

NATIONAL ACTION PLAN  
TO REDUCE HEALTH  
INEQUALITIES 2008–2011



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## SUMMARY

*National Action Plan to Reduce Health Inequalities 2008–2011. Helsinki 2008. 79pp. (Publications of the Ministry of Social Affairs and Health, ISSN 1236-2050; 2008:25) ISBN 978-952-00-2700-1 (pb), ISBN 978-952-00-2701-8 (PDF).*

The National Action Plan to Reduce Health Inequalities outlines proposals for strategic policy definitions and the most important measures to reduce socioeconomic health inequalities in Finland. A separate action plan was deemed necessary since inequalities persist despite the efforts undertaken through health and social policy. Narrowing health gaps has been the objective of Finnish health policy since the 1980s. This objective has not been achieved, however, and the inequalities have partly even grown.

The National Action Plan to Reduce Health Inequalities is closely linked with the Government's Health Promotion Policy Programme. The Action Plan will also for its part implement the aim of the national "Health 2015" programme to reduce mortality differences by a fifth by 2015.

The preparation of the Action Plan began in autumn 2006 at the multisectoral Advisory Board for Public Health (within the Ministry of Social Affairs and Health) on assignment from the ministerial group for social policy issues of Prime Minister Vanhanen's first Government. Throughout the preparation, a vast number of experts from several administrative sectors, research institutes, universities, local governments and the health service system as well as NGOs and professional organisations have been consulted. Members of the TEROKA project, which is being carried out together by the National Public Health Institute, the National Research and Development Centre for Welfare and Health and the Finnish Institute of Occupational Health, have had an important role in planning and preparing the Action Plan.

The objective of the Action Plan is to reduce social inequalities in work ability and functional capacity, self-rated health, morbidity and

mortality by levelling up. Narrowing of the inequalities will have a positive effect on public health and help to secure the services as the population ages, raise the employment rate and restrain the costs.

Changes in the health of entire population groups often take a long period of time to materialise. Persistent, multisectoral work is needed to reduce health inequalities. Social determinants of health and the processes behind the inequalities must be addressed. To pursue the objective of reduction in health inequalities, the Action Plan mainly operates in the following three priority areas:

- Social policy measures: improving income security and education, and decreasing unemployment and poor housing
- Strengthening the prerequisites for healthy lifestyles: measures to promote healthy behaviour of the whole population with special attention to disadvantaged groups where unhealthy behaviour is common
- Improving the availability and good quality of social and health care services for everyone

To pursue these goals and monitor the attainment of them, reliable knowledge base and effective communication are needed. For this purpose,

- a follow-up system for health inequalities is developed
- knowledge about the scope of and trends in health inequalities is strengthened
- education and communication concerning health inequalities and their reduction is advanced.

Fifteen new actions are proposed in the Action Plan. These represent the most essential actions to bridge the health inequalities that have not been addressed sufficiently elsewhere. The proposals have been chosen so that they can be launched and partly realised during the current Government's four-year period in office. However, a long-term perspective for structural changes is emphasised and many of the aims extend beyond the present Government term.

Many ongoing programmes and projects address health inequalities either directly or indirectly. Some proposals given in other pro-

grammes are included in the Action Plan in order to further emphasise them. The role of the Action Plan is also to ensure that the involved actors take account of the impacts their actions have on different population groups.

A detailed implementation plan including result and process indicators to be used in monitoring and assessment of the Action Plan will be prepared. The Ministry of Social Affairs and Health is responsible for the implementation and its monitoring and assessment. The Advisory Board for Public Health acts as a steering group for the Action Plan. Research institutes operating under the Ministry of Social Affairs and Health participate in the implementation, monitoring and assessment of the Action Plan. The institutes' expertise will be channelled through the project for reducing socioeconomic inequalities in health, known as TEROKA.

### **Key words**

Action programmes, health, health policy, social policy, wellbeing

# TIIVISTELMÄ

*Kansallinen terveyserojen kaventamisen toimitaohjelma 2008–2011. Helsinki 2008. 79 s. (Sosiaali- ja terveysministeriön julkaisuja, ISSN 1236-2050; 2008:25) ISBN 978-952-00-2700-1 (nid.), ISBN 978-952-00-2701-8 (PDF).*

Terveyserojen kaventamisen toimintaohjelmassa määritellään käytännön toimintalinjat sosioekonomisten terveyserojen vähentämiseksi. Erillinen toimintaohjelma katsottiin tarpeelliseksi, koska terveyserot ovat osoittautuneet vaikeaksi terveys- ja yhteiskuntapoliittiseksi ongelmaksi. Terveyserojen vähentyminen on ollut Suomen terveyspolitiikan tavoitteena jo parin vuosikymmenen ajan, mutta tavoitetta ei ole saavutettu, vaan erot ovat osittain jopa kasvaneet.

Terveyserojen kaventamisen toimintaohjelma kytkeytyy tiiviisti hallituksen Terveyden edistämisen politiikkaohjelmaan. Terveyserojen kaventamisen toimintaohjelma toteuttaa osaltaan myös terveyspolitiikkaa pitkällä aikavälillä linjaavan Terveys 2015 -kansanterveysohjelman tavoitetta, jonka mukaan ammattiryhmien sekä koulutusryhmien välisten kuolleisuuserojen pitäisi pienentyä viidenneksellä vuoteen 2015 mennessä.

Toimintaohjelman valmistelu aloitettiin syksyllä 2006 pääministeri Vanhasen I hallituksen sosiaalipoliittisen ministerityöryhmän toimeksiannosta kansanterveyden neuvottelukunnassa. Valmistelussa on kuultu laajaa joukkoa asiantuntijoita eri hallinnonaloilta, tutkimuslaitoksista, yliopistoista, kunnista, terveyspalvelujärjestelmästä sekä kansalais- ja ammattijärjestöistä. Kansanterveyslaitoksen, Stakesin ja Työterveyslaitoksen yhteistyöhanke TEROKAn asiantuntijoilla on ollut tärkeä rooli toimintaohjelman suunnittelussa ja valmistelussa.

Toimintaohjelman tavoitteena on sosioekonomisten väestöryhmien välisten erojen väheneminen työ- ja toimintakyvyssä, koetussa terveydessä, sairastavuudessa ja kuolleisuudessa. Terveyseroja pyritään vähentämään siten, että terveydeltään huonommassa asemassa olevien terveydentila lähentyy paremman terveyden saavuttaneiden ryhmien

terveyden tasoa. Terveyserojen väheneminen vaikuttaa myönteisesti koko kansanterveyteen, palveluitten turvaamiseen väestön ikääntyessä, työllisyysasteen nostamiseen sekä kustannusten hillintään.

Väestöryhmätasolla tapahtuvat terveyden muutokset edellyttävät usein pitkäjänteistä työtä ja eri sektoreiden välistä yhteistyötä. On puututtava terveyserojen taustalla oleviin sosiaalisiin syytekijöihin ja prosesseihin. Tässä ohjelmassa terveyserojen vähentymistavoitteeseen pyritään seuraavien päälinjojen kautta:

- Vaikuttamalla yhteiskuntapoliittisilla toimilla köyhyyteen, koulutukseen, työllisyyteen ja asumiseen
- Tukemalla terveellisiä elintapoja koko väestössä ja erityisesti niissä väestöryhmissä, joissa epäterveelliset elintavat ovat yleisiä
- Parantamalla sosiaali- ja terveystalouden tasa-arvoista ja tarpeenmukaista saatavuutta ja käyttöä

Näihin tavoitteisiin pyrkiminen ja tavoitteiden saavuttamisen seuranta edellyttävät luotettavaa tietopohjaa ja tehokasta tiedonvälitystä, joita varten

- kehitetään terveyserojen seurantajärjestelmää
- vahvistetaan tietopohjaa
- kehitetään koulutusta ja viestintää koskien terveyseroja ja niiden kaventamista

Toimintaohjelmassa on esitetty 15 toimenpidettä. Nämä edustavat terveyserojen kannalta keskeisimpiä toimia, joiden ei ole katsottu etenevän riittävän vahvasti muualla. Toimenpiteet on valittu siten, että ne voidaan aloittaa ja osin myös toteuttaa kuluvan hallituskauden aikana. Ohjelma tavoittelee kuitenkin pitemmän aikavälin yhteiskunnallisia vaikutuksia ja monet tavoitteet ulottuvat hallituskauden ohi.

Terveyseroihin vaikutetaan monissa meneillään olevissa ohjelmissa ja hankkeissa joko suoraan tai välillisesti. Toimintaohjelmaan on koottu näistä sellaisia toimenpiteitä, joita halutaan tämän ohjelman myötävaikutuksella vahvistaa. Toimintaohjelman tehtävänä on myös huolehtia siitä, että asianomaisilla toimijatahoilla kiinnitetään huomiota eri väestöryhmiin kohdistuviin vaikutuksiin.

Toimintaohjelman toimeenpanoa ja seurantaan varten tehdään tarkennettu toimeenpanosuunnitelma, josta käyvät ilmi myös seurannassa ja arvioinnissa käytettävät tulos- ja prosessiosoittimet. Sosiaali- ja terveysministeriö vastaa ohjelman toimeenpanosta sekä sen seurannasta ja arvioinnista. Kansanterveyden neuvottelukunta toimii ohjelman ohjausryhmänä. STM:n hallinnonalan tutkimuslaitokset KTL, Stakes ja TTL osallistuvat toimeenpanoon, seurantaan ja arviointiin. Tutkimuslaitosten asiantuntijatuki kanavoidaan laitosten Terveyserojen kaventamisen yhteistyöhanke TEROKAn kautta.

## **Asiasanat**

Hyvinvointi, terveys, terveyspolitiikka, toimintaohjelmat, yhteiskuntapolitiikka

## SAMMANDRAG

*Handlingsprogram för minskning av hälsoskillnaderna 2008–2011. Helsingfors 2008. 79 s. (Social- och hälsovårdsministeriets publikationer, ISSN 1236-2050; 2008:25) ISBN 978-952-00-2700-1 (inh.), ISBN 978-952-00-2701-8 (PDF).*

Handlingsprogrammet för minskning av hälsoskillnaderna fastställer de praktiska riktlinjerna för verksamheten för att minska de socioekonomiska hälsoskillnaderna. Ett separat handlingsprogram ansågs nödvändigt eftersom hälsoskillnaderna hade visat sig vara ett svårt hälso- och samhällspolitiskt problem. Målet för hälsopolitiken i Finland har redan under ett par decennier varit att minska hälsoskillnaderna men målet har inte nåtts utan skillnaderna har delvis till och med vuxit.

Handlingsprogrammet för en minskning av hälsoskillnaderna är nära förknippad med regeringens Politikprogram för hälsofrämjande. Handlingsprogrammet för minskning av hälsoskillnaderna förverkligar för sin del även målet för folkhälsoprogrammet Hälsa 2015 som på lång sikt drar upp riktlinjerna för hälsopolitiken. Enligt detta program ska skillnaderna i dödlighet mellan yrkesgrupper och utbildningsgrupper minska med en femtedel fram till utgången av år 2015.

Beredningen av handlingsprogrammet inleddes på hösten 2006 i folkhälsodelegationen på uppdrag av den socialpolitiska ministerarbetsgruppen i statsminister Vanhanens första regering. Vid beredningen har en bred grupp sakkunniga hörts inom olika förvaltningsområden, forskningsinstitut, universitet, kommuner, hälsoservicesystemet samt medborgar- och yrkesorganisationer. Sakkunniga inom Folkhälsoinstitutets samarbetsprojekt TEROKA har haft en viktig roll i planering och beredning av handlingsprogrammet.

Målet för handlingsprogrammet är att minska skillnaderna mellan de socioekonomiska befolkningsgrupperna i fråga om arbets- och funktionsförmåga, upplevd hälsa, sjukfrekvens och dödlighet. Man strävar efter att minska hälsoskillnader så att hälsotillståndet för de sämst lottade närmar sig hälsonivån för de grupper som uppnått en

bättre hälsa. En minskning av hälsoskillnaderna inverkar positivt på hela folkhälsan, tryggar servicen när befolkningen blir äldre, höjer sysselsättningsgraden och hejdar kostnaderna.

Förändringar av hälsan som sker på befolkningsgruppsnivå förutsätter ofta ett långt tidsintervall. För att en minskning hälsoskillnaderna ska lyckas krävs långsiktigt arbete och samarbete mellan olika sektorer. Man måste ingripa mot sociala orsaksfaktorer och processer bakom hälsoskillnaderna. Detta program strävar efter målet att minska hälsoskillnaderna genom följande huvudlinjer:

- Genom samhällspolitiska åtgärder påverka fattigdom, utbildning, sysselsättning och boende
- Stödja sunda levnadsvanor inom hela befolkningen och särskilt inom de befolkningsgrupper där osunda levnadsvanor är utbredda
- Förbättra jämlik och adekvat tillgång till och användning av social- och hälsovårdstjänster

Att sträva efter dessa mål och följa upp att målen nås förutsätter tillförlitligt kunskapsunderlag och effektiv informationsförmedling för vilka man

- utvecklar ett uppföljningssystem för hälsoskillnader
- förstärker kunskapsunderlaget
- utvecklar utbildning och kommunikation med avseende på hälsoskillnader och en minskning av dem

Handlingsprogrammet har presenterat 15 åtgärder. Dessa utgör de viktigaste åtgärderna i fråga om hälsoskillnader som man inte har ansett ha framskridit tillräckligt på annat håll. Åtgärderna har valts så att de kan börja vidtas redan nu och delvis även genomföras under den innevarande regeringsperioden. Programmet strävar dock efter samhälleliga effekter och flera mål sträcker sig över regeringsperioden.

Flera pågående program och projekt inverkar på hälsoskillnaderna antingen direkt eller indirekt. I handlingsprogrammet har man från dessa samlat åtgärder som har inverkan och som man vill förstärka genom programmets medverkan. Handlingsprogrammets uppgift är även att se till att aktörerna fäster uppmärksamhet på effekterna för olika befolkningsgrupper.

För genomförande och uppföljning av handlingsprogrammet upprättas en preciserad genomförandeplan, ur vilken framgår även resultat- och processindikatorer som används vid uppföljning och utvärdering. Social- och hälsovårdsministeriet svarar för genomförandet av programmet samt uppföljning och utvärdering. Folkhälsodelegationen fungerar som styrgrupp för programmet. Forskningsinstituterna inom SHM:s förvaltningsområde, Folkhälsoinstitutet (KTL), Forsknings- och utvecklingscentralen för social- och hälsovården (Stakes) och Arbetshälsoinstitutet (TTL), deltar i genomförandet, uppföljningen och utvärderingen. Forskningsinstitutens sakkunnighjälp kanaliseras genom samarbetsprojektet för minskning av hälsoskillnaderna (TEROKA).

## **Nyckelord**

Handlingsprogram, hälsa, hälsopolitik, samhällspolitik, välfärd

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## FOREWORD

Reducing health inequalities has been a goal of Finnish health policy for a long time now, but insufficient progress has been made. This new National Action Plan to Reduce Health Inequalities defines for the first time not only the main strategies but also strands of practical action aimed at reducing socio-economic inequalities in health at various levels of planning and operations.

Preparations for the National Action Plan were initiated in autumn 2006 by the ministerial group for social policy issues of Prime Minister Vanhanen's first Government, and work began within the cross-sectoral Advisory Board for Public Health at the Ministry for Social Affairs and Health. The Advisory Board is Government appointed, and its members represent several administrative sectors, local government, the health service system, NGOs and professional organisations, and health research institutes.

The Board is chaired by Permanent Secretary Kari Välimäki. Preparatory work was carried out by the sub-committee for national co-operation of the Advisory Board for Public Health, chaired by Tapani Melkas. The individual Board and sub-committee members are listed in annex 1. Initially, work followed the seven main areas laid down in the memorandum drawn up for the ministerial group for social policy, which provides a basis for the National Action Plan. The following persons and expert secretaries (names in brackets) were appointed to work on the seven main strands:

- 1) Reinforcing the theme Health in All Policies (HiAP) and firmly integrating the health inequalities into it (Tapani Melkas, Ministry of Social Affairs and Health MSAH; Timo Ståhl, National Research and Development Centre for Welfare and Health STAKES);
- 2) Strengthening work to reduce health inequalities in municipalities (Kerttu Perttilä, STAKES; Tuulia Rotko, STAKES);

- 3) Alcohol and tobacco policies (Erkki Vartiainen, National Public Health Institute; Eila Linnanmäki, MSAH/ National Public Health Institute);
- 4) Enhancing the equity in the services (Juha Teperi, MSAH/STAKES; Hannele Palosuo, STAKES);
- 5) Reducing health inequalities among children and youth and preventing social exclusion (Marjaana Pelkonen, MSAH; Tuija Martelin, National Public Health Institute);
- 6) Reducing health inequalities among people of working age (Hilkka Riihimäki, Institute of Occupational Health; Simo Virtanen, Institute of Occupational Health);
- 7) Developing systems for monitoring health inequalities between population groups (Seppo Koskinen, National Public Health Institute; Eila Linnanmäki, MSAH/ National Public Health Institute).

Experts from a joint project to reduce socio-economic inequalities in health (known as TEROKA) between the National Public Health Institute, STAKES and the Institute of Occupational Health helped with planning and drafting the National Action Plan. During a one year leave-of-absence from TEROKA, Eila Linnanmäki coordinated work on the National Action Plan at the Ministry of Social Affairs and Health. In addition to those mentioned above, a large number of other experts from various administrative sectors, research institutes, universities, municipalities, the health service system, and NGOs and professional organisations worked on the Plan. All their names are listed in annex 1.

# 1 STARTING POINTS OF THE NATIONAL ACTION PLAN

## 1.1 General aims and strategies

The National Action Plan to Reduce Health Inequalities also contributes to the aims of Prime Minister Vanhanen's second Government in promoting health and working and functional capacity and reducing health inequalities between different population groups. The National Action Plan is thus linked closely with the Government's Policy programme for health promotion. It also has connections with many other ongoing programmes and projects in various sectors.

The National Action Plan to Reduce Health Inequalities likewise supports implementation of the national 'Health 2015' programme (Government Resolution 2001). The main objectives of this long-range health policy programme are to extend people's healthy and functional life and reduce health inequalities between population groups. The programme presupposes that action towards all targets aiming to promote health and develop health services will ensure less inequality and greater well-being and improved health levels among population groups currently in a disadvantaged position. The Health 2015 programme is also the first programme to set a quantitative target: to cut mortality inequalities between different vocational and educational groupings by one fifth by the year 2015. However, the most recent research findings indicate that no progress has been made towards these targets; on the contrary, some inequalities have even grown.

The aim of the National Action Plan is to reduce inequalities between different socio-economic population groups in terms of their work ability and functional capacities, self-rated health, morbidity and mortality. The effect aimed at in reducing health inequalities is to bring the status of the less healthy closer to those who now enjoy better health.

In striving to reduce health inequalities between population groups, it should be noted that it often takes a very long time to achieve changes in health status at the population group level. Successfully reducing health inequalities demands persistent work over a protracted period, and collaboration between different sectors and spheres of government. The factors and processes lying behind health inequalities must be worked upon. This National Action Plan adopts the following main approaches in its aim to reduce health inequalities:

- Adapting social policy measures to influence poverty, education, employment, working conditions and housing
- Supporting healthy lifestyles in general and specifically among the population groups where unhealthy habits are common
- Improving the equity and need-based availability of social and health services

Work towards these goals and monitoring of their achievement presupposes a reliable information base and effective transmission of information, to which ends

- a health inequalities monitoring system will be developed
- the information base will be strengthened and
- training and information on health inequalities and ways of reducing them will be developed.

A whole broad and complex field of reductions in health inequalities was surveyed in putting the National Action Plan together. Many programmes and projects already in progress or in preparation affect health inequalities directly or indirectly. From these, the Plan selects certain actions to focus on in reducing inequalities. It also wishes to ensure that the various actors involved will pay attention to the impact of policy measures on different population groups.

Fifteen new measures are proposed in the Plan, representing areas where progress in reducing health inequalities is considered to have been inadequate. Some of the measures consolidate action already being taken. Many call for additional analysis and/or resources, though others can be carried out by retargeting existing resources. The actions chosen can all begin during the term of the present Government. The

Plan also aims to have a wider social impact over the longer term, however, and in particular, the objectives requiring structural changes extend beyond the end of the Government term. The National Action Plan is scheduled to be updated in 2011.

The broader background and justifications for the targets and measures included in the National Action Plan to Reduce Health Inequalities in various fields are explained in eight memoranda (annexes 3-10). These also list proposals for action other than those covered by the present Plan.

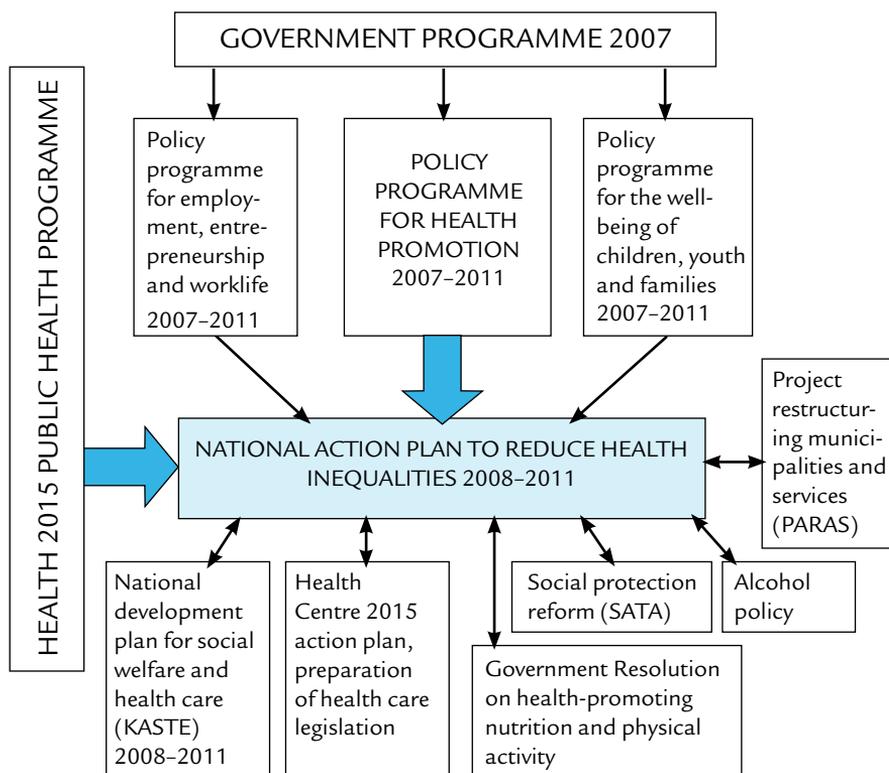
## 1.2 Links between the National Action Plan and other programmes

The National Action Plan has links with several programmes and projects already under way. The main ones are shown in figure 1.

Prime Minister Vanhanen's second Government has three cross-sectoral policy programmes: on employment, entrepreneurship and worklife; on health promotion; and on the well-being of children, youth and families. These policy programmes bring together various actions by different actors and different administrative sectors aimed at targets prioritised by the Government.

The aim of the **Policy programme for health promotion** is to improve public health and reduce health inequalities. It aims to strengthen the structures of health promotion, achieve lifestyle changes that will help prevent chronic diseases, develop working and living conditions that promote healthy lifestyles, strengthen basic social and health services and develop new ways of promoting health, and strengthen the activities and role of organisations, particularly in encouraging participation and sense of community.

Figure 1: Links of the National Action Plan to Reduce Health Inequalities to other plans and programmes



The main focus of the **Policy programme for the well-being of children, youth and families** is preventive work and early intervention. The aim is to further a child-friendly Finland which supports the everyday well-being of children, youth and families, reduces social exclusion, ensures that youth participate and are consulted more, and are better informed about their rights. One of the aims of the **Policy programme for employment, entrepreneurship and worklife** is to increase the labour supply and reduce the number of people lacking vocational training, reduce problems encountered on entering the labour market, and improve working conditions and coping at work.

In summer 2007 the Government launched work on a broad **social protection reform (SATA)** aimed at raising work incentive, reducing poverty and ensuring an adequate level of basic security in every life

situation. The committee is expected to complete its work by the end of 2009.

In 2005 the Government launched a **project restructuring municipalities and services (PARAS)**. The aim is to secure the organisation and provision of local government services for local residents. This objective will be achieved by strengthening the structure and financial base of municipalities, furthering cooperation between them and ensuring full coverage by the service network. Modes of operation will also be changed. Legislation on the restructuring of municipalities and their services came into force on 23 February 2007.

The **National development plan for social welfare and health care (KASTE)** approved by the Government at the beginning of 2008 defines development targets for social welfare and health care over the next few years and the main means by which they can be achieved. The programme provides both an overall picture of the way municipalities will be steered during the programme period and lists the main actions to which the work input and budget appropriations for development of STAKES, the National Public Health Institute, the Institute of Occupational Health and the provincial state offices will be devoted over the 2008-2011 period. The aim of the Ministry of Social Affairs and Health's **Health Centre 2015 action plan** is that by that date health centres will become high-quality units providing basic services for the whole population, with a coordinating role in promoting the well-being of the population and a key role in managing health care's service chains. The Ministry of Social Affairs and Health set up a working group to draft a proposal for new **legislation on health care** by the end of May 2008. The aim of the new legislation will be to support and strengthen primary health care and promote the availability and efficient provision and development of the health services. It is also aimed at lowering the thresholds between primary health care and specialist care. The main emphases of the working group's brief include reducing health inequalities between population groups and across geographical locations.

The Ministry of Social Affairs and Health is currently working on a **Government Resolution on health-promoting nutrition and physical**

**activity** in cooperation with its own committee on health-promoting physical activity and an advisory committee on nutrition from the Ministry of Agriculture and Forestry. One key goal of this Resolution will be to reduce socio-economic inequalities related to physical activity and nutrition.

Many other countries, such as the Sweden, Britain and Norway, have actively developed actions and programmes designed to reduce health inequalities (annex 2). Experiences in these countries indicate that reducing health inequalities means allocating considerable resources to developing and testing related measures.

### **1.3 Socio-economic health differences and inequalities**

Socio-economic health inequalities mean systematic differences between socio-economic population groups in terms of their state of health, morbidity and mortality. The most common indicators of socio-economic status are education, occupation-based social class, labour market standing, and income and assets. These indicators are closely inter-related, but each also has its own independent link with health. Socio-economic health inequalities partly overlap with other health inequalities by population group, the most important being differences in gender, marital status, geographical location and ethnic group.

Health inequality refers to unjust variations in health. That means health differences clearly affected by social factors, the occurrence of which cannot be interpreted solely as the result of a person's exercise of free choice or unavoidable biological factors. When we speak of health inequalities, we usually specifically mean socio-economic differences.

Health is one of the main dimensions and factors in overall well-being, others being education, employment, living conditions, living environment, family relations, social relations, and financial and political resources. Deficiencies in well-being, such as poor health, may accumulate in certain population groups, leading eventually to a deepening of the social divide.

Demographic research demonstrates consistently that as social standing improves, so too does a person's state of health. This phenomenon is called the social gradient in health.

## 1.4 Present situation in health inequalities and current trends

The average state of health of the Finnish population has improved in many respects over the last few decades, but socio-economic inequalities have largely remained unchanged and in some areas they have grown.<sup>1</sup> Differences in life expectancy come out particularly clearly. A 35-year-old Finnish man in the upper white-collar bracket can expect to live six years longer than a working man of the same age; among women, the difference is something over three years. There are similar differences between the educational groups, and these have grown appreciably in the last two decades.

There are also distinct differences in morbidity. Long-term morbidity is roughly 50 per cent more common in the lowest educational and social groups than in the highest groups. Socio-economic differences in functional capacity and work ability and in self-rated, i.e. subjective, health are also great. Serious mental problems are also more common in the lowest socio-economic groups.

Because those with poor social standing die younger and suffer more commonly from disease and disabilities, differences between the socio-economic groups in healthy lifespan are actually much greater than the overall differences in life expectancy above. Calculations from 1990s data found that 25-year-old men and women with a tertiary education could expect to live an average of 13 healthy years longer than those with only a basic education.

Lifestyle currently has a major impact on the health of the population. It also displays clear differences according to socio-economic status, especially among those of working age. However, differences are

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<sup>1</sup> Research findings on the extent of and changes in health inequalities in Finland over the last 25 years are compiled in a report by Palosuo H, Koskinen S, Lahelma E. et al (ed.). Finnish title *Terveyden eriarvoisuus Suomessa*. Ministry of Social Affairs and Health publications 2007:23.

already visible in younger age groups, foretelling even greater health inequalities later in life. High-risk drinking and smoking are estimated to cause up to half of the socio-economic differences in mortality among men of working age. Alcohol consumption has increased substantially overall, and drinking is fairly common in all socio-economic groups. However, heavy drinking and binge drinking are more common in the lowest socio-economic groups, so the harmful effects of alcohol there are many times those in the highest groups.

Socio-economic differences in smoking among those of working age are growing. As regards the impact on children, it is significant that mothers and fathers with little education smoke more during pregnancy than others. Youth studying at vocational institutes smoke and binge drink far more often than their contemporaries at upper secondary schools.

There have been encouraging changes in Finnish eating habits during the last few decades: consumption of vegetables and fruits has increased, while that of dairy products has decreased. However, people of good socio-economic standing tend to follow the recommended diet more commonly than others. Socio-economic differences in overweight people begin as early as infancy. Mothers with little education breast-feed for a shorter time than other mothers and give their babies supplementary food earlier than is recommended.

Recreational exercise among children and adolescents is known to vary according to the family's socio-economic status. Success at school and educational level seem to be linked with physical activity: those children who do poorly at school and abandon their studies early on exercise less than those who continue their education longer. Among men of working age, recreational exercise continues to be most common in the highest socio-economic groups. Socio-economic differences in the biological risk factors of chronic diseases causing the highest number of deaths, high blood pressure and cholesterol and classification as overweight remain great.

There are socio-economic differences in use of the health services that do not correspond to the estimated service need; rather, they reflect the unequal targeting of services and care. There are differences,

too, in hospital treatment of serious diseases: for instance, relative to the need, more heart bypass surgery and joint replacements are carried out on the affluent than those of limited means.

## 1.5 Justifications for reducing health inequalities

Several justifications for reducing health inequalities can be put forward in terms both of ethical acceptability and social significance, and of financial impact and public health impact.

### 1) *Health inequalities are not ethically acceptable*

Preventable health inequalities cannot be viewed as just in a welfare society aiming at equality among individuals and population groups.

### 2) *Poor health is a factor in social exclusion*

Reducing health inequalities in a way that improves the health of the disadvantaged can increase social cohesion. This is also a question of safeguarding human rights, a matter considered important in a Nordic welfare state.

### 3) *Public health can be improved most effectively if we can succeed in boosting the health of the population groups where health problems accumulate.*

From the viewpoint of the whole nation's health, we can say that most of Finland's public health problems affect the groups with little education: for instance, over half of all diabetics and daily smokers are in the group with only a basic education, while a mere 10% fall into the group with tertiary education.

### 4) *Reducing health inequalities helps safeguard adequate services*

It is estimated that, as the population ages, the need for help and care will rise 40 per cent between 2000 and 2015, and as much as 80 per cent between 2000 and 2030. The increase in service needs can be reduced if we can improve the functional capacity specifically of poorly educated ageing people. For instance, the number of Finns suffering from walking problems would fall by half if the occurrence of these problems in groups with little education were to fall to the level among the highly educated.

*5) Reducing health inequalities will restrain costs*

The fact that a large proportion of the population falls far short of the health level possible in principle gives rise to substantial costs and loss of income at all levels – to the national economy, to local government and to individual households.

*6) By reducing health inequalities we make it possible to raise the employment rate*

If we wish to ensure a sufficient labour supply and raise the age of retirement, it is sensible to invest in increasing the working capacity and ability to continue working, specifically among those in blue-collar occupations with only a basic education. About half of all those aged 30-64 who consider their working capacity limited only have this basic education.

## **1.6 Reasons for health inequalities and areas where social policy has an influence**

Health inequalities emerge because of the combined impact of many factors. Behind the differences between population groups there lies an unequal distribution of material, social, informational and cultural resources in society. The reasons for health inequalities are thus bound up with social structures (e.g. income distribution and the education system) and with working and living conditions. Working and living conditions detrimental to health are links in a chain that leads from poor socio-economic status to poor health. Traditions, values, attitudes and social networking also guide behaviour patterns differently in different population groups.

Health care may also aggravate health inequalities between groups. Research has demonstrated that, relative to need, those with a good income receive more surgical treatments, health checks, home care and support services and psychotherapy than others, and they also visit a doctor more often. These differences derive at least partly from the structures of the service system. Generally speaking, the significance of various background factors may vary at different times and in different

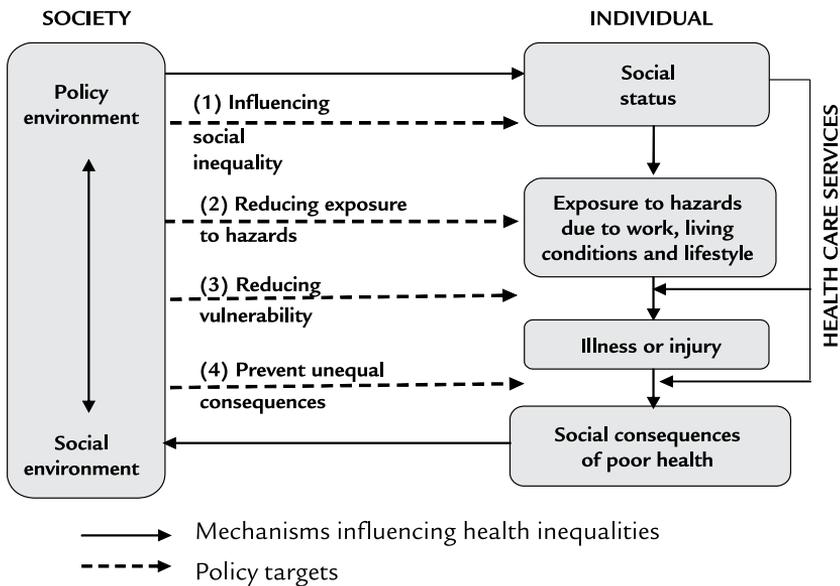
countries, and depend for instance on the particular health sector or population group studied.

The roots of socio-economic health inequalities lie in childhood, because some children have to grow up in poor living conditions and environments. Factors detrimental to good health tend to concentrate around those with low social status, little education and low income. They are also ‘inherited’ from one generation to the next. Similarly, if we look at the population as a whole, factors promoting good health concentrate around advantaged groups.

Health inequalities between social groups are not the result of some natural law, but the result of human activities and social decisions. Which means that they can also be reduced by social activities and decisions. Figure 2 shows a model of the mechanisms affecting health inequalities and areas where social policy has an influence. The National Action Plan to Reduce Health Inequalities aims to target the reasons behind health inequalities and to cut the chains of cause-and-effect at various policy levels.

Social policy methods can be used first and foremost to influence the socio-economic resources of well-being, such as education, incomes and employment (target area 1 in the figure). These factors determine people’s standing in social hierarchies. Secondly, it is possible to improve the working and living conditions and lifestyles of the disadvantaged (target area 2). Thirdly, action can be targeted at support for individuals in a vulnerable position, softening the impact of risks and reducing susceptibility to disease (target area 3). Fourthly, existing damage can be repaired and the effects of poor health prevented from affecting people’s livelihood and living conditions (target area 4).

Figure 2. Framework of background factors leading to health inequalities and areas where social policy can have a potential influence.



Source: Diderichsen F, Evans T ja Whitehead M. 2001. The Social Basis of Disparities in Health. Teoksessa Evans T, Whitehead M, Diderichsen F, Bhuiya A ja Wirth M (eds.). Challenging Inequalities in Health. The Rockefeller Foundation, Oxford University Press.

Health problems caused by genetic and biological factors are not included among socio-economic health inequalities. Even so, some of their consequences can be softened by equal health services and rehabilitation.

Within the policy of reducing health inequalities, it should also be noted that political and economic decisions that affect health are increasingly made at the EU level and globally, as well as at the national, regional and municipal levels.

## 1.7 General principles of the National Action Plan to Reduce Health Inequalities

Public health is largely determined by factors beyond the scope of health care, such as working conditions, lifestyles, the environment and product quality. National and local government affect the preconditions for people's health through all their sectors of administration.

Private enterprise and various interest groups also have a major impact on health and the preconditions for it. Local decisions in different sectors and involving different actors, affecting everyday life in homes, day care centres, schools, workplaces, services and transport can either promote or damage health. The impact may be different for different population groups.

Health in All Policies (HiAP) is a strategic approach which aims to enlist every area of policy to support better public health and well-being. For a long time now, the WHO has been translating health targets into social policy and cross-sectoral health promotion. During its EU Presidency in 2006, Finland made Health in All Policies approach the main focus of its health policy. The concept of a horizontal, comprehensive health policy has grown in strength in the EU and the Health in All Policies principle is incorporated into the Union's health strategy.

The Health in All Policies approach also has great potential in reducing health inequalities. Persistent work is needed towards the same goals and by many parties together at the same time if this is to succeed. In all decision-making, at the national, regional and municipal levels, attention should be paid not only to the general health impact of decisions but also to their effects on different socio-economic groups. The health sector must harness its expertise to helping other administrative sectors to ensure that their activities promote health and reduce health inequalities.

However, the health sector is not the only one that needs to cooperate with other administrative sectors. In its decision-making and pursuit of its own goals, each sector is equally dependent on all the others. Resources must therefore be invested in promoting collaboration between the various administrative sectors and different organisations and actors.

In international cooperation and EU policy, it is also important to bring out the traditional values and goals of Nordic welfare policy, which strongly endorse equality considerations.

In many respects, the policy of reducing health inequalities calls for what could be called dual strategies. The National Action Plan embodies the guiding principle of health policy programmes, to achieve both

a good health standard and an even distribution of good health among the various population groups.

The National Action Plan is aimed at both the most disadvantaged groups and the largest groups that find themselves in the middle of the health care spectrum. One aim is to launch measures to improve the health of specifically the most disadvantaged, such as the long-term unemployed. Another is to bring the health of all socio-economic groups as close as possible to the level that the most advantaged have already reached. That means raising the health of, for instance, poorly educated blue-collar workers and low-income population groups closer to the level enjoyed by highly educated, upper white-collar groups with a good income.

The National Action Plan strives throughout also to pay attention to certain special groups such as immigrants, families suffering from intoxicant or mental health problems, single parents, school drop-outs, those unable to complete or not participating in military or non-military service, those in mental health rehabilitation, old people living alone, the homeless and those just released from jail. These groups are extremely heterogeneous, and not everyone in such a group is necessarily socially disadvantaged. In some cases, individuals suffer from several factors endangering their health, and these groups can be described as vulnerable.

Universal services that are available to all and from which everyone benefits form the essential basis for work to reduce health inequalities. However, they do not solve all the problems of the most disadvantaged. Universal services must therefore be supplemented with measures aimed specifically at such people.

## 2 STRATEGIES AND MEASURES

Measures under the National Action Plan are based on meetings with experts within the Advisory Board for Public Health and its sub-committees, and the views of expert groups consulted in the preparatory work. They represent key actions to combat health inequalities where insufficient progress is being made otherwise and that can be launched within the term of the present Government.

Also covered by the National Action Plan are measures within other programmes and projects that have direct effects on health inequalities or the factors behind them. Including these measures in the Plan is intended to add impetus to their work.

### 2.1 General social policy actions to reduce health inequalities and prevent social exclusion

Important preconditions for health and well-being are sufficient income, a place to live and opportunities for work or other rational activity. Confidence in society and other people and a sense of security are other important factors contributing to good health. If these basic elements are lacking it may be impossible to improve a person's state of health or even maintain it.

Social exclusion can be defined as a process of decline in which problems accumulate in various areas of life, feeding upon each other. Exclusion finds expression in various dimensions: as exclusion from education and training, from work, from social relations and from opportunities to influence matters. The process often also involves health-threatening lifestyles. Problems may also be transferred from one generation to the next.

### 2.1.1 Reducing poverty

There may be several reasons behind a poverty trap. Research shows an increasingly clear link between long-term unemployment and poverty. Other individual or combined reasons for poverty might be an inadequate wage or pension, being a single parent, high housing costs, and high outlay on health care, medicines, aids and treatment. Poverty may also be a consequence of short-term jobs repeatedly followed by long periods of unemployment, and the relatively low level of labour market subsidies and social benefits in place for those who are down on their luck, such as income support and housing allowance.

Poor financial and social living conditions in childhood increase the risk of social exclusion and have a powerful impact on adult health. Poverty and deprivation often persist from one generation to the next. Poverty in the childhood home has been found to mean a double risk of poverty in adulthood. The percentage of children living in families below the relative poverty threshold (child poverty rate) has been rising since the 1990s in Finland. In 2005 it was around 12 per cent, compared with only 5 per cent in 1995. The situation of single parents, families with small children and those with many children is worse than in other families. In 2005, a quarter of all single-parent families were on income support.

In autumn 2007 a broad-based group of experts published a report 'Problems of basic security and reform alternatives'.<sup>2</sup> This concluded that **basic social security benefits**, such as old-age pension, the basic daily rate of unemployment pay and labour market subsidy, minimal parental benefits, the daily sickness allowance, child benefit and study grants should all be raised and tied to the cost-of-living index.

A good social security system prevents and corrects social exclusion and marginalization. It should be client-oriented, flexible and react rapidly to people's real needs and situations. The Government Programme includes a total overhaul of social security (SATA), assessing the need to review **taxation, basic security** (including housing allowance) and

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<sup>2</sup> Särkelä R, Eronen A (eds.). Perusturvan pulmat ja uudistamisen vaihtoehtot. Sosiaali- ja terveysturvan keskusliitto ry. 2007.

**unemployment security.** The position of recipients will be improved by **simplifying and clarifying the system**, also ensuring that the funding of social security is on a sustainable basis in the long term.

At the same time, the **taxation of social benefits and client charges** will also be reviewed. Government plans for the **social insurance legislation and income security** in working life will be drawn up in consultation with the social partners.

Under the Ministry of Education's current child and youth policy development programme, special attention should be given to **income trends in low-income families** with children and care taken to maintain the level of **family policy income transfers**. Its Policy programme for the well-being of children, youth and families also includes the goal of reducing poverty among families with children, which will help promote equality among children. To this end, the programme is monitoring the work and proposals of the SATA committee set up to reform overall social protection. The programme is also assessing the feasibility of **alternative low-cost housing solutions** for all population groups and all regions equally.

Kela, the Social Insurance Institution of Finland, is responsible for various social security benefits designed to reduce social inequalities through income transfers and services, and thereby also reducing health inequalities. However, no assessment has been made of how far these benefits actually reduce health inequalities. An appraisal of the situation is particularly timely just now, when social protection as a whole is being reformed. Kela is planning an assessment of the benefits within its remit from the viewpoint of health inequalities.

### **2.1.2 Improving ways in which comprehensive schools can prevent and reduce health inequalities**

The Finnish constitution requires government to ensure that everyone has an equal chance of education to suit their talents and special needs, and to develop themselves despite lack of financial means. Comprehensive schools have ways of intervening in elements in

their pupils' development paths prompting health inequalities when these arise from the home background, learning difficulties or other factors.

According to the Ministry of Education's 'Education and research 2007–2012' development plan, efforts are being put into reducing drop-out rates and ensuring that pupils get through all the relevant levels of comprehensive schooling. **Study guidance, collaboration between home and school and school health care** are all targets for development. The **flexible basic education (JOPO) scheme** and guidance and **preparation for vocational education** will be made permanent.

The Ministry of Social Affairs and Health is drafting a decree to define for instance the **role of health checks and counselling in school health care**. The aim of the decree is to promote better identification of individual service needs, special needs and other targeted measures, to improve guidance into further care, and to benefit from various kinds of professional expertise. The Policy programme for health promotion also directs attention to the development of school health care.

The Development programme for child and youth policy proposes that all 1st and 2nd grade pupils should be guaranteed a **place in morning and afternoon activities**, whether their family can afford it or not, and that children in a less advantaged position financially must be able to take part in municipal **recreational activities**. The programme calls for a provision to be added to the Youth Act (72/2006) on the activities of **municipal groups enabling cross-sectoral professional collaboration**. These groups, representing municipal departments for health and social affairs, youth and schools and the police, are to work full-time with parishes and NGOs to promote good living and growth conditions for children and youth. The collaborative role of schools will be reinforced via their own pupil welfare services. The present National Action Plan also deals with these collaboration groups in section 2.1.4.

In 2006 the Ministry of Education launched a several-years-long action programme to increase well-being at school, prevent social exclusion and develop schools into communities that genuinely promote their pupils' well-being. The main focuses are:

- problem prevention and early intervention (peer conciliation, LukiMat)
- reduction in bullying (KiVa)
- discouraging children from dropping out (JOPO flexible schooling project)
- developing the structure of pupil services
- increasing pupil participation
- expanding morning and afternoon activity programmes

According to the aims of the Ministry's programme to improve basic education, special central government grants for raising the quality of comprehensive school teaching will be channelled into improving instruction and other help for pupils in need of special support, and into developing pupil guidance. The focus of teaching for pupils needing special support will shift to preventive support at an early stage. Pupil guidance at the basic level, and specifically careers guidance, will be increased at key stages in the education process. A further aim is to reduce class sizes, and promote club activities and collaboration between home and school.

As part of the Policy programme for children, youth and families, a basic survey will be made of the support services provided for children and youth and their availability.

The Advisory Board on the health and well-being of children and youth at the Ministry of Social Affairs and Health monitors changes in health and welfare inequalities among children, youth and families, and helps to steer development work.

### **2.1.3 Promoting the health and well-being of youth at vocational schools**

About 10 per cent of all adolescents who start vocational school drop out at some stage. The health of students at this level is poorer than average, and they display risk behaviour and symptoms more commonly than their contemporaries at senior secondary school. Student welfare services and health care clearly work less effectively here than elsewhere. If the current harmful trends in these students' health and

well-being are not forcefully halted, health inequalities between vocational and educational groups will persist and perhaps grow even greater.

The Ministry of Education's Development plan for education and research states that school graduation rates must be improved. To reduce dropping-out, **study guidance, information and consultation about courses, etc., student selection, study grants, individualized study processes and a system of study monitoring will all be developed, together with student health care.** The Policy programme for employment, entrepreneurship and worklife also directs attention to reducing drop-outs from vocational education, in order to secure the future labour supply.

The Ministry of Social Affairs and Health is currently drafting a decree that will for instance define **student health care** in greater detail (see also section 2.1.2.). The Policy programme for health promotion also directs attention to developing student health care.

Together with the National Board of Education, the Ministry of Education is developing its **work health passport** for vocational students, to encourage them to look after their functional and working capacity. The idea behind the passport is to increase students' knowledge, skills and motivation in looking after their own well-being while they are studying, ensuring both a smooth transition into working life and a better ability to cope well there. A further aim is to encourage training providers to arrange leisure activities and include students in planning, aiming at a well-functioning study environment. The experimental programme began in autumn 2008.

The Advisory Board on the health and well-being of children and youth at the Ministry of Social Affairs and Health monitors changes in health and welfare inequalities among children, youth and families with children, and also contributes to steering development work.

### **A measure of the National Action Plan to Reduce Health Inequalities:**

1. The municipalities will, jointly with other actors, arrange student health services in vocational education in accordance with national guidelines. Education providers will develop student health welfare services at schools and institutes, and instruction in health information. The National Public Health Institute and STAKES will develop information about good health promotion practices and disseminate it among education institutes.

#### **2.1.4 Ensuring that youth receive sufficient support at key transition points between schooling and working life**

Structural changes in working life have brought stiffer demands for qualifications and have increased the risk of exclusion from working life among youth who do not get beyond a basic education. This also enlarges their risk of deprivation in other areas of life throughout their adulthood. Failing to complete, or even to enter, military or non-military service may also bring problems in various aspects of life. Ensuring that such youth complete their education and then properly enter working life is one way to prevent social exclusion and reduce health inequalities.

As well as at schools, transition stage work is being done in the labour administration, in social affairs, at workshops and in youth activities. The target groups are adolescents finishing comprehensive school who do not yet have a place in secondary education, drop-outs from secondary studies, and the unemployed and others who are clients of the labour administration. In practice, this work may for instance include improving comprehensive school grades, help with choosing a career and instruction in social skills.

Within the Policy programme for employment, entrepreneurship and worklife, more energetic labour policy actions will be targeted at getting youth firmly into the labour market.

The measures proposed in the Development programme for child and youth policy to further the education, training and employment of the above-mentioned youth include the following:

- The Youth Act (72/2006) should contain provisions on the activities of cross-sectoral collaboration groups at municipalities. Every municipality must have a cooperation group with members representing its employment office, social welfare and health care sectors, youth services and schools, charged with monitoring how successful youth find a place in further education and working life.
- Each young person under the age of 25 without work or a study place must be given the opportunity to receive help in drawing up a personal plan and support in carrying it out.
- Regular monitoring of the number of youth excluded from further education and working life and their backgrounds.
- A guarantee that the availability of guidance services provided for youth by the labour administration will not fall below the present level.
- Increase easily-accessible guidance provided by municipal youth services.
- Workshop activities will be increased as needed in areas where they do not yet exist.

The Act on Public Employment Services in Finland refers to a **‘social guarantee for youth’** affecting unemployed young people under 25. Under this guarantee, every unemployed young person under 25 must be provided with a place in training or education, a traineeship, work in a workshop or a job within three months of becoming unemployed. Each employment office is responsible for this in its own area.

The **Youth Participation Project** carried out by the National Board of Education in 2003–2007 formulated new operating models for the transition stage referred to above. The project website contains a ‘practices bank’ comprising 37 good practices developed in local projects.

For those not participating in military or non-military service, an operating model called ‘**Time out!** Getting life on track’ has been formulated which has had promising results. The Policy programmes for health promotion and the well-being of children, youth and families promote extension and establishment of this operating model throughout the country.

The Advisory Board on the health and well-being of children and youth at the Ministry of Social Affairs and Health monitors changes in well-being equity among children, youth and families with children, and helps to steer development work.

### **2.1.5 Providing work for the long-term unemployed and those living on disability pensions or rehabilitation assistance**

Increasing involvement in working life is an important economic and human goal in society. For instance, the rise in the total sum of disability pensions is a burden on the dependency ratio and increases the risk of excluding these people permanently from the labour market. Opportunities for those rehabilitated after a long period of disability to return to working life are few and far between.

According to Policy programme for employment, entrepreneurship and worklife, solutions to the problem of getting those difficult to employ back into paid work on the labour market must be sought not only using labour policy methods but also by improving the functioning of the **interim job market** and ensuring that the **social security system actually encourages people to work**. Social enterprises, rehabilitative work, adult workshops, easily accessible jobs, and rehabilitation and health services for the unemployed will be focus areas in developing the interim work market in the near future. Ways for social security to encourage people to work will also be studied by the SATA committee, which is working on an overall reform of social protection.

The Ministry of Employment and the Economy has a key role to play in promoting the interim job market as a means of providing employment for people with only partial disability. In 2007 the Ministry

appointed a special adviser to chart the preconditions for employing people living on rehabilitation allowance and disability pension, and for giving them a chance to return to working life. A report called 'New opportunities for those who want to get back to work' was issued in March 2008. The special adviser estimated that some 30,000 people on disability pension would like to re-enter the workforce, and proposed for instance the following measures:

- those with partial working capacity wishing to transfer back from disability pension to work should be able to use all the services and job-finding support provided by employment offices
- wage support should be granted towards the pay costs of a person on disability pension
- long-term wage support should be paid to social enterprises employing a former pensioner
- employers should be paid support for recruiting a person on disability pension
- a monthly earnings ceiling of EUR 700 will be set for disability pensions and a guaranteed pension system will be set up for pensions under the Employees' Pensions Act
- attention will be paid to improving occupational safety and health and well-being at work at social enterprises, and funding possibilities explored

Those difficult to employ are often clients of both the labour administration and the social and health services. Actions to be carried out under the KASTE programme are covered in section 2.3.3.

### **2.1.6 Making health promotion a permanent feature at the workplace**

The workplace is the main arena for promoting the health of people of working age. Action to further health and well-being is particularly important in those working sectors particularly susceptible to health risks, such as the construction industry, the cleaning business, the ho-

tel and restaurant business, and transportation. It is here, too, where lifestyles detrimental to health are most common.

Workplaces have good opportunities for collaborating with health care services in the promotion of staff health and work capacity. Well-being at work can be furthered by improving the functioning of work communities and organizations, by improving occupational and work environment safety, by promoting the vocational skills of the staff, by supporting the working ability of the staff and by influencing their habits.

A joint development project with the Policy programme for health promotion is being carried out within the National Action Plan to Reduce Health Inequalities to formulate **criteria for a health-promoting workplace**, launch a **well-being at work forum**, and disseminate the **good practices** generated in various programmes to develop working life and well-being at work more widely at workplaces. With an eye to lengthening people's working careers as laid down in the Policy programme for employment, entrepreneurship and worklife, it is also important for cut career interruptions caused by health problems to a minimum.

### **A measure of the National Action Plan to Reduce Health Inequalities:**

2. The Institute of Occupational Health, in broad collaboration with other actors, will develop action to promote health in those fields and sectors where factors detrimental to health are present and harmful lifestyles are common.

## **2.1.7 Reducing homelessness**

Homelessness is a social problem that has proved particularly difficult to solve. It is especially hard to find homes for several kinds of people, including those in mental health and intoxicant abuse rehabilitation programmes, clients with dual or multiple diagnoses, and persistent re-offenders in the justice system. Persistent re-offenders are known to

be the poorest, most disadvantaged and sickest members of the Finnish population. There are not very many such people, but they are the most socially marginalized in a process that reaches out into many areas of life, so it is right and proper to seek to develop subsidised and other service housing to meet their special needs. Research has also found that some people are able to turn their lives around if they receive sufficient support.

On 14 February 2008 the Government passed a resolution on a housing policy programme. This addresses housing-related issues and development measures throughout the country. A separate programme aimed at reducing long-term homelessness will create the necessary preconditions. It includes the following measures:

- Building more housing in growth centres and specifically in the Helsinki region, and ensuring adequate rental housing there
- Improving the housing situation for special groups, such as the homeless, those suffering from mental problems, and disabled older people in poor condition.

## **2.2 Influencing lifestyles through policy**

The areas of policy affecting lifestyles dealt with here concern policies on drinking, smoking, and physical activity and nutrition, as research identifies these to be the most important areas affecting socio-economic and gender differences in morbidity and mortality. Excessive drinking that poses a risk and smoking lie behind up to half of the cases that cause a difference in life expectancy between blue-collar and upper white-collar workers. If we are to reduce socio-economic inequalities in obesity levels, we must also influence nutrition and physical activity. Physical activity is also important for reducing inequalities in general fitness and mental health.

### **2.2.1 Reducing excessive drinking**

The pervasive drinking culture and the immediate environment have a major impact on alcohol consumption. According to research, heavy

drinkers change their habits according to what the rest of the population are doing. Consequently, efforts to reduce overall consumption aimed at the whole population must continue. These include raising the consumer price of alcoholic beverages and restricting availability. Intervention in price and availability are also among the best ways of influencing consumption by youth. It would be good idea to incorporate into the Alcohol Tax Act a mention of the importance of the tax in reducing consumption and health hazards, similar to the mention included in the Tobacco Tax Act. The Policy programme for health promotion notes the need to change **alcohol taxation**. At the beginning of 2008, the tax on strong liquors was raised 15% and the tax on wines and beers was raised 10%. It has also been decided to carry out a further increase during the term of the present Government. The aim of the KASTE programme approved by the Government on 31 January 2008 is to bring overall alcohol consumption down to the 2003 level (9.4 litres per capita) by 2011, which would mean a roughly 10 per cent drop on the 2006 level (10.3 litres).

As well as these measures affecting the whole population, it is also important to help heavy drinkers and other special groups to reduce their intake and eliminate the harmful effects. The various thresholds facing intoxicant abusers that make services inaccessible, like the need to meet scheduled appointments and the fact that those in a state of intoxication are barred from access to treatment, make it difficult for the socially excluded to get the help they need. Municipal budget appropriations for such services often run out in mid-year, making it difficult for those repeatedly needing institutional care to gain access to it.

Preventive work with intoxicant abusers is closely linked with the creation of functioning and living environments that promote their well-being and health. Such work is done not only by municipal social and health services but by various other departments, such as education, youth services and recreation. Other organisations and businesses also play an important role. The three-step intoxicant abuse services process of prevention, treatment and rehabilitation requires resources for better planning and coordination.

In the case of drinking, the Policy programme for health promotion supports intensified use of **risk assessment and mini-intervention** in primary health care and occupational health services, and their wider use in special medical care and social services. Through its **training development project in intoxicant abuse services**, STAKES should promote networking among teachers in this specialist area, and develop further training for educational institutions and teachers. The Finnish Centre for Health Promotion is carrying out a similar project among those working in organisations. Under the Policy programme for health promotion, the Ministry of Social Affairs and Health is drawing up a proposal for setting up system for identifying and treating **pregnant women with intoxicant problems**. Action should also be taken in the case of expectant fathers. Under the Policy programme for children, youth and families, children and adolescents are provided with **support services** particularly when there are problems with violence, mental health or intoxicants in the family. The Development programme for child and youth policy also proposes that **collaboration among child protection, intoxicant abuse and mental health services** should be increased, allowing the need for protection and rehabilitation among the children of parents needing adult services to be recognised, and children and adolescents suffering from intoxicant and mental health problems to be helped.

The Internal Security Programme focuses on the importance of recognising accidents associated with intoxication as a risk factor in personal security. Housing arrangements for those with intoxicant problems must take account of their high accident risk and provide guidance for living safely.

### **Measures of the National Action Plan to Reduce Health Inequalities:**

3. The alcohol tax will be raised to reduce consumption to or below the 2003 level. The need for tax increases will be reassessed annually.
4. Municipalities will incorporate substance abuse prevention into the structures of health and well-being promotion and integrate substance abuse services smoothly into other social services and health care.

### 2.2.2 Reducing smoking

Smoking is highly polarised according to educational group at the moment. Only about ten per cent of all smokers fall into the most highly educated bracket. Smokers know about the health risks of smoking, and no appreciable reduction in the habit can be attained with provision of conventional information. Prohibitions on smoking must be encouraged as an automatic feature of people's everyday environments, such as schools and colleges (see section 2.1.3), recreational facilities and small workplaces (see section 2.1.6). Health clinics specialising in maternity and child care should discourage parents' smoking from the onset of pregnancy. The cost of tobacco products must be raised through taxation, availability must be restricted, and people who want to stop smoking should be assisted.

For the spring 2008 session of Parliament, the Ministry of Social Affairs and Health drafted a bill for an amendment to the Tobacco Act which proposes that **retail sale** of tobacco products should be made subject to permit, and processing and grant of permits, together with **supervision of sales**, made subject to a charge. The Ministry has set up a Working group on smoking that submitted its interim report on proposals for increasing the tobacco tax in early May 2008. The group proposes that the tax should be raised gradually at the beginning of 2009 and 2010. It is drafting a proposal for an **increase in the tobacco tax** and structural changes, together with various measures to avert the threat of **illegal trading** likely to result from price hikes. Tax-free imports of tobacco products by those travelling from new EU member states is threatening to give rise to a dual pricing system in which sales of products taxed in Finland will fall while imports from neighbouring countries will rise many times over. If traveller imports of tobacco products is not restricted in the Tobacco Act, smuggling and onward sale to underage youth will increase.

According to the Policy programme for health promotion, **treatment for weaning smokers off tobacco** will be made a standard part of the care of every patient with an illness caused totally or partly by smoking. Pharmaceutical input will also be utilized in advisory serv-

ices. **'Best treatment' recommendations** will be integrated into regular health services, and stepped up during pregnancy and for families with small children.

### **A measure of the National Action Plan to Reduce Health Inequalities:**

5. The tobacco tax will be raised gradually, at the beginning of 2009 and 2010, in order to achieve an appreciable reduction in smoking. At the same time, legislative action will be taken to limit traveller imports and under-the-counter trading. A decision will be made on the inclusion of tobacco and nicotine addiction withdrawal drugs in health insurance coverage.

## **2.2.3 Promoting a healthy diet and exercise**

The objective of increasing healthy eating habits and exercise can best be achieved by improving the availability of healthy food and opportunities for exercise in the day-to-day environment. Non-specific methods available to all that seem to be effective include support for meal provision at day care centres, schools and workplaces, advice on nutrition and exercise at health clinics caring for mothers and children, the integration of exercise into the normal functioning of day care centres, schools and workplaces and leisure activities and supporting walking, cycling and the use of public transport.

The **Government Resolution on health-promoting nutrition and physical activity** currently in preparation will have an impact by 1) influencing the environment, living conditions and structures, 2) ensuring that everyone has sufficient information and skills as a basis for healthy choices, and 3) encouraging and helping people to make such choices. An implementation plan will be appended to the resolution listing projects to promote these goals. These projects will aim to promote physical activity and healthy diet among different population groups and ages, develop the everyday environment and recreation centres, take exercise and healthy diet into better account at various levels of decision-making, and promote training, research and monitoring

related to exercise and diet. All activities will strive to consider the viewpoint of the most disadvantaged.

The Policy programme for health promotion proposes that the Ministry of Social Affairs and Health appoint of a **group to monitor and develop various forms of group meal provision. Maternity and child welfare clinics** must pay due attention to overweight parents and to exercise and dietary habits from the onset of pregnancy, and be in a position to provide more comprehensive individual advice and guidance regarding everyday activities (e.g. family exercise opportunities, instruction in healthy food preparation) in cooperation with local organisations. In addition, there should be support for breastfeeding according to national recommendations, particularly in the case of mothers with little education.

The Policy programme for health promotion includes exploring the potential for providing **free or inexpensive opportunities for physical activity for older people**. The programme also supports launch of a **joint project package** between municipalities and, for instance, organisations specializing in physical activity, where the target would be overweight children and adolescents and their parents, and families, children and youth of low socio-economic standing. The Policy programme for the well-being of children, youth and families promotes **joint municipal projects providing afternoon exercise activities**.

### **Measures of the National Action Plan to Reduce Health Inequalities:**

6. Promote the availability of reasonably-priced meals that comply with nutritional recommendations, particularly at small workplaces and among employees required to travel frequently, in accordance with the recommendations of the Working group on monitoring and developing mass catering services.
7. A Government Resolution on health-promoting nutrition and physical activity will be formulated. On this basis, action will be launched to safeguard adequate exercise and healthy diet for the most socio-economically disadvantaged and marginalized.

## 2.3 Developing social welfare and health care services

The Finnish constitution states that every person has the fundamental right to adequate social welfare and health care services. It is the government's task to ensure that these services are provided to meet the actual need and not, for instance, according to the client's paying power or place of residence. At the moment, this objective is not adequately met.

The system of social welfare and health care services must ensure equal treatment of diseases, and prevent or at least reduce their social and financial consequences. Health promotion and preventive work play a key role in reducing health inequalities in this process. The challenge is to make preventive work an integral part of the whole system's basic structures and activities, including its information systems and management.

According to the 2003-2007 Development project for social services,<sup>3</sup> the social services in many municipalities tend to focus on responsive work and work resembling first aid. Services for older people are viewed as the weakest link in the chain. There are staff shortages in home and institutional care and deficiencies in working practices. In addition, the whole country suffers from a shortage of competent social workers, and the smallest municipalities sometimes find themselves without a single qualified social worker. As regards timeliness of assistance, the project points to shortcomings in the client orientation of the social services, especially the offices, where service guidance, for instance, should be improved. Inadequate information provision by the social services and the lack of sufficient assessment data on services were viewed as key obstacles to the services' ability to provide and develop services in a timely manner. There are significant deficiencies in charting services needs, statistics, data compilation and assessment of service quality and impact.

In the last few years, great inequalities have emerged between the social strata in mortality that the health services could have prevented. A large amount of research data has accumulated in the last few years

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<sup>3</sup> Sosiaalipalvelut toimiviksi. Sosiaali- ja terveystieteiden tutkimuskeskuksen selvityksiä 2007:3

showing that access to various types of service favours those in a better position socially. Recent findings also indicate similar inequalities in coverage and quality of care. Though monitoring of individual diseases has developed considerably, the health services lack any standard practices for assessing the coverage and quality of the care given. The target must be a system able to guarantee that methods to develop prevention and care provide the full health and well-being benefit for everyone living in Finland.

### 2.3.1 Developing social work and primary health care and cooperation between the two

Social work plays a central role in the prevention of health inequalities. Its objective is to support the independent activities of individuals, families and communities. The basis of the work is the prevention of social problems and help for those in need so that they can cope with their situation. Social work must be developed further so that it can better promote and maintain the well-being of individuals and communities and social safety.

The Advisory Board for social work outlined the main areas for the development of social work until the year 2015 in its programme 'Social work as a tool for well-being policy 2015'.<sup>4</sup> The programme strategy is as follows: 1) building the **work orientations of social work** into an expertise basis, 2) changing the **structures and organisation of social work** so that they can meet client needs and be in accordance with social work expertise, 3) encouraging more **client participation** and strengthening the ethical principles of social work and 4) making the **training and research** of social work more focused on general research in the field and enabling them to address the rapid changes in society. The National Development Programme for Social and Health Care (KASTE) seeks to strengthen the **permanent structures of social work development** and their links with the universities and the universities of applied sciences.

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<sup>4</sup> Social work as a tool of welfare policy 2015 – an action programme. Publications of the Ministry of Social Affairs and Health 2005:13

Primary health care is the foundation upon which health promotion and efforts to reduce health inequalities are based. **Strengthening of primary health care** is one of the objectives of the new **Health Care Act** under preparation in the Ministry of Social Affairs and Health and reducing health inequalities between population groups and regions has been a major consideration in the preparation process. The Health Centre 2015 action plan, part of the KASTE programme, also contains recommendations on strengthening primary health care. Under the programme, the **promotion of health and health equity should be integrated more effectively into health centre operations**. Preventive health services that serve entire age groups must be strengthened and good cooperation with social services ensured. A primary health care **development unit** will be established at STAKES that will cooperate with health centres, universities and other institutions to produce information about best care practices and operational procedures and see to it that the necessary development tools are readily available. A service innovation project included in the KASTE programme will produce a Best Practices network supporting the process of making service innovations into products, and disseminating and implementing them.

**Development of occupational health care** is part of the Policy programme for health promotion and the work will be in line with the Occupational Health 2015 programme. The focus will be on small businesses, the construction industry, the hotel and restaurant business, temporary workers and the self-employed, and the issue will be examined from the viewpoint of health care equality. According to the Occupational Health 2015 programme, health guidance for the unemployed will be a cooperative effort between the occupational health care services, primary health care services, the employment service centres and social welfare services.

The present payment policy for social and health care is the result of numerous separate decisions made over the last few decades. In recent years the payment system has mainly been examined from the technical and financial perspectives. The entire payment system must be re-evaluated and the assessment should cover all social and health care services regardless of who is financing or producing them. In the evalu-

ation, consideration should be given to the general objectives of the social and health care policies and special emphasis should be on the implementation of the health equity objective. The SATA committee is already working on payment ceilings.

A substantial amount of research is available on the allocation of client payments and health care deductibles among population groups but not much is known about their impacts on the way the services are used. To estimate their effect, it may be necessary to launch a research project on the subject.

### **A measure of the National Action Plan to Reduce Health Inequalities:**

8. Social and health care services will be developed and allocated on the basis of the results of health monitoring among individual population groups or other identified needs.

### **2.3.2 Improving opportunities of day care services and child welfare clinics to prevent health inequalities as a part of networked services**

The socio-economic differences in well-being become apparent already at childhood. Parent unemployment, mental health or intoxicant abuse problems, insufficient income, poor living conditions and problematic living environments cause physical and psychological health problems among children and result in risky lifestyles. The number of children in need of child protection has grown and regional variations are great.

The health differences among children and youth can only be narrowed if more consideration is given to their well-being in legislation, planning and decision-making.

The system for predicting and assessing their impacts on children, currently under preparation, supports this aim. All endeavours to improve the well-being and involvement of children, youth and their families also help to reduce health inequalities. For this reason, it is necessary to improve the environments which influence the social and

physical growth of children and youth, support everyday well-being and ensure that universal services are available and that they are developed on a long-term basis. On the other hand, it is imperative to allocate correctly timed resources to those families, children and youth that are in danger of becoming marginalized. Support services must be provided as part of normal services and the children, youth and families must be properly consulted, while at the same time labelling should be avoided.

The KASTE programme aims to **reform child, youth and family services** by developing and consolidating basic services that support development and prevent and correct problems and disturbance across existing sectoral borders (e.g. health, social, youth, education and culture, and police work). **Special services** will also be developed to provide alternatives to basic services (e.g. children's psychiatry, child protection, child guidance and family counselling). According to the Development programme for child and youth policy child guidance and family counselling clinics' resources should be strengthened so that the threshold for supporting families with children could be lowered, and the support provided by **municipal home assistance services** should be more readily available for families in their everyday situations.

Reducing inequalities in well-being and health requires the development of a **cooperation framework for actors working with families with children**, which should be in line with models provided by family centres and family service networks. The cooperative framework will enable the resources to be targeted on the basis of the needs of families so that their health and well-being can be promoted. As part of these efforts, consideration will also be given to the needs of those in weaker socio-economic positions. STAKES will continue development of the family service network and take the assessment results of the 2004-2007 PERHE project into consideration in its work.

The Ministry for Social Affairs and Health is preparing a decree which will define, among other things, **the content of good family counselling services**, including health check-ups and health advisory services (see section 2.1.2 and 2.1.3 on the development of school and education health care). Early identification of the need for special sup-

port and the arrangement of the necessary assistance is also emphasized. It is proposed in the Development programme for child and youth policy that **guidance be prepared for clinics specialising in health care for mothers and children** in early identification of special needs and the arrangement of appropriate services. In the Policy programme for health promotion consideration is given to the work on the decree and **on allocating sufficient resources to the counselling services.**

Day care services for all children safeguard equality among children regardless of the financial situation of the families. The task of the Advisory Board for early education, which operated under the Ministry for Social Affairs and Health between 2005 and 2007 was to support the long-term development of early education in anticipation of the future needs. In its final report<sup>5</sup> the Board recommends that legislature covering such areas as **day care staff, the number of children to be cared for, children requiring special services and the foundation of the early education plan** should be reformed. The Board was of the view that families should be provided more **open and part-time options for early education services** as alternatives to full-time day care. **Special needs** must be identified at day care and **support services** must be provided.

The Unit for development of immigrant work in the Advisory Board for early education recommends that steps be taken to ensure that **children of immigrants** can participate in at least part-time early education by the time they are three years old. For children still in the sphere of integration services, the early education services should be free of charge.

The new **Child Welfare Act** (417/2007) which entered into force in early 2008 supports the prevention and reduction of health inequalities among children and youth. The new Act strengthens the status of **preventive child welfare**. Under the Child Welfare Act broad and systematic action must be taken in child welfare and in other social service sectors (such as day care and substance abuse services) and other municipal services (in clinics specializing in health care for mothers and children

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<sup>5</sup> Early child education and care up to 2020. Reports of the Ministry of Social Affairs and Health 2007:72.

and other fields of health care and education) so that child and family problems can be prevented. According to the Act, the bodies responsible for municipal social care and the other municipal authorities must jointly monitor and promote the well-being of children and youth and eliminate and prevent discrepancies in their living conditions. Municipalities must prepare a plan for the duration of the council term covering the **promotion of child and youth well-being and the organization and development of child welfare**. The plan will be a good basis for monitoring differences in well-being and health and for their long-term reduction. The KASTE programme includes the **practical implementation of the new Child Welfare Act**, which will be done by arranging **training in municipalities and other national guidance**.

The Advisory Board for the health and well-being of children and youth in the Ministry of Social Affairs and Health monitors changes in the health and well-being inequalities among children, youth and families with children and also participates in the guidance of the development work.

### **2.3.3 Developing timely and need-based rehabilitation for people of working age**

The Finnish rehabilitation system is intricate and, from the customers' point of view, complicated. Several stakeholders are involved in medical rehabilitation: primary health care and specialised health care actors, the Social Insurance Institution Kela, and accident insurance companies. In cases involving insurance companies, the services are provided by private rehabilitation institutions and other private sector health care companies. Occupational rehabilitation is provided by specialised health care actors, Kela, employment pension institutions, labour administration, and accident insurance companies, while the services are mostly provided by the private sector. Insurance company rehabilitation is in part arranged by VKK, the Insurance Rehabilitation Association of Finland. A specification of the tasks of different stakeholders in the distribution of occupational rehabilitation work has been prepared by the Advisory Board for rehabilitation matters.

A client can make use of parallel and partly alternative services, but the system as a whole is difficult to manage because each actor makes its own decisions. From the system perspective, it is apparent that each actor optimises the use of its own resources. The intricacy of the system also weakens the framework structure of the activities: an input by one system in rehabilitation may lead to an increase or decrease in costs in other systems.

An Act passed in 2003 on Client cooperation in rehabilitation requires that each municipality has a client cooperation group for rehabilitation with representatives of social services, health services, education, employment services and Kela as members. **Cooperation** between the actors in the rehabilitation system and the **distribution of work** among them must be further improved.

Research into rehabilitation needs has shown that the percentage of people in need of rehabilitation is significantly larger than the number of people who have actually received it. It would be important for rehabilitation equity that all those in need of rehabilitation would have equal access to the rehabilitation that is available. Factors such as social group, vocational field, employment and unemployment history and size of the workplace should not affect access to medical and occupational rehabilitation.

The need for rehabilitation must be identified early. Rehabilitation procedures should be timely and relevant to the work in question. To this end, **occupational health services** must be further developed and **models for early intervention** must be adopted at workplaces. Those in non-typical work employment can also be directed to rehabilitation through the employment services offices.

Kela should develop rehabilitation **supporting the re-entry of the unemployed into the workforce**. Unemployed job seekers **who are denied pension** are in a particularly high risk of social exclusion, and therefore their rehabilitation should be a collective responsibility.

In cooperation with the KASTE National development programme for social and health care, people with reduced employment capacity are helped to find appropriate rehabilitation with the following measures:

- the content of rehabilitation work will be developed and legislation updated
- occupational rehabilitation models will be formulated to support people with reduced employment capacity in cooperation with the labour administration, municipalities, organisations, social service companies, employers and providers of other services
- information about the effects of activating procedures on employment and well-being will be produced
- the social, health and rehabilitation services offered by employment service offices will be further developed and successful models made available to municipalities with no employment offices of their own.

The Advisory Board for rehabilitation matters directs, develops and coordinates the cooperation of authorities, organisations and institutions. The Board is now preparing a comprehensive analysis of **rehabilitation needs and the contributions of the rehabilitation service stakeholders**. Among other things, the analysis covers the relationship between the propensity for ordering rehabilitation through municipal social and health care as opposed to the propensity for ordering rehabilitation through Kela or some other insurance institution. Clear strategies are also needed for determining the role of insurance institutions vis-à-vis the obligations of municipal social and health services to provide rehabilitation. It must be determined how rehabilitation works from the customers' point of view, what are the customers' equal rights to rehabilitation, what expertise can be institutions provide and is it necessary to redirect rehabilitation activities on the basis of needs.

### **A measure of the National Action Plan to Reduce Health Inequalities:**

9. With the Advisory Board for rehabilitation matters acting as a coordinator, an analysis will be made of the allocation of rehabilitation. The socio-economic status of the rehabilitation clients will be taken into account in the development of the services.

#### **2.3.4 Safeguarding health services that support the working ability of the long-term unemployed and other people of working age that are outside of the occupational health service network**

The Government Resolution ‘Occupational health 2015’<sup>6</sup> states that health centres must provide health care for the long-term unemployed. A Development project on health services for unemployed people is underway as part of the Policy programme for health promotion. The project is coordinated by STAKES and jointly carried out by the Ministry for Social Affairs and Health, the Ministry of Labour, Kela, the National Public Health Institute, the Finnish Institute of Occupational Health and the municipalities. The Development project on health services for the unemployed contains 17 local projects that will run up until May 2009.

#### **A measure of the National Action Plan to Reduce Health Inequalities:**

10. Drawing on the experiences gathered during the trial projects, municipalities will put the health services aimed at maintaining working ability among the unemployed on a permanent basis.

#### **2.3.5 Developing and strengthening mental health services**

The causal relationships between socio-economic status and health are often more complex in mental disorders than in somatic illnesses. On the one hand, problems associated with and deficiencies in living conditions make people more susceptible to mental disorders, and, on the other, mental disorders that begin early in life weaken opportunities to participate in education and employment and to start a family. Serious mental disorders in particular have been found to be linked with poor social standing, low education levels, unemployment and living alone. Access to mental health services is difficult and some of those in need of treatment fail to get any care or the care is inadequate. Access to proper

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<sup>6</sup> STM 2004:3

care is especially problematic for special groups and the socially and financially challenged.

One of the focus areas of the MASTO Project is the **development of the rehabilitation system**. This is because at the moment mental health rehabilitation is not sufficiently effective. Mental health rehabilitation should be seamlessly integrated into best health care practices and care chains should **allocate their resources** accordingly.

A national **Plan for mental health and substance abuse** will be drawn up in 2007-2008 in the Mieli 2009 working group appointed by the Ministry of Social Affairs and Health.

The aim is to produce models for mental health and substance abuse services and emergency support as regional entities and, if necessary, provide suggestions for guidance measures. Preparation of the plan is based on the mental health and substance abuse projects already underway, including the Rainbow project of the City of Vantaa, the Ostrobothnia Project and the mental health and substance abuse development project in the region of Rovaniemi. In these projects, the development of service entities targets all age groups and the emphasis is on cross-sectoral cooperation and basic services.

The Policy programme for health promotion also covers the implementation of the Plan for mental health and substance abuse. In addition, as part of the Policy programme, depression recommendations for the **Best practices for occupational health care** are prepared, the legislation covering **partial daily sickness allowance** is reviewed and mental health services for **children and youth** are strengthened and their correctly timed availability improved.

### 2.3.6 Ensuring equal services for older people

The functional capacity and health of older people varies according to their socio-economic status, and in this respect education, previous profession, income and living conditions are especially important. As the functional capacity of elderly individuals weakens, poor financial status, loneliness, isolation, inadequate living conditions and lack of support persons make them increasingly vulnerable. Functional capac-

ity can be improved by focusing resources on the treatment of illnesses, prevention of accidents, encouraging older people to stay active and the improvement of living environments.

In 2008, the Ministry of Social Affairs and Health prepared a **National Framework for High-Quality Services for Older People**.<sup>7</sup> The Framework contains strategies for improving the well-being and health of older people and the quality and effectiveness of services in three areas: 1) promotion of health and welfare and development of the service structure, 2) staffing levels, staff skills and management, and 3) old-age living and care environments. One of the central elements of promotion of health and welfare in the Framework is the reduction of inequalities in health and well-being.

Both the Framework and the Policy programme for health promotion call for the creation of a nationwide **network of advisory centres for older people**. Low-threshold advisory centres will offer information and guidance about services, including sport and other recreational activities, organisational activities, housing alternatives, everyday aids and prevention of accidents. Advisory centres will also be able to assess and monitor the functional capacity and health of their clientele and direct them to services as needed.

The Framework and the Policy programme stress the importance of **preventive home visits**. The purpose of the visits is to support and assess independent living and living at home for as long as possible, inform people of the services that are available and anticipate the need for individualized services. Preventive home visits are primarily targeted to those older people who are not regular clients of social and health care services. Special attention is paid to risk groups, e.g. those in a poor socio-economic position, those who are in danger of being marginalized, those with multiple illnesses and those suffering from loneliness.

**Rehabilitation and rehabilitative care** that begin immediately after acute treatment bring results and investing in them prevents people

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<sup>7</sup> National Framework for high-quality services for older people. Publications of the Ministry of Social Affairs and Health 2008:5.

from being put into long-term institutional care. Allocating rehabilitation requires exact definition of the grounds and needs for rehabilitation so that those older people who benefit from rehabilitation will receive appropriate rehabilitation services. There should be more rehabilitation cycles that work towards the discharge of clients to their homes and more rehabilitation at home.

### 2.3.7 Developing and strengthening immigrant services

Under the Act on the Integration of Immigrants, the general development, planning and management of immigrant integration has, as of 1 January 2008, been under the auspices of the Ministry of Interior. The development of social and health care services for immigrants has largely been the responsibility of the municipalities receiving the immigrants.

The service needs of people with an immigrant background should be taken into account in the planning of services in all administrative areas of the municipalities and the principle of mainstreaming should be adhered to. Key areas of consideration include language and other training, employment services, and social services such as day care, housing and health care. It must also be remembered that the needs of immigrant groups are very different. Immigrants should be made aware of the services provided by Finnish society. Arrangements should be made for cross-administration coordination and monitoring of immigrant integration.

It is proposed in the Policy programme for health promotion that, in line with the development of integration measures for immigrants, a plan be drawn up for the **special needs of immigrants** covering health promotion. The plan will take into account the Ministry of Interior's National Framework Programme for Integration and Ethnic Relations currently being prepared. The timeframe for preparation of the Framework Programme has been extended until the summer of 2008.

### **A measure of the National Action Plan to Reduce Health Inequalities:**

11. In cooperation with other ministries, the Ministry for Social Affairs and Health will prepare a plan containing measures for the development of immigrant social and health care services as part of the normal service system. National Public Health Institute, STAKES and the Finnish Institute of Occupational Health will jointly produce a study on the health and service needs of immigrants.

## **2.4 Developing systems to monitor health inequalities**

A health equity monitoring system must be developed so that 1) health inequalities among population groups and measures central to their elimination can be made visible at all levels of decision-making and operation, from the government administration to the municipalities and their service centres, 2) services and other activities can be targeted according to the needs of the population at the relevant levels of administration or operation, 3) information can support the assessment of health effects at all levels of health-policy decision making, and 4) that proper conditions for research into the reasons for health inequalities and their reduction can be established.

The health equity monitoring programme should produce up-to-date and comparable information on population groups in the following areas:

- the most important dimensions of health and functional capacity in the age groups in question
- living conditions, working conditions and lifestyle factors that have the greatest impact on health inequalities
- service needs, care and prevention of illnesses, and the extent, content and effectiveness of health promotion
- availability of social security benefits associated with illnesses.

The information must be in such a form that those in need of it can use it. An electronic data distribution system must be developed for the monitoring of health inequalities, in which the collection, reporting and distribution of the most important health equity information is guaranteed.

There must be a common nationwide protocol for archiving essential data about health inequalities in welfare-services data systems. Easy-to-use user interfaces and reporting systems enabling up-to-date recording of statistics on all levels must be developed by software manufacturers. Health inequality monitoring serving municipal needs must, in addition to national coordination, also rely on regional expertise centres. Pilot projects are needed in municipalities/hospital districts for the development of data collected and reported using the service system.

The National Public Health Institute has established a working group charged with producing a presentation for the Ministry of Social Affairs and Health in cooperation with other stakeholders on the key indicators of health and well-being used in the monitoring of general health and health equity and their background factors and data sources on national, municipal and local levels.

### **Measures of the National Action Plan to Reduce Health Inequalities:**

12. Data about education and vocation compiled by the Statistics Finland will be added to key health monitoring registrars every 1-4 years and to surveys and interviews when such data is being collected. Data on health inequalities will be presented in the electronic distribution systems and basic health monitoring reports of general health monitoring statistics.
13. The need for separate assessments and their funding will be determined jointly by different actors. The National Public Health Institute will expand its key sample sizes for population research so that it can better examine different population groups.

## 2.5 Strengthening the information base and communications

In addition to the development of the health equity monitoring of the population, it is vital that the reasons behind health inequalities between population groups, the causal mechanisms and means to reduce them are also examined. Research into the strategic choices of social and health care policy and their implementation can crucially support the meeting of the objectives of the National Action Plan.

One of the most important challenges of health research is the transfer of research data to those who need it and the subsequent application of the best available data in social and health policy. There must be a better overall awareness of health inequalities, their causal mechanisms and the means available to influence them. The health inequality reduction perspective must be made more visible in national, local, municipal and organisational activities, projects and programmes. This requires that the work to prevent and narrow socio-economic health gaps in the field of social and health care services is strengthened.

### **Measures of the National Action Plan to Reduce Health Inequalities:**

14. The sectoral research institutes of the Ministry of Social Affairs and Health will continue and strengthen their research into health inequalities and develop the assessment of health impacts based on the consideration of inequalities. The Academy of Finland will include health inequality in two of its upcoming research programmes: Responding to Public Health Challenges, which will start in 2009, and the Research Programme on Child Welfare and Health, which is under preparation.
15. In cooperation with organisation representatives, the sectoral research institutes of the Ministry of Social Affairs and Health and the Association of Finnish Local and Regional Authorities will, as appropriate, compile and carry out a collaboration plan for the distribution of data on the strategic and practical levels to municipalities and local and organisational actors.

## 3 ACTORS, IMPLEMENTATION AND MONITORING

### 3.1 Central actors working to reduce health inequalities

#### 3.1.1 Government

Due to the diverse nature of health inequalities and their background factors, the responsibility for health inequality reduction is shared among several administrative sectors. The Ministry of Social Affairs and Health has the main responsibility for health inequality reduction work and its coordination.

The reduction of health inequalities requires more than just social and health policy, however, as it should also include such elements as the building of working and living conditions that support health, and action in the fields of the economy, employment, education, housing, and regional and urban planning. The 2006 Report on Social Affairs and Health<sup>8</sup> took a more exhaustive look at the work of all governmental administrative sectors in the promotion of health and well-being among the population between 2002–2005. The analysis showed that government sectors were involved in a broad range of activities in which health was at least an indirect consideration even if it might not be specifically referred to in administrative documents.

The administrative sector of the Ministry of Transport and Communications covers such matters as traffic safety, the promotion of pedestrian and bicycle traffic, traffic noise abatement, the promotion of barrier-free movement and the safeguarding of information society services for disabled user groups.

By managing food policy and by working to prevent infectious diseases the administrative sector of the Ministry of Agriculture and Forestry emphasizes the health perspective. Activities to promote the

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<sup>8</sup> Social and health report 2006. Publications of the Ministry of Social Affairs and Health 2006:4.

diversity of the countryside and to safeguard the services in rural areas are fields in which the emphasis is on the social welfare perspective.

The Ministry of Justice is responsible for the basic functions of a civil society, for ensuring democracy and justice and for laying the prerequisites for effective crime prevention. In its administrative sector, the focus is on measures reducing violence, promoting the health and social inclusion of prisoners, and preventing repeat criminal offences.

The Ministry of Education oversees the development of education, science, sport, culture and youth policy. The education policy covers such matters as the well-being of children receiving basic education, morning and afternoon activities for schoolchildren, health guidance, securing the transfer from basic to upper secondary education, preventing school drop-out and the training of social welfare and health care professionals and education personnel. Culture, sport and youth policies cover youth workshops, increasing opportunities for physical activity locally, promoting exercise opportunities for children and youth, and providing media education and library services.

The Ministry of Defence is responsible for the general fitness, health and well-being of conscripts during their term of service.

The sphere of authority of the Ministry of the Interior covers such central health-related matters and well-being issues as public order and security, municipal administration and rescue services. Immigration and integration matters are also the responsibility of the Ministry of the Interior.

The Ministry of Employment and the Economy is responsible for developing the efficiency and quality of working life and promoting employment. The work of the Ministry affects every person in working age, including the unemployed who are in danger of becoming excluded from the labour market, such as the long-term unemployed, older persons and the disabled. Reducing youth unemployment is also one of the central goals of the Ministry's administrative sector. Economic and industrial policy is used for regulating and shaping the daily life of citizens. By taking legislative measures covering competition, the Ministry can also influence the structure of commerce and the availability of services, even though municipalities and planning authorities are

also central players in the availability of commercial services. The aim of the consumer policy is to increase economic security, promote high-quality food markets and ensure consumer protection.

The international agreements covering the foreign trade policy, a responsibility of the Ministry for Foreign Affairs, help to prevent hazardous products from entering the country.

The central contribution of the Ministry of Finance to health and well-being is associated with tax policy and customs control. Tax policy is used for regulating the taxation of alcohol and tobacco. Customs control seeks to prevent narcotics and doping substances and non-regulated foodstuffs and products from entering the market. The Ministry of Finance is also charged with the preparation of the state budget.

The administrative sector of the Ministry of Environment has several areas of operation that have an direct or indirect effect on the health and well-being of the population. These cover air quality, the purity of water and the soil, living environments, housing planning, regional and urban planning, building, noise, chemicals and waste.

### **3.1.2 Local government and municipal federations**

Municipalities are in a key position to implement health policy. Due to their self-governing status and broad sphere of authority, they are well-equipped to promote the well-being and health of the population. The challenges of reducing health inequalities and promoting health are different in big cities, as opposed to small towns and rural areas. Social problems can accumulate in bigger cities, while in the countryside, decreasing population and a distorted age structure lead to a decline in services, which in turn leads to the erosion of opportunities to support community spirit and healthy lifestyles. Many tasks of local government can be carried out through joint municipal efforts. The future shape of this cooperation is currently considered as part of the Project restructuring local government and services (PARAS).

The central task of the Policy programme for health promotion is to strengthen the extent to which decision-makers and providers of social service systems on the national, regional and local administra-

tion levels consider the health perspective. The Policy programme and strengthening of the structures of health promotion in the PARAS project should be carried out so that the reduction of health inequalities is a central component of health promotion efforts.

Good health and good functional capacity among the population are the basic objectives of health and welfare policy. The fact that a large proportion of the population fails to achieve the attainable level of health means extra costs and loss of revenue for municipalities. For example, the growth in the need for services could be slowed down by investing in the general fitness of low-income older people and by identifying the threat of and early intervention in the social exclusion of vulnerable children and youth. An emphasis on corrective and acute care means more expenses for local government. The promotion of health is considered the most effective way of cutting growth in health care costs over the long run.<sup>9</sup>

To reduce health inequalities between population groups, the following strategies must be adopted:

1. The promotion of well-being and health must be key areas in the strategy and activity planning of local government. Activities should be focused on efforts to reduce health and welfare inequalities.
2. The structure and management of well-being and health promotion must be developed by all administrative areas as a joint effort.
3. The availability of data on well-being and health inequalities must be improved and welfare and management data systems developed. Local government management must also use the information and distribute it to all relevant actors.
4. The fair allocation of services, the availability of basic services and the effectiveness of preventive services must be secured.
5. Healthy living environments and conditions must be ensured and decaying neighbourhoods and living environments improved.
6. Activities to promote healthy lifestyles must focus on those groups who stand to benefit most.

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<sup>9</sup> Valtioneuvosto 4/2007. Terveysthuollon menojen hillintä: rahoitusjärjestelmän ja ennaltaehkäisyn merkitys.

The top municipal management is responsible for health promotion. All municipalities (or municipal federations) should draw up municipal strategies containing **welfare objectives** in such a way that reduction of health inequalities is not only part of health promotion but also an aim incorporated in **operational and financial planning** and implementation programmes. Care should be taken to place health promotion units and **supervisors** in the new local government structure (a continuation of the PARAS project) so that they will have authority across administrative sectors in solutions promoting health (for example, in the use of quality recommendations for health promotion).

To reach these strategy objectives, better **information systems** serving local and regional levels should be established. The information systems promoting health and well-being should be constructed so that they can provide comprehensive information on the health and well-being of the population and its sub-groups, the ability of the service system to meet the well-being needs of the population and the effectiveness of such activities. More information is also needed about operational practices and cost comparisons. Proper assessment of effectiveness and cost requires a comprehensive **monitoring programme** that generates essential information for health policy decision-making, such as information on the different methods used for improving the situation of those in the weakest position. Development of a site-specific comparative data system promoting health will provide tools for this process. Procurement and analysis of statistics and research data requires **professional and specialised skills** and it is upon these skills that a working system must be founded. (see sections 2.4 and 2.5).

The municipal health care organisations can help to improve the health basis of municipal residents by encouraging **cooperation** with other administrative areas of the municipality and with such local actors as organisations, businesses, employment administrations, churches and the media. Expertise in social welfare services and health care must be utilized in such areas as land-use planning processes so that they also cover impacts on living conditions, living environments and health. There is currently little advance assessment of the health effects of activities and decisions on individual population groups. The

aim is that municipalities and municipal federations introduce an **impacts assessment process** in their decision-making so that they can raise awareness about the effects of decisions made in the administrative sector on health and well-being. Furthermore, municipal councils should require that in impact assessments consideration is also given to health inequalities and both the councils and the audit committees should **monitor and assess** the attainment of these goals.

Well-functioning and effective primary health care, including occupational health care, is the basis of health promotion. The promotion of health and the health inequality reduction perspective should be better integrated into primary health care. This requires sufficient health-centre resources for health promotion and the prevention of illnesses.

### 3.1.3 Non-governmental organisations and church welfare services

NGOs play an important role in the promotion of well-being and the generation of societal benefit. The objectives of the organisations include working against growing inequality, staying in touch with the daily life of the population and ensuring that services are available to everybody.

In organisations, people can take part in the workings of society and in different recreational activities. Organisational activities make it easier for people, who would otherwise have little influence, to have a say in social issues. NGOs try to ensure that actors providing welfare services carry out their work as diligently as possible.

Social and health organisations bring people together so that they can relieve the consequences of problems brought on by illness, injury or social dysfunction, and, if possible, to eliminate them. One of the central tasks of many organisations is to defend the rights of people in danger of marginalization or suffering from long-term illness, and to provide them with support.

NGOs mainly use peer support and voluntarism to help people to cope with their situations but they often also provide professional assistance. On societal level, the key task of organisations focusing on social welfare and health matters is to look after the interests of their

members, offer peer and volunteer support, provide expertise in research and development activities, provide welfare services, and be involved in international cooperation. Ensuring the clients an opportunity to participate in the activities is an important part of NGOs' work.

In 2007 the Finnish Centre for Health Promotion assessed the efforts of NGOs promoting social welfare and health to reduce socio-economic and gender differences. It was found that the organisations tended to focus on the weakest population groups or the population as a whole. Weak population groups included those suffering from substance abuse, homelessness, unemployment or financial hardship, and children, youth and older people at a risk of social exclusion.

According to the study, NGOs that focus on the weakest groups concentrate on improving the material and cultural resources of their target groups and developing social welfare and health care services. Those NGOs that focus on large segments of the population focus on the improvement of social and welfare services and promote healthy lifestyles. Activities directed at large population groups concentrated on the improving of average levels of health, rather than the reduction of inherent health inequalities.

By building up the community and encouraging interaction, NGOs generate social capital. Moreover, the public and private sector can work with NGOs, combining their expertise to find solutions to different social and health problems. Developing cooperation and forging new partnerships among the NGOs and between municipalities and NGOs play an important role in the reduction of health inequalities between population groups.

### *Church welfare services*

The organisation of the Evangelical Lutheran Church of Finland covers all corners of the country. One of the church's strategy guidelines extending to the year 2015 is to take care of the weak and act as an advocate for them. Diaconal work in reception centres and home visits reach people going through hard times in their life.

The National Church Board's unit supervising diaconal and social welfare work has established a nationwide working group to consid-

er health and illness matters in diaconal work. The working group is charged with producing suggestions for the better implementation of health promotion in the diaconal work. The report of the working group will be published in spring 2009. The goal is to emphasize better health promotion in the further training of nurses and deacons. The Diaconia University of Applied Sciences and STAKES have jointly launched a study to determine the problems in the health care system from a diaconal perspective. The study will be published in early 2009.

The diaconal work of the church is particularly supportive of mental health patients in out-patient care and older people living alone and in remote areas. It is necessary to determine where the distribution of responsibility lies in these matters and create the necessary conditions for good cooperation with health care actors and other organisations.

### **3.1.4 Social partners and businesses**

The primary task of social partners is to supervise the interests of their members. Promoting working ability and health and reducing health inequalities is in the interests of both the employers' and employees' organisations and their members. A healthy employee is a major competitive and productive factor for the employer. Concern for staff well-being and health will be an important advantage in the future when employers compete for skilled and competent workers, especially if the predicted labour shortage becomes a reality. As the labour force ages and age groups moving into working life grow smaller, everyone must do their best to further the competitive ability of Finland on the global market.

Promoting health and reducing health inequalities increase well-being and improve the quality of life for employees at the workplace and outside it.

Social partners can participate in health promotion and reduce health inequalities with joint appeals and recommendations, by disseminating information through their own information channels about how to promote health and reduce health inequalities and by

actively supporting development of occupational health promotion and health equity.

Occupational health care is fundamental to the development of a healthy workplace and acts as a support organisation for different companies. As part of their tripartite cooperation, social partners work actively to develop occupational health care in the Ministry for Social Affairs and Health's Advisory Board for occupational health care. The Advisory Board has reviewed and approved development programmes to make occupational health care more effective for entrepreneurs, small businesses, the construction industry, the transport industry, hotel and restaurant work and employees with temporary work contracts.

The workplace is an ideal arena for the promotion of working ability and health and the reduction of socio-economic and gender-specific health inequalities in different ways. The opportunities at the workplace have still not been fully taken advantage of. The workplace's ability to support and strengthen choices that promote health and healthy behaviour must be better utilized. In particular, measures to reduce health inequality must be directed to fields of business and professions with the highest amount of exposure and strain and in which unhealthy lifestyles are common.

The good health of the population is a central part of the human capital that is an increasingly important prerequisite for a sound national economy and industrial competitiveness. People put a high value on their health, which also influences their choices as consumers of goods and services. The demand for healthy and health-promoting products and well-being services is growing rapidly. Thus, health is important for our economy in many ways.

Economic activities are a major part of the everyday environment that is central to our health. They manifest themselves as working environments, as environmental impacts of the industrial plants and production, as products and services and as the impact of marketing on the information and cultural environment. In terms of implementation of this National Action Plan, it is crucial that companies see their potential and their obligation to promote health in cooperation with other parties with similar interests.

### 3.2 Implementation, monitoring and assessment of the National Action Plan

The National Action Plan to Reduce Health Inequalities and its annexes form the first comprehensive and cross-sectoral description of work to reduce health inequalities in Finland. The reduction of health inequalities must be incorporated permanently into the development of welfare policy, basic health care activities and the promotion of health.

The implementation of the National Action Plan will be guided by legislation, the performance agreements of research institutes, the implementation of the Government Policy programme for health promotion, the National development plan for social welfare and health care (KASTE), and various appropriations of the Ministry of Social Affairs and Health for health promotion.

The Ministry's Unit for the promotion of well-being and health is responsible for the implementation of the National Action Plan and its monitoring and assessment. The Advisory Board for Public Health, chaired by the Permanent Secretary, acts as the programme steering group. The research institutions in the Ministry's administrative sectors, Kela, STAKES and the Finnish Institute for Occupational Health will participate in the implementation, monitoring and assessment. The expertise of the research institutes will be channelled through TEROKA, the joint co-operation project for reducing health inequalities.

Monitoring of the National Action Plan is using two methods. The implementation of the National Action Plan measures in accordance with the implementation plan will be monitored using process indicators. The use of the indicators describing the activities is separately agreed with the parties in question. The implementation of the goals will be monitored with the help of monitoring indicators. The indicators will be chosen on the basis of a proposal made to the Ministry of Social Affairs and Health (see section 2.4).

A more detailed Implementation Plan will be drawn up for implementation and monitoring of the National Action Plan. The Implementation Plan will also define the indicators that will be used in the monitoring and assessment of the plan.

An assessment of the situation regarding implementation of the National Action Plan will be made before the end of the current Government's term in 2010. The situation assessment will be published in connection with the monitoring report based on the survey Health Disparities in Finland.<sup>10</sup> The National Action Plan will be updated in 2011 on the basis of the assessment.

A separate communications plan will also be drawn up for the National Action Plan. The main communications channel will be the on-line service of the Health 2015 programme of the Ministry of Social Affairs and Health ([www.terveys2015.fi](http://www.terveys2015.fi)). The general monitoring of health inequalities will be available on the web pages of the TEROKA joint project for reducing health inequalities ([www.teroka.fi](http://www.teroka.fi)).

### 3.3 Implementation plan

Subject	Measures	Actors responsible for coordination	Participating actors	Schedule
Promote the health and well-being of youth in vocational education	1. The municipalities will, jointly with other actors, arrange student health services in vocational education in accordance with national guidelines. Education providers will develop student health welfare services at schools and institutes, and instruction in health information. The National Public Health Institute and STAKES will develop information about good health promotion practices and disseminate it among education institutes.	Ministry for Social Affairs and Health  Finnish National Board of Education  National Public Health Institute STAKES	Local governments, providers of vocational education, Finnish National Board of Education, Advisory Board on the health and well-being of children and youth	2008–2011
Making health promotion a permanent feature at the workplace	2. The Institute of Occupational Health, in broad collaboration with other actors, will develop action to promote health in those fields and sectors where factors detrimental to health are present and harmful lifestyles are common.	Finnish Institute of Occupational Health	Social partners, employers, Ministry of Social Affairs and Health, occupational safety administration, units of occupational health care	2008–2011

<sup>10</sup> Terveyden eriarvoisuus Suomessa. Sosiaali- ja terveysministeriön julkaisuja 2007:23

Subject	Measures	Actors responsible for coordination	Participating actors	Schedule
Reducing excessive drinking	3. The alcohol tax will be raised to reduce consumption to or below the 2003 level. The need for tax increases will be reassessed annually.	Ministry of Finance	Ministry of Social Affairs and Health	2009–2011
	4. Municipalities will incorporate substance abuse prevention into the structures of health and well-being promotion and integrate substance abuse services into other social services and health care.	STAKES	Ministry of Social Affairs and Health, municipalities, Finnish Centre for Health Promotion, NGOs, churches, representatives of business and industry	2008–2011
Reducing smoking	5. The tobacco tax will be raised gradually, at the beginning of 2009 and 2010, in order to achieve an appreciable reduction in smoking. At the same time, legislative action will be taken to limit traveller imports and under-the-counter trading. A decision will be made on the inclusion of tobacco and nicotine addiction withdrawal drugs in health insurance coverage.	Ministry of Finance	Ministry of Social Affairs	2008–2011
		Ministry of Social Affairs and Health	Kela	2009
Promoting a healthy diet and exercise	6. Promote the availability of reasonably-priced meals that comply with nutritional recommendations, particularly at small workplaces and among employees required to travel frequently, in accordance with the recommendations of the Working group on monitoring and developing mass catering services.	Ministry of Social Affairs and Health	Ministry of Social Affairs and Health, Ministry of Agriculture and Forestry, Ministry of Social Affairs and Health Working group on monitoring and developing food services that can accommodate large groups, National Nutrition Council, Social partners, food service producers	2008–2011

Subject	Measures	Actors responsible for coordination	Participating actors	Schedule
	<p>7. A Government Resolution on health-promoting nutrition and physical activity will be formulated. On this basis, action will be launched to safeguard adequate exercise and healthy diet for the most socio-economically disadvantaged and marginalised.</p>	Ministry of Social Affairs and Health	Ministry of Agriculture and Forestry, Ministry of Education, Ministry of Transport and Communications, Ministry of the Environment, Advisory board for health-promoting physical activity, National Nutrition Council, municipalities, sport and health organisations	2008–2011
Developing social work and primary health care and the cooperation between the two	8. Social and health care services will be developed and allocated based on the results of health monitoring in population groups or other recognized need.	Ministry of Social Affairs and Health	STAKES, municipalities	2008–2011
Developing timely and need-based rehabilitation for people of working age	9. With the Advisory Board for rehabilitation matters acting as a coordinator, an analysis will be made of the allocation of rehabilitation. The socio-economic status of the rehabilitation clients will be taken into account in development of the services.	Ministry of Social Affairs and Health, Advisory Board for rehabilitation matters	Kela, employment pension institutions, municipalities, State Treasury, STAKES	2008–2011
Safeguarding health services that support the working ability of the long-term unemployed and other people of working age that are outside of the occupational health service network	10. Municipalities invest in permanent health services for maintaining working ability among unemployed people, based on experimental projects.	STAKES	Municipalities, Ministry of Social Affairs and Health, Ministry of Employment and the Economy, National Public Health Institute, Finnish Institute of Occupational Health, Kela	2008–2011

Subject	Measures	Actors responsible for coordination	Participating actors	Schedule
Developing and strengthening immigrant services	11. Together with the other ministries, the Ministry for Social Affairs and Health will prepare a plan containing measures for the development of immigrant social and health care services as part of the normal service system. National Public Health Institute, STAKES and the Finnish Institute of Occupational Health will jointly work to produce research mapping out the health and service needs of immigrants.	Ministry of Social Affairs and Health	Ministry of Social Affairs and Health, Ministry of Employment and the Economy	2008-2011
		National Public Health Institute	STAKES, Finnish Institute of Occupational Health	2008-2010
Developing systems to monitor health inequalities	12. Data about education and vocation from Statistics Finland will be added to key health monitoring registrars every 1-4 years and during the selection of samples for surveys and interviews that collect such data. Data on health inequalities will be presented in the electronic distribution systems and basic health monitoring reports of general health monitoring statistics.	National Public Health Institute	Statistics Finland, STAKES, Ministry of Employment and the Economy, Finnish Centre for Pensions, Kela, Association for Finnish Local and Regional Authorities	2008-2011
				13. The need for necessary separate assessments and their funding will be determined jointly by several actors. The National Public Health Institute will expand its key sample sizes for population research, which will better enable examination of different population groups.
Strengthening the information base and communications	14. The sector research institutes of the Ministry of Social Affairs and Health continue and strengthen their research into health inequality and assessment of the health effects of developing health equity gaps. The Academy of Finland includes health inequality in two of its upcoming research programmes: Responding to Public Health Challenges, set to begin in 2009, and the Research Programme on Child Welfare and Health, which is now being prepared.	National Public Health Institute, STAKES, Finnish Institute for Occupational Health  Academy of Finland	Ministry of Social Affairs and Health, universities	2008-2011

Subject	Measures	Actors responsible for coordination	Participating actors	Schedule
	15. In cooperation with organisation representatives, the sector research institutes of the Ministry of Social Affairs and Health and the Association for Finnish Local and Regional Authorities will, in proper capacity, jointly compile and carry out a collaboration plan for the distribution of data on the strategic and practical levels to municipalities, local and organisational actors.	STAKES, National Public Health Institute	Finnish Institute of Occupational Health, Association of Finnish Local and Regional Authorities, Ministry of Social Affairs and Health, Provincial authorities, Finnish Centre for Health Promotion	2008–2011

In addition to the measures presented above, the progress and implementation of the following programmes and project must be monitored carefully in terms of their impact on the reduction of health inequalities:

Subject	Measures	Working group/programme/project	Actors responsible for monitoring
Reducing poverty	Basic social security benefits, unemployment benefits	SATA committee	Ministry of Social Affairs and Health
	Income hike for families with children	Policy programme for the well-being of children, youth and families	Ministry of Education
Improving ways in which comprehensive schools can prevent and reduce health inequalities	Study guidance, support for those in need, afternoon activities	Development plan for education and research, Development programme for child and youth policy	Ministry of Education
Ensuring that youth receive sufficient support at key transition points between schooling and working life	Cooperation groups with representatives from various vocations, workshop activities, study guidance	Development programme for child and youth policy, Development plan for education and research	Ministry of Education
	Securing work for youth in the job market	Social guarantee for youth	Ministry of Employment and the Economy
	Support to prevent social exclusion	Time out! project	STAKES

Subject	Measures	Working group/programme/project	Actors responsible for monitoring
Providing work for the long-term unemployed and those living on disability pensions or rehabilitation assistance	Developing the interim job market, wage support, recruiting assistance, monthly earnings ceiling for disability pensions	Administrator report	Ministry of Employment and the Economy
Reducing homelessness	Improving the housing situation for special groups	National Action Plan for housing policy	Ministry of the Environment
Developing social work and primary health care and cooperation between the two	Unit for the development of primary health care, preventative health services, cooperation between health care and social welfare services	National development plan for social welfare and health care (KASTE) Health Centre 2015 programme	Ministry of Social Affairs and Health  Ministry of Social Affairs and Health
Improving opportunities of day care services and child care clinics to prevent health inequalities as a part of a networked services	Preventive child protection, networking of services, cooperation between representatives of various vocations, appropriately targeting services	Child Welfare Act, Government Resolution on preventive health services for children, youth and families, Advisory Board for the health and well-being of children and youth, KASTE programme	Ministry of Social Affairs and Health
Strengthening mental health services	Development of rehabilitation programmes Operational models for arranging mental health and substance abuse services	MASTO Project  Mieli 2009 Working Group	Ministry of Social Affairs and Health  Ministry of Social Affairs and Health
Ensuring equal services for older people	Network of advisory centres, preventive home visits	National Framework for High-Quality Services for Older People	Ministry of Social Affairs and Health