



NATIONAL INSTITUTE
FOR HEALTH AND WELFARE

Annual Review 2012

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Language revision: Mark Phillips

Layout: Raili Silius

Juvenes Print – Tampere University Print
Tampere, Finland 2012

General overview

Health and welfare: research, guidance and expert functions (THL)

The year 2011, the third financial year of the National Institute for Health and Welfare (THL), marked the completion of many merger-related issues. Several practicalities concerning the merger were dealt with already during the first two financial years (2009–2010), and the Institute's strategy was developed further during the second year (2010). In 2011, the management and administrative processes were improved and the process of turning the strategy into practice was initiated. Also, emphasis was put on the development of leadership skills: an important task in an agency of THL's size.

THL's internal collaboration and division of tasks were also further improved in 2011, and co-operation was intensified with agencies within the administrative branch through a newly established research consortium and also on a larger scale with other branches of government. Moreover, the new Government Programme and the new strategy of the Ministry of Social Affairs and Health gave an important framework for planning THL's activities in 2011.

In 2011 THL continued its work on a wide variety of issues, carried out its several statutory functions, and took part in topical research, development and expert tasks. On the basis of THL's expert reviews, two themes moved to the centre of the public debate and were also important topics during the parliamentary elections. One of them focused on social inequality, health and welfare inequalities, exclusion, as well as issues of poverty and basic security, and the other on the challenges involved in the delivery and financing of social and health services. Also, several measures focusing on the two themes were included in the new Government Programme, and THL started preparations to support the measures.

In the field of infectious disease control, THL's work focused especially on the narcolepsy problem linked with the H1N1 pandemic and vaccinations. It also submitted a proposal to the Ministry of Social Affairs and Health recommending that HPV vaccine is introduced into the national vaccination programme and that the screening programme for cervical cancer be remodelled.

In the field of chronic disease prevention, THL strongly supported the national work to prevent diabetes and took part in global expert work on chronic non-communicable diseases. It also took part in the lively national debate on alcohol policy through its expert reports.

The development and expert work at THL is based on competent and high-quality research carried out in its strategic divisions, usually in collaboration with universities and international research agencies. The high level and impact of THL's research activities were confirmed in 2011 both nationally and internationally when the Finnish Ministry of Education and Culture and the international SIR World Report ranked THL as the most cited among the Finnish research agencies and universities.

A key objective in THL's new strategy is to use evidence-based data to protect and promote health and welfare in Finland. The many tools used in this work, ranging from communication to drafting of legislation, were improved in different ways. A particular emphasis was put on improving co-operation with interest groups and monitoring their feedback. THL's media image was assessed to be at a high level in 2011. Also feedback from interest groups was on a good level, although national actors gave more positive feedback than local actors. A particular challenge is, therefore, to support social and health service providers and other actors at the local level.

In 2011 THL faced a new and extensive challenge as it took over the operative guidance of the national reform on the electronic patient data system in social welfare and health care, as required by new legislation. Also the management and guidance of the state reform schools were reformed. Another challenge was to develop the guidance of the state mental hospitals, the UKK Institute, the Finnish Cancer Registry, the Current Care guidelines of the Finnish Medical Society and certain other external actors. At the same time THL started to develop measures to enable a more open and extensive national utilisation of information resources.

THL was very active in the international field in 2011. The Secretariat of the International Association of Public Health Institutes (IANPHI) is located at THL. In 2011 it held its annual meeting in Helsinki, inviting its roughly 80 member public health institutes to convene in Finland. In addition to research, a lot of THL's international activities involve infectious disease control in co-operation with WHO and the European Centre for Disease Prevention and Control (ECDC). THL also participated either in its own right or together with the Ministry of Social Affairs and Health in several issues relating to, for example, the UN, WHO, EU, Nordic countries, and neighbouring areas.

Supervision of social welfare and health care (Valvira)

Supervision of social welfare was assigned to the National Supervisory Authority for Welfare and Health (Valvira) in 2010. Both in social welfare and in health care the desire was to move away from reactive control to proactive and planned supervision. It was agreed that the tools for this are the supervision programmes prepared in co-operation with the Regional State Administrative Agencies.

Supervision programmes have already been used in the care of older people and in non-urgent access to health care. In 2011 the supervision programme for access to care was updated and seven new national four-year programmes for 2012 were prepared: one for health care and six for social welfare.

Another tool for stronger management and supervision is the promotion of self-monitoring of service providers. Valvira issued regulations on the self-monitoring of private social services in early 2012. The self-monitoring regulations on private health services enter into force in autumn 2012.

The number of notifications and complaints on social welfare and health care continues to increase, and reactive supervision and control is necessary. The supervision programmes and self-monitoring will gradually shift the focus of control towards proactive supervision. However, it will naturally take time before the programmes and self-monitoring are established parts of management and supervision in social welfare and health care. Only then can we expect that the need for reactive control will decrease.

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Future views on health and welfare in Finland, 2012

In the spring of 2012, THL published its first annual foresight report. This report points out many aspects of positive development in public health and welfare in the long run in Finland. By and large, this development will be continued in the near future.

However, there are also shadows falling on the overall positive picture. Examples include increasing differences in health and well-being between socioeconomic groups, uncertain economic development, changes in environmental conditions particularly in regard to climate change, rapid technological development, with its good and bad fruits, the onslaught of globalization with a diminishing space for national action, a diversification of the basic values of the population, and the uncertain outcomes of many administrative and structural reforms.

Two special topics are highlighted in the foresight view, one being ageing population and the other one the situation of children, young people and families. In both cases, the increasingly multi-faceted needs for health and social services become visible.

POPULATION: The overall picture takes in the ageing population, increasing variation in living conditions and lifestyles, and increasing differences between the health and well-being of population sub-groups. Increasing inequality is a potential threat.

ECONOMY: Even in uncertain global conditions there is potential for positive economic development in Finland. One of the key elements is the successful mobilization of all Finns and their capacities. One of the foremost goals of experts and professionals working with issues of health and well-being is to support functional capacity and active participation of all population groups.

Environmental conditions: Health risks related to changing environmental conditions, such as climate change and the effects of motor vehicle traffic are rising up the health policy agenda.

TECHNOLOGY: Technological change is penetrating everyday life. In particular, revolutionary changes in production, processing and use of information will have an effect on all spheres of life. The effects will be strongly felt in the practices of health and social welfare services and information systems.

GLOBALIZATION: Diminishing the harmful consequences of globalization is possible with international efforts. Globalization also improves the prospects for international collaboration. One of the effects of globalization is the increasing number of international enterprises providing health and social services.

VALUES: Health, family and social justice will continue to be the cornerstones of Finnish basic values. Rapid global changes force decision-makers into repeated value-based choices. Thus, the importance of values will be increasing.

ADMINISTRATIVE REFORMS AND STRUCTURES IN HEALTH CARE AND SOCIAL SERVICE SYSTEMS: In Finland, reforms have been proposed in the structures of local administrations (municipalities), in systems of health and social service provision, in the financing of health and social services, and in information systems related to health and welfare. The National Institute for Health and Welfare is the key expert organization to support the reforms with expertise, assessments of effects, and evaluation.

AGEING: For long, the basic scenario for the future in Finland is one million older people in a population of less than 6 million. While the health of older people is still improving, the demand for support and help by professionals and family members will increase. The improved functional capacity of the elderly also opens new possibilities in the future.

CHILDREN, YOUNG PEOPLE AND FAMILIES: The economic, social and cultural environments of children, young people and families are in constant flux. Life situations and work and family structures are increasingly variable. This is reflected in changing needs for health and social services.

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Reforms and structures in health care and social service systems

The reform of social welfare legislation

In April 2009 the Ministry of Social Affairs and Health set up a working group to prepare a reform of social welfare legislation. It was assigned to investigate the need to revise the overall structure, scope and content of social welfare acts. The progress report in June 2010 proposed that the starting point in reforming social welfare legislation should be the individual with his or her own needs. The revised legislation must support and promote people's inclusion, own initiative and opportunities to influence matters in society. The goal should be to take into account the social point of view in societal decision-making and actions as well as to reinforce the role of social welfare as a positive force for change in society.

The working group also pointed out that in the 21st century, social welfare should strongly focus on the relation between individuals and their living environments. The objective should be to promote the welfare and social security of individuals and communities by contributing to the favourable development of living conditions and by supporting individuals to cope with everyday life. Social welfare must provide well-timed quality services and supportive measures, reduce inequalities in welfare, prevent social exclusion and poverty, and ensure everyone an opportunity for a life with dignity at all ages.

The present Social welfare act is already thirty years old and it has been changed several times. During the same period the operational environment has changed a lot. The discussion on reforming the social welfare legislation has been ongoing for some time. The final impulse for this reform was given by a project to restructure Finnish local government and services, known as the Paras project, that was launched in 2005. The Act governing this reform entered into force in February 2007 and will remain in force until the end of 2012. A new law on providing, financing, developing and supervising social welfare and health care is being prepared to implement the restructuring of services. This work is closely linked with the Government's plan to reorganise the municipalities. The proposals for the reorganisation will be completed in 2012. The goal is to form bigger, economically robust municipalities that are better able to attend to their duties.

The objective is to build a service structure that can ensure sufficient quality services for all at a reasonable cost. Curbing the demand for services by means of promoting welfare is the key to developing the system. The basic idea behind the social welfare legislation reform is to see that social welfare does not constitute only supplying services but implementing a holistic welfare policy that means flexible cooperation between different sectors of society. There is a need to actively promote social cohesion in all policies.

The process of reforming the Social Welfare Act has been unique because of its exceptional openness. Many interest groups, clients and municipalities have taken part in hearing procedures in order to evaluate the functionality of the draft. Also the process of formulating the bill differed from the usual process. The working group first considered the diverse service needs that people might have and how

the social welfare system should respond to them. Only after this process of definition did the working group start the discussion on concrete social services.

Key changes proposed

The working group has drawn up its proposal for a new Social Welfare Act in the form of a Government bill. The emphasis of the proposal is on promoting welfare and moving towards more client-oriented services. The objective is to change the focus from curative to preventive. The working group emphasises a comprehensive view on responding to the client needs. The starting point must be the client, not the system itself.

The proposal for a new Social Welfare Act does not define the functions of social welfare by listing the services that municipalities have to organize. Instead, the aim is to leave space for offering flexible service structures that respond best to the local needs. This kind of regulation calls for clear and strong national guidance in order to make sure that people around the country will be treated equally.

The proposal includes separate sections for prevention, the social support needs of individuals and families and how to respond to them. It also proposes new legislative openings, like articles on responding to the need for support in acute crisis situations and on combating domestic violence.

The operational processes are also defined from the clients point of view more clearly than before. For example the status of an individual service plan is strengthened. Also it highlights the principle that the basis for every client process is an individual evaluation of his or her needs. The client also has a right to have a dedicated worker to help in organising the services or other measures of support.

Next steps

The report on the overhaul of social welfare legislation will be completed in summer 2012. Because of the great number of laws and their interdependence the working group proposes implementing the reform in three complementary steps: the first phase is a preliminary proposal for a new Social Welfare Act, the second phase consists of revising the content of the special acts steering social welfare in accordance with a legislation programme to be presented later, and the third phase will revise the regulation of interfaces in social welfare. A further step will be an Act on Care Services for the Elderly, which was drafted in April 2012. According to the draft Act, the goal is that every elderly person would view his or her life as being safe and meaningful, and as having dignity. The basis for access to services will be the capabilities of the elderly person, rather than age in itself. The aim is to present a proposal to Parliament in the autumn of 2012.

A hearing on the Social Welfare Act will be arranged and the report will be circulated for comments in late summer 2012. The aim is to present the Bill to the Parliament in autumn 2014, in which case the legislation would come into force at the earliest in 2015.

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Social and health care reform

The Finnish health care system offers universal coverage, services of high quality and on average good health outcomes at moderate cost. Nevertheless, a wide consensus exists on the need for a comprehensive health and social care reform. The parallel, sometimes unclear, funding and provision arrangements in Finnish health and social care services and the relatively small administrative units, i.e., municipalities, responsible for care arrangement have led to service delivery fragmentation and decreasing productivity within the health and social care system. Moreover, the reforms during the last decade, such as the restructuration of services and incentivised municipality mergers, have not led to the desired improvements in the municipalities' capabilities to organize and fund these services. The Finnish welfare system continues to be plagued by inequalities in access to care and by lack of integration between health and social sectors, and correspondingly between primary and secondary care. The experts, including the OECD Secretariat, have estimated that the highly decentralised system is not capable of facing the future challenges, such as the increasing cost of medical technology, rising patients' expectations and the rapidly ageing population. Also, small municipalities often struggle to supply adequate medical care, in particular, due to difficulties in hiring qualified personnel.

According to its programme, the current Government in Finland aims to create a stronger municipal structure built on economically robust entities which are large enough to be able to provide the wide range of public services that the Finnish municipalities are responsible for. While the reform will thoroughly change the municipal sector, it includes several changes in legislation: the legislation on the structure and administration of the municipalities (1), the laws on the provision, funding, development and supervision of social and health services (2), the municipal financing system (3), and the reform of the administration of the capital region (4). At the moment, the Government is zealously preparing the reform on the municipal structure and the reform on social and health services.

Municipal reform: reorganisation and merger of municipalities

The aim of the reorganization of the municipalities is to ensure high-quality local services throughout the country as well as stable and sustainable local government finances. According to the Government's policy definition this objective will be achieved through the mergers of the municipalities. A working group appointed by the Ministry of Finance prepared a proposal on local government structures for the reorganisation of municipalities. The proposal presented in February–March 2012 included decreasing the number of the municipalities from the current 336 to 66–70. The proposal has been evaluated by the municipalities as well as widely debated in public. Although the majority of the municipalities accept the need for reforming the municipal and public service structures, only 90 municipalities are ready to adopt the proposal as such. Presently the future of the proposal is somewhat unclear. On the grounds of the strong autonomy of the Finnish municipalities, some experts have suggested that forced municipal mergers would be unconstitutional. However, it is assumed that the number of municipalities will eventually decrease. The Government has decided to create an economic incentive for municipal mergers but only for those municipalities that will make the decision on mergers by April 2014. According to the proposed timetable, the actual mergers should be realised between 2015 and 2017, depending on the scope of the change.

Reforming health and social services

The health and social care reform has already been in preparation during previous governments. The overall goals of the health and social care reform are widely accepted and include increasing the equity between regions and population groups regarding service provision, promoting client-centric care, and sustaining the municipalities' capacity to face future challenges, such as the ageing population and limitations in personnel and economic resources.

As a result of the ongoing reform, a new Health Care Act entered into force in May, 2011. The Act partly replaces the former Public and Specialised Health Care Acts. It aims to guarantee equal access to services and improve the quality of care and patient safety. This law gives the clients freedom to choose the place and provider of their care. This right will be geographically extended little by little up to 2014, when it includes an option to choose from all providers within national boundaries, whether privately or publicly financed. The Act also states that the social and health care sectors are organized as one entity. Accordingly the integration of health and social services is defined to be a guiding principle in the planned reforms in social and health care.

The Health Care Act is due shortly to be supplemented by a Decree of Emergency Services that will in all probability primarily regulate the quality of urgent care services. The aim of this Decree is to limit the number of hospitals providing emergency care and outsourcing of primary care on-call personnel.

Restructuring health and social services

The Health Care Act focuses mainly on the content of health services. In parallel, the Government is preparing a reform of social welfare legislation and a law on the provision, funding, development and supervision of social welfare and health care services. A working group appointed in March 2012 by the Ministry of Social Affairs and Health has been preparing a proposal on the restructuring of health and social services. This proposal will serve as a basis of administrative and financing reforms for the coming health and social care system in Finland.

The working group has a mandate until the end of 2012, but gave, according to its assignment, its preliminary recommendations in May 2012. The working group presented three optional models for the future organizational and governance structure of Finnish health and social services. These models were promptly scrutinized by the social and health policy ministerial group which concluded that the working group should elaborate the model based on a two-tier structure of health and social care with municipalities and social welfare and health areas responsible for most social and health services and special responsibility areas responsible for the coordinative and collaborative tasks in health and social services.

The model agreed to be applied to the future preparation of health and social care restructuring will mean a radical reform in the current health and social care organisation. Currently, the municipalities are responsible for organising and financing health services which are then provided by the five university hospital districts and 15 other hospital districts and over 160 local health authorities that are organising the health care services. In social services, the municipalities are also responsible for organising and financing the services. There are social services provided by municipal federations but at least some social services are provided by nearly all 336 individual municipalities.

In the new model, the health and social services would be funded and organised by the municipalities, which would be on average much larger than the current size of the Finnish municipalities, or alterna-

tively, by social welfare and health areas, which are administratively federations of municipalities. According to the working group proposal, the total number of municipalities and municipal federations organising health and social services would be around 25–30. In addition to primary health and social services they would also answer for a significant part of specialised services.

For five special responsibility regions that geographically correspond more or less to the present university hospital district responsibility areas, the working group suggests a role in managing the coordinative and collective tasks of the municipalities and social welfare and health areas, such as research and development. The working group's proposal does not yet, however, address the definition of the juridical position of the five special responsibility regions. Moreover, the division of many tasks, such as emergency services, between the regional, and municipal / social welfare and health area level is not yet clearly defined.

No major reform planned for financing of health and social services

Regarding the financing of health and social services the Government Programme reiterates the policy on reforming the robust municipal structure in order to form larger municipal units. According to the Programme, the responsibility for financing and providing social welfare and health care is, as a rule, vested in strong municipalities. However, the Government has stated that it is not planning to reform the basic structure of the Finnish health and social care financing system with two major public sector financing streams; the municipalities funding public health and social services and the Social Insurance Institution funding private and occupational health care. The acknowledged drawbacks in the multi-source financing system of health and social services are to be addressed within the overall reform of the municipal health and social care system. Accordingly the municipal health care and the health insurance system run by the Social Insurance Institution should be coordinated better in order to enable more efficient management of the total expenditure. This is expected to mitigate problems associated with the current parallel funding system, which provides incentives for cost-shifting between services financed through different sources. The measures to improve the coordination of the municipal and health insurance funded services are being assessed by a separate working group.

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Reform and operational management of health and welfare information

Information is a core element in health and social care systems. Health and social care professionals need information on their patients and customers for care planning and decision-making. Care systems operate as processes with complicated logistics. Citizens are actors in the system and need information on their condition and available services. Those responsible for organizing the health and social care system need information on processes for fiscal and other decisions. Nations are building health and social care information and communication technology systems (eHealth, eSocial Systems) to support health and social care delivery in their country.

The Finnish health care system is very decentralized. Point-to-point communication between different organizations becomes very complicated when the number of actors is big. In Finland the Government decided that the core of the Finnish ICT infrastructure for social and health care will reside in a national digital archive for patient documents (eArchive). The service will be maintained by the Social Insurance Institution (KELA). The service includes a national public key infrastructure (PKI) system for health care professionals. The legislation dealing with the creation of a national level IT infrastructure for health came into effect in July 2007. All the public care providers must join in. Private care providers can choose between the national archive and paper archiving. The National electronic patient record archive will offer citizens a chance to browse selected personal health information (eAccess). This will include items such as reference information for the use of services, referral and discharge letters, certificates, statements and results of examinations, and log data about accesses to the personal patient record and a possibility to manage their consent. KanTa combines eHealth systems

The national ePrescription legislation came into effect in April 2007. All public health care providers and pharmacies have to be connected in 2014 and all private health care providers in 2015. The national ePrescription database is hosted by the Social Insurance Institution (KELA). Strong authentication and a smart ID card for professionals with an e-signature are used. The Finnish ePrescribing is fully integrated with the different local electronic patient record systems and the centralised receipt data depository.

Today KanTa, the National Archive of Health Information, is the central core of the Finnish National Health Information (NHIS) system. KanTa is a collective name for several national medical information systems. These are the electronic prescription (ePrescription) and the national Pharmaceutical Database, the electronic archive of patient records (eArchive), and online access by citizens to their personal prescription and medical data (eAccess).

Currently the ePrescription system is in a rapid implementation phase, with over one million prescriptions have been made. The National eArchive service system is ready. Testing and piloting in Kuopio, Eastern Finland, was done between November 2011 and February 2012. The actual deployment will start in early 2013. The service will start with the most essential document types from the viewpoint of clinical users. Additional document types will be added gradually later.

Towards social welfare client information archives

Plans to implement ICT in health and social care continue. The national health information system will be connected to a nationwide eGovernment infrastructure (eService platform and account) that is

being developed in a national SADe-programme. The SADe-project will provide new services such as a service provider catalogue, evaluation information on health and illness and standardized electronic booking systems. An eWelfare program in order to develop ICT for social services was launched in 2004. There is a need to harmonise electronic social welfare client records and information systems. The contents and technical specifications for social welfare client information systems have today been designed. Work on a national social welfare client information archive is under preparation. Legislative reforms enabling the implementation of the systems are set to begin in 2013. It is expected that the national client information archive will be ready for adoption after the year 2016.

There are also several other ongoing developments in Finland that have an effect on the national health and social care information system. The Act on Information Management Governance in Public Administration (634/2011) is an enterprise architecture approach that enforces and promotes interoperability, standards, descriptions and definitions and the utilization of common data. The aim of the legislation is to reinforce interoperability between products that are used in public health care (and other public services as well). The Act on healthcare (1326/2010) gives the patient the possibility to choose the healthcare provider, thus information needs to flow from provider to provider. The law also simplifies regional data sharing between public sector health care, with easier consent managing.

Several challenges will need to be overcome during the implementation of the national health and social care information system. It is a technologically complex system that has to be implemented alongside the everyday service routines of health and social care. It can therefore only be realized step by step. At present, most of the transfer of patient data takes place by operative local and regional systems. In order to function on a nationwide level, the interoperability of the systems is crucial. In addition, volumes of information transfer, for instance in radiology, may be very large and can overload data networks. For health care employees, the system requires the usage of an electronic signature and learning new ways to work, such as documenting patient information in a structured manner.

THL as the operational actor in eHealth development

Finland's National Institute for Health and Welfare (THL) is an internationally recognised research organisation. The institute has been an active contributor to international eHealth and eSocial Welfare research and development initiatives, for example through the sphere of data structures and classifications. Due to changes in legislation, the position of the Institute changed. The law on processing of electronic information in social and healthcare gave the operational responsibility for eHealth development in Finland to THL at the beginning of 2011. The Ministry of Social Affairs and Health (STM) still has responsibility at the strategic level. This includes architecture, legislation, planning of state funding etc. THL is in charge of the operational level work that includes planning, guidance, steering and follow-up of the Finnish eHealth development. THL founded a new unit, the Unit for the Operational Management of Health and Welfare Information (OPER) in 2011.

Along with the national developments, Finland's THL participates in the common European eSOS initiative, which aims to develop technological solutions and operating principles for the exchange of patient records between EU Member States. The objective is to protect the rights of citizens as they move from one EU country to another. Increasing citizens' choice and ensuring the implementation of the EU Directive on Patients' Rights are other important goals. THL is also a member of EHTEL (European Health Telematics Association), an organisation dedicated to promoting the adoption of electronic health care and social welfare information systems. The Institute is also an active contributor to

the development of eHealth indicators for the OECD and the Nordic Council as well as to the PAR-ENT project of the EU, which aims to promote the interoperability of patient information systems.

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Inequalities and development of public health

Tackling inequalities

Inequalities in health and social welfare are among the key focuses of THL's work on welfare and health policies. In 2011 some 700 000 Finns were estimated to fall below the relative poverty line as defined by the European Union. THL provided studies and other expert contributions to the societal discussion on minimum income security, the performance of social protection, and income and subsistence of people on minimum income security. Our researchers participated in the government negotiations during May–June 2011 as consultants on poverty and minimum income security.

Further, THL produced the first national evaluation on the Sufficiency of Basic Benefits. This evaluation is to be produced every four years in accordance with the program of the Finnish Government so as to make it possible for each new government to have up-to-date information on the development of subsistence in people at risk of poverty. The evaluation demonstrated that depending on the type of household, the disposable income of households on basic benefits has increased by between 4% and 41% in real terms between 1990 and 2011, but disposable income after housing costs has decreased in all groups except pensioners. For guarantee pension recipients living alone, disposable income (after housing costs) has increased by 27% in real terms. By contrast, for persons living alone on basic unemployment benefit, minimum sickness allowance or on a study grant (including study loans), disposable income after housing costs has decreased by about 2% in real terms since 1990.

The report shows also that even though by international comparison, Finnish minimum subsistence before housing costs is about average, most of the households living on basic benefits are unable to meet reasonable minimum living costs out of their income. Further, taking into account housing costs, Finnish minimum subsistence falls somewhat below the western European average.

The status in income distribution of persons living on basic benefits was also studied using empirical data. The study showed that in 2009, some 150 000 Finns were living in households where more than 90% of the gross income consisted of basic benefits. The number of these people has doubled since 1990, and the risk of poverty among households on basic benefits has also increased since the early 1990s. The risk of poverty among households on basic benefits was 89% in 2009, and the poverty deficit (the difference between income and the poverty limit) is considerably larger than for low-income persons on average.

Government-level actions against inequalities

These findings and the THL involvement in the government negotiations are reflected in the Finnish Government programme. The programme (<http://valtioneuvosto.fi/hallitus/hallitusohjelma/en.jsp>) has three core objectives: (1) reduction of poverty, inequality and social exclusion, (2) consolidation of public finances and (3) enhancing sustainable economic growth, employment and competitiveness. According to the programme, the government is aiming at narrowing the disparities in income levels, wellbeing and health status. The aim is also to strengthen the basic public services by a service

reform and by introducing new legislation on services and care for older people. A wide-ranging action plan to reduce poverty, inequality and social exclusion is currently being prepared that includes such elements as addressing social exclusion and its risk factors, such as the dropping out and unemployment of young people. This is tackled with the implementation of a social guarantee for young people, according to which, each person aged younger than 25 years and each recent graduate under 30 years of age shall be offered work, a traineeship, a study place, a place in a programmed workshop for young people on improving their ability to enter labour markets, or rehabilitation for that, within three months of becoming unemployed or finishing the primary education.

THL also contributes to this field by co-ordinating a multi-centre research programme on inequality in Finnish society. The Societal Inequalities Programme (SIP) is part of a larger SOTERKO consortium (Consortium of Research Institutes in Social and Health Sector) that aims at developing a research collaboration among state research institutes and Finnish Universities. The SIP has launched six research programmes focusing on inequalities in the Finnish Welfare State, on topics such as socioeconomic health inequalities, inequalities in welfare and quality of life between different birth cohorts, and life course effects of inequalities, among others. The aim is also to provide alternative scenarios for the future on how to diminish inequality and improve the social sustainability of the Finnish Welfare Model.

The THL strategy on inequality

One of the four strategic horizontal actions for 2012–2015 defined in THL's strategy is prevention of inequality and of marginalization starting from childhood. In its action plan, three focus areas are defined: 1) children's living conditions, risks of marginalization and social protection; 2) development of services to children, youth and their families; 3) communal support for children's growth, development and inclusion. The activities to be developed in the focus areas are, firstly, systematic and persistent data gathering and analysis, and evaluation of all areas of societal policy connected with children's welfare; secondly, analysis of the development of universal services directed at all children and the strengthening of services to children with special needs, as well as development of working methods in the services; thirdly, making good use of existing tools to influence policy making, as well as developing new tools.

A new website was launched by THL on May 2011. The website *Kaventaja* www.kaventaja.fi – Reducing Inequalities in Health and Wellbeing, offers information on inequalities in health and wellbeing, on factors influencing such inequalities and on ways of reducing them. The website contains information in compact form on the research and development activities of THL and its co-operation partners. The website is maintained by THL. The *Kaventaja* website supports decision-making and planning on the level of municipalities, regions and central government. Key target groups include leading officials and elected officials, together with the specialist staff of the various administrative sectors.

Bridging the Gap? Review into Actions to Reduce Health Inequalities in Finland 2007–2010 was produced by THL. The starting point for this report is the National Action Plan to Reduce Health Inequalities 2008–2011. The emphasis is on actions relating to social determinants of health. This report discusses the key actions taken to reduce health inequalities during the previous Government's four-year term of office. Recommendations for further action are also proposed for the current Government Programme. These include an emphasis of the health equity dimension to be integrated into all policy areas. Further, it is recommended that responsibility for actions and follow-up should be the main

concern and that both nationally and locally, a co-ordinated intersectoral co-operation is needed. (National Institute for Health and Welfare (THL), Report 8/2011. Helsinki, Finland 2011.)

Programmes targeted at migrants and the unemployed

THL has been co-ordinating the implementation of the National Development Plan for Social Welfare and Health Care or the KASTE programme as it is known (2008-2011). It has also contributed to the formulation of the KASTE programme for the second period 2012–2015. The programme was renewed by the Government on 2 January 2012. Currently the two main targets for the KASTE programme are that

1. inequalities in wellbeing and health will be reduced
2. social welfare and health care structures and services will be organised in a client-oriented and economically sustainable way.

THL has also launched two research projects aimed at tackling inequalities, the MAAMU or Migrant Health and Wellbeing Study (2010–2012) and the PALTAMO project or The Full Employment Project in the Municipality of Paltamo in Kainuu Region (2009–2013).

The starting point for the MAAMU project is that there is little knowledge available on the health, wellbeing, and use and need for health services of migrants in Finland. MAAMU specifically focuses on collecting information on the health, wellbeing, service use, and living conditions of adults of Russian, Somali and Kurdish origin in Finland. The study has been carried out in Helsinki (2010–2011), Espoo, Vantaa, Turku (2011), Tampere, and Vaasa (2012).

The study will produce new and much needed information on the health, wellbeing, and service use of migrants. Information from the study will be used to advance the integration and employment of migrants and to promote the wellbeing of migrants and their families. Based on the survey data, a monitoring system on the health and work ability of migrants will be developed together with the participating municipalities. One of the goals of the monitoring system is to reduce socioeconomic and health inequalities between population groups.

The health of the Finnish core population is simultaneously being studied in the Health 2011 Follow-up Study. Comparative information from this study will enable the health and wellbeing of the Finnish core population and migrant population to be compared.

In Paltamo, a five-year full employment project is going on from 2009 to 2013. THL coordinates the evaluation of the effects of the project. Several corresponding studies are being conducted between 2009 and 2013 by several co-operating organisations.

The full-employment project aims to provide work for all jobseekers of the municipality. Depending on their work ability, the registered unemployed are referred to rehabilitation or pension. According to earlier research, the health of the unemployed and especially the long-term unemployed is weaker than the health of the employed. Hence, the project aims to reduce the overall costs of unemployment by improving the health of jobseekers.

The results of a 2011 report are in accordance with previous that showed substantial health differences between the employed and unemployed for several indicators. Follow-up data has been gathered during autumn 2010 and winter 2011 in order to evaluate the initial effects of project interventions. A third data collection has been carried out at the beginning of 2012.

Internationally THL has been active on developing the welfare policy research agenda by taking part in developing the Joint Programming Initiative (JPI) on Demographic Change, to be funded by the EU. Currently, THL is chairing the general assembly of the initiative 'More Years, Better Lives – the potentials and challenges of demographic change'. As members of the JPI and its working groups, THL experts are involved in the development of the Strategic Research Agenda on demographic change, presenting the European challenges for research on demographic change for the next 20 years. THL is also a partner in the Equity Action, which is an EU-funded Joint Action on Health Inequalities.

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Social work with adults as a tool for tackling exclusion

In Finland, adult social work is a relatively new concept, and as a result the field is still evolving, even if social work involving financially or socially underprivileged adults has been going on for as long as professional social work has been in existence. Adult social work involves interacting with people in challenging life situations and also often in need of social assistance as a last-resort measure. Adult social work has been defined in many ways, but there is no single generally accepted definition of either the content or the client groups of adult social work. In this article, adult social work is considered as part of the public-sector service system.

Finnish social welfare is based on the Nordic welfare state model. Its cornerstones are extensive public responsibility and funding through taxation. Central government plays a strong guiding role in setting the basic principles of social welfare. The actual provision of social welfare is carried out in municipalities. The Ministry of Social Affairs and Health prepares the legislation governing the organization and financing of social and health care, and also monitors its implementation. (Social welfare in Finland 2006.) Adult social work is mainly carried out at the municipal social office or, depending on the size of the municipality, at a regional social welfare office. In municipal social offices, adult social work is carried out by social workers and social counsellors. Those who have graduated with a Master's degree in social work at the university level are qualified to work as social workers. Social counsellors have a Bachelor's degree from a university of applied sciences.

National survey of adult social work

According to the VALTAISTUS report (Blomgren & Kivipelto 2012) the principal client groups in adult social work are substance abusers, the unemployed and long-term unemployed, and young clients. The adult social work clients are usually visiting the social welfare office regularly. Adult social work involves typically the client's life management and income issues, but also unemployment, substance abuse and addiction.

Nearly one third of the social workers/counsellors spent up to 60% of their working hours dealing with social assistance, while others did not do this at all (Blomgren & Kivipelto 2012). Under the obligations of social welfare, social assistance is last-resort financial assistance received in situations where the income and assets of an individual or family are insufficient to cover the essential expenses of everyday life (Social welfare in Finland, 2006). According to the National Institute for Health and Welfare's annual social assistance statistics, expenditure on social assistance has increased by 31 per cent since 2005. This trend, for its part, reflects the fact that social assistance is becoming an increasingly long-term form of assistance for its recipients. As was the case during the recession in the early 1990s, the new economic downturn struck young adults aged 18–29 first and their situation has not improved (Social Assistance, the National Institute for Health and Welfare). On average, social counsellors are spending a higher percentage of their working hours on social assistance than social workers. Most of the working hours of both social workers and social counsellors are taken up by direct contact with clients and client work recording and documentation. For senior social workers, supervisors and managers, most of their working hours are taken up by administrative and HR duties, client work and cooperation with interest groups.

Case work, working with individuals and their close networks are the most common working orientations in Finnish adult social work. More concretely, social workers and social counsellors are listening clients and showing empathy, making plans and decisions, and encouraging and supporting them. Service referrals, benefits counselling and discussing the client's financial situation are also im-

portant procedures. Social workers and social counsellors used largely the same range of adult social work methods and procedures. Discussing the client's financial situation, service referrals and benefits counselling are more prominent in the social counsellors' work than in the social workers' work. Client encouragement, resource exploration, listening to the client and showing empathy are the most important methods used in adult social work. Service referrals, benefits counselling, handling crisis situations, discussing the client's financial situation and assisting in employment and training matters are also considered important. (Blomgren & Kivipelto 2012.)

Adult social work clients also require employment services, other health services, housing services and substance abuse services. Therefore networking with other authorities is important in adult social work. Most frequently, adult social workers are networking with the Social Insurance Institution (Kela), other social services and the Employment and Economic Development Office (Blomgren & Kivipelto 2012).

Encouraging new forms of working

Professional social work in Finland is not particularly oriented to being critical or transformative (Kivipelto 2004). Social work is directed by legislation, norms and juridical elements (Nummela 2011). Even though it is accepted that clients' problems are born out of social and structural conditions, social work targets mainly the individual level and client problems (Juhila 2008). The reason is usually said to be caused by resources: they are targeted mainly to case work and social assistance. Community work, structural social work and political social work should be supported more. Further development, research and evaluation are needed to encourage this.

In addition, social work education prepares graduates for managing, developing and doing research on welfare services (Social welfare in Finland, 2006). Those involved in adult social work are working mainly at a workplace where regular meetings happen and work supervision structures exist. Soliciting feedback from clients and developing the social work processes are quite regular features of the workplace for just under one third of adult social workers. Social work evaluation is not done on a regular basis in very many workplaces, even though the development structures themselves are in place in most cases; one form of indicator or another for monitoring client work is in use in 42% of workplaces, and practical social work is evaluated in some way in their workplaces. Client work evaluation is mainly conducted on the basis of statistics obtained from the client information system. Practical evaluation of social work takes place mainly at staff meetings and in informal discussions; there are workplaces where there are no tools for monitoring client work and no procedures for evaluating social work (40% of workplaces). (Blomgren & Kivipelto 2012.)

Towards effectiveness evaluation

Adult social work is an important area in the Finnish health and welfare system. Adults are related to many other client groups and their wellbeing, such as children. Many adults are not doing very well, though. According to the WHO, poor economic situation, low education level and exclusion from society are causing illnesses and increasing mortality. For example, in many countries smoking is generally more prevalent among lower socioeconomic groups. There is higher prevalence of obesity and excessive alcohol consumption in lower socioeconomic groups, particularly in richer countries. (WHO 2007.) This has been noticed in Scandinavian countries, too, though effective welfare politics is still focusing too much on consequences rather than causes.

To address the specific causes requires efficient evaluation methods and measures. Effectiveness evaluation is needed to show the importance and outcomes of the work to the customers of social work, employees, government and other decision-makers. However, approaches and attitudes towards effectiveness evaluation, evaluation implementation, methods, and data collection systems require a lot of development work in Finland. Great opportunities and expectations arise from the KASTE programme (The National Development Plan for Social Welfare and Health Care). In the KASTE programme effectiveness evaluation research and development projects are supported by the National Institute for Health and Welfare. It is seen that the different projects in the KASTE programme have to make use of each other's experiences and existing knowledge of effectiveness evaluation.

In addition, the Technologies and Practices Assessment Unit at the National Institute for Health and Welfare is researching and developing adult social work effectiveness evaluation and developing tools for evidence-based practice in adult social work. The WHO suggests influencing inequities that are to be found in the social, economic and political mechanisms that give rise to a set of hierarchically ordered socioeconomic positions within society, whereby groups are stratified according to income, education, occupation, gender, race/ethnicity and other factors. The fundamental mechanisms that produce and maintain (but that can also reduce or mitigate effects) this stratification include: governance; the education system; labour market structures; and redistributive welfare state policies (or their absence). (WHO 2007.) Evidence-based practice explores the causes and focuses on appropriate solutions. In adult social work, solutions are what the WHO call for, both methodical and political, such as promoting the position of marginalized groups. This requires continuous national co-operation, co-ordination and clear responsibilities among different parties, for example, the programmes of the Ministry of Social Affairs and Health, the National Institute for Health and Welfare, Social Welfare Centres of Expertise, the KASTE programme, social welfare associations, and service providers, as well as universities and universities of applied sciences.

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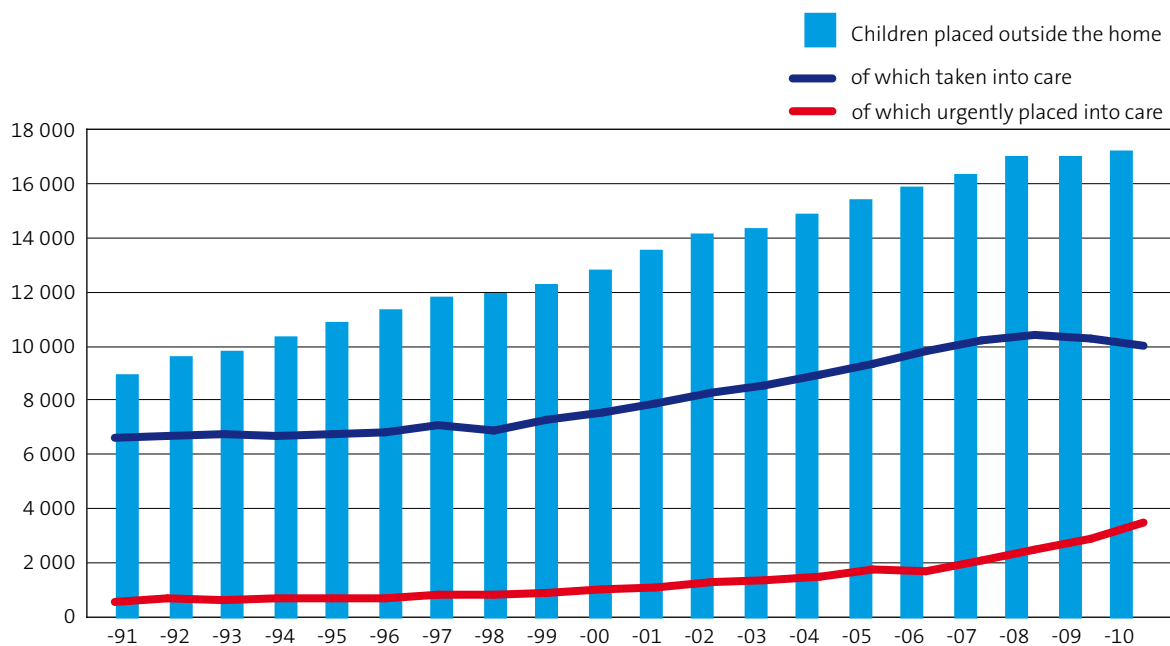
Child welfare and protection

The legislative reform of child welfare was carried out in Finland in 2008 when the new Child Welfare Act came into force. The reform aims at reducing the need for out-of-home placements by strengthening the early intervention approach in universal services for families as well as enhancing cooperation between professionals working with children and families. In order to strengthen the protection of children, the threshold of mandatory reporting was lowered and the duty to report was assigned to a larger group of professionals working with children and families.

The impact of the reform has been somewhat controversial. The number of child welfare notifications has risen from 76 000 (2008) to nearly 90 000 (2010) and the number of children in open care services from 67 000 (2008) to 78 500 (2010). These are logical outcomes of the new definition of reporting and prioritizing open care. It seems that the reform has been able to hinder the growth of volume in the numbers of out-of-home placements. The year 2009 was the first year since 1991 when the number of children taken into care did not grow. What was not expected was the expansion of emergency placements of children. The implementation of these measures has almost doubled 1900 (2008) to 3400 (2010) placements. (Figure 1)

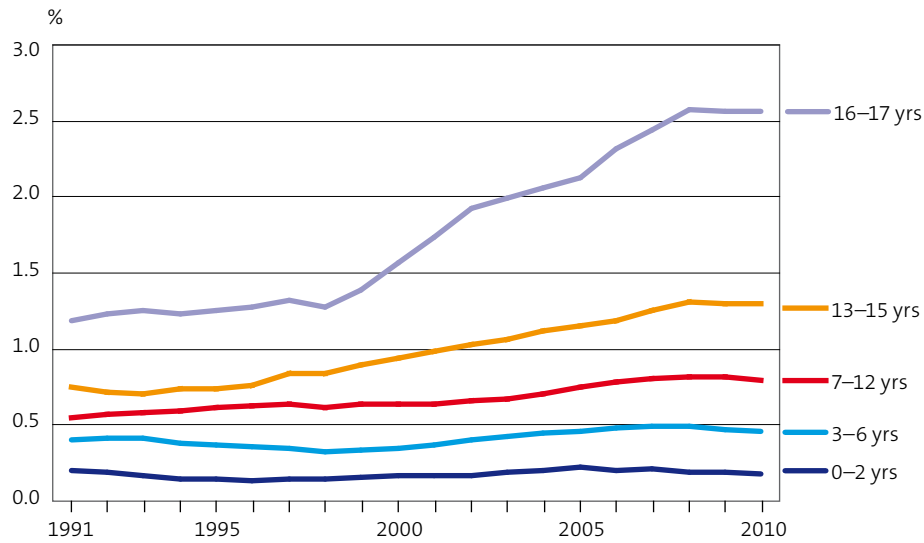
It is noteworthy and alarming that, according to child protection statistics and other indicators, the situation of young people in Finland has deteriorated. The percentage of young people aged 16–17 years in care was much higher than in younger age groups and has been rising since 1998. (Figure 2)

These observations raise questions about how the early intervention scheme is working in practice, and how universal services are capable of supporting children and families, and preventing the need for stronger child protection measures. Within the child protection services, both the lack of social work resources and the heavy turnover of social workers is a risk factor affecting the system's ability to act in organized way.



Source: Child Welfare 2010. Statistical Report 29/2011. THL

FIGURE 1. Children and young people placed outside the home and, out of that total, the children taken into care and the children in emergency placement, 1991–2010



Source: *Child Welfare 2010. Statistical Report 29/2011. THL*

FIGURE 2. Children in care as a percentage of the population of the same age in 1991–2010, %

THL and child protection

THL has been tackling these questions by means of data production, research, and development projects. THL produces the annual national statistical report on child welfare and has been following the trends with the same data collection frame from 1991 onwards. Currently there are several research projects making use of the data in the child welfare register and other relevant statistical registers. The Institute is providing expert support to the Ministry of Social Affairs and Health in implementing the reforms of child welfare services via the Kaste Program.

THL maintains extensive web-based resources to support professionals working in social and health services. One is the Kasvun Kumppanit ('Partners in promoting the well-being of children'), targeted at primary health and social services professionals; another is the Lastensuojelun käsikirja (eHandbook of Child Protection) for professionals working in child protection services.

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Social marginalization of young people

The social marginalization of young people is arguably the most pressing problem of many affluent western states, Finland included. Even the more conservative estimates of the number of young people in the process of social marginalization in Finland place it in the magnitude of 50 000 – a whole per cent of the total population. The immense economic cost and loss of the human potential of these youngsters in Finland is a powerful drain on any country, especially one looking forward to a rapid decline in the employment-population ratio. It is also a question of ethics: many if not most of these youngsters could be helped to find a rewarding role in society. Marginalization is a process that could and should be countered.

Marginalization can be defined as a cumulative process of social exclusion leading to an identity of alienation and an entrenched position at the lower margins of society. There are some common elements, not all of which are relevant to every case, but often more than one are working in combination. These elements are: early and continued social-emotional difficulties, often combined with learning difficulties; the need for extensive child-protection activities, especially placement outside of the home; dropping out from school; recurrent involvement with the law; long-term unemployment; early pensioning, often on grounds of mental health and substance abuse issues; and dependence on elective welfare services. These same elements often describe the parents of the families, and thus marginalization is an inter-generational issue.

The integration of an individual into society begins at birth, and the foundation for enduring well-being is built in childhood. Similarly, socioeconomic marginalization and inequalities in well-being and health are often rooted in early childhood. Risk factors for health and welfare problems stem already from the pre- and perinatal period, and they include environmental as well as genetic influences. Inequalities in health, income and social capital leading to varying opportunities in life chances are interwoven. The intergenerational continuity of these problems results from both social and biological processes.

Social marginalization in Finland is in some ways an enigma. Children in Finland are born healthier than ever; the early childhood health services are ubiquitous and free of charge; early childhood education is universal and of a high standard; the schooling system is famous for its equality and excellent learning outcomes. Yet, based on the recent need for child protection and mental health services, adolescents' ill-being has continually increased. Answers must be sought from various levels.

On a societal level, the competitiveness of both education and the work-place has increased, and the possibilities for employment with a very modest education have declined. Many parents have too little time for their children as work demands are higher than before – parents of small children work more overtime than any other group; and the use of alcohol at a risk level especially for fathers of small children is high. At another level, while different sectors of the welfare state address the risk of marginalization in multiple ways, these systems of support are limited by administrative boundaries. Much of what could be done at an early stage gets blocked in referrals and waiting-lists. More often than not, interventions are too narrow in scope, aimed at the individual, do not use the resources of the natural development environments, such as the family, the day care personnel, and the school.

THL activities

THL does both research and development work on many aspects of social marginalization. The social policy research is described in Professor Karvonen's article. The development trajectories on the determinants that lead children into care is a major research program that is part of the Finnish Academy Skidi-Kids programme. Other research programmes include the health determinants of inequality (TEROKA); the use and availability of services (LapsYty), which also comes under the Finnish Academy program; the well-being of families (HYPA); and various research programmes into child and adolescent mental health.

An important area has been epidemiological research. The 1987 Finnish Birth Cohort study has identified various early childhood determinants and risk factors associated with social exclusion in adolescence and adulthood. Based on the 1987 Finnish Birth Cohort Study, it is evident that problems in education, mental health, criminality and poor living conditions accumulate, leading to a polarization of well-being.

A major co-ordination effort in development work aimed at increasing the effectiveness of services for children, adolescents and their families is the KASTE programme of the Ministry for Social Affairs and Health. THL is working together with various communities across the country in several development tasks. These include developing dialogical networking both in: client work and administration, which means tapping into the resources of the family and the network of adults around the child or adolescent; creating Family Centres for integrative work together with the third-sector organizations; increasing companionship between parents and professionals in day care and school (Kasvatuskumppanuus); developing open care in child protection (see Mikko Oranen's article); creating ways of working together between school health and expert mental health services; operationalising family wellbeing indices into regular child and school health check-ups.

There has been a legislative effort in Finland towards strengthening preventive work, both in primary medical services and in child protection. THL has faced a major task in creating national guidelines to implement this new legislation. Both the eHandbook of Child Protection and the eHandbook of child health clinics are being widely used. A guide to the family wellbeing check-ups in child health clinics and school health is to be published this autumn.

Research results from the 1987 Finnish Birth Cohort study show that the accumulation of problems is strongly linked to one's educational attainment. Those adolescents with only a comprehensive school education suffer much more often from mental disorders, substance-abuse, criminality and financial shortages in their twenties. For example, at the age of 21, more than every fifth male and every sixth female of the 1987 Finnish Birth Cohort had no educational degree other than comprehensive school, and 40% of those had used specialised psychiatric services or psychopharmaceuticals. As a group, they are at greater risk of social marginalization.

Parental mental health and substance abuse problems are commonly seen as determinants of accumulating child difficulties. According to the 1987 Finnish Birth Cohort study, chronic parental health problems increase the likelihood of children needing specialised psychiatric care. The younger the children at the time of parental illness, the more they are affected. In THL, there has been a long-standing development project to tackle this risk of marginalization: The Effective Child and Family programme trains professionals in strengthening the resilience of children when parents experience long-standing mental health stressors.

Managing in school and attaining an education are important factors for integration into society. The nature of work today favours those with an education. But in an even more important way, compre-

hensive school, as an extremely important developmental environment, affects every child. It is a place that can facilitate social coping, integration and resilience, but it can also foster the early determinants of social exclusion and marginalization. One example is bullying, which can have long-lasting effects later in life. According to Finnish studies, bullying often starts already in pre-school. Working against bullying in a comprehensive way is a combined project between the Ministry of Education and THL. One group especially vulnerable to poor school attainment are children in care. THL is in charge of the most specialized institutions for helping these children, the state reform schools. The expertise attained through these will, in the future, be used to support regular schools in helping children most at risk of future marginalization.

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Non-communicable disease surveillance in Finland

Finns are healthier today than at any other time: disability-free life expectancy has increased by ten years over the last three decades. Among the new challenges faced are the increasing prevalence of obesity and type 2 diabetes, together with widening health gaps between socioeconomic groups.

The overview of Finns' state of health at the population level is based on data from the Cause of Death statistics, national registers for social welfare and health care, and separate registers for pharmaceuticals and specific diseases, such as the Cancer Register and the national infectious diseases register. Register-based data-sources need to be supplemented with recurrent population-based survey data because register data can be affected by changes in 1) diagnostic criteria, 2) awareness of diseases and their risk factors, and 3) the management of diseases. These surveys can be conducted using postal questionnaires, face-to-face interviews and personal health examinations.

The Finnish health monitoring and surveillance system uses several independent data sources in addition to register-based data. At THL, population-based surveys on health and welfare include:

- National FINRISK Study – chronic disease risk factor and health examination survey conducted at five-year intervals since 1972
- Health Behaviour and Health among the Finnish Adult Population – postal survey conducted annually
- A nationwide population study on health and functional capacity (Health 2000) – conducted at ten-year intervals
- Regional Health and Well-being Study – to monitor health and well-being at municipal level in the population; conducted according to region-specific timetables
- Migrant Health and Wellbeing Study – to produce information on the health and wellbeing, work ability and need for services of migrants; launched recently
- Additional population-based surveys include School Health Promotion Study, Child Health Monitoring Survey, Drinking Habits Survey and National Drug Survey

The health monitoring and surveillance system has been an important tool in the prevention of chronic diseases in Finland. The information obtained from these surveys has been utilized for prevention planning and policy, and for health communication in the media. In addition, the data has been used extensively in evaluating and monitoring the progress of non-communicable disease prevention activities.

The National FINRISK Study celebrates its 40th anniversary

The National FINRISK Study conducted in 2012 marks 40 years of non-communicable disease surveillance as well as research on the risk factors of major chronic diseases affecting the Finnish population and possible changes to these risk factors. The study focuses on cardiovascular and cerebral diseases, cancer, diabetes, asthma and allergies and the related preventive and risk factors. The survey in 2012 is the ninth in a series of studies that began in 1972 in eastern Finland and have been carried out every five years since. In addition to monitoring the changes in the risk factor levels, these studies have provided us with valuable information on the causes and effective preventive measures of the most common chronic diseases in Finland. The results of these studies have been used in the planning and follow-up of national health policies. Similarly extensive, long-term population studies using standardized methods over time are rare in any country.

The FINRISK 2012 Study covered 88 towns and municipalities in five areas across different parts of Finland between 23 January and 2 April. Invitations to take part in the study were sent to 10 000 people aged 25–74 living in North Karelia, Northern Savonia, Northern Ostrobothnia and Kainuu regions, as well as in Helsinki, Vantaa, Turku, Loimaa and five municipalities in the region of Satakunta (Finland Proper). Participants are selected at random from the population register.

According to the FINRISK Study, the average cardiovascular risk factor levels have decreased markedly in Finland since 1972. During the same time period, cardiovascular disease mortality has decreased by 80% in the middle-aged population. Most of this decline can be explained by the changes in the main cardiovascular disease risk factor levels. In addition, favourable changes in self-reported health status, leisure time physical activity, physical fitness and quality of life in the general population have been observed.

The National Institute for Health and Welfare will publish preliminary results of the FINRISK 2012 Study in autumn 2012. The results will be used in long-term research for preventing chronic illnesses, discovering new treatments and developing social and health care services.

The European Health Examination Survey (EHES)

The National Institute for Health and Welfare (THL) is drawing on its experience of maintaining registers, conducting population studies and utilizing their results to build a new European health information system. The intention is to obtain reliable and comparable data on health and health trends for different European countries, regions and population groups. Only when such data are available can correct conclusions be drawn concerning health differences between different countries and the underlying causes that could be prevented. Information on health at the population level is needed in all EU Member States and the European Union as a whole in order to ensure that health policy actions, health promotion measures, provision of health services and research are targeted correctly.

The European Health Examination Survey, EHES, is a collaborative activity between European countries and the EU to provide comparable information on health, functional capacity and the major chronic disease risk factors in the European adult population. This information will provide an evidence base for policy making and evaluation of preventive activities in Europe. The national surveys are organized and carried out by national organizations.

THL has been successfully coordinating the EHES pilot project in 13 countries (Czech Republic, Finland, Germany, Greece, Italy, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Spain and the UK/England). In addition, the EHES Reference Centre for European level co-ordination, standardization, training, evaluation and reporting has been established.

Experiences from the pilot study indicate that health examination surveys based on the EHES protocol are feasible in Europe. Wider adaptation and implementation of these experiences in the already planned national surveys would lead to an increased standardization and comparability of national health surveys in Europe.

New thinking in allergy prevention

The prevalence of allergic disease has grown in Finland similarly to many other western countries. An increasing body of evidence indicates that modern living in urban built environments brings depri-

vation of environmental protective factors, like soil microorganisms, that are fundamental for normal tolerance development. Current dogma on allergen avoidance has not proven effective in stopping the epidemic, while the Finnish consensus for restoring and strengthening tolerance should be more in focus. The Finnish Allergy and Asthma program (2013–2018) aims to prevent and control allergy in Finnish population.

Can dementia be prevented?

In cohort analyses dementia is predicted to a great extent with the same risk factors as cardiovascular diseases. A multi-centre randomized trial has been started to assess if dementia can be prevented by behavioural changes. Recruitment has been completed and trial results can be expected in next few years.

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Alcohol policy in Finland as a member of the European Union

Finnish alcohol policy as well as alcohol policies in other Nordic countries except Denmark has rested on three pillars: restrictions of private profit-seeking by a comprehensive state alcohol monopoly, restrictions of the physical availability of alcohol, and high prices for alcoholic beverages mainly through high alcohol excise duties. Finland's membership of the European Union (EU) since 1995 has greatly influenced the preconditions for realizing different kinds of alcohol policy measures as well as influencing those alcohol policy measures already in force.

Background

In the three decades preceding Finnish EU membership, the physical availability of alcoholic beverages had already increased considerably. The most dramatic change was the enacting of the 1968 Alcohol Act and Medium Beer Act, which made it possible to retail medium beer containing at most 4.7 per cent alcohol by volume in ordinary grocery stores and cafés. Moreover, in 1969 the age limits for selling alcoholic beverages off the premise were lowered and the State Alcohol Monopoly's (Alko) liquor stores could be opened also in rural municipalities and not only in cities and towns. It also became much easier to obtain licenses for the on-premise retail sale of alcoholic beverages both in cities and in rural communities.

During the 1970s and 1980s the number of Alko stores and on-premise restaurants increased greatly. At the same time, Alko stores were changed from counter-service stores to self-service stores, and the regulations concerning both off- and on-premise retail sale were liberalized. As a result of the huge increase in alcohol consumption from the late 1960s into the 1970s, restrictive alcohol policy measures were enforced, such as the ban on alcohol advertising in 1977.

Finnish EU membership and the 1994 Alcohol Act

The enactment of the 1994 Alcohol Act was clearly motivated by Finnish EU membership from the beginning of 1995. The most important EU induced change was the abolishment of the comprehensive alcohol monopoly structure because of EU rules on free movement of goods within the single market. Consequently, according to the 1994 Alcohol Act, state monopolies on production, import, export, wholesale and on-premise sale of alcoholic beverages were abolished. In 1995 the new state-owned alcohol corporation, Alko-yhtöt took over all production, wholesale and off-premise retail sale activities of the former comprehensive Alko monopoly. In 1998, the ties between Alko and the commercial parts of the former monopoly were broken and Alko became an independent off-premise retail monopoly under the Ministry of Social Affairs and Health.

Besides medium beer, the 1994 Alcohol Act allowed grocery stores to retail also other alcoholic beverages up to 4.7 per cent alcohol by volume if the ethyl alcohol in them was produced by fermentation. Besides grocery stores these fermented beverages were allowed to be sold also in kiosks and gasoline stations. The motivation for these changes most probably stemmed from equal treatment of fermented alcoholic beverages.

The 1994 Alcohol Act also included changes that were totally independent of Finnish EU membership. For the first, the 1994 Alcohol Act allowed the newly founded Finnish fruit wine farms to sell their own

wines with at most 13 per cent alcohol by volume directly to consumers, thereby endangering the retail sales monopoly principle. Some years later they even obtained the permission to extend the selling hours on Sundays. The 1994 Alcohol Act also abolished the ban on alcohol advertising by allowing for the advertisement of light alcoholic beverages under 22 per cent ethyl alcohol by volume.

When the Finnish Alcohol Act was enforced in 1995, drinking in public places was for the first time since 1733 allowed in Finland. Soon after this, however, the negative consequences of allowing public drinking, i.e. drunken disorderly behaviour and public urination became a visible nuisance, especially during the summer months. Public drinking was still regulated in many local ordinances but it was not until the enactment of the Ordinance Act in 2003 that public drinking was once again prohibited across the entire country. The difference to the situation prior to 1995 was that orderly picnic style drinking was still allowed in parks and similar places.

The fulfilment of the EU rules in 2004

In 2004, the effects of the start of Finnish EU membership in 1995 further brought about two important changes in the Finnish alcohol field. First, in January 2004, the derogation for quantitative quotas for travellers' alcohol imports from other EU countries was abolished. After that travellers were allowed to bring with them an unlimited amount of alcoholic beverages from other EU member countries as long as those alcoholic beverages were meant for own consumption and not for commercial use.

The abolition of the quotas for travellers' alcohol imports had only limited importance in January as the nearest EU countries with cheap alcohol were Denmark and Germany. The practical importance of this new rule became evident in May 2004 when Estonia with its low prices on alcoholic beverages and situated only 80 kilometres south of Finland joined the EU. In order to combat increases in travellers' alcohol imports and to protect the tax base and alcohol employment in Finland, the Finnish Parlia-

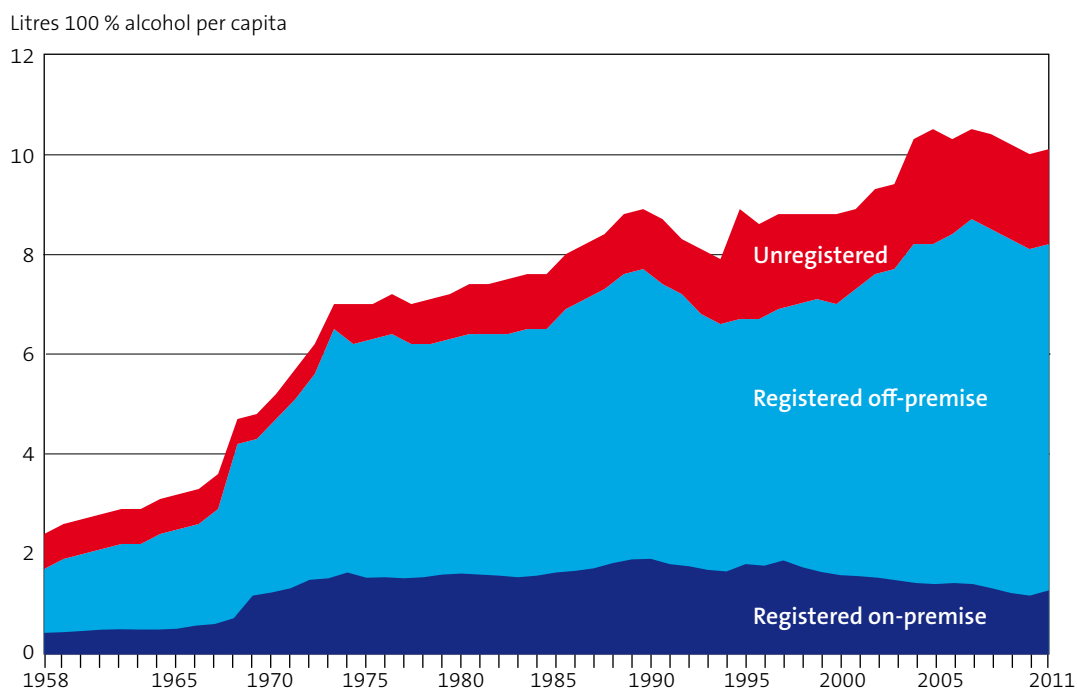


FIGURE 1. Total Alcohol consumption in Finland in 1958–2011 in litres of 100 per cent alcohol per capita

ment decreased alcohol excise duties on average by a third. The tax decrease was much greater for distilled spirits than for wine and also greater for distilled spirits than for beer, as the price differences between Estonia and Finland was highest in regard to distilled spirits.

Situation in 2005 and subsequent developments

By 2005 the three pillars of Finnish alcohol policy had greatly weakened. First, physical availability of alcohol was hit already after 1968, followed by abolishment of the comprehensive alcohol monopoly in 1995 and finally a considerably decrease in alcohol prices in 2004. By 2005 total alcohol consumption had grown to a level of 10.5 litres per capita, a four-fold increase compared to the mid-1960s. Likewise alcohol-related harms had increased considerably. While alcohol-related acute harms linked to intoxication have increased in line with total alcohol consumption, harms connected to long-term heavy alcohol consumption had increased at a much faster pace than total alcohol consumption. Nowadays, besides intoxication-related social and public order problems, Finns also suffer from public health problems connected to the heavy consumption of alcohol.

Since 2005 there have not been any major changes in the alcohol monopoly structure. However, the fruit wine producers have claimed that they should be allowed to retail their own liqueurs off-premise. In 2012, the discussion, like the discussion on wine sales in grocery stores, has basically died out. On the contrary during the last year, a much discussed topic has concerned proposals to stop the sales of medium beer and other fermented alcoholic beverages with equal alcohol content in grocery stores, kiosks and gasoline stations.

No big changes in the physical availability of alcohol have recently occurred. The number of Alko stores and licensed restaurants has increased somewhat, but the number of places retailing only medium beer have decreased. Moreover, there have also been some decreases in alcohol availability, such as allowing the retail sale of alcoholic beverages only from 9:00 am as of April 2007. From the beginning of 2008, it has been prohibited to use so-called quantity discounts, that is, to offer several packages of beer or other alcoholic beverages at a reduced total price. It is also prohibited to advertise happy-hour prices outside restaurants and bars and alcoholic beverages on the television and in cinemas before 9 pm. During the last year there have also been serious discussions to shorten the opening hours of restaurants. There have been heated discussions on forbidding image advertisements. In the period 2008–2011, the minister responsible for that matter came from the National Coalition Party, and the committee she appointed to prepare the new law on alcohol advertising had many representatives from the alcohol industry and trade. The work of this committee did not lead to an amendment of the Alcohol Act. In spring 2012 the same questions have been brought up again, this time by a minister coming from the Social Democratic Party. The new law proposal forbidding the image advertisement of alcoholic beverages is still under preparation but should go before the Parliament in autumn 2012.

The economic availability of alcohol has become more stringent in recent years, with alcohol excise duties raised four times, first in January 2008, then twice in 2009 (in January and October), and again in January 2012. Increases in excise duty rates have been 10 per cent each time for each beverage category, except 15 per cent for distilled spirits in 2008 and 15 per cent for beer in 2012. These increases have been motivated both by the need to improve public health and the need to collect more tax revenue for the state. These increases have meant that in 2012, excise duty rates for wines and beer were in nominal terms higher than they were before the tax cut in 2004. Also, following on from the drop in state alcohol incomes in 2004, alcoholic excise duty incomes have nominally returned to the 2003 level. Since 2005, total alcohol consumption has decreased from 10.5 litres to 10.0 litres.

Future prospects

According to the government programme for the period 2011–2014, the Alcohol Act should be renewed. It is difficult to forecast what will be the changes and in what direction. The mood in alcohol policy discussions has changed markedly however in recent years. While an important topic in alcohol policy discussions in the mid-1990s was the proposed retail sale of wine in ordinary grocery stores, the most burning topic today is moving medium beer away from grocery outlets. Further, shortening the on-premise selling hours in restaurants is an important discussion topic. In 2012 the suggestion to restrict public drinking in places where families come together, such as children's playgrounds and parks, has been raised by a working group on improving internal security in Finland. No decisions on further restricting public drinking have, however, yet been made.

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Monitoring the population effectiveness of pneumococcal conjugate vaccination in the Finnish national vaccination programme

The ultimate goal of any vaccination programme is a significant reduction of the disease burden. Before new vaccines are introduced, the expected health benefits are usually estimated using available data from efficacy and immunogenicity studies and experiences of other countries. Many older vaccines, such as smallpox, diphtheria, polio, measles, mumps and rubella vaccines had far more apparent effects on disease epidemiology than rota, human papilloma virus and pneumococcal conjugate vaccines can ever be expected to have. The latter group of microbes typically do not cause a single clinically distinct syndrome but are associated with several clinical presentations. Moreover, the clinical syndrome associated with rotavirus or pneumococcus is also associated with several other microbes. This makes it challenging, but by no means less important, to demonstrate the effect of the vaccination programme on the disease burden.

Pneumococcal conjugate vaccines (PCVs) have the potential to reduce the burden of *Streptococcus pneumoniae* diseases, not only through direct protection provided to vaccinated children but also through indirect protection of the unvaccinated children and adults. In the United States, where infants have been vaccinated with the 7-valent PCV (PCV7) since 2000 (and with PCV13 since 2010), the incidence of Invasive Pneumococcal Disease (IPD) has decreased considerably in all age groups. In addition, hospitalization rates for pneumonia have also markedly decreased after the introduction of PCV7 into the national vaccination programme (NVP) in the USA, for children younger than 2 years but also for adults aged 18–39 years. However, the decreases in IPD due to the vaccine serotypes has in some regions been accompanied by increases in IPD caused by non-vaccine serotypes, especially serotype 19A. In Europe, serotype replacement appears to have been more aggressive, and the observed reduction in the total IPD disease burden consequently smaller, than in the US.

Finland introduced the 10-valent pneumococcal conjugate vaccine (PCV10) into the national infant vaccination programme in September 2010. The target group is all children born at or after June 1, 2010. The vaccination schedule is 2 primary doses at the ages of 3 and 5 months and a booster dose at 12 months of age. No catch-up vaccination schedules are used.

Continuous monitoring of pneumococcal diseases and evaluation of the population impact of PCVs are an essential part of the vaccination programme. Finland has an ideal infrastructure for such surveillance: several established nationwide health registers, universal use of unique and life-long Personal Identity Numbers for each Finnish citizen, expected high coverage of the NVP, and a public health care system equally accessible for each citizen as well as a relatively stable population.

Nationwide effectiveness study preceded PCV introduction

According to vaccine sales data obtained from the Finnish pharmacy records, the private sector use of PCVs has been minimal since their licensure in February 2001 (an average of 100 doses/month). The use of 23-valent polysaccharide vaccine in the adult and elderly population has similarly been infrequent.

In May 2009, before PCV was introduced into the NVP, THL initiated the Finnish Invasive Pneumococcal disease vaccine effectiveness (FinIP) trial, in co-operation with 80% of Finnish health care centres and the vaccine manufacturer GlaxoSmithKline, to evaluate the overall effectiveness of PCV10 in the population. The FinIP trial was designed as a community-randomized, double-blind trial that will enable the evaluation of the overall effectiveness of the PCV10 against IPD by measuring the effects both among vaccinated children (direct and indirect effects, i.e. total effects) and among unvaccinated children and adults (indirect effects i.e. herd effects). Two thirds of the study clusters use PCV10 and one third of the clusters are control areas, in which the children receive either the hepatitis B vaccine (children aged 6 weeks to 11 months at enrolment) or hepatitis A vaccine (children aged 12 to 18 months at enrolment). The effectiveness of immunization according to a 2-dose or 3-dose primary schedule, followed by a booster dose, will also be assessed in the randomized study among children enrolled at <7 months of age. In addition to IPD, the trial will evaluate total and indirect vaccine impact on the incidence of hospital-diagnosed pneumonia, as well as the vaccine's impact on tympanostomy tube placement and outpatient antibiotic prescriptions. All outcome data for the FinIP trial will be collected from the national registers.

Since approximately 50 000 children are participating and vaccinated in the FinIP trial from 2009 to 2010, this needs to be taken into account in the evaluation of the overall NVP impact. However, the years before 2009 can serve as a reference for limited or no PCV use.

Register data sources for pneumococcal disease

The following national registers are or will be used in the evaluation of PCV NVP:

- National Infectious Disease Register, maintained by KTL/THL since 1995
 - Invasive pneumococcal disease (incl. serotyping and antimicrobial susceptibility)
- National Care Register maintained by STAKES/THL since 1994
 - Hospital-diagnosed pneumonia (ICD-10 coded)
 - Tympanostomy tube placement (performed in public health care)
- Social Insurance Institution register
 - Tympanostomy tube placement (performed in private health care) (since 1964)
 - Outpatient antibiotic prescriptions (since 1995)

The primary data source for the NVP PCV evaluation is the National Infectious Disease register (NIDR) which is a population-based and laboratory-based surveillance system. It includes all IPD isolates reported by the Finnish clinical microbiology laboratories. Approximately 90% of these laboratories use commercial laboratory software, which automatically extracts notifiable findings from the laboratory databases and sends these as encrypted data directly to the NIDR central database via the internet. A case of IPD, defined by detection by culture or detection of DNA/RNA either from blood or cerebrospinal fluid, is typically recorded into the NIDR within 2 weeks of the date of sample collection.

Duplicate reports of cases within 3 months are merged into episodes at THL. The reference laboratories at THL provide serotyping and antimicrobial susceptibility data for the pneumococcal isolates.

Other clinical syndromes potentially caused by pneumococcus are, among others, pneumonia and AOM. The National Care Register (HILMO) contains all outpatient and inpatient diagnoses (ICD10) given at Finnish hospitals. The HILMO has been operational since 1994, and has included outpatient visits since 1999. In accordance with the current legislation, the data accumulates to the HILMO in yearly batches.

The Social Insurance Institution maintains a register that has been operational since 1964 with multiple changes and adaptations to Finnish laws. Expanding data have been collected on national insurance reimbursements, including drug prescriptions, since 1995. From 2006 onwards all prescription medications bought from pharmacies are included in this register.

First results on IPD

The total (i.e. the sum of direct and indirect) effectiveness of the NVP will be evaluated among children born after 1st of June 2010. Those born between June 2007 and June 2010 have largely been eligi-

TABLE 1. IPD incidences by age and calendar-time.

Age group	Incidence/100,000 pyears (N cases)						Percentage Reduction from 2004–2008 to 2011		
	2004–2008		2009–2010		2011		Estimate	95%LGL	95%UCL
0–5 months	30.8	(45)	23.0	(14)	26.2	(8)	15	-71	63
6–11 months	59.5	(87)	51.0	(31)	9.8	(3)	83	56	96
12–23 months	81.1	(236)	64.6	(78)	55.9	(34)	31	3	53
24–59 months	21.3	(183)	20.1	(72)	15.0	(27)	29	-4	54
5–49 years	6.8	(1028)	7.4	(438)	6.3	(187)	8	-7	21
50–64 years	18.0	(1009)	19.8	(459)	19.0	(221)	-6	-22	9
> 64 years	31.6	(1363)	32.4	(599)	31.8	(299)	0	-14	12

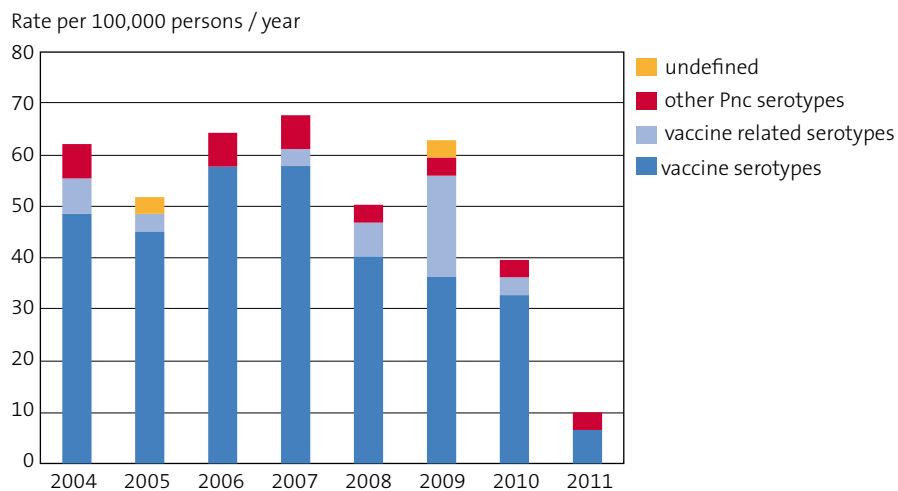


FIGURE 1. IPD incidence in 6–11-month-olds by calendar year

ble for the FinIP study, and will mainly be evaluated in the trial setting. Indirect effectiveness will be evaluated in those born before 1st of June 2007, stratified by age.

The Table reports the rates/100 000 person-years by age and calendar period, along with the pre/post-vaccination comparison.

The rates by serogroup in 6–11-month-olds, the first age-group post-vaccination period where the majority of children are immunised, are presented in the Figure.

Up to the end of 2011, no breakthrough vaccine serotype cases had been observed in children older than 5 months who had received at least 2 doses of PCV10.

A marked reduction in the IPD incidence among those aged 6–11 months was observed within one year of NVP implementation in Finland. As expected, no changes in the disease incidence have so far been observed during the short follow-up after the PCV10 introduction (Table). Continued surveillance will determine potential indirect effects and vaccine-induced changes in the IPD serotype distribution.

Further register data—including hospital-diagnosed pneumonia, tympanostomy tube placement and outpatient antibiotic prescriptions—will be collected to assess the overall effects of the NVP on the total disease burden.

Furthermore, THL is in the process of implementing an online nationwide vaccination register. This register is expected to become operational during 2012. The vaccination register will be utilized in the follow-up of NVP coverage, effectiveness and safety.

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Reference

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Global health challenges require the networking of public health institutes

The network of NPHI directors gather together each year for the IANPHI Annual Meeting. In 2011 the meeting, which was co-hosted in Helsinki by THL, gathered together public health leaders from around the world to explore topics ranging from the growing prevalence of non-communicable diseases (NCDs) and associated tobacco risk factors to maternal health, HPV vaccines, and NPHI response to disasters – in particular the recent experiences of Japan and Germany. Attending were national public health institute directors from 50 countries plus representatives from the WHO and other IANPHI partners, who participated in technical sessions, networking, and sharing experiences to strengthen capacity and prevent and respond to health threats. These themes will be further elaborated in the 2012 Annual Meeting as it will focus on networking to address global health challenges. The meeting will be hosted by the Mexican National Public Health Institute and it will take place in Mexico City in late September 2012.

During 2011, the IANPHI's international collaboration was also reinforced when the IANPHI Executive Board (EB) mid-year meeting was held in Bangkok, Thailand, May 1-2, 2011. Six EB members under Vice-President Pekka Puska and representatives of the IANPHI Secretariat from Finland and Atlanta participated in the meeting. In connection with the Board meeting, the EB made a site visit to the National Institute of Hygiene and Epidemiology (NIHE), Hanoi, Vietnam. The board met with the Institute's management and representatives of WHO Vietnam, with discussion focussed mainly on the NCDs in Vietnam. In addition to Hanoi, a short visit was also made to Phnom Penh, Cambodia, where the EB visited the local National Institute of Public Health (NIPH) and discussed the health situation in Cambodia. Infectious diseases such as HIV/AIDS, TB, gastric and respiratory illnesses are the main health problems in Cambodia, while the prevalence of noncommunicable diseases are increasing in the country.

IANPHI strengthens ties within Europe and the EU

As a part of IANPHI's advocacy work, the organisation together with THL presented a report which discusses the European take on NPHIs. *National Public Health Institutes – European perspective* was written to function as a practical tool in the work to strengthen European National Public Health Institutes, their network and the collaboration with EU/SANCO. The report was initiated during meetings with representatives of DG SANCO during 2010, with Director General Pekka Puska acting to drive the process of engaging a group of directors of European NPHIs. The report describes the nature and status of national public health institutes and defines their role in protection and promotion of public health in their countries. It also aims to define the current core functions of the institutes, and discusses their role in supporting both national public health programmes, strategies and policies, as well as the Health Strategy of the European Union.

The IANPHI has been strongly connected with collaboration within Europe in other ways, as it currently has over twenty European members, most of them in EU countries. The European NPHI collaboration is very topical and important in advocating for a unified health strategy in the EU, and to maintain and further develop the existing network. As a consequence, the European NPHI directors meeting to discuss current public health topics in Europe has established itself as an annual function linked to the Presidency of the Council of the European Union, and hosted by the IANPHI member institute from the country currently holding the EU presidency. The public health topics and activities defined in the Presidency program, carried out by both the host institute and the national Ministry of Health, have formed a technical part of the meeting program, with themes for NPHI collabora-

tion and partnerships forming the other parts of the agenda. Thus the meeting of the European NPHI directors has also served as a platform for a regional meeting of IANPHI members.

In 2011 the meeting was organized in Poznan, Poland in 5–6 November. During the 6th European NPHI directors' meeting in Poznan, it was discussed how it has become increasingly clear that the role of NPHIs in both providing the EU with evidence-based data on public health and implementing EU public health strategies requires good collaboration amongst European NPHIs. The Europe-wide health monitoring and indicator work has shown the areas in which good cooperative progress has been made, and these topics were further discussed during the meeting. As a result of these discussions addressing EU-level health monitoring, a letter to EU Health Commissioner Dalli was drafted and co-signed by 16 European NPHI directors. In May 2012 the letter was delivered to the Commissioner and also the EU Ministers of Health, the Director General of EUROSTAT and the Directors General of National Statistical Institutes.

The next European NPHI directors' meeting is planned to take place in spring 2013, during Ireland's EU presidency and thus it will be hosted by the Institute of Public Health in Ireland. The 7th European National Public Health Institutes Directors' Meeting would further link the IANPHI's work with European public health partners such as WHO Euro, EU DG DEVCO/SANCO, ECDC, EuroHealth-Net, and EUPHA.

Also, in future the European collaboration may prove to be even more important, as the IANPHI is currently going through a transition period with changes both in leadership—new presidents will be elected in the autumn—and in funding, with the Gates Foundation grant expiring in October 2012. However, the association will remain operative beyond October with the Secretariat remaining in THL in Helsinki and continuing to work to maintain the existence of the association. A comprehensive fundraising plan is also being developed for the association through a short-term consultant and in addition to membership fees, external funding has been and will be applied for. Some of this alternative funding highlights the European collaboration and especially connections between neighbours within the EU. In general, the EU enlargement plans have to be accounted for in finding new partners and possible IANPHI members from the European Union neighbouring countries.

The IANPHI Foundation has been established to secure a sustainable future for the IANPHI as an international umbrella organization for National Public Health Institutes. The Foundation serves as a technical body supporting and executing IANPHI Executive Board decisions and to facilitate activities of the IANPHI. It was established in Finland in March 2011 by the THL Foundation in accordance with Finnish law. The founding capital required for the establishment of the Foundation was donated by the THL Foundation. Since the establishment of the Foundation, it has also acted as the technical body for collecting membership dues and may receive independent donations supporting the IANPHI. The Finnish IANPHI Secretariat supported the technical process of the establishment of the Foundation and continues to coordinate its functions, such as collecting membership dues.

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Supervision programmes and self-monitoring as enhancers of effective social welfare and healthcare supervision

The focus of social and health care in Finland has gradually shifted from reactive supervision to proactive supervision. The licence administration of private social welfare and healthcare is proactive supervision at its best: the information provided in a licence application and the terms and conditions applying to the activities included in licences give the licence issuer a picture of the provider and of any risks related to the activities concerned. This type of proactive supervision is still absent in public social welfare and healthcare.

In practice, reactive supervision still forms the focus of supervision in social welfare and healthcare. The number of complaints and malpractice reports about social welfare and healthcare continues to grow the whole time and the limited resources available must be used to investigate these. However, there is an awareness of the significance of proactive supervision and this is increasingly being deployed wherever possible. Systematic plan-based supervision has earlier been carried out in the supervision of access to non-urgent treatment in the healthcare sector and in the care of older people on the social welfare sector. For example, proactive supervision based on supervision programmes has longer traditions in environmental healthcare and alcohol administration.

Cornerstones of systematic proactive supervision

Proactive social welfare and healthcare supervision is being developed with the help of two new tools: supervision programmes and self-monitoring. In 2012, Valvira, the National Supervisory Authority for Welfare and Health, and Finland's six regional state administration agencies have completed six social welfare and two healthcare supervision programmes. The programme on supervision of the care of older people was completed earlier. Launching of the supervision programmes and training of the supervising officers is currently under way and the programmes are being implemented in the same context. Systematic social welfare and healthcare supervision will be implemented in accordance with the following national supervision programmes drawn up for 2012-2014:

Social welfare

- General principles of the supervision of social welfare
- 24-hour services for older people
- 24-hour care and upbringing in child welfare
- 24-hour residential services in mental health and in social welfare for substance abusers and institutional care for substance abusers
- 24-hour residential services for disabled persons
- Services and care to be given at home
- Compliance with the deadlines for social assistance

Healthcare

- Proactive healthcare services for children and young people
- Access to non-urgent treatment

Supervision programmes will promote changes within supervision, *inter alia*, with regard to:

- More consistent supervision across Finland.
- More proactive, systematic and effective supervision.
- Supervision more often based on risk analyses.
- Supervision programmes guide service providers in the development of self-monitoring.
- Scant supervision resources can be allocated more effectively.
- Clear division of roles between the various agencies.
- Supervision programmes are public documents and increase the transparency of supervision for the organisations, practitioners and employees to be supervised, as well as for customers and patients.
- Customers, patients and their families know the type of services, treatment and care they are entitled to. If necessary, they can intervene over shortcomings in treatment or care.

Right of self-determination as a focus in supervision programmes

The focus of supervision in 2012 is the implementation of customers' right of self-determination in 24-hour care and upbringing within child welfare, in 24-hour residential services for disabled persons and persons undergoing mental health and substance abuse rehabilitation and in the institutional care of substance abusers.

To obtain a situational awareness of the implementation of the right of self-determination, Valvira has carried out a survey based on a sample of the units referred to above. The results of the survey will be reported in the autumn 2012.

Challenges facing supervision programmes

For supervision to be effective, the legislative basis must be adequate. Social welfare and healthcare legislation is largely framework legislation and does not give detailed quantitative and qualitative criteria of what is required of services. Therefore service providers have interpreted legislation in different ways. Moreover, the decisions of licence and supervision agencies have varied across the country.

The Ministry of Social Affairs and Health has issued sector-specific recommendations, especially for social welfare. Recommendations have been issued, for example, of the care units' personnel resources and room space. In the absence of binding norms, the supervisory agencies lean on these recommendations. Also courts of law have taken into account these recommendations in their decisions. From the supervision perspective, however, it would be better if legislation were to define in detail the criteria of good enough care in social welfare and healthcare.

Another factor affecting supervision is the absence of up-to-date, objective and comprehensive situational awareness. It is hard to allocate supervision on a risk basis if the agencies have no information

on the standards of treatment and care in the field. Valvira has proposed that in conjunction with new legislation, the agency responsible for collecting the information needed for situational awareness and for passing it on to the agencies should always also be specified in the law.

As things stand at present, Valvira has itself had to carry out surveys of care units. This takes considerable time from supervision work proper. The supervision officers are generally not trained researchers, which quality reports and reporting would nevertheless require.

Systematic self-monitoring acts to support supervising officers

Supervision plans make the proactive supervision of social and health care carried out by agencies more vigorous and improve the effectiveness of supervision. However, supervision cannot be based solely on the supervision carried out by agencies, but must be based on systematic self-monitoring by the service provider.

Self-monitoring has been provided for earlier in the Act on Private Healthcare (1990/152) and in the Act on Private Social Services (922/2011). On the other hand, the Health Care Act (1326/2010) that entered into force in 2011 does not provide for self-monitoring, although under the Act, the health-care operating unit must draw up a plan for quality management and patient safety enforcement. A government decree provides for which matters must be agreed on in the plan. In practice, the quality management plan equates to the self-monitoring plan, although wishes have already been expressed for a harmonisation of the term “self-monitoring” in legislation governing private and public social welfare and healthcare.

Self-monitoring means that a service provider independently assures quality so that the quality criteria required by legislation, licence conditions and supervision programmes are implemented in activities and the quality criteria imposed by the service provider on its own activities take into account the recommendations given for the quality of services.

Self-monitoring is part of the quality management to be implemented in a care unit or activities. This will typically entail a description of the courses of action planned to ensure and improve customer and patient safety, the documents used and the continuous assessment and monitoring of activities. A self-monitoring plan is drawn up for each care unit and service.

A self-monitoring plan is a public document that must be kept available for the inspection of customers and employees. This means that also customers and employees have a possibility to monitor its implementation.

Besides self-monitoring being an integrated part of the responsible activities, leadership and quality management of each operating unit, it is also necessary because of the small number of supervisory agencies. In Finland, there are tens of thousands of social welfare and healthcare units maintained by the public and private sector. In addition to this, supervisory agencies oversee the activities of almost 400 000 registered healthcare professionals.

Supervision programmes focus on supervision based on risk, but it is obvious that with existing resources, the supervising officers are unable to provide a sufficiently comprehensive systematic supervision of care units and professionals, especially since reactive supervision takes up, at least for the moment, a large part of their work input. This situation can only change when proactive supervision and systematic guidance are made to work better than they do at present. The current situation is a vicious circle: reactive supervision takes up a large part of the supervisors' work; there are insufficient resour-

es to develop proactive supervision, which in turn adds to the number of complaints and malpractice reports.

Self-monitoring could be part of the solution to the problem. However, the supervisory agencies cannot merely rely on the functioning of self-monitoring. Methods must be developed to enable the agencies to check that service providers have drawn up plans. At the same time, we have to ensure that the plans do not only exist on paper, but that they are actually put into practice and activities are supervised systematically to ensure the quality of activities. The plan is, in autumn 2012, to implement self-monitoring in 24-hour care and upbringing within child welfare, in 24-hour residential services for disabled persons and persons undergoing mental health and substance abuse rehabilitation and in the institutional care of intoxicant abusers a particular target of supervision in accordance with the supervision programmes drawn up for these sectors.

It is important that both supervision programmes and self-monitoring plans are public documents. Customers and patients, their families and the personnel of operating units can use the supervision programmes to check the minimum that the supervisory agencies require of the services. They can use the self-monitoring plans to see how a service provider has promised to ensure the appropriateness of its activities. If there are any shortcomings in activities, the supervisory agencies can intervene.

The Health Care Act gives patients and customers greater freedom of choice than previously, for example, on choosing where they are treated. The Social Welfare Act currently being drafted is based on customer needs and the obligation of a municipality to respond to those needs. It is only natural for patients and customers to also have an opportunity themselves to oversee the appropriateness of the treatment and care they receive. This does not of course replace agency supervision.

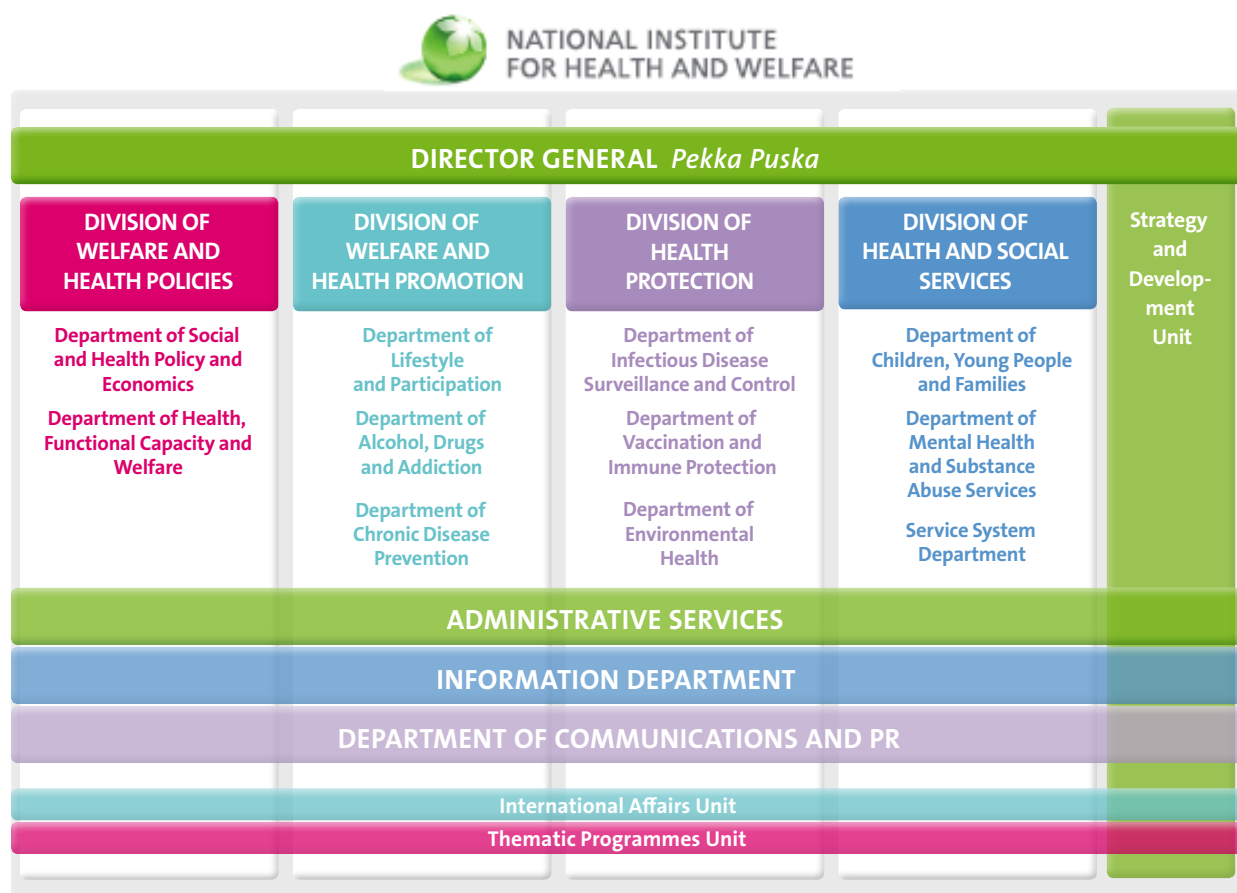
To ensure the implementation of self-monitoring, Valvira has issued a regulation and guidance for the self-monitoring of private social welfare. A similar regulation concerning private healthcare will also soon enter into force. A start has been made on the training of service providers. The challenge is how self-monitoring can be made into an obvious integrated part of activities for practitioners, care unit personnel, patients and customers, their families and relatives.

If a social welfare and healthcare customer is dissatisfied with the service received, he or she can lodge a complaint with the municipal official. Valvira has proposed that use of the complaint procedure be enacted as the compulsory primary appeal procedure. Properly used, the complaint procedure could thus be an effective and practical operational model to process customer feedback incorporated in the quality management system.

Marja-Liisa Partanen
Director General
National Supervisory Authority for Welfare and Health (Valvira)

THL in a nutshell

The National Institute for Health and Welfare (THL) promotes the health and welfare of the population, prevents diseases and social problems, and develops social welfare and health care services in Finland.



Organization

- Director General: Professor Pekka Puska
- Management Board: the Director General, the Deputy Director General, three Assistant Directors
- General, a Strategic Director and an Administrative Director
- Four divisions, 14 departments and 62 units
- Horizontal functions, departments and units
- THL's operations are guided by an annual performance agreement made with the Ministry of Social Affairs and Health. The Director General reports directly to the Ministry
- THL is a national agency
- THL's main office is located in Helsinki. Six satellite offices are situated in other cities: Turku, Tampere, Jyväskylä, Kuopio, Oulu and Vaasa.
- State institutions subordinate to THL:
 - State mental hospitals (Niuvanniemi and Vanha Vaasa)
 - State reform schools

Funding

- THL's total budget for 2011 was some EUR 118 million:
- 65% from the State Budget, 28% from outside funding sources and 7% from chargeable services.

Personnel

- Highly multiprofessional personnel
- The average age is 45
- 74% are women and 26% men
- 70% are permanent employees, 30% fixed-term employees
- THL has a total staff (in person years) of about 1200