Implementation of Health in All Policies on the local level for more effective prevention of non-communicable diseases in the Baltic Sea Region/ Northern Dimension Area – Healthification

February 2014

The project was financed by Northern Dimension Partnership in Public Health and Social Well-being.
Contents

1. Introduction.................................................................................................3

2. Health in All Policies as a concept..........................................................3

3. Problem of non-communicable diseases
   in the Baltic Sea Region/Northern Dimension area
   3.1 Main health facts..............................................................................4
   3.2 How Health in All Policies can help tackle the NCD problems?........10
   3.3 How the analysis of Potential Years of Life Lost
       can help respond to NCDs?.................................................................11
   3.4 Potential of the eHealth solutions for prevention
       of non-communicable diseases..........................................................13

4. Implementation of Health in All Policies on the local level
   in the Baltic Sea Region/Northern Dimension area
   4.1 Lithuania.......................................................................................14
   4.2 Latvia............................................................................................17
   4.3 Estonia..........................................................................................17
   4.4 Poland...........................................................................................20
   4.5 Finland..........................................................................................21
   4.6 Sweden..........................................................................................23
   4.7 Norway..........................................................................................25

Summary.........................................................................................................27

5. Obstacles and gaps in the implementation of Health in All Policies
   on the local level in the Baltic Sea Region/Northern Dimension area
   5.1 Obstacles and gaps in Lithuania....................................................27
   5.2 Obstacles and gaps in Latvia..........................................................28
   5.3 Obstacles and gaps in Estonia.......................................................28
   5.4 Obstacles and gaps in Poland.........................................................28
   5.5 Obstacles and gaps in Finland.......................................................30
   5.6 Obstacles and gaps in Sweden.......................................................31
   5.7 Obstacles and gaps in Norway.......................................................31

Summary.........................................................................................................31

6. The voice of city mayors

7. Analysis of Potential Years of Life Lost
   in the Baltic Sea Region/Northern Dimension area
   7.1 PYLL in Lithuania...........................................................................34
   7.2 PYLL in Latvia................................................................................34
   7.3 PYLL in Estonia.............................................................................35
   7.4 PYLL in Poland...............................................................................35
   7.5 PYLL in Finland...............................................................................35
   7.6 PYLL in Sweden.............................................................................36
   7.7 PYLL in Norway.............................................................................36

Summary.........................................................................................................36

8. Conclusions and recommendations for further actions in the field
   of implementation of Health in All Policies on the local level
   in the Baltic Sea Region/Northern Dimension area

List of contributors........................................................................................37
List figures.....................................................................................................38
Annexes........................................................................................................38
1. Introduction

The Report on Implementation of Health in All Policies on the local level for more effective prevention of non-communicable diseases in the Baltic Sea Region/Northern Dimension area is a final product of the Healthification seed-money project, financed by the German Ministry of Health through the Secretariat of the Northern Dimension Partnership in Public Health and Social Well-being, and realized in December 2013 - February 2014. The Healthification project, in general, aims to address the problem of epidemics of non-communicable diseases and the role of local governments in tackling them. The recent law changes in several countries of the Baltic Sea Region/Northern Dimension area increased the responsibility of municipalities in delivery of public health and health promotion. While most of the countries have national strategies on non-communicable diseases, their implementation locally faces the limitation of capacity and resources. Practically all the countries support Health in All Policies approach, however its application at municipal level is challenging.

The report serves as a background review for a bigger-scale Healthification project and collects the information about the state of play in implementation of Health in All Policies approach on the municipal level and availability of reliable and updated health data that can be used for evidence-based decision making, with the special focus on the analysis of Potential Years of Life Lost (PYLL). The report covers geographical area of Lithuania, Latvia, Estonia, Poland, Finland, Sweden and Norway.

2. Health in All Policies as a concept

Health in All Policies (HiAP) as a concept is adopted by the European Union in the Public Health Article 152 (Lisbon Treaty Article 168) within the context of ensuring a high level of health protection in all policies. During the Finnish EU Presidency in 2006, Health in All Policies was strongly highlighted. The aim was to review policy making at all levels of governance in Europe and to support measures to review the health impacts of key decisions and policies. Since that the HiAP has been part of the overall policies in the European Union. Still, there is discussion and debate of the lack of health considerations as part of the EU integrated impact assessment procedures.

Europe has reached unprecedented levels of health and wealth, but this success cannot be taken for granted. There are worries about a new, emerging scourge, but in particular the debate is focusing on the demographic change in European societies, which are ageing and shrinking. The other problems include increasing obesity, mental health problems, alcohol consumption in some countries and also accessing to health care services. If unaddressed, these changes will result in severe consequences for health and wealth in Europe. Labor market participation may dwindle, productivity may decline, tax revenues may contract, the ageing population may be in need of more health services, and chronic diseases will be on the increase.1

In the European Union level, many declarations call the health promotion and health perspective when taking political decisions and preparing guidelines in non-health policy sectors. Helsinki Statement which was accepted at the 8th Health Promotion Conference (Helsinki, 2013) confirms that "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". The Statement highlights the role of governments – they have a responsibility to take care for the health of citizens. The good health promotes also the quality of life, learning capacity and strengthens families and communities and also improves workforce productivity. Health sector is not responsible for health alone, e.g. trade and foreign policy has responsibilities for health as well. The whole government in each community should have a political will to engage in health. Helsinki Statement calls on governments to:

- Commit to health and health equity as a political priority by adopting the principles of Health in All Policies and taking action on the social determinants of health.

---

• Ensure effective structures, processes and resources that enable implementation of the Health in All Policies approach across governments at all levels and between governments.

• Strengthen the capacity of Ministries of Health to engage other sectors of government through leadership, partnership, advocacy and mediation to achieve improved health outcomes.

• Build institutional capacity and skills that enable the implementation of Health in All Policies and provide evidence on the determinants of health and inequity and on effective responses.

• Adopt transparent audit and accountability mechanisms for health and equity impacts that build trust across government and between governments and their people.

• Establish conflict of interest measures that include effective safeguards to protect policies from distortion by commercial and vested interests and influence.

• Include communities, social movements and civil society in the development, implementation and monitoring of Health in All Policies, building health literacy in the population.2

Within the years European Commission has funded several projects related to Health in All Policies. At the European level, Health Impact Assessment and progress in the WHO Healthy Cities indicate that equity in health, solidarity in health, participation in decision-making and sustainability has generally been accepted.3 Finally, during the Annual Conference of the Health Forum Sustainable Health Systems for Inclusive Growth in Europe in Vilnius in 2013, the policy makers remarked that health has an impact on everything and everything impacts health.

3. Problem of non-communicable diseases in the Baltic Sea Region/Northern Dimension area

3.1 Main health facts

Non-communicable diseases (NCDs) are the biggest public health problem in Baltic Sea Region/Northern Dimension area. Currently NCDs are responsible for about 78% of all causes of deaths. NCDs risk factors consist of alcohol consumption, tobacco use, unhealthy diet and physical inactivity, which cause diabetes type-2, cardiovascular disease, overweight and obesity, inter alia. Biggest problems are diseases of circulatory system (44%), malignant neoplasms (23%) and respiratory diseases (9%). NCD mortality rates ranges from Estonia’s 87% to Norway’s 76% of all NCDs (Figure 1). According to the figures, it seems that the Baltic States, Russian Federation and Poland are behind other countries and have some challenges to face, especially in preventing cardiovascular diseases. Reducing alcohol consumption and tobacco use and also improving nutrition could narrow figures between countries.4

Cardiovascular diseases

Cardiovascular diseases (CVDs) consist of coronary heart disease, cerebrovascular disease, raised blood pressure and peripheral artery disease, rheumatic heart disease, congenital heart disease and heart failure. Tobacco use, physical inactivity and also unhealthy diet are major causes of these cardiovascular diseases. According to WHO, over 80% of cardiovascular disease deaths happen in low- and middle-income countries. This can be observed in the Figure 2; in Baltic States, where the income level is lower than e.g. in Nordic countries, CVDs rates are higher than in other countries (Figure 2).

---

**Figure 1** Share of NCDs of all mortality in NDP area

The share (%) of NCDs of all mortality in NDP area in 2010 or latest available year

<table>
<thead>
<tr>
<th>Country</th>
<th>Share (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estonia</td>
<td>87%</td>
</tr>
<tr>
<td>Latvia</td>
<td>85%</td>
</tr>
<tr>
<td>Lithuania</td>
<td>85%</td>
</tr>
<tr>
<td>Russia</td>
<td>85%</td>
</tr>
<tr>
<td>Poland</td>
<td>83%</td>
</tr>
<tr>
<td>NDPHS</td>
<td>82%</td>
</tr>
<tr>
<td>Iceland</td>
<td>81%</td>
</tr>
<tr>
<td>EU</td>
<td>80%</td>
</tr>
<tr>
<td>Germany</td>
<td>79%</td>
</tr>
<tr>
<td>Sweden</td>
<td>77%</td>
</tr>
<tr>
<td>Finland</td>
<td>77%</td>
</tr>
<tr>
<td>Norway</td>
<td>76%</td>
</tr>
<tr>
<td>Denmark</td>
<td>76%</td>
</tr>
</tbody>
</table>

Source: WHO-EURO 2012

**Figure 2** Diseases of circulatory system

SDR, diseases of circulatory system, 0–64 per 100 000

Source: WHO/Europe, European HFA Database, January 2013

---

5 Northern Dimension Partnership in Public Health and Social Well-being, NCD-EG, NCD-Charts 2013, Draft

6 Ibidem
Several policy areas and interventions could impact on CVDs, and Health in All Policies approach has an important role in tackling this issue. Different policy areas could e.g. 1/introduce comprehensive tobacco policies, 2/implement taxation to decrease consumption of unhealthy food (high fat, sugar, salt), 3/boost physical activity by building walking and cycling ways, and 4/provide healthy school meals to children and adolescents.

**Alcohol consumption**

Alcohol can damage all human body and it can be a risk factor in cancer, cardiovascular diseases and also in diabetes (Figure 8). Pure alcohol use is relatively high in the whole Baltic Sea Region/Northern Dimension area (Figure 3), even if some of the Nordic countries have lower rates than others.

Regarding the alcohol related causes of death, the problem is much bigger in the Baltic States, both between men and women. Although, it is important to notice that in all countries rates of alcohol related causes are decreased and the decrease has been considerable within the years.

**Figure 3** Pure alcohol consumption (liters/capita, 15+) in Baltic Region Sea Region/ Northern Dimension area

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>6.5</td>
<td>7.3</td>
<td>9.2</td>
<td>10.5</td>
<td>11.2</td>
<td>13.7</td>
</tr>
<tr>
<td>Estonia</td>
<td>5.8</td>
<td>6.9</td>
<td>8.4</td>
<td>9.7</td>
<td>10.3</td>
<td>12.7</td>
</tr>
<tr>
<td>Finland</td>
<td>6.2</td>
<td>7.0</td>
<td>8.5</td>
<td>9.5</td>
<td>10.2</td>
<td>12.3</td>
</tr>
<tr>
<td>Iceland</td>
<td>5.0</td>
<td>5.8</td>
<td>7.2</td>
<td>8.3</td>
<td>9.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Latvia</td>
<td>4.5</td>
<td>5.3</td>
<td>6.8</td>
<td>7.8</td>
<td>8.6</td>
<td>10.7</td>
</tr>
<tr>
<td>Lithuania</td>
<td>4.0</td>
<td>4.8</td>
<td>6.3</td>
<td>7.4</td>
<td>8.2</td>
<td>10.3</td>
</tr>
<tr>
<td>Norway</td>
<td>5.1</td>
<td>6.3</td>
<td>8.0</td>
<td>9.1</td>
<td>9.9</td>
<td>12.0</td>
</tr>
<tr>
<td>Poland</td>
<td>4.7</td>
<td>5.6</td>
<td>7.2</td>
<td>8.2</td>
<td>9.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Russia</td>
<td>6.0</td>
<td>7.2</td>
<td>9.0</td>
<td>10.1</td>
<td>11.0</td>
<td>13.5</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>6.0</td>
<td>7.2</td>
<td>9.0</td>
<td>10.1</td>
<td>11.0</td>
<td>13.5</td>
</tr>
<tr>
<td>Sweden</td>
<td>5.5</td>
<td>6.4</td>
<td>8.0</td>
<td>9.1</td>
<td>9.9</td>
<td>11.9</td>
</tr>
<tr>
<td>EU</td>
<td>5.8</td>
<td>6.7</td>
<td>8.2</td>
<td>9.3</td>
<td>10.0</td>
<td>12.1</td>
</tr>
</tbody>
</table>

Source: WHO/Europe, European HFA Database, January 2013

Policy may have a great impact on reducing alcohol consumption and diseases, and conditions caused by it. Raising awareness of alcohol consumption, alcohol pricing (taxation), drink-driving policies, limitations of marketing of alcohol and reducing the public health impact of illegally and informally produced alcohol, have potential to reduce alcohol related consumption (WHO/alcohol).

\(^7\) Ibidem
**Tobacco use**

According to WHO, tobacco is the greatest single preventable cause of death in the whole world (WHO/tobacco). It is interesting to look at the graphs presenting the problem of smoking and smoking related causes from different countries. Figure 4 shows the big difference in male population of daily smokers (age 15+) in Baltic Sea Region/Northern Dimension area. Smoking is a huge problem in Lithuania, Latvia and Poland while it was decreased considerably in Nordic countries.

**Figure 4 Daily smokers in the population (age 15+), male**

![Daily smokers in the population (age 15+), male](image)

Source: WHO/Europe, European HFA Database, January 2013

**Cancer**

Tobacco and alcohol use, poor nutrition, overweight and obesity, physical inactivity, some chronic infections and environmental and occupational risks are factors, which influence cancers. Even more than 30% of cancers are caused by behavior and environmental risks, and tobacco is one of the largest preventable causes of cancer. Tobacco control, healthy diet, promotion of physical activity and prevention of alcohol consumption can be effective ways to tackle the epidemics of cancer. Early diagnoses and screenings have likewise an important preventable role.

Finland has done great work in decreasing cancer rates since 1970 when the rates were really high. In other countries rates seems to be decreasing as well (Figure 5).

---

8 Ibidem
Figure 5 Trachea/bronchus/lung cancer, all ages, male\textsuperscript{10}  

SDR, trachea/bronchus/lung cancer, all ages per 100 000, male

Source: WHO/Europe, European HFA Database, January 2013

Figure 6 Average amount of fruits and vegetables available per person\textsuperscript{11}  

Average amount of fruits and vegetables available per person per year (in kg)

Source: WHO/Europe, European HFA Database, January 2013

\textsuperscript{10} Northern Dimension Partnership in Public Health and Social Well-being, NCD-EG, NCD-Charts 2013, Draft
\textsuperscript{11} Ibidem
Nutrition
Poor diet and low fruit and vegetable intake have large effects on health, and the availability of healthy food is a very important health aspect. Unhealthy nutrition shortens life expectancy and decreases quality of life. Diet has comprehensive health impacts, e.g. in reference to cancers and cardiovascular diseases. There are differences between countries in the average amount of fruits and vegetables consumed but the figure below (Figure 6) shows that the situation is improving.

Food industry and policy makers can influence healthy diet by reducing use of salt, eliminating industrially produced trans fatty acids, reducing consumption of saturated fat and intake of free sugars and also by increasing the use of fruits and vegetables. Interventions can be implemented cost-effectively in schools, workplaces and other communities.12

Physical inactivity
Physical activity has great impact both on physical and mental health. It lowers the risk of cardiovascular diseases, type-2 diabetes and metabolic syndrome. It strengthens bones and muscles that help coping in daily life, and it supports the weight control. For mental health, physical activity helps to decrease depressive condition and stress.13

Within the Baltic Sea Region/Northern Dimension area the situation in Nordic countries is better than in the other nations but the physical inactivity is still a problem. Many things determine the physical activity, e.g. income, education, infrastructure and healthcare. This means that many policy sectors can affect these aspects and support the physical activity of the population.

Figure 7 Insufficiently active, male & female14

---

14 Northern Dimension Partnership in Public Health and Social Well-being, NCD-EG, NCD-Charts 2013, Draft
3.2 How Health in All Policies can help tackle the NCD problems?

The main risk factors of non-communicable diseases are known, and it is also understood that they have a comprehensive impact on high blood pressure, overweight and obesity, high cholesterol and high blood glucose (diabetes).\(^{15}\) They are interrelated, which means that one risk factor or set of the factors causes one or many non-communicable diseases, as the Figure 8 shows.

**Figure 8** Four non-communicable diseases, four shared risk factors\(^{16}\)

<table>
<thead>
<tr>
<th>Noncommunicable Diseases</th>
<th>4 Diseases, 4 Modifiable Shared Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular</strong></td>
<td><img src="check" alt="Tobacco Use" />, <img src="check" alt="Unhealthy diets" />, <img src="check" alt="Physical Inactivity" />, <img src="check" alt="Harmful Use of Alcohol" /></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><img src="check" alt="Tobacco Use" />, <img src="check" alt="Unhealthy diets" />, <img src="check" alt="Physical Inactivity" />, <img src="check" alt="Harmful Use of Alcohol" /></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td><img src="check" alt="Tobacco Use" />, <img src="check" alt="Unhealthy diets" />, <img src="check" alt="Physical Inactivity" />, <img src="check" alt="Harmful Use of Alcohol" /></td>
</tr>
<tr>
<td><strong>Chronic Respiratory</strong></td>
<td><img src="check" alt="Tobacco Use" />, <img src="check" alt="Unhealthy diets" />, <img src="check" alt="Physical Inactivity" />, <img src="check" alt="Harmful Use of Alcohol" /></td>
</tr>
</tbody>
</table>

This also means that Health in All Policies approach has great potential in reducing NCDs. It is an approach to be chosen by the decision makers in all sectors.

\(^{15}\) Northern Dimension Partnership in Public Health and Social Well-being, NCD-EG, NCD-Thematic-Report 2013, Draft

\(^{16}\) Four noncommunicable diseases, four shared risk factors, WHO, http://who.int/ncdnet/about/4diseases/en/
3.3 How the analysis of Potential Years of Life Lost can help respond to NCDs?

The Potential Years of Life Lost (PYLL) rate describes the number of potential years of life lost due to premature death in a population. From a social point of view, this is equal to loss of human capital.

The rate is calculated on the basis of the difference between the age at death and the expected length of life, and it is determined by the cause of death according to the ICD-10. The method reviews the time of death in relation to pre-defined life expectancy. The rate is age-standardized and expressed as a sum of all deaths per 100,000 person-years. The simplified graph below (Figure 9) presents the principles of PYLL calculation.

Figure 9 The logic behind the calculation of Potential Years of Life Lost (PYLL)

Starting point: simple calculation

- **Standard-life to which all preventable deaths are reflected**

  \[ A = \text{Ivan died of coronary heart attack at age of 55 years} \]

  \[ \text{Ivan’s PYLL} = 70 - 55 = 15 \text{ years} \]

- **B = Anna died of alcohol poisoning at age of 28 years**

  \[ \text{Anna’s PYLL} = 70 - 28 = 42 \text{ years} \]

- **C = Pelagiya died of stroke at age of 71 years**

  \[ \text{Pelagiya’s PYLL} = 70 - 71 = 0 \text{ years} \]

The PYLL rate provides comparable information about the wellbeing of a population concerning all death causes. It provides supplementary information for planning and decision-making for health policies.

- The PYLL rate is one of the most used indicators for the wellbeing of the population. It is used, for example, by the World Bank, OECD, WHO and EU when evaluating the development of the wellbeing of population in different countries.

- The differences in wellbeing between countries and regions are affected by various factors: genes, living habits and environment, catastrophes, health policies in a country or region, various functions of different sectors of the society and practiced social and health policies.

- The PYLL rate offers the possibility to compare, monitor and evaluate the wellbeing of population internationally between municipalities, sub-regions, regions and countries.

- The PYLL rate produces comparable information to support strategic planning and decision-making on both country and municipality level.

All countries of the Baltic Sea Region/Northern Dimension Region have digitalized death-registers, which means that using PYLL as planning and monitoring tool for public health strategies is possible and feasible.
The PYLL rate is very sensitive for indicating death at early years. For instance, one individual who has died at the age of 40 will give the rate the same numerical value as ten individuals who died at 67.

Originally the Potential Years of Life Lost rate was used in epidemiology to become later a method serving in national economy. By combining information acquired from the PYLL rate with information provided by other indicators, the results of health policies, wellbeing strategies or other measures can be reviewed. With monitoring the Potential Years of Life Lost in a long period of time conclusions can be made on whether the wellbeing of a population is improving or not. The indicator offers a possibility to set the necessary measures in promoting wellbeing in order of importance.

The aim of using PYLL in Healthification project is to describe the premature loss of human capital of the population (measured by the Potential Years of Life Lost rate) in different countries, and to compare the situation nationally, internationally, in other comparable cities/municipalities, or even city parts, concerning all preventable premature causes of death. The data will be used in designing and implementing strategic interventions to improve the situation with the focus on most important priority areas, where evidence based innovations and tools exist.

The data available (Figure 10) show big differences in PYLL rates between the countries covered by the report. The Healthification project will deliver the analysis of the situation on the local level (i.e. local data), which is currently not available in most of the countries. Only the local level data can motivate the local decision makers to take the action.

**Figure 10** Inter-country comparison of PYLL, all ages, male and female
3.4 Potential of the eHealth solutions for prevention of non-communicable diseases

Health and social care environment is changing - people live longer and the modern societies have to cope with growth of years lived with chronic conditions. If this trend preserves, more care specialists will be needed. This is an unreachable goal – due to the lack of professionals and budget limitations.

The increasing number of citizens with chronic conditions on one hand and pervasive access to the medical information in the web on the other has made people increasingly searching for diagnostic and treatment options from internet. Even though this tendency is positive in regard to the health literacy, the information available is not always proper or originates from trustful sources.

Above mentioned trends demand reconsidering of health policies and reengineering of health care pathways. For the time being the most important factors regarding health, health promotion and health and social care are the data concerning health and the complete and access to the data not depending on time or geographical location of the citizen or healthcare professional. Open and secure access to own health data together with the opportunity to read and learn health related topics from trustful sources on the web has potential to increase health awareness of the citizens and promote healthy living.

Digital health and healthcare data and services are integral parts of everyday health and social care environment. Though digital environment is not and would not replace human interaction in the healthcare, the trend of the use of new e-services and shared environments in healthcare is rapidly increasing. eHealth and telemedicine services have become one of the health care services.

The term eHealth covers several components. It could be divided into four categories:

1. Electronic Health Record (EHR);
2. Applications for healthcare institutions;
3. Applications for citizens;
4. Telemedicine and telemonitoring.

EHR collects data from multiple healthcare organizations or patients and includes patient case summaries (incl. allergies, prescriptions, recent events, etc.). Applications for healthcare institutions are e.g. electronic patient records for hospitals, electronic patient records for general practitioners, picture archiving and communication systems and other digital imaging systems, and business intelligence and financial manage-
Applications for citizen are personal health records (PHR) and different computer health applications. Telemedicine and telemonitoring include remote diagnosis, like teleradiology, teledermatology and remote consultations, virtual visits, e-referrals and remote monitoring.

From the citizen’s point of view the most important applications of eHealth domain are personal health records, health applications for computers and mobile devices, remote consultation and monitoring applications, and also case summaries from different healthcare institutions.

Project Healthification will use digital health applications and eHealth tools to promote healthy living in order to avoid or at least postpone the onset of non-communicable diseases. The digital data and shared eHealth services to improve health quality of people with chronic conditions and to help them to avoid complications will also be developed and piloted.

One of the aims of Healthification is to involve citizens into the decision process. The planned activities are as follows:

- Introduction of the role and importance of health data (not disease data!);
- Examples of the use of health data:
  - Health games,
  - Physical activity trackers,
  - Health promotion applications;
- Integration of health and clinical data:
  - Understanding of own health trends;
- Introduction of health and disease trends in society:
  - Epidemic growth of chronic conditions;
  - Measures to counteract with non-healthy living.

Possible interventions will include:

- Implementation of national/regional e-health policy for health promotion;
- Addressing specific groups:
  - Children to understand the importance of healthy living,
  - Smokers,
  - People with chronic condition;
- Gamification and support to develop new health applications based on the medical/statistical evidence.

4. Implementation of Health in All Policies on the local level in the Baltic Sea Region/Northern Dimension area

All countries participating in the Healthification seed-money project and covered by this report support Health in All Policies (HiAP) approach. It is reflected in their public health strategies, national health programmes and promoted by the agencies responsible for public health. This part of the report reviews the countries’ commitment towards HiAP and explores if and how it is implemented on the local level.

4.1 Lithuania

In Lithuania, the requirement to increase integration of health care (not only to improve health care system, but also to create healthy environment) in reducing prevalence and incidence of diseases was provided in the "Sustainable Development Strategy" and in Lithuanian Health Program 2014-2023 prepared according to "Health 2020: a European policy framework supporting action across government and society for Health and wellbeing". The program indicates that reaching its strategic goals requires cooperation of national government, all economic sectors, communities and families. National
Public Health Care Strategy 2006-2013\textsuperscript{19} provided need to create modern and effective system of public health care by the reform, management of social and economic processes, participation of all sectors and society. In the Lithuania’s progress strategy "Lithuania 2030\textsuperscript{20}" one of the objectives is to raise quality of life index and happiness index, building sustainable development, clean and safe environment, smart society, smart economy, smart governance, and open creative responsible people. Lithuanian Health System Development Dimensions for 2011-2020\textsuperscript{21} predict that public health at the highest political level is not only the part of governmental social and economic politics but an economic segment on its own. In order to ensure integrated actions improving health, provisions of international documents were accepted and were implemented inter-institutional programs.\textsuperscript{22}

On the local level there is a strong support for Health in All Policies (HiAP) approach written in the Municipal Development Plans. These plans support the understanding that health is strongly related with economics in the municipalities. Municipal strategies maintain cooperation of different sectors to improve health and health care. Different municipality strategies support different sectors, NGO and public institutions contribution improving citizens’ health: (e.g.: Vilnius City Mental Health Strategy for 2011-2015\textsuperscript{23}; "Children Well-being Development Strategy for 2013-2020"; "Elderly People Care Strategy for 2012-2020"\textsuperscript{24}. When enforcing public health functions in municipalities, different divisions of municipality administration work together (Departments and Divisions of Administration; Education, Culture, Sport, Public Institutions, Environment and etc.). Public Health Bureaus that are the main providers of public health in Lithuania, are one of the main institutions implementing HiAP approach on the local level. The law provides the framework for cooperation or bureaus with social partners and integration of public health promotion to other activities as one of bureau functions.\textsuperscript{25} Specific functions of Public Health Bureaus are presented in figure below (Figure 11).

\textbf{Figure 11 Functions of Public Health Bureaus}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{functions_of_public_health_bureaus.png}
\caption{Functions of Public Health Bureaus}
\end{figure}

\begin{itemize}
\item Health impact assessment
\item Health promotion in the community
\item Health monitoring
\item Cooperation with social partners
\item Child and youth health promotion
\item Implementation of public health programmes
\item Prevention of infectious diseases
\item Prevention of non-communicable diseases and injuries
\end{itemize}

\textsuperscript{22} Report on Interinstitutional Cooperation Analysis Accomplishment, Similar Experiences of EU Countries and the Existing Legal Framework in Lithuania Evaluation. Public Politics and Management Institute, Vilnius, 2012, p.28-29. http://www.esparama.lt/\textunderscore es\textunderscore parama\textunderscore pietrai\textunderscore failiai\textunderscore ES\textunderscore produktai\textunderscore 2012\textunderscore terpinstitucinio\textunderscore bendradarbiavimo\textunderscore analize.pdf
\textsuperscript{25} Lietuvos Respublikos Sveikatos apsaugos ministro įsakymas „Dėl Savivaldybių visuomenės sveikatos biuro pavyzdinių nuostatų patvirtinimo“ Zin.2008 Nr.35-1953
Moreover, every municipality has a Community Health Board which is independent health coordination body. The composition of the boards shall be as follows: 1/3 of the board members shall be persons appointed by the municipality; 1/3 - representatives of municipal enterprises, institutions and organizations, 1/3 - representatives of public organizations protecting public health interests. The programme of activities of the municipality’s Community Health Board shall be financed from the municipal budget. Community Health Board of the municipality shall coordinate the preparation and implementation in the municipality’s territory of measures of health promotion, alcohol, tobacco and drugs control, public health protection and health strengthening and disease prevention, shall lay down the priorities for the use of municipality’s health fund resources, submit to the Municipal Council for approval the draft budget of the fund and perform other functions assigned to it pursuant to this Law and other laws as well as its regulations. Figure 12 presents a structure of institutions in the municipalities in Lithuania responsible for public health.

Figure 12 Structure of institutions responsible for implementation of health in all policies in municipality in Lithuania

INSPIRATION

Public Health Bureau of Klaipeda organized the "The Healthiest Company Competition". An objective of this was to incorporate organizations in creation of Healthy City process and stimulate health promotion in organizations, improve employees’ healthy lifestyles and encourage their interest in their own health. During this competition Public Health specialists conducted preventive health examinations in the participating companies free of charge and provided information on preventive health screening programs, available free of charge. Private companies, public organizations and schools participated in the event. After all, 808 employees were reached by the campaign. It is a good example on cross-sectoral action for better health.

To sum up, the political system as well as strategic and political documents support HiAP approach in Lithuania where the decisions are made according to HiAP principles. HiAP concept is used in the municipalities, especially in the activities of Public Health Bureaus, but there are still several gaps in practical implementation.

4.2 Latvia

The key documents which are valid and emphasise the intersectoral cooperation on public health issues in the national level in Latvia are:

- The Sustainable Development Strategy "Latvia 2030", with a special attention on second part: "Long-term investment in human capital";
- National Development Plan 2014 to 2020 (the initial version);

The guidelines for Health in All Policies can also be found in other political strategies and programs, e.g. employment and social sector policy, education and science policy, agricultural policy.

There are policy documents on the local level which contain questions about the implementation of HiAP. Taking the Riga municipality as an example, these documents are:

- Riga Long-term Development Strategy to 2025;
- Riga Development Program for the period 2014 to 2020 (the program is under development right now, until it is established the Riga Development Program for the period 2010-2013 is still in action);
- Riga City Municipality Public Health Strategy for 2012-2021;
- The Ministry of Health Guidelines for Health Promotion in Municipalities.

In 2012 Riga City Council established the Riga City Council Health Board, whose primary function is to monitor the implementation of the Public Health Strategy of Riga City for the years 2012-2021. The Board of Health acts as a coordinating body in the municipality, bringing together all department directors, deputies and municipal corporations for a dialog and thus ensuring that public health is put high in the political agenda. The mayor of Riga City had said that main instrument for development and good quality of life is cooperation between sectors and institutions, and health of citizens is one of main goal for being a developed city. The number of health issues and improving lifestyle of citizens shows that city development goes to right direction. Head of Social Committee admits that health is the foundation of a strong and stable city which is able to compete with other cities on regional or international level.

In establishing the Public Health Strategy and Action Plan Riga City takes into account the interaction between all sectors and the aims of Health in All Policies. The action plan for the public health strategy is based on the HiAP concept, ensuring that all sectors are involved in the activities written in the action plan. As mentioned before, the Public Health Strategy Action Plan is based on cross joint cooperation in order to promote health goals set. In order to monitor the implementation of Public Health Strategy and for achieving stated objectives, the Board of Health was established.

4.3 Estonia

There are several political documents in Estonia that include the concept of Health in All Policies (HiAP) even though this term is not widely used yet. The importance of determinants of health and healthy citizens are generally understood both at national and at local level. Also a new Public Health Act is expected to address the principles of HiAP. At the moment the main document at local level where the concept of HiAP can be found is the Municipal Health Profile. However, only 50% of local municipalities have one.

One of the goals described in the National Reform Programme "Estonia 2020" 27 (Estonia’s competitiveness strategy for achieving the objectives of Europe 2020) is increasing healthy life expectancy by improving health-related behaviour and continuing to work toward reducing accidents and improving healthcare infrastructure.

---

It is admitted that people’s positive health behaviour is most impacted by the comprehensive provision of different measures, including increasing people’s awareness, providing required services, establishing regulations that provide restrictions and incentives as well as an effective enforcement mechanism. This approach has been successful in recent years in such fields as water safety, leading to a significant drop in the number of drowning fatalities.

At the moment the functions of local governments in regard public health and health promotion, including HiAP are defined quite generally in the Public Health Act\(^\text{28}\), adopted in 1995. Also, the Act does not provide any instructions for implementation. It is the municipality’s choice how to organize health promotion activities. In some counties and local governments not enough attention is paid to health-related issues which may cause differences in county and local municipality health status.

In October 2013 the draft concept note of the revised Public Health Act was published. The new act, which is expected to be enforced in 2017, should define the main determinants of health, the functions, rights and responsibilities related to public health of all the ministries, agencies and levels (state, county, local government and individuals) as well as mechanisms for intersectoral work. One of the principles that the new act addresses is HiAP. The responsibility of all ministries and agencies in public health has to be defined and all ministries need to take into account the health policy objectives in their work.

The main health policy document in Estonia is the National Health Plan 2009–2020\(^\text{29}\) (NHP), compiled by the Ministry of Social Affairs in 2008. Since 2012 most of national public health strategies were cancelled and their actions were integrated into NHP action plan. The goal is to integrate all national public health strategies under one central public health strategy that is NHP. The Ministry of Social Affairs coordinates planning, implementation and evaluation of the NHP. The NHP has a Steering Committee whose responsibilities are to plan the activities and necessary resources based on the analysis of the previous implementation period and targets. There is scope to develop this Steering Committee into a more strategic intersectoral body.

On the municipal level, some municipalities have a separate health development plan, some have a separate chapter about health development in their (comprehensive) development plan, some have addressed health issues in connection to other activities (education, sport, city planning, environment etc). Examples of health-related objectives from the development plan (action plan) of Kuressaaare for 2014–2020 (2030) are: higher health awareness and better health behaviour of local people; living, work, studying and recreational environment that supports health.

One of the significant innovations in Estonian public health system is the wide use of County and Municipal Health Profiles. In 2008 National Institute for Health Development (NIHD) in cooperation with Ministry of Social Affairs started a five-year European Social Fund programme, which included a wide range of activities for community health promotion capacity building. The aim was to motivate municipalities for action and help them achieve the needed skills and tools to effectively practice evidence-based health promotion. One of the activities was the focus on health profiles as a way for local people to achieve a better understanding about health and its determinants in their community.

Health Profile is a strategic document that maps community’s health indicators and analyses local determinants of health. To keep it all in a cohesive system, the structure of the health profile was based on Estonian National Health Plan 2008–2020. This way every community could actively participate in achieving national health goals. The main topics of the profile were the same as in NHP: (a) Supportive Society; (b) Smart and Healthy Kids; (c) A Healthy Living Environment; (d) A Healthy Way of Life; (e) Stronger Health Care. Health profile also had one added topic – Demographic Trends.

Many municipalities have said that they never before realized how much determinants like economy, environment, social coherence or social capital effect population’s health. Since health profiles are mostly created by social work specialists, education specialists or even municipality mayors who have never before focused on health this way, this reaction is not surprising. Health profiles have also helped to achieve the activation of local health coalitions - it brought together local people from all different life areas to sit together and discuss local issues. Some have even said that this was the first time in their community that all these people from different fields sat down at one

---


Most municipalities who have compiled their health profile, have also an action plan for implementing activities that are based on the issues described in the profile. NIHD has recommended municipalities not to create a specific health action plan, but to integrate these activities into the overall municipal action plan. The argument for this is to support HiAP – that health does not need to be something that is discussed separately from other local issues.

In conclusion, the political documents in Estonia generally support the concept of HiAP, but the degree of understanding and implementation of the principle at local level depends on politicians and civil servants working in local government. It is necessary to raise awareness about determinants of health as well as about public health as a horizontal theme in the development of a local municipality that different sectors and organisations need to contribute to. For many politicians public health still means only health care and/or health promotion (physical activity, nutrition issues, alcohol and drug prevention) that is the responsibility of medical personnel, social workers, youth workers and sports clubs. But the results of activities implemented nationally during the last 5–6 years have shown that the situation is getting better. City Government cooperated with: Saare County Government, Foundation Kuressaare Sports Facilities, the Association of Entrepreneurs of Saaremaa and Saaremaa Sports Association.

**INSPIRATION**

In 2012 Kuressaare City Government implemented a project that was aimed at promoting healthy lifestyle and physical exercise among working-age people. The main objective of the project was to increase the number of people in Kuressaare who make healthy choices and are physically active in order to prevent people dropping out of labour market because of health reasons.


The activities of the project included health promotion days in 11 organisations in Kuressaare. The lecturers introduced possibilities for physical exercise in Kuressaare and gave suggestions how to make healthy choices at home and at work. Blood sugar and cholesterol level of the employees were measured at the health promotion day and a masseuse taught self-massage techniques.

Since 2008 Kuressaare has its own annual recreational sports series “Healthier by Moving” that is comprised of many events for all age groups all year round. In 2012 five events (skiing in February, walking in April, rollerblading in June, swimming in October and athletics in November) were included in the City Government’s project. In addition to practising different sports people got information from experts about the main principles of physical exercise, how to choose the right equipment, how to warm up before exercising, how to prevent injuries etc.

A popular place for pole-walking, running and skiing in Kuressaare is the Health Park with its various tracks. New information boards were installed in the park with the map of the tracks and guidelines for physical exercise in order to make information about warming up and stretching after walking or running available for all visitors.

To raise health awareness among the working-age people of Kuressaare, the project also included production and distribution of information materials. In order to remind constantly the importance of making healthy choices in the office as well as at home, mousepads and tablepads that include simple recommendations (for example exercises for office workers, main principles of healthy eating etc.) for a healthy lifestyle were designed and distributed to employees of public and private sector organisations in Kuressaare.
4.4 Poland

In Poland, the recognition and understanding of the term “Health in All Policies” is rather low, even if it is in practice implemented to some extent. On the national level, the intersectoral cooperation for health is regulated by law. Since 2002, all normative acts of law are subjected to intersectoral public consultations before they are approved as draft legislation. Each new piece of legislation or change in existing legislation must be preceded by a regulatory impact assessment which determines which entities (public or private) are affected by the proposed regulation and the potential impact on population health. The assessment of the anticipated effects of the legislation is carried out in cross-ministerial discussions, and opinions from the relevant research institutions are often requested to aid decision-making.

Moreover, the National Health Programme (NHP) for years 2007–2015 which was written in 2007 by the National Institute of Public Health – National Institute of Hygiene, and adopted by the resolution of the Council of Ministers, sets the goals which achievement requires intersectoral cooperation. The NHP consists of 8 strategic health-objectives and 15 operational objectives.

Therefore, an interdepartmental team was appointed to manage the Programme’s implementation. All Ministries and organizations involved in the NHP implementation are represented in the team, which is chaired by the Prime Minister, with the Minister of Health as the deputy. Generally health is taken into account in policy decisions in a wide range of sectors. E.g. in the area of agriculture, it is considered in relation to the quality and safety of agricultural produce and the use of chemicals that may affect consumer health. Regarding the public health, the 1950s and 1960s system focused primarily on hygiene and infectious diseases is still in place today. Except for the activities carried out under the State Sanitary Inspectorate, there is no separate structure for the provision of public health services, and other public health care activities are carried out by various bodies across different sectors, at both the national and local levels.

Regarding the municipalities, the territorial self-governments, a law to specify their duties and responsibilities was drafted in 2011. It has not yet come in force. The local level is however included in the National Health Programme 2007–2015. The operational objectives concerning risk factors and actions for health promotion include many of the activities that the municipalities are responsible, at least to some extent or in cooperation with other institutions and other levels, for, e.g. reducing smoking and alcohol consumption, improving nutritional habits or increasing physical activity. Operational objective 12 “Activation of local government units and non-governmental organizations for the benefit of health of the society” directly refers to the local governments and suggest their “activation” without putting any specific responsibilities, roles and supervision on them. Moreover operational objective 15 “Increasing and optimizing the utilization of the health care system as well as of local government infrastructure for the purposes of health promotion and education” calls for actions targeted at enhancing the national health promotion capacity through developing infrastructure (policy, supervision system, programme implementation mechanisms).

In realization of all objectives, local authorities are free to choose from the list of priorities from the NHP and, according to the latest monitoring, around 400 of them follow the NHP. This is around 20% of all 2479 municipalities in Poland.

According to the programme, it is expected in 2015 that all local government units will have long-term plans for health policy as well as for securing health-related needs; a partnership for the system of health protection will be built, higher number of well-qualified public health managers will be employed in territorial self-governments and the rules of task management in the health protection sector will be changed into systemic and task-oriented. In order to achieve the results, the regional and local programmes of providing health care services, including prevention and promotion of health should be established and implemented, the local partnership for health should be supported and a network of regional and local plenipotentiaries for health-oriented policy should be built.
As the National Health Programme did not allocate any financial resources for the tasks and the trainings for the local decision makers and administrators were not provided, we can assume that the goals will not be met and the objective will not be fulfilled by 2015. The framework provides the potential project partners with a relevant reference point for further actions in this area.

4.5 Finland

Finland is one of the leaders in implementation of Health in All Policies (HiAP) approach. Public Health Act obligates municipalities to follow the HiAP principles. In all ministries in Finland, health aspect is taken into account when taking decisions. Every four years those efforts are viewed in the Social and Health report. However, the report does not tell how things should be done in the future, it only list the actions done. Health care sector also produce a health and welfare report every year where HiAP is included.

The governmental program Health 2015 is a cooperation program between different sectors of administration. The Advisory Board of Public Health is one of the most important coordination mechanisms in its implementation. The Board consist of 17 members from all sectors of government and non-government organisations, research institutes and municipalities.

The program focuses on the most important health themes and emphasizes health inequalities between population groups. Its aim is to improve health and functional capacity, add active years to life and to reduce health inequalities between population groups. Program is based on the principle that health and well-being is not only the issue of health care but all areas of society. Local governments, businesses and NGOs are involved in the program and the purpose is that health is taken into account in all areas of local and central government, in the private and in the actions of individual citizens. Program was evaluated and the acknowledgement was given for the health policy thinking, planning and implementation of comprehensive health promotion programs and for the strong knowledge and high quality research. However, the critic was also presented. For example, according to the evaluators, the cooperation between different sectors was not strong enough and Health Impact Assessment was not used effectively. On the municipal level the resources allocated for health promotion were not sufficient and the skills were lacking.

Social and Health Policy strategy "Socially sustainable Finland 2020" supports HiAP by including a point "Health and welfare features in all decision-making" in the document.

In general Finnish municipalities have great possibilities to implement health promotion work as they are responsible for social and health care services, culture and sport, basic and upper secondary education, infrastructure (e.g. urban planning) and the protection of environment. They are responsible for provision of public health and primary health care services. Every municipality must provide a Municipal Welfare Report, which presents information about the health and wellbeing of its inhabitants. The Report supports decision making and gives the directions of preferable actions by defining the priorities for interventions. The process of information collection brings together the experts from different fields and strengthens the health knowledge of people from different sectors.

One of the most powerful tools on the municipal level is the Health Impact Assessment. All municipalities must include Human and Health Impact Assessment in decision making within all sectors. In Finland, the assessment process has opened up the planning process of municipality by getting various actors to commit to decisions and choosing the right option. Local social and health authorities in Finland have implemented over 50 Human Impact Assessments. One example of HiAP approach is this case from Kajaani. In 2008 in Kajaani, in Finland, a large paper mill was closed and hundreds of workers were left without a job. It was anticipated that the closure would cause negative health impacts and the intersectoral cooperation was launched. National Institute for Health and Welfare (THL) launched a health and well-being impact assessment study

33 Olilla, E; Ståhl, T; Wismar, M; Lahtinen, E; Melkas, T; Leppo, K. Health in All Policies in the European Union and its member states. 2006.
35 Ibidem
and the local mill company invested money into supporting the workers. Moreover the Finnish Government allocated the funding for structural reforms in the area of Kajaani.

The other tools in use include e.g. TEAviisari (TEA = Health Promotion Capacity Building)\(^\text{36}\) - an online service that depicts municipalities’ activity in promoting their inhabitants’ health. The service, which is available free of charge, supports the planning and management of municipal and regional health promotion. TEAviisari calculator visualizes the health promotion activities of municipalities in four areas: municipal managers, primary health care and sport and education. By the use of the colors, TEAviisari graphs show the strengths of municipalities and the need for improvements in certain areas. The graphs below show the comparison between Turku and Helsinki with the TEAviisari tool (Figure 13).

Figure 13 Turku and Helsinki in the comparison with the TEAviisari tool\(^\text{37}\)

\(^{37}\) Ibidem
4.6 Sweden

Sweden has relatively low level of income inequality, population health status is high and people have universal access to health and medical services that are nearly completely tax-funded. However, health inequalities are increasing also in Sweden and the obesity rates, alcohol consumption and violence-related injuries are growing.\textsuperscript{38}

Swedish government and other public stakeholders at national, regional and local level focus on gaining more knowledge, by means of follow-up activities, of how different interventions affect the health of the population. One goal of Swedish National Institute of Public Health is to monitor the development of health determinants and evaluate public health interventions.\textsuperscript{39} Sweden has a mixed parliamentary system with three autonomous levels of government, central, regional and municipal. These three levels are involved in the organization and delivery of public health and health services. Municipalities have responsibility for decisions which impact on the health determinants, like schools, childcare and elderly care. Municipalities also take care of water and sewerage infrastructure. The municipality administration, which includes public health board, shares a great responsibility for the maintenance of public health together with 21 regions.\textsuperscript{40}

The Swedish Parliament adopted the Swedish National Public Health Policy in 2003 in the legislative proposition Objectives for Public Health (2002/03:35). The aim of the policy was "creating societal conditions to ensure good health on equal terms for the entire population". Since the policy has been implemented, health has been relatively high on political agenda in Sweden. The focus is on the social determinants of health and intersectoral public health work, nationally, regionally and locally. The proposition A Renewed Public Health Policy (2007/08:110) was then presented in 2008. A special Minister of Public Health is responsible for the policy, with access to a high level national steering committee composed of directors-general from main national state agencies and a representative of regional and local authorities. 11 public health objectives are defined according to the remits and responsibilities of the government departments. Overall responsibility for monitoring and coordinating the policy implementation has been with the Swedish National Public Health Institute.\textsuperscript{41}

The 11 objective domains of the Public Health Policy are:
1. Participation and influence in society
2. Economic and social prerequisites
3. Conditions during childhood and adolescence
4. Health in working life
5. Environments and products
6. Health-promoting health services
7. Protection against communicable diseases
8. Sexuality and reproductive health
9. Physical activity
10. Eating habits and food
11. Tobacco, alcohol, illicit drugs, doping and gambling

Eleven objective domains are divided in three strategic areas: Good living conditions, Health-promoting Living Environments and Living Habits, and Alcohol, Illicit Drugs, Tobacco and Gambling. These 11 objective domains cover the most important determinants of health of the Swedish population. With these domains, the policy has set public health targets upstream (in the health determinants) instead of downstream (in disease and health outcomes). The renewed policy emphasizes initiatives aiming at supporting parents, decreasing suicide rates, promoting healthy eating habits and physical activity and also reducing the tobacco use as well as alcohol and illicit drugs consumption.\textsuperscript{42}
The Swedish National Public Health Institute develops and makes the health determinant indicators available, develops planning and steering tools for reviewing and integrating public health at the local municipal level, arranges training activities in health and other sectors and develops Health Impact Assessment and other tools. According to the Ten Years of Swedish Public Health Policy – Summary Report, just few of the county administrative boards used regularly impact assessment to see how decisions influenced to the population’s health. County administrative boards have stated that better access to data at regional and local level, more measurable goals for the county administrative boards’ public health efforts and support from the national level would help facilitate the use of indicator to measure goal attainment in their public health efforts.  

The county administrative boards have focused on the objective domains of the public health efforts on alcohol, illicit drugs, tobacco and doping (ANDT) in the counties and regions. This new ANDT strategy is an important driver for work in this area and the goal is to develop structured, long-term and knowledge-based local ANDT activity. Most of the county councils and regions and half of the municipalities use specific indicators to measure their public health efforts goals. Majority of those also demonstrate that the national public health policy has facilitated systematic public health praxis. The national public health policy has been used as a tool, usually in collaboration with other public health stakeholders.

The Swedish administrative system is characterized by a high degree of decentralization. This means that most decisions affecting public health are made at the regional or local level. Within the Stockholm County Council, the public health policy has also been adopted. A work to coordinate and increase knowledge on health and regional planning has been initiated within the Stockholm region.

The Swedish experience in implementation of HiAP shows that health aspects are not always easy to understand for those from outside the health sector. Working with other sectors in order to make them understand the impact of their policies and programs on health needs to be taken into account, in a realistic timeframe. It is often a long process.

---

SMADIT, Joint action against alcohol and drugs in traffic, is a method used jointly by police, social and treatment services that is intended to reduce the number of repeated drunk driving offences. The goal of the measure is that every suspected drunk or drug driver shall, as soon as apprehended by the police, be offered contact with the social services or the dependency care and treatment services, who can offer a consultation and, if needed, suitable treatment.

Recent evaluation shows potential for improvement of the SMADIT method. It is important that the police always provide the suspected drunk driver with sufficient and accurate verbal information about SMADIT and hand over the written information leaflet with contact information for local social treatment services. The folder may give the suspected drunk driver further information and a chance to take contact on their own initiative. It is also important that the offer is given to people who have been freed from suspicion of drunk driving. Further, it is important that a person, who answered no to SMADIT, is asked again at another time.
4.7 Norway

The Public Health Act\textsuperscript{45}, 2012 governs the long-term and systematic health promotion and provides tools for Norwegian counties and municipalities to meet future health challenges. The law obliges the central health authorities to support counties and municipalities in their public health and to provide information, advice and guidance. An important objective of the reform conducted in 2012 is that it promotes prevention where possible. In principle Public Health Act contributes to the society by promoting public health and reducing social inequalities in health (§ 1). "Community development that promotes public health" makes clear that the goal of the law is, through a broad social approach, to work with all the various influences in the community that may affect public health. The target group of the work is the population or part of the population, not individuals with identified risk.

Public Health Act makes municipalities, counties and state government responsible for promoting public health (§ 2). The principle of promotion of Health in All Policies ("health in all we do") applies to municipalities, county and state. This means that health should be integrated into decision-making processes and, e.g. in exercising the role of the owner of the business and property, employer, development actor or service provider. Public Health Act gives different coordination and supervision duties for county councils, counties and National Institute of Public Health and Health Directorate.

The Public Health Act is built on five general principles:

1. **Levelling** - The goal is not only to improve the average health or maximize the overall health of the community but to reduce social inequalities in health.

2. **Health in everything we do - Health in All Policies** - This involves a recognition that everything, from culture, education, and transport to business influences public health and vice versa. One must think "health" when designing policies and measures in all these sectors.

3. **Sustainable development** - Involves both the population’s health as an important goal for community development, but also implies that health is a fundamental resource to ensure sustainability of the community.

4. **The precautionary principle** - If an action or policy has a suspected risk of causing harm to the public or to the environment, the absence of scientific consensus that the action or policy is harmful, cannot justify postponed action to prevent such harm.

5. **Participation** - This is the guiding principle in Public Health work. Public health work is about transparent, inclusive processes with participation by multiple stakeholders. Promotion of participation of civil society is key to good public health policy development.\textsuperscript{46}

With the Public Health Act a new foundation for strengthening public health work in politics and social development and in planning to regional and local needs was established. Among other things, a requirement is that each municipality / county will have a good overview of their own health challenges. Identified health challenges will form the basis for the goals and strategies rooted in the planning system under the Planning and Building Act. Local authorities have a duty to take appropriate measures to address local challenges.

The Act builds on a broad determinant perspective on public health work as presented below (Figure 14). Overview of public health and health determinants constitutes the starting point for evidence based public health work. Based on a local assessment of the public health challenges, public health policy development must be an integrated part of ordinary societal and spatial planning and administration processes in counties and municipalities and in other social development strategies.

\textsuperscript{45} Norwegian Public Health Act, http://www.regjeringen.no/upload/HOD/Hoeringer\%20FHA\_FOS/123.pdf
\textsuperscript{46} Norwegian Public Health Act – short introduction: http://www.regjeringen.no/upload/HOD/Hoeringer\%20FHA\_FOS/1234.pdf
The Municipality of Brønnøy is committed to the systematic public health work, health monitoring, planning and action with a special focus on prevention among all age groups. Brønnøy has a broad social perspective on public health, and pays increased attention to the social determinants of health, including the underlying factors as education, job, housing and childhood environment. The goal of Brønnøy is to build good structures that - as a result - cooperation will become natural, systematic and binding. The process wheel is used as a public health strategy. Plans are important coordination tools to set goals and policies across sectors. HiAP is integrated and "health across" the municipality’s top planning document. Public health has there the same level of importance as environment and sustainability.
Summary

The presented analysis of the political support and practical implementation of Health in All Policies (HiAP) in Lithuania, Latvia, Estonia, Poland, Finland, Sweden and Norway shows that the concept of cross-sectoral work for health is well supported in Baltic Sea Region/Northern Dimension area countries. There are documents, strategies and political guidelines for health promotion adopted by the national governments, influencing also the work in the municipalities. Health in All Policies as a concept is largely understood, even if it is not widely used. Examples of most natural and common intersectoral work are in the traffic and water safety sectors. Municipalities in Baltic Sea Region/Northern Dimension area have paid great attention to the health and well-being of the vulnerable groups, especially to children, adolescents and elderly. One aim in most of the countries is to develop a central public health strategy that incorporates all so far diversified national health strategies and focuses on the public health efforts. Reduction of inequalities seems to be an important topic in Baltic Sea Region/Northern Dimension area.

Generally, the local governments understand well that working together with different sectors, especially with education, health care and environment, is important for good health developments and effective public health work. Some cities have developed health promotion trainings which might help the implementation of Health in All Policies. However, even if all countries included in this report have adopted public health strategies and have settled objectives of health promotion, the Baltic States and Poland lay behind the Nordic countries, which have been working with modern public health and Health in All Policies for decades already.

5. Obstacles and gaps in the implementation of Health in All Policies on the local level in the Baltic Sea Region/Northern Dimension area

As presented in Part 4, all countries participating in the Healthification seed-money project and covered by this report are committed to the Health in All Policies (HiAP) principles. However, the municipalities, which have gradually become more responsible for public health and health promotion services, find the intersectoral work and evidence-based decision making challenging. This part of the report looks into the factors that hamper the implementation of HiAP on the local level.

5.1 Obstacles and gaps in Lithuania

As presented in previous part of the report, there is support for Health in All Policies (HiAP) approach in Lithuania. However, there are still several gaps in its practical implementation. There is lack of intersectoral collaboration, NGOs are not enough involved in decision making and the inter-institutional plans often don’t include public health and health promotion aspect. Analysis of inter-institutional cooperation showed that the concept of health mainly relates to the health care system and is interpreted from the sectorial point of view. The lifestyle, social and environmental factors are not considered. Public Health Bureaus as main institutions promoting HiAP approach, still have rather low visibility and insufficient financing, which make their operations challenging. The main funding is allocated for personal health care. The leadership in public health should be stronger.

5.2 Obstacles and gaps in Latvia

Currently Health in All Policies is still something new for Latvian municipalities. However, the concept of multi-level and cross-sectoral cooperation is being promoted. The mission of Boards of Health is to promote, from the position of supervisors, the awareness of public health as inter-institutional implementation of activities. In order to increase the knowledge and recognition of Public Health Strategy, the Action Plan is updated every year and this is done in collaboration with different institutions.

---

47 Report on Inter institutional Cooperation Analysis Accomplishment, Similar Experiences of EU Countries and the Existing Legal Framework in Lithuania Evaluation
5.3 Obstacles and gaps in Estonia

Most municipalities understand the importance of public health work and health promotion but the concept of Health in All Policies is not widely understood and used. Even though raising awareness is important, more attention should be paid to creating healthy environment in local municipalities. Often the main obstacle here is lack of finances in a local budget. Also, mandatory public health activities are not very specifically described in the Public Health Act and that leaves municipalities confused, causing questions about the nature of activities they should implement. The currently drafted act is hopefully going to change that. It also needs to be considered that systematic and structured work on building local capacities for health promotion has been conducted in Estonia only for few years – since 2009. Before that (for 15 years) the focus was on building the county level health promotion structure.

Only a few bigger municipalities have health promotion specialists in their local government’s structure. There is usually nobody hired to systematically develop the health promotion process at the local level. About 15% of all municipalities have formed their health coalitions (health councils, health promotion committees etc). Local governments receive no regular health promotion financing. Since most municipalities are small and have very limited financial resources, the motivation has been low to devote resources to activities not seen as necessary.

Even though municipalities have possibilities for cross-sectoral work, they need more guidance on how to use their resources for better health. Moreover, the attitude of the mayor and/or the chairman of the local council and their support are important when developing and implementing Health in All Policies thinking in a municipality.

5.4 Obstacles and gaps in Poland

The fundamental objective in drafting the National Health Programme (NHP) for the years 2007–2015 was to unify the efforts of the society and of public administration with the aim to reduce the inequalities in health and to improve the state of health of the Poles and, in consequence, to enhance their quality of life. The Programme provides the Minister of Health with a possibility to influence the activities in the area of health undertaken in other sectors, and in the opinion of its authors, is an excellent tool for taking joint actions in the domain of public health. However, the NHP has not been equipped with administrative tools that could influence health in other sectors; it provides only general guidance in health-related matters across various sectors.49

In regard to local level, the NHP provides them only with general directions. As the monitoring and evaluation functions are institutionally not sufficiently developed or coordinated and nobody monitors the performance of self-governments, it is very difficult to access the progress and obstacles on the way to success.

The other challenge is the independency of every of the levels of territorial self-government. The decentralization reform in Poland in 1999 established three levels of administration. Each level has its own organizational units and responsibilities which makes the cooperation and coordination of activities in the health sector difficult. The same is visible in planning of the actions – different entities plan the actions for different periods. The long-term strategies are developed by National Institute of Public Health – National Institute of Hygiene. They are not legally bound. The NHP 2007–2015 does not provide any specific sources of funding for the actions promoting healthy lifestyles. Funding depends on needs, awareness and capabilities of those in charge of their implementation.

Centre for Public Opinion Research of Poland (CBOS) conducted a study in 2010 on how the municipalities realize the health care and health promotion tasks.50 The results of the interviews with the mayors are demolishing. In most of the municipalities, only 1% of the budget was allocated for the health promotion activities, not related to the financing of hospitals, health care centers etc. It gives around 0,80, max 5 EUR per inhabitant. The explanation of this situation was three-fold:

1. The mayors claimed that the health promotion does not belong to the tasks of the municipality (there are the other institutions that have funds for it),

---

49 CBOS, Realizacja zadań z zakresu ochrony i promocji zdrowia. Prezentacja wyników badań realizowanych w wybranych gminach, 2010.
2. Health promotion is not a priority in the municipality, there are more important issues to take care of,
3. There are no funds that can be allocated for health promotion activities.

The results of the study also present a tendency to conduct the same activities year after year and to plan the actions according to the budget, not the budget according to the actions needed.

In the light of limited budget, general lack of understanding that health is not only about treatment, and lack of long-term strategic planning for health, the accidental activities dominate the portfolio of the health actions in the municipalities. They are mostly initiated by pharmaceutical companies, NGOs, schools or sport clubs. The municipality acts here as a host, delivering the logistics and providing visibility but no funds.

Generally the main problems in the realization of health promotion tasks are:

1. Lack of cooperation between all levels of territorial self-government and not clearly defined roles and responsibilities of the institutions,
2. Lack of funding (limited budget or different prioritization),
3. Lack of knowledge, competences, interest.

Finally, the study presents the need for better statistical data about the health status of the inhabitants of the municipality and their health needs. Currently low-level data is not available.

"National Health Programme for years 2007–2015 mentions that all municipalities should have a long-term action plan until 2015 and play a bigger role in health promotion activities. Unfortunately, in my opinion, achieving this goal is rather unrealistic.

The National Health Programme provides only general guidelines, without any allocation of financial resources for implementation or training. The municipalities need to take care for it on their own. We need to remember that even if someone received the National Health Programme 2007–2015 when it was published, i.e. 7 years ago, it has been already forgotten. The Association of Polish Healthy Cities still reminds the member cities (currently 40) about the cross-sectoral cooperation for health, the long-term strategies and action plans.

In Lodz where I work, there is a Policy 2020 document which was accepted by the resolution of the City Council. It confirms the inclusion of the health dimension in the strategies of different sectors of the city administrators. But this is not the case of all cities in Poland, not even those that belong to the Polish Association of Healthy Cities. Currently we have 40 members and only 60% of them report having long-term action plans for health. However, there is an account of cross-sectoral cooperation on the operational level in Poland. The sectors of environment, education, transport, urban planning as well as NGOs cooperate closely within many initiatives. The problem is that often the results are not sustained – after the project ends the cooperation finishes and is not naturally continued."

Iwona Iwanicka,
Acting Vice-Director of the Health and Social Affairs Division,
Social Affairs Department, City of Lodz
Healthy City Coordinator in Lodz and National Network Coordinator of Polish Healthy Cities Association
5.5 Obstacles and gaps in Finland

In Finland, Health in All Policies (HiAP) approach is widely understood and much has been done already to promote it. Policy makers have a lot of information about HiAP but how things are implemented in practice is another issue.\(^{51}\) Although the knowledge and awareness is there, the municipalities lack the structures and more specific guideline on how HiAP should be realized. The culture for HiAP hasn’t been developed yet. Usually the decision makers and administrators don’t know other organizations good enough and this may hamper the cooperation. Different sectors have different understanding of health, different terms are used in different context and the language is not common for all. Health is still considered a competency of health sector only. Moreover, the economic issues overweight health very often.

According to the Finnish Social Barometer 2013, HiAP approach is well known in municipalities but the practical touch is missing. Only 29% of municipal social managers and 36% of health care center managers reported that HiAP approach is taken into account in their working area. They also mentioned that on the strategic and planning level HiAP is present but it is not realized in practice. Those, who reported successful implementation of HiAP, also admitted that the health and well-being promotion is realized well.

Last but not least, many municipalities still don’t consider health and well-being as important aspect of municipal competitiveness and vitality.\(^{52}\)

"Health in All Policies as a method of working is good for every municipality. I understand that the local governments have troubles in implementing it in practice, that they do not know how to do it. The national laws do not specify it and they can’t – municipalities are different, their organization is different and they should know best themselves what method of working serves them better. However, there are some factors that should be taken into account, to my mind.

First of all, we need to make the evidence visible and the cooperation with media should not be neglected. Also the third sector, NGOs need to be stronger involved in the cooperation with the city service providers. They are very important to work with on the issues regarding children, youth and families. We know that health promotion prevents social problems. Also primary health care still could take a stronger role, as well as the self-supporting groups, whose message is always stronger."

Maija Perho
Member of the City Council in Turku,
former Minister of Health and Social Affairs of Finland,
chair of the board of the Baltic Region Healthy Cities Association

\(^{52}\) Ibidem
5.6 Obstacles and gaps in Sweden

Many good examples of intersectoral cooperation and how the different branches of administration and institutions work on health promotion and injury prevention can be found in Sweden. However, the work done is not always labelled as Health in All Policies. Most municipalities, county councils and regions have conducted active public health efforts with each other and other public health stakeholders. Public health approach is integrated in regional development plans and some also have published social investment funds. Many county councils and regions have also joined the networks of Health Promoting Hospitals and Health Services and therefore it seems that positive development will continue within these areas.

The county administrative boards have commented that the public health policy has facilitated systematic public health efforts, but this is not commented so strongly by authorities and non-profit organizations. According to them, the public health objective still needs to be strengthened and enforced by workshops and trainings. Authorities and non-profit organizations have own codes of practice and this might explain why many of them don't use the overarching public health policy objective.53

5.7 Obstacles and gaps in Norway

In Norwegian municipalities, the public health concerns are increasingly emphasized in connection with development of municipal plans and other projects. However, not all municipalities have capacity to operationalize the intentions of Public Health Act well enough in their management. The overall system for implementation of Health in All Policies on the local level is still missing in Norway. The municipalities need a concrete framework, guidelines, toolbox and procedures that would be common for all of them.

Summary

The presented analysis shows that even if the principles of Health in All Policies (HiAP) are mostly understood in the municipalities, there are still gaps and obstacles in intersectoral cooperation on the local level. Generally, the local decision makers and administrators understand the need for collaboration with other sectors but they indicate the factors which prevent public health and health promotion from being a priority on the agenda of city councils or other sectors, which are not directly linked with health. The common problems are: budget limitations, lack of clear responsibilities of municipalities in this field, weak leadership for health, lack of guidelines and procedures. In most of the countries the other challenges (economic, environmental) overweight health in decision making.

We can see a big difference in implementation of HiAP between Baltic States and Poland and Nordic countries. While in Finland, Sweden and Norway, the need for cross-sectoral cooperation, whole-of-government, whole-society approach and need to work with social determinants of health are widely recognized, in Baltic States and Poland health is still seen in a narrow way – as curative measures and investments in primary health care system. In that sense, the countries can share experiences and learn from each other's experiences. The Nordic countries can be a pilot area for developing an advanced system for HiAP.

It is important to admit that in all the countries it was reported that the NGOs are not enough involved in decision making and that the health sector and other sectors often speak different language, which causes confusion and lack of understanding.

Another aspect is lack of the monitoring and assessment tools. Health Impact Assessment has been used in many countries or at least considered to be taken into use, but the other tools are not common. More resources and skills are needed for more effective use of the methods already available.

The picture is not that grim though. There are a lot of initiatives implemented which contribute to better understanding and implementation of HiAP in Baltic Sea Region/Northern Dimension area. The most powerful actors which successfully support the delivery of health promotion campaigns to the population are community-based programmes, like Health Promoting Schools, Healthy Cities, Health Promoting Hospitals or Programme of Health Promotion at Work. At the current stage, the above mentioned programmes should be treated as models and a training ground for implementing innovative solutions in interdisciplinary and intersectoral cooperation for health.

6. The voice of city mayors

VYTAUTAS GRUBLIAUSKAS
Klaipeda City Mayor

Mr. Grubliauskas, can you say that you know and understand the concept of Health in All Policies?
I would like to think that it is understandable. In principle it means that health is determined also by the factors which are beyond health. That implies that all important political areas, especially social and regional policy, taxes, environment, education and research should be included in order to improve the efficiency of health policy. We have to use this principle on national, regional and local level to achieve maximum results. Health is one of the biggest priorities in most of European Union strategies. Majority of EU initiatives must comply with the official guidelines for the assessment. We have to take into account its impact on health when we are building a new policy. EU economic strategy said that "Health is our wealth". In sustainable development strategy health benefits are mentioned as well. The main goals of the strategy are: health promotion, health inequalities and protection from health risks. It is important to consider health questions while building new policies.

How Health in All Policies is implemented in your municipality when executing public health policy and health promotion?
In Klaipeda city the Health in All Policies is implemented within: Strategic Development Plan, which was adopted in 2013 for 2013-2020 economic period with three main goals which are: progress, health and sustainability. Priority is given to health and safe community. The other two priorities are also very important: sustainable urban development and improving the competitiveness of the city. I would also like to remind that in 2011 Klaipeda was designated as a member of European Healthy Cities Network, so far the only city from Lithuania. Klaipeda undertook to reach Healthy City qualities and we know what it means to implement Health in All policies. Healthy City qualities are clean, safe and good quality environment and stable ecological system, strong community and attempting to supply people with food, water and shelter, to ensure safety and work.

Is there a political support towards Health in All Policies in Klaipeda?
Yes. When coalition programme is prepared in our city all parties give their priorities for ecology, health, sport, investments. There is understanding of importance of Health in All Policies.

Can you say that health issues are discussed while decisions are made in an other sector which is not related with health sector (e.g. transport or economy)?
Undoubtedly, Klaipeda is member of the WHO Healthy City Network and dealing with all issues related to health and environment is our priority. Health is discussed when decisions are made on investments, transport, or economy. Klaipeda is the only Lithuanian city so far which introduced the new technology of waste management. In all decisions we think first how it can influence quality of life and health. Even dealing with "industry whales" like port or railway, everybody knows that in Klaipeda nothing can be done if health question is not discussed.
Do you think that Health in All Policies is needed in Lithuania?
It is needed not only in Lithuania, but also in Europe and even in the whole world, because healthy human is a fundament of sustainable development and strong economy.

What kind of gaps can you see in practical implementation of Health in All Policies?
There is always room for improvement. To achieve better health outcomes HiAP is necessary, but there is need to discuss more and formulate clear goals, set concrete objectives and measures on national level. Currently it seems like everyone knows what to do, but do not know how to do it. There is a practice in Lithuania that ministries create a lot of governmental programmes and delegate their implementation to the municipalities without allocation of funding. In this way municipalities fund programmes solving national problems. For example, Klaipeda city finances the programme "Hope line". It is anonymous psychological consultation on the phone. Klaipeda municipality enforces this programme since 1988. This line provides 24-hour support to all Lithuanians in crisis. Klaipeda city mental health specialists work from 8 pm till 6 am. 13,000–14,000 calls are responded per year, and a lot of calls are from people who had been in violence and in risk of suicide. This line usually became a bridge back to life for a lot of people. Three posts for specialists are funded by Klaipeda even though calls come from all Lithuania.

In your opinion, who should initiate implementation of Health in All Policies?
In order to implement HiAP the coordination is needed, realized probably by a specific institution or by government chancellor. An intersectoral institution should be created. In the other words, there should be coordination from one "belfry".

MADIS KALLAS
Deputy Mayor of Kuressaare

Mr. Kallas, do you think that Health in All Policies is an approach that is understood by politicians?
For many people health still means either health care or sports. There are two groups of politicians. The first group is aware of the importance of health promotion and the other group is not interested in it. The big gap between these two groups can be seen as one of the main problems causing inequity in municipalities, because local decision makers value health and creating healthy environment differently.

Are health issues considered when taking the decisions?
Health impacts of decisions and activities are taken into account, but the formal process of health impact assessment is not implemented at the local level. The awareness and implementation of the concept of Health in All Policies has improved during last years, but there is no systematic work yet.

The main reason for low commitment to Health in All Policies is directly or indirectly the lack of financial and human resources.

What do you think should happen in order to improve the current situation?
It is necessary to raise awareness about public health as an intersectoral subject that the politicians and people working on the local government could understand better how their work and decisions have an impact on public health in a municipality.

It is important how the leaders of organisations value health and healthy environment – what kind of work conditions are created for employees, if and how the employees are encouraged and supported to make healthy choices at work and after work.

One possibility for getting more attention to public health at the local level is to make the health profile compulsory for every municipality that the connections between different sectors and health can be analyzed systematically. In order to raise awareness about Health in All Policies among the members of a local municipality council, the issue of public health should be in the official agenda of the council meeting at least once a year.
7. Analysis of Potential Years of Life Lost in the Baltic Sea Region/Northern Dimension area

As presented in Part 3, the analysis of Potential Years of Life Lost (PYLL) helps the decision makers understand the problem of premature loss of human capital of the population and therefore supports the evidence-based policy making. This part of the report examines countries’ practices in calculating PYLL and use of other health-related data for identification of public health priorities in the municipalities.

7.1 PYLL in Lithuania

In Lithuania following statistical data is used on the local level for decision making: mortality rate, average life expectancy, incidence and prevalence of diseases, infant mortality, and risk factors. The monitoring report with statistical information is provided by Municipal Public Health Bureaus.

Generally, the information available supports the decision makers in defining the priorities for actions but certainly it does not provide the full picture and more effective methods (e.g. DALY, PYLL) could be used for evidence-based planning.

The rate of Potential Years of Life Lost (PYLL) is not included in the yearbooks of Statistics Lithuania or Institute of Hygiene. PYLL is used by Institute of Hygiene in scientific research and it is the Institute who can calculate it. There is no wider practice of using PYLL in Lithuania and the PYLL rates are not used for decision making on the local level.

Data needed for PYLL calculation can be retrieved from Lithuanian Death Causes Registry. Ministry of Health of the Republic of Lithuania is the main administrator of the register. All data can be provided free of charge to the governmental institutions, or for persons who have right by law to get confidential information. In order to obtain information data recipients should sign a contract with lead institution of registry.

7.2 PYLL in Latvia

In the policy documents of Latvia the Potential Years of Life Lost (PYLL) indicator is often used to reflect the economic capital of the country and as a public health indicator. It is used to measure the changes in the economic situation and health status of the population. Each year a report of PYLL is issued with the data of PYLL by age, sex and death cause presented. However, the PYLL rate is not used for the decision making on the local level.

PYLL data analysis can be obtained in absolute figures or per 100 000 inhabitants. It has already been calculated and is available for request in Disease Prevention and Control Center of Latvia. Death rate by age, sex and death cause, according to the data needed (along with years of age) can be obtained in the Disease Prevention and Control Center which also maintains the cause of death database of Latvia. Payment for the data is needed in case if the Disease Prevention and Control center are asked for services that require a greater investment of working time.

7.3 PYLL in Estonia

In Estonia, the public health statistical information is used for compiling municipality health profiles and action plans as well as for local development plans and strategies. Local level uses mortality data that is already calculated by national experts and is available in national public databases or materials. Municipalities mostly do not have the skills or capacity to get raw mortality data from registries and conduct their own analysis.

Potential Years of Life Lost (PYLL) data at national, county and municipal level has been calculated by Ministry of Social Affairs in 2006 and new calculations are planned to be published in the end of 2014.

54 Lithuanian Death Causes Registry. Available at: http://sic.hi.lt/mapr1/
Even though PYLL has been calculated for municipalities and the results have been presented in articles and publications in a generalized way, there is lack of knowledge of the concept of PYLL. That is why most probably PYLL has never been used in decision making at municipal level. As it was mentioned earlier, the specific public health skill and knowledge to fully understand and interpret the PYLL data is still quite low in municipalities.

The population statistical data by gender and by population groups can be retrieved from Statistics Estonia that is a government agency. The administration of Estonian national health statistics and five population based registers (including the Estonian Causes of Death Registry) and databases is the responsibility of the National Institute for Health Development (NIHD). The official death registry (The Estonian Causes of Death Registry) collects data on all cases of death registered on the Estonian territory and in Estonian foreign missions. Most of the data on deaths (standardised mortality rates per 100 000 inhabitants by cause of death and gender, prevalent causes of death by gender, deaths from diseases caused by alcohol by gender etc.) are available only by county or by region.

Detailed data for each death in a municipality are collected, but according to the Head of Registry the use of data is restricted by the personal data protection rules as well as by the issue of statistical reliability. However, if requested, then data on death causes in a municipality by gender and age can be received from the Estonian Causes of Death Registry. The access to the statistical data is free of charge.

7.4 PYLL in Poland

As practice shows, local decision-makers do not use health monitoring data, e.g. PYLL or DALY, for the prioritization of the activities and when planning allocation of resources. There are signals showing that politicians have troubles in understanding the classic health indicators, let alone more comprehensive measures. The new trends support measurements of positive aspects of health, e.g. Healthy Life Years (HLY). PYLL is not calculated regularly. The data is collected ad hoc for the analysis of the burden of disease in the population. In the Polish conditions, PYLL is a supporting indicator, used only on the national level.

However, the death registers are well organized and well managed. The death register is run by Central Statistical Office. According to the Polish law, the access to the data collected on the regular basis is free of charge. An administrative fee might apply to cover the work of the Office in regard to the preparation of relevant files. The price depends on the amount of work needed. However, in general, access to the data should not meet any legal or logistic obstacles. Therefore it is possible to measure PYLL on the different levels of the territorial self-government.

7.5 PYLL in Finland

In Finland there is some practice of using the Potential Years of Life Lost (PYLL) indicator in the decision making on the local level, e.g. in the city of Heinola and Lahti PYLL is calculated regularly.

There is also a project on PYLL being implemented. FIN-PYLL project aims to develop a network between 15–25 biggest cities of Finland, under the leadership of the Local and Regional Government of Finland. The purpose is to find out and evaluate, if there are differences in PYLL between different city neighborhoods and what would be reasons if differences appear. Municipalities can e.g. share good practices and experiences within the network. It is meant to promote citizens’ wellbeing and reduce early years of life lost figures between cities and city neighborhoods. One of the results for the participating municipalities will be costs savings (interventions and funding is directed there where needed) and good practices developed for systematic monitoring of wellbeing of citizens.55

---


HEALTH IN ALL POLICIES FOR HEALTHIER COMMUNITIES
According to consultation firm Finnish Consulting Group, PYLL calculation takes 2–3 months. The data on deaths and causes of deaths in Finland is collected by Statistics Finland.

### 7.6 PYLL in Sweden

Data available from the National Health Survey is used by the municipalities, especially for preparation of their local health profiles. The Potential Years of Life Lost (PYLL) data is not included in the statistical yearbook in Sweden and it is not known in the municipalities.

The death registry is administrated by the National Board on Health and Welfare and the data is available free of charge.

### 7.7 PYLL in Norway

The following statistical data are included in the public health profiles of the municipalities and counties: basic data on population and living conditions, safety, school, lifestyle, health and illness. In addition to statistics that are used in the profiles, statistics bank provides the municipalities also with other relevant information. The bank is updated each year and expanded with new indicators.

The method of Potential Years of Life Lost is however unknown in Norway. The Institute of Public Health doesn’t use PYLL as a method of measuring or monitoring health situation in the country. They know the method only to some extent.

### Summary

While the statistical data is generally largely used in planning and elaborating strategic documents, action plans or municipality development plans, the method of Potential Years of Life Lost (PYLL) is not used at the local level, with the exception of some Finnish municipalities. All countries can provide the data needed for calculation of PYLL, free of charge but against a service fee.

Even if PYLL is calculated on the national level, the municipalities don’t have local-level data that can be used for the evidence-based decision making and planning. One of the challenges and concerns which needs to be taken into account is the fact that there is still lack of knowledge, skills and resources of how to use the information in an effective way.
8. Conclusions and recommendations for further actions in the field of implementation of Health in All Policies on the local level in the Baltic Sea Region/Northern Dimension area

The presented overview of implementation of Health in All Policies (HiAP) in the countries participating in the seed-money Healthification project and covered by this report suggests that there is a big commitment from the national governments towards the intersectoral work and evidence-based decision making in the domain of public health. Within the years municipalities have become more responsible for public health and health promotion and they need to embrace the principles of HiAP in order to best care for their citizens and to carry out the delegated responsibilities. The analysis of current municipal practices in this field brings a lot of positive examples of realization of HiAP. However, there are several obstacles and gaps in its full implementation, which prevent the municipalities from benefitting from its potential. The evidence-based policy making should also be improved for better identification of local health and wellbeing problems and strategic planning in the environment of inter-sectoral collaboration.

Several recommendations for further actions to promote HiAP on the local level have been made. They will be used in planning of the big-scale Healthification project. They are:

- Municipalities need more guidance on implementation of HiAP – on definitions, on procedures, effective use of resources and tools for monitoring of health problems;
- Knowledge about the public health and health promotion of interventions which work should be exchanged;
- Local politicians and administrators need to be educated in non-communicable diseases, principles of health promotion and evidence-based decision making;
- Local health data should be available in a user-friendly format for decision making;
- Leadership skills of public health practitioners should be enhanced that they can better advocate for health in their municipalities.

List of contributors

Laura Aaben, National Institute for Health Development, laura.aaben@tai.ee
Milda Andriunaite, Center for Health Education and Disease Prevention, milda.andriunaite@smlpc.lt
Sturla Ditlefsen, Brønnøy Municipality, Sturla.Ditlefsen@bronnoy.kommune.no
Inga Dreimane, Welfare Department of Riga City Council, Inga.Dreimane@riga.lv
Marko Harapainen, Finnish Healthy Cities Network, marko.harapainen@thl.fi
Kaisa-Reetta Korpela, Baltic Region Healthy Cities Association, kaisa.korpela@marebalticum.org
Karolina Mackiewicz, Baltic Region Healthy Cities Association, karolina.mackiewicz@marebalticum.org
Justina Račaitė, Center for Health Education and Disease Prevention, justina.racate@smilpc.lt
Johanna Reiman, Baltic Region Healthy Cities Association, johanna.reiman@marebalticum.org
Peeter Ross, Estonian eHealth Foundation, Peeter.Ross@e-tervis.ee
Årstein Skjæveland, Norwegian Healthy Cities Network, dagligleder@sunnekommuner.no
Maria Söderlund, Stockholm County Council, maria.soderlund@sll.se
List of figures

Figure 1  Share of NCDs of all mortality in NDP area
Figure 2  Diseases of circulatory system
Figure 3  Pure alcohol consumption (liters/capita, age 15+)
in Baltic Sea Region/Northern Dimension area
Figure 4  Daily smokers in the population (age 15+), male
Figure 5  Trachea/bronchus/lung cancer, all ages, male
Figure 6  Average amount of fruits and vegetables available per person
Figure 7  Insufficiently active, male and female
Figure 8  Four Non-communicable diseases, four shared risk factors
Figure 9  The logic behind the calculation of Potential Years of Life Lost (PYLL)
Figure 10  Inter-country comparison of PYLL, all ages, male and female
Figure 11  Functions of Public Health Bureaus
Figure 12  Structure of institutions responsible for implementation of health
in all policies in municipality
Figure 13  Turku and Helsinki in the comparison with the TEAviisari tool
Figure 14  Systematic public health work

Annexes:

Annex 1: Report from the Healthification project meeting in Turku,
Finland 27–28 January 2014
Annex 2: Problem tree and objective tree extracted during the Healthification
project meeting in Turku, Finland 27–28 January 2014
Annex 3: Potential extended partnership for the Healthification main project
in the Baltic Sea Region/Northern Dimension Area
Annex 4: Examples of the initiatives (projects, other activities) on implementation
of HiAP in Europe.

Annex 1
Report from the Healthification project meeting in Turku, Finland 27–28 January 2014

Objectives of the meeting

The objectives of the meeting were threefold:

1. To discuss the partners’ contributions to the report on the state of play,
i.e. the final outcome of the Healthification seed money project;
2. To plan the main project;
3. To discuss the expanded partnership for the main project.
Meeting participants

The meeting was hosted by Baltic Region Healthy Cities Association – WHO Collaborating Centre for Healthy Cities and Urban Health in the Baltic Region (Lead Partner) and took place in the Baltic Sea House of Turku. Following persons were representing organizations involved in project consortium:

- Karolina Mackiewicz, Baltic Region Healthy Cities Association
- Johanna Reiman, Baltic Region Healthy Cities Association
- Inga Dreimane, Welfare Department of Riga City Council
- Justina Račaitė, Center for Health Education and Disease Prevention, Division of Non-communicable Diseases Prevention
- Peeter Ross, Estonian eHealth Foundation
- Sturla Ditlefsen, Norwegian Healthy Cities Network
- Dmitry Titkov, Northern Dimension Partnership in Public Health and Social Wellbeing, Expert Group on Non-Communicable Diseases (NDPHS NCD-EG)
- Mikko Vienonen, Northern Dimension Partnership in Public Health and Social Wellbeing, Expert Group on Non-Communicable Diseases (NDPHS NCD-EG)

Moreover, Marko Harapainen representing Finnish Healthy Cities Network and National Institute for Health in Welfare, Finland and Anu Vares from Estonian Healthy Cities Network, Kuressaare City Government were present.

Heini Parkkunen from City of Turku, Recreational Services and Healthy City Coordinator, Misha Dellinger, a politician from City of Turku and Katarina Korkeila from City of Turku Welfare Department, Primary Health Care services, Director of Division attended the Monday afternoon programme and shared their experience, expertise and view on the problem of implementation of the Health in All Policies on the local level.

Expectations towards the meeting

Following expectations towards the meeting were expected by the participants at the beginning:

- To have a clear picture – after the meeting – of what we should and can do,
- How explore how digital health data can be used in "Healthification",
- To start the close collaboration for a great health project targeted at cities,
- To collect good experience and make possible a better implementation of HiAP in the participating countries,
- To collect more information about implementation of HiAP on the local level,
- To learn from the other countries how the HiAP is implemented there,
- To learn more about PYLL and its utilization for HiAP,
- To prepare a project plan, ready to apply for funding and implementation,
- To have the bigger project application ready.

Opening

In the opening words, Karolina Mackiewicz from Baltic Region Healthy Cities Association presented the origin of the Healthification project, its background, goals and expected results. She spoke about the Northern Dimension Partnership for Public Health and Social Wellbeing conference in Vilnius that took place in November 2013 and allowed to build the initial project consortium, as well as access the funding for the project. Healthification project derives from the work of NDPHS Expert Group on Non-communicable Diseases Related to Lifestyles and Social and Work Environments (NCD EG) but concentrates on the local level. It focuses on the implementation of Health in All Policies on the local level, i.e. in the municipalities.

The objective of the small seed money project is to prepare the report on the state of play in the field of Health in All Policies on the local level and to plan the bigger international project, i.e. main project.

All partners presented themselves as well as the organizations they represent. Mikko Vienonen, Chairman of the NDPHS NCD EG presented briefly the history of the partnership.
After the introductions, Mikko Vienonen presented the Potential Years of Life Lost methodology. The methodology has proven to be useful in order to stimulate the evidence-based decision making and its utilization in work with local decision-makers was piloted during the "Healthier People – Management of Change through Monitoring and Action" project in St. Petersburg in 2012 – 2014, a project supported and supervised by the NDPHS. The strength of the method is that it allows to show the economic loss of human capital in monetary terms to the decision makers.

Partners presentations
After the presentation of PYLL, the project partners presented their findings regarding the implementation of Health in All Policies on the local level in the Baltic Sea Region countries. Inga Dreimane from Latvia spoke about Riga City Health Strategy 2012-2021 slogan of which is: "Healthy Riga citizen in a healthy city". The strategy has 8 goals and directions, and involves Council of Health at political level as well as all departments responsible for safety, infrastructure, education, welfare and health promotion, environment on the lower – administrative and planning level. At the grass-root level it is about healthy schools, drug-free schools, family-friendly city, etc. Next steps that need attention is to create the system for annual monitoring. The first evaluation will be done in late 2014.

Justina Racaite from Lithuania spoke about Public Health Bureaus in the country goal of which is to deliver the public health services in the municipalities. She presented the health system structure and documentation at local and national level (public health bureaus centres for health promotion, altogether 33 bureaus). There are several plusses of the operations of Public Health Bureaus, among others: they provide support for HiAP from national and local level, municipalities are empowered to organize health promotion, and the institution in charge is named and established. However, there is still a lot to be done in the sphere of cross-sectoral cooperation, namely: NGOs should be better involved in decision making, the intersectoral plans should pay closer attention to health promotion issues, Moreover, Public Health Bureaus still have a rather low visibility and unsustainable funding.

Marko Harapainen from Finland presented the Finnish Health Care Act which obligates communities to produce health and wellbeing reports annually, with HiAP included. He mentioned the need to meet with and overview the health-related actions of other sectors. Thanks to the tools developed by National Institute for Health and Welfare or municipalities themselves (e.g. TedBM, TEAvisari tools) it is possible to compare how well the municipalities are doing. Still there is lack of understanding, guidance or culture; often other issues (economic) overweigh. This means that HiAP should have a strong economic evidence base.

Anu Vares from Estonia presented political documents, among others the Public Health Act that puts the responsibilities for public health on the municipalities. She mentioned that few municipalities have health development plans. The structures that support HiAP in Estonia are mainly local council committees and Estonian Healthy Cities Network.

Sturla Ditlefsen from Norway presented the Public Health Act which has recently been updated and put the big responsibilities in the promotion of health on the municipalities. There are 428 municipalities in Norway and generally the understanding of HiAP is profound, however the system for implementation is lacking. At municipal level, PYLL methodology is not used but generally DALIs and QALIs are used; HiAP is well integrated, work is done through underlining factors at homes, educational sector, jobs. Municipalities have freedom for implementing HiAP, which also creates challenges – how to do it best.

After a break, Peeter Ross from Estonian eHealth Foundation opened the discussion on the potential eHealth tools that can be used and introduced in the main Healthification project. He gave an introduction about the role and importance of the health data, not disease data. The achievements in the field of eHealth in Estonia were presented and potential of the smart and health promoting application explored. What could be done within the Healthification project is e.g. implementation of national/ regional e-health policy for health promotion – addressing specific groups (smokers,
people with chronic diseases, children) to understand the importance of healthy living, and gamification and support to develop new health applications based on the medical/statistical evidence. Nowadays there are more than 100,000 health applications available in the world for mobile devices and computers, many of them however don’t base on the evidence.

Discussion on the problems with implementation of HiAP

After the Peeter Ross’ presentation the external guests have joined discussion on the problems related to the implementation of Health in All Policies at the local level. Heini Parkkunen, Misha Dellinger and Katarina Korkeila helped the project partners to understand better the municipal point of view and challenges the local administration has with cross-sectoral cooperation. The group of Turku experts and international experts debated for long time on the issues related to the HiAP in the municipalities. After the discussion the initial problem tree and clusters of problems were defined and thoughtfully discussed.

Problem tree

The work was being continued on the second day of the meeting, during the morning session where the problem tree was finalized. Annex 2 presents the final problem tree for implementation of Health in All Policies on the local level.

Three clusters of problems were identified:

1. People are not aware what is healthy and what is not;
2. There is lack of monitoring of health situation in the municipalities and evidence on economic gains from cross-sectoral cooperation;
3. The cooperation between the sectors is not sufficient; the public health sector is not lobbying for it enough.

Moreover, the problem tree exercise proved to be helpful and useful in identifying and understanding what are the core problems in the municipalities in regard to HiAP and what the causes of the current situation are and what are the effects. For example the budget limitations, commonly identified as a problem in the initial discussion, was identified as an effect of the whole array of other problems that should be solved first. It was interesting to realize that there were no disagreements between the partners in relation to the problems, even if the project consortium consists of very different countries with different stage of adoption, integration and implementation of HiAP. The problems and challenges turned out to be common. This view allows working on the joint project application with a bigger scope.

Objective tree

Afterwards the group worked on the objective tree. Annex 2 presents the final objective tree for implementation of Health in All Policies on the local level.

Three clusters of objectives were identified:

1. To increase the health awareness of the city inhabitants (e.g. through media, campaigns, health promotion education, primary health care services);
2. To establish a sustainable system for monitoring of health situation in the municipalities (e.g. through PYLL methodology);
3. To increase the information sharing and cooperation between sectors (e.g. through enhancing the skills of public health professionals).

The problem tree finalized during the meeting will serve as a starting point in planning of the main Healthification project. Again, there were no disagreements between the partners regarding the objectives and what actions are relevant to be included in the bigger project application.
**Stakeholder analysis**

After the problem and objective trees were finalized, the group worked on through I DO ART exercise, facilitated by Dmitry Titkov, International Technical Advisor of the NDPHS NCD EG. The objective of this task was to design the initial project plan by identifying the intention, desired outcomes, actors, roles and timeframe. As a result following stakeholders from local, regional, national and European levels were identified that should be involved – directly or indirectly - in the main project: municipal health department, municipal financial department, municipal education department, city councils, public health professionals in municipalities, traffic police, police, national ministries of health, schools of public health, researchers, universities, national institutes of health, CVDs associations, cancer societies, municipality medical officer, Healthy City coordinators, associations of local authorities, NGOs, school administrators, WHO Euro and country offices in the region, EU programmes, institutions that calculate PYLL, journalist associations, media, business planners, artists and designers, doctors and nurses, youth workers, youth councils.

The next step was to assign the roles that the stakeholders can play in the project. Should they be directly involved in the project implementation as the partners and beneficiaries, should they be lobbied or should they be addressed by the actions of the project.

**Timeframe**

The timeframe was discussed shortly. The plan is to finalize the report on the state of play until the end of February and plan the main project during the spring months of 2014. If the call for proposals open before or during the summer, the application shall be ready. The project consortium will seek partners from other organizations in February and in spring. Potentially up to 10–12 partners should be involved in the main project. There is already initial interest expressed by the Stockholm County Council, City of Turku, Estonian Healthy Cities Network, and Polish Healthy Cities Association. Finnish Healthy Cities and Estonian National Institute of Health Promotion should join as well.

After the discussion the next steps towards the finalization of the report on the state of play and financial reporting were presented.

The meeting was closed and ended by the joint lunch. The feedback towards the meeting was that the expectations expressed before the work had started, were met. More time for sharing the experience between the countries would have been appreciated.

**Annex 2**

Problem tree and objective tree extracted during the Healthification project meeting in Turku, Finland 27–28 January 2014
Annex 2 Problem tree

Lack of sufficient funding for public health

Separate budgets for sectors

Lack of understanding among politicians

Lack of support among politicians

Lack of system for HiAP

Lack of investments in health

Public doesn’t push

Public is confused

Media confuse people

Information is not easy & meaningful

Not easy to find balance between healthy/unhealthy

Lack of feedback

Evidence is not displayed

No evidence it is working

No easy tools for monitoring of health outcomes

Lack of driving power (Leaders)

Lack of lobbying public health professionals

Lack of check list for HiAP coordinators

No horizontal dimension

Lack of communication

Lack of win-win solutions

Lack of support among politicians

Lack of understanding among administrators

Separate budgets for sectors

Lack of investments in health
Annex 2 Objective tree

1. Improved investment in health
   - Sufficient funding for public health
   - System for HiAP
   - Monitoring for HiAP

2. Politicians understand and support HiAP
   - Public push
     - Public is well informed and therefore aware
       - Media support health
       - Driving power/Enthusiasts
   - Evidence that HiAP works is displayed
     - Evidence is collected
       - Tools for monitoring of health outcomes
       - Improved communication
     - Win-win solutions displayed
   - Common understanding among administrators
     - Horizontal dimension in administration
   - Lobbying of public health professionals
     - Check list for HiAP coordinators (quality check)

3. Easy and meaningful information
   - Simple facts about health for various recipients
   - Scientific papers are “translated” into a common language

4. Monitoring for HiAP
   - Physicians understand and support HiAP
     - Public push
     - Public is well informed and therefore aware
   - Evidence that HiAP works is displayed
     - Evidence is collected
   - Tools for monitoring of health outcomes
   - Improved communication
     - Win-win solutions displayed
   - Common understanding among administrators
   - Horizontal dimension in administration
   - Lobbying of public health professionals
     - Check list for HiAP coordinators (quality check)

5. Improved communication
   - Physicians understand and support HiAP
     - Public push
     - Public is well informed and therefore aware
   - Evidence that HiAP works is displayed
     - Evidence is collected
   - Tools for monitoring of health outcomes
   - Improved communication
     - Win-win solutions displayed
   - Common understanding among administrators
   - Horizontal dimension in administration
   - Lobbying of public health professionals
     - Check list for HiAP coordinators (quality check)
## Annex 3 Potential extended partnership for the Healthification main project in the Baltic Sea Region/Northern Dimension Area

<table>
<thead>
<tr>
<th>COUNTRY/INSTITUTION</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LITHUANIA</strong></td>
<td></td>
</tr>
<tr>
<td>Lithuanian University of Health Sciences – WHO Collaborating Centre of Non-communicable Disease Prevention, Health Promotion and Monitoring</td>
<td><a href="http://www.ismuni.lt">www.ismuni.lt</a></td>
</tr>
<tr>
<td>Institute of Hygiene</td>
<td><a href="http://www.action-for-health.eu/partner/institute-hygiene-lt">www.action-for-health.eu/partner/institute-hygiene-lt</a></td>
</tr>
<tr>
<td>Lithuanian University of Health Sciences</td>
<td><a href="http://www.ismuni.lt/en/">www.ismuni.lt/en/</a></td>
</tr>
<tr>
<td>Vilnius University, Faculty of Medicine Institute of Public Health</td>
<td><a href="http://www.mf.vu.lt">www.mf.vu.lt</a></td>
</tr>
<tr>
<td><strong>LATVIA</strong></td>
<td></td>
</tr>
<tr>
<td>Centre of Disease Prevention and Control</td>
<td><a href="http://www.spkc.gov.lv">www.spkc.gov.lv</a></td>
</tr>
<tr>
<td><strong>ESTONIA</strong></td>
<td></td>
</tr>
<tr>
<td>National Institute for Health Development</td>
<td><a href="http://www.tai.ee">www.tai.ee</a></td>
</tr>
<tr>
<td><strong>POLAND</strong></td>
<td></td>
</tr>
<tr>
<td>City of Torun</td>
<td><a href="http://www.torun.pl">www.torun.pl</a></td>
</tr>
<tr>
<td>National Institute of Public Health</td>
<td><a href="http://www.pzh.gov.pl">www.pzh.gov.pl</a></td>
</tr>
<tr>
<td>Polish Healthy Cities Association</td>
<td><a href="http://www.szmp.pl">www.szmp.pl</a></td>
</tr>
<tr>
<td><strong>FINLAND</strong></td>
<td></td>
</tr>
<tr>
<td>City of Turku</td>
<td><a href="http://www.turku.fi">www.turku.fi</a></td>
</tr>
<tr>
<td><strong>SWEDEN</strong></td>
<td></td>
</tr>
<tr>
<td>Stockholm County Council</td>
<td><a href="http://www.sll.se">www.sll.se</a></td>
</tr>
<tr>
<td><strong>NORWAY</strong></td>
<td></td>
</tr>
<tr>
<td>Norwegian Directorate of Health</td>
<td><a href="http://www.helsedirektoratet.no">www.helsedirektoratet.no</a></td>
</tr>
</tbody>
</table>

---

**NOTE:** The websites provided are for information purposes and may change over time. Always verify the current status of the websites.
Annex 4 Examples of the initiatives (projects, other activities) on implementation of HiAP in Europe.

Some initiatives to promote cross-sectoral work and Health in All Policies have been already undertaken at the European level. Three of them – Equity Action, Crossing Bridges and DETERMINE – are presented here. The Healthification project will base on their experience and will seek synergy with the actions already implemented.


Equity Action project was the European Union funded Joint Action project between the EU and Member States. Its aim was to reduce health inequalities by contributing to the policy change both at national and regional level and to strengthen the contribution of the stakeholders. It focused on developing capacity of Member States in four particular areas:

- Developing knowledge for action on health inequalities;
- Supporting the engagement of Member States, regions and also other stakeholders in action to tackle the socioeconomic health inequalities;
- Sharing the knowledge between the Member States and other actors;
- Promote the development of effective action to catch socioeconomic health inequalities at the European Union policy level.

The project consisted of four work packages: Tools, Regions, Knowledge and Stakeholders.

The objective of the Work Package Tools was to promote equity focus in policy making by identifying tools to analyze and affect policy making process, like Health Impact Assessment with an equity focus and Health Equity Audits. This work package provided three training sessions on Health Impact Assessment to the partners.

The objective of the Work Package Regions was to develop a regional network to collect and share regional approaches to decrease health inequalities and to strengthen the capacity for the use of Structural Funds to address regional equity issues. These goals were reached by establishing a regional and sub-national entities: network between Member States that was, online communication platform, circulating a Situation and Needs Assessment Questionnaire to all regions within those Members States that were in this work package. Moreover, three regional network meetings were organized and one training workshop.

The aim of Work Package Knowledge was to facilitate the transfer of scientific and technical knowledge and evidence to policy makers within the context of the Equity Action project. The focus was on intersectoral action to promote health equity and evidence on the effectiveness of action on the social determinants of health inequalities.

The aim of the Stakeholders Work Package was to enhance stakeholder commitment processes in the Member States and at European Union level to address health inequalities. The objective was to involve stakeholders from different sectors into a discussion and to develop a guide how to identify, engage and support stakeholders in tackling the health inequalities. These aims were reached with different National and EU level workshops, debates and conferences.

The project involved 15 EU Member States and Norway, 25 partner organizations, 30 regions and stakeholders under the lead of Health Action Partnership International.

**Partners:** EuroHealthNet; Public Federal Service Health, Food Chain, Safety and Environment (Belgium); National Institute of Public Health (Chez Republic); Department of Health (England); National Institute for Health and Welfare (Finland); Direcion Générale de la Santé (France); Federal Centre for Health Education (Germany); National Centre for Social Research (Greece); National Institute for Health Development (Hungary); Institute of Public Health of Ireland (Ireland); Azienda Ospedaliera Universitaria Integrata Verona (Italy); Azienda Sanitaria Locale TOS Regione Piemonte, Struttura Complessa adreizione Universitaria Epidemiologia (Italy); Agenzie Nazionale per I Servizi Sanitati Regionali (Italy); Centre for Disease Prevention and Control of Latvia (Latvia); National Institute for Public Health and the Environment (Netherlands); Norwegian Directorate of Health (Norway); National Institute of Public Health – National Institute of Hygiene (Poland); The Scottish Executive (Scotland); Directorate General for Public Health and Foreign Health. Ministry of Health and Social Policy (Spain); La Fundacion Vasca de Innovacion e Investigacion Sanitarias (Spain); Region Västr Gotland (Sweden); Swedish National Institute of Public Health (Sweden); Welsh Government (Wales).

For further information, Project Manager Mark Gamsu: mark.gamsu@hapi.uk
Crossing Bridges (2011-2012, Lead Partner: EuroHealthNet)
The Crossing Bridges project identified the factors that ensure a successful Health in All Policies (HiAP) approach through the analysis of case studies across the Europe. Crossing Bridges project continued the work of the "Closing the Gap" (2004-2007) and "Determine" (2007-2010) projects, which aim was to advance the implementation of Health in All Policies approaches in the European Union Member States. These projects promoted the development of practical tools, which are needed when turning the HiAP theory into practice. The starting point of Crossing Bridges project was that implementation of HiAP approach in practice seems difficult even if the concept is broadly known and accepted.

The specific objectives of the Crossing Bridges were:
• To develop practical tools to turn HiAP theory into practice
• Investigating to specific examples of inter-sectoral collaboration to identify effective methodologies that can be further developed
• Developing the capacities of national and regional public health institutes in order to promote HiAP (Health Inequality)

The outcomes of the different areas of work were thought to lead to greater clarity on the principles and concepts that suit implementation of HiAP and to outline practical approaches that were missing in even the most advanced countries.

The project was implemented within 18 months in the consortium led by EuroHealthNet. Crossing Bridges involved 13 partners working on national and regional level and 12 collaborating partners. The project was co-financed by the European Union in the framework of the Health Program.

Partners: Austria Gesundheit Österreich GmbH, Czech Republic National Institute of Public Health, Germany Federal Centre for Health Education, Hungary National Institute for Health Development, Italy Verona University Hospital, Poland National Institute of Public Health – National Institute of Hygiene, Wales Public Health Wales, Belgium Flemish Institute for Health Promotion and Disease Prevention, England NHS Sefton, Greece Institute of Preventive Medicine, Environmental & Occupational Health, Ireland Institute of Public Health in Ireland, Netherlands Netherlands Institute for Health Promotion, Slovenia National Institute for Public Health

For further information: Yoline Kuipers from EuroHealthNet: y.kuipers@eurohealthnet.eu

The aim of EU-wide DETERMINE project was to stimulate action and to promote awareness about the socio-economic determinants of health. It brought together a consortium of more than 50 health bodies, public health and health promotion institutes and governments and various other organizations from 26 European countries. During the project the partners identified innovative approaches in their countries in regard to e.g. public-private partnership. It is know that health inequalities are caused by unequal distribution of social determinants, but there is lack of consensus of which approaches should be used when reducing inequalities in health. DETERMINE project provided new insights in this area. First, effective national policies and practices, which promote health equity, should be identified. Second, innovative approaches to promote health of disadvantaged population groups need to be recognized.

The project aim was to foster co-operation between health and other sectors to promote health. The main goal was to reach greater awareness and capacity among decision makers in all policy sectors in order to take health and health equity into consideration when developing policies and interventions. Shortly, the DETERMINE tried to contribute to the evidence base of how to reduce social inequalities in health in the Europe, in all policy sectors.

The Coordination of the DETERMINE project was EuroHealthNet and the main partner of the project was the IUHPE (International Union for Health Promotion and Education). Seven organizations were leading each different work packages (Consortium; Coordination; Dissemination; Evaluation; Innovative approaches; Evidence, transferability and cost-effectiveness; Capacity Building and Awareness Raising). The consortium’s activities were undertaken through these work packages (IHUPE).
Three pilot projects were set up by DETERMINE: in Hungary, Slovenia and Denmark. Hungary’s project aim was to improve living conditions of those living in slums. Project in Slovenia promoted health of people who live in streets. In Denmark the project worked in a public-private cooperation with local employers to promote health of the obese, inactive men with little or no education.


For further information, Lead Partner: [www.eurohealthnet.eu](http://www.eurohealthnet.eu)

---

**More information about Healthification project:**
[www.marebalticum.org](http://www.marebalticum.org)  [www.ndphs.org](http://www.ndphs.org)