

Public health ‘good practice’ – the case of Finland

By: Sara Allin

Finland has received international attention for its success in mobilising government, industry and local communities towards developing a sustained, integrated approach to improving public health. This article describes the organisation and decision-making in public health in Finland, summarises two examples of ‘good practice’ in public health: cardiovascular disease and diabetes prevention, and discusses future challenges facing public health in Finland.

The Finnish health system is highly decentralised; most responsibility for curative and public health lies with the municipalities, with broad policy direction from central government. At the centre, the Ministry of Social Affairs and Health enacts legislation in health and social policy and sets national policies, supported by several agencies. The National Research and Development Centre for Welfare and Health (STAKES) is responsible for health care evaluation (e.g. regarding public health policies like tobacco and alcohol control, regarding medical performance and regarding health technology). The National Public Health Institute (KTL) is a research institute and expert body responsible for providing decision-makers, health care professionals and the public with health information. The Finnish Centre for Health Promotion supports and monitors local health promotion programs. At local level, municipal health committees, coordinated by the federation of municipalities, decide the priorities and local organisation of health services and implement national strategies [1].

Spending on health care in Finland constitutes approximately 7.3% of GDP, with 3.6% of total health expenditure directed towards public health and prevention [2]. However, since many public health activities in Finland are multi-sectoral in nature, it is likely expenditure is underestimated.

National priorities in health are determined through an inclusive process with groups such as professional and patient organisations, trade unions, service providers, researchers, leading to the development of five-year plans. Finland was among the first countries to have a national health for all policy, with the publication of its first national health strategy developed in collaboration with WHO – “Health for All by the year 2000 – the Finnish National Strategy” in 1987. This strategy had four targets: reducing premature deaths, reducing chronic diseases and other health problems, lengthening functional capacity, and reducing health inequalities.

In 2001 the Finnish government drew on the previous health policy and WHO Health for All 2000 strategy to develop a resolution – “Health 2015” – with the broad aims to reduce health inequalities and improve healthy life expectancy, this time accompanied by specific targets and action plans [3]. Certain preconditions were identified to support this national strategy: involving all sectors (including private) and levels of government, using indicators to monitor progress, including main areas of everyday life, and emphasising health throughout the lifespan. Although most of the targets are broad and qualitative, some are specific and quantifiable (e.g. decreasing the number of young people (ages 16-18) smoking to less than 15%). The government outlined an implementation plan based on action plans for each target, and for all actors (i.e. municipalities, industry, research centres, non-governmental organisations).

There is some degree of evidence-based policy making in Finland. For instance, certain national public health policies are based on pilot projects that are evaluated. These evaluations then guide national policy development. Moreover, the policy-making process in Finland highlights the importance of multi-sectoral, coordinated approaches, involving relevant industry and integrated across all levels of government.

Cardiovascular disease prevention – the North Karelia Project onwards

Even before Finland developed its first national health policy, the 1970s marked the beginning of concerted action to improve public health, in response to the rapid increase in cardiovascular disease (CVD) and other chronic diseases in the previous decades. In 1972 a community-based CVD prevention program started in North Karelia with the aim to reduce the key risk factors and health behaviours identified through previous studies, international recommendations and the epidemiological situation in the province [4]. The risk factors identified were: smoking, high cholesterol, and high blood pressure.

Evaluation of the first five years of this program revealing significant reduction in risk factors in North Karelia led to the development of a nation-wide prevention policy in 1977. Thus a comprehensive, community level approach was rolled out across the country in the late 1970s and early 1980s, involving not only health services, but also voluntary organizations, mass media, food industry and public policy. Approaches ranged from community campaigns (e.g. quitting smoking – “Quit and Win”), competitions (e.g. prizes for towns most successful in lowering cholesterol), cholesterol screening (every 5 years for individuals over age 20), to national legislative changes (e.g. tobacco regulations, shifting agricultural subsidies to encourage low-fat alternatives) [5, 6].

The positive impact of these initiatives on public health is uncontested. Between 1972 and 2002 mortality from CVD fell by 82% in North Karelia and 75% nationwide [6]. This dramatic decline has been largely attributed to a reduction in the three risk factors targeted by the program: cholesterol, due to sharp decline in saturated fat intake (mainly through replacing butter and whole milk with low-fat alternatives); blood pressure, due to a decline in salt consumption and improvement in medication, despite an increase in obesity and alcohol consumption; and smoking, only among men (smoking prevalence increased among women until the mid 1990s) [5]. Along with these improvements, lung cancer mortality (among men) and strokes have also declined.

Prevention of type 2 diabetes

Following the success of the North Karelia and subsequent national prevention programs, the 1990s and 2000s mark a time of concerted public health policies. Despite the decrease in some of the most important risk factors for chronic disease, there has been an increase in obesity, alcohol consumption, smoking among women (although this may have reached a plateau), and diabetes. In light of the growing number of individuals suffering from obesity and diabetes, the projected 70% increase in diabetes by the year 2010, and the projected escalation in health care costs, preventing diabetes and its complications has become a priority area in public health [7].

In the 1990s, the Finnish Diabetes Prevention Study assessed the effectiveness of a lifestyle intervention in preventing type 2 diabetes among high-risk individuals. The risk of diabetes was reduced by 58% among those who were advised and supported to make dietary changes and increase physical exercise, consistent with other studies.

Based on this evidence, the Finnish Diabetes Association in partnership with KTL, the National Heart Association and the persons responsible for the Cardiovascular Program, developed a national diabetes prevention program [7]. This program represents a response to the WHO World Health Assembly resolution urging health departments to launch national nutrition- and physical exercise-based programs targeting the major public health problems (Resolution WHA55.23: Diet, Physical Activity, and Health). It is also closely linked to the national public health strategy, Health 2015, along with local government health programs.

The diabetes prevention program was planned collaboratively by diabetes, nutrition and obesity researchers, health care providers and authorities. The plan encompasses three concurrent strategies: the population strategy focuses on general health promotion; the high-risk strategy provides a systematic model for identifying, educating and monitoring people at risk of developing

the disease; and the strategy of early diagnosis and management targets individuals with newly diagnosed type 2 diabetes. The practical feasibility and cost-effectiveness of this prevention program will be assessed in four hospital districts as a part of a five-year implementation pilot project (2003-2007) with the intention to roll out the program nation-wide. Implementation will involve all levels of government, health professionals, non-governmental organisations, pharmacies and media.

Future challenges and potential

The accomplishments of the North Karelia project and the recent approach to tackling diabetes demonstrate that considerable progress can be made in improving public health by combining political will and commitment from all relevant bodies (including the population and industry), having multi-sectoral and integrated approaches, in addition to continually improving public health infrastructure.

Despite these achievements, there are existing challenges and emerging health threats that need to be addressed. First, the impact of the increase in smoking among women, which may have reached a plateau, will become increasingly noticeable, potentially reversing the positive trend in CVD and lung cancer. Second, there are rising number of Finns consuming alcohol and using illicit drugs, also presenting serious health risks. Third, health inequalities – measured by mortality discrepancies across socio-economic groups – have shown signs of worsening since the 1980s [8]. Finally, there are other important areas of public health that this article has not addressed, such as environmental hazards and infectious diseases.

In addition to these threats to public health, there are some weaknesses with the Finnish public health system. A recent WHO external assessment made some recommendations to address these weaknesses, such as increasing evidence-based policy-making, strengthening inter-sectoral collaboration, and better supporting municipalities in health promotion activities [9]. Also, while quantifiable health targets have been used as a tool for policy-making, perhaps these could be improved. For, it has been argued that these targets largely remain rhetoric as opposed to useful goals, because they are not being effectively implemented [10].

Despite these challenges, Finland has made important strides in developing and implementing some effective public health programs.

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