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Health monitoring and reducing health inequalities in Finland - observations of health inequalities and practical measures

MAIN FINDINGS

- In the past 30 years, reducing health inequalities has been the key focus area in Finnish health policy. However, health inequalities between population groups have not declined significantly in the 2000s and have even grown partly.
- Reducing health inequalities requires regular monitoring of the situation. In Finland, national population surveys and register data are the main sources of information.
- The health of the population should be looked at regularly at least from the points of view of gender, area of residence, socioeconomic status, origin and restrictions in functional capacity, while also considering intersecting factors.
- Finland's legislation obliges the public authorities to the promote the health and well-being of people and implement equity in the quality and availability of services. Using knowledge and information to support decision-making and to enable effective measures requires broad-based specialist work between different actors.

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There have been positive developments in many subareas of the health of Finnish people. However, it has not been possible to significantly reduce the health inequalities between population groups and inequalities have even grown partly. (Koskinen et al. 2018, Karvonen at al. 2017; Rahkonen at al. 2011)

Decision-making based on high-quality research, appropriately focused measures and assessing their productivity require regularly updated data on the population's health and its inequalities. Data is needed nationally, regionally and by population group, such as according to different ethnic backgrounds and socioeconomic status. (Koskinen et al. 2018.)

This working paper presents observations on health inequalities, health monitoring and the practical measures taken to reduce health equalities in Finland. Observations were collected in the European Union's project Joint Action Health Equity Europe (JAHEE) aimed at "better health equality in the European countries". Finland's objectives in the project included describing the national target state for monitoring health inequalities and developing and testing different ways of turning the information on inequalities into actions.

Observations on health inequalities

It is typical of health inequalities that the lower the person's socioeconomic status, the poorer their health. Almost without exceptions, this applies to the different areas of health, such as morbidity, mortality and perceived health. (e.g., Karvonen & Kauppinen 2009 & 2014; Koskinen et al. 2018; Parikka et al. 2017; Rissanen et al. 2020.) (Figure 1., Figure 2. and Figure 3.)

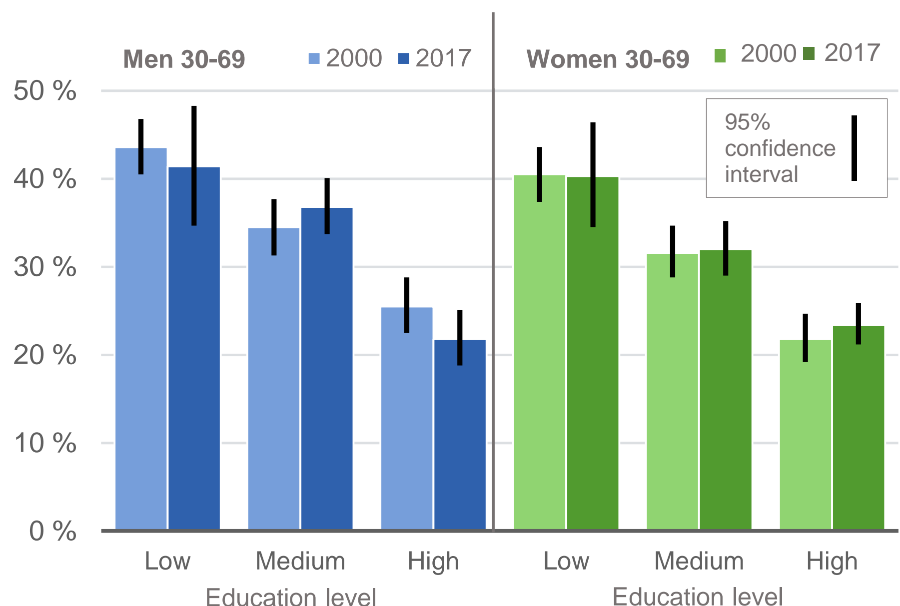


Figure 1. Perceived health moderate or worse in 2000 and 2017 (research material of Health 2000 and FinHealth 2017 surveys)

Health inequality indicators, proposal:

- Life expectancy of 30-year-olds, by level of education
- Alcohol-related deaths, potential years of life lost (PYLL) at ages 25–80 / 100,000 inhabitants, by income group
- Self-rated health moderate or poor (%), aged 20 or over, by level of education
- Severe mental strain, aged 20 or over, by level of education
- The share of those provided with insufficient doctor's appointment services, (%) of those needing the services, aged 20 or over, by level of education
- Avoidable hospitalisations, inequality index (RII) according to income group
- Going short of food, medicines or physician visits because of lack of money (%), aged 20 or over, by level of education
- Daily smokers (%), aged 20 or over, by level of education
- Obesity (Body Mass Index BMI ≥ 30 kg/m2) (%), aged 20 or over (measured weight), by level of education
- Proportion of those who eat vegetables and fruit in accordance with nutrition recommendations (%), aged 20 or over, by level of education
- Proportion of those meeting the physical activity guidelines (%), aged 20 or over, by level of education
- Self-reported reduced work ability (%), aged 20–74, by level of education
- Share of those with activity limitations due to health problems, share (%), aged 20–64, by lev-el of education

[National health inequality indicators (group ID 813)](#) in the Sotkanet web service

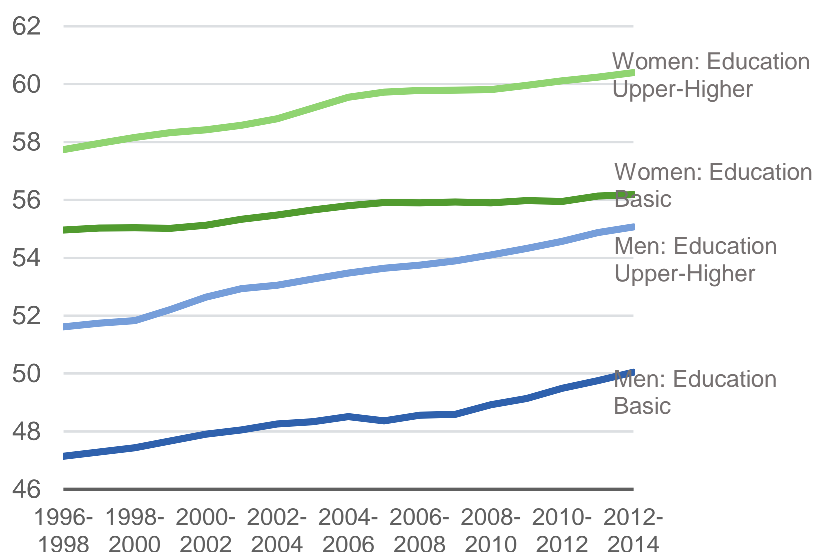
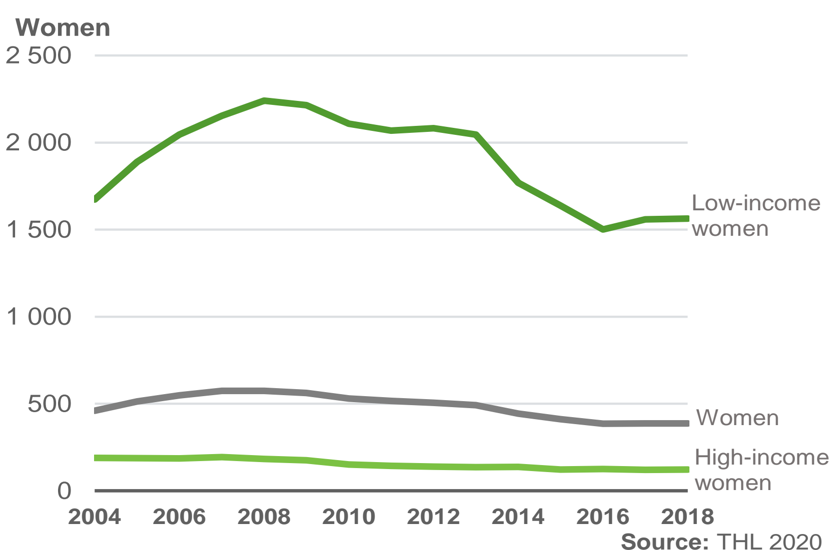


Figure 2. Life expectancy at the age of 25 years, by sex and education, 1996-2014 (Source: Parikka et al. 2017, Terveytemme.fi).



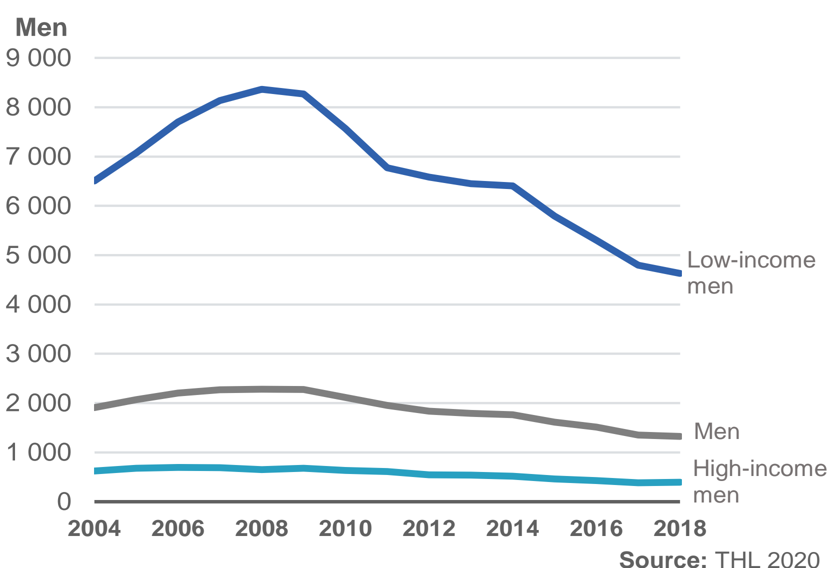


Figure 3. Alcohol-related deaths, potential years of life lost (PYLL) at ages 25–80 / 100,000men and women of corresponding age.

Health also varies between linguistic and cultural groups, such as between the Roma and the whole population and between immigrants and the whole population. There are also considerable health and wellbeing inequalities within the groups. For example, immigrants perceive their health as poorer than the whole population, but the perceived health among immigrants also varies by country of birth (Figure 4.)

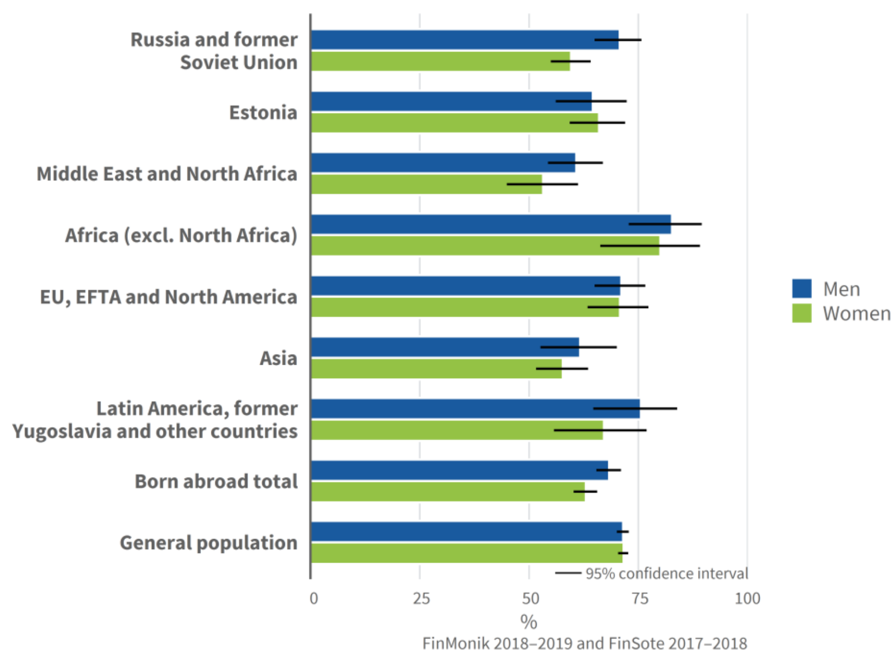


Figure 4. Self-rated health good or fairly good by country of birth, standardised according to age and gender

In addition to socioeconomic factors, the health of the population also varies between the regions. People in southern and western Finland are on average healthier than people in eastern and northern Finland. For example, people living in eastern Finland rate their work ability deteriorated more often that those who live in western Finland. (Parikka et al. 2017.)

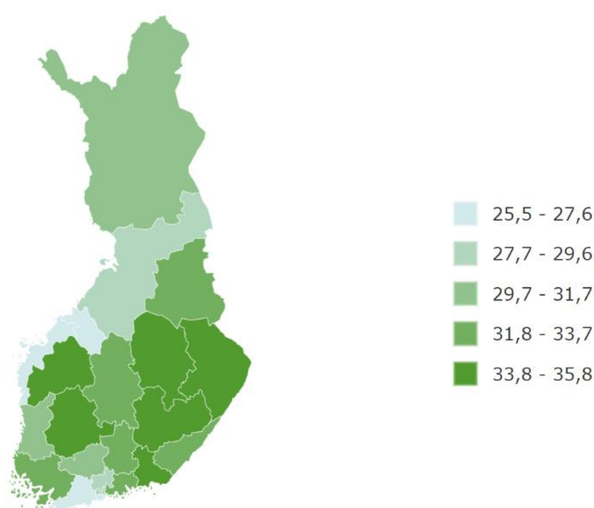


Figure 5. Proportion (%) of self-rated deterioration of work ability (max. 7/10) in 2020 (source: terveytemme.fi).

Description of the JAHEE project

Joint Action on Health Equity Europe (JAHEE) June 2018–November 2021. 25 participating EU countries.

Reducing health inequalities is an important European goal, which the JAHEE project tackles through cooperation between different countries.

Finland participates in three different theme areas through its own actions:

1. In the Work Package “Monitoring health inequalities”, a proposal is made for national monitoring of health inequality data and for improvement proposals.
2. In the Work Package “Migration and health”, key policy measures for promoting the health and equity of immigrants are identified.
3. In the work package “Health and equity in all policies”, two selected regions are supported and evaluated with regard to how attention is paid to inequality in the promotion of health and wellbeing.

The measures taken in Finland and the lessons learnt from them have been compiled in this report.

Premature deaths are more common in eastern and northern Finland than in southern and western Finland. There are clear differences in mortality between the regions and the differences are wider in men than in women. The life expectancy of men is shorter than that of women in all the regions. Between 2017 and 2019, the gender gap was greatest in Kainuu, where the life expectancy of men was 6.7 years lower than that of women. The gender gap was the lowest, 3.9 years, in Central Ostrobothnia. (SVT 2019.)

Monitoring of health inequalities

Reducing health inequalities requires regularly accumulated monitoring data that guides the actions aimed at reducing the inequalities and the assessment of their impacts. (Rotko et al. 2012). In Finland, registers, statistics and data from population surveys are the main data sources describing the population’s health and wellbeing.

So far, the challenge has been the lack of data on some population groups. The information missing from registered data and deficiencies in up-to-date information are a problem especially when people of foreign origin are looked at (e.g., mobility, immigration and emigration). In addition, data on some population groups cannot be obtained from registers at all (e.g., data on the Sámi, the Finnish Roma and undocumented persons). Regional and other differences between population groups may partly be distorted, for example, because of different treatment and recording practices.

The need for data on different population groups has been identified and population surveys are improved considering the current gaps in data and the groups in a vulnerable position. Several separate studies to reliably assess health, wellbeing and access to social welfare and health care services in different population groups have been conducted in Finland. Five of these separate collections of information have focused the population of foreign origin in Finland (incl. one on asylum seekers) and one on Finland’s Roma population (Castaneda et al. 2012; Nieminen et al. 2015; Skogberg et al. 2019; Weiste-Paakkanen et al. 2018; Kuusio et al. 2020). The aim is to include the monitoring of the health and wellbeing of linguistic and cultural minorities on the basis of population surveys as part of THL’s data collections focusing on the whole population.

Observations on practical measures

The JAHEE project supported the preparation of strategic goals for the promotion of wellbeing and health and for reducing inequalities in two future wellbeing services counties (see THL 2021a). The future wellbeing services counties were preparing a county welfare report in which the state of wellbeing in the county is described by population group and strategic goals are proposed for the upcoming county council term to increase wellbeing and reduce inequalities (for more information on the preparation of the report, see e.g., THL 2021b). The indicators presented in the sidebar were tested in the course of the preparation and used in setting the objectives.

Welfare reports are statutory documents in accordance with the Social Welfare and Healthcare Act and they are drawn up regularly both in the wellbeing service counties and in municipalities (Act on Organising Social Welfare and Healthcare 612/2021, sections 6,7). Welfare reports are prepared in a large multiprofessional working group and the work often involves different wider forms of participation. In these workshops and seminars, participants brought up a large number of observations concerning inequalities that were related to their own experiences or to already existing concerns caused by indicators describing inequality. The existence of the indicators is important so that the parties involved can either identify the manifestations of inequality or receive confirmation of the truthfulness of their own experiences.

So far, it has not been easy to find indicators related to inequality in Finland and they are not all available regionally. Inequality indicators require several types of data to be combined and different regional and national sources of information to be identified. For the first time, indicators and sources of information on inequalities have now been compiled on the website of the Finnish Institute for Health and Welfare (THL 2021c) and in this publication.

A concern related to health inequalities does not always need to be supported by an indicator to become a strategic goal of the wellbeing services area. A concern that had emerged in the multiprofessional discussions, could be agreed to be included as a strategic goal without any concrete measured data. In the background, there was often an awareness of the development trends or conditions that might have already been described at the national level. For example, such goals could include children's use of intoxicants, multigenerational marginalisation or variations in the availability of a certain service.

On the other hand, the project observed clear inequality indicators that had been previously reported by region and discussed in the preparation stage but had not been made goals for reducing health inequalities in the region. Some of the very specified concerns may lose their original health perspective when the welfare report is condensed. For example, a shared concern over long-term unemployed people with certain characteristics faded into a measure concerning health examinations for unemployed people generally. or just concerning the work ability of working-age people. Goals focusing on specific groups of people may remain in the background because of the better acceptability of universal measures that can be developed for larger population groups.

There was simply not enough room for some of the shared and measurable socioeconomic wellbeing and health inequalities in the compact whole of strategic goals in the welfare reports. The existence of indicators alone is therefore not enough. What is required is a multidisciplinary shared understanding of the phenomenon described by the indicator and of the development trends and potential consequences resulting from the phenomenon described by the indicator. When the indicator data is presented in the wellbeing services counties, descriptions of the cause and effect chains and alternative cost modellings of the phenomena involved in the indicators would be needed.

Although not all of the identified matters could be included, several inequality-related objectives remained in the welfare reports of the two future wellbeing services counties. The welfare report is a political choice and an expression of will of the persons who prepared it and the elected decision-makers. Only a few matters requiring development can be selected to the report at a time.

The proper discussion on health inequalities in the region needs:

- easily found, regularly updated indicators describing inequalities by region,
- a sufficiently multidisciplinary group with sufficient expertise to identify the special features of inequality in the region and valuate the amounts of concern with indicators,
- an opportunity to model possible alternative future development trends to assist the valuation, and
- an open preparation and decision-making process, in which genuine interaction between different actors is possible.

Conclusions

Health inequalities between population groups have not declined significantly in the 2000s and have even grown partly in Finland. For example, this means that people with a lower level of education are increasingly ill and those with a high level of education are healthier.

High-quality data from population surveys and registers makes it possible to monitor the health of the population and the inequalities in it. Population surveys (both health examination surveys and health interview surveys) are required to supplement register data. Relatively comprehensive data on the users of public services is obtained from registers, but there are gaps concerning those people who for one reason or another do not seek services or have access to them. Registers also do not provide data on the perceived health, functional ability and health habits, or on phenomena based on individual experiences, such as discrimination, trust or treatment when using services. The latter have a known link with people's health, which in turn increases health inequalities. (Castaneda & Kuusio 2019.)

Population surveys also provide valuable information on the risk factors of illnesses, such as lifestyle. From the point of view of reducing health inequalities and broad-based welfare

policy, people's health should be examined comprehensively using data obtained through different data collection methods.

A person's socioeconomic background, such as educational background and main activity or position in the labour market should be included in studies looking at the health of the population and the inequalities emerging in it. Furthermore, the person's origin and restrictions in functional capacity are important factors in the monitoring of health inequalities, not forgetting the examination of intersecting factors.

However, there are still challenges in combining the data received from different data sources, and efforts must be made to solve them. Another problem is that inequality information at the regional level is not available on all phenomena.

An indicator is not always required to support decision-making regarding a concern related to health inequalities. It is often enough that the people preparing the welfare report agree about the importance of the matter.

Finland has expertise and tools for monitoring the health inequalities of the population. A recommendation to use them has been given in the JAHEE project.

With regard to the data content of many of the health indicators, THL is the main party producing the data in Finland. However, there are still challenges in combining the data received from different data sources, and efforts must be made to solve them. Using data to support decision-making and enable effective measures requires both multiprofessional work and collection, compilation and interpretation of data jointly by different actors.

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