decisions for people. In countries with a more centralised (deconcentrated) model of public institutions, health promotion, as the main activity within public health, is conducted by governmental agencies, national institutes of public health, ministries of health, ministries of education and sport, and the public media. In a more decentralised countries, where public institutions are placed at regional and local levels, health promotion is conducted in a decentralised manner and often autonomously (i.e. independently from the central level).

Lately, there has been development in the research of health promotion in places where people live, study, work, and spend free time, including, increasingly in virtual spaces. This research refers to the idea of a community. The meaning of community, as described in texts from the field of sociology where community is the central object of research, lies in the process of identifying with a group, respecting common values, accepting and observing a certain standard of behaviour considered appropriate (Love et. al. 2002). The significance of community for healthcare and for leading a healthy lifestyle is commonly postulated. Development and political reinforcement of communities in healthcare was introduced by the WHO within the recommendations included in the Bangkok Charter for Health Promotion (WHO 2007). The idea of community in actions for health resulted in the concept of health promotion based on the place of living (The Setting Based Approach – SBA), and in the consequence, many health programmes, such as healthy city, healthy school, healthy university, healthy company, healthy home or healthy hospital. The concept of implementing health promotion rules in people's dwelling place gained widespread recognition, although it commonly concerns places on a smaller scale (school or workplace) rather than the whole city (Dooris 2009, Barton 2014).

The final recipient, or beneficiary, of health promotion is an individual person or a group of people, defined by factors such as age, health status, family status, place of residence, education, gender, or income. In the “Pro-Health 65+” project, the recipients of the actions are elderly people in a wide age range. Three groups of elderly people have been defined:

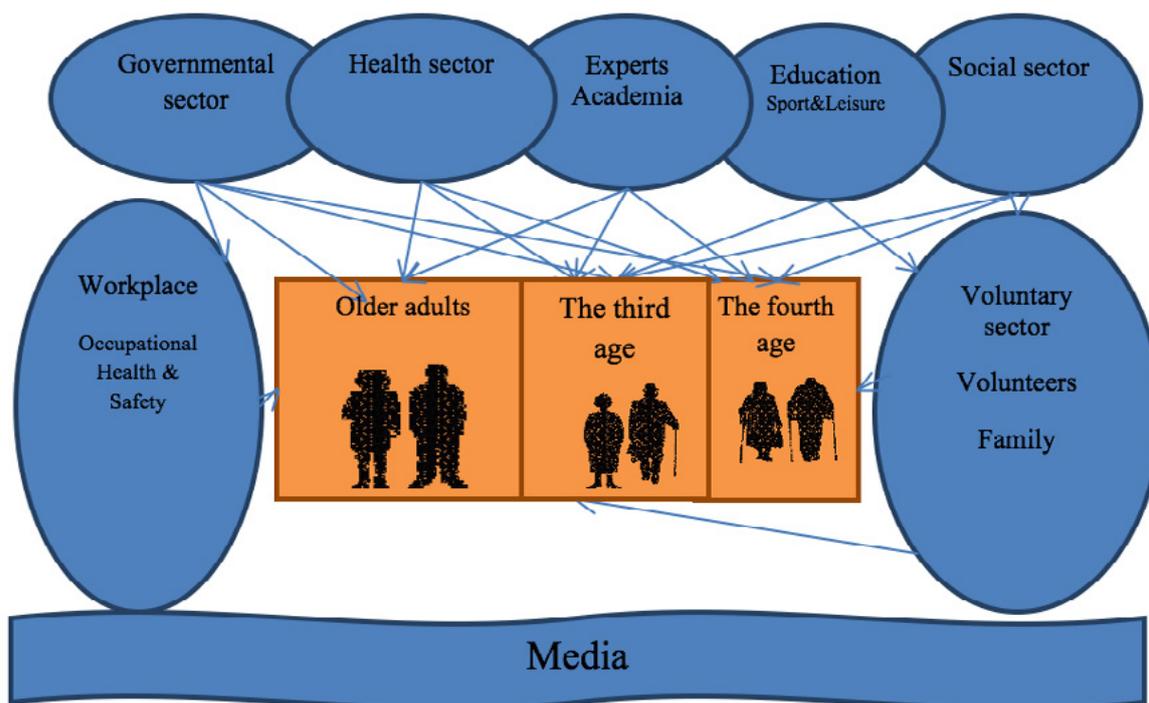
1. The first group - **from the age of 55-67** - comprises people who are about to enter the period of older age. These people are usually still professionally and socially active (in pre-retirement age). At this age the first more serious health conditions occur, and are often chronic. Activities in the area of health promotion and disease prevention directed to this age group are usually conducted individually in the context of occupational medicine or primary care, but in many countries cardiovascular disease and cancer screening programmes are also implemented at a community level.
2. The second group includes people **aged 67-80/85**. These people have entered retirement and are typically inactive in the labour market, although they are still active socially and in their families. In this period of life health promotion and disease prevention is organised in the framework of multiple programmes and interventions, mainly in the local community, and it is aimed at maintaining physical, social and cultural activity, health education and information as well as education in other spheres of life.
3. The last group is composed of the so-called “oldest old”, **above 80/85 years**. These are the people with a far worse health status, among whom care needs are rising (Poscia 2015). Health promotion in this age group, although it still might bring positive health effects, is often conducted indirectly, in cooperation with family and care providers. Actions and interventions for this age group are organised in health and social sectors, both at home and in institutions.

In the research of institutional structure of health promotion, the scope of issues was recognised as well as the ways to identify tasks, the forms of their implementation, and the efficiency of the undertaken actions. The sectoral approach is not a novel kind of institutional research found in health promotion, but it often may not be as clearly defined as it is presented here. It refers to the responsibility of the state and public institutions for health. It indicates the entities with the permission and expertise to determine appropriate programmes of health promotion. This approach, let us call it The Sectors Based Approach, answers the question of who is (or should be) in control of launching a programme, of financing it and implementing it. It also fits in the concept “health in all policies”. Good health requires effort on the part of many different entities situated in different sectors, on diverse levels of power and in many places where people live. This approach was applied in the analyses of the “Pro-Health 65+” project, which we are presenting here.

The scope of research conducted in reference to sectors and groups of elderly people has been presented in the graph below.

In-depth studies of health promotion were conducted for selected institutions in the countries where they played a relatively greater role. This was verified through a survey sent to experts from the countries taking part in the “Pro-Health

Graph: Sectors in health promotion for the three groups of older people



65+” project (Sitko et. al. 2016). Governmental institutions were active in all cases, more centralised in some countries and more decentralised in others. The health sector played a crucial role, both as a part of the governmental sector and a more autonomous structure. Health promotion was often undertaken in the education and sport sectors, where the recipients of the activities were normally children and young people rather than elderly people. This changed to some degree when life-long learning became more important and when sport included amateurs in its scope of activities. For the oldest group of elderly people, the social sector was also essential, both within care institutions and regarding family support.

Non-governmental and religious institutions conduct health promotion actions in all places. Surprisingly, they were indicated as more active in post-communist countries, but this is perhaps due to the fact that the public sector is weaker in this respect. Therefore, the voluntary sector seems relatively stronger.

Although the media is crucial in providing health information and promotion, experts did not indicate the media as a significant sector for professional health promotion. This might be related to numerous ‘faults’ of the media in this field. Similarly, the workplace is not considered by the experts as one of the leading sector for HP4OP in any of the European countries, even if according to the literature, it is of growing importance for health promotion considering the widespread ageing of the European workforce (Poscia 2016).

The choice of 10 partner countries in the project was dictated by a need for proper representation of the European welfare state models (Golinowska, Pavlova 2017). The analyses are focused on three group of countries (1) that, so far, have been analysed to at least some extent: European post-communist countries (Poland, Hungary, The Czech Republic, Bulgaria and Lithuania), (2) Southern European countries (Italy, Portugal and Greece) and two countries with advanced capitalism: (Germany and the Netherlands).

In this Special Issue of the journal *Epidemiology, Biostatistics and Public Health* the following articles on sectors and settings of health promotion for older people from the European countries comparative perspective were presented:

1. Central and territorial governmental institutions involved in health promotion for older people in the European Union countries.
2. Health promotion for older people performed in the health sector.
3. Workplace health promotion programs in different areas of Europe.
4. Voluntary (NGO) Sector’s Involvement in Health Promotion for the older population in Europe.
5. Health promotion for the oldest seniors in the social sector. Examples of policies and programs from Poland and the Czech Republic.
6. Health promotion actions in mass-media for seniors in selected European countries.
7. Health promotion actions for older people in the sport sectors in selected European countries.
8. Furthermore, a special focus is dedicated to a couple of raising and complementary issues among older adults: the avoidance of loneliness and social isolation, and the society efforts towards a more effective work engagement. Finally, a paper on the methodological issues related to the research in older people is provided as a closure of this supplement in order to help dealing with the challenges of longitudinal studies in elderly.



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