Date: **15 May 2002**

Venue: **Committee Room 3, National Assembly for Wales**

Title: **Report of Ministerial Visit to Finland**

Purpose

1. To provide feedback from my visit to Finland on 26-28 March 2002.

Summary

2. Preventing coronary heart disease and tackling inequalities in health are challenges common to all European countries. My short visit, during which I met my Finnish counterpart and key institutions, proved both useful and interesting. It provided an insight into Finland's approach and triggered thoughts on a number of issues. Over and above prevention issues, the visit also provided an opportunity to learn more about the Finnish healthcare system. This paper to note summarises the main points.

Background

3. I first met my Finnish counterpart when I represented the UK at the 2001 World Health Assembly. Discussion suggested that a visit to Finland would be useful given their work on preventing CHD and this thought was reinforced by discussion with Anglesey GP and Chair of the Local Health Group Dr Wil Roberts. He and a colleague visited Finland's North Karelia CHD prevention project together with two members of the Executive Team from Ysbyty Gwynedd.

4. My visit comprised a full programme of meetings with the Ministry for Social Affairs and Health, the National Public Health Institute, the National Development Centre for Research into Welfare and Health, the North Karelia project, and a Regional Hospital and Health Centre. I also met the British Ambassador along with Sue Essex who also travelled to Finland for a separate programme of visits in her capacity as Environment Minister.

5. Finland (population 5.2 million) has one of the world's lowest infant mortality rates. Cardiovascular and cerebrovascular diseases are the most common causes of death. Female mortality is below the

European average, but the death rate amongst men raises overall mortality above the European average, although there has been some change for the better. Cancer is the second most common cause of death, although mortality rates are lower than elsewhere in Europe. Death rates from accidents, suicides and violence are higher than the European average and mental health and well being is one of Finland's priorities.

6. Communicable disease is not considered a problem because of an effective immunisation programme. Take up of MMR, for example, is 98% and there are no public concerns. Communicable disease is monitored very closely in the view of the seriousness of problems in Russia.

7. There has been a gradual change in Finnish eating habits, mainly for the better, although it remains the case that only a third of the population have cholesterol levels within the recommended range (<5 mmol/l). Weight problems and obesity have become more common. Levels of smoking are below the European average but despite preventive programmes, there has been no reduction in smoking amongst young people. Inequalities in health exist with a difference of 5 years in life expectancy between some areas, which is similar to Wales.

Healthcare organisation and financing

8. Responsibility for health in Finland rests with the Minister of Health and Social Services, one of two Ministers in the Ministry for Social Affairs and Health. Below Parliament, healthcare is organised around:

- Government - Ministry of Social Affairs and Health
- 5 Provincial Boards – responsible for guidance, supervision and development of the social welfare and health care sector.
- 450 Municipalities – responsible for organising healthcare for populations ranging from 1,000 to 500,000 (average 11,000). They provide healthcare services independently or in joint arrangements with neighbouring municipalities.
- 256 Health Centres - providing inpatient and outpatient treatment and care.
- 20 Hospital Districts - cover populations of between 70,000 – 1.3 million. Includes acute hospitals and psychiatric hospitals

9. Finland has 5 medical schools, 17 central hospitals and over 30 less specialised hospitals. Hospitals are non-profit making organisations owned by federations of municipalities. Currently, 550 doctors are trained each year but this will increase to 600 per year from this autumn in a move to reduce shortages. Action is also in hand to increase the numbers of other health professionals in training.

10. Healthcare is financed from public and private sources. Public funding accounts for approximately three-quarters of expenditure and comprises government grants, funding from municipalities through local tax, and social insurance. The private health sector funding includes fees paid by individuals, by private insurance, and employers. Individuals can receive partial reimbursement of fees from insurance funds towards the cost of some private healthcare. Parliament decides the upper limits on fees paid by people for visits to hospital and health centres. For example, the annual fee for an adult to visit a health centre is currently 22 euros (approx. £13).

11. Over the last 10 years, decisions on health expenditure and spending patterns has graduated towards the 450 municipalities. The Ministry for Social Affairs and Health influences healthcare in three main ways, by legislation, by providing additional 'special' monies in exceptional cases on priorities issues, and through information. Information is considered a key tool and developments have included quality frameworks that, in broad terms, appear similar to our National Service Frameworks.

Health 2015

12. *Health 2015*, a Resolution made by the Government last year, sets out Finland's programme and targets for its national health policy over the next 15 years. It focuses on improving health. Amongst other things, it requires all sectors and levels of government to make the population's health a key principle guiding choices and for the social dimension to be made an element in results management by each Ministry. It aims to achieve better conditions for improving people's health and for people to have opportunities to influence decision-making concerning healthy environments. It commits the Government to consider the health impacts of policies and programmes.

13. The focus of *Health 2015* shows that Wales and Finland have much in common in the approach to protecting and improving health. There is considerable common ground on broad themes such as improving health, multi-sectoral action, reducing inequalities in health, and on specific issues e.g. health impact assessment, and the development of targets and indicators. Many themes - action to building health into other policy areas for example - are inherent in our approach and will be reinforced further through the development of the follow up to Better Health Better Wales, which I will bring to Committee in July prior to public consultation. While I was there to learn about Finland, officials there were well familiar with our work on health impact assessment and were interested in other developments e.g. our NHS Resource Allocation Review, mental health strategies. My officials will share information with their Finnish counterparts.

North Karelia project

14. The North Karelia area in East Finland, one of its poorer areas and in receipt of Objective 1 support, is home to some 170,000 people. It is a shining example of what people can do if they put their mind to it. Launched in 1972, the project was the direct result of pressure from local people who petitioned local politicians and community leaders for urgent action to reduce the exceptionally high death rates from heart disease. Action by the community and co-operation between local and national organisations led to

a wide range of action to persuade and help people of all ages to take steps to reduce their risk of heart disease and to improve their health.

15. By 1995, the annual death rate from heart disease in people of working age in the area had fallen by 75% compared with that before the project. A remarkable decline has taken place in smoking among men for example, major changes in people's diets and levels of cholesterol and blood pressure have fallen. The North Karelia project shows that it takes time to impact on the whole population but the benefits to individuals of action to improve their health will be seen much quicker.

16. In Wales, we are already focusing support at the community level but it is clear that the interest and pressure from local people was a powerful driver for a sustained and concerted effort in the North Karelia area. We must continue our efforts to raise awareness of the risks of heart disease and its impact on people and their families. Local councillors and community leaders can help to do this. In establishing Local Health Boards, we have a major opportunity to reinforce our efforts to protect and to improve people's health in partnership with others. I will be looking to the Chairs of Local Health Boards to ensure that coronary heart disease prevention, and improving health more generally, sits alongside effective and efficient health services as an equal priority.

17. I understand that those from North Wales who took part in the North Karelia Visitor's Programme learnt a great deal from their visit on focused approaches to primary prevention and its effectiveness. As a result, Anglesey is developing similar programmes in co-operation with, amongst others, local newspapers and radio, the local authority and Town Council. With the establishment of Local Health Boards, I am mindful of the benefits to others of learning more about the North Karelia project.

National Research and Development Centre for Welfare and Health (STAKES)

18. The Centre monitors and evaluates the development and operation of social welfare and health care, and carries out research and development in the field of social and health care services. It produces and acquires Finnish and foreign information and know-how, and transfers this to field workers, workplaces and decision-makers. The Centre, which has 450 staff core funded by Government, co-ordinates a wide range of national social and health statistics and is focusing on co-ordinated approach. It also houses the Health & Development Co-operation Unit, the Health Care Method Assessment Unit, and the Centre for Excellence for Information and Communications Technology in Welfare and Health. Inequalities in health are one of the Centre's priorities and targeting the municipalities for local action is a key strand of the approach.

National Public Health Institute (KTL)

19. The Institute brings together a number of areas of public health work in one organisation. It covers infectious diseases (monitoring, immunisation and other prevention activities), research and development into health and chronic diseases (e.g. CHD, cancers), and environmental health. Its role includes research and expert functions, national monitoring, laboratory services and reference functions,

scientific development (e.g. research into genetics and health), professional education, and information provision. The Institute and the way it brings together a range of public health functions struck me as relevant given the development of our Wales Centre for Health. The Institute was founded in 1911 and has grown to employ over 1,000 staff. Around 450 posts are core funded by the Government while the remainder stem from the critical mass of expertise it has developed and the research and other monies it attracts.

Hyvinkaa Regional Hospital and Health Centre

20. I was impressed with the facilities I saw in Hyvinkaa, a small town some 60 kms from Helsinki. The hospital, which is similar to some of our District General Hospitals, has 250 beds and is owned by a group of 30 municipalities. Half of all surgery is day surgery and increasingly, patients come in on the morning of their operation as opposed to the night before. A new Health Centre has been built alongside and thus primary and secondary care share the same reception for emergency treatment. The Health Centre is also a 24 hour service and has a number of beds at the disposal of the GPs who work there.

21. Some of the problems we face are similar e.g. nursing vacancies, and occasional violence to staff in A&E. However, while clearly one of Finland's newer facilities, I was impressed with what I saw. This ranged from issues such as occupational health for staff and patients, with far greater emphasis than here in Wales, to design issues. The design was based on 3-bedded wards each with en-suite facilities, and the use of natural light and the use of locally produced artwork made for a bright and welcoming environment. I was struck by their development of a Patient Learning Centre as a means of educating patients and their families about their conditions and their treatments, and for its use with groups of patients in ongoing support programmes. This strikes me as something that might be relevant here.

Welsh-Finnish Society

22. The British Ambassador has helped a Welshman to establish a Welsh-Finnish Society in Helsinki and was keen to talk with Sue Essex and myself about developing it further. Several opportunities were identified. My officials have provided additional information and are helping to make the necessary connections within Wales.

Timescale

23. Paper for information only.

Compliance

24. The Ministry of Health Act 1919 covers action conducive to the health of people. The National Health Service Act 1977 covers services related to health. Powers for both have been transferred to the Assembly and are delegated to staff. The Government of Wales Act 1998 provides the Assembly with the power to do anything to facilitate, or conducive or incidental to, the exercise of any of its functions

(Section 40). Expenditure is covered by Section 85(2). There are no issues of regularity or propriety.

Finance

25. There are no financial implications arising from this paper, which is provided for information.

Jane Hutt
Minister for Health and Social Services

Contact point: Ceri Breeze
Public Health Strategy Division
029 2068 3214