Target 2000

Tapani Melkas

A sustained attack on noncommunicable diseases

Finland's health strategy is a response to changes in public health problems. Particular attention is paid to chronic noncommunicable diseases.

In Finland during the 1960s much attention was given to the high mortality of men, especially that caused by cardiovascular diseases. Among women and children the situation was better but the relative importance of noncommunicable diseases was growing.

In the 1970s, resources for public health care were increased considerably and a reform of the system was implemented. In 1972 new legislation on primary health care was put into effect. A comprehensive network of municipal health centres was given special preventive responsibilities. The planning system facilitated the allocation of new resources and the direction of activities in municipal health care according to national priorities. The number of people engaged in public primary health care tripled in ten years. Selective allocation of resources led to the elimination of large regional differences in the availability of services.

Considerable health-orientated measures were taken in other sectors. The labour protection administration, in which workers participated, was developed, and prevention-orientated occupational health care became statutory. Anti-smoking legislation entered into force in 1977. Traffic safety measures were successfully adopted. Insurance was used to spread the burden of expenditure caused by sickness. Drugs were supplied free of charge to people suffering from certain chronic diseases; this applied, for example, to hypertensives, in order to diminish the high incidence of cerebrovascular and heart diseases.

Priority was given to public health research. The causes of noncommunicable diseases, life-styles, environmental health risks, nutrition, growth and aging, and health care systems were given special attention.

Large-scale scientific interventions were launched, the most significant being the North Karelia project (1). Simultaneous nationwide measures make it difficult to
assess this project's effects, although the feasibility and usefulness of community-based action were clearly demonstrated.

The health policy of the 1970s led to a reduction in mortality among men, particularly that caused by accidents and cardiovascular diseases. Mortality among women and children continued to decline, and by the early 1980s the infant mortality rate was one of the lowest in the world (2).

**National health-for-all programme**

Following a review of health policy, a national health-for-all programme was unveiled in 1986 (3). Noncommunicable diseases being outstandingly significant, the strategy was developed largely with a view to their prevention and control. The main approaches involved the promotion of healthy life-styles, the elimination of preventable risks, and the development of the health services. All this required cooperation with other sectors and the participation of the public and health care personnel.

In Finland the promotion of healthy life-styles demands that special consideration be given to nutritional issues, smoking, alcohol consumption, and factors affecting mental health. Intersectoral cooperation is vital. Legislative action during the 1970s reduced smoking but the downward trend has now halted; future progress probably depends on public campaigns and other kinds of action. Pricing policy plays an important part in the fight against tobacco and alcohol. Special attention is given to suicide prevention and extensive research is being conducted in this area.

Efforts will be made to reduce environmental risks through new legislation and the establishment of norms, as well as by counselling and stimulating voluntary activities. Consideration is being given to the possibility of amending the Public Health Act so as to give the prevention of noncommunicable diseases more weight than that of infectious diseases. Considerable importance is attached to intersectoral activities for the prevention of accidents in the home and elsewhere.

The steady growth of health care resources will be continued. The number of people employed in the municipal health services will be increased by approximately 1.5% a year, and primary care will be the first priority. People are being encouraged to take a large measure of responsibility for their own health. Efforts are being made to provide a good organizational basis for health promotion and preventive work as well as for the continuity of care in both the primary and specialized fields. In primary care, physicians and other teams are given responsibility for the health of a population in order to stimulate community-oriented work and personal contacts. Evaluation of this effort in four cities shows better continuity of care, a sharp decrease in visits outside of normal working hours, and increased satisfaction among patients and physicians (4).

Four special fields of development have been designated.

- Adult dental care will be improved in order to maintain the good results obtained from systematic dental care for children and to diminish the marked social inequities in this matter.
Mental health care will be modernized with the help of new resources. The number of mental hospital beds will be reduced to half that existing in 1980, and the capacity for non-institutional care will be increased.

Health care for the elderly being outdated and too institutionalized, efforts will be made to increase cooperation between health care and social welfare, and to develop various forms of semi-institutional treatment and support.

The development of rehabilitation, involving new resource allocation and the clarification of organizational structures, aims at securing as full a life as possible for the chronically ill.

Implementation

The implementation of the programme requires:

- governmental and other political support;
- realization of health-related activities by other sectors;
- adoption of the principles of the programme by health care personnel and the community.

Special attention has been paid to securing political support. Having been drawn up in the Ministry of Social Affairs and Health, the programme is, of course, supported by the health authorities. At the preparatory stage its central points were presented in a report to parliament (5). This document was modified after consultation with other ministeries and was then discussed in parliament. It was particularly important to win the support of the other administrative branches, since the programme has considerable implications for them. This support will be underpinned by high-level negotiations between the ministries during implementation. In so far as the health sector is concerned, implementation is based on the channelling of municipal health care activities in accordance with national priorities. At the same time, central health care legislation is being revised.

The steering group and secretariat involved in the preparation of the programme consisted of health care professionals. Initially, the trade unions in the health sector were also consulted. After completion of the programme it is intended to encourage health care personnel to adopt its principles by means of an educational scheme covering health promotion, rehabilitative ideology, the linkage between social deprivation and ill health, and the promotion of cooperation with other sectors. The reform of curricula in medical schools and nursing institutes is also of crucial importance.

The health-for-all programme cannot direct voluntary activities, but its targets follow, to a large extent, the guidelines that public health associations set themselves. Thus it is quite natural for community organizations to contribute to the implementation of the programme. The aim is to stimulate this role. The organizations have traditionally participated in public health projects, and it is logical for them to find tasks related to

---

Consideration is being given to the possibility of amending the Public Health Act so as to give the prevention of noncommunicable diseases more weight than that of infectious diseases.
the promotion of healthy life-styles, the furthering of environmental health, the building of social networks supportive of people with mental disabilities, and the maintenance of self-sufficiency among the elderly and the chronically ill. Indeed, several organizations have even adopted the health-for-all programme as the main plank in their activities.

* * *

Quite a lot is known about the causes and risk factors of noncommunicable diseases. We know what influences should be brought to bear on individuals and populations. However, can we choose and implement the most effective methods for achieving these influences? Can health care personnel be persuaded to participate fully in a programme that presupposes professional reorientation? Can we persuade other sectors to implement health-orientated activities, particularly if conflicts of interest are involved? Is it possible to ensure that social and economic policy as a whole guarantees the implementation of the health programme?

Parliamentary discussion has revealed a large measure of agreement on health strategy. The published programme was greeted favourably by the media, health professionals and voluntary organizations. Among the many measures already taken has been the publication of nutritional recommendations jointly by the agricultural and health authorities for the guidance of persons responsible for the provision of meals in school canteens and other establishments.

The national health-for-all programme, with the prevention of noncommunicable diseases prominent among its aims, presents society with a formidable challenge. The progress achieved so far gives strong grounds for confidence in its ultimate success.

References