Abstract

Background: In 2003, the German Federal Centre for Health Education (BZgA) initiated the national Cooperation-Network (CN) "Equity in Health". The CN is constantly increasing in size and scope, supporting setting approaches aimed at reducing health inequalities. A detailed description of the CN has not yet been available in English.

Results and key activities: The CN comprises a total of 66 institutional cooperation partners. Information concerning the structure and activities can be found on a special website. Coordination Centres (CC) have been established in the 16 federal states, for the coordination of all state-specific activities. Funding for the CN and CC is provided by the BZgA, the German statutory sickness funds and by the state-specific ministries of health. These partners also support the continuous quality improvement, which is based on the good-practice criteria developed by the Advisory Committee of the CN. In 2011, the "Municipal Partner Process (MPP)" has been launched, specifically supporting local partners and integrated life-course approaches focussing on children. In 2015, the focus has been widened to include all age-groups.

Perspectives: In July 2015, a new national health law concerning health promotion and prevention has been ratified by the federal Parliament, with a focus on reducing health inequalities. Currently, the details of its implementation are discussed on a nationwide basis. The CN has long advocated for such a law, and today the CN is a well-accepted partner providing concepts, methods and a strong and long-standing network. The paper closes with future challenges faced by the CN.

Background

Substantial socio-economic differences in health have been shown to exist, over and over again. Today the discussion has shifted from empirical studies specifying the characteristics of these health inequalities towards the question of how these inequalities could be reduced (Horton et al. 2015). Little progress has been made in this regard, though, despite many statements from public health researchers and policy makers that these health inequalities should be reduced. There are many reasons for this failure, and the task is difficult indeed. Political alliances have to be built, the underlying causes are complex and deeply woven into the social fabric, financial and human resources have to be secured for policy interventions and also for research evaluating these interventions.

Almost all upstream and downstream approaches for reducing health inequalities are not directly controlled by the health care sector. They include topics such as educational opportunities, income and tax policy, social policy and welfare system, employment promotion and environmental justice, and the responsibility for these topics is scattered across a wide range of agencies. Any strategy to improve health equity should therefore be intersectoral and include as many stakeholders as possible. This objective is summarized in the slogan "Health in All Policies (HiAP)", well accepted in the public health community and also among some policy makers (Leppo et al. 2013; McQueen et al. 2012). It is also well accepted that setting-based approaches provide a good starting point for health promotion programs aimed at implementing HiAP and at reducing health inequalities (Whitelaw et al. 2001; Newman et al. 2015).

Progress along this road has been rather slow in Germany, much slower as compared with other European countries such as Finland (Leppo et al. 2013). The HiAP-concept is well known, but implementation in public health policy is still rare. A similar picture can be seen concerning the objective to reduce health inequalities. There are large morbidity and mortality differences by socio-economic status, policy makers no longer doubt this fact, and many statements can be found asking for the reduction of these health inequalities. Until recently, though, the effort to actually reduce these inequalities has been very limited and fragmented, with little centralized planning or coordination. In Germany, the

implementation of nationwide health policies is challenging, as the responsibility for health policy largely lies under the responsibility of the federal states or municipalities; but there is one important exception: The statutory sickness funds, which include about 90% of the population, are controlled by national law. The Social Insurance Law specifies that all sickness funds are obliged to health promotion, and that these activities should contribute to the reduction of health inequalities (§20, SGB V). Evaluation has been very limited, though, and until now it is not known if the law has actually contributed to this objective.

The national Cooperation-Network (CN) "Equity in Health" has been founded about 13 years ago (in 2003) in order to provide a fresh start for all activities aimed at reducing health inequalities. It is a voluntary association of partners across a whole range of stakeholders. The paper aims at describing this CN in more detail, its origin and structure, the focus on settings and its major areas of activities, including a large database on local projects, the establishment of Coordination Centres (CC) in all 16 federal states, the jointly approved criteria for good-practice and the selection of examples of good-practice. The potential contribution to the implementation of the new national health law concerning health promotion and prevention, which has been ratified by the federal Parliament in 2015, will be discussed as well. There are a number of German publications on the CN (Kilian et al. 2016), but to date no detailed description has been available in English.

Origin, structure and major areas of activities

At present (April 2016), there are 66 institutional partners in the CN. They comprise all major state- or federal-level NGOs focussing on health promotion, large statutory sickness funds, physician, nursing and midwifery associations, charity organizations, and also the associations of municipalities and cities in Germany. The Federal Centre for Health Education (BZgA), an institution of the Federal Government, is the founder of this network and has funded it ever since. In 2002, the BZgA began to set up a national database of local projects explicitly or implicitly aimed at reducing health inequalities. The database (openly available online) filled an important gap, as knowledge about these small scale projects was mostly limited to those working in it, making it hardly possible to exchange experiences and to learn from past successes and failures. Within a few weeks, more than 2,000 projects were self-listed from many different providers, clearly demonstrating the

great interest in this topic. The database is still kept up-to date on a regular basis, at present it includes about 2.800 projects. Funding for this CN largely comes from the federal ministry of health, via its funding of the BZgA.

The database showed the wide range and great variety of these projects, and the need for more cooperation and quality improvement. It was apparent that many providers should be constantly informed and involved, and that it was necessary to organize this process in a more systematic way. This is why the Advisory Committee decided to develop criteria for good-practice and to identify examples of good-practice. Thus the national Cooperation Network was founded shortly after, in November 2003. At the beginning it was named "Health Promotion for the Socially Disadvantaged" (in German: Gesundheitsförderung bei sozial Benachteiligten), and in 2012 it was renamed to "Equal Chances for Good Health" (in German: Gesundheitliche Chancengleichheit). In their cooperation agreement, all partners of the CN emphasize that successful health promotion is based on a joint strategy for health education, capacity-building and structural measures, and that setting approaches provide the best chances for success.

The website "www.gesundheitliche-chancengleichheit.de"
(most information available in German only)

The website of the CN was launched 2003, it serves as the primary source of information concerning the structure of the CN and all areas of activities, it can be openly accessed thus also informing the public as a whole. The database with the local projects (see above) can easily be accessed by this website and searched by keywords, a contact person is listed for each project in order to facilitate direct cooperation. Another important component of the website is centred around good-practice, giving information on the criteria developed within the CN for defining good-practice and examples of good-practice from Germany (for more information see below). The website also gives information on new studies and policy statements concerning health inequalities and setting-based health promotion in Germany. Today it is the most comprehensive platform for these topics in Germany, well known and accepted by individuals, projects and organizations working in this field.

Coordination Centres (CC) in the federal states

The CN was well aware of the fact that the promotion of local projects should be based on a decentralized structure covering all federal states. In 2004 it was decided to build a Coordination Centre (CC) in each of the 16 federal states, and three years later this task could be completed. The CC were first named "Regional Nodes" (in German: Regionale Knoten), in 2012 the name was changed to "Coordination Centres for equity in health" (in German: Kordinierungsstellen Gesundheitliche Chancengleichheit). To secure funding for the CC was not easy. To date the CC are still jointly financed by state-specific ministries of health and by some sickness funds, with details differing from CC to CC. The difficult point is that this funding is rather low and has to be secured each year again. A good point is, however, that the cooperation with the sickness funds provides an excellent opportunity to lobby for setting-based health promotion. It was more easy to find an "organizational home" for the CC, they are placed under the authority of state-specific associations responsible for health promotion.

The duties of the CC are widespread. They have to lobby for setting-based health promotion addressing health inequalities, distribute information from the CN, participate in committees, organize workshops, advice and support local projects, help to define good-practice and identify examples of good-practise. To date each CC is still staffed with just one person (some full-time, some half-time) and they have to focus on a few selected topics specific to each state.

Good-practice criteria: a framework for continuous quality improvement

A major objective of the CN is to promote good-practice, to find examples of good-practice projects and make them known all over Germany, and to advice other projects that want to move into this direction. Shortly after setting up the CN it became clear that it was essential to develop criteria for good-practice and to agree upon a joint definition. In 2004, a subgroup of the Advisory Committee of the CN (comprising experts from research, sickness funds, health policy and local projects) started to develop these criteria, based on the international discussion on good-practice concerning health promotion focusing on the reduction of health inequalities, and based on experiences from a large German project

focusing on structural improvements in deprived neighbourhoods (i.e. "Soziale Stadt"). The result was a list of 12 criteria, divided later into three groups (see table 1).

In Germany, it was the first time that criteria for good-practice in equity-oriented health promotion had been developed. The criteria were quickly accepted by German public health researchers, practitioners and policy makers. They are seen as an important contribution to quality improvement in health promotion as a whole, in addition to other well established approaches such as quint-essenz[1]. In 2014, a survey was conducted among different providers of health promotion concerning the acceptability of the criteria, and the feedback was very positive. The good-practice criteria were largely seen as easy to apply in practice, attractive due to their clear presentation and their easy access on the well-known and accepted website of the CN. Nowadays all providers are faced with the question whether their projects or measures have an effect on health inequalities, thus the 12 criteria could give them valuable support concerning the evaluation of their own activities. The criteria are included, for example, in the advanced training courses at health promotion agencies, and in the official document of the statutory sickness funds specifying how their health promotion activities should be planned and implemented.

The guiding principles of this good-practice process can be summarised in the following way:

- Focus on practical experiences: The criteria are linked to specific examples from real practice which can be found in the database of local projects (see above).
- Practice learns from practice: The objective is to raise awareness for good-practice without sparking off competition between the projects (and celebrations of the "winners"). This is why it was decided to name it "good" rather than "best" practice.
- Generic approach: The criteria should be applicable in many different settings. The challenge was to define criteria that are as specific as possible, but that can still serve as a common point of reference suitable to various providers and settings. This implies that the criteria will have to be "translated" for every project in order to define how they can

[1] www.quint-essenz.ch/en

be applied in a specific setting at a specific point in time. This "translation" is an important step in the continuous process of quality improvement.

- Complementary approach: Most organizations already have their own quality assessment. It would make little sense to lobby for a replacement of these well-established (and often mandatory) systems. The good-practice criteria proposed by the CN should not be seen as a competing system, but as a complimentary tool enriched with examples from practical experiences, focusing on reducing health inequalities.

To define these 12 criteria was just a starting point. It soon became clear that the criteria had to be explained to many providers of health promotion in more detail, that there are large differences concerning the appreciation and understanding of these criteria. This is why fact-sheets have been developed for each criterion. This task was completed in November 2015 and the fact-sheets are now available on the website (in German only). The "on-road test" among providers of health promotion is still underway, but to date the feed-back has been very positive. The fact-sheets are short (about four pages) and each consists of four sections: (a) short description of the criterion; (b) description of gradually increasing stages of implementation (for example: not at all implemented - implemented partly - implemented fully); (c) brief description of each stage based upon an example from real practice; (d) further reading. It is important to differentiate stages of implementation, in order to avoid the black-and-white logic which so often prevails in the general perception (i.e. either "implemented" or "not implemented"), and in order to promote a process of continuous quality improvement (i.e. step-by-step "upgrading" of each criterion).

Focus on the setting "municipality"

It is well known that a setting-based approach focusing on the local environment where people live provides an excellent starting-point for health promotion, as many health determinants can be addressed here. There are many challenges, of course, but this approach seems to be especially suited for projects aimed at reducing health inequalities (South 2014). This setting-based approach has also been in the centre of the CN right from the beginning. A critical assessment of the progress made concerning "Healthy Public Policy" concluded that health promotion should focus more on the community level (de

Leeuw et al. 2011). We agree with this recommendation and with the finding that 'negotiations between the city, the local public health authorities, private foundations and community organizations (…) can be a way of building a shared understanding of (…) the importance of urban planning for public health (and vice versa) and integrate health considerations into the urban plan.' (de Leeuw et al. 2011, ii242).

For municipalities it is often difficult to know how setting-based health promotion projects aimed at reducing health inequalities can be designed and implemented. Thus, in 2009, five booklets were published by the CN in order to provide answers and to give examples from practical experiences, with each booklet covering another topic (e.g. need assessment, design of a project, implementation, evaluation). The booklets, available on the website free of charge (German only), are titled "Get Active for Health – Tools for municipal-level health promotion and prevention". They are explicitly addressing municipal actors outside the health care sector, showing how they could promote health equity on the local level. The booklets also include results from several workshops discussing these recommendations with public health professionals and policy makers. The information has been revised and expanded several times und meanwhile comprises seven booklets.

To be more specific, the CN promotes "integrated municipal strategies" linking different areas of municipal administration and their activities concerning deprived population groups. Usually several departments are involved (e.g. departments focusing on health, on children, social services or schools), each having its own rationale. Sometimes cooperation is poor and clients from the target group can get "lost in translation", especially when biographical transitions occur (such as entering day-care, kindergarten, school or vocational training). A catchword was coined to express the objective that health promotion should follow the life course of a person, supporting him or her as needed along the way. The English translation would read "health promotion linkage / integrated local health strategy" (the German term is: Gesundheitsförderungs- und Präventions-Kette / integrierte kommunale Gesundheitsstrategie). This kind of linkage is still rare, but meanwhile some cities have firmly embarked on the concept. The examples of "pioneer-municipalities" such as Dormagen or Monheim are widely discussed, positive results are reported and other cities have started to follow.

The terms "integrated municipal strategies" and "health promotion linkage" both express the concept that different municipal services should be integrated into a network of health promotion activities, providing support, advice, and care to those in need. Each municipality is different, and each will have to find its own way of establishing health promotion linkage, based on its specific resources, strengths, weak points and problems. Nevertheless, the challenges will be similar, there will be common experiences that could be helpful to share, there will be great potential to learn from one another concerning the procedures and the organization of this process.

To start with, this intersectoral, interdisciplinary approach focused on children, trying to ensure a smooth transition between services and institutions as children in special need of support grow up. In 2011 this initiative culminated in a large project called "Growing up Healthily for All" (in German: Gesund aufwachsen für alle). Since then the CN mainly concentrates on integrated municipal strategies and health promotion linkage. In 2015 the focus was expanded to include all age groups, and the project was renamed to "Health for all" (in German: Gesundheit für alle). The expansion is a great conceptual challenge. Life course transitions in childhood and adolescence are shaped by just a few institutions, and most transitions follow a similar path. Concerning adults and the elderly, though, the transitions are much more diverse and complex, making it more difficult for a municipality to design and implement a system of health promotion linkage.

In 2012 a new website was introduced (available in German only) in order to support this "Municipal Partner Process (MPP)" (in German: kommunaler Partnerprozess). The objective was to provide municipalities with a platform for the exchange of their own experiences. Regarding content there are many links between the MPP and the national database that was introduced about 10 years before (see above), of course. The database still serves as a broad pool of information on local projects aimed at reducing health inequalities, but participation in the MPP is not confined to communities that have contributed to the national database. Officials from all municipalities can place a "business card" for his or her municipality and participate in open or closed discussion forums, either with partners from the same community or nationwide. They can access information on the CN as a whole und supply written information from their own municipality. Today about 2,300 persons are registered on this website, and about 50 municipalities (with a total

population of about 11 million people) are actively involved in this MPP. It is also important to note that the MPP has been endorsed by the conference of the state-specific health ministries and by the associations of cities and rural municipalities in Germany.

Preliminary conclusions

How can we reduce the health inequalities in Germany? This was the guiding question of the Cooperation-Network (CN) since the beginning in 2003. The CN has tried to shape and organize this discussion every since, its line of argument can be summarized in the following way: It is important to get to know as many corresponding local projects as possible in order to learn from their practical experience. A Coordination Center (CC) is needed in each federal state in order to promote the discussion on projects aimed at reducing health inequalities. Information about these projects should be easily accessible via internet for all those interested. Criteria for good-practice are needed in order to constantly improve these projects. Municipalities engaged in projects aimed at reducing health inequalities should be supported by a special network.

The preliminary conclusions focus on the structures and processes initiated by the (CN). Five points can be highlighted here: (a) The national database with local projects has been widely used by officials from local communities for more than 10 years now. The impact has not been assessed in a systematic way, but over and over again officials have stated that a new project aimed at reducing health inequalities can hardly be designed without referring to the database, that the database is indispensable for gaining new ideas and for understanding the potentials and problems of these projects. (b) The website of the CN is well known and accepted all over Germany. (c) Coordination Centres (CC) were established in all federal states and they are active for about 10 years now. (d) The 12 criteria for good-practice are well accepted as an important point of reference, and (e) the same is true for the "Municipal Partner Process (MPP)" promoting integrated municipal strategies and health promotion linkage. It is also important to mention that the number of municipalities engaged in the MPP is steadily increasing.

Apparently the CN had a rather good start, and it filled an important gap. There have been some efforts before to reduce health inequalities by setting-based approaches, but

coordination was poor on all levels (i.e. federal, state and municipality), and many researchers and policy makers have been very much aware of this fault. The discussions with policy makers and officials showed that most of them appreciated the initiative to organize a coordinated effort and that they agreed with the strategy chosen by the CN, despite the great challenges this process inevitably involves. A survey conducted in 2013 by a member of the Advisory Committee among 15 key public health officials showed the same picture, and it also revealed some important recommendations for future development (e.g. more support for the dissemination of good-practice projects to other municipalities).

Many other problems remain to be solved. To highlight just three: (a) Funding of the CC is still weak and it has to be safeguarded each year again. It would be important to secure stable funding for considerably extended personal resources. (b) The good-practice criteria are designed to be generic (see above), but the task to integrate them into the different quality assessment systems used by providers of health promotion is still largely pending. (c) It has always been intended to make the general recommendations proposed by the CN applicable to specific municipalities. The MPP (see above) is one step into this direction.

Perspectives: Future opportunities and challenges

Currently the public health discussion in Germany is strongly influenced by a new national law ratified by the federal Parliament in July 2015, i.e. the "Preventive Health Care Act". The objective, as stated on the official website[2], is to strengthen health promotion and disease prevention in settings. Concerning funding, the official website states: 'The health insurance and long-term insurance funds will be investing over 500 million euros for health promotion and prevention in the coming years. The main focus, thereby, will be on health promotion in life settings such as child day-care facilities, schools, local authorities, workplaces and long-term care facilities, with a total investment of at least some 300 million euros per year.' This is an important step in Germany. In the course of implementing the new law major stakeholders (e.g. federal parliament, statutory sickness

[2] www.bmg.bund.de/en/prevention/the-preventive-health-care-act.html

funds, statutory insurances concerning pensions, accidents and long-term-care) have to agree upon mandatory goals for health promotion and prevention in Germany and also upon a national strategy for achieving those goals.

The statutory sickness funds were obliged to health promotion since 2000 already, with a focus on reducing health inequalities. The new law provides a much needed, strong boost to this objective, as other stakeholders are included now as well, as funding increases, and as all stakeholders have to agree upon a joint national strategy. The "general agreement" (in German: Bundesrahmenempfehlung) on the strategy has been published just recently (February 2016). It states repeatedly that all projects implemented under this new law should contribute to the objective to reduce health inequalities (concerning gender and socio-economic status), and that this objective could best be reached by setting-based health promotion on the municipal and local level.

In the years to come the CN will be facing great opportunities and great challenges. On one hand, the CN is well established as the expert group for the implementation of health promotion along the lines stated above, and its recommendations are widely known and accepted. The new law will increase this awareness even more, and it can be expected that funding for the CN will increase as well (e.g. concerning the CC, i.e. the state-specific Coordination Centres). On the other hand, from a public health point of view, the new law does have some important flaws. It may be too early to say, but the general impression is that downstream interventions such as screening, vaccination and health behaviour are given the highest priority. This might be due to the fact that funding is first and foremost limited to funds provided by the statutory sickness funds. The term "setting approach" highlights the need to change the setting itself (i.e. not just to focus on the health behavior of people living in this particular setting but on the social determinants for health as well). A recent review (Newman et al. 2015) states that most health promotion activities sailing under headlines such as "community" or "setting" still focus on individual behavior, though, and the same is true for Germany. The CN will have to lobby intensively for upstream setting-based interventions aimed at improving the living conditions of those most in need. It will also be important to secure funding from more stakeholders. To date it is not planned, for example, that funding for the projects and measures specified by the new law is also provided by federal or state-specific ministries. Setting-based health

promotion aimed at reducing health inequalities should be on the agenda of all major social and political institutions, and the CN will continue to lobby for better funding from all stakeholders in order to achieve "Health for all" and "Health in all Policies".

Another major challenge will be the evaluation of the measures initiated by the new law. Documentation and evaluation are integral parts of the new law, but their implementation will have to be checked closely. Especially among public health researchers focussing on setting-based health promotion the need for more and better evaluation is well known. It is widely accepted that we are still facing great 'challenges to generating evidence of effectiveness' (Bauman et al. 2014; Dooris 2006; St Leger 2008; Whitelaw et al. 2001). In Germany as well this has been discussed for quite some years already (Loss et al. 2007). New tools will be needed, such as the tool "goal attainment scaling" that has recently been tested in Germany quite successfully (Kolip and Schäfer 2013). It will be a great challenge to incorporate all these thoughts and recommendations, to jointly create a system for evaluation that could satisfy both policy makers and researchers.

References

Bauman, A.E., King, L., Nutbeam, D. (2014) Rethinking the evaluation and measurement of Health in all policies. *Health Promotion Internationa*l, 29 (Suppl 1), i143-151.

de Leeuw, E., Clavier, C. (2011) Healthy public in all policies. *Health Promotion International*, 26 (Suppl 2), ii237-244.

Dooris, M. (2006) Healthy settings: challenges to generating evidence of effectiveness. *Health Promotion International*, 21(1), 55-65.

Horton, K., Friel, S., de Leeuw, E., McKeone, C., Bolam, B. (2015) Fair Foundations for health equity. *Health Promotion International*, 30 (Suppl 2), ii2-7.

Kilian, H., Lehmann, F., Richter-Kornweitz, A., Kaba-Schönstein, L., Mielck, A. (2016) Gesundheitsförderung in den Lebenswelten gemeinsam stärken - Der Kooperationsverbund Gesundheitliche Chancengleichheit. [Consolidated efforts to strengthen health promotion in living environments. The cooperation network "Equity in Health"]. *Bundesgesundheitsblatt*, 59, 266–273. [publication in German]

Kolip, P., Schaefer, I. (2013) Goal attainment scaling as a tool to enhance quality in community-based health promotion. *International Journal of Public Health,* 58(4), 633-636.

Leppo, K., Ollila, E., Peña, S., Wismar, M., Cook, S. (eds) (2013) Health in All Policies – seizing opportunities, implementing policies. Ministry of Social Affairs and Health, Finland.

Loss, J., Eichhorn, C., Gehlert, J., Donhauser, J., Wise, M., Nagel, E. (2007) Gemeindenahe Gesundheitsförderung - Herausforderung an die Evaluation [Community-based health promotion - a challenge for the evaluation] *Gesundheitswesen*, 69(2), 77-87. [publication in German]

McQueen, D.V., Wismar, M., Lin, V., Jones, C.M., Davies, M. (eds) (2012) Intersectoral Governance for Health in All Policies Structures, actions and experiences. World Health Organization, Copenhagen, DK.

Newman, L., Baum, F., Javanparast, S., O'Rourke, K., Carlon, L. (2015) Addressing social determinants of health inequities through settings: a rapid review. *Health Promotion International*, 30 (Suppl 2), ii126-143.

South, J. (2014) Health promotion by communities and in communities: current issues for research and practice. *Scandinavian Journal of Public Health,* 42 (15 Suppl): 82-87.

St Leger, L. (2008) Evaluating community-based health promotion initiatives: an ongoing necessity and challenge. *Health Promotion International,* 23(4), 299-301.

Whitelaw, S., Baxendale, A., Bryce, C., MacHardy, L., Young, I., Witney, E. (2001) 'Settings' based health promotion: a review. *Health Promotion International,* 16(4), 339-353.

(last access of internet-links mentioned in the paper: June 2016)

List of abbreviations

BZgA	Federal Centre for Health Education
CC	Coordination Centres (in the federal states)
CN	Cooperation-Network
HiAP	Health in All Policies
MPP	Municipal Partner Process

Table 1: 12 Criteria for 'Good Practice'

Core criteria - concept of the project or measure (clear description of the objectives and rational for the activities) - target group (clear definition of the deprived group that the project or measure wants to reach) - setting approach (inclusion of structural improvements in the setting)
Activities specifically tailored to the target group - empowerment of the target group - participation (transfer of decision-making power to the target group) - low-threshold approach (avoidance of barriers for taking part in the project) - multiplier concept (systematic training of person who could act as multipliers)
Sustainability and quality improvement - sustainability (continuous improvement and further development of the project) - integrated strategy (integration into the network of other activities in the community, interdisciplinary and intersectoral) - quality management (continuous quality assessment of all activities) - documentation and evaluation (continuous documentation and evaluation of all activities) - cost-effectiveness (assessment of the costs and the effects of the project)