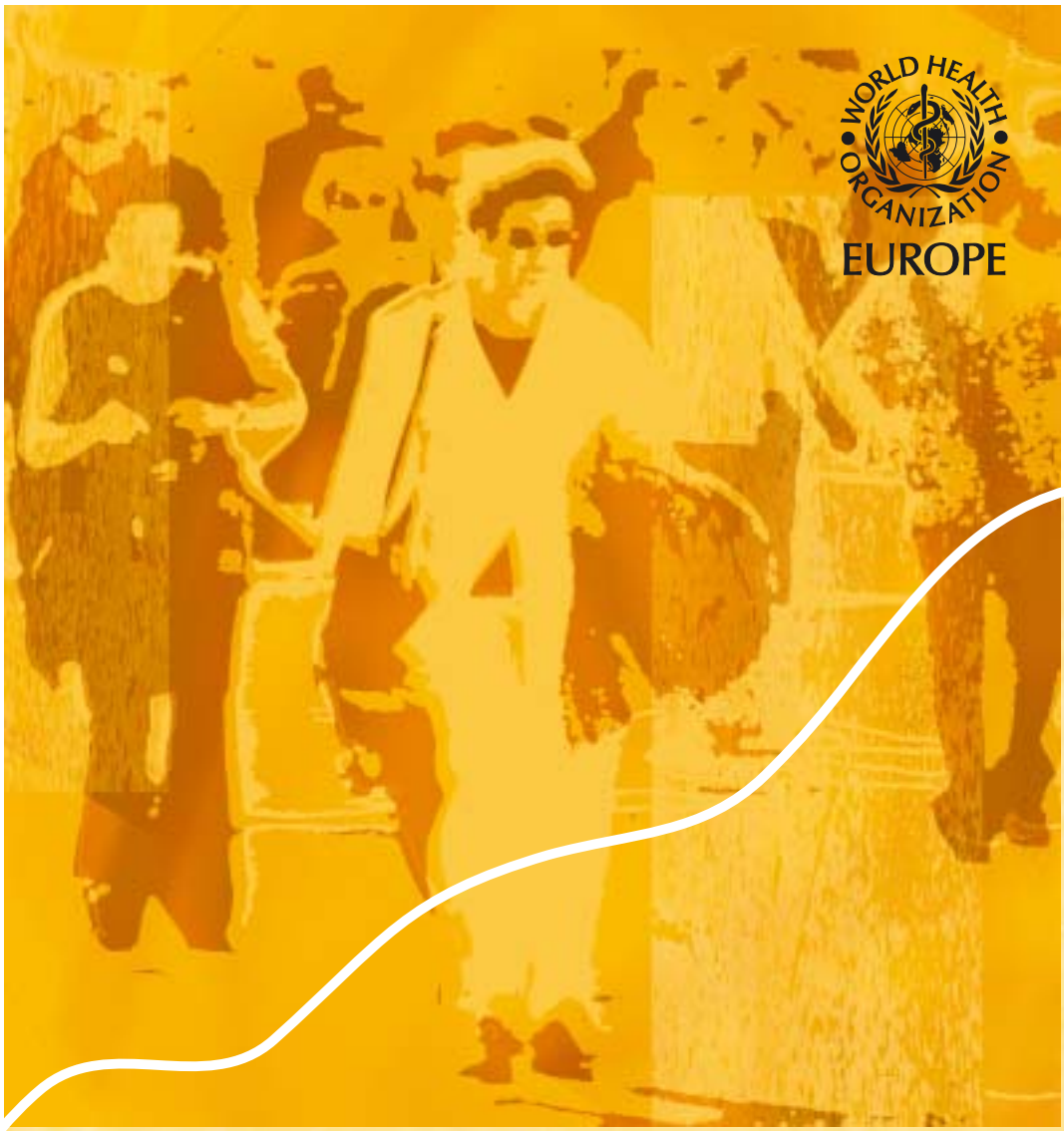

WORLD HEALTH ORGANIZATION
EUROPE

Review of national Finnish health promotion policies and recommendations for the future

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KEYWORDS

EVALUATION STUDIES;
HEALTH PROMOTION – organization and administration;
HEALTH POLICY;
FINLAND

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The Venice Office was set up to advise Member States in the WHO European Region on understanding and acting upon the social and economic determinants of health.

There is increasing evidence that economic wealth and people's health are closely linked. Social and economic determinants play the major role in influencing the health of populations, whether through poverty, employment, education, housing, or the many other factors that shape people's daily lives. The Venice Office works in three main areas:

- Research and development - review, monitoring and dissemination of research on social and economic determinants and their impact on the patterns of ill health.
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- Information material - developing and disseminating evidence through specially designed information about knowledge and know-how in the area of social and economic determinants.

FOREWORD

This review of national Finnish health promotion policies follows the strong Finnish tradition of requesting external policy reviews. The review appraises the overall Finnish health promotion system – its past performance and its future potential – in the light of the rapidly changing policy context of Finland within the wider world. The participatory process of cooperation and openness that was followed has allowed the review to take place as a transparent democratic process, providing an example for emulation by many other countries. The promotion of health is both an opportunity and a challenge for all countries, and the request of Finland for policy review was a commendable effort openly to identify shortcomings and successes and to implement proposed recommendations made by the review team.

It is my hope that many other WHO Member States will follow suit in requesting such reviews that meet with WHO's country focus priority – making it possible to respond to specific country needs and requests for technical assistance.

Marc Danzon
Regional Director
WHO Regional Office for Europe

FOREWORD

Finland has a long, reciprocal and valuable collaboration with WHO, especially in health policy matters. Therefore, it was natural for Finland to request from the WHO Regional Office for Europe an external expert evaluation of our health promotion policies. Our wish was to receive objective opinions on how we have performed in the past and what we should improve in the future, with a focus on the national level.

Promotion of welfare and health by the authorities has recently become a civil right in Finland. One reflection of this is our new public health programme, *Health 2015*. Now, with the review process behind us, we find it both relevant and useful. Thus, it is necessary to further develop our health promotion system according to up-to-date good practices. We will now engage ourselves in a process of consultation concerning the implementation of the recommendations.

The evaluation process was a rewarding experience. We warmly recommend that such procedures become a standard part of the WHO service. Member States should be encouraged to take advantage of this service as a normal contribution to their work in the field of health promotion.

Eva Biaudet
Minister of Health and Social Services
Finland

EXECUTIVE SUMMARY

This report results from a request of the Ministry of Social Affairs and Health of Finland to the WHO Regional Office for Europe to appraise the overall Finnish health promotion system – its past performance and future potential – in the light of the rapidly changing policy context of Finland within the wider world. Particular emphasis was placed on: consistency of implementation; short term and long term impact of policy processes adopted; factors that have facilitated reforms; relevance, appropriateness and timing; unplanned side effects (if any) of actions undertaken: and opportunities for future progress.

The appraisal was conducted by an international team assembled by the WHO Regional Office for Europe. The method used was adapted for the purpose by the team from other approaches to appraisal and evaluation. Its main approaches and resources were: an analysis of key documents (making extensive use of Web-published materials as well as hard copies, and including already published overview articles), interviews with officials, key informants and stakeholders; meetings with selected committees and groups, and site visits; methodological experiences from earlier WHO health for all evaluations and investment for health appraisals; reviewing competence represented by the team members' individual experiences.

The main findings of the review were a re-affirmation of Finland's strong basis in health policy thinking and planning, but with questions raised about a number of aspects of the current system, in particular:

- the performance by national institutions collectively of the required range of functions and responsibilities to lead and support contemporary health promotion;
- the extent of leadership, systematic practice and professional and technical resources of health promotion at the municipal level, especially the engagement of health promotion in the overall social and economic agendas locally, and the systematic sharing of good practice among the municipalities;
- the mandate, scope, resources and infrastructure of the Ministry of Social Affairs and Health to fulfil the major challenges of strategic leadership and coordination of the intersectoral policy agenda;
- the possibilities for strategically directing and managing the range of funding instruments available for health promotion funding at the national level;

- the availability in future of people having the range of requisite skills and experiences, in the numbers, places and positions required in order to achieve the national health policy objectives.

Detailed recommendations were provided, which can be summarized as a need to give attention to:

- sustaining and strengthening the intersectoral mechanisms;
- ensuring the numbers, skills, strengths and preparedness of human resource capacity at all levels, for both strategic planning and management functions and for implementation;
- considering the introduction and application of the technique of health impact analysis to all major health-relevant initiatives;
- ensuring robust implementation arrangements for *Health 2015*, including developing the role of the Public Health Advisory Board, ensuring the existence and systematic management of all the necessary elements for modern health promotion, optimizing funding arrangements;
- working out how best to assist the municipalities in their crucial role of promoting the health of the populations they serve;
- ensuring that the critical roles performed at the national level to support and facilitate local health promotion are appropriately assigned and managed; and
- tailoring the research and development agenda to the priorities of knowledge-based policy-making and practice.

1. INTRODUCTION

This review – whose purpose is set out in Section 4 – has been prepared at the request of the Ministry of Social Affairs and Health of Finland. As such, its feasibility and ultimate usefulness have depended greatly on a number of critical factors. Chief among these are the spirit of cooperation, the energy and the transparency of the Ministry, and the logistical arrangements which they have made for the work of the review team. All have been unfailing in their excellence. Full acknowledgement of all the help received from many different organizations and individuals in Finland is contained in Section 12. At the same time, it is stressed that the review team, on behalf of WHO Regional Office for Europe, takes full responsibility for the content of this report.

In commending this report to the Ministry of Social Affairs and Health, Finland and to WHO, the review team expresses the hope that it will help to provide the basis for a wider discussion within WHO about the usefulness of such reviews, the approach taken, and the potential for wider applicability to other Member States. The Government of Finland, with its strong record of active participation in the development of WHO thinking and practice in the field of health policy and its implementation, and its critical and constructive engagement in this review, would be well placed to contribute strongly to such a discussion.

2. PURPOSE OF REVIEW

The terms of reference of the review can be found in Annex I.

For the purposes of this review, health promotion is defined as:

"the process of enabling people to increase control over *the determinants of their health* and *thus* to improve their health".

With the addition by WHO in 1998 (Health Promotion Glossary, WHO, Geneva, 1998) of the words in italics, this is the definition contained in the Ottawa Charter for Health Promotion (1986); the Charter is reproduced as Annex V. The prerequisites for health, the roles of advocacy, enablement and mediation, and the five action areas – all set out in the Charter – continue to provide the fundamental values and guiding

principles of health promotion policy-making and practice, and have informed the work of the review team accordingly.

The review aimed at appraising the overall Finnish health promotion system – its past performance and its future potential – in the light of the rapidly changing policy context of Finland within the wider world.

In particular, the review aimed to appraise:

- consistency of implementation
- short term and long term impact of policy processes adopted
- factors that have facilitated reforms
- relevance, appropriateness and timing
- unplanned side effects (if any) of actions undertaken
- opportunities for future progress.

As the review was requested by the Ministry of Social Affairs and Health, its point of departure was Finland's health promotion system, including a review of the Ministry's role within that system. The team was provided with extensive contacts with representatives from across the field of public health in Finland. Additionally there were opportunities for more limited interaction with representatives from some of the sectors with clear health-related responsibilities or impact, namely:

- transport & communication
- education
- agriculture
- environment.

However, contact with other sectors with significant impact upon health – such as the Ministry of the Interior (with responsibility for regional development) and the Ministry of Labour were not part of the planned review procedure.

3. BACKGROUND AND CONTEXT

3.1 Acknowledgement of Finnish health policy

Finland is acknowledged to be one of the world leaders in the field of public health. Moreover, this is matched by its openness to external review of its achievements,

progress and problems in public health. It has consistently invited and experienced such reviews and is exemplary in its endeavours to learn from them and to share its experiences internationally for wider benefit.

Finnish health policy and organization represent a high level of strategic thinking in the area of health and sustainable development and are also characterized by articulation into systematic planning and reporting.

Finland has been engaged in a longstanding process of close cooperation with WHO for the development and renewal of health policy in Finland and European Region. A pertinent example is the development of Finland's health for all policy in the 1980s and its review by a WHO external review group, published in 1991, which contributed to shaping the country's health agenda, policy processes and actions during the 1990s. This review covers the period 1991–2002 and looks forward to future progress, within the overall framework of health for all values and principles.

3.2 Developments from 1990 to 2000

In the decade 1990 to 2000, despite an environment characterized by severe economic depression and cuts in all development work, determined strategic development not only continued, but successfully maintained many of the themes considered necessary and important in the preceding decade.

The 1990s can in fact be seen to have been a maturation period for much earlier developments. In a real sense, they were the culmination of developments which had earlier taken place at many levels of administration, in which ideologies had been expanded and major structural modifications had been made in the functions of the Finnish public health system. Although it happens that many major developments took place during the 1990s, most of those developments were the result of work in previous decades. The changes were in many ways interlinked and had an effect on health promotion. They helped to maintain Finland's "leading edge" thinking about health and its determinants. They were, in brief:

- **The development of broader public health policy thinking.** On a general level, thinking advanced from a focus on (individual-level) risk factors into a broader emphasis on the need for society, environment and community to be supportive for health and to enable healthy living, i.e. a more comprehensive approach based on health determinants. In the same way, the adopted policy increasingly emphasized the creation and strengthening of the preconditions for health, rather

than emphasizing health services as a "guarantee of good health" for the population.

- **An increasingly analytical approach to intersectoral health policy development.** The Government Public Health Report (later the Social and Public Health Report), presented for the first time to the Parliament in 1996, was a manifestation of the intersectoral standpoint of the Ministry of Social Affairs and Health and can be regarded as a sign of the intention of the Ministry to take and maintain a prominent role in health promotion as leading strategist and coordinator. The reports are based on legislation, according to which all ministries have to contribute by reporting their health-relevant activities: the fact that this obligation is mentioned in the law is itself a result of advocacy work done in 1990s.

- **The organizational development of the Ministry of Social Affairs and Health**. This included the founding of a special department in the Ministry of Social Affairs and Health for health promotion in 1992, combining preventive health and social work. This was intended to improve the general intersectoral thrust of health promotion by bringing together two core sectors. In 2002, the Ministry of Social Affairs and Health organization was again changed, once again separating social and health departments, this time under the headings Department for Family and Social Affairs on one the hand, and Health Department on the other. Health Promotion is now part of the work of the Health Department.

- **The development of government agencies**. The National Research and Development Centre for Welfare and Health (STAKES) was founded by combining the national health and social boards. STAKES was developed to become, in the first place, an R&D organization and a support centre for the municipalities. Support for the municipalities was increasingly emphasized also in the development of the National Public Health Institute.

- **The increase of municipal autonomy.** This was done by redefining the relations of the central government and local authorities in a way which was intended to increase considerably the municipalities' competence in so called "basic services" (health, education and social services). The idea was that – as the municipalities collect their own taxes, and legislation gives them considerable freedom in organizing the required services to inhabitants – increasing the responsibility of the municipalities would benefit the health and wellbeing of the citizens, including

health promotion. A revision of the Local Government Act strengthened the trend towards greater local autonomy.

- **The revision of the State subsidy system.** The State financially subsidizes municipalities. The subsidies used to be earmarked in a detailed fashion. The earmarking was abolished and each municipality now gets its share of the national budget according to a model formula. Simultaneously, municipal autonomy has been increased, according to the principle of planning service delivery with local expertise, based on the needs of the population. The economic recession of the early 1990s has also been influential, as the State became less able to transfer subsidies to municipalities at the previous ambitious and demanding levels. Framework laws set minimum requirements for health, education, social welfare and other vital service provision. Beyond these framework laws, there is considerable freedom and scope; for instance, it depends on local-level politics and decision-making to what extent health promotion work is carried out. It appears that the increase of autonomy and the revision of the funding system has had clear effects on local-level investment priority-setting, in favour of health services and to the detriment of health promotion. The role of the Ministry of Social Affairs and Health is to develop the legislation and to give information (and in a limited number of cases funding) guidance. Recently, Ministry of Social Affairs and Health recommendations have been increasingly used as a tool for information guidance.

- **The relationship of public health nongovernmental organizations (NGOs) and the State was redefined, and an umbrella organization of public health NGOs was strengthened.** The NGOs – as civil society organizations – were recognized as full partners in health promotion. Their umbrella organization, the Finnish Centre for Health Promotion (founded in 1962), was given a role within decision-making on the funding of NGO activities. The NGOs work at all the levels, local, regional and national, and have different partner roles depending on the level: at the local level they deal with individual people and groups of people, whereas at the regional and national levels they have coordinating functions and carry out experimental projects and innovative initiatives and bring their experience into both national-level policy-making and research work. The main aims of the Finnish Centre for Health Promotion are:
  - to strengthen cooperation between NGOs and other actors in the sphere of health promotion;
  - to advance and advocate for health promotion issues in legislation; and

- to provide a centre of excellence for its members, including method development and the quality of materials.

- **Health promotion research was significantly strengthened.** The Academy of Finland provided funding for research in health inequality, a programme which has come to its end, and the Academy presently runs an extensive health promotion research programme.

- **The development of the health promotion funding system of the Ministry of Social Affairs and Health.** Under the framework dictated by the Tobacco Act, the Temperance Act and some other regulations, a specific instrument of health promotion funding has been created. It is as a separate budget item, which currently provides € 7 million per annum, controlled by the health promotion officers of the Health Department of the Ministry of Social Affairs and Health. Making decisions about funding for both the agencies and other actors provides the facility for horizontal strategic development and for improving the consistency of what is done. The goals of the health promotion plan of the Ministry of Social Affairs and Health are:
  - strengthening health promotion structures
  - nonsmoking measures and implementing the Tobacco Act
  - reducing the use and harmful effects of intoxicants
  - promoting health enhancing nutrition
  - promoting musculoskeletal health and functional ability
  - accident prevention
  - mental health promotion
  - promotion of sexual and reproductive health.

- **The contribution to European Union (EU) policies.** Finland's approach appears to stem from the same broad outlook to health which has inspired national policy development. Health, even as a term, has only been on the EU agenda since the Maastricht European Council of Ministers Meeting in 1992. During its short membership of the EU, Finland has emphasized that health should be addressed in all policies and not dealt with primarily by isolated disease-oriented programmes. Finland contributed significantly to the adoption of "health in other policies" as one of the general guiding principles for the implementation of the new EU action programme on public health. It is also worthy of note that, during its Presidency of the EU in 1999, Finland introduced mental health as a new topic on the EU public health agenda.

To coordinate all EU affairs at Government level, Finland has created a comprehensive committee structure, within which the Ministry of Social Affairs and Health systematically coordinates Finland's EU public health policy with other sectors and has a say in the EU policies of other sectors. Such a comprehensive coordination approach seems to be almost unique in comparison with other EU countries.

3.3 Health policy process in Finland

Taken together, this work is recognizably systematic policy-making for health, including information and data analysis, needs assessment, strategy development, stepwise introduction of measures for new legislation, implementing the new measures and evaluating their implementation. Without such continuity of systematic policy development, the policies for which Finland has become well known internationally – such as heart health, cancer prevention, tobacco control and nutrition – could not have been planned and implemented, monitored, evaluated and evolved. It also sets a high standard and raises high expectations to be met in a review process.

3.4 Broader societal changes in Finland and their impact on health

Finnish society in the period since 1990 has experienced rapid and profound changes, springing principally from a combination of:

- the effects of the deep economic recession which followed the collapse of the USSR;
- the impact of global forces, and in particular of the EU, which Finland joined in 1995; and
- the continuous acceleration of urbanization and its concentration in the larger cities of southern Finland.

Finland's economic recession of 1990 was the most profound to affect any Organisation for Economic Co-operation and Development (OECD) country since 1945. To cope with the serious effects of the recession on public finances, income taxation was greatly raised and public expenditure heavily reduced.

Though income tax was subsequently reduced, it remains among the highest in the OECD. Public expenditure cuts mainly affected municipal subsidies, unemployment benefits, housing allowances and other social benefits and expenditure on public administration. As a result, although its basic Nordic character has survived, the Finnish welfare state is weaker: less universalistic, with less generous social benefits,

and with far more means testing of the eligibility of social benefits seekers. Nevertheless, these measures have achieved their main goals: the avoidance of mass poverty, multiple deprivation and gross inequality of wealth.

Although the continuing recovery, which began in 1994, has restored the overall economy, it has been characterized by continuing high levels of unemployment, steadily (albeit slowly) growing relative poverty, increasing differentials in income and other social disparities, including health. The main explanation appears to be that, while capital accumulation has increased the advantages of the wealthiest 10% of the population, the persistence of high levels of unemployment has forced many people to subsist for long periods on a far less generous safety net than was formerly provided. Consequently, Finland – while still a relatively equitable, "typical Nordic" society – is significantly less equitable than in 1990, and the trend towards greater inequity appears to be continuing. At the same time, the value basis of Finnish society has been tending towards greater individualism.

STAKES has assessed the impact of globalization on health in Finland as mainly acting through:

- policies which influence the marketing and consumption of products which affect health (e.g. liberalization of regulation of alcohol sales and tobacco controls);
- trends in functional foods and the use of health arguments to promote food and nutrition sales (i.e. commercialization);
- improved access to information via the Internet (i.e. information and marketing);
- more international markets for food and their direct and indirect effects, such as bovine spongiform encephalopathy and genetically modified products (i.e. access, consumption and avoidance of goods);
- the impact of economic policies on equity in health;
- the impact of employment policies on the ability of people to stay healthy and promote health in a tighter labour market and more competitive employment and working conditions;
- the changing policy environment, with diminishing resources and capacity to act in the public sector, and increasingly more networked civil society and corporate sectors (i.e. actors and resources); and
- urbanization, which threatens to drain municipalities in rural northern and eastern Finland, with older people left behind, the economy weakened, and public service functions difficult to maintain.

Added together, the effects of the economic recession and its continuing aftermath, and economic policies and the changing policy environment, are the factors most

likely to have far reaching impacts on health and wellbeing, with the burdens and stresses of work increasing the rates of "burnout", compromising family life, especially adversely affecting the welfare of children, breaking up older social networks and diminishing overall social cohesion (with further knock-on effects on general wellbeing and mental health). At the same time, globalization's implicit policy assumptions, of separate sectors for health and economic policies and preference for smaller public budgets, may tend to diminish the potential for effective responses by the education, health and social sectors to the damage being done. With urbanization challenging both health care and prevention services in large parts of rural Finland, special efforts will be needed to maintain equal access to the services of the health system.

3.5 The *Health 2015* process

The international review of Finland's health for all policy, published in 1991, noted that policy formulation had been strongly led by the Ministry of Social Affairs and Health and had enjoyed all-party political support, but was essentially top-down, with participation mainly limited to the central structures of the health sector, leaving local actors largely without the sense of ownership necessary for successful implementation. Other conclusions were that there had been insufficient attention to setting priorities among policy objectives and to policy implementation, and that quantitative targets needed to be set. A revised policy document adopted in the greatly changed socioeconomic circumstances of 1993 responded to the findings and conclusions of the international review and contained quantified targets, including the reduction of inequality in health. The structural changes which took place in the 1990s were also responsive to the critique of the international review team about the previous top-down, very normative approach.

In 1997, the Council of State set in train a broad, multisectoral, multi-level process, through an Advisory Board for Public Health to renew the national health for all policy. This led to published informal reviews of existing health promotion programmes, of inequality and health and of the life–course approach to health. A series of seminars, involving several hundred participants from a diversity of relevant backgrounds, then discussed health promotion from the perspectives of life course, settings and actors. They provided the basis for a consultative paper sent out for comments at the end of 1999, leading to a decision in principle document (on the *Health 2015* public health programme) prepared by the Ministry of Social Affairs and Health and adopted by the Council of State in 2001.

Thus *Health 2015*, though conceived out of the earlier health for all policy formulation and review processes, was developed during a markedly different social and economic era. It sets both general and life course–related health goals. The general health goals aim at increased life expectancy, reduced inequality and greater satisfaction with the health care system, while the life–course goals aim at:

- children – improved health and welfare;
- adolescents – reduced smoking, and limited use of drugs and alcohol;
- young men – reduced mortality from violence and accidents;
- working adults – increased retirement age through improved functional capacity; and
- older adults – maintaining upward trends in functional abilities of people 75 years and older.

Unusually in the contemporary European scene, *Health 2015* does not contain any specific health policy targets nor any structural targets. In this sense, there is a lack of consistency in *Health 2015*.

A variety of actors is challenged to play a significant role in implementing *Health 2015*, including municipalities, the business community, the research community, the educational sector and civil society. However, with the exception of the health sector, the national level is absent, and the Ministry of Social Affairs and Health is the only ministry given explicit responsibilities.

STAKES has observed that, "while the text (of *Health 2015*) reflects a broader view of health as a reflection of the multi-dimensional society, the priorities given for the health promotion activities reflect a narrower view". Moreover, according to STAKES, the apparent emphasis in "level targets" (as compared with "distribution targets") risks continuing the tendency of most Finnish health promotion programmes neither to aim at reducing socioeconomic health differences nor to propose measures capable of doing so, and thus instead to risk contributing to growing inequality.

4. CONTRIBUTION AND ADDED VALUE OF EXTERNAL REVIEW

The benefits of using an external review team are:

- The team's interest is vested in the subject rather than the country.

- The team represents a selected mixture of relevant competencies, both technical and managerial, as well as experiences from international, EU and Nordic health promotion contexts.
- The team is able to take a "helicopter" view of the situation.
- The team represents experiences and views on the field being considered which allow it to incorporate different perspectives and thinking about the issues.
- The team way of working generates a creative synergy which adds value to the interpretation and understanding of the topics and to the resolution of problems.

5. METHOD AND WORKING PROCEDURES

The review process was defined by the Ministry of Social Affairs and Health to take place within the policy framework provided by the Programme of Prime Minister Paavo Lipponen's Second Government (15 April 1999, Chapter 8) and the subsequent "Government Resolution on the *Health 2015* public health programme" (Ministry of Social Affairs and Health, Publication 2001:6). The overall approach was outlined in a preparatory process. Several background documents in English were provided to the review team. Altogether 10 days were spent on fieldwork in Finland for interviews, meetings and summing up sessions including reflections, analysis and preliminary conclusions among team members. Methodological experiences from the Finnish review have afterwards been further discussed, for the purpose of developing a generic method for future review missions.

There is no established model or method for doing a health promotion policy review, although there are guidelines on various aspects of evaluation proposed by a number of professional bodies. Nevertheless, there exists considerable experience of carrying out different types of public health policy reviews in Europe and other western countries. The different terminology in use indicates different definitions of evaluation, monitoring, audit and appraisal, which certainly is the case in theory but not is consistent in practice. This policy review focuses on the:

- relationship between the formal policy contents and their consistency as expressed in official and public documents;
- how policy is understood both formally and informally;
- how (and if) it is translated into other concerned sectors and levels; and
- how it is intended and factually facilitated and planned to be implemented.

The review includes an analysis of the appropriateness of the existing means and the necessary means to achieve the aims and goals of the policy.

WHO has previously undertaken investment for health appraisals in some countries which lacked an up to-date health policy and mainly were in the process of transition and thus in need of external consultation, in order to build up comprehensive public health policy. Health programme reviews, or evaluations, have normally been undertaken to review the outcome of long-or mid-term action-oriented programmes, through intermediate results related to ideally more operational and specific targets. The intention is often to explore the efficiency of the working methods applied for the implementation of the programme.

Measuring and reviewing health outcomes related to interventions has been subject to dispute about appropriate scientific methods between health promoters, epidemiologists and clinical medical professionals. The Cochrane method has set the gold standard for evidence-based clinical medicine but is rejected among most health promoters for most practical purposes, since randomized controlled trials are normally not appropriate nor feasible for the practical evaluation of health promotion methods. In many countries the development of knowledge-based health promotion is now a high priority for public health institutions, in order to elaborate an agreed method for assessing the effectiveness of different health promotion and disease prevention methods. This must be regarded as "work in progress", with a very large number of challenges ahead. For example, an estimate has been made in the United Kingdom that about 95% of all scientific public health publications deal with explaining causal relationships between different health risks and ill health. At the most, 5% are concerned with what effectively can be done to bring about positive change.

There being no standard method, the review team needed to draw on elements from mainly sociological and policy evaluation theory, monitoring and auditing techniques built together into a comprehensive approach. Experiences from earlier appraisals of health promotion or investment in health in Hungary, Latvia, Malta, Romania and Slovenia have contributed to knowledge about the process but, as already indicated, these mainly focused on how to initiate and develop a public health policy and implementation process. In the case of Finland – with one of the most advanced public health policies in the world – these were already in place. This circumstance has – as a side effect – offered an opportunity to develop a more specific review method. Guidance has been sought from relevant literature, which is listed in Annex V.

Initially, the methodological approach was incremental and subjective, represented by the individual knowledge of each team member. During the review process it

gradually evolved into a more comprehensive structure, which is briefly presented below.

The nature of a policy review is not self-evident. Related concepts are evaluation, monitoring, audit and appraisal. As such, the review process was first and foremost seen by the review team as making a key contribution to the country's own reflections on its health promotion system and to its response to the demands of implementing its policy objectives, by adding an international professional perspective on:

- the achievement of the country's defined health promotion policy objectives;
- the scope and limitations of those objectives; and
- the potential for more effectively positioning the promotion of health within Finland's wider and rapidly evolving social and economic development agenda.

The intention was therefore not a static appraisal of how the country had performed over the course of the previous decade but a contribution to the continuous process of future orientation to reinforce public health and improve the effectiveness of health promotion.

The main approaches and resources for the review were:

- analysis of key documents (paper copies as well as Web-published) in English (mainly) and in Swedish (selected) provided by the Ministry of Social Affairs and Health and published overview articles including comparisons of Finnish public health policy (see Annex II);
- interviews with officials, key informants and stakeholders and meetings with selected committees, groups etc. including site visits;
- methodological experiences from earlier WHO health for all evaluations and investment for health appraisals; and
- reviewing competence represented by the team members' individual experiences.

This approach allowed for a reasonable triangulation in securing the reliability and validity of presented facts, expressed statements and findings. Triangulation has been defined as "the use of multiple methods to investigate the phenomenon of interest". Briefly and more simply, it means that a certain topic is covered from more than one source of information. The triangulation was performed between connecting interviews (where the sequencing and representation of interviewees so allowed) as well as with documentary sources. It should be noted that it was not possible to fulfil this ambition completely, owing to the order and relations between the interviews and the limited time the team spent in Finland. For some topics there was only one source

of information available during the fieldwork. For core topics, additional information has been requested and delivered by the Ministry of Social Affairs and Health afterwards.

The review team combined the following consecutive steps and methods to build the review model (Fig. 1):

1. Scoping the review field, which covered:

- public health/health promotion sector policies (Ministry of Social Affairs and Health) – approaches, priorities, expected impact, contradictions and conflicts of interest, feasibility etc.;
- healthy public intersectoral policies (other ministries) – approaches, priorities, expected impact, contradictions and conflicts of interest, feasibility etc.;
- mainly national focus, including the relationship with local and regional levels;
- public, NGO and private actors and their responsibilities respectively; and
- overall organizational structures.

The scoping, based on the terms of reference, provided printed and electronic information sources and existing knowledge about the Finnish health policy and its system. The scoping provided a preliminary context for the review, under three broad elements:

- understanding and interpretation of the health promotion concept;
- societal and structural changes which have taken place in Finland over the past decade; and
- health policy development as outlined in the Finnish health for all policy to the present *Health 2015*.

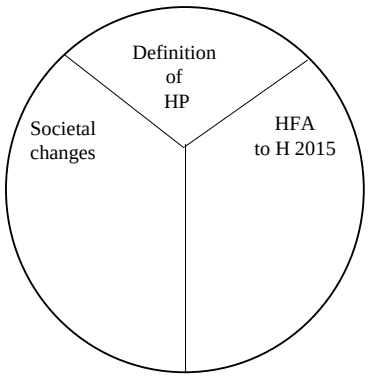

Fig. 1. The review structure

2. Interview preparation. The review group prepared jointly the structure and areas for questions for both interviews with groups and individuals. Specific aims and core topics were identified. The division of roles within the team was defined.

3. Debriefing analysis. After the interview session, or at the end of each day, the outcomes from the interview were preliminarily analysed by each team member and collectively documented and placed in the review context (see 1).

4. Analysis step 1. Based on the review context (see 1), an operational analytical framework was gradually developed. The following elements were identified:

Legislation	Policy
Organisation	Leadership
Human resources	Knowledge based methods
Research	HP capacity
Funding	Information & communication

Fig. 2. The review elements

The strengths, weaknesses, opportunities and threats were identified in respect of each element (a SWOT analysis).

5. Formulation of key issues, mainly in the format as imperative statements, but also as open questions put into the structure of the operational analytical framework. The statements and questions covered tentative conclusions and formed the base for a full-day workshop to which key informants and stakeholders were invited.

6. A full-day workshop (3 + 3 hours), with the purpose of testing, qualifying and further exploring preliminary findings. Participants were divided into mixed groups of approximately six persons each, staying in the same group over the whole workshop. The operational analytical framework and its thematic structure were explained. Each theme was briefly introduced. The statements and questions were presented in plenary and provided in writing for each group. Each participant first made their own judgement, followed by a joint discussion within the group. The group agreed on what to present in plenary (both shared and conflicting views and opinions). After the

plenary presentations each participant was asked to write their personal views on a Post-It note and attach it under the most relevant heading prelabelled on a flip-chart. Afterwards the views and comments were structured and summarized. It should be noted that the participation in the workshop was incomplete and maybe selective, thus limiting the possibilities to draw firm conclusions.

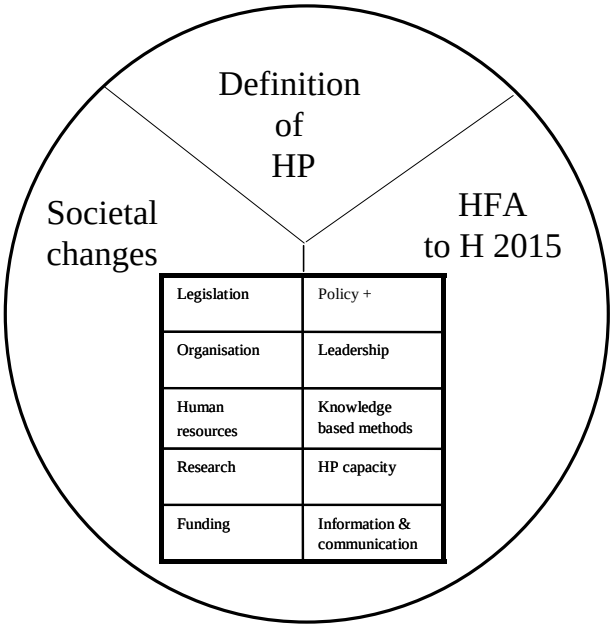

Fig. 3. The operational analytical framework

7. Analysis step 2. Outcomes from the workshop were added to the preliminary findings – some rejected, some confirmed, some reinforced. Information gaps were identified.

8. Additional information was requested and gradually delivered from the Ministry of Social Affairs and Health.

9. Analysis step 3. Pre-final findings were compiled by the review team, based on overall analysis of available information, followed by future challenges and recommendations.

10. A draft executive summary report with the findings was sent to the Ministry of Social Affairs and Health for fact-checking and comments.

11. Final findings and proposals were set out by the review team after consideration of the delivered comments. The complete draft report was sent to the Ministry of Social Affairs and Health to check its accuracy and readability and to prepare for translation

into Finnish as well as to confirm that the requirements agreed upon in the terms of reference were met.

12. Presentation of the final review report and discussion with the Ministry of Social Affairs and Health and other stakeholders at a seminar. The aim of the seminar is to facilitate further progress for health development in Finland and implementation of the findings.

6. INFRASTRUCTURES AND FUNCTIONS

6.1 Legislation

Health promotion in Finland takes place on the basis of a series of legislative measures which define the basic constitutional rights of the population to health promotion, set out the duty of primary health care to promote health, provide great scope, high authority and significant funding for the purpose to the Ministry of Social Affairs and Health, involve major responsibilities for at least one other ministry (the Ministry of Education) and local governments, and direct particular attention towards the problems of tobacco, narcotics and alcohol. A synopsis of the main legislative measures is as follows:

- The Constitution of Finland (731/1999)

Chapter 2. Basic rights and liberties
Section 19. The right to social security
... The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. ...

- Primary Health Care Act (66/1972)

Chapter 1. Primary health care
Section 1.

(1) Primary health care means health care addressing individuals and their living environment, medical care for individuals, and related activities aimed at maintaining and promoting the state of health of the population.
(2) Unless otherwise provided in other acts or provisions issued under them, the provisions of this Act apply to the primary health care referred to in paragraph 1, excluding the protection of health of individuals and their living environment (environmental health protection) which is provided for separately. (1131/1997)

- The Alcohol Act (1143/94, amended 1477/94)

Chapter 1. General provisions

Section 1. Purpose of the Act

The purpose of this Act is to prevent detrimental societal, social and health effects caused by alcoholic substances by controlling the consumption of alcohol.

Chapter 7. State Alcohol Monopoly

Section 36. The tasks of the State Alcohol Monopoly

The State Alcohol Monopoly shall:

1) manage the retail trade provided by this Act to be its sole right;
2) to the extent prescribed in greater detail by the Ministry of Social affairs and Health, carry on alcohol research, monitor the development of alcohol conditions in the country as well as give information about adverse effects of the consumption of alcohol and other related health education; and
3) annually submit to the Council of State a report on the development of alcohol conditions in the country and the measures which have been taken in order to achieve the target defined in paragraph 1.

... For managing the tasks prescribed in paragraph 2, point 2, an appropriation which corresponds to at least 0.7% of the assessed annual revenue from alcohol beverage tax shall annually be included in the Government budget.

- The Act on Measures to Reduce Tobacco Smoking (910/1984)

Section 1. Paragraph 27 requires the government budget to include an appropriation allocating a minimum of 0.45% of the estimated revenue from the tobacco excise duty to the prevention of smoking and health education as well as for supportive measures such as information, research and follow-up according to the annual allocation plan confirmed by the Ministry of Social Affairs and Health. In 2000, the appropriation amounted to 0.75% of the estimated revenue from tobacco duty.

- Decree on Measures to Reduce Tobacco Smoking (Statute No. 225/1977)

Chapter 5. Research, follow-up and information and education

Section 15. In organizing information and education and in producing health education programmes and other material aimed at reducing smoking, the Ministry of Social Affairs and Health shall use specifically the expertise and services of the Ministry of Education, central organizations of local authorities, and the relevant NGOs.

Section 17 requires the Ministry of Social Affairs and Health to issue an annual statement on changes in smoking, an estimate on the impact of different measures and a report on future measures to decrease the adverse health effects of tobacco.

Section 19. The organ appointed by the local authority is responsible for guiding and coordinating the education and information activity intended to reduce smoking, and for the preparation and decision-making regarding other duties resting with local authorities under the Tobacco Act.

- The Temperance Work Act (828/1982)

Paragraph 10 requires the government budget to include an annual appropriation covering a minimum of 40 pennies per citizen registered in the country, which must be used to prevent the adverse effects of substance abuse according to the annual allocation plan confirmed by the Ministry of Social Affairs and Health. In 2000, the appropriation amounted to 50 pennies per inhabitant.

- Health Protection Act (763/1994)

Chapter 1. General provisions

Section 1. Aim of the Act

The aim of this Act is to maintain and promote the health of the population and the individual and to prevent, reduce and eliminate factors in the living environment that may constitute a health hazard (health protection).

For the purpose of this Act, *health hazard* means a sickness or another disturbance of health in a person or the occurrence of a factor or condition that may reduce the healthiness of the living environment of an individual or population.

Section 4. The supreme management and control

The supreme management and control of supervision and compliance with this Act, and subsequent rules and regulations based on it, and the planning and steering of health protection shall rest with the Ministry of Social Affairs and Health. ...

- The Finnish Local Government Act (17 March 1995)

Chapter 1. General provisions

Section 1. Municipal autonomy

Finland is divided into local authorities where the autonomy of residents is safeguarded in the constitution. The decision-making power of local authorities is exercised by a council elected by the residents. Provisions on said councils, and on referenda and the right of residents otherwise to participate in and influence the administration of their local authority, are laid down in later sections of this Act.

Local authorities shall strive to promote the welfare of their residents and sustainable development in their areas.

Section 2. Functions of local authorities

Local authorities shall perform the functions that they have undertaken by virtue of their autonomy and those laid down for them in the law. Local authorities may not be allotted new functions or duties, nor shall they be deprived of functions or rights, other than by passing legislation to this effect. By agreement, local authorities may undertake public functions other than those falling within their autonomy.

Local authorities shall perform the functions laid down for them by law either alone or in cooperation with other local authorities. Local authorities may also secure the services they need to perform their functions from other service providers.

Section 8. Relationship between the State and local authorities

The Ministry of the Interior shall monitor the operations and finances of local authorities in general and ensure that municipal autonomy is taken into account in the preparation of legislation concerning local authorities. Following a procedural appeal, the provincial State office can investigate whether a local authority has acted in accordance with the current law. The legislation on local authorities, matters of municipal administration and finances that are important and far-reaching in principle and coordination of State and municipal finances shall be dealt with in a negotiating procedure between the State and local authorities, provisions on which will be laid down by decree.

Chapter 4.

Section 27. Opportunities to participate and exert influence

The council shall ensure that local residents and service users have opportunities to participate in and influence their local authority's operations. Specifically, participation and influence can be furthered:

1) by electing representatives of service users to municipal organs;
2) by setting up administrations for component areas of a local authority;
3) by providing information about local affairs and holding hearings;
4) by finding out residents' opinions before taking decisions;
5) by providing for cooperation in managing the local authority's functions;
6) by helping residents to manage, prepare and plan matters on their own initiative; and
7) by arranging municipal referenda.

6.2 Current policy framework

The current policy framework for health promotion is set by the Programme of Prime Minister Paavo Lipponen's Second Government (15 April 1999).

Section 8: Working life, social and health policy. This strongly links dynamic social development with personal opportunities and active participation in society, stresses the "paramount importance of work" and promotes measures to "guard against and reduce the problems of poverty, social exclusion and the accumulation of vulnerability'. Particular stress is laid on the making the "health of the population and its improvement ... one of the prime factors affecting public and general decision-making', thus putting the promotion of health at the heart of the Government's programme.

The specific measures which are outlined include:

- income tax, social income transfers, payments and services being welded into a well designed and motivating whole;
- promoting cooperation between different branches of administration to find a solution to the problems of the dispossessed sections of the community as regards subsistence, work, education, housing, social structure, living environment and the need for services, in order to prevent and eliminate exclusion from society;
- extending and improving occupational health care; and
- maintaining the functional capacities and general wellbeing of older workers, and providing a variety of incentives, so as to extend the working life span.

As described in Section 5 of this report, *Health 2015* is the health policy response to this overall government policy framework, with a variety of actors challenged to play a significant role in implementation, including municipalities, the business community, the research community, the educational sector and civil society, but with the national level absent outside the health sector, and thus the Ministry of Social Affairs and Health being the only ministry given explicit responsibilities.

6.3 Intersectoral policies

An important legacy of Finland's early adoption of the health for all approach has been the commitment of the Ministry of Social Affairs and Health to the continuing development of intersectoral action, at the local level as well as the national level. The Ministry's own organization exemplifies this commitment, with first the integration of the National Boards of Social Welfare and Health in the early 1990s, and then their transformation into STAKES (the National Research and Development Centre for Welfare and Health). The Council of State's creation of the multisectoral advisory Board for Public Health in 1997 is another example of the same policy trend. However, the Ministry of Social Affairs and Health itself was reorganized in 2002 into separate departments of social affairs and family on the one hand and health on the other.

Many important intersectoral actions pertaining to health are under the auspices of the Ministry of Social Affairs and Health, including the National Board of Work Protection, the National Council of Disabled People, the Advisory Board on Roma Affairs, the Council for Gender Equality and permanent standing committees dealing with alcohol, drugs, chemical safety and other issues.

Two major policy areas serve as good examples of the extent and continuity of intersectoral actions.

- Towards Healthy and Sustainable Transportation, under the auspices of the Ministry of Transport and Communications, Ministry of Social Affairs and Health and Ministry of the Environment. With its accent on walking, cycling and public transport, its emphases are on traffic safety, noise, air quality, climate change and the effects on welfare and mental health.
- Maintenance of Work Ability (MWA), a comprehensive government programme started in 1999, has 20 goals. These aim to promote working life, through the population being fitter in all respects to contribute to and benefit from work, and better supported to do so, in order to engage a higher proportion of the people in the workforce throughout their working lives, avoid labour shortages, and maintain them in work for a longer period before retirement. As such, it is integrated into social welfare and health policy, labour policy and pensions policy, and into development processes in the economy and in working life.

6.4 System and organization – local

Section 1 of the 1972 Primary Health Care Act (quoted on page 13 of this report) was conceptually advanced for its time, aiming to address not only individuals but also their living environment and, moreover, to undertake activities which aimed to maintain and promote the state of health of the population. Municipalities were required to prepare intersectoral plans for health education, which involved partners in education and youth services, sports clubs, NGOs, churches and other partners.

As a result, in the 1970s and 1980s, health education coordinators (many of them drawn from public health nursing) were appointed to staff positions in the Primary Health Care Centres which had been established under the Act. The health education coordinators established a national network, and through them health education concepts evolved into health promotion. But no mechanisms were put in place to address most of the broader structural issues implied by the requirements of Section 1 of the Act.

The 1972 Primary Health Care Act also required the municipalities to do regular health examinations of the population. This was unevenly and never fully implemented, despite guidance letters from the national administration about implementation.

The loss of the normative framework, with devolution of responsibilities from the national level to the municipal level in the 1980s and early 1990s, and then the effects of the deep economic recession in the first half of the 1990s, led to a significant diminishment of both health education/promotion and the regular health examinations. With municipalities setting their own priorities, many of the coordinators were returned to former duties and health promotion activities were reduced. Only a few municipalities, including Tampere for example, have continued the regular health examinations. Health promotion can therefore no longer be said to lie within the mainstream of health care services.

At the same time, primary health care became increasingly preoccupied with the control of the volume and costs of secondary care. Meanwhile, as the primary health care steering and coordination of local health promotion weakened, many NGOs strengthened their roles in health promotion.

The current situation is that the municipal-level organization of health promotion is generally not strong, with very little evidence that there are in general skilled teams able to advocate for health promotion, to lead the construction, coordination and facilitation of multi-agency alliances for health promotion, and through such alliances to play a major role in the analysis, advocacy, mediation and enablement of health in and through other policies. A mutual and credible interface in health promotion between the State and local levels is essential for productive working relationships.

6.5 System and organization – national

The national level in Finland is characterized by a small number of significant organizations with defined roles (Ministry of Social Affairs and Health, National Public Health Institute, STAKES, Finnish Institute of Occupational Health and the Finnish Centre for Health Promotion), which work closely together under the strategic leadership of a small team of Ministry of Social Affairs and Health officials. This has been described in Section 5, subsection: Developments from 1990 to 2000).

The performance of each of the dependent institutes of the Ministry of Social Affairs and Health is individually monitored by the Ministry. All have also been subject to

external review in recent years. These organizations (and previously their predecessors) have over a very long period developed and ensured the continuity of health policy development and the national elements of the arrangements for its implementation. However, apart from the teams with direct responsibility for health promotion, it is unclear how successful these organizations have been in mainstreaming health promotion concepts and principles in their work.

In the current "*Health 2015* era", all these organizations, together with others – including, importantly, local and NGO representatives – are represented in the Public Health Advisory Board. The Public Health Advisory Board therefore appears to have a major challenge, to identify and promote the optimum arrangements for effective national and local coordination and role performance in the evolution and implementation of public health policy.

6.6 Human resources

While there are able professionals working in health promotion at many levels in the public sector, in NGOs and in research and teaching institutions, there is no national human resources plan for health promotion. The total numbers working in the field are not known, and whereas professional education opportunities exist, systematically organized in-service professional training appears to be lacking, and career opportunities for qualified people are unclear.

6.7 Health promotion capacities

The development and subsequent retrenchment of health promotion at local level, the concurrent devolution of responsibilities from national to local level, and the roles and responsibilities of actual existing institutions have been described in previous subsections. The retrenchment of local health promotion capacity is demonstrated each year in monitoring by the Finnish Centre for Health Promotion. Taken together with the human resources situation, this is also a key part of the challenge facing the Public Health Advisory Board and its members and those they represent.

6.8 Research and knowledge-based methods

As already described, health promotion research has been significantly strengthened in recent years, with major programmes funded by the Finnish Academy, and with the Ministry of Social Affairs and Health also having an important research funding role. For a number of years, the contribution of the Ministry of Social Affairs and Health has included investment in "centres of excellence" at the UKK Institute and at the Universities of Jyväskylä, Kuopio and Tampere.

Research from Finland's leading institutions makes a well recognized contribution to the international evidence-based health promotion literature. However, the arrangements for the most efficient practical application of the results of such research – both Finnish and international – depend on a number of important factors, especially:

- the priority accorded to the development, dissemination and active implementation of knowledge-based methods;
- the scope, available capacity and human resources to do so; and
- the focus on, and support for, intervention research on effective methods.

Again, this appears to be a key part of the challenge facing the Public Health Advisory Board and its members and those they represent.

6.9 Information structures

Finland collects, analyses and publishes a vast and orderly array of data and commentaries on health and social issues. These have been of great value to national-level policy-makers and are constantly being adapted to suit the needs of health policy-making and implementation.

However, whereas the interest and need for data for use at a local level in specific localities was expressed, the data available are more limited.

Another challenge for the Public Health Advisory Board is to address the local-level needs and to identify the information needs for multisectoral actions for health. The presentation of health information to influence the nature of mass media handling of health issues is another important strategic issue.

6.10 Funding

State budget

The focus areas for health promotion in the State budget – within the areas health education, substance use and the reduction of smoking – are determined each year, a year at a time, based on proposals to the Ministry of Finance from each ministry and its institutions and agencies. The Ministry of Finance discusses the proposals from all ministries and reconciles them into a single proposal for incorporation into the State budget and submission to Parliament.

Municipal funding

The municipalities collect taxes for their own use at the municipal level and can use that funding for health promotion purposes. This tax revenue is in fact the most

important funding instrument for health promotion. However, it is currently impossible to estimate what proportion of municipal tax income is used for health promotion.

Ministry of Social Affairs and Health allocation

This is a two-year transferable appropriation in the State budget based on the 1976 Tobacco Act, the 1982 Temperance Act and the 1998 and 2000 Government Resolutions on Drug Policy and on the funds which had been devoted to information and education about alcohol by the former government alcohol monopoly Alko Ltd, which were transferred when it was axed. The original intention of consolidating the health promotion allocation as a separate funding channel under the Ministry of Social Affairs and Health, and an argument repeated and underlined by the transfer of the funds of Alko Ltd to the specific health promotion budgetary line, was to ensure their coordinated use for health promotion and disease prevention in support of general health policy.

The Ministry of Social Affairs and Health sees the central implementers of health promotion policy as first of all the agencies of the Ministry, the public health NGOs and the Finnish Centre for Health Promotion, and also supports innovative municipal projects that are distinct from basic municipal activities. The development of new health promotion tools by Ministry of Social Affairs and Health agencies for municipal use is also funded from this allocation.

The allocation is advertised annually, and funding is on a project-by-project basis. About 150 projects are funded out of about 300 proposals received each year. Funding is granted for a year at a time, but 3 years of funding are in principle guaranteed once a project is approved.

In recent years, the goals of the Ministry of Social Affairs and Health have been to:

- strengthen the strategic guidance of the Ministry of Social Affairs and Health and reduce the number of Ministry tasks related to technical management;
- involve the most important actors in drafting the allocation plan;
- develop “Hantti’, a database and information management system to serve the evaluation of project proposals and the preparation of the allocation plan;
- develop a framework that reflects the special characteristics of health promotion, for the design, choice, follow-up and evaluation of the projects;
- improve the quality of the projects, using specific quality criteria; and
- check whether the projects are compatible and complementary in terms of Ministry of Social Affairs and Health objectives, prior to detailed planning.

RAY – the Slot Machine Association

National policy allows gambling for money only if the profits are devoted to charities or similar public goods. The Council of State allocates RAY's profits. They are devoted to promoting health and social wellbeing, via 1200 NGOs and other organizations for public good, specifically in the fields of:

- promoting public health
- child protection or youth education
- care of disabled people
- care of elderly people
- rescue services
- social holiday activities
- welfare of intoxicant abusers.

Lately, the emphasis has been on help and support to families and population groups with problems associated with long-term unemployment, debt, disability, sickness and general insecurity.

Other sectors

The Ministry of Education is involved in a wide range of health promotion and social exclusion prevention activities in its sector, the majority of funding for which comes from the municipalities where the activities actually take place.

The Ministry of Labour's main emphasis – on preventing social exclusion and promoting education and training – indirectly promotes health by addressing some of its central determinants.

The Ministry of Environment's role in promoting a better quality living environment contributes to reducing the risks to population health; similar to the Ministry of Communications and Transport through its R&D programme on transport systems.

NGOs and patient associations primarily promote the health of their members, drawing their income from membership fees, some user fees, RAY, the Ministry of Social Affairs and Health, the Ministry of Education and other ministries, and from grants from municipalities and some municipal purchases of health promotion services, e.g. from temperance associations.

Other funding

Other funding is provided by:

- provincial state offices by developing regional cooperation for welfare promotion, legal safeguards, justice, equality and the implementation of civil rights;
- accident insurance at work: campaigns and information;
- traffic insurance: campaigns and information;
- KELA (National Social Insurance Institution): rehabilitation and prevention of diseases and R&D work; covers about 50% of occupational health costs;
- employee pension system; and
- work accident compensation scheme: promotes occupational safety.

EU public health programmes

Finland's participation has been relatively limited owing to the difficulties and demands of organizing networks involving participation from all EU countries. Nevertheless, Finland has been an active participant in a number of past public health programmes.

6.11 Health promotion delivered on a routine basis by the regular infrastructure

Finland's organizational infrastructure and funding system provides for a highly flexible programme of high quality health promotion project work, within the overall legislative framework and the policy directions of the Government and the Ministry of Social Affairs and Health, as well as by other funding provisions as described above. As in other countries, funding arrangements are scattered. There is no given standard about what works most effectively from a health promotion point of view. However, noting the expectations of what the local level should deliver, that is also where resources are lacking the most. Given the range and levels of organizations involved, and the great degree of autonomy at municipal level, the following would appear to require a particular effort to coordinate under this system through:

- planning and funding long-term, coordinated, multifaceted programmes, conducted among different sectors, at different levels, by different types of actors;
- planning and conducting specific issue campaigns, employing a range of techniques and actors, including mainstreaming health promotion again within the health care sector and especially in primary health care;
- guaranteeing – particularly in the context of the national health care project – that health promotion concepts and principles are mainstreamed generally in the municipalities, and especially in the health care sector and primary care; and
- policy level work, programme planning and implementation, for "health in other policies", for the integrated development of economic, social and health development.

7. CONCLUDING ANALYSIS AND FINDINGS

In this and the following section, the review team summarizes the outcomes as concluding analysis and findings, future challenges and recommendations as follows.

1. The national long-term public health programme (*Health 2015*) builds on the sound Finnish tradition in health policy thinking and planning and rests on the firm basis of the Government's broad, intersectoral April 1999 programme.

2. Finland has long demonstrated strength in policy thinking, planning and implementing comprehensive health promotion programmes in important topic areas, with Finnish initiative often becoming European and international leadership, for example in combating tobacco smoking, prevention of cancer and in promoting heart health. The field of mental health provides a good up-to-date example.
   - Finland's EU Presidency provided a strong basis for getting health promotion onto the national (as well as EU) agenda.
   - Innovative policies were formulated, based on local needs assessment and international good practice.
   - Intervention models were designed on a respected theoretical basis and evaluated in the field.
   - Recommendations for municipal-level mental health work were prepared.
   - A cross-sectoral communications strategy aimed to add visibility to mental health at the national level.

   Another excellent up-to-date example is the long-advocated re-establishment of health promotion in the curriculum of Finnish schools, which is now being planned in detail for a long and thorough period of implementation.

3. Finland's knowledge base for public health is in many respects strong: its successes are built upon very competent national institutions and high quality research. It is noteworthy that resources for health promotion research are currently being allocated through the most credible research council (the Academy of Finland). However, the emphasis given to public health appears to be relatively weak in the universities, especially in medical training. More generally, urgent attention needs to be given to the issue of whether the national institutions are – collectively – fulfilling the range of functions and responsibilities to lead and

support health promotion which is nowadays required from the national level and is provided in a number of other advanced European countries.

4. It is also significant and noteworthy that success has been based on strong, coherent and well established national public health leadership over a long period. However, at the municipal level this is not the case, despite the great responsibilities of municipalities for maintaining the health of the populations they serve; this also is an important issue which needs to be addressed.

5. Another major issue is the role of the Ministry of Social Affairs in the Government's intersectoral policy agenda. The review team considers that the intersectoral approach necessitates:

    - ensuring that public health policy is formulated in response to broad social and environmental determinants, in order to make it consistent with the overall ambitions, and that individual-level risk factors be addressed within that context;
    - taking a strategic approach to intersectoral health policy development, which:
        - recognizes health as a strategic resource for social and economic development
        - puts the reduction of inequalities in health at the heart of the development and implementation agenda
        - establishes and sustains a legal base and effective systems, resources and tools in which the health sector can play a full part in helping to define, shape, contribute to and benefit from the overall development agenda, including:
            - facilitating all sectors to fully exploit and implement their potential for promoting health in all their policies
            - monitoring health promoting resources and their deployment across all sectors and levels
            - assessing systematically the impact on health of major initiatives in other sectors at appropriate levels; and
    - systematically engaging with the population about the determinants of their health and the measures required to improve it.

    The Ministry of Social Affairs and Health has played a major role in the development of the Government's intersectoral health policy agenda and continues to have a significant and influential role in its fulfilment. However, the review team questions whether the scope of the Ministry and the resources it is

able to devote to the task are sufficient to fulfil the major challenges of strategic leadership and coordination of an intersectoral health policy agenda, as outlined above. Ministry of Social Affairs and Health staff would require a clear mandate, human resources and appropriate infrastructure to do so.

6. Linked to the question of national leadership is the issue of local implementation.

   In Finland's highly devolved system of government, responsibilities at the national level cannot be directive but have to be indicative, guiding and supportive. The actions and intentions of the Ministry of Social Affairs and Health and the Public Health Advisory Board – to provide information, develop concrete tools and establish demonstration projects – appear admirable. Clearly, at this early stage of *Health 2015* implementation, it is too soon to make judgements about their efficacy in respect of local implementation. The review team would, however, draw attention to the following critical issues:
   - the need to rigorously evaluate national-level initiatives, not only their outcomes, but the processes by which they are undertaken;
   - the need – as noted in the previous WHO evaluation – for municipalities to go beyond their continuing strong emphasis on medical care services into the systematic promotion of health;
   - the need for health promotion at the municipal level to transcend projects devoted to particular health subjects and to become fully integrated with the overall social and economic agendas locally (and thus engaged with other sectors as well as health);
   - the need for mainstreaming health promotion within the health care sector, especially in primary care; and
   - the need for rigorous formative, process and outcome evaluations of local health promoting initiatives and the carefully pre-planned sharing of good practice among municipalities.

   The review team saw no evidence to suggest that the municipalities are – in general – equipped to respond to these critical challenges, either at a leadership level or in terms of the available professional and technical skills. Logically, however, the municipalities will need a clearly identified leadership focus, backed up by sufficient resources, to fulfil their far-reaching responsibilities to maintain and promote the health of the populations they serve.

7. A wealth of information about health, and of relevance to health, and also about health promotion, is produced in Finland by central authorities and agencies,

universities and NGOs. As well as health data, the information which is produced embraces development matters, policy questions, effective methods, quality assurance and other important issues. The review team considered this information to have high relevance for professionals at all levels, and for local and regional actors, as well as those at national level. However, the potential of the information appears to be underrealized, with an apparent lack of well designed, well structured and well coordinated information functions among the central actors and a deficiency of mechanisms which could facilitate the efforts of professionals and decision-makers at the regional and local levels to obtain and use the information for developing and implementing health promotion.

8. A related issue is the apparent underuse of information technology in many aspects of health promotion, for example the absence in Finland of a Government Web site providing health promotion information of guaranteed quality to professionals and public alike. Such sites have the potential to provide up-to-date information related to self health care, promoting better health and health promotion service issues.

9. The Public Health Advisory Board is composed of representatives of a great spectrum of public health and health promotion organizations. The current early stage in the Board's development – and the review team's lack of contact with its horizontal and local subcommittees – does not make it possible for the team to assess the efficacy of the Board in performing its functions. The team does, however, draw attention to the apparent lack of an effectively developed consultative and negotiating structure with the many other sectors which affect health and in which neither the Ministry of Social Affairs and Health nor the Public Health Advisory Board has a formal mandate or jurisdiction.

10. As plans for monitoring "*Health 2015*" were still being drawn up by the local "horizontal" subgroup of the Public Health Advisory Board at the time of the review, no clear structure and approach was presented to the review team about how this important issue is to be addressed. That allowed no assessment to be made by the review team of whether there would be a monitoring system capable of providing strong enough assistance to the Public Health Advisory Board to enable it to provide sufficiently powerful steering to the implementation processes.

11. The persons performing the top public health leadership at national level, which has envisioned and steered the development of health policy in Finland for many

years, are all due to retire over a relatively short period rather soon. There appears to be no planning and preparedness for this predictable phenomenon. It is of concern that in the run-up to these changes, promoting health – in contrast with issues of health care services – remains the concern of a relatively small circle, without signs of the development of informed "champions" among the people who make the decisions about the determinants of health: the political parties, Members of Parliament and municipal councillors.

12. The review team recognizes that the role of NGOs in undertaking regular, routine public responsibilities is a strongly established tradition in health development in Finland. While respecting this tradition, the team nevertheless has concerns about:
    - where democratic accountability for NGO actions lies, since by definition civil society (or "third sector') organizations are outside politically accountable frameworks, which this leads to concerns about accountability for:
        - the systematic performance and continuity of essential activities, including registers
        - the achievement of equity, accessibility and other core values, and the inherent need to "trade off" among core values in operating environments; and
    - how the essential NGO role of monitoring and critiquing public provision is to be performed when NGOs are themselves major providers in partnership with public authorities.

13. Funding arrangements for health promotion in Finland are particularly complex. A number of legal authorizations govern funding sources and distribution at different levels and in different sectors. Five aspects are of special interest to the review team.
    - The Ministry of Social Affairs and Health's has shown skill in directing its allocation in recent years, towards improving the focus, quality and general applicability of the health promotion projects funded by the allocation (€ 7.15 million in 2002). Without this funding instrument, the ability to guarantee the current priority for health promotion R&D would be very limited.
    - The overall guaranteed sum from the national level which is available for health promotion, of about € 1.4/capita per annum, appears a little low by current western European standards.
    - The Ministry of Social Affairs and Health, while maintaining its current, largely topic-based, projects agenda, needs to direct resources towards the

much broader challenge of health and overall development with and through other sectors.

- The possibility of strategically directing and managing most of the non–Ministry of Social Affairs and Health funds available for health promotion funding, according to a pre-determined vision and goals, is apparently limited.
- There is a current lack, but strong future potential for considering more broadly and jointly planning with others the overall resources within the health sector and in other sectors which could be available for integrated social, economic and health development.

14. The review team notes the role of the Finnish Association of Local Authorities in providing an important link between local administrations and central policy-making in health and health care services. The long tradition of close collaboration between the Association and the Ministry of Social Affairs and Health in joint activities (such as accident prevention) is also noted, as is the Association's involvement in the major National Health Care Development Project. The team notes, however, that the Association appears to have no clear policy focus on health promotion and extremely limited resources and professional capacity in this area. If it created such a policy focus, and modestly augmented its own resources, the Association would appear to have great potential to become an important player in a constructive and functional public health alliance and to provide strong and dynamic support to the local government sector in the promotion of health and the integration of social, economic and health development.

15. If the milestones of *Health 2015* are to be achieved, sufficient numbers of human resources are needed, deployed at both national and local levels, and skilled in the principles and practice of promoting health, influencing policies and managing complex organizational change. The review team finds no evidence that this issue is being addressed, in terms of:
    - defining the range of skills needed for contemporary health promotion and integrated social, economic and health development;
    - identifying and funding the numbers and types of posts for skilled individuals that will be needed at different levels and in different sectors; and
    - formulating educational programmes and professional training schemes for these individuals in the requisite academic knowledge and practical skills and defining career paths.

The law coming into force in 2003, which obliges municipalities to provide their health care workers with 3–10 days of updating training every year, will at least provide a basic platform for the considerable in-service training needed by the present workforce, once the task of skills definition has been done, and given that the content of the health promotion training is prioritized.

16. Overall, there is a need to strengthen:
    - the intersectoral mechanisms;
    - the interconnection between the State level and the local/municipal levels;
    - the numbers, skills, strengths and preparedness of human resource capacity at all levels; and
    - the structure and direction of funding for implementing strategic priorities and monitoring and evaluating their achievement at all levels.

8. FUTURE CHALLENGES AND RECOMMENDATIONS

- **Challenge:** To ensure that the strengths and achievements of the Ministry of Social Affairs and Health in the field of health promotion are sustained in the changed organizational circumstances and to ensure that health promotion is consistently mainstreamed in the future work of the Ministry of Social Affairs and Health.

  Recommendation: A continued intersectoral thrust within the Ministry of Social Affairs and Health is an essential prerequisite for intersectoral working across government and wider society.

- **Challenge:** To ensure that the Ministry of Social Affairs and Health has sufficient staff for the sound strategic management of the growing contribution which health promotion is capable of making to the nation's development.

  Recommendation: Assessing the workload and the skills needed for the range of tasks to be performed by Ministry of Social Affairs and Health officials, and responsively defining the necessary posts, training and recruitment issues.

- **Challenge:** Despite the integrated, multisectoral nature of the Government programme, and despite Finland pioneering within the EU the concept of "health in other policies", the technique of health impact analysis, which is increasingly discussed, for example in several EU countries, is not yet part of the practice or mandate of the Ministry of Social Affairs and Health.

Recommendation: Serious consideration should be given to the introduction of health impact analysis and its application to all major health-relevant initiatives, across all sectors of government, such as major policy initiatives and big infrastructure projects. If this were introduced, and the Ministry of Social Affairs and Health became responsible for ensuring that health impact analysis was done systematically across all sectors, it would need adequate resources or support from one or more of the national agencies.

- **Challenge:** To ensure robust implementation arrangements for *Health 2015*, and to go on to address the demanding policy challenges of the integration of social, economic and health development.

  Recommendations:
  - Development of a major role by the Public Health Advisory Board, recognizing that this would have implications for the future scope of its mandate.
  - Overall systems planning for health promotion in Finland, done on a cooperative basis by all the main players in the system (rather than the former central direction), with the purposes of:
    - ensuring that all necessary elements for modern health promotion are available in the system;
    - optimizing the contribution from each element of the system – national, local, public, NGO, academic and private; and
    - making the most efficient and effective use of all available funds, considered together.

- **Challenge:** Recognition of the policy and resource implications of the crucial role of the municipal level in the promotion of the health and wellbeing of the people within the overall local development agenda, and of the significant potential of the Finnish Association of Local Authorities to support the municipalities in this respect.

  Recommendation: Urgent attention needs to be given to municipalities, as follows:
  - starting with the biggest municipalities, creating a leadership focus for health promotion at the top management level;
  - municipalities committing themselves to pursue “health in all local policies”; and
  - municipalities providing enough resources to enable the tasks of effective modern health promotion to be effectively performed.

- **Challenge:** Careful building up of the human resources needed for promoting the health of the population.

  Recommendation: Defining the range of skills needed both for policy development work and for implementation, nationally and locally; identifying the numbers and types of posts that will be needed and the funding arrangements for the posts; formulating appropriate educational programmes and professional training schemes, including continuing professional development.

- **Challenge:** Ensuring national-level provision of the critical elements needed to support and facilitate local-level development of health promotion, including: the provision of appropriate information, the identification and dissemination of knowledge-based practices, and coordinating the design and management of a human resource development plan.

  Recommendation: Urgent attention needs to be given to whether the roles of the national agencies are appropriately assigned and whether the performance management role of the Ministry of Social Affairs and Health in relation to the agencies is sufficiently strong, in order to ensure that all the key national level functions are undertaken, not only the health monitoring and research functions, which the agencies have long performed well, but also such essential practical tasks as planning and contributing to comprehensive, multi-channel health promotion programmes at national and local levels, and assisting municipalities to implement effective practices.

- **Challenge and recommendation:** Design and management of the research and development agenda to identify and fulfil the priorities for knowledge-based policy-making and practice.

9. CONCLUDING REMARKS

The exemplary efforts of the Finnish authorities and personnel have made an incomparable contribution to the work of the review team. Without the excellence of the organization, the transparency of the exchanges, the exceptionally open attitude to critical observations, and the warmth and hospitality with which the team was received, much less would have been possible.

The review team expresses its sincere gratitude to everyone with whom it has worked so far, and looks forward to concluding its work in the same spirit of fruitful cooperation.

ANNEX I – TERMS OF REFERENCE OF THE REVIEW

1. Background

Finland has a long-standing process of cooperation with the WHO Regional Office for Europe. One of the most significant examples of this cooperation was the review of the way in which Finland implemented its health policy within the framework provided by health for all. This review was undertaken and published by the Regional Office in 1991 (Health for all policy in Finland, WHO health policy review, Copenhagen: WHO) and was very instrumental for rethinking and reinforcing action for health for all policy implementation.

Thus, Finland has experience in utilizing external appraisals with the aim of reviewing progress made and identifying gaps and opportunities for further development within a given policy area.

During the fiftieth session of the WHO Regional Committee for Europe, the Finnish delegation explored the possibility for the WHO Regional Office for Europe to carry out an expert review of the Finnish health promotion policy. Over the last 30 years, Finland has developed health protection and health promotion policies in a comprehensive manner, including also issues traditionally not directly connected with health care provision, such as environmental health, occupational health and safety, prevention of cardiovascular diseases, promotion of physical activity, healthy nutrition and other lifestyle issues, promotion of mental health and prevention of infectious diseases.

The scope, review process and resources for meeting this request are set out below.

2. The review framework and its scope

The Finnish health promotion policy system comprises national, regional and local levels of government, a strong structure of NGOs, professional bodies and institutions and an increased attention to the role of the media and visibility of health in the media. The review's main focus will be on the role of national level in fostering progress and creating opportunities for policy development and implementation.

The review will cover the years 1991–2001 against the background of the general Finnish health for all policy. The overall analytical framework is provided by health for all values and principles. The conceptual definition of health promotion embodied in the review is "the process of enabling people to increase control over the

determinants of their health" as developed from the Ottawa Charter for Health Promotion. The review is expected also to contribute to the planning and management of the implementation process of the newly adopted Finnish health for all-policy, *Health 2015*.

The review aims at appraising the way in which the overall Finnish health promotion system has performed in the past, and can improve further in the future, in the face of a rapidly changing policy context characterized, among others, by:

- the globalization of a wide range of health promotion-related issues;
- the changes in population health status problems; and
- the dynamic of cultural, social and economic development, which directly or indirectly impinge on the creation of opportunities for (or barriers to) population health (e.g. EU membership; economic fluctuations, the rapid development of the information society; etc.).

Within the context described above, the review will appraise Finland's:

- consistency of implementation;
- short term and long term impact of policy processes adopted;
- factors that have facilitated the reforms;
- relevance, appropriateness, timing;
- unplanned side effects (if any) of actions undertaken; and
- opportunities for future progress.

The review will provide concise conclusions. A set of clear and feasible recommendations for further development in this area will be distilled from the review's conclusions. In operational terms, the recommendations will be tailored to national level policy-makers and fall into three categories:

- structures and their functioning: how to improve the consistency and performance of the overall policy-making system covering health promotion;
- setting priorities: how to ensure Finland prerequisites to deal with present and new emerging issues in the area of promoting the health of the population; and
- health in other policies: how to better position the promotion of health within Finland's overall strategic development, social agenda and management of intersectoral relationships.

In order to accomplish the above aims, the review team, in full cooperation with Finnish expertise, will analyse a number of health promotion-related elements including:

- value basis;
- legislation and policy development;
- setting priorities;
- organizational structures and functions;
- resources and funding mechanisms;
- horizontal collaboration;
- leadership;
- accountability; and
- adequacy of the system regarding the implementation of health for all 2015.

3. Members of the WHO team:

Ms Christine Brown (Germany), public health specialist
Dr Mojca Gruntar Cinc (Slovenia), Under Secretary of State for Health
Dr Spencer Hagard (United Kingdom), Head, Health Promotion Research Unit, London School of Hygiene and Tropical Medicine, professional coordinator and rapporteur
Ms Tina Kiær (WHO Social and Economic Development), administrative coordinator
Mr Bosse Pettersson (Sweden), Deputy Director-General, National Institute of Public Health, public health policies and strategy development
Dr Anna Ritsatakis, expert on health policy evaluation
Dr Erio Ziglio (WHO European Office for Investment for Health and Development), Head of Office, team leader

4. Report writing and submission

As fieldwork draws to a close, the team's attention is increasingly directed to the construction of its report to the Ministry of Social Affairs and Health. The team leader and rapporteur facilitate this process with a view to agreeing overall structure, and broad conclusions and recommendations, before the team disperses. The local expert

group is intended to have an essential role at this stage, as a sounding board for ideas in its own right, and also in helping to identify other experts for their purposes, before the main elements of the report are discussed with the representative(s) of the Ministry of Social Affairs and Health.

The WHO team rapporteur is responsible for writing, consulting with the other team members, and clearing a draft report with the team leader within 6 weeks for submission to the Ministry of Social Affairs and Health for verifications of facts and comments. The report will then be completed and formally submitted to the Ministry of Social Affairs and Health and other ministries as appropriate.

The team leader, in submitting the report, aligns it with the central aim of the whole review process, by drawing attention to the fact that the report is already the result of a wide-ranging and participatory process, now assembled into a format capable of being used for enhancing discussion, fostering consensus, stimulating synergy and focusing action. Thus, the Review report should not be seen as a "static" document. It is intended to become an important instrument to facilitate progress in formulating, implementing and sustaining efforts for effective health promotion. The contents of the report will be in line with both the concept and principles of health promotion (e.g. the Ottawa Charter) and with HEALTH21, recently endorsed by the European Member States of WHO. The support of the WHO Regional Office for Europe in following through the recommendations is also offered.

5. Presentation of the WHO review's conclusions

The team's review is set down in three parts:
first, concerning the overall situation of the policy-making context and implementation arrangements covering health promotion in the country;
second, analysis of the Finnish system's strengths, weaknesses and readiness for addressing emerging new issues in the area of health promotion (the role of the national level to increase Finland overall capacity in this domain will be the main focus of the review); and
third, structural, organizational, financial, human resources and institutional issues to be addressed for further progress in health promotion.

The first and second parts are presented in terms of strengths and weaknesses of current practice, followed by an assessment of future opportunities and possible threats.

Reporting of structural, organizational and institutional issues focuses on the extent to which there exists a policy environment sufficiently conducive to further improvement in health promotion. The catalytic role of the national level will be particularly addressed. Thus, in this part the review efforts will particularly focus on how to:

- increase capacity at the national level;
- deploy incentives for alliance building at all levels;
- fine-tune existing survey, research and evaluation practices;
- secure long-term resources, incentives and their flexible use; and
- position health promotion more centrally in the economic and social agenda of Finland.

6. Presentation of the review's recommendations

Recommendations will be few in numbers and refer to fundamental issues to be addressed to ensure further progress in health promotion in Finland. Recommendations will be made about how to address specific deficiencies in the current infrastructure, funding mechanisms, human resources and other development-related issues for progress in health promotion.

ANNEX II – DOCUMENTS AND WEB SITES CONSULTED

A Written background material (with relevant URLs)

1) History and geography

a) History of the Ministry of Social Affairs and Health. http://www.vn.fi/stm/english/organ/minhist.htm

b) Facts about Finnish social welfare and health care

2) Constitution. http://www.om.fi/constitution/

3) Programme of Prime Minister Paavo Lipponen's second government. Chapter 8: Working life, social and health policy

4) Relevant laws

a) Primary Health Care Act

b) Alcohol Act

c) Act on Measures to Reduce Tobacco Smoking

d) The Narcotics Act

e) Decree on Measures for the Restriction of Tobacco Smoking

f) Health Protection Act

g) The Finnish Local Government Act. http://www.kuntaliitto.fi/english/law.htm

5) Key economic and fiscal data

a) Publications of the National Public Health Institute: Health behaviour and health among Finnish adult population, spring 1999

b) Publications of the National Public Health Institute: Health behaviour among Finnish elderly, spring 1999, with trends 1993–1999

c) Publication of the Association of Finnish Local and Regional Authorities: Healthcare provision and financing in Finland. http://www.kuntaliitto.fi/english/health.htm

6) Demography, social, health and sickness data

a) Facts about Finnish social welfare and health care

b) Sociobarometer 2001. http://www.stkl.fi/sbm2001_eng_www/baro2001_ENGtiivistelma.htm

c) Chapter 9 of Finland, Koskinen and Melkas

7) Relevant structural, organizational and institutional information

a) Ministry of Social Affairs and Health organization. http://www.stm.fi/english/organ/organisation_fset.htm

b) Health care system. http://www.stm.fi/english/pao/publicat/paocontents22.htm + http://www.stm.fi/english/tao/publicat/taocontents29.htm

c) Organigram of the Ministry of Social Affairs and Health. http://www.stm.fi/english/organiza/orggraph.htm

d) Health care structures, themes, strategies and trends. Ministry of Social Affairs and Health. http://www.stm.fi/english/health/healthcare_fset.htm

e) Principal lines of implemented health policy. http://www.vn.fi/stm/english/eho/publicat/healthre/osa4.htm

f) Social welfare in Finland, Ministry of Social Affairs and Health Brochures 1999:6 eng

g) Health care in Finland, Ministry of Social Affairs and Health Brochures 1999:13 eng. 27.10.99. http://www.vn.fi/stm/english/pao/publicat/health/health3.htm

h) Strategies for social protection 2010. Ministry of Social Affairs and Health. 02.10.01

i) Association of Finnish Local and Regional Authorities: Healthcare provision and financing in Finland (http://www.kuntaliitto.fi/english/health.htm)

j) Finnish social protection in 2000. Ministry of Social Affairs and Health. 2001

k) Ministry of Social Affairs and Health and related authorities. Brochures 1999:3 eng

l) Finnish health policy Brochures 1999:13eng 1.9.99. http://www.vn.fi/stm/english/publicat/health/health2.htm and http://www.vn.fi/stm/english/pao/publicat/health/healthteksti.htm

m) Future challenges for health policy. http://www.vn.fi/stm/english/eho/publicat/healthre/osa5.htm

n) The health care system in Finland. http://www.vn.fi/stm/english/pao/paoengteksti.htm

o) Health care in Finland, Ministry of Social Affairs and Health Helsinki 1999. http://www.vn.fi/stm/english/pao/publicat/health/health1.htm

p) Health care in Finland. http://www.kuntaliitto.fi/english/healthca.html

q) Public health reports 1996, 1999 and 2000

r) Statistical yearbook on social welfare and health care 2001

s) Social welfare and health report 2000

- Strategies and trends
- Social policy strategy to 2010
- Social welfare and health report 2000
- Trends in social protection 1999–2000
- The Finnish social protection system and its operations in 1999
- Guidelines on health care in Finland
- Insurance supervision in Finland
- National ageing policy up to 2001
- Towards a society for all (disability policy)
- Drug strategy 1997
- Asthma programme in Finland 1994–2004
- Poverty & social exclusion in Finland in the 1990's

t) Allocation scheme for health promotion for the year 2000. Ratified plan.
u) Health promotion allocation plans 1990–2000 summary, unedited.
v) UKK Institute International evaluation of the UKK Institute
w) International evaluation of the National Research and Development Centre for Welfare and Health, Ministry of Social Affairs and Health Publications 1999:12 eng
x) International evaluation of the research activities of Radiation and Nuclear Safety Authority (STUK), Ministry of Social Affairs and Health Reports 2001:5
y) National Public Health Institute (KTL). Background material for the international evaluation
z) Investment in health. The follow-up report of the international evaluation of the Finnish Institute of Occupational Health
aa) Health in Finland: Chapter 9, Seppo V. Koskinen, M.D, Tapani A. Melkas, M.D. (in print)
bb) Ministry of Social Affairs and Health, Helsinki 1999. Government decision on target and action plan for social welfare and health care 2000–2003
cc) Summaries of Ministry of Social Affairs and Health publications in English. http://www.vn.fi/stm/english/publicat/publications_fset.htm + http://www.vn.fi/stm/english/publicat/publications_main.htm
dd) Basic elements in Finnish social protection: summary. http://www.vn.fi/stm/suomi/julkaisu/julk01fr.htm

8) Health promotion policies, strategies, programmes and infrastructures

Health for all Finland documentation

a) Report health for all by the year 2000. The Finnish national strategy, Ministry of Social Affairs and Health, 1987
b) Health for all policy in Finland. Policy review. WHO Regional Office for Europe, Copenhagen 1991
c) HFA Revised strategy for cooperation. Ministry of Social Affairs and Health, Finland, Pub Series 1993:9
d) Third evaluation of progress towards health for all – Finland, Ministry of Social Affairs and Health Finland. Reports 1998:2 eng
e) Health in Finland, 1999. KTL and Ministry of Social Affairs and Health
f) Government resolution on the *Health 2015* public health programme. Ministry of Social Affairs and Health, Publications 2001:6
g) Allocation scheme for health promotion for the year 2000
h) Ratified plan health promotion allocation plans 1990 – 2000 summary, unedited
i) Health care systems in transition (HiT) profile: Finland. European Observatory on Health Care Systems. 2001
j) Papers on the Finnish health for all strategies: K. Leppo; A. Ritsatakis; M. Sihto

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- *10 heart weeks to promote heart health.* 31 pp.
- *Heart and food programme.* Finnish Heart Association. Helsinki, no date. 6 pp.
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http://www.vn.fi/stm/english/index.htm http://www.vn.fi/stm/english/organ/org-eng.htm
National Public Health Institute (KTL)
http://www.ktl.fi/en/nphi.en.html

National Research and Development Centre for Welfare and Health (STAKES)
http://www.stakes.fi/english/index.html +
http://www.stakes.fi/english/publicati/Publications.htm
Radiation and Nuclear Safety Authority of Finland (STUK)
http://www.stuk.fi/english/

Finnish Institute of Occupational Health (TTL)
http://www.occuphealth.fi/e/
Finnish Centre for Health Promotion (FCHP) (TEK)
http://www.health.fi/english/index.html
Association of Finnish Local and Regional Authorities
http://www.kuntaliitto.fi/english/indexeng.htm
RAY (Finland's Slot Machine Association)
http://www.ray.fi/english/index.htm
UKK Institute
http://www.ukkinstituutti.fi/index_en.html

Social Insurance Institution/Research Centre
http://www.kela.fi/tutkimus/research.html

University of Tampere/Nursing Science
http://www.uta.fi/laitokset/hoito/nureng.htm

FIOH – Information Service Centre
http://www.occuphealth.fi/e/dept/tpk/

C Other Web sites

Government of Finland
http://valtioneuvosto.fi/liston/base.lsp?l=2

Citizen's guide to information on the publications and structures of Finnish health care
Guidelines on health in Finland
http://www.vn.fi/stm/english/pao/publicat/guide/guiengte.htm

ANNEX III – FIELDWORK PROGRAMME AND PERSONS INTERVIEWED

Day	Time	Meeting
Sunday 10 March 2002	1830–2000	On arrival – Brief on the week's programmes **Ministry of Social Affairs and Health** Jarkko Eskola and Eero Lahtinen **Ministry of Social Affairs and Health** Mari Hakkala
	0900–1000	**Minister** Osmo Soininvaara **–** Primary care and social welfare and services, health promotion, preventive social action, environmental health, occupational health **WHO Team** **Ministry of Social Affairs and Health** Kimmo Leppo, Jarkko Eskola and Tapani Melkas **Ministry of Social Affairs and Health** Eero Lahtinen
	1000–1130	**WHO Team** meeting
	1200–1300	**Advisory Board for Public Health** **Chair**: permanent secretary Markku Lehto. – The new *Health 2015* Public Health Programme – Collaboration in health promotion **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen

Monday **11 March** **2002**	1400–1600	**STAKES** The National Research and Development Centre for Welfare and Health **General Director** Vappu Taipale and colleagues **WHO Team**
	1630	**Ministry of Social Affairs and Health briefing** Kimmo Leppo, Jarkko Eskola and Tapani Melkas **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen

Tuesday 12 March 2002	0830–1000	**Centre for Health Promotion** **Director** Harri Vertio + colleagues **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen **Minister** Maija Perho **–** Social protection, insurance, legislation, pharmaceuticals, disability and child care allowances, unemployment security
	1030–1100	**WHO Team** **Ministry of Social Affairs and Health:** Jarkko Eskola, Tapani Melkas, Eero Lahtinen
	1130–1300	**Partners and collaboration with other ministries** Ministry of Agriculture and Forestry Ministry of Education Ministry of Environment Ministry of Transport and Communication **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen
	1300–1445	**Advocacy for health, policy-makers and opinion leaders** Eeva Kuuskoski, Mannerheim Child Protection League Eero Lahelma, Professor of Medical Sociology **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen
	1500–1630	**Association of Finnish local and regional authorities** Matti Liukko **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen

Wednesday 13 March 2002	0830–1000	**National Institute of Public Health** **Director** Jussi Huttunen + colleagues **WHO Team** (part) **Ministry of Social Affairs and Health** Eero Lahtinen, Mari Hakkala
	1000 –1300	**Social Insurance Institution (KELA)** Jorma Järvisalo **WHO Team** (part) **Ministry of Social Affairs and Health** Mari Hakkala
	1200–1315	**Local Expert Group** **Chair:** Juhani Lehto + other members of the group **WHO Team** (part) **Ministry of Social Affairs and Health** Kimmo Leppo, Jarkko Eskola, Tapani Melkas, Eero Lahtinen
	1330–1500	**Research and Universities** Health Promotion Research Programme (TERVE), Doctoral Programmes in Public Health, Economic Crisis of the 1990s: Reasons, Events and Consequences Timo Hakulinen, Merja Hiltunen, Sakari Karjalainen, Juhani Lehto, Seppo Miilunpalo, Helena Taskinen **WHO Team**

Thursday 14 March 2002	0830–1000	**Finnish Institute of Occupational Health** The Finnish Institute of Occupational Health is a research and advisory institute whose main tasks are research, training of occupational health and safety professionals, provision of advisory services, and dissemination of information. The Central Institute and six Regional Institutes provide services for the whole country. Director General **Jorma Rantanen and colleagues** **WHO Team** (part) **Ministry of Social Affairs and Health** Eero Lahtinen
	0830–0930	**Briefing with Ministry of Social Affairs and Health Officials** Kaija Hasunen (nutrition), Sami Kinnunen (drugs), Eero Lahtinen (mental health), Liisa Ollila, Kari Paaso (alcohol) Juha Pyotsia (environmental health) **WHO Team** (part)
	1000–1300	**Social Affairs and Health Committee of the Parliament** The Social Affairs and Health Committee is responsible for handling matters related to social services and health care, social insurance, pension legislation, alcohol and temperance work, occupational and environmental health care. The committee also reviews the annual report on substance abuse and the annual report of the Commissioners of the Social Insurance Institution. **Chair** Marjatta Vehkaoja and members of the committee **Secretary** Eila Mäkipää. **WHO Team** **Ministry of Social Affairs and Health** Eero Lahtinen
	1330–1500	**NGOs group** Cancer Society: Liisa Elovainio, Finnish Association of Mental Health: Pirkko Lahti, Finnish Federation of the Visually Impaired, Klas Winell, Folkhälsan, Georg-Henrik Wrede, Health Care Association: Eeva-Liisa Urjanheimo, Heart Association: Hannu Vanhanen, Nurses' Association: Katriina Laaksonen, RAY, Markku Ruohonen **WHO Team**

	1800–2030	**UKK Institute, Tampere** Seppo Miilunpalo, Päivi Moisio, Ilkka Vuori **WHO Team** (part), **Ministry of Social Affairs and Health** Mari Hakkala

Friday **15 March** **2002**	Day Visits	**JYVÄSKYLÄ** **WHO Team** (part) **Ministry of Social Affairs and Health** Mari Hakkala **Director of the District** Paavo Luukkonen **Head Physician** Jarmo Koski **Chair of Social and Health Board** Veijo Koskinen **Director of Social and Health Services** Sakari Möttönen **Director of International Affairs** Erkki Pänkälä Ulla Kuittu, social worker **Health Promotion Unit** Kaija Korpela, Arja Lyytikäinen, Jukka Puolakka, Jouko Ridell, Sirpa Valkama **Two health promotion projects and discussion** Meidän Jykä **Project on education in collaboration (Our Jykä)** Ms Aila Koistinen, Ms Merja Larkkonen Leena Ruuskanen **Organizing physical rehabilitation for the elderly** Ms Sirkka Kannas **Kumppanuustalo – Partnership House** **Cooperation with the third sector – the NGOs** WIRE-project, Ms Niina Koponen, Mr Antti Hakulinen Hyve-project **Representatives of different sectors of municipal administration and the Polytechnic University of Jyväskylä** Lasse Kannas, Pia Laukkanen, Harri Suominen, Marjatta Marin, Ritva Sakari-Rantala, Jorma Tynjälä, Timo Ståhl

15 March 2002 Kuopio – Health Promotion Policies of the Municipal Social Services and Health Care and University of Kuopio		**KUOPIO** **WHO Team** (part of) and **Ministry of Social Affairs and Health** Eero Lahtinen **Health Promotion Policies of the Municipal Social Services and Health Care and the University of Kuopio**
	0900 –1100	Regional Government **Harjula Hospital, Building 4, Meeting Room 4**
	11.00	**Welcome to Kuopio** The Kuopio vision paper 1996 and its main strategies: Kuopio is a town of new, more comprehensive responsibility for health and welfare, and it is committed to preventing social exclusion and to responding to the needs of the citizens in its administration and decision-making. Future vision and strategy will be revised in 2002. – Ms Terttu Vilpponen-Salmela, Chief Doctor (councillor in the 1990s) **Health promotion in the 1990s** Kuopion health education programme 1992–1996 and the work of the Health and Social Welfare Group since 1996 – Ms Marjatta Pirskanen, Planner **The principal changes in social services and health care in the 1990s and their impact on the 1999 strategy. Health promotion and monitoring of health in annual budget and planning documents** Chief doctor of outpatient care, Mr Matti Pietikäinen **Promotion of well-being as the town leadership sees it – revising the Vision and the Strategy up to 2012** Mr Jukka Pulkkinen, Deputy Mayor
	12.15	**Lunch at the Harjula Hospital Canteen**

	13.30	**Health promotion – examples of the 1990s and beginning of the next century** - Children and young people's health and welfare account of 1999, - Child and youth policy document of 2000 - Substance abuse policy document - Ms Anneli Helminen, Director of Psycho-social work - Need for comprehensive mental health promotion planning - Director Seppo Ikonen, Psychologist - Promoting the health of the elderly both at home and in hospital - Ms Soili Paljärvi, director of Home Services, and Ms Terttu Vilpponen-Salmela, Chief Doctor - Nutrition in health promotion, Ms Lea Turpeinen, Nutritionist - Developing care and promoting health (examples) - Ms Pirja Pirja Varjoranta, Director of Nursing Services
	15.00 – 17.00	University of Kuopio in Health and Welfare Promotion - Professor Anna-Maija Pietilä, Department of Nursing Science - Professor Juha Kinnunen, Health Administration and Health Economics - Professor Pirjo Pölkki, Department of Social Sciences - Professor Jussi Kauhanen, Department of Public Health - Ms Outi Nuutinen, Senior Lecturer, Department of Nutrition Science
Saturday and Sunday 16–17 March 2002		Working days for the Review Group

Monday 18 March 2002	0830–0900 0900–1400 1430–1630	Breakfast and briefing about the Reference Workshop **Reference Workshop** Members of Local Expert Group, Ministry of Social Affairs and Health senior officials, members of Public Health Advisory Board, municipal representatives, and others **WHO Team** Feedback from workshop and discussion on future steps **WHO Team**
Tuesday 19 March 2002	Various times during the day	**Briefing with Ministry of Social Affairs and Health Officials** Maarit Kokki (communicable diseases) Eero Lahtinen (mental health) Taru Mikkola (General secretary, Public Health Advisory Board) Antti Uutela (health behaviour surveys) **WHO Team** (part) **Ministry of Social Affairs and Health Eero Lahtinen** **Briefing about the Health Care Project** Jussi Huttunen (General Director KTL) **WHO Team** (part)
Wednesday 20 March 2002		Travelling day

ANNEX IV – MEMBERSHIP OF THE LOCAL EXPERT GROUP

- Risto Aurola, Ministry of Social Affairs and Health, Branch of Environmental Health
- Dr Jarkko Eskola, Ministry of Social Affairs and Health, Department of Family Matters and Social Affairs
- Ms Mari Hakkala, Ministry of Social Affairs and Health, Technical Assistant
- Dr Jorma Järvisalo, Social Insurance Institution, Finland
- Ms Meri Koivusalo, STAKES
- Dr Eero Lahtinen, Ministry of Social Affairs and Health, Department of Health
- Professor Juhani Lehto, University of Tampere (chair)
- Dr Tapani Melkas, Ministry of Social Affairs and Health, Department of Health
- Dr Aulikki Nissinen, Public Health Institute (KTL ETEO)
- Ms Eeva Ollila, STAKES
- Ms Liisa Ollila, Ministry of Social Affairs and Health, International Affairs Bureau
- Mr Mikko Paunio Ministry of Social Affairs and Health, Branch of Environmental Health
- Ms Marita Sihto, STAKES
- Dr Harri Vertio, Finnish Centre for Health Promotion (TEK)

ANNEX V – LITERATURE SOURCES for POLICY REVIEWING

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Ritsatakis, A, Barnes, R, Dekker, E, Harrington, P, Kokko, S, Makara, P. (eds, 2000). *Exploring health policy development in Europe.* WHO Regional Publications European series, No 86. Copenhagen.

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Vedung, E (1997). *Public policy and program evaluation.* New Brunswick, NJ, US.

Vedung, E (1994). *Utvärdering i offentliga sektorn – problem och lösningar*. Rapport utgiven av Stat-kommunberedningen, Civildepartementet. Ds 1994:117: Stockholm.

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ANNEX VI – Ottawa Charter for Health Promotion

Ottawa Charter for Health Promotion
First International Conference on Health Promotion
Ottawa, Canada, 17–21 November 1986

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health promotion action means

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and

governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to health promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;

- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and wellbeing;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, health for all by the year 2000 will become a reality.

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Review of national Finnish health promotion policies and recommendations for the future

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