# THE FINNISH AND BRITISH HEALTH INEQUALITIES STRATEGY: THEORY, PRACTICE AND EFFECTIVITENESS.

CHANTAL VERDONSCHOT
STUDENT NUMBER: 419627

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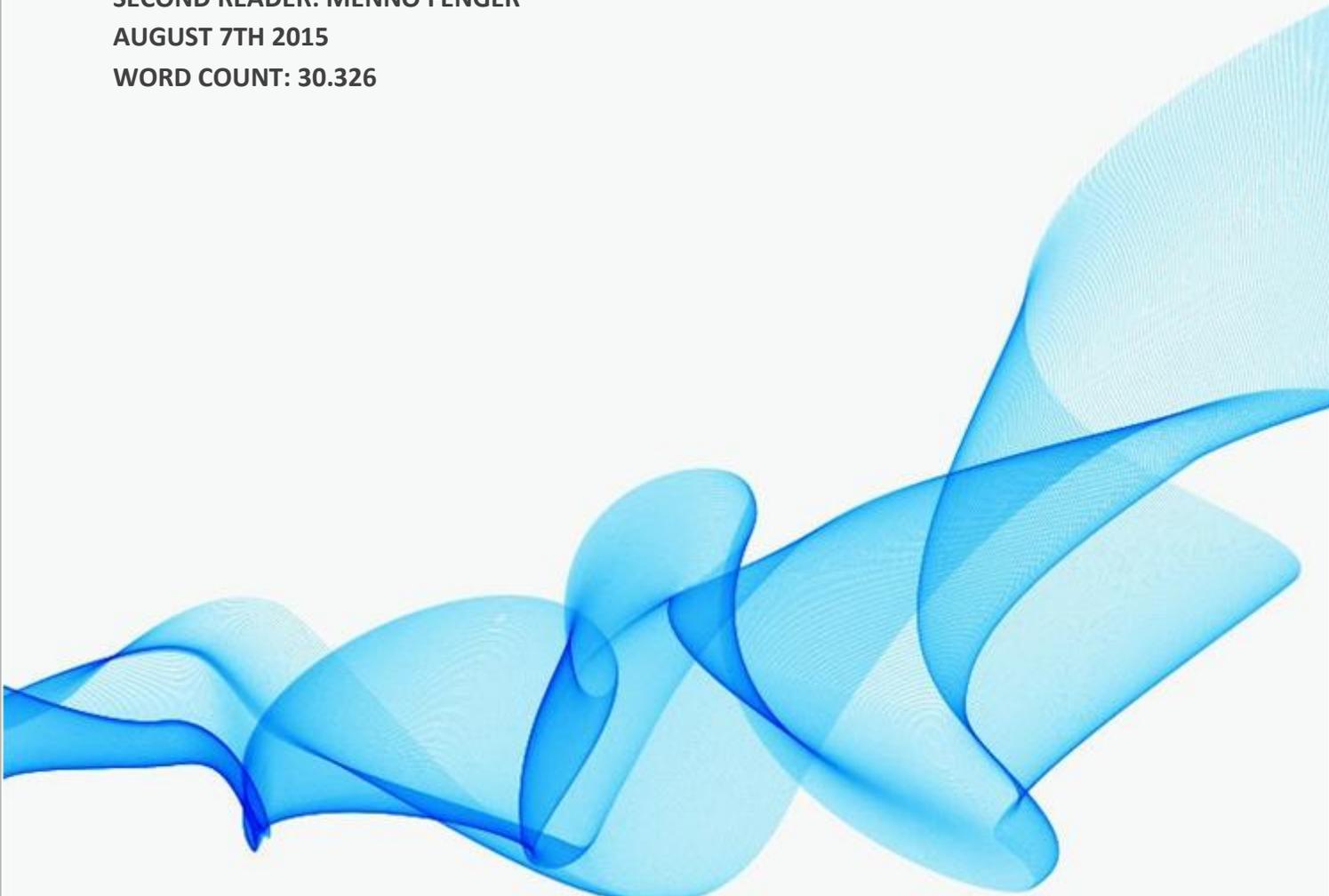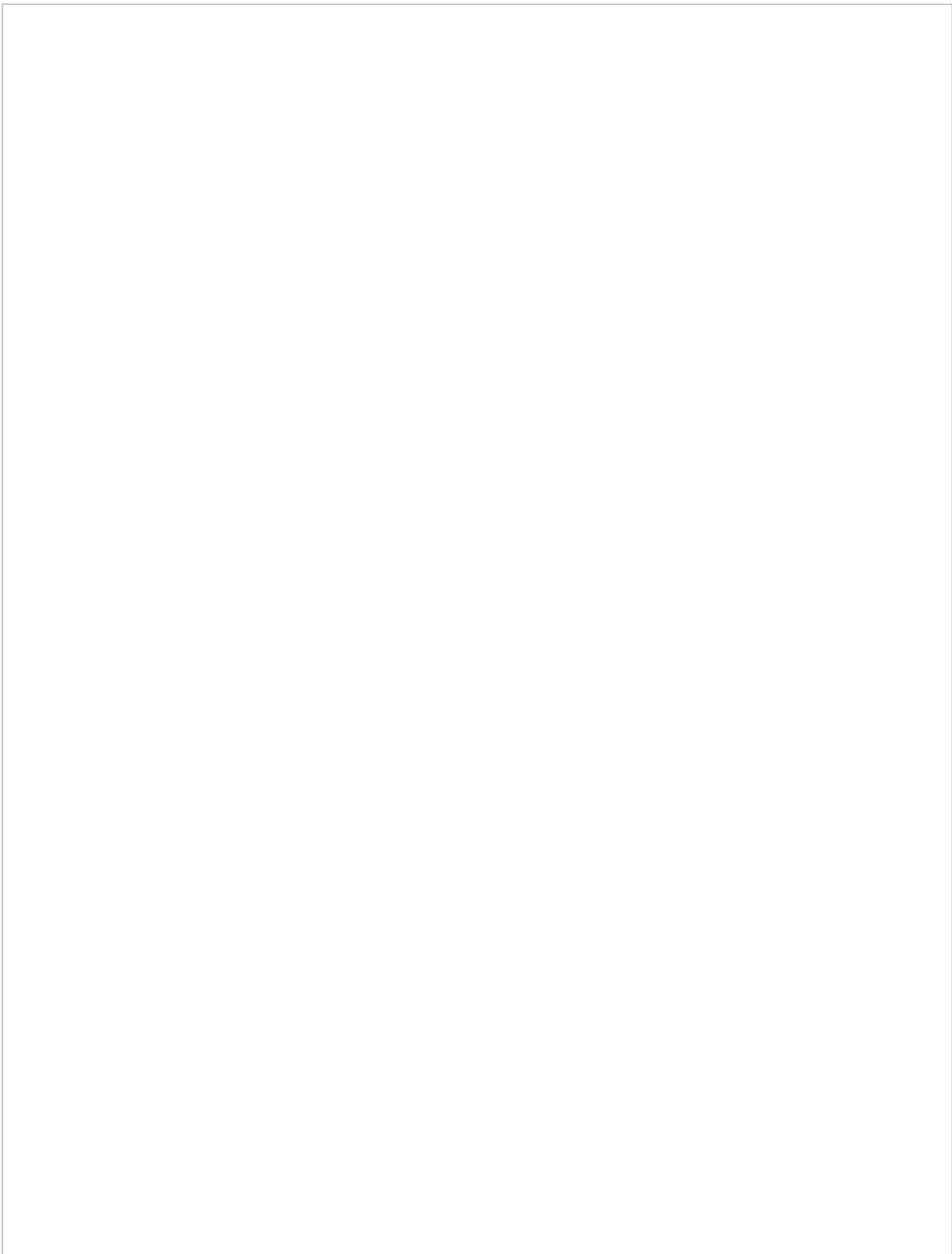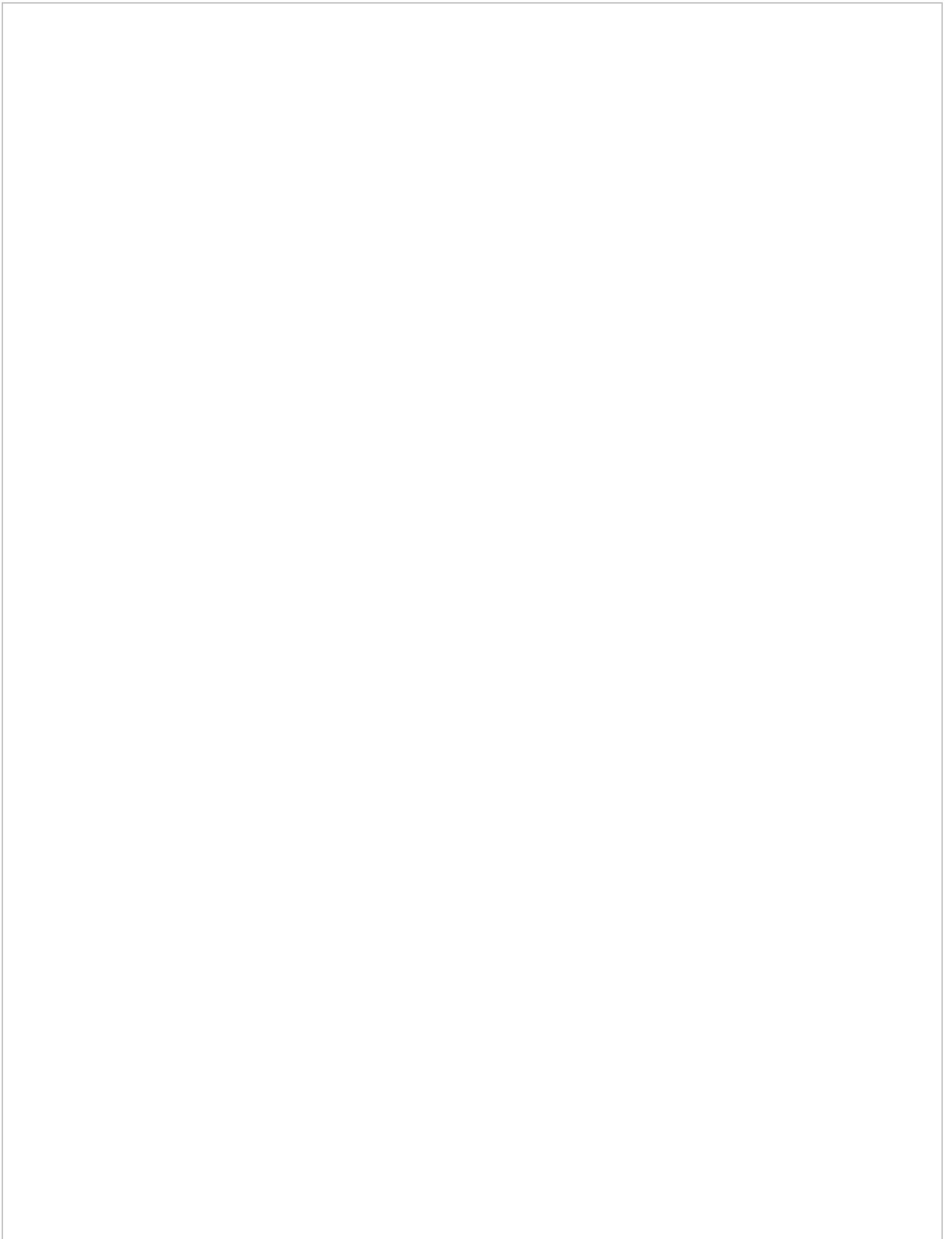
ABSTRACT

Health inequities are differences in health outcomes caused by social injustice in society, and are present within every country in the European Union. This research analyzed the Finnish Health 2015 and British national Tackling Health Inequality strategy to tackle health inequalities and inequities. We created logic models that reflected our expectations about the target groups and social determinants that were expected to be tackled by the programmes. These expectations were based on the model of the social determinants of health, WHO framework of the social determinants of health and health inequalities, and the strategies. The programmes that were created to implement the strategies were compared with the logic models, in order to analyze whether or not the promises that were set out in these strategies were actually implemented in practice. Moreover, we compared whether or not these strategies already showed results at this point in time. We found that the Finnish Health 2015 tackled a wider range of target groups and social determinants. and focused very much on equal treatment and social conclusion, children, people of working age, and vulnerable groups. However, efforts to reduce smoking, alcohol consumption, homelessness, and poverty were missing, and some programmes did not specify actions. The Finnish strategy seemed to have improved self-assessed health and smoking prevalence, but these effects could not be attributed to a specific policy category. For the British Tackling Health Inequalities we found that a smaller range of target groups and determinants were tackled. Efforts focused mainly on ensuring a good start in life for children and families, and these determinants were tackled in a very comprehensive manner. Unfortunately where was only limited attention for improvements in well-being in specific vulnerable groups, and efforts to decrease poverty, homelessness, discrimination, participation, and improve social inclusion were missing. The Tackling Health Inequalities strategy seems to have improved self-assessed health, and decreased alcohol-related mortalities. However, these effects could not be attributed to a specific policy category. Unfortunately, the Demetriq database provide only limited data to fully evaluate the effects of the national strategies. Data for many relevant health indicators were missing, data was only stratified according to educational achievements, and no data in social determinants was available. Moreover, the Finish and British health strategies are very recent. Unfortunately, many of the effects of the strategies are not yet visible at this point in time.
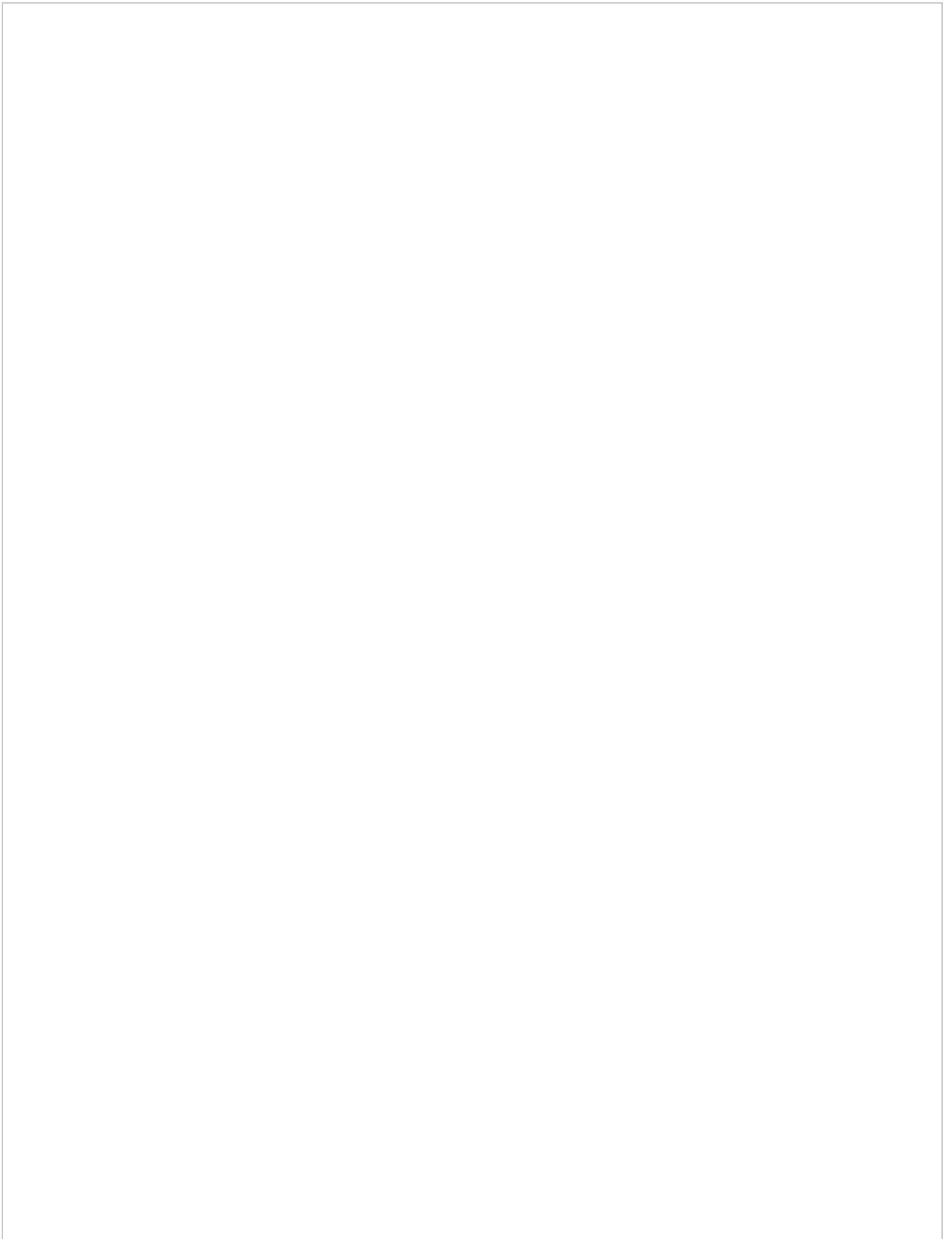
PREFACE

This thesis was written as part of the International Public Management and Policy Master's programme at the Erasmus University Rotterdam. During my Bachelor's programme in European Public Health, my interest was drawn to the area of public management and policy, and especially to how policies cause inequalities and inequities in health. Therefore, when I had the chance to design my own research for my master thesis, I did not have to think twice about my topic; I wanted to analyse and compare different national strategies to tackle health inequalities, and evaluate their effectiveness.

I want to thank my thesis supervisor, Kees van Paridon, for guiding me in writing this thesis, and providing me with feedback. Kees really pushed me to ask more questions and to think more critically. I also want to thank Mariëlle Beenackers, who was so kind to offer me a internship at the Erasmus Medical Centre, provide me with access to the Demetriq database, and coach me in writing my thesis. Mariëlle really pushed me to think outside the box, and therefore helped me to lift this research to a higher level. I also want to thank the Erasmus Medical Center for providing me with all the resources that I could possibly need to do my research. Furthermore, I would like to thank Menno Fenger, the second reader of this thesis, for taking time out of his busy schedule to read and evaluate my thesis, and provide me with feedback.

On a more personal note, I want to thank my parents for giving me all the opportunities in the world to receive education and always supporting me at every step of the way. And last but not least, I want to thank my boyfriend for putting up with me in these hectic times, and helping me see the bigger picture at times that I could not see it.
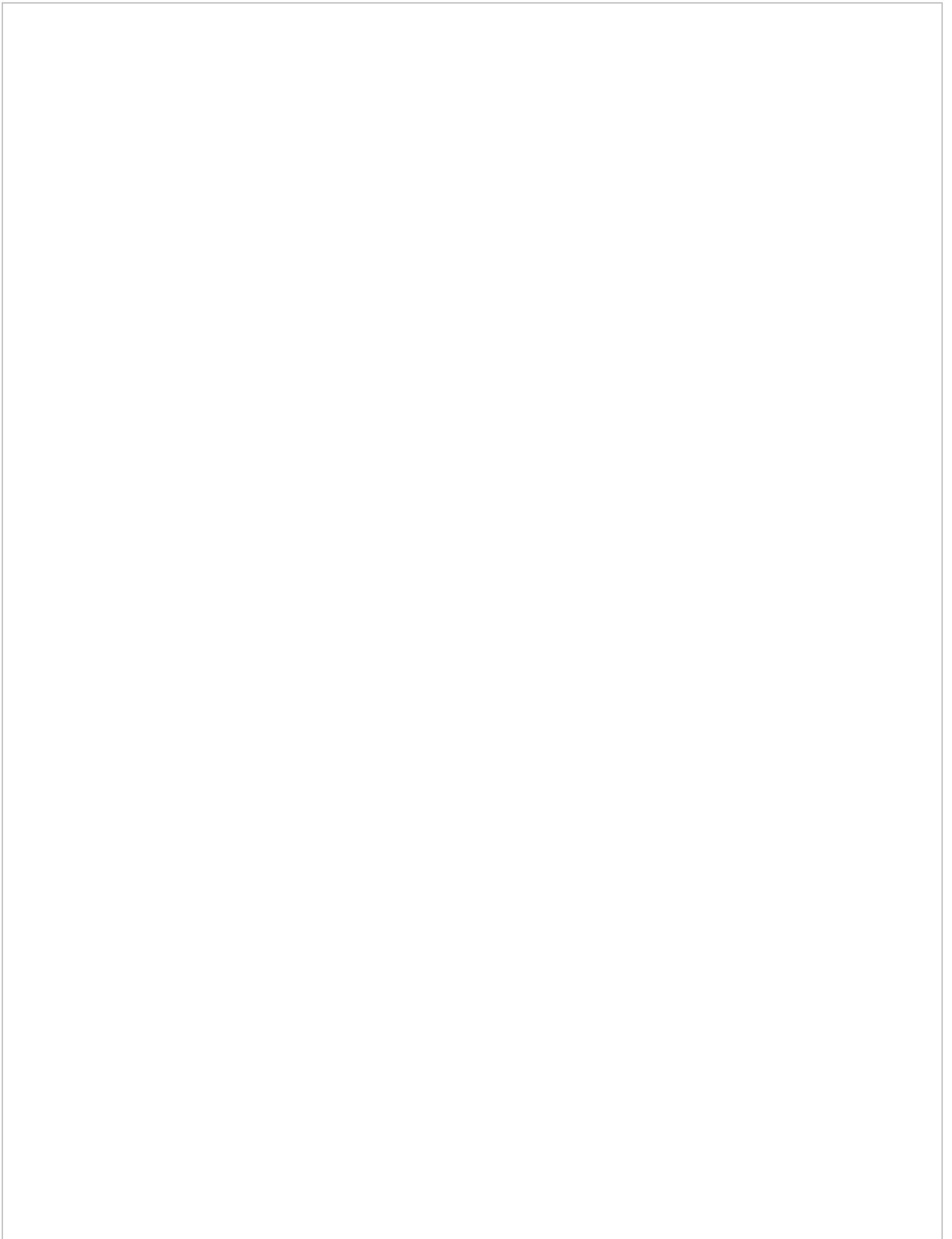
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1. Who gets to live to 100?

In 2014, the Independent reported that life expectancy of new-born girls in some parts of the United Kingdom (UK), such as Northburn, Basingstoke and Dean was now greater than 100 years. Meanwhile, in other parts of the UK, such as West Yorkshire, new-born girls were expected to live for only 72.5 years (1). A difference in health expectancy can also be found in Finland, where in 2007 35-year old-men who fell in the category high income were expected to live 12.5 years longer than men of the same age but with low incomes. For women this difference was only seven years (2). The United Kingdom and Finland are both high-income countries where health care services, education and social security are affordable and provided by the government. However, despite high levels of welfare, life expectancy seems to differ according to social and geographical factors. This raises certain questions: What factors cause that some people can grow to be a 100 years old, while others die at a young age? Can these differences also be found in other countries? What can be done to decrease these differences? What are European governments doing about this problem? And are these approaches successful? In the next sections we attempt to provide answers to these questions.

The differences that we just discussed are examples of health inequities, which are defined by the World Health Organization (WHO) as '*avoidable* inequalities in health between groups of people within and between countries' (3). They are avoidable or remediable differences in social factors, health services and health outcomes among segments in society, and are one of the greatest challenges in the field of public health. The concept of health inequities entails three distinguishing features; they are systematic and consistent, produced by social processes rather than biological differences, and are generally considered to be unfair because they are caused by unjust social arrangements (4). It is because the reason for this difference is often sociological rather than biological, that all inequities are considered to be unfair. Even systematic differences in lifestyles between socioeconomic groups are to a large extent shaped by structural social factors, such as education, knowledge, and stress (4). Inequities are caused by inequalities in social, economic, geographic or demographic conditions, called social determinants. Social determinants are the conditions in which people are born, grow up, live, work and age and are shaped by economics, social policies, politics and culture. They affect people's risks of illness and the actions taken to prevent or treat illness (5).

People with a lower socioeconomic status (SES), which is both a key indicator and an underlying determinant of health inequity, generally die at an earlier age, and encounter disabilities and disease earlier in life (6-13). These differences are not just an ethical, but also a financial and economic issue. Health is an important factor in human capital, and therefore for economic growth, as it increases labour productivity, labour supply, educational achievements and savings. Moreover, poor health generates high costs to society and business, as the need for health care and social security, and thereby the financial burden and the need for governmental action, increases (14). In England productivity losses caused by health inequities are estimated on 50 billion US$ per year, and lost taxes and higher welfare payments losses are estimated to cost up to 52 billion US$ (15). Moreover, the additional costs of health care were estimated at 9 million US$ a year. Furthermore, if all people in England had the same death rates as the richest 10% of the population, all people dying prematurely would together enjoy up to 2.5 million extra years of life each year. Imagine the economic benefits if these additional years could be realized; people would live longer, thereby increasing productivity and tax revenue, and would spend the money they earn, thereby boosting the economy (15).

1.1. Research Question

The concept of health inequities has often been approached from a health, economic or methodological perspective (6, 9-12, 16, 17). Great amounts of information are now available about what health inequities are, the measurement of inequities, the mechanisms behind the phenomenon, and the economic and societal effects of it. Moreover, recently literature has focused on different national policies aimed at tackling health inequities (18-22). Now, the next step is to look at what governments are doing to reducing health inequities in their population, and whether or not these strategies have effect. Therefore, this research focuses on the policy side of health inequities by answering the following research question and sub questions:

- **How do European member states tackle health inequities and how successful are these strategies?**
  - **What are different strategies to tackle health inequities in European Union (EU) Member States?**

- **How did health inequities change over time in EU member states, and what does this tell us about the effectiveness of the national strategies?**

1.2. Societal Relevance and Link to the IMP Study Program

The main purpose of this research is to contribute to the current base of knowledge about health inequities and strategies aimed at increasing social equity in societies. Furthermore, knowledge about the determinants of success of policies aimed at tackling health inequities might contribute to inform policy makers about different policy options and the effects of these policies. Although there are many issues to tackle in each society, resources are inherently limited and policy makers have to prioritize some causes over others. Moreover, information is omnipresent and sources of information are diverse. This creates the difficult task for policy makers to select reliable and relevant information to base their decisions on. This study aims to help policy makers to make informed decisions for policies which are most likely to be successful, and therefore to spend resources in a optimally efficient manner. Although the scope of this research is limited due to a narrow time span, it might create a base on which future research can built further, in order to create more comprehensive picture.

The link with the author's current Master's programme in International Public Management and Policy lies in the administrative aspects of the concerned policies. Policies to increase equity in a society are generally not based on political but on administrative questions. Already in 1941, Wilson made a distinction between these two sorts of questions. Whereas political questions are based on opinions such as 'should there be a road between A and B?', administrative question are based on science and common sense, e.g. 'where should the road exactly be built?' (23). Concerning health inequities in society, the question is no longer whether or not something should be done about it, but rather what the most effective approach is to decrease inequities.

In the next section we discuss what is already known about health inequities, how they come to existence, what the situation in the European Union (EU) is, and what governments are doing in order to tackle this problem.

2.Health inequities: The basics

The first step to understanding inequities is understanding the distinction between inequities and inequalities. Whereas health inequalities simply are measurable differences in health between people or groups of people, inequities have a political dimension and an inherent implication of a moral commitment to social justice (24). Whereas all health inequities are inequalities, not all inequalities are inequities. For example; a difference in level of education between a high and low SES group is an inequity (caused by uneven chances to educate oneself), but also an inequality (because of the measurable difference in education levels between the two groups). Differences in smoking levels, on the other hand, rather represent inequality than inequity, since these differences are caused for a large part by choices made by individuals, rather than social injustice (24, 25). However, even for unhealthy behaviour such as smoking, there are social factors that influence different groups in society differently. For example, low SES groups might be subjected to higher levels of stress, might be more likely to grow up with parents who smoked, and might have less knowledge about the effects of smoking.

Another important step to understanding health inequities is to define what health equity means. According to Dahlgren and Whitehead (2006) health equity '*implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstances*' (14, page 4). In order words, health equity means that everyone enjoys equal opportunities to maximize their own health. The implications of health equity go beyond decreasing morbidity and increasing life expectancy. When individuals are able to reach their full health potential, they are more likely to be successful in other expects of life, such as employment and education, as well. The reason that health inequities exist is that individuals are affected differently by different social and economic events and policies, exposure to hazards, and life events due to fundamental differences in social and economic determinants. Although efforts can be made to reduce health inequities, it is not realistic to think that they can ever be fully eliminated.

In 1992, Dahlgren and Whitehead created a model explaining how health, and therefore differences in health, come into being (26). This model can be found in Figure 1, and shows that health is a multilayer concept. Health inequity is not just caused by unequal access to health care, but by a multitude of

factors in society. In the inner circle, personal characteristics can be found, such as age, and sex. These are factors that the individual cannot change. The surrounding layers present factors that, in theory, can be modified by policies. In the first layer one can find personal behaviour factors, such as alcohol consumption and smoking behaviour. These factors influence health in a very direct way. The second layer presents interaction with peers and the immediate community, and the influence these have on the individual. In the third layer we find the factors that influence the individual's ability to maintain their health, such as living and working conditions, food supply, and access to essential goods and services. The final layer presents economic, cultural and environmental influences that prevail in the overall society and affect population health, such as economic welfare or pollution. This model emphasized the interaction between these layers; the way people live is embedded in social norms and networks, and in living and working conditions. These factors are in turn influenced by the wider socioeconomic and cultural environment (14, 26).

Figure 1. Model of the determinants of health by Dahlgren and Whitehead (26)

According to a later study of Dahlgren and Whitehead (14), individual, commercial and political decisions influence the layers and create positive health factors, protective factors, or risk factors. Positive health factors, such as economic security or adequate housing, contribute to the maintenance of health. Protective factors, such as vaccination projects and healthy diets, eliminate risks of disease or support resistance to it. Risk factors, also called risk conditions, are factors that cause health problems and diseases. These factors are potentially preventable, can be economic or social, and can be related to specific environmental- or lifestyle-related health hazards. Examples of this kind of factors are polluted

air or smoking. Although the focus in policy making and research often lies on risk factors, it is also useful to identify positive and protective factors, and to secure and enhance these factors (14).

Whereas for some time it was thought that health inequity was a threshold phenomenon (meaning that only people below a certain level of socioeconomic status experience inequities), it is now clear that the relationship to SES is a linear one, in which inequities increase as SES decreases. In other words, health inequities appear in all segments of society, and not just in the lowest classes. Moreover, they appear in low, middle, but also high income countries (4, 24, 27). The social gradient on health can also be expressed as the 'shortfall in health', the number of lives that would have been saved if all social groups had the same health levels as the highest social group. For example, in 1994, Mackenbach estimated that Dutch mortality would decrease by 25-50% if men with lower levels of education had the morbidity and mortality levels of men in the highest educated groups (28).

Furthermore, the fact that health inequities have persisted and even grown in some countries over the years, does not mean that population health has not improved over the years. What it means is that health in higher social classes has improved as much, or more, as in lower classes over the same time, thereby sustaining or increasing the gap between social groups (4). One on the most important determinants of health inequity is SES, which represents an individual's social position in society, as defined by education, occupation and economic resources. People with a high SES generally have more resources to attain their full health potential (29). Another important determinant is the level of exposure to health hazards. The level of exposure is very much related to SES. People with a high SES often have resources to avoid exposure to hazards, whereas people with a low SES often work and live in circumstances that expose them to hazards, and do not have the resources to avoid exposure (17). Moreover, even when exposed to similar levels of exposure, different SES groups might experience different impacts because of different social, cultural and economic environments. For example, when exposed to high levels of occupational stress, people with a high SES might have more influence on the source of stress, more resources to relieve this tension, and less sources of stress in other parts of their lives, in comparison with people with a low SES. Furthermore, greater impacts in low SES groups might also be explained by simultaneous exposure to other hazards. Another important determinant is life-course effects, which are the cumulative outcome of SES, exposure to health hazards and impact of health hazards. Events early on in live can have great health effects later on in live, and circumstances in early life have stronger predictive value for health than SES in adulthood. Also an important indicator is

the social and economic effect of being sick. These effect, such as loss of earnings, unemployment and social exclusion, tend to become more severe with decreasing SES. Moreover, poor health might generate additional financial burdens due to high out-of-pocket payments for health care and drugs. These negative effects of poor health are likely to result in a downward spiral, damaging health even further (4, 16, 30).

2.1. Measuring health inequities

In general, health is expressed in life expectancy or healthy life expectancy. Life expectancy is the number of years an individual is expected to live given his/her age, year of birth, education, and demographic conditions such as gender. Healthy life expectancy is the number of years an individual on average lives before encountering serious health issues. Another important indicator of health is self-assessed health, which is measured by questionnaires in which individuals rate their own health and individual aspects of it (31). Moreover, maternal health factors such as neonatal mortality and maternal mortality are good indicators of health and quality of care.

Differences in health can be measured either in absolute or relative terms. Whereas absolute terms express the absolute difference in incidence of disease, morbidity, mortality, life expectancy, and so on, a relative term expresses the increased or decreased risk of a certain group (32). For example, if the incidence of a particular disease is 100/100.000 in a high SES group and 200/100.000 in a low SES group, the absolute difference is 100/100.000, while the relative difference is a twice as high chance of getting the disease in the low SES group. Moreover, if incidence is 1000/100.000 in the high SES group, and 11.000/100.000 in the low SES, the relative difference, similarly to the other example, is 100. However, the absolute difference is only 1.1. Both methods have advantages and disadvantages. Absolute measurement produce straight up results, but may project a decrease in inequity when total mortality rates fall. Relative measures, on the other hand, are able to pick up on changes in inequities, but create ambiguity in situations where mortality or morbidity rates go up (32). Mackenbach argues that policies should focus on reducing absolute inequities because of the lack of literature on reduction of relative inequities, and because of the tremendous efforts and amount of resources that reducing relative differences requires (32). Overall, the problem with measurement of health inequities is that methods

might differ between countries or studies. This makes comparison between countries and studies difficult.

2.2. Health inequities in Europe; the current situation

As we discussed before, health inequities can occur both between and within countries. In this section we first discuss the health inequities between EU member states, after which we discuss inequities within EU member states.

2.2.1. Health inequities between EU member states

With regards to health inequities in Europe, a division can be made between East and West. Disparities in health due to different historical, political and economic backgrounds can still be observed. In Western-European countries life expectancy has increased over the last century, and is now roughly at the same level in all countries. This increase can largely be attributed to economic prosperity, but also to safer living conditions, lifestyle changes, more effective public health systems, and improved healthcare (33, 34). In Central and Eastern-Europe, however, life expectancy has seen up and downs over the last fifty years. During the 1960s, 1970s, and 1980s, life expectancy in the Soviet union and communist European countries stagnated or even decreased. After 1990 life expectancy began to increase, but at a different pace in each country. Because of conflicts and ethnic violence, life expectancy decreased (mostly for men) in many countries and data collection was interrupted (33). As a result life expectancy varies between Central and Eastern and Western European countries.

In Table 1 we see life expectancy at birth for men in EU member states. All 25 countries that were a member of the EU in 2005 were included in the table, and categorized by the author of the current study into two groups; members since before 2004 and members that joined the EU during the 2004-enlargement. We see a clear division between these two groups. In the older member states, which are almost all Western-European countries, life expectancy is on average 76.8 years, while in Central-Eastern-European countries men are expected to live 6 years shorter on average. The lowest life expectancy is found in Lithuania, where it is only 65.3 years, while Swedish life expectancy of 78.5 years

is the highest in the EU. The divide in life expectancy between East and West was confirmed by Marmot in 2013 (35).

Table 1. Life expectancy at birth for men in EU member states in 2005 (36, page 30).			
Country	Life expectancy in years	Healthy life expectancy in years	Healthy life expectancy / life expectancy in %
Member-States before 2004	**76.8**	**61.9**	**80,6**
Austria	76.7	57.8	75.4
Belgium	76.2	61.7	81.0
Denmark	76.0	68.4	90.0
Finland	75.6	51.7	68.4
France	76.8	62.1	80.9
Germany	76.7	55.0	71.7
Greece	76.8	65.7	85.5
Ireland	77.3	63.0	81.5
Italy	78.2	66.3	84.8
Luxembourg	76.6	62.2	81.2
Netherlands	77.3	65.0	84.1
Portugal	74.9	58.4	78.0
Spain	77.0	63.2	82.1
Sweden	78.5	64.2	81.8
United Kingdom	77.1	63.2	82.0
Member states since 2004	**70.9**	**56.0**	**78.9**
Cyprus	76.8	59.5	77.5
Czech Republic	72.9	57.9	79.4
Estonia	67.3	48.0	71.3
Hungary	68.7	52.0	75.7
Latvia	65.4	50.6	77.4
Lithuania	65.3	51.2	78.4
Malta	77.3	68.5	88.6
Poland	70.8	61.0	86.2
Slovakia	70.2	54.9	78.2
Slovenia	73.9	56.3	76.2

Denmark does not only have a very high life expectancy, but its healthy life expectancy is also the second highest in the EU. Estonia, with 48.0 years, has the lowest absolute healthy life expectancy of the EU. Even though its life expectancy at birth is also low, relative healthy life expectancy is only 71.3%. In Denmark, on the other hand, as much as 90% of years are lived in good health. Even though there are some exceptions, in general the proportion of healthy life years is higher in Western-European (85.5%) countries than in Central- Eastern-European countries (78.6%).

What is remarkable is that in Finland, with a life expectancy of 75.6, only 68.4% of years are lived in good health. Whereas life expectancy in Finland is among the highest in the EU, the healthy life

expectancy is among the lowest. As the difference in life expectancy and healthy life expectancy is extremely high, we tried to find other sources that either explain this big difference, or indicate that this difference is incorrect. Between 2004 and 2012, healthy life expectancy at birth in Finnish men was between 51.7 and 58.6 years according to the Eurostat database. The OECD database presents similar data for Finland over this period of time, which makes it unlikely that the big difference in Table 1 was simply caused by typing error (37-39). However, the Finnish data in Table 1 and the Finnish data in the Eurostat and OECD database, were derived from the same Finnish national database, making it possible that the big differences are caused by errors in the prediction and measurement system. Whereas according to the Eurostat database healthy life expectancy in newborn boys was only 57.3 years in 2012, according to the WHO it was 68 years. (37, 40). However, although the WHO predictions are more similar to our expectations and it is unlikely that healthy life expectancy dropped 15 years between 2000 and 2005, the database does not provide information about the origin of the Finnish data and two other respectable datasets have confirmed the Finnish findings in Table 1. Therefore, we cannot invalidate the Finnish findings in Table 1, and have to look at the prevalence of morbidity in Finland for possible explanations. Although Finland seems to score normal on many sorts of morbidity, we found extremely high rates of dementia in the Finnish population. Whereas the prevalence of dementia is approximately 30/10.000 or lower in most European countries, it is approximately 150/10.000 in Finland (41). In 2013 dementia was the third most prevalent cause of death, and as it is known that individuals might suffer a long time from dementia before eventually dying because of it, this might (partially) explain the difference between life expectancy and healthy life expectancy (42, 43). Moreover, dementia prevalence might be higher in Finland because of excessive alcohol consumption, which can lead to alcohol dementia, but might also elevate other sorts of morbidity such as physical disabilities due to accidents, and several sorts of cancer and cardiovascular diseases (43-45).

2.2.2. Health inequities within EU Member States

The INEQ-CITIES project (2009-2012) studied health inequities according to education, employment and general SES in several European cities. The study found that inequities were existent in every city in the EU. Interestingly, relative inequities were largest in Northern- and Central-Eastern European countries, SES-related inequity was highest in Helsinki and Stockholm, both cities in countries with highly-developed welfare systems (46). In 2012 Mackenbach provided three possible explanations for this

paradox; [1] although health in general has improved, access to material and immaterial resources might still be unequally divided across populations; [2] as in recent decades many people have moved upwards on the socioeconomic ladder, the homogeneity of personal characters associated with ill health in people with low SES might have increased; and [3] as consumption behaviour is now the most important determinant of ill-health, the benefits of immaterial resources might have increased in high SES groups who can afford such resources (47). However, these explanations are just hypotheses, and more research is needed in order confirm the real explanation.

Moreover, the INEQ-CITIES project suggested that geographical location within cities plays an important role in socioeconomic inequalities in health. A possible explanation for this finding is that factors such as physical environment, presence of government institutions and socioeconomic conditions vary according to location, and that the costs of housing are lower for places were these factors are more unfavourable (46).

Concerning trends in inequities within countries, Marmot, who measured changes in several inequity indicators, concluded that within the Czech Republic, Poland, Slovakia and Sweden inequities were increasing, while a decrease was found in Spain, the Netherlands and Romania (35). With regards to Table 1 on life expectancy in EU member states, these findings indicate that EU member states in which life expectancy and the proportion of healthy life expectancy is low, are facing an increase in health inequities, while in countries with a high level of overall health, health inequities are decreasing

2.3.The Effects of Policies

The conceptual framework in Figure 2 was developed by the WHO Commission on Social Determinants of Health, and further demonstrates how the socioeconomic and political context affect distribution of health and well-being. This model suggests that interventions (such as policies) should either change the circumstances of daily life, or the structural drivers of inequity.
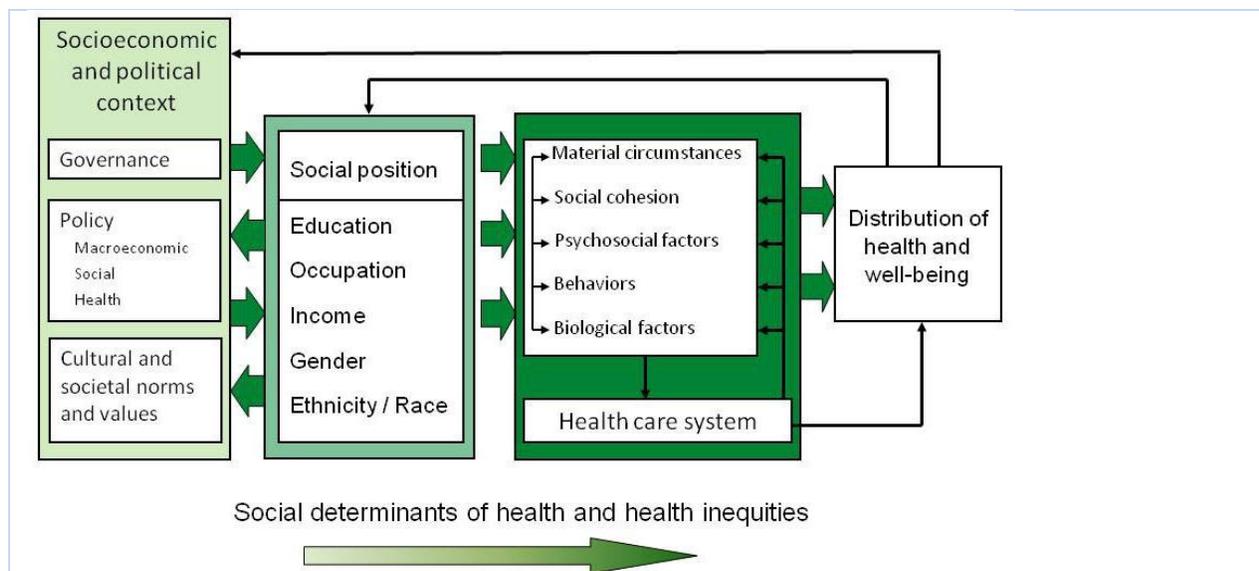
Figure 2. Conceptual framework of the social determinants of health and health inequities by the WHO Commission on Social Determinants of Health (48)

This framework shows how fundamental factors are causing inequities and how social policies can influence the size of the influence. Simply ensuring quality of and access to health care is not enough. For example, families that live in poor housing conditions might experience health problems because of mould, draft or limited space. Governments can tackle this problem by setting housing standards. Moreover, people who are in bad health (e.g. because of their poor housing conditions) are less likely to be hired for a job, or more likely to be fired, leading to an aggravated financial status, increasing the likeliness of financial problems. A troubling financial status might create problems in affording proper nutrition, affording health care, or even affording housing, and therefore affect people's health status and relevant social determinants (26). Governments have the ability to fight health inequity by, for example, creating policies to increase employment in disadvantages groups, creating financial security for these groups, ensuring (affordable) education in the whole of society, and so on.

However, although governments have great potential to decrease inequities, their policies can unintentionally increase inequities (14). For example, if governments create a policy to lower minimum wages, it might lead to an increase in financial problems for families. These families might, for example, encounter problems to afford preventive care and proper nutrition. Moreover, the effects of policies are not necessarily just positive or negative. Imagine a policy which releases employers from any restrictions when laying off employees. On the one hand this can lead to higher employment rates, as employers might be less hesitant to hire new employees. On the other hand, however, this policy can also lead to

an increase in unemployment and financial instability, as employees can more easily be fired. Therefore, the effects of policies on health and social factors should be assessed before implementation. In order to make reliable assessments, appropriate Health Impact Assessments (HIA), that provide an accurate picture of the possible effects of policies, should be developed that provide an accurate picture of possible effects (14).

Besides governments there are other actors that can play a significant role in decreasing inequities. Many of these actors can be found in the model of social determinants of health in Figure 1. The most obvious actor is the individual, who influences his/her health by lifestyle choices such as whether to smoke or not, what level of exercise to take, and what food to eat. Moreover, in some extent an individual can improve his/her SES, e.g. by education or seeking better employment. However, these chances may be limited, as individuals might not have the resources to undertake such actions. Another important group of stakeholders is the individual's social network and the community in which he/she lives, since individuals and their behaviour are influenced by the social environment in which they live. A third important group of stakeholders are employers, who, in accordance with policies and laws determine the work environment and employment conditions, and are in charge of hiring and firing. Another group of important actors are national and international nongovernmental organizations, which create expertise on health and social problems, thereby informing governments and individuals about health inequities and how to decrease them. The last important group are international governmental organizations, such as the United Nations and the EU. These organizations provide policies, agreements and guidance with regards to the environmental and economic situation. As one of the principles of successful policies, Dahlgren and Whitehead prescribed that health policies should involve individuals and other stakeholders (14). Involving stakeholders at all levels of the model of social determinants, ensures the creation of truly comprehensive strategies.

The Demetriq project, which is part of the EU Seventh Framework Program and which database was used later in this research, aimed to develop, evaluate and refine methodologies for assessing the effects of policies on health inequities, to assess the effects of policy experiments on different determinants of health, and to synthesize the evidence of the former two objectives. The project focused on natural policy experiments in the field of unemployment and poverty reduction, tobacco and alcohol control, and access to education and preventive health care. It found that many experiments did not positively affect health inequity, and some even made the situation worse. Furthermore,

interventions that in theory produce positive results, such as modern tobacco control efforts and expansion of higher education did not produce clear results. However, some policies did prove to be effective in reducing health inequities. These policies were mostly concerned with financial security and employment opportunities for disadvantaged groups, health care funding, and breast cancer screening (49). These outcomes illustrate the importance of the evaluation of policies. Evaluation provides information about which policies are successful and which are not, and might even identify factors that determine success or failure. However, although the current knowledge base and the model of the determinants of health indicate that governments should create policies to decrease health inequities in their country, empirical studies often do not find significant results (41, page 33). This can partially be explained by the fact that it is very difficult to measure the effects of such policies due to multilayeredness of the concept and because issues of inequity are like a tank ship; once you steer in the right direction it still takes a very long time for the tanker to move an inch towards the right direction. However, this does not explain why studies found that some interventions increased inequities (41, page 33). This finding indicates that policies might focus on the wrong determinants or groups in society.

2.4. What are governments doing?

Over the recent years, national governments and international organizations have recognized the importance of decreasing health inequities and promised to tackle the problem. For example, in 2014 the Netherlands started Alles Is Gezondheid (Everything Is Health), which aimed to tackle health inequalities through cooperation between different actors in society, such as schools, health care institutions, employers, research institutes, etc. (50). In 2003 the UK started its strategy called Tackling Health Inequalities, which focused on improving a broad range of social determinants, with specific focus on the more vulnerable groups in society (51). Finland started its second strategy to decrease health inequalities, called Health 2015, in 2001. This strategy set out eight targets to improve health and well-being, of which four were aimed at specific groups in society such as children and the elderly (52). In other countries such as Italy, Latvia, and Iceland, however, policy actions for decreasing health inequalities has just involved the monitoring of inequalities (53). Promises to tackle health inequalities by governments are often not followed up by comprehensive policies and actions. The lack of action are possibly explained by the fact that health inequities are often invisible in everyday life, because death and disease seem to hit families and friends quite randomly.

Although the EU does not have the right to create policies in the field of health care in member states, it does create policies in other fields that affect the determinants of health. These policies guide and restrict EU member states in their domestic policies, and influence their national strategies towards tackling health inequities.

2.4.1. European action

The Lisbon strategy in 2000 first created a commitment towards reducing poverty and social exclusion, and thereby established economic and health equity as a significant policy issue (54). This strategy was followed by the Europe 2020 strategy, which included a special programme focused on health. This programme, Health 2020, was created in cooperation with the WHO European regional office, the European member states, and many relevant actors, and aimed to "significantly improve the health and wellbeing of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality" (55, page 1). Health Equity 2020 was one of the projects that fell under Health 2020. This project aimed to develop evidence-based action plans to reduce health inequalities and inform the use of European Structural Funds. Moreover, this programme explored potential action areas, and provided evidence for the benefit of investments to reduce inequalities (56).

Moreover, in 2006 during the Finnish EU presidency, the Health in All Policies principle was accepted for all future policies. This principle created an obligation for all future policies to undergo a health impact assessment in order to evaluate the effects of the proposed policy on health. Policies were no longer allowed to negatively impact health, and, where possible, opportunities to benefit health through proposed policies have to be utilized (57). Furthermore, the EU has created the Equity Action initiative, which creates opportunities for Member States and Stakeholders to cooperate in tackling health inequity and exchange information and expertise (58).

<u>2.4.2. Success cases</u>

One of the first and most successful cases of public health policy in history is the elimination of Cholera in London in 1848. In that year, John Snow published a pamphlet which was called 'On the Mode of Communication of Cholera', in which he argued that cholera spread through the contamination of food and water (59). This was in contrast with the common idea of cholera, which assumed that the disease, like many other diseases, was transmitted through air. In 1954, when Cholera hit London again, Snow was able to prove his theory by plotting the cases of cholera-related mortality on the map of London. In that time water was supplied by two water companies, and the results showed that the cases were substantially more present in the region of London were water was supplied by the company that drew its water from the downstream location. This location had been contaminated by the city's sewage. In one of the neighbourhoods an extreme number of deaths were found. The city responded by cutting of the direct water supply to this neighbourhood, thereby containing the epidemic. Mapping of morbidity and mortality is now a commonly used method in epidemiology (59, 60).

Another successful case of public health policy is the case of abortion and contraception in Romania. In the 1970s and 1980s Romania strictly banned abortion and modern contraceptives. The result was an extremely high level of maternal mortality, of which 87% could be attributed to complications during illegal abortions. The change of regime in 1989 initiated a change in many policies, of which the restrictive contraceptives and abortion policy was one. Abortion was further liberalized and access to safe procedures increased. Moreover, women had now access to family planning and reproductive health services. Over this period of time maternal mortality rates decreased from approximately 160/100.000 live births in 1989 to approximately 40/100.000 live births in 2008 (61-63).

<u>2.5. What is next?</u>

In this chapter we discussed what is currently known about health inequities in order to understand what the problem is, and in order to create a good knowledge base for understanding the health problems and national strategies to tackle health inequities in Finland and the UK. We saw that health inequities are present between as well as within EU member states. Moreover, we found that several governments are taking action to decrease health inequities, and that the EU has created initiatives to

gather more information about this problem and provide policy support to national governments in tackling this problems. The model of the social determinants of health and the WHO conceptual framework of the social determinants of health and health inequities are specifically relevant for this study, as these models describe the determinants of health, which are often influenced by policies. In other words, social determinants form opportunities for governments to improve health equity. However, the way in which determinants are tackled is of big influence for the success and efficiency of policies. On the one hand, a lack of information might lead to big and unfocused policy actions, while actions aimed at more specific problems or specific groups in society might create better results with less resources. On the other hand, actions have to be well coordinated in order to avoid that several initiatives focus on the same factors, and thereby waist valuable resources.

In the next sections the model of the social determinants of health and the WHO framework are used to create well-informed expectations about the national strategies and to evaluate these strategies. In order to evaluate the coordination and orientation of policies, we do not just look at the determinants of health that were targeted, but also at how these determinants were tackled and at what specific groups action was directed.

3. Methods

Because of the limited scope of this paper, only two national strategies were investigated, those of Finland and the UK. Finland, as a Scandinavian country, is known for its comprehensive welfare state, and has repeatedly taken action on the European level to make EU policy making more health friendly. Its first strategy to tackle health inequalities took place already in the 1980's, and since then Finland has paid much attention at the effects of non-health related policies on health. However, nowadays Finland is still facing health problems, such as high suicide rates, high prevalence of dementia and high rates of alcohol-related health problems (64-66). The latest Finnish health strategy, called Health 2015 was analysed in this paper.

The UK, as a liberal welfare state, has a long history with the National Health Service (NHS), which was established already in 1948 and provides primary and secondary health care services to all Brits. However, contrary to Finland, the UK does not have a history with policies to decrease health inequities or with initiatives to make all policies more health friendly through health impact assessments. Nowadays, some of the biggest health problems in the UK are the rising prevalence of obesity, and high alcohol consumption rates, which result in, among others, a high prevalence of cardiovascular diseases, cancer, and strokes (67-69). In 2003 the British government accepted its first health equity strategy called 'Tackling Health Inequalities', which is the other document that was analysed in this research.

The different national backgrounds form an interesting basis for comparison, because they are expected to lead to different results. Moreover, the geographical features of Finland, might have interesting effects, as the dark winters are thought to lead to increased mental health problems. It might be interesting to compare governmental efforts to improve mental health, in order to see if Finland appropriately reacted to this situation. Moreover, the differences in spread of population might also lead to interesting differences in the strategies. Finland, as the least populated country of Europe, might have problems to provide (health care) services, as people might live very far away for service points, while the UK is more populated and people might be closer to service points. However, the UK consists of four partially independent countries, which might lead to different implementations of the strategy, while Finland does not have to deal with such a problem. A practical reason for this choice of countries

was that in Finland and the UK data was collected over the same period of time and in the same age group for the Demetriq project, increasing the comparability of the cases. For the purpose of this research the author has access to the summary database of this European project, which created a longitudinal database of health determinants and health outcomes, and analysed the extent of health inequities in the EU and governmental action to decrease inequities[1]. Moreover, in contrast with some other EU member states, Finland publishes many of its policy documents in English, a language that is well known by the author.

For the first sub question, about the different strategies to tackle health inequities in the UK and Finland, a qualitative policy review was performed, which compared the Finnish Health 2015 strategy and the British Tackling Health Inequalities strategy with the different programmes that were invented as part of these national strategies. In other words: were the promises that were made by the national strategies backed up by appropriate programmes that focused on the right groups in society and the right social determinants? All documents in this research were found through the snowballing effect, for which the Health 2015 and Tackling Health Inequalities strategy documents[2,3] were the starting point. All programmes that were mentioned in these documents as part of the strategy were included in the research and analysed. If these programme documents mentioned any not aforementioned programmes, these were also included in this research as well. This process was repeated until all documents were analysed without discovering new programmes. All projects and programmes that were mentioned as part of the original strategies were screened to see if they were actually realized, if they were applied at the national level, and if their original documents, or at least evaluation reports or summaries were available in English.

The following step was to group these programmes into categories according to their purpose, in order to compare the priorities that the two countries have set. This division was based entirely on the personal judgment of the author. For these different groups logic models were created in which the relevant social determinants, the relevant groups in society, and the predicted health outcomes were represented, in order to create expectations about the national strategies and to be able to evaluate

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[1] More information about the Demetriq project can be found on http://www.demetriq.eu/

[2] The Finnish strategy: Ministry of Social Affairs and Health. (2001). *Government resolution on the Health 2015 public health programme.* Helsinki: Ministry of Social Affairs and Health.

[3] The British strategy: Department of Health. (2003). *Tackling Health Inequalities: A programme for action.* London: Department of Health Publications.

whether or not these expectations were met. The included programmes divided into categories and the logic models that were created can be found in chapter four.

The next step was to analyse each specific programme and to map the target groups and the targeted social determinants of health, in order to provide an overview of the whole national strategy and to identify gaps in the target groups and determinants that were addressed. The outcomes in these tables were compared to the expectations that the strategy and the logic models created. Essentially these chapters compared the strategy, as it was intended in theory, to the strategy as it was applied in practice.

For the second sub question about trends in health inequities we used the summary data of the Demetriq project. Data on several health indicators for Finland and the UK was presented in graphs to show increases and decreases in specific mortality and morbidity, but was not statistically tested. As this research focuses on health inequities, we focused on indicators which express differences that are more directly related to social injustice. These indicators are: self-assessed health, longstanding
 limiting health problems, the prevalence of smoking, smoking-related mortality, the prevalence of visits to the general practitioner (GP) or hospital, prevalence of overweight and obesity, alcohol-related mortality, amenable mortality, mortality caused by road accidents, and total mortality.

For the sake of clarity chapter five contains the whole analysis of the Finnish national health strategy, and chapter six contains the analysis of the British national health strategy. In the conclusion section the answers to the sub questions are combined in order to provide a comprehensive answer to the main research question about the different national strategies and their success.

4. The relevant policy documents, determinants, age groups, health indicators, and logic models

In this section we discuss what programmes were included in this research, the different policy categories in which these programmes were categorized, and the logic models that present our expectations about the relevant social determinants of health and the relevant health indicators.

4.1. The programmes that were included in this study

The search for policy programmes resulted in 30 documents for Finland and 32 documents for the UK. All documents, reviews, or at least a summaries of the programme were available in English and the projects and programmes were applied at the national level during the same time period as the national programmes. Whereas for the UK all required documents were found, for Finland seven documents were missing. An overview of the policy documents included in this research and their references can be found in Annex I (Finland) and Annex II (the UK).

In Table 2 programmes that were included in this research were grouped according to the topic of focus. The programmes were put together in one table, in order to see the differences in the priorities of the countries, and in order to identify gaps in the focus of the two countries. We immediately see some differences in the topics that Finland and the UK tend to focus their efforts on. The UK has made great effort in the categories Neighbourhood & Physical Environment and Provision of Basic Needs, where Finland has ran no programmes at all. For the categories Employment & Working Life and Equal Treatment and Opportunities, however, the UK ran only four programmes, while Finland ran sixteen. The British and Finnish choices and priorities in their national Health Inequalities programme can possibly be explained by the initial situation in the countries. In chapter five and six we identify the initial situation that led to the drafting of the Finnish and British health inequalities strategies, the strategies in theory, and the strategies as they were applied in practice. For each of the programmes the target groups and the targeted determinants were identified, mapped, and compared with our expectations, and the initial intentions of the programmes. Later this information was used to compare

Table 2. The Finnish and British programmes and projects that were included in the current research, grouped according to their topic of focus.	
Finland	**United Kingdom**
Lifestyle & health choices	**Lifestyle & health choices**
Development Guidelines for Health-Enhancing Physical Activity and Nutrition.	2010 National Drug Strategy
	Smoking Kills - A White Paper on Tobacco
	5 A DAY Project
	School Fruit Scheme
Neighbourhoods & Physical Environment	**Neighbourhoods & Physical Environment**
	Strategy for Neighbourhood Renewal
	Making the Connection
	Sustainable Communities
	Living Places 2002
Healthcare & Social Services	**Healthcare & Social Services**
PERHE project: Partnership Programme for Family Services	Delivering 21st Century IT Support for the NHS
Promoting Patient Safety Together: Finnish Patient Safety Strategy 2009-2013	Getting the Right Start: National Service Framework for Children
High-Quality Services for Older People	National Health Service Plan
National Development Programme for Social Welfare and Health Care 2008-2011	Priorities and Planning Framework 2003-2006
	Health Visitors Implementation Plan 2011-2015
	Living Places 2002
Employment & Working Life	**Employment & Working Life**
Action Programme on extending Working-Life Well-being at Work and Rehabilitation	Employment retention and Advancement Demonstration Project (ERA)
Workplace Development Programme (TYKES)	Skills for Life
Strategy of the Finnish Institute of Occupational Health 2011-2015	
TEROKA: Decreasing the Health Inequalities between Professions	
Occupational Health 2015: Development Strategy for Occupational Health Care	
Policy Programme for Employment, Entrepreneurship and Worklife	
Equal Treatment & Opportunities	**Equal Treatment & Opportunities**
Social Protection 2015	Key Stage 3 Strategy
Action Plan for Gender Equality 2004-2007	White Paper: Valuing People
Disability Policy 2006	
Action Plan to Reduce Violence against Women	
Finland's Disability Policy Programme VAMPO 2010-2015	
Cross-sectoral Action Plan for reducing Social Exclusion, Poverty and Health Problems	
Towards a Social Protection Reform: Creating Opportunities	
National Action Plan to reduce Health Inequalities 2008-2011	
European year for Active Ageing and Solidarity Between Generations 2012.	
Government Action Plan for Gender Equality 2012-2015	
Finnish Homelessness Programme	
Provision of Basic Needs	**Provision of Basic Needs**
	Welfare Food Schemes
	Fuel Poverty Strategy
	New Child and Working Tax
Well-being of Children, Youth & Family	**Well-being of Children, Youth & Family**
A Finland Fit for Children: the National Plan of Action	Framework for Assessment of Children in Need and their Families
National Action Plan to Reduce Corporal Punishment of Children	Safeguarding Children in whom Illness is fabricated or induced
Youth Participation Project 2003-2007	Framework for the Assessment of Children in Need
Child & Youth Policy Programme 2007-2011	Healthy Schools Programme
Policy Programme for the Well-Being of Children, Youth and Families	Sure Start Programme
	Extended Schools
	New Opportunities for PE and Sports (NOPES)
	Vulnerable Children Grant
Overall Health	**Overall Health**
MIELI: National Plan for Mental Health and Substance Abuse Work in Finland	National Services Framework for Coronary Heart Disease
Time Out! Getting Life Back on Track!	National Service Framework for Mental Health
Policy Programme for Health Promotion	NHS Cancer Plan

the two national strategies. However, first we discuss the logic models that were created in order to reflect our expectations about the policy categories and to evaluate these expectations.

4.2. The logic models of the different policy categories

In Box 1 we find the social determinants of health that can be influenced by policies, as derived from the model of the social determinants of health, and the WHO framework of the social determinants of health and health inequity in Figure 1 and 2 (26, 48). These determinants were processed in logic models (Figure 3-9), which

Determinants derived from the Dahlgren and Whitehead model, and the WHO Framework of the social determinants of health and health inequity that are subject to policy influence

- Individual lifestyle factors/behavior
- Education
- Work environment
- Living conditions
- Working conditions
- Psychosocial factors
- Material circumstances
- Income
- Employment
- Housing
- Health care services
- Social and community networks
- Social cohesion
- Gender equality
- Ethnicity/race equality
- Agriculture and food production
- Water and sanitation

Box 1. Overview of the possibly relevant determinants that might be affected by the national health strategies, and which form the basis of the logic models.

helps us assess the programmes and identify their effects on population health. These models reflect our expectation in terms of the relevant social determinants and health outcomes, which enables us to evaluate whether or not the programmes have tackled the right determinants, and whether or not they were effective. It is important to note that these logic models were created by the author, and are therefore influenced by her personal interpretation, logical reasoning and choices.

For the first seven policy groups logic models were created, as can be found below. In these logic models we find the relevant determinants and health indicators for the policy categories. For the last group, Overall Health, however, no logic model was created, as all determinants, target groups, and health indicators are relevant for this group. In the model we had to make a distinction between health indicators for which this study has data (blue boxes), and health indicators for which no data is available (white boxes). Moreover, in some logic models we were able to predict what specific groups in society are targeted, which are indicated by a bold fond.

In Figure 3 we find the first logic model for the category Lifestyle & Health Choices. The relevant determinants for improvements in the population's lifestyle and behavior are lifestyle factors such as nutrition, physical activity, smoking, and alcohol consumption. If these determinants are tackled, they are likely to improve physical and mental health through an improvement of lifestyle. The improved

physical and mental health is likely to manifest in improvement of several health indicators, which can be found in the last column of the model. The other logic models, which we discuss next, are all structured in a similar manner.
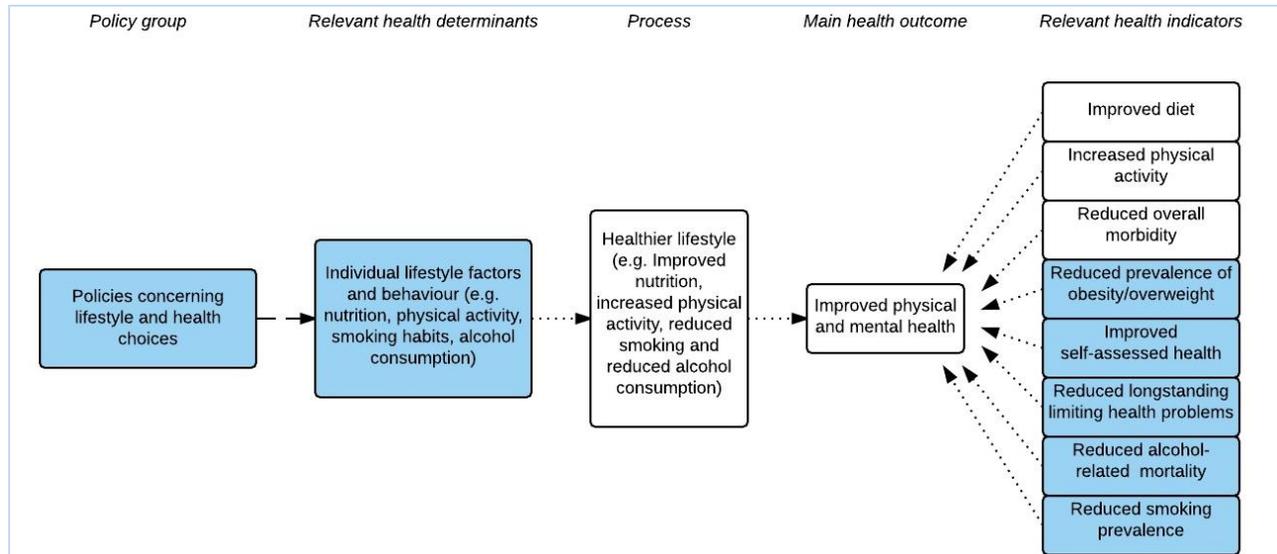
Figure 3. Logic model of the policy group Lifestyle & Health Choices, the relevant social determinants, and the relevant health outcomes.

In Figure 4 we see the logic model for the policy category Neighbourhoods & Physical Environment, which is very relevant for health, as the circumstances in which people live seem to directly influence their health and well-being. The determinants that are tackled in this category are expected to be of a social and material nature, such as housing and social cohesion. Actions are expected to be aimed at the whole population, but especially at vulnerable groups, since these groups are thought to be more likely to live in bad physical circumstances and neighbourhoods. These improvements are thought to enable people, especially vulnerable groups, to live healthy lives, which should result in improved health and general well-being.
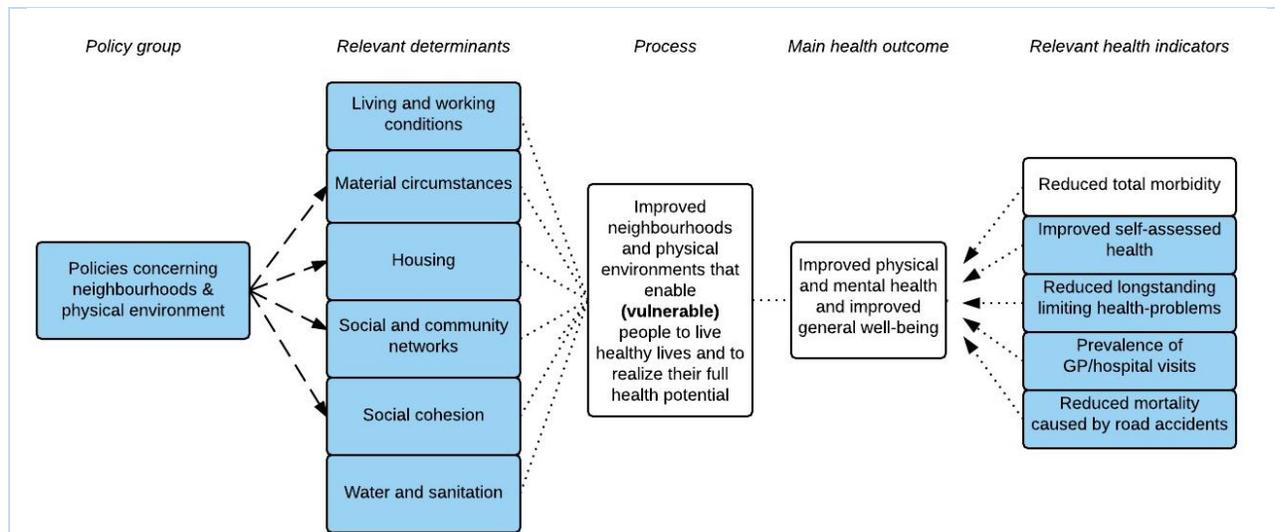
Figure 4. Logic model of the policy group Neighbourhoods & Physical Environment, the relevant social determinants, and the relevant health outcomes.

In Figure 5 we see the logic model for the policy category Healthcare & Social Services. The relevant determinants for this category are related to social services that are provided by national governments, such as education and income security. Changes should be especially present in the more vulnerable groups in society, but programmes can also be targeted at the whole population, and should eventually lead to improved health and reduced prevalence of health problems.
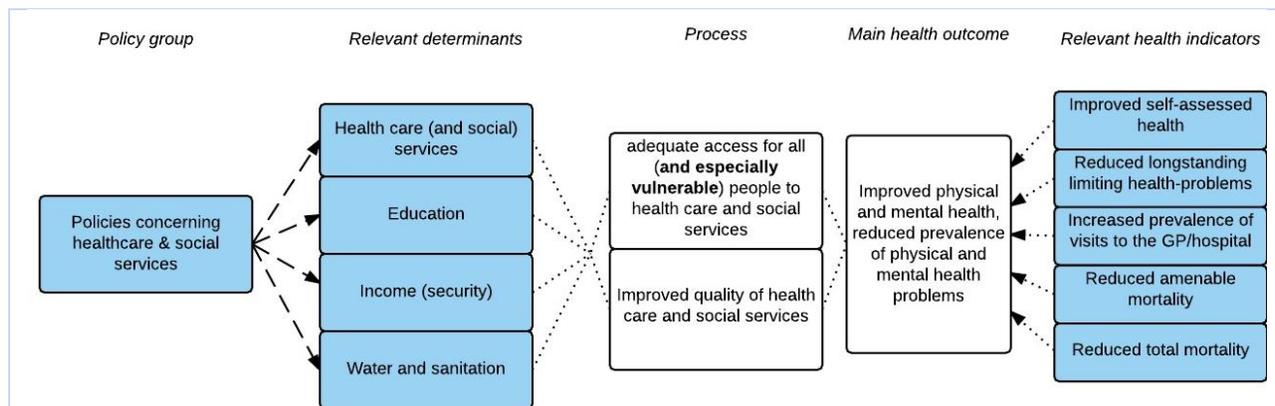
Figure 5. Logic model of the policy group Healthcare & Social Services, the relevant social determinants, and the relevant health outcomes

Figure 6 represent the logic model for the policy group Employment & Working Life. This category is expected to target working people exclusively. The relevant determinants for this category are all related to employment conditions and employment skills, such as education and working conditions. If this category is successful, we expect to find changes in physical and mental morbidity. There are five

relevant indicators for these improvements, from which self-assessed health and longstanding limiting health problems are unfortunately the only available ones.
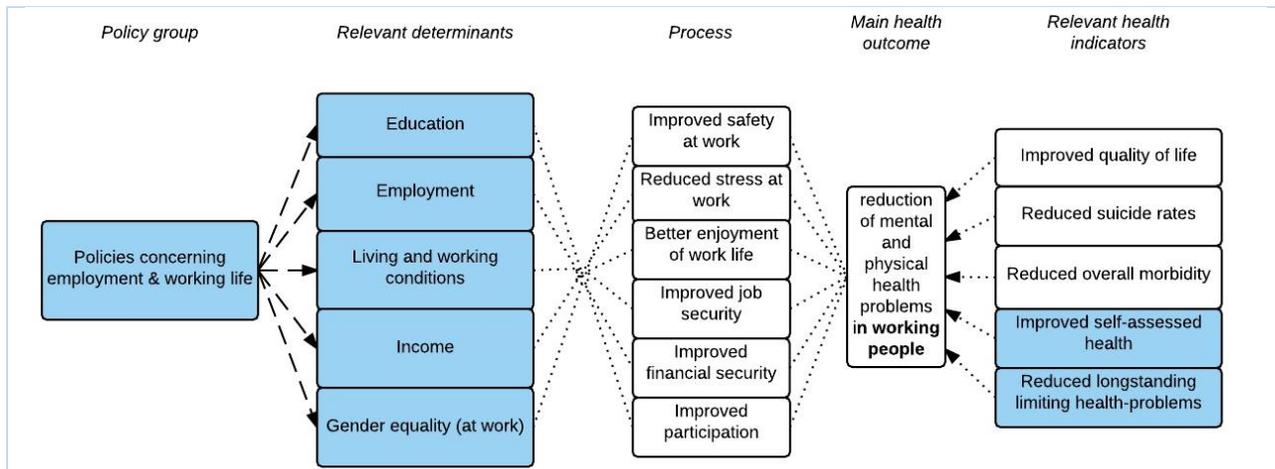
Figure 6. Logic model of the policy group Employment & Working Life, the relevant social determinants, and the relevant health outcomes.

Figure 7 displays the logic model that was created for the policy group Equal Treatment & Opportunities. This category is relevant for health in a less direct manner than many other categories. Equal treatment ensure that all citizens have opportunities to educate themselves, have a decent housing, have safe jobs, etc., which eventually leads to better health. Efforts are expected to be specifically targeted at vulnerable groups in society, and not so much on society as a whole. The accessibility of health care and social services is thought to be improved by this category, and vulnerable groups are expected to have more equal opportunities to maximize their own health. Eventually, these improvements are thought to result in improved physical and mental health, although it might take some time for these results are visible.
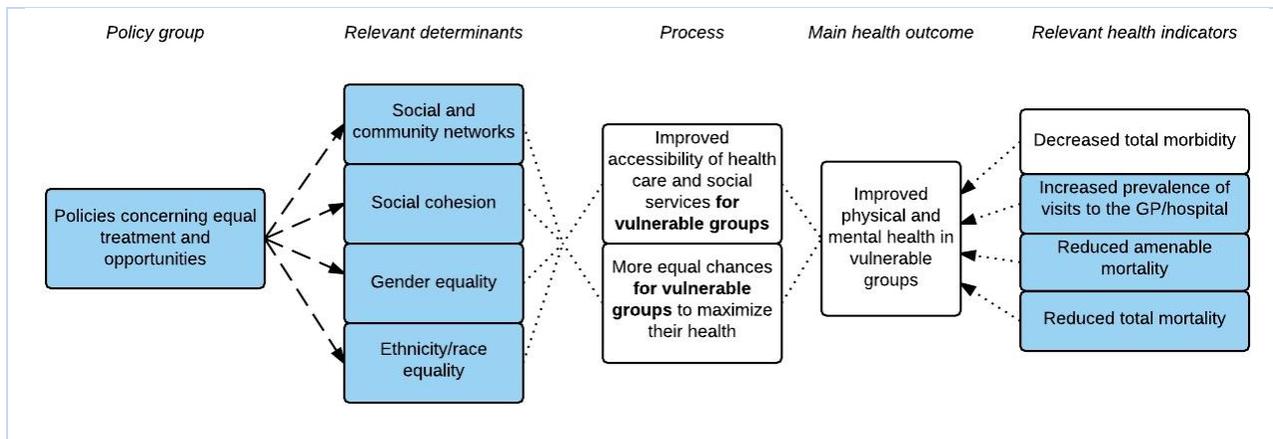
Figure 7. Logic model of the policy group Equal Treatment & Opportunities, the relevant social determinants, and the relevant health outcomes.

In Figure 8 we find the logic model for the policy group Provision of Basic Needs. Just as for the last category, the connection between the provision of basic needs and health is a bit indirect. If basic needs, such as good nutrition and decent housing, are not fulfilled, this might result in bad health outcomes. For example, homeless people might be more vulnerable for physical health problems such as pneumonia. Moreover, if people's basic needs are fulfilled, they can focus on functioning in society and realizing their life and health potential. This policy category should improve people's capability to take care of their own, especially in more vulnerable groups, and physical and mental health should be increased in both society as a whole, and in more vulnerable groups. However, as was the case in the last category, there might be a time lapse between actions and results, as it takes time for the health effects of e.g. improved housing, better nutrition and improved income security, to become obvious.
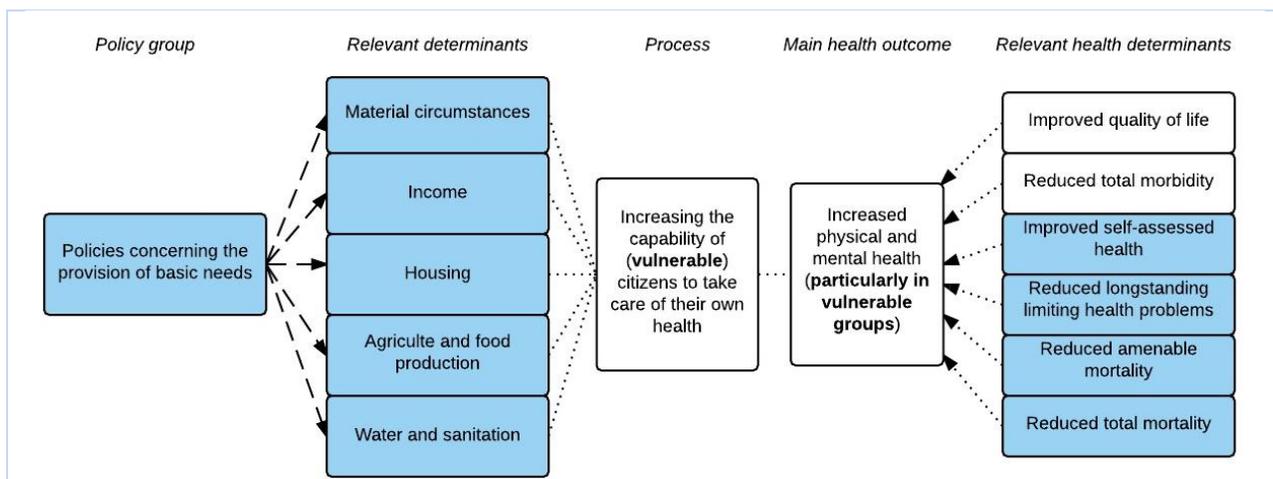
Figure 8. Logic model of the policy group Provision of Basic Needs, the relevant social determinants, and the relevant health outcomes.

Finally, Figure 9 shows the logic model of the policy group Well-being of Children, Youth & Families. This category is expected to focus solely on children, youth and families, and to maximize these groups' ability to reach their full health potential. On the long term this should improve physical and mental health in children.
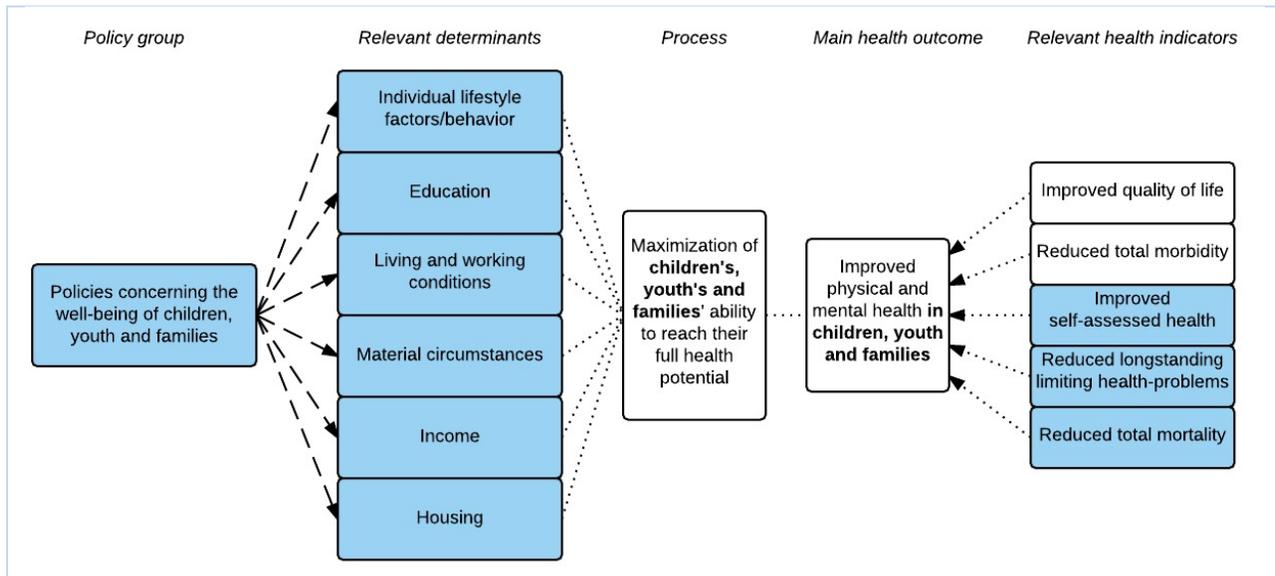
Figure 9. Logic model of the policy group Well-being of Children, Youth and Families, the relevant social determinants, and the relevant health outcomes.

5. The Finnish Health 2015 Strategy

The Finnish strategy Health 2015 started in 2001, and focused on promoting health, rather than improving health care services, and emphasized the need for cooperation between various components of society. It recognized that a population's health is mainly determined by factors that lie outside of the scope of the health sector. Moreover, it framed health as a crucial element of welfare and development, a basic human right, and the key to eliminating poverty (46). We first discuss the background of the Health 2015 strategy, after which we discuss the strategy as it was intended in theory and as it was applied in practice.

Health 2015 was not the first Finnish attempt to decrease health inequities. Since the mid 80's, Finnish policy making had been increasingly guided by the Health in All Policies approach, which urges public policies in all sectors to take into account the effects of decisions on health and health systems (57). This approach aims to seek synergies and avoid harmful health impacts in order to improve the population's health. In 1999, when Finland was president of the EU, it put health high on the agenda, leading to a council resolution to ensure health protection in all policies and activities of the EU. Moreover, during Finland's second presidency in 2006, greater progress was made on terms of Health in All Policies, leading to the incorporation of Health in All Policies in article 168 of the Lisbon Treaty (57).

In 1986, the national Health For All strategy set four targets to improve health for 2000, which can be found in Box 2. In general, some progress has been made on all targets. For example, concerning the first target of adding years to life, Finnish life expectancy increased 6 years for men and 7 years for women between 1986 and 2000, but mortality among young

> **Health for All Targets 1986:**
> 1. Adding years to life: declining premature deaths
> 2. Adding health to life: declining chronic diseases, accidents, and other health problems
> 3. Adding life to years: increasing good health and functional capacity for longer in life, with welfare to match
> 4. Reducing health disparities between population groups: decreasing health differences between genders, socioeconomic categories, and people living in different regions.
>
> **Box 2. Health for All Targets 1986 (70)**

adults was still much higher than Western-European standards. These high numbers were mostly related to accidental and violent deaths, suicides, and deaths related to alcohol and mental health problems (70). Another common cause of death was cardiovascular disease, which had decreased drastically, but was still twice as high as that of the Mediterranean countries (70). Concerning the

second target of adding health to life, significant improvements in morbidity were made, as prevalence of heart attacks, stroke, hypertension, and other serious diseases decreased. However, whereas morbidity in the elderly population decreased, it had started to increase in the younger population, where diabetes, alcohol and drug problems, asthma and allergies were now more common (70). Concerning the 3th target of adding life to years much progress had been made. Fins now felt significantly healthier than in the '70s (70). In the case of the last target concerning the reduction of health disparities, results were mixed. Differences in mortality between genders had decreased, but were still gigantic compared to other Western-European countries. For example, in 2000 mortality caused by road accidents was approximately 35/100.000 in women, but 60/100.000 in men (71). Alarmingly, health differences between socioeconomic groups had increased, as was shown by increased gaps in life expectancy and morbidity. For example, the life expectancy of a white 35-year old high paid male was 5.5 years more than the life expectancy of a low paid male of the same age (70).

5.1. The initial situation that led to the creation of Health 2015

In 2000 and 2001, the Finnish Health 2000 survey collected data on the Finnish population's health (72). While the 1985 Health for All strategy had had significant results, and overall health, functional capacity and self-assessed health had improved, Finland was still facing many health problems. Obesity had continued to increase. Now 21.2 percent of men and 23.5 percent of women above the age of 30 were considered obese. While there were no indications that mental health problems had become more common since the 1980s, depression, alcohol dependence and burnout were still very common. During the survey 6.5 percent of men and 1.5 percent of women over 30 said they had been dependent of alcohol, and 3.5 percent of men and 6.7 percent of women said to have experienced depression over the past 12 months. 2.2 percent of men and 2.9 percent of women aged 30-64 had faced severe burnout over the last 12 months (72).

Health disparities, which Health for All had already tried to target, had also increased. The survey showed that people who had enjoyed a higher level of education were significantly healthier. Whereas 73.5 percent of men with the highest levels of education reported good or fairly good health, this percentage was only 52.4 percent in men who enjoyed only basic education. Moreover, marital status also seemed to have an effect on health, as 63.5 percent of married men against 55.5 percent of single

men reported their health to be good or fairly good. Region also seemed to have an important influence on health. There was a 9.7 percent difference in reporting of good or fairly good health between men in the most healthy and less healthy region (72).

The Health 2000 survey predicted that health care needs would increase in the future because of the ageing of the population and because of a change in the needs of patients (72). Moreover, it predicted an increase in the need for rehabilitation in the elderly and in people of working age. In order for rehabilitation services to meet these needs, they had to be further developed (72). Additionally, the ageing population and increased cultural and ethnic diversity posed problems for the implementation of health policy, as it created a risk of exclusion of vulnerable population group, such as immigrants and disabled people (52). Moreover, new environmental, biological and physical risks had emerged, and these now had to be taken into consideration during the policy making process (52). Finally, the Finnish membership of the EU, agreements with neighbouring countries, and the increasing autonomy of municipalities now affected the competencies of national governments, and ultimately influenced Finnish health (52).

5.2. Health 2015 in Theory

The results of the 1986 Health for All strategy lead the Ministry of Social Affairs and Health to conclude that much improvement in Finnish public health was still to be made, and that a new health program was needed. In order to decrease inequities, Health 2015 introduced 8 concrete targets, which, if realized, represented a broad improvement of population health. Targets were divided into two groups: ones for specific age groups, and ones for the overall population. They were supported by 36 statements that set out the lines of action, and incorporated challenges and guidelines related to citizens' everyday environment, and the many actors that are involved in improving public health (52). The targets and statements can be found in Box 3.

The tasks and lines of action of the strategy were divided over several actors. Because of their autonomy and extensive powers, municipalities were expected to bare a great deal of the burden of action. It was thought that municipal health departments have the potential to influence their local population's

health by cooperating with other municipalities and local actors. Many of the lines of actions were therefore meant to be implemented as collaborative projects between several municipalities (52). The

<table>
<tr><td>

Targets for different age groups

1. Child wellbeing and health will increase, and symptoms and disease caused by insecurity will decrease appreciably.
2. Smoking by young people will decrease to less than 15% of those aged 16-18; health problems associated with alcohol and drug use among the young will be dealt with appropriately and will not exceed the level of the early; '90s.
3. Accidental and violent death among young adult men will be cut by a third of the level during the late '90s.
4. Working and functional capacity among people of working age and workplace conditions will improve, helping people to cope longer in working life; retirement will be about three years later than in 2000.
5. Average functional capacity among people over 75 will continue to improve as it has during the last 20 years.

</td><td>

Targets for the overall population

6. Finns can expect to remain healthy for an average of two years longer than in 2000
7. Finnish satisfaction with health service availability and functioning, and subjective healthiness and experiences of environment impact on personal health will remain at least at present level.
8. In implementing these targets, another aim will be to reduce inequality and increase the welfare and relative status of those population groups in the weakest position. The objective will then be to reduce mortality differences between the genders, groups with different educational backgrounds, and different vocational groupings by a fifth.

</td></tr>
</table>

Health 2015 Targets

Preconditions to fulfil Health 2015 Targets

- All sectors and levels of government, the private sector and civil action must make the population's health a key principle in guiding choices. The social dimension must be incorporated into the public sector's long-range policies, programmes and action plans, and be made an element in result management in the administrative sector of every ministry. Progress must be monitored using indicators that will be devised for the purpose.
- the main arenas of everyday life, such as homes, schools, workplaces, leisure environments, transport and public services, must be given better preconditions for promoting the population's health. At the same time, everyone will be given the right to a healthy environment and opportunities to influence decision-making concerning it.

Preconditions must be strengthened for health promotion at all phases of life, from birth to old age.

Box 3. Health 2015 targets and the preconditions to fulfil the targets (52)

health care system was tasked to secure equally high-standard and accessible services in preventing and treating diseases and disabilities, and in general care and attention. This should be achieved by tailoring the services to the needs of the patient. Businesses and industry were recognized as playing a crucial part in everyday human health, and they were urged to acknowledge opportunities and responsibilities in cooperating to promote health. The importance of NGOs and civil society were said to be in creating goals for health promotion, taking action towards them, evaluating, and reorientation of efforts. By taking a bottom-up approach, the strategy tried to intensify the power of civil action. Lastly, the importance of research and the support it provides for policies and policy choices illustrated the need for research institutions and the state to stimulate research (52).

In general Health 2015 created an ambitious framework for reducing health inequalities, but was vague about the actions that should be taken and initially no resources were allocated to implement the framework (70). However, later on several Finnish funded projects were initiated in order to accomplish the goals that Health 2015 had set, as is extensively analyzed in the third paragraph of this chapter. First however, we discuss our expectations about the target groups and targeted determinants in these programmes, based on the logic models and the initial Health 2015 strategy. This helps us to compare whether or not the programmes that were created as part of the national strategy actually focused on the right groups and determinants.

5.2.1. Expectation concerning the target groups in Health 2015

Since the main aim of Health 2015 is to decrease health inequalities and inequities in the Finnish society, we expect that specific attention was paid to improving health and the preconditions of health in the more vulnerable groups in society, such as immigrants, the unemployed, disabled people, or people with a low SES in general. Moreover, because the eight targets of the strategy are divided into targets concerning only specific groups and targets concerning the whole population, we expect that some programmes focused on the whole population, while others focused specifically on children, youth, people of working age, and the elderly.

The logic models also created expectations about the groups that were targeted in the different policy categories. For the policy categories, Healthcare & Social Services and Equal Treatment & Opportunities, we expect that efforts are targeted specifically on vulnerable groups. The actions in these categories are expected to attempt to fulfil the basic requirements for a life in good health, such as education opportunities, decent employment and living conditions, and the elimination of discrimination. These attempts need to be focused on vulnerable groups and not so much on other groups in society, since the preconditions of good health are often already (more) present here. The policy category Employment & Working Life is expected to target people of working age specifically. As working life is a large part of everyday life, this category is expected to ensure healthy working conditions and improve employment perspectives through education. Finally, the policy category Well-being of Children, Youth & Families is expected to focus specifically on children, youth and families, in order to create the right preconditions

for children and youth to get a healthy start in life, such as decent nutrition, education and decent living conditions.

Lastly, because of the preconditions that Health 2015 set out, we expect that efforts are made to involve the different levels of government and actors in the private sector. Creating the preconditions for health is expected to be incorporated in public sector policies, and ideally influences all areas of daily life.

5.3. Health 2015 in Practice

In this section we compare our expectations of the Finnish target groups and targeted determinants, which were derived from the initial Health 2015 document and the logic models, with our findings from the documents that specified the specific actions that were to be taken. We first discuss the target groups, then the targeted determinants, after which we finish with some statements about the completion of the total strategy and the policy groups.

5.3.1. Health 2015 target groups

In Table 3 we find the different programmes that were part of the Health 2015 strategy and the particular groups in society that these programmes focused on. We see that there are quite some programmes that focus on society as a whole, but simultaneously pay attention to specific groups in society. For example, the National Development Programme for Social Welfare and Healthcare tries to improve health care and total well-being in the whole Finnish society, but specifically tries to improve well-being for children by improving family life and reducing placements in care outside of home. Simultaneously, it aims to tackle unemployment, to reduce homelessness, increase functional capacity among elderly, and increase participation of youth in education (73).

We also see that not all groups are equally targeted by the programmes. Groups such as children and youth, families, people of working age, and the elderly are often targeted in programmes, while homeless people or men in general are not often specifically mentioned in programmes. It is especially curious that men and pregnant women are not specifically targeted at all. However, this does not mean

Table 3. The Finnish programmes that contributed to the Health 2015 strategy and the particular groups in society in which they focus

	Whole society	Children and youth	Adults	Elderly	Families	Pregnant women	Women	Men	Working People	Disabled	Homeless	Immigrants	General Low SES
		Families								Vulnerable groups			
Lifestyle and health choices													
Development Guidelines for Health-Enhancing Physical Activity and Nutrition	X												
Healthcare and Social Services													
PERHE project: Partnership Programme for Family Services					X								
Promoting Patient Safety Together: Finnish Patient Safety Strategy 2009-2013	X												
High-Quality Services for Older People				X									
National Development Programme for Social Welfare and Health Care 2008-2011	X	X		X	X							X	
Employment and Working Life													
National Action Programme on extending Working-Life Well-being at Work and Rehabilitation.									X				
Workplace Development Programme (TYKES)									X				
Strategy of the Finnish Institute of Occupational Health 2011-2015									X				
TEROKA: Decreasing the Health Inequalities between Professions									X				
Occupational Health 2015: Development Strategy for Occupational Health Care									X				
Policy Programme for Employment, Entrepreneurship and Worklife									X				
Equal Treatment and Opportunities													
Social Protection 2015	X	X			X		X			X	X	X	X
Action Plan for Gender Equality 2004-2007	X						X						
Disability Policy 2006										X			
Action Plan to Reduce Violence against Women							X						
Finland's Disability Policy Programme VAMPO 2010-2015										X			
Cross-sectoral Action Plan for reducing Social Exclusion, Poverty and Health Problems	X	X		X						X	X	X	X
Towards a Social Protection Reform: Creating Opportunities	X												X
National Action Plan to reduce Health Inequalities 2008-2011	X	X								X	X	X	X
Government Action Plan for Gender Equality 2012-2015	X						X						
Finnish Homelessness Programme											X		
Well-being of Children, Youth and Family													
A Finland Fit for Children: the National Plan of Action		X			X								X
National Action Plan to Reduce Corporal Punishment of Children		X											
Youth Participation Project 2003-2007		X			X								
Child & Youth Policy Programme 2007-2011		X			X								
Policy Programme for the Well-Being of Children, Youth and Families		X			X								
Overall Health													
MIELI: National Plan for Mental Health and Substance Abuse Work in Finland	X												
Time Out! Getting Life Back on Track!								X					
Policy Programme for Health Promotion	X	X		X									
Total number of programmes targeting this specific group	11	10	0	4	7	0	4	1	8	5	4	2	5

that these group were not targeted indirectly. For example. pregnant women may be targeted as part of the category family, or youth. The well-being of the unborn babies, as part of the category pregnant women, might also be improved by actions targeted at children. Moreover, a large part of adult men

also belongs to the group working people. While the first group was not targeted at all, the latter was targeted eight times.

Our first expectation was that there would be attention for vulnerable groups such as immigrants and the homeless. In the table we see that four vulnerable groups were addressed: the disabled, the homeless, immigrants and people with a low SES in general. Four programmes focused on homelessness. The National Development Programme for Social Welfare and Healthcare 2008-2011 aimed to halve homelessness by 2011, and was supported by the Finnish Homelessness Reduction programme for the homeless by focusing specifically on special groups which encounter more problems in finding housing, such as disabled homeless people (74). However, these programmes just focus on reducing homelessness, and to not make any efforts to improve other social determinants, such as health care services, discrimination, or education in this group. The same accounts for immigrants, where Social Protection 2015 aimed at improving social inclusion, and the National Action Plan to Reduce Health Inequalities solely focused on improvement of social services for immigrants (74, 75). Programmes that targeted disabled people, on the other hand, composed a more comprehensive framework for improving health in this group. Social Protection 2015 helped people with disabilities to actively contribute to society, supported disabled people in finding employment, and guaranteed an income for those who cannot work (75). The Disability Policy 2006 focused on improving equality in employment and education and supported disabled people to live independently and to function in daily and social life (76). Finland Disability's Programme further improved the situation for disabled people by focusing on SES, poverty, and improving and developing social services aimed at this specific group (76).

Our second expectation was that children, youth, people of working age, and the elderly would be specifically targeted by the programmes. A first look at Table 3 confirms this expectation, as these groups were the most targeted groups of all. Programmes that targeted children and youth mainly focused on improving health and well-being and increasing social protection, but not so much on the wider social determinants of health. There were two programmes (Social Protection 2015 and the Cross-Sectoral Action plan for reducing Social Exclusion, Poverty and Health Problems), however, that also focused on improving security at home (75, 77). The seven documents that targeted people of working age focused mainly on working conditions, occupational health, access to health care for employees, employment opportunities and education, and did not focus on other social determinants of health (78-83). However, these factors might be targeted in other groups, such as families, general low SES, or

society as a whole, as these are groups which also include people of working age. The four programmes that targeted the elderly mainly focused on health promotion, the quality and accessibility of social services, and social protection (73, 83-85). However, a more comprehensive approach might be desirable for this group, as factors such as income security and housing conditions also greatly affect health. Overall speaking, for some groups in society programmes created a comprehensive approach to improve health, in which a diverse range of health-related factors were targeted. For some other groups, however, programmes focused only on a limited number of factors.

The logic models also created expectations for the targeted groups in the specific categories. The policy categories Healthcare & Social Services and Equal Treatment & Opportunities were expected to focus on vulnerable groups specifically. In the latter category all vulnerable groups were targeted several time. However, in the category Healthcare & Social Services the homeless were targeted by one programme, and no other vulnerable groups were targeted (73). More efforts to increase accessibility of services for vulnerable groups would be expected and desired in this category. For the policy category Employment & Working Life we expected that people of working age were targeted specifically. Six out of six programmes in this category focused solely on this group in society, thereby fulfilling our expectation (78-83). Finally, the category Well-being of Children, Youth & Families was expected to focus specifically on children, youth and families. In Table 3 we find that, as expected, these groups were targeted several times by programmes in this category (77, 83, 86, 87).

Finally, we expected that the programmes that gave content to Health 2015 involved the different levels of government, actors from the private sector, and areas of everyday life. The Policy Programme for Health Promotion, and the National Development Programme for Social Welfare and Healthcare involved organizations in health promotion by supporting their activities (73, 78). The Development Guidelines for Health-Enhancing Physical Activity and Nutrition tried to involve individuals by improving their knowledge base and skills in order to make healthy choices (88). Moreover, the Finnish Patient Safety Strategy involved health care workers in improving their education and professional skills to improve the quality of health care (89). Finally, municipalities, were involved in programmes such as the National Development Programme for Social Welfare and Health Care (73). These are only examples of some programmes that involved different actors, but in general, we can say that our expectations were met and many different actors were included in the Health 2015 strategy.

<u>5.3.2. Health 2015 targeted social determinants of health</u>

In Table 4 we see the programmes that were part of Health 2015 and the social determinants of health that these programmes aimed to tackle. General knowledge, involving the education and information of citizens to make informed decisions in daily life, was targeted in eighteen programmes, and was therefore the most targeted social determinant of health. Homelessness, transportation and research were the least targeted determinants. The policy category Equal Treatment & Opportunities seems to be the most comprehensive category, as 22 of 26 involved determinants were tackled in this category. This is a good sign, as this was also the category in which the vulnerable groups were targeted most. By taking a comprehensive approach in which a wide range of determinants is tackled, the health and SES of this groups might really improve.

We found differences in the comprehensiveness of programmes. Some programmes, such as the Workplace Development Programme, the Policy programme for Employment, Entrepreneurship and Worklife, the Youth Participation Project, and the Time Out! project just focused on one or two of the social determinants of health (79, 83, 87, 90). Other programmes such as Social Protection 2015, the Cross-Sectoral Action Plan for reducing Social Exclusion, Poverty, and Health Problems, and the Child & youth Policy Programme focus on a whole range of different social determinants (75, 85, 87). However, as was discussed before, the number of programmes that target a determinants might not say so much about the quality and diversity of actions taken. Therefore, we did not just look at whether or not determinants were tackled, but also on what actions were taken, and whether or not these actions together form a comprehensive approach to realize improvements for the relevant social determinant.

The category Lifestyle & Health Choices contains only one programme called Development Guidelines for Health-Enhancing Physical Activity and Nutrition (88). According to the logic model this programme is supposed to focus on factors related to individual lifestyle factors and behaviour. Nutrition and physical activity were tackled by promotion of knowledge and skills for healthy eating and physical activity, and influencing living conditions and the physical environment. Schools were required to provide fruits, healthy meals, and education about healthy life styles. However, no specific resources were allocated to this programme, which only stated that more resources would be allocated to improving nutrition and physical activity than before. Moreover, no efforts were made to decrease smoking, alcohol

Table 4. The Finnish programmes that contributed to the Health 2015 strategy and the social determinants of health which they targeted

	Lifestyle / Habits					Daily Life					Physical Circumstances						Social security				Community factors			
	Nutrition	Physical Activity	Smoking	Alcohol consumption	Substance Abuse	Leisure	General Knowledge	Family Life	Education	Employment	Working life	Housing	Homelessness	Transport	Physical Environment	Violence/Crime	Social services	Quality/Access Health	Income security	Poverty	Participation	Social Inclusion	Discrimination	Research
Lifestyle & Health Choices																								
Development Guidelines for Health-Enhancing Physical Activity and Nutrition	X	X					X		X															
Health care & Social Services																								
Partnership Programme for Family Services								X									X	X						
Promoting Patient Safety Together: Finnish Patient Safety Strategy 2009-2013							X		X									X						
High-Quality Services for Older People						X						X		X	X			X			X	X		
National Development Programme for Social Welfare and Health Care 2008-2011			X	X				X	X	X					X			X	X					
Employment & Working Life																								
National Action Programme on extending Working-Life Well-being at Work and Rehabilitation.			X	X			X		X		X					X		X	X					
Workplace Development Programme (TYKES)											X										X			
Strategy of the Finnish Institute of Occupational Health 2011-2015											X				X			X						
TEROKA: Decreasing the Health Inequalities between Professions							X								X						X			
Occupational Health 2015: Development Strategy for Occupational Health Care							X				X							X						X
Policy Programme for Employment, Entrepreneurship and Worklife										X	X													
Equal Treatment & Opportunities																								
Social Protection 2015					X			X	X	X							X	X	X	X		X	X	
Action Plan for Gender Equality 2004-2007						X	X		X	X						X						X	X	
Disability Policy 2006		X				X	X		X	X								X				X	X	
Action Plan to Reduce Violence against Women						X	X			X						X		X						
Finland's Disability Policy Programme 2010-2015							X											X						X
Cross-sectoral Action Plan for reducing Social Exclusion, Poverty and Health Problems		X		X			X		X	X								X	X	X	X	X	X	X
Towards a Social Protection Reform: Creating Opportunities							X		X		X							X						
National Action Plan to reduce Health Inequalities	X	X	X	X			X		X	X	X							X	X			X		
Government Action Plan for Gender Equality '12-'15							X		X	X						X						X		
Finnish National Action Plan for the European Year of Active Ageing and Solidarity between Regions 2012							X		X													X		
Well-being of Children, Youth & Family																								
A Finland Fit for Children: the National Plan of Action						X	X	X	X		X					X	X	X	X			X	X	
National Action Plan to Reduce Corporal Punishment of Children							X									X								
Youth Participation Project 2003-2007																						X		
Child & Youth Policy Programme 2007-2011	X	X			X	X		X	X	X	X				X		X	X	X			X	X	
Policy Programme for the Well-Being of Children, Youth and Families							X		X												X	X	X	
Overall Health																								
MIELI: National Plan for Mental Health and Substance Abuse Work in Finland					X		X		X									X						
Time Out! Getting Life Back on Track!																								
Policy Programme for Health Promotion							X										X	X						
Number of programmes focusing on this determinant	3	5	3	4	3	4	18	7	13	11	9	4	1	1	6	4	5	16	10	3	7	10	5	1

consumption, and substance abuse, three behaviours with massive influence on health. However, these behaviours were targeted sporadically in other categories. Smoking was targeted by three other programmes. Two of these programmes focused specifically on young people through education and early intervention (73, 78). The other programme, the National Action Plan to Reduce Health Inequalities aimed to reduce smoking by raising taxes on tobacco products and creating new legislation to reduce import and black market exchanges (74). Alcohol consumption was targeted by four programmes, which focused on education, intervention, raising taxes on alcoholic beverages, and a revision of the Alcohol Act (73, 74, 78, 85). Lastly, substance abuse was targeted in three programmes by preventive actions such as education of children and adults, promotion of healthy lifestyle, reorganization of substance abuse services, and strengthening of the status of substance abuse service users 75, 87, 91). In general the relevant lifestyle determinants were targeted in a comprehensive manner, although only two of them were targeted in this specific category. However, the division of programmes was created by the author herself and is therefore subjected to personal judgment, and programmes tend to fall into more than one category, creating several possible divisions of programmes.

The logic model of the policy category Health Care & Social Services predicted that the relevant determinants for this category were health care (and social) services, education, income (security), and water and sanitation. All of these determinants, except for water and sanitation, were targeted in this category. Healthcare and social services were targeted by four programmes which aimed to ensure adequate resources and competences in healthcare workers, create a safety culture in health care facilities, and create new legislation concerning the provision of services. Moreover, the National Framework for High-Quality Services for Older People aimed to involve the elderly in designing health care and social services on the local level (84). However, most efforts to improve health care were made by programmes which did not fall in the category Healthcare & Social Services. The National Action Plan to Reduce Health Inequalities aimed to improve cooperation between health care and social services, and safeguard special services that support working ability (74). Moreover, it focused on further developing and strengthening mental health services and ensuring equal services for older people and immigrants. Other programmes focused on the improvement of occupational health services, by creating connections between workplaces and occupational health services, and creating regional working structures (80, 81). Furthermore, there were programmes that aimed to improve services for specific groups. The Programme for High Quality Services for Older People aimed to improve involve the

elderly in the organization and designing of health care and social services on the local level (84). The Action Plan to Reduce Violence Against Women aimed to improve the healthcare responses in case of violence against women, but did not specify how (92). Social Protection 2015, and Finland's Disability Policy aimed to ensure access to services for disabled people to help them live independent lives (75, 76). Lastly, the National Action Plan to Reduce Health Inequalities aimed to ensure quality of and access of services for children, youth, families, elderly and immigrants, but also did not specify actions to do this (74). In general health care was targeted in many different ways, creating a comprehensive approach, but only limited action to improve services was taken in this category. Moreover, in general we find that actions that were to be taken should have been more specified. Another relevant indicator, education, was targeted by two programmes in this category. Promoting Patient Safety Together aimed to improve the education of healthcare workers specifically, by making patient safety an important part of the programmes (89). The National Development Programme for Social Welfare and Health Care aimed to integrate healthy lifestyle in children's education as part of prevention (73). However, programmes outside of this category also made many contributions to improve education. Towards a Social Protection Reform: Creating Opportunities, and the National Action Plan on Extending Working Life, Well-being at Work and Rehabilitation aimed to reform education to be more appropriate for employment later on in live (78, 93). The National Action Plan to Reduce Health Inequalities focused on access to education, especially in more vulnerable groups, as the Disability Policy 2006 did specifically for disabled children (74). Although education was thoroughly targeted by many of the programmes, only two of these programmes fell in this specific category (73, 89). Lastly, income security was tackled by the National Development Programme for Social Welfare and Health Care, which aimed to ensure a proper system (73). Income security was targeted by nine other programmes in other categories, which tried to contribute to decent working system for providing income (73-76, 78, 80, 83, 85-87, 93). Water and sanitation was not targeted in this category, but this might be explained by the fact that Finland has maximized these services already. Some other factors that were not predicted by the logic model, were targeted in this category as well, making this category more comprehensive. Overall we can say that this category fulfilled our expectations, although some programmes should make more efforts to clearly define actions that are to be taken, and the relevant determinants were not solely tackled by the programmes in this policy category.

Derived from the policy model for Employment & Working Life the determinants that should be targeted by this category are education, employment, living and working conditions, income security,

and gender equality. Education and employment were both targeted once in this category. As was discussed before, Occupational Health 2015 aimed to reform education in order to better prepare children and youth for employment (80). Moreover, this programme, together with the National Action Programme on Extending Working-life, Well-being at Work and Rehabilitation, focused on providing income security for people who are unable to work, or have lost their jobs (78, 80). Working life, an important part of working and living conditions, was targeted by five programmes in this category (78-81, 83). Occupational Health 2015 and the Strategy of the Finnish Institute of Occupational Health focused on making work environments safer and more health friendly (80, 81). The National Action Programme on Extending Working Life, Well-being at Work and Rehabilitation focused on allowing for diversity and equality on the work floor (78). Social Protection 2015 and A Finland Fit for Children, two programmes that did not fall into the category Employment & Working Life targeted working life by making work and family life more reconcilable and boosting the incentive to work provided by social insurance (75, 86). Physical environment, another important part of living and working conditions, was targeted by three programmes, focusing mainly on safety of the workplace (78, 81, 82). Income security was tackled by two programmes, and as discussed before these focused on building a decent system for the provision of income security. These last three determinants forms a quite comprehensive approach to improve living and working conditions. Gender equality, however, was not specifically targeted at all in this category, where we expected to find efforts to reduce discrimination on grounds of gender. However, as can be seen in Table 3, women were targeted in four different programmes in the category Equal Treatment & Opportunities, in order to improve equality between men and women in daily life situations such as working life. Therefore we can say that, although the Health 2015 programme made efforts to increase equality between men and women in the work environment, this specific category did not. However, overall we can say that our expectations for this category were largely met.

The logic model of the policy category Equal Treatment & Opportunities predicted that the relevant determinants were social and community networks, social cohesion, gender equality and ethnicity/race equality. Participation, an important part of social and community networks and of social cohesion, was targeted by the Cross-Sectoral Action Plan for Reducing Social Exclusion, Poverty and Health Problems, which aimed to develop a channel through which young people's opinions could be heard (85). Social inclusion was targeted seven times in this category. For example, Social Protection 2015 aimed at encouraging social inclusion in immigrants and ethnic groups (75). The Action Plan for Gender Equality aimed at equal inclusion of men and women in society, while Disability Policy 2006 aimed at inclusion of

disabled people in everyday life and working life (92, 76). However, these programmes did not specify the actions that were taken to increase inclusion. Discrimination, an important aspect of gender equality and ethnicity/race equality, was targeted by five programmes (75, 76, 85, 94, 95). Nonetheless, for these programmes the same goes as for social inclusion. Programmes are ambitious about reducing discrimination of vulnerable groups, but concrete actions are missing. As we discussed earlier this particular category is most comprehensive. Many other factors that contribute to health and increasing opportunities for vulnerable groups were also tackled in this policy programme. As we look closely at Table 3 we even see that Equal Treatment & Opportunities has tackled every determinant in the table, except for homelessness, transport and physical environment. However, for the determinants that were expected to be tackled, we found that plans were ambitious, but concrete steps were missing.

For the category Well-Being of Children, Youth & Families, individual lifestyle factors, education, living and working conditions, material circumstances, income, and housing were expected to be targeted. Quality of nutrition and physical activity, and prevention of substance abuse in children and adolescents were targeted by the Child & Youth Policy Programme, and are the only lifestyle factors tackled in this category (87). No efforts were made here to decrease alcohol consumption and smoking, although we already discussed that these determinants were tackled in some other categories. The quality and accessibility of education was targeted as part of A Finland Fit for Children and the Child & Youth Policy Programme, but actions were again not specified (86, 87). Working life, housing and the physical environment were tackled as part of improving living and working conditions. A Finland Fit For Children aimed to better conciliate working life and family life, decent housing was targeted by the Child & Youth Policy Programme, and both these programmes aimed to create a healthy and stimulating physical environment for children, youth and families (86, 87). However, once again the envisioned actions remained vague and unspecified. Moreover, in order to improve living conditions, indecent housing and homelessness should also be tackled in this category. Although these determinants were tackled in some programmes in other categories. Quality of and access to health was tackled in an effort to improve material circumstances, but no efforts were made to improve social services as well. Some efforts were made to ensure a stable income for families, but unfortunately none of the programmes in this category focused on reducing poverty. In general many programmes promise to tackle relevant social determinants for this policy category, but fail to specify the actions to reach this goal, making it very questionable whether action was actually taken. Moreover, important determinants, such as homelessness, poverty, or smoking and alcohol consumption were not targeted in this category.

For the category Overall Health no logic model was created, as all determinants might be relevant in this case. However, the determinants that were actually targeted are not so wide spread. The three programmes only tackled 6 determinants: substance abuse, general knowledge, education, social services, and quality of and access to health care. We would expect to find a wider range of tackled social determinants, as all these determinants are relevant for health. Overall we expected that this category would be the most comprehensive of all categories, while in practice it was one of the least comprehensive ones. Finally, some of the tackled determinants in 4were not predicted by the logic models. Leisure and family were unexpected tackled determinants, and might actually be a very important factor for health. After all, during leisure time people can relax and relieve tension, which can be beneficial for both mental and physical health. General knowledge, the most targeted determinant of all, was also not expected to be targeted. However, in today's society where health care budgets are shrinking and people are more and more responsible for their own health, know-how about living a healthy lifestyle might be one of the most important means for living in good health. Another unexpected determinant was violence/crimes, which was tackled in 4 programmes that mainly focuses on women and children (77, 92, 94). Reducing violence is a logical step to improve public health, seeing the great physical and mental health problems that it can cause. Finally, one programme, Occupational Health 2015, also focused on research as an important means of improving occupational health policies in the future (80).

5.4. Trends in Finnish health and the effect of Health 2015

In this section we discuss the data from the Demetriq database with regards to the Health 2015 programme. This Finnish data's origin lies in two studies: The Health Behavior and Health among Finnish Adult Population Study (respondents 15-64 year old) and the Health Behavior and Health among the Finnish Elderly Study (respondents 65-79). All data was standardized to the European Standard Population. The indicators that are discussed here are the available relevant indicators that were predicted by the logic models . Their implications for the effectiveness of the strategy are discussed at the end of this section.

In Figure 10 we find the percentage of men and women who rate their own health as less than good. We see that there are big differences between the different groups in both men and women. In men self-assessed health is quite stable, while in women it shows some fluctuations. For men in general we see a decrease in the number of people who are in less than good health, followed by an increase. After the start of the Finnish health strategy in 2001 we see a steeper and more long term decrease, especially in low educated men, indicating that Health 2015 might have positively influenced self-assessed health. Because of the fluctuation in women's self-assessed health it is more difficult to identify trends. In general we see that from 1995 on the percentage of people in less than good health increased until 2003, right after the start of Health 2015, when it decreased in low and medium educated people. However, in high educated people this decrease did not start until 2009. These trends suggest that Health 2015 had positive influence on self-assessed health in women, especially in lower educated groups. In general the trends indicate that health 2015 might have positively affected self-assessed health, especially in low educated groups.
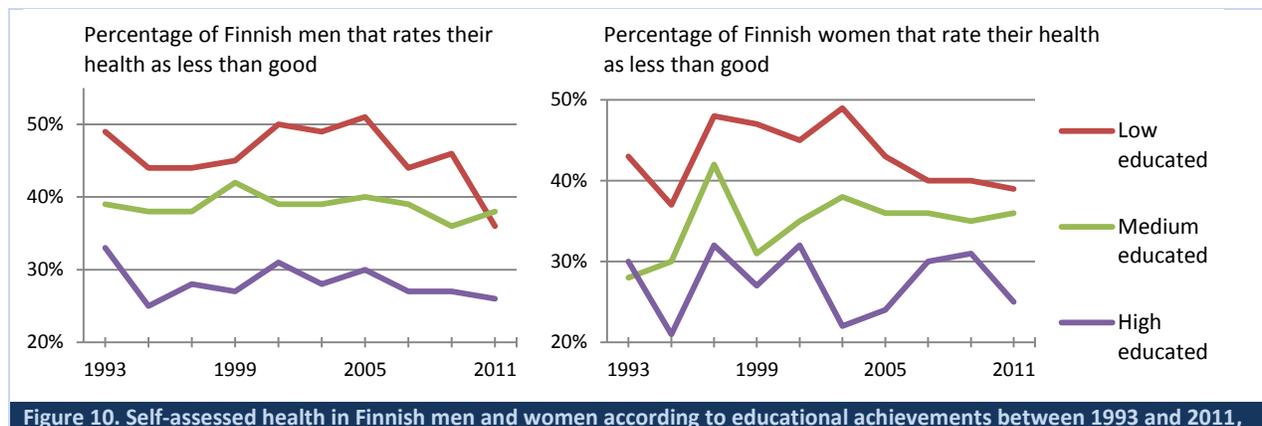
Figure 10. Self-assessed health in Finnish men and women according to educational achievements between 1993 and 2011,

In Figure 11 we see the prevalence of longstanding limiting health problems in Finnish adult men and women. Since the start of Health 2015 in 2001 there have only been some minor fluctuations in the three male groups. By 2011 the prevalence in low educated men had decreased, while it had increased in medium and high educated men, thereby decreasing inequity. However, we would rather have seen a decrease in inequity that was not caused by an increase in morbidity rates of high SES groups. In medium and high educated women the prevalence of longstanding limiting health problems also remained quite stable since 1999. For low educated women, however, we see an increase in the

prevalence, and therefore an increase in inequity, since the start of the strategy. Overall we do not find many positive effects of the Health 2015 strategy on longstanding limiting health problems and inequity.

Percentage of Finnish men that deal with long-standing limiting health problems

Percentage of Finnish women that deal with long-standing limiting health problems

Figure 11. Prevalence of longstanding limiting health problems in Finnish men and women according to educational achievements between 1993 and 2011
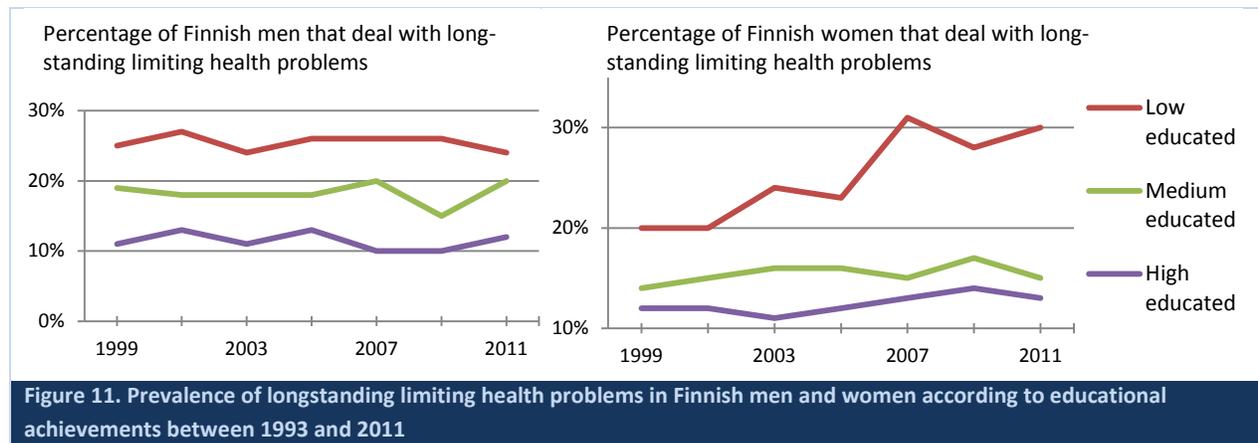
In Figure 12 we see the daily smoking prevalence in Finnish men and women. In medium and high educated men we see a slow decline over the whole period. This decline does not seem to get stronger since the start of the national strategy. In low educated men, however, we see an increase from 2001 to 2007, right after the start of the national strategy. From 2007 on there is a sharp decrease in this group, causing a decrease of inequity. Moreover, in 2011 smoking prevalence is even lower in low educated people than in medium educated men. For women the data creates a whole different picture. We see fluctuations in both the high and low educated group, while the medium educated group remained quite stable. Overall smoking prevalence is still lower in women than in men. For high educated women we see a slow increase until 2001 (the start of Health 2015) after which we see a slow decrease. In low educated women we see a very sharp increase in daily smoking until 1999 after which we see a sharp decrease. However, in 2003, right after the start of Health 2015, there was an increase again, which was followed by an decrease since 2009. However, smoking in women might be influenced by many more factors than just policies. One of these factors is women's emancipation during the second half of the nineteenth century, which turned female smoking from a taboo into desired behavior and a symbol of status and independence. The tobacco industry responded to this phenomenon by specifically targeting women in advertising and reinforcing the image of cigarettes as a symbol of freedom (96). While in some countries, such as Portugal and Latvia, the female smoking rates are now around 10 percent, some countries such as Germany and the Netherlands are still coping with smoking prevalence around 30 percent (97). Finland, with its female smoking prevalence of approximately 15 percent might belong to the group in which the smoking epidemic has already laid down. However, the effects of the strong

image of smoking and decades of advertising might still make it very difficult for smoking policies to be really effective. Overall, we see decreasing trends in smoking prevalence in some groups, but these do not seem to be affected by the start of the national health strategy in 2001. Although the strategy might have been effective in low educated men, we do not see clear effects for low educated women. In total we find no clear effects of the strategy on daily smoking prevalence.


Figure 12. Daily smoking prevalence in Finnish men and women according to educational achievements between 1993 and 2011.
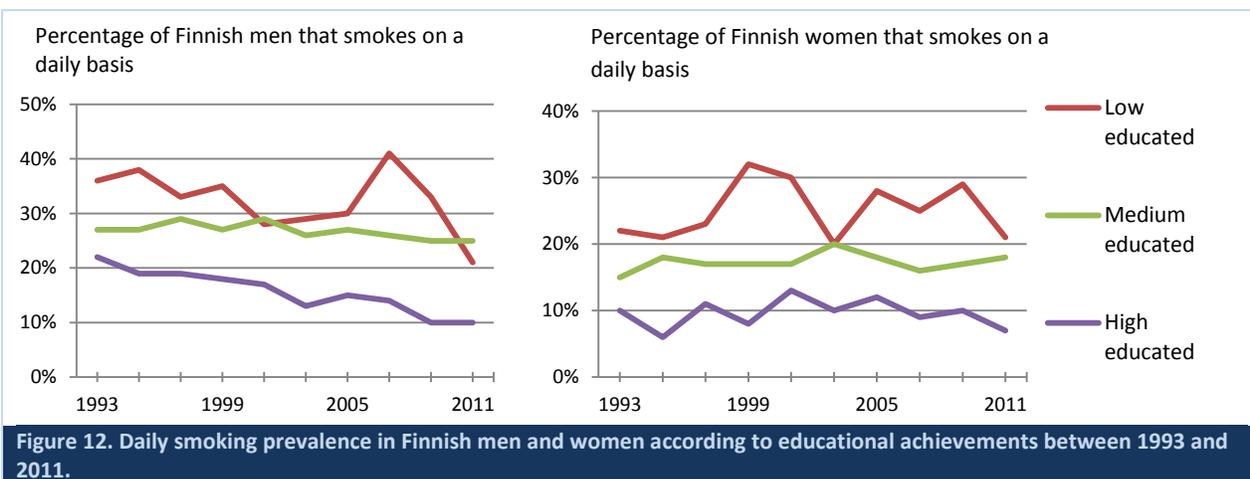
In Figure 13 we see the prevalence of GP visits in the last year for Finnish men and women. For men we see quite some fluctuations, especially in the low educated group. Here we see a increases rapidly followed by decreases. For the other groups in general we see a slow increase of the prevalence. For women we also find many fluctuations in the prevalence of GP visits, especially in the low educated group, where in general there seems to be a decreasing trend. The prevalence of GP visits generally remains steady in the medium and high educated groups. Overall there is no clear effect of the Health 2015 strategy on the prevalence of GP visits. In some groups there has been an increase or decrease in prevalence. However, the effects of increased GP visits on health are disputable. On the one hand more GP visits can represent better awareness of health, earlier detection of problems, and better accessibility of care. On the other hand, however, it can also represent increased morbidity and need of care. Overall, the prevalence of GP visits does not lend itself to draw conclusions about the effectiveness of Health 2015.

Percentage of Finnish men that visited the GP over the last 12 months

Percentage of Finnish women that visited the GP over the last 12 months
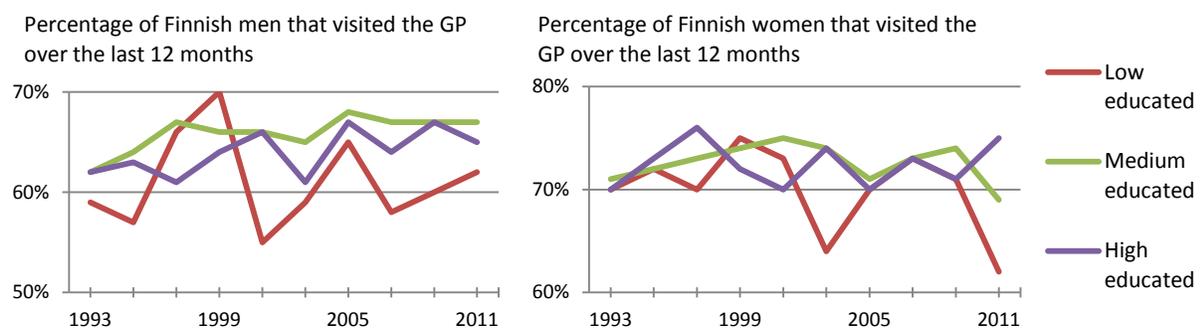
Figure 13. Prevalence of GP visits over the last 12 months in Finnish men and women according to educational achievements between 1993 and 2011.

In Figure 14 we find the prevalence of overweight and obesity in Finnish men and women. In general we see upward trends in both overweight and obesity. This increase seems to be fairly similar in all levels of education, although we see a sharp increase in overweight in 2009 in low educated men. Moreover, we do not see changes in patterns since 2001, the start of national strategy, which leads us to conclude that we have no evidence that Health 2015 has affected the prevalence of overweight and obesity in Finland.

Percentage of Finnish men that is overweight

Percentage of Finnish women that is overweight

Percentage of Finnish men that is obese

Percentage of Finnish women that is obese
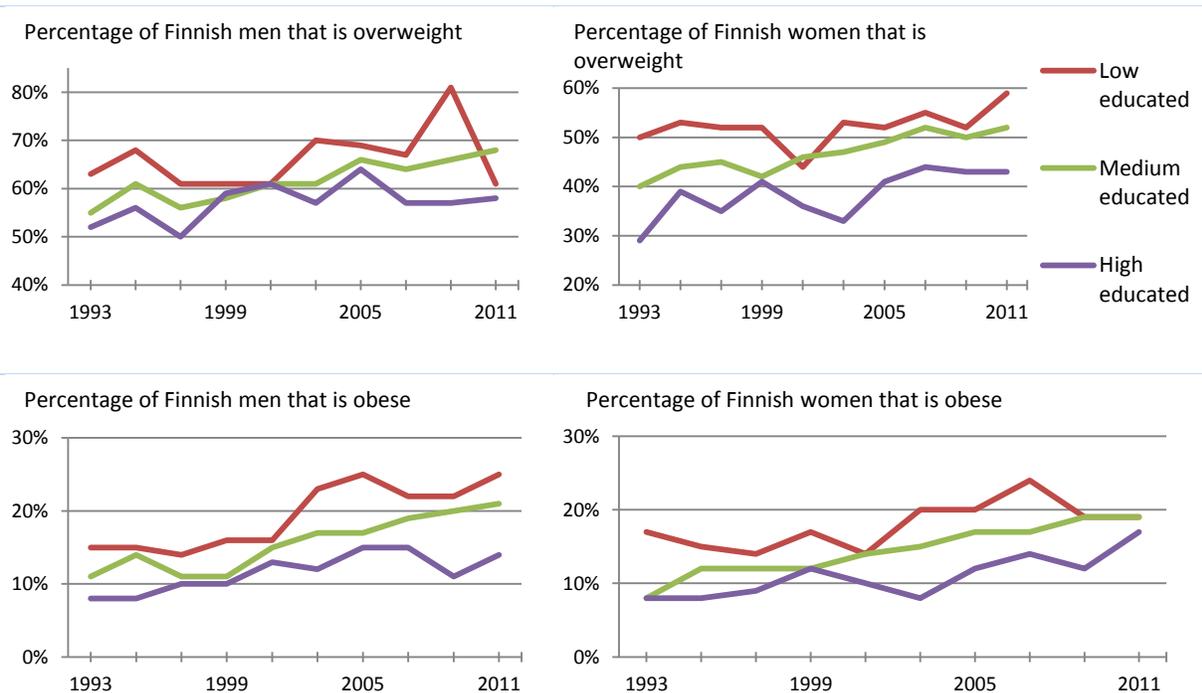
Figure 14. Prevalence of overweight and obesity in Finnish men and women according to educational achievements between 1993 and 2011.

In Figure 15 we find the smoking-related mortality in Finnish men and women. In general we see a decreasing trend for men, while we see an increasing trend for women, similarly to the prevalence of daily smoking. As we discussed earlier, in the second half of the nineteenth century there had been a strong increase in smoking in women. It is likely that this increased smoking prevalence over the last decades has resulted in an increase in smoking-related mortality in women over time. However, where the prevalence of smoking is still much lower in women than in men. These trends do not seem to be affected by Health 2015 which started in 2001. It is unlikely, however, that these effects of the strategy are already visible, because of the time lapse between smoking and smoking-related mortality.

Figure 15. Smoking-related mortality in Finnish men and women according to educational achievements between 1975 and 2010.
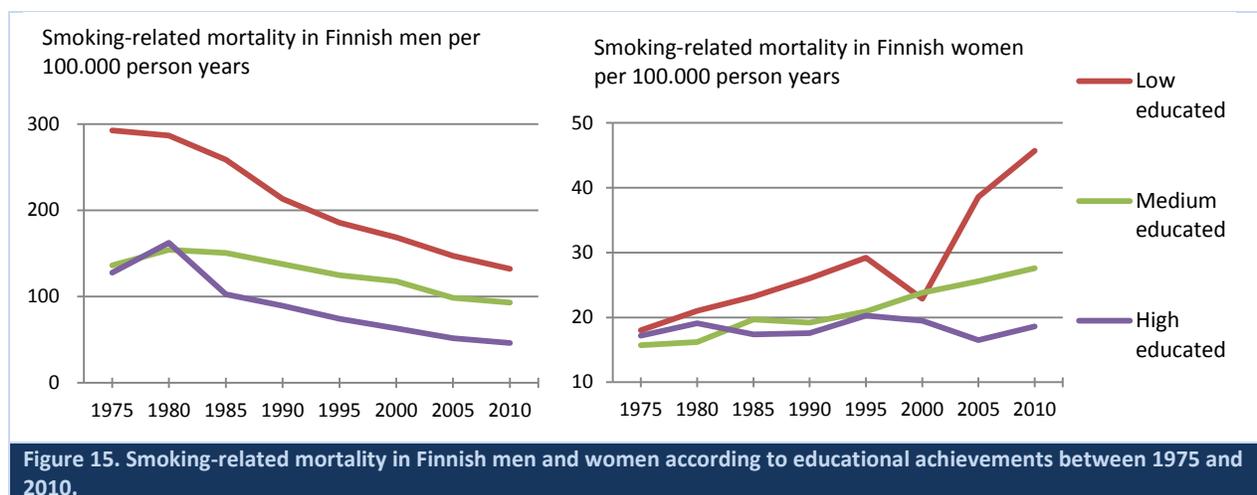
In Figure 16 we see alcohol-related mortality in Finnish men and women. In general we see an upward trend in both genders, although mortality is lower in women. Since the start of the national health strategy in 2001, we do not see changes in this trends, except for medium educated women where alcohol-related mortality already started to decrease in the early 2000s. However, not all effects of the strategy might be visible at this point, because of the time lapse between alcohol consumption and many forms of alcohol-related mortality. Moreover, as the increase was much bigger in low than in high and medium educated groups, inequities in alcohol-related mortality increased even further since the start of Health 2015.
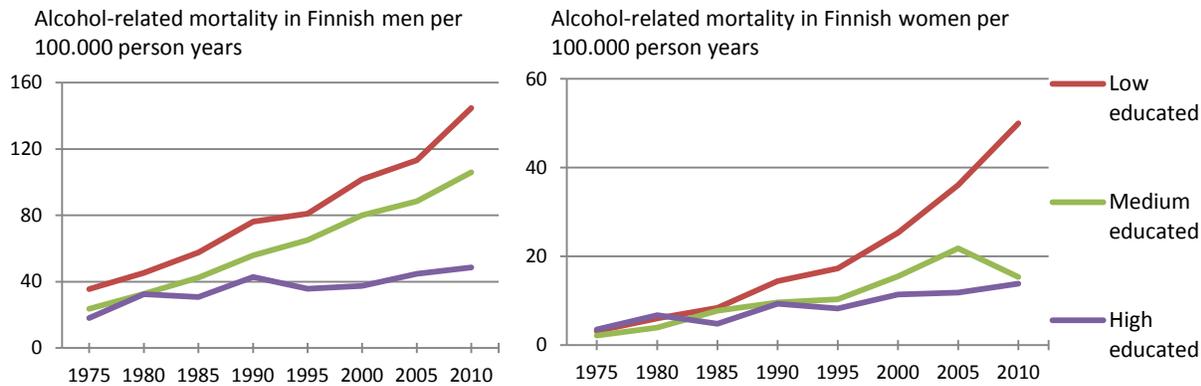
Figure 16. Alcohol-related mortality in Finnish men and women according to educational achievements between 1975 and 2010.

In Figure 17 we see the total mortality rates for men and women. In both genders we see declining numbers. Inequities within educational groups do not seem to change much over time. In men mortality is still twice as high as in women. Since the start of the national health strategy in 2001 we see no changes in the declining trend, indicating that Health 2015 probably did not decrease total mortality.
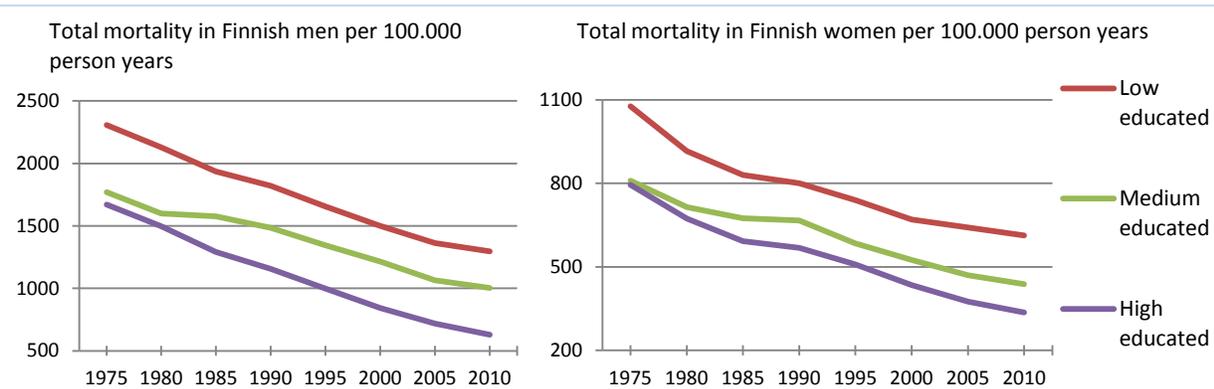
Figure 17. Total mortality in Finnish men and women according to educational achievements between 1975 and 2010.

In Figure 18 we find the amenable mortality rates in Finnish men and women. Because this kind of mortality involves lost life years and not reaching full life potential, this is a very important indicator for health inequity. For this form of mortality trends are quite similar in both genders. We see a constant decrease in all different groups. This decrease, however, does not seem to be influenced by the Health 2015 strategy that started in 2001, and the differences between male groups also do not seem to change. In women we see that inequities have decreased since 1975, but not since the start of the strategy in 2001. Therefore, it is likely that Health 2015 did not positively affect amenable mortality.

Amenable mortality in Finnish men per 100.000 person years

Amenable mortality in Finnish women per 100.000 person years
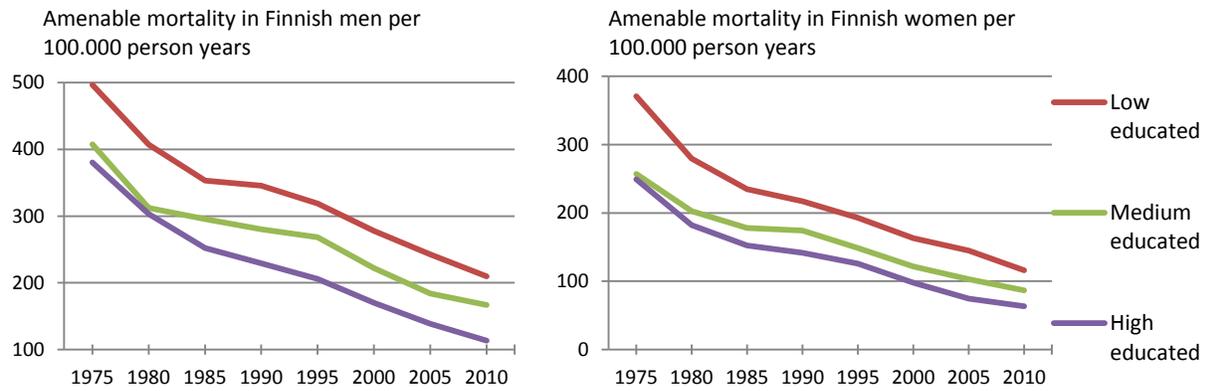
Figure 18. Amenable mortality in Finnish men and women according to educational achievements between 1975 and 2010.

Finally, in Figure 19 we find mortality caused by road accidents. This kind of mortality might also be an important indicator of inequity, as high accident rates might be associated with unsafe neighbourhoods, and therefore with bad housing, and low SES in general. Overall we see that this kind of mortality rates are declining, although they are still much higher in men than in women. However, the decline does not seem to be affected by the start of health 2015 in 2001. Inequities seem to have decreased since 1975, but not since 2001.

Mortality caused by road accidents in Finnish men per 100.000 person years

Mortality caused by road accidents in Finnish women per 100.000 person years
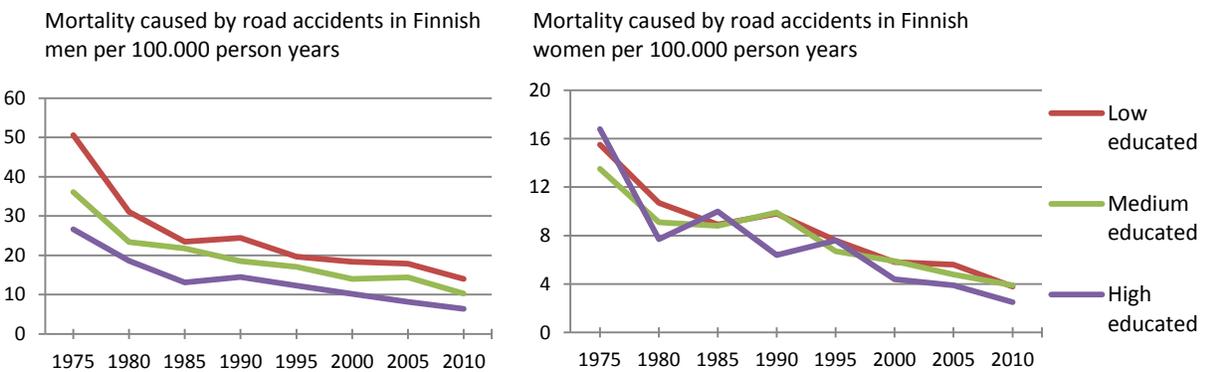
Figure 19. Mortality caused by road accidents in Finnish men and women according to educational achievements between 1975 and 2010.

5.4.2. Health indicators and the effectiveness of the policy categories

For the policy category Lifestyle & Health Choices the relevant available determinants are the prevalence of overweight and obesity, self-assessed health, longstanding limiting health problems, alcohol-related mortality, and smoking prevalence. From these five indicators, the only indicators for which we found that Health 2015 might have had a positive affect are smoking prevalence and self-

assessed health. For smoking prevalence effects were only found in low-educated men, which might cause a decrease in inequity in male smoking-related mortality and some sorts of male morbidity on the long term. However, information on the relevant indicators alcohol consumption, drug abuse, physical activity, nutrition and overall morbidity is missing, making it very difficult to draw conclusions about changes in lifestyle and the effectiveness of this category.

For the policies in the category Healthcare & Social Services the available relevant indicators are self-assessed health, longstanding limiting health problems, prevalence of GP visits, amenable mortality, mortality caused by road accidents, and total mortality. This category was also expected to focus on the whole society and on vulnerable groups specifically. For the prevalence of longstanding limiting health problems, the prevalence of GP visits, amenable mortality, mortality caused by road accidents, and total mortality no effects were found. However, it might not be realistic to expect changes in amenable and total mortality at this point already. For self-assessed health we found that the whole population benefited since the start of the Health 2015 strategy in 2001, while improvements were greatest in low educated men and women.

In the policy category Employment & Working Life efforts were specifically targeted at the working population. Unfortunately, we do not have data for this specific group, and therefore we just have to rely on the data that is available for the different educational groups. For this category the only available relevant indicators were self-assessed health and longstanding limiting health indicators. While self-assessed health seemed to have improved since the start of the strategy, this is not the case for longstanding limiting health problems. Especially quality of life and the prevalence of suicide might have been useful, because these indicators might change on the short term. Without these indicators and relevant data for this target group we are not able to draw a conclusion about the effectiveness of this category.

For the policy category Equal Treatment & Opportunities, efforts were directed mainly at vulnerable groups. The three available relevant indicators are the prevalence of GP visits, amenable mortality, and total mortality. For none of these three indicators effects of the Health 2015 strategy were found in society as a whole, or vulnerable groups specifically. However, it might still be too early to find the effects of the strategy on mortality rates, and data on total morbidity is not available. Therefore we cannot surely say that the policy category Equal Treatment & Opportunities did not produce results.

Finally, for the policy category Well-being of Children, Youth & Families the available relevant determinants were self-assessed health, longstanding limiting health problems, and total mortality. As was the case in some previous categories the only indicator which seemed to be positively affected was self-assessed health. However, data on the relevant indicators quality of life and total morbidity is missing. Moreover, this data is extracted from people aged 15 to 70, and is therefore not representative for children and youth. Therefore we can say that, although there are some indications for improvements in self-assessed health and longstanding limiting health problems, too much information is missing to draw any conclusions for the effectiveness of this category.

5.5. Overall results for Health 2015

The second Finnish national Health strategy, Health 2015, provided an ambitious framework to tackle health inequalities and improve overall health in the Finnish population. It aimed to tackle problems in society as a whole, as well as in specific groups in society, and set out thirty-six lines of actions in order to achieve this goal. The Health 2015 policy documents and the logic models helped us create expectations concerning the targeted groups in society, the targeted determinants of health, and the relevant indicators for improvements in public health and effectiveness of the strategy. Our expectations concerning the target groups were largely met. Much effort was made to improve health and well-being in the most vulnerable groups in society, but also in children, youth, families, children and working people. However, for some groups in society, such as the homeless, a more comprehensive approach targeting a wider range of social determinants was desired. For the most part our expectations for the targeted determinants were also met. The strategy set out to target a wide range of social determinants, and almost all determinants were targeted by several programmes. Nonetheless, there were some social determinants for which more effort might have been needed. These determinants were unhealthy behaviours such as smoking, alcohol consumption and drug abuse, mortality caused by violence or traffic incidence, environmental impact on health, homelessness, poverty, housing, the quality and accessibility of social services, and general welfare in society. Moreover, some programmes made big promises about the determinants that would be tackled, but did not back these promises up with concrete action point. Also, a higher number of programmes tackling a certain determinant might not necessarily ensure a better outcome. It can even be argued that it is more efficient to tackle a

problem by just one programme, because that takes away the need for coordination of efforts and division of resources. Action might be more effective and resources might be spend more efficiently in such a situation.

Whereas the expectations that Health 2015 in theory had set for the national strategy were met quite well in practice, our expectations about the effects of the national strategy were not met. Some positive effects were found for self-assessed health and smoking prevalence, but not for any of the other indicators. Self-assessed health was a relevant indicator for quite some policy categories, but it is just that that makes it very difficult to reach conclusions about the effectiveness of the particular categories. We cannot attribute its effect to one category or the other, and can now only conclude that Health 2015 seems to have positively affected self-assessed health.

6. The British Tackling Health Inequities strategy

In this section we discuss the British Tackling Health Inequalities strategy as it was intended in theory and as it was applied in practice. Moreover, we discuss relevant data of the Demetriq project in order to identify any effects of the national strategy. However, first we discuss the initial situation that led to the creation of the strategy, in order to understand the priorities and action points in the strategy.

6.1. The initial situation that led to the creation of Tackling Health Inequalities

At the beginning of the 21th century life expectancy was high in the UK. Men were expected to live 75.8 years, and women were expected to live 80.5 years. However, healthy life expectancy did not seem to increase at the same rate as general life expectancy, and therefore it was expected that in 2030 the population would have aged considerably, and that health care systems would need to adjust to provide more geriatric care, prevent and manage chronic diseases, and provide long-term care (98). Moreover, the prevalence of overweight and obesity was among the highest in Europe. 63 percent of men and 53 percent of women were overweight in 2002, and respectively 21 and 23 percent were obese. Approximately a quarter of the population did not take any physical exercise (98). Moreover, alcohol consumption was also high in the UK, where 40 percent of drinking occasions involved binge drinking, and, contrary to the EU average, mortality caused by chronic liver cirrhosis was increasing (98).

Moreover, around 2002, health inequalities in the UK were still very prominent. There was no evidence that they had decreased over the last 30 years, and some evidence even suggested that gaps between the health of population groups had even widened. Whereas in the 70s death rates were two times higher for unskilled workers than for professional groups, in the 90s these numbers were three times higher. Moreover, health inequalities between regions in the UK had now become apparent as well. In 1999 boys in North Dorser were expected to live 9.5 years longer than boys in Manchester. This differences was 6.9 years for girls (51). Moreover, mortality due to respiratory diseases, digestive diseases, and several forms of cancer was higher in British women than in many other countries, while

British men had mostly normal mortality rates. Therefore, health policies were urged to recognize that men and women have different needs and problems regarding their health and well-being (98).

6.2. Tackling Health Inequalities in theory

The British Tackling Health Inequities strategy ran from 2003 to 2010. It was the first British strategy that aimed to decrease health inequalities and inequities and to improve the health of the British population in general. The strategy's main aim was to decrease inequalities that were found across different geographical areas, genders, different ethnic communities, and between different social and economic groups, and to address the underlying factors of this phenomenon. These aims were supported by one central target: to reduce inequalities in health outcomes by 10 percent as measured by infant mortality and life expectancy at birth by 2010. Two more detailed objectives were formulated to support this target, which were to [1] starting with children under one year, by 2010 to reduce at least 10 percent the gap in mortality between routine and manual groups and the population as a whole, and to [2] starting with local authorities, by 2010 reduce by at least 10 percent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole (51).

Although actions were to be taken on a national level, the strategy relied on local and regional contributions. On the local level the focus was on Local Strategic Partnerships, which required different forms of citizens participation and engagement in order to be successful. On a regional level, the Government Offices fostered greater partnership and a regional response to health inequalities.

The strategy was organised around four themes, which were underpinned by five principles. These themes and principles can be found in Box 4. The first theme about supporting families, mothers and children, was supported by six points of change. First of all, health care staff en social workers now worked with children and young people from one stop centres, which provide help and advice on a range of council services. Second, Primary care services were transformed to be more oriented towards children and youth, and to more outreaching. Third, in order to avoid information duplication, staff working with children and youth now worked in multidisciplinary teams. Fourth, by means of a common assessment system, problems were now supposed to be detected earlier and support to be given more promptly. Fifth, families with children with challenging behaviour had now earlier access to support

services, and last, young people were now more involved in the designing and evaluating of the impact of public sector services (51).

For the second theme about engaging communities and individuals in health policies and health promotion, six supporting goals were set up. Firstly, local people were now to be involved in identifying local needs, influencing decision making and evaluating local services. Secondly, community development teams were now working in areas where needs were greatest. Thirdly, health and social care was now provided by the community and voluntary sector within the principles of social enterprise. Fourthly, services were reshaped to meet the needs of more vulnerable groups in society. Fifthly, patients with long-term illnesses were now in charge of managing their own conditions with support of a health staff. Lastly, black and ethnic minority communities were now active partners in addressing mental health needs (51).

The third theme about preventing illness and providing effective treatment and care was also supported by six goals. Firstly, primary care trusts (PCTs) by 2010 were supposed to have resources that matched their needs. Secondly, prevention and treatment was to be more equally challenged, especially for illnesses which have great impact on health inequalities. Thirdly, service provision was to be based on evidence of need, and focused on disadvantaged groups and populations with high levels of certain illnesses. Fourthly, increased levels of activity were to be achieved, especially in disadvantaged groups, women and older people. Fifthly, services were to be tailored to culture, language and religions, and provided in the community by reaching out to improve access. Lastly, the national service framework (NSF) programmes and National Institute of Clinical Excellence (NICE) were to improve quality and quantity of care (51).

The fourth theme, about addressing the underlying determinants of health was underpinned by five goals. Firstly, the aim was to raise housing quality standards and improve local environments and quality

The four themes of Tackling Health Inequalities
1. Supporting families, mothers and children to ensure the best possible start in life and break the inter-generational cycle of health.
2. Engaging communities and individuals to ensure relevance, responsiveness and sustainability.
3. Preventing illness and providing effective treatment and care – making certain that the NHS provides leadership and makes the contribution to reducing inequalities that is expected of it.
4. Addressing the underlying determinants of health – dealing with the long-term underlying causes of health inequalities

The five principles of Tackling Health Inequalities:
1. Preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health.
2. Working through the mainstream by making services more responsive to the needs of disadvantaged populations.
3. Targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
4. Supporting action from the centre by clear policies effectively managed.
5. Delivering at a local level and meeting national standards through diversity of provision.

Box 4. The four themes of the British Tackling Health Inequalities strategy, and the five principles that guided how health inequalities were tackled in practice.

of life. Secondly, efforts were to be made to ensure that more people take up welfare benefits and tax credits. Thirdly, working environments were to be made better and safer in order to reduce the risk of accidents and illness among the workforce. Fourthly, a sustainable policy concerning the local environment was to be developed that covered waste management, air pollution, waste quality, and street cleaning. Lastly, the strategy aimed at improving access to key services was to be developed further (51).

6.2.1. Expectation concerning target groups in Tackling Health Inequalities

The four themes of Tackling Health Inequalities created expectations about the groups in society which were targeted by the programmes. Because the first theme aimed to support families, mothers and children in maximizing their present and future health, we expect that specific attention was paid to target these groups. The second theme aimed to engage communities and individuals in policy making and health promotion, and was less specific concerning the target groups. However, we expect that specific efforts were made to involve vulnerable groups such as immigrants and homeless people, as these groups often have little say in policy making. The third theme, directed at preventing illness and providing effective treatment and care, is expected to be mostly targeted at the whole population. However, efforts specifically targeted at vulnerable groups are expected here as well, as the burden of disease lays mainly in these groups, and access to health care might not be optimal in these groups. Lastly, the fourth theme, aimed to address the underlying determinants of health, is expected to have targeted the whole population, while paying specific attention to the more vulnerable groups in society where the possible gain in greatest.

Moreover, our logic models also create expectations about the groups that were targeted by the policy categories. Programmes in the categories Neighbourhoods & Physical Environment and Healthcare & Social Services are expected to focus both on the whole society and on vulnerable groups in particular, in order to improve the environment in which individuals live and to improve the accessibility and quality of services. The categories Equal Treatment & Opportunities and Provision of Basic Needs are expected to focus solely on vulnerable groups, such as immigrants and homeless people, in order to ensure that these groups live in the same healthy conditions, and that they do not have to struggle to provide for their basic needs. The category Employment & Working Life is expected to target solely

people of working age, in order to increase employment and to create a healthy work environment. Finally, the category Well-Being of Children, Youth & Families, is expected to focus on children, youth and families in order to ensure a healthy start in live and a healthy family life.

Lastly, the fifth principle of Tackling Health Inequalities leads us to expect that the local and regional levels of government are involved in the strategy as well.

6.3. Tackling Health Inequities in practice

In this section we compare our expectations of the targeted groups in society and determinants of the Tackling Health Inequalities programme with the target groups and determinants that were found in our analysis.

6.3.1. Tackling Health Inequalities target groups

In Table 5 we see our findings as for the target groups of the programmes that were part of the Tackling Health Inequalities strategy. What we immediately see is that there are five specific groups that were not targeted by the British programmes. These are the elderly, the disabled, women, the homeless, and immigrants. Moreover, the only specific vulnerable groups that were targeted were disabled people and people with low SES. Children were targeted fifteen times, which was the greatest number of programmes, and was targeted even more often than society as a whole.

The themes of the strategy made us expect that families, mothers, children, and vulnerable groups were targeted by the programmes that were part of Tackling Health Inequalities. Families were targeted by nine different programmes. All these programmes also focused on children and youth, except for the New Child and Working Tax, which proposed a reform of the current tax credit system, in which families with low income receive benefits and tax exemptions (99). The Vulnerable Children Grant, Extended Schools Programme, Healthy Schools Programme, and the Key Stage 3 Strategy aimed to increase well-being of children through education. These programmes aimed to improve access to education for vulnerable children, such as children who do not speak English, or have a (learning) disability, provide a

Table 5. The British programmes that contributed to Tackling Health Inequalities and their target groups		Families								Vulnerable groups			
	Whole society	Children +	Adults	Elderly	Families	Pregnant	Working	Women	Men	Disabled	Homeless	Immigrants	Low SES
Lifestyle and health choices													
2010 National Drug Strategy	X												
Smoking Kills - A White Paper on Tobacco	X	X				X							
5 A DAY Project		X											
School Fruit Scheme		X											
Neighbourhoods & Physical Environment													
Living Places 2002	X												
Strategy for Neighbourhood Renewal	X												X
Making the Connection	X												X
Sustainable Communities	X												
Healthcare and Social Services													
Delivering 21st Century IT Support for the NHS	X												
Getting the Right Start: National Service Framework for Children		X			X								
National Health Service Plan	X	X											X
Priorities and Planning Framework 2003-2006	X												
Health Visitors Implementation Plan 2011-2015	X												X
Living Places 2002	X												
Employment and Working Life													
Employment retention and Advancement Demonstration Project							X						
Skills for Life							X						
Equal Treatment and Opportunities													
Key Stage 3 Strategy		X											
White Paper: Valuing People		X			X					X			
Provision of Basic Needs													
Welfare Food Schemes		X			X	X							X
Fuel Poverty Strategy	X												X
New Child and Working Tax					X			X					X
Well-being of Children, Youth and Family													
Framework for Assessment of Children in Need and their Families		X			X								
Safeguarding Children in whom Illness is fabricated or induced		X			X								
Framework for the Assessment of Children in Need		X			X								
Healthy Schools Programme		X											
Sure Start Programme		X			X								
Extended Schools		X			X								X
New Opportunities for PE and Sports (NOPES)		X											
Vulnerable Children Grant		X			X								X
Overall Health													
National Services Framework for Coronary Heart Disease			X										
National Service Framework for Mental Health			X										
NHS Cancer Plan	X												
Total number of programmes that tackle this determinants	13	16	2	0	10	2	3	0	0	1	0	0	9

school environment in which children can stay after school hours and receive help with education, health, and social inclusion, improve education, incorporate health education in school frameworks and create a network in which schools and social services cooperate to survey the well-being of children

(100-103). Moreover, New Opportunities for PE and Sports focused on providing opportunities for children to do sports and physical activity both at schools and in the home environment and neighbourhood (104). The Sure Start programme was concerned with the provision of education, health care, and nutrition, social and parenting services for military families living abroad (105). Some other programmes focused on proper nutrition. The National Fruit Scheme and the 5 A DAY Project made schools provide fruit and vegetables to children, and the Welfare Food Schemes provided nutritional food to pregnant women, children and families who face financial problems, in order to meet their nutritional needs (106-108). Smoking Kills created new legislation to reduce smoking, in which advertising was restricted further to prevent children and youth to be influenced (109). The White Paper: Valuing People focused on individuals with learning disabilities, and tried to ensure education, healthcare and social care for children with learning-disabilities. Moreover, it aims to support families that care for a learning-disabled child by information provision and financial support, and to improve the physical environment in which these families live to be more child friendly (110). Four other programmes tackled at healthcare and social services for children and families. The National Service Framework for Children aimed to make healthcare services more child friendly (111). The Frameworks for Assessment of Children in Need and their Families aimed to improve the old service framework to better assess and identify children and families who are in need (112). Finally, Safeguarding Children in whom Illness is Fabricated or Induced aimed to improve the service framework in order to better identify parents which induce illness in children (113). Pregnant women were targeted two times in order to reduce smoking and improve nutrition in this group (106,109), but mothers were not targeted specifically and no specific attention was paid to women.

With respect to vulnerable groups we see that only two groups were tackled by the programmes in Tackling Health Inequalities. The White Paper: Valuing People aimed to improve opportunities for people with a learning disability, through increasing accessibility to education, employment, health care, and social services, provide independent housing, supporting independent life choices and providing financial support for care takers (110). People with low SES were targeted in eight programmes. The Fuel Poverty Strategy and the New Child and Working Tax aimed to decrease living costs by reducing the costs of fuel for low income families, making houses more fuel efficient, and providing tax benefits for families with low income (114). The Priorities and Planning Framework and the Health Visitors Implementation Plan focused on improving access to health care for vulnerable groups, improving general medical services for drug users, and providing home visit for people who have problems

receiving health care (115, 116). Moreover, other programmes focused on improving neighbourhoods, living environments, and housing. The Strategy for Neighbourhood Renewal and Making the Connection aimed to improve houses, employment, access to social services, and safety, and reduce crime and violence in poor neighbourhoods (117, 118). Finally, two programmes focused on the role of education and schools in the well-being of vulnerable children. The Vulnerable Children Grant mainly focused on providing access to education for vulnerable children, while the Extended Schools programme aimed to provide school environments where children can stay after school hours to receive help with their education, health, and social inclusion (100, 101). In general our expectation was realized, as almost of the groups that we expected were targeted in the strategy. Moreover, these groups were targeted in a comprehensive matter, providing action on a wide range of factors, that together might actually cause an improvement in well-being. However, more attention should have been paid to vulnerable groups, such as homeless people and immigrants, as these groups might fall outside of the surveillance system and suffer from very bad health. Moreover, it is for these reasons that there is a lot to gain in these groups, which could really decrease health inequities.

6.3.2. Tackling Health Inequalities targeted social determinants of health

In Table 6 we find the social determinants of health that were targeted by each programme of the Tackling Health Inequalities strategy. In total the social determinants were tackled 120 times. The most targeted determinants was general knowledge (fourteen times), followed up by quality of and access to health care, which was targeted twelve times. Working life and discrimination were not targeted at all. Alcohol consumption, leisure, homelessness, transport, participation, and social inclusion were targeted just once. The category Employment & Working Life targeted the smallest number of determinants. The category Well-being of Children, Youth & Families was most comprehensive and targeted seventeen different determinants.

The logic model for the category Lifestyle & Health Choices predicted that the relevant determinants were related to healthy lifestyles. Nutrition was targeted two times in this category by the 5 A DAY programme, and the School Fruit Scheme, which aimed to provide children with fruit and vegetables, and therefore instil a healthy habit in them (107, 108). Smoking was targeted by only one programme, the Smoking Kills White Paper, which aimed to raise taxes on tobacco products and eliminate advertising

Table 6. The British programmes that contributed to Tackling Health Inequalities and the determinants they targeted

Programme	Nutrition	Physical Activity	Smoking	Alcohol consumption	Substance Abuse	Leisure	General Knowledge	Family Life	Education	Employment	Working life	Housing	Homelessness	Transport	Physical Environment	Violence/Crime	Social services	Quality/Access Health Care	Income security	Poverty	Participation	Social Inclusion	Discrimination	Research
(group)	Lifestyle/Habits					Daily Life					Physical Circumstances						Social Security				Community factors			
Lifestyle and health choices																								
2010 National Drug Strategy					X		X																	
Smoking Kills - A White Paper on Tobacco			X				X																	
5 A DAY Project	X						X		X															
School Fruit Scheme	X						X		X															
Neighbourhoods & Physical Environment																								
Strategy for Neighbourhood Renewal							X			X		X			X									
Making the Connection	X					X			X					X				X						
Sustainable Communities							X					X	X	X	X	X	X							
Living Places 2002							X								X									
Healthcare and Social Services																								
Delivering 21st Century IT Support for the NHS							X											X						
Getting the Right Start: National Service Framework for Children								X	X								X	X			X			
National Health Service Plan	X		X							X								X						
Priorities and Planning Framework 2003-2006					X													X						
Health Visitors Implementation Plan 2011-2015																		X						
Employment and Working Life																								
Employment retention and Advancement Demonstration Project										X									X	X				
Skills for Life							X																	
Equal Treatment and Opportunities																								
Key Stage 3 Strategy									X															
White Paper: Valuing People									X	X		X					X	X						
Provision of Basic Needs																								
Welfare Food Schemes	X																X		X					
Fuel Poverty Strategy												X							X	X				
New Child and Working Tax																			X					
Well-being of Children, Youth and Family																								
Framework for Assessment of Children in Need and their Families				X	X		X	X	X			X				X	X		X					
Safeguarding Children in whom Illness is fabricated or induced																		X						
Framework for the Assessment of Children in Need	X							X	X	X		X				X	X	X	X					
Healthy Schools Programme	X	X					X		X															
Sure Start Programme	X								X								X							
Extended Schools									X													X		
New Opportunities for PE and Sports (NOPES)		X					X		X															
Vulnerable Children Grant									X															
Overall Health																								
National Services Framework for Coronary Heart Disease							X											X					X	
National Service Framework for Mental Health							X											X						
NHS Cancer Plan	X		X				X											X					X	
Total number of programmes focusing on this determinant	9	2	3	1	3	1	14	3	13	6	0	6	1	1	4	3	7	12	6	2	1	1	2	0

(109). Substance abuse was targeted only by the 2010 National Drug Strategy, but this strategy provided a very comprehensive approach towards reducing drug abuse (119). It tackled to reduce the demand for drugs by early intervention, identifying and supporting vulnerable groups, providing information and education about drugs to young people and parents, enforcing effective criminal sanctions to deter drug use, and supporting recovery by cooperation between services. Moreover the strategy aimed to restrict supply by reforming law enforcement, integrating local enforcement, reducing the drug supply in prisons, tackling all links in the drug supply chain, obstruct the money supply, and strengthening international partnerships. Finally, the programme aimed to support recovery, by creating locally led and locally owned recovery systems, involving other factors such as employment and mental health, providing care for children and families in order to provide incentives for addicts to join recovery, and providing money for recovery systems that show success (119). Physical activity and alcohol consumption, however, were not targeted at all in this category, although they were targeted sporadically in other categories. Finally, general knowledge and education, two determinants which were not predicted by the model were targeted as well in this programme (107, 108). These two determinants indicate that this category also aimed to educate and inform citizens in order to enable them to make healthy choices. However, in general we can conclude that the expectations for this category were not totally met. Although some lifestyle factors were addressed, efforts to address alcohol consumption and physical activity were missing.

The logic model for the category Neighbourhoods & Physical Environment predicted that there were five relevant determinants: living conditions and housing, material circumstances, social and community networks, social cohesion, and water and sanitation. Living conditions were targeted through improvements in social housing, providing housing for homeless people, and improvements of public spaces (117, 120, 121). Making the Connections aimed to improve the access to social and health care services in poorer neighbourhoods (118), but no programmes attempted to improve income security, another important factor of material circumstances. Social and community networks, and social cohesion were not targeted at all. Here we would have expected to find efforts to reduce poverty and discrimination, and increase participation and social inclusion. These determinants were also not targeted through other determinants, except for social exclusion, which was targeted by the Extended Schools programme (101). Finally, water and sanitation were not targeted by the national strategy at all, but as was the case in Finland, this can probably be explained by the fact that these services are already optimized in the UK. Overall, this category did not live up to the expectations, as only a few of the

expected determinants were tackled in a rather narrow manner. However, some other determinants that might be relevant for well-being in neighbourhoods, such as employment and education were targeted in this category

The logic model of the policy category Healthcare & Social Services predicted that the determinants to be tackled in this category were healthcare and social services, education, income security, and water and sanitation. The Delivering 21st Century IT Support programme focused on updating IT software in health care settings in order to prevent mistakes and use resources more efficiently (122). The National Service Framework for Children aimed to make social services and healthcare services more children friendly and to give children a chance to have their opinions taken into account in their treatment plans (111). Moreover, the Priorities and Planning Framework set out the priorities on which healthcare should focus, which were to improve access to all services through better emergency care, and reduced waiting and increased booking and admission for patients, and to improve the overall experiences of patients (115). The Health Visitors Implementation Plan attempted to increase access to healthcare by creating a plan for healthcare workers to make house visits to families who have trouble receiving care (116). Finally, the National Health Service Plan aimed to improve social and health care services by increasing and improving primary care in vulnerable neighbourhoods, introducing screening procedures for men and women, and stepping up services to reduce smoking (123). Moreover, this strategy also targeted education and nutrition by making schools provide fruits and information about healthy eating (123). However, no other groups than children were targeted with respect to education in this category. We expected to find efforts to increase income security, as this is an important social service, but these were already extensively tackled in other categories. Finally, as was seen before, water and sanitation was not targeted at all. There were also quite a few determinants that were tackled while not expected to, which were substance abuse, general knowledge, family life, employment, and participation. Overall, our expectations for this category were quite well met, although more efforts to address education and income security would be welcome.

For the category Employment & Working Life the logic model predicted that education, employment, working conditions, income, and gender equality were targeted. The Employment Retention and Advancement Demonstration Project aimed to improve employment chances and income security including poverty reduction (124). Education was not targeted at all in this category, but was targeted thirteen times in other categories in quite a comprehensive manner . For working conditions no relevant

determinants were targeted. We would have expected this category to at least try to improve working life, Finally, for improving gender equality no relevant determinants were targeted as well. Here we would have expected efforts to reduce discrimination and improve social inclusion. Overall, we can conclude that the expectations for this category were not met.

For the category Equal Treatment & Opportunities only five determinants were tackled. The logic model predicted that these determinants would be social and community networks, social cohesion, gender equality, and ethnic/race equality. For all these factors, the relevant social determinants of health are participation, social inclusion and discrimination. However, no efforts were found to tackle these determinants in this category at all. Participation and social inclusion were both targeted in one other category but focused only on children (105, 111), and discrimination was not targeted by any of the programmes. However, education, employment, social services, and quality of and access to health care were covered in this category, indicating that efforts are made to improve the opportunities of vulnerable groups to access education, find employment, and receive health care and other services (103, 110). Overall this leads us to conclude that the expectations for this category were not met at all, although other seemingly relevant determinants were tackled in this category.

For the category Provision of Basic Needs the relevant determinants are supposed to be the material circumstances, income security, agriculture and food production, and water and sanitation. Only five different determinants were targeted in this category. Concerning material circumstances, housing was the only relevant determinant that was tackled. The Fuel Poverty Strategy aimed to make houses more fuel efficient, but did not focus on providing housing in general (114). Efforts were expected in the field of homelessness and the physical environment, but were not found. Income security was tackled by all three programmes, which aimed to decrease the costs of fuel for poor households, provide child and working benefits for poorer families, and provide nutrition for people who cannot afford it (99, 106, 114). Agriculture and food production, and water and sanitation were not targeted in any of the programmes. As said before this can possibly be explained by the fact that these services are already of high quality in the UK. Overall, we can say that most of the determinants that were predicted were also targeted in practice, but that most determinants were not targeted very thoroughly.

The social determinants of health that were predicted to be relevant for the category Well-being of Children, Youth & Families were individual lifestyle factors and behaviour, education, working

conditions, material circumstances, and income. Concerning lifestyle factors and behaviour, the relevant determinants that were tackled were nutrition, physical activity, alcohol consumption, and substance abuse. The Frameworks for Assessment of Children in Need aimed to improve nutrition and reduce alcohol consumption and substance abuse by early intervention and information sharing (112). Other programmes focused on nutrition and physical activity by providing advice for families and obliging schools to provide fruit, vegetables, education about healthy eating, and opportunities for physical activity. However, efforts were missing for the reduction of smoking, which was only tackled three times in other categories. Education was targeted by seven of the eight programmes in this category, which focused mainly on ensuring access to education for vulnerable groups and providing education about healthy lifestyle (100, 102, 104, 105, 111, 125). Concerning material circumstances, the Frameworks for the Assessment of Children in Need supported child friendly housing and environments (111). However, more efforts were expected to reduce homelessness, as a very important part of material circumstances and well-being in general. Unfortunately income security was not targeted in this category, although it was targeted by three different programmes in other categories. For working conditions, no relevant determinants were addressed, while working life was expected to be targeted. Overall most relevant determinants were tackled, while more efforts could be made to reduce smoking, homelessness, poverty, and improve working life.

For the category Overall Health no logic model was created, because all determinants are relevant. However, only a few different determinants were tackled in this category, such as general knowledge about living a healthy life, the quality of and access to healthcare, and research in order to improve health practices and policies in the future. While this category was expected to be very comprehensive, in reality it was quite narrow.

6.4. Health Trends in the United Kingdom

In this section we discuss the trends in health indicators in the UK over the last few decades, in an attempt to identify effects from the Tackling Health Inequalities Strategy. The data that is used was extracted from the Demetriq database, and was originally from the Health Survey for England in 2010. Although data was available for the United Kingdom, this data was only available until 2005. Therefore, we chose to use data for England, which was available until 2010, and therefore enables us to say more

about the effects of the strategy. Moreover, no data for the prevalence of obesity and overweight was available for this study, and data was collected from a population aged 15 to 79 and therefore is not presentable for children and youth.

In the next section we first discuss the trends in the relevant available health indicators, after which we combine these findings to assess the effectiveness of the different policy categories.

6.4.1. Trends in health indicators

In figure 20 we see the percentage of people who rate their health as less than good in England. In both men and women we see that self-assessed health problems are most prevalent in low educated groups and that there is a general increasing pattern until 2005, after which there was a strong decrease in all groups. In high educated women this decrease started already in 1995, but became much sharper after 2005. This indicates that the Tackling Health Inequities strategy, which ran from 2003 until 2010, affected self-assessed health in a positive way. In both groups, however, differences in self-assessed health between the different groups remained more or less stable between 2000 and 2010, indicating that the strategy did not decrease inequities in self-assessed health.

Figure 20. Self-assessed health in English men and women according to educational achievements between 1980 and 2010.
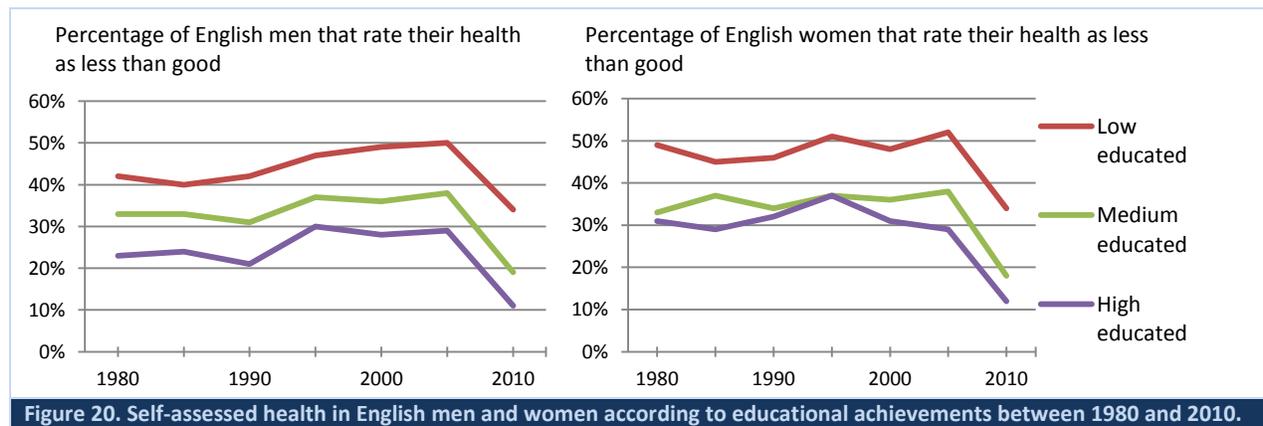
In Figure 21 we find the percentages of people in England that cope with longstanding limiting health problems. Unfortunately there was no data for the year 2010. In both men and women we see that the prevalence of problems increased until 1995, after which a decrease set in. However, this decrease was much stronger in high educated groups than in low educated groups. In low and medium educated women and in medium educated men we even see that in 2005 the prevalence had increased again.

Moreover, since 2000 the differences in longstanding limiting health problems between different female groups seem to have grown. Whereas in 2000 the difference between the high and low educated group was seven percent, in 2005 it was ten percent. In general it seems that the Tackling Health Inequalities strategy might have had some positive effects on longstanding limiting health problems in high educated, but not on low and medium educated groups. There even are some signs that the strategy might have caused an increase in lower educated groups and an increase in equity. However, since we do not have data for 2010, these findings remain very preliminary.
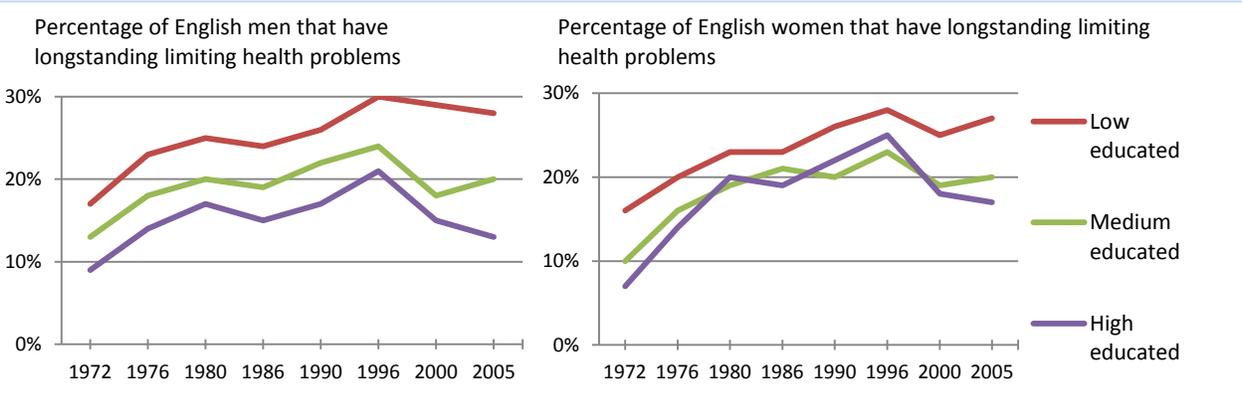
Figure 21. Prevalence of longstanding limiting health problems in English men and women according to educational achievements between 1972 and 2005

In Figure 22 we find the prevalence of daily smoking in men and women in England and Wales. Contrary to other indicators, such as morbidity and mortality, changes in smoking prevalence can be seen quite quickly, and can partially predict a reduction of some sorts of morbidity and mortality on the long term. Therefore, it is a good shortterm indicator for the effectiveness of the Tackling Health Inequality strategy. In both men and women we see that smoking prevalence is decreasing, while remaining highest in low educated groups. We also see that smoking prevalence is decreasing faster in high educated women than in low educated women, thereby increasing inequity. We do not find changes in these patterns since the start of the strategy in 2003, except for high educated men and women, where the decrease became a bit more steap, thereby increasing inequities even further. Overall, these findings indicate that the national strategy did not positively influence smoking prevalence, except in high educated groups, thereby effectively increasing inequity in smoking prevalence. However, as was discussed in the case of Finland, smoking in women is a specific case in which women's emancipation and status play an important role. Therefore, smoking policies might have only limited ability to achieve reductions in smoking prevalence in women.

Percentage of English men that smokes on a daily basis

Percentage of English women that smokes on a daily basis
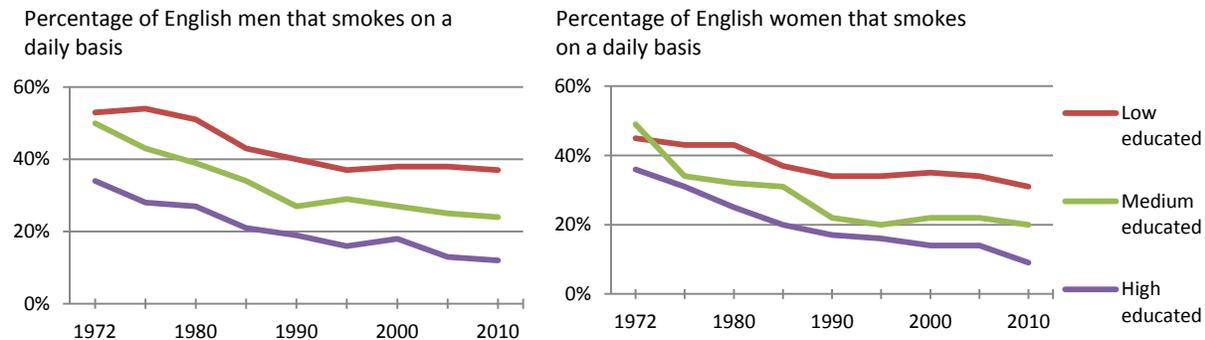
Figure 22. Daily smoking prevalence in English men and women according to educational achievements between 1972 and 2010.

In Figure 23 we see the percentage of people that visited their GP over the last two weeks in England and Wales. In general we see that the prevalence of GP visits increased since 1975, but saw some fluctuations since 1995, and is higher in women than men. Since 2005, the first measurement after the start of the Tackling Health Inequalities strategy in 2003, the prevalence of GP visits decreased (further) in low and high educated men, while it increased in medium educated men and in all female groups, making it very difficult to establish the effect of the strategy. Moreover, an increased prevalence of GP visits can indicate two thing. On the one hand, it can indicate that people have become more involved with their health, and search for healthcare services at an earlier point in their disease. This might lead to a decrease in morbidity and mortality in the long run. On the other hand, it can also indicate that more people experience health problems for which they search for healthcare. In general, the trends in GP visits show too many different results to draw a conclusion about the effects of the strategy. Moreover, even in the results were clear, due to the different possible explanations of a change in this prevalence we would still be unable to reach a conclusion.

Percentage of English men that visited the GP over the last two weeks

Percentage of English women that visited the GP over the last two weeks
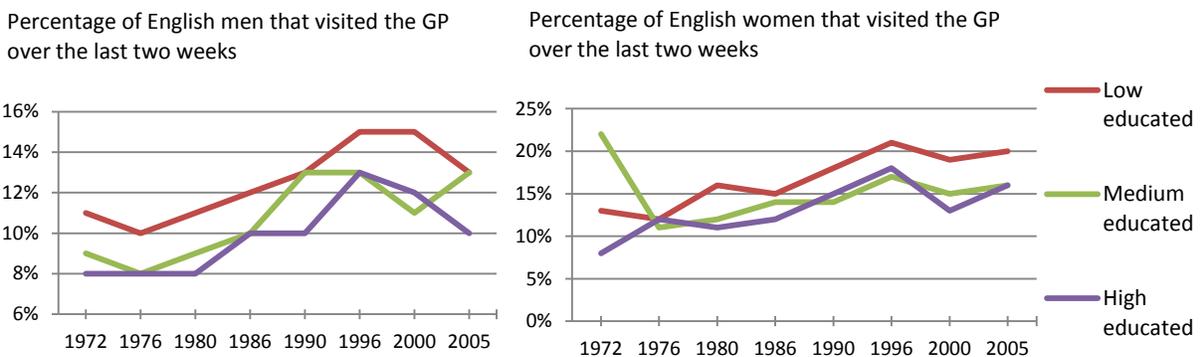
Figure 23. Prevalence of GP visits over the last two weeks in English men and women according to educational achievements between 1971 and 2005

In Figure 24 we find the prevalence of smoking-related mortality in men and women. In general this prevalence is much higher in men than in women. In men we see that smoking-related deaths are declining in all groups, although the decline is more steep in low educated than in high educated men, effectively reducing inequities in smoking-related death. These decreases seem to have become a bit stronger since the start of the Tacking Health Inequalities strategy in 2003. In women we see a general increasing trend of smoking-related deaths. As is the case for men, smoking-related deaths are much more prevalent in low educated groups. However, prevalence is rising quickly in high educated women, and the difference between groups is now smaller than before. Although this means that inequities decreased, this decrease is caused by a worsened situation in the high educated group, which is not very desirable. In 2005 and 2010, after the start of the national strategy, the number of smoking-related deaths increased a bit, indicating a negative effect of the strategy. In general we find positive effects of the strategy on smoking-related deaths in men, but negative effects in women. However, the question is how much of these findings are really caused by the Tackling Health Inequalities strategy, since its effect on smoking-related mortality are not likely to show in such short term. Nonetheless, some of these effects might be caused by improvements in healthcare services and healthcare techniques, which might have prevented smoking-related morbidity to result in mortality.


Figure 24. Smoking-related mortality in English men and women according to educational achievements between 1975 and 2009
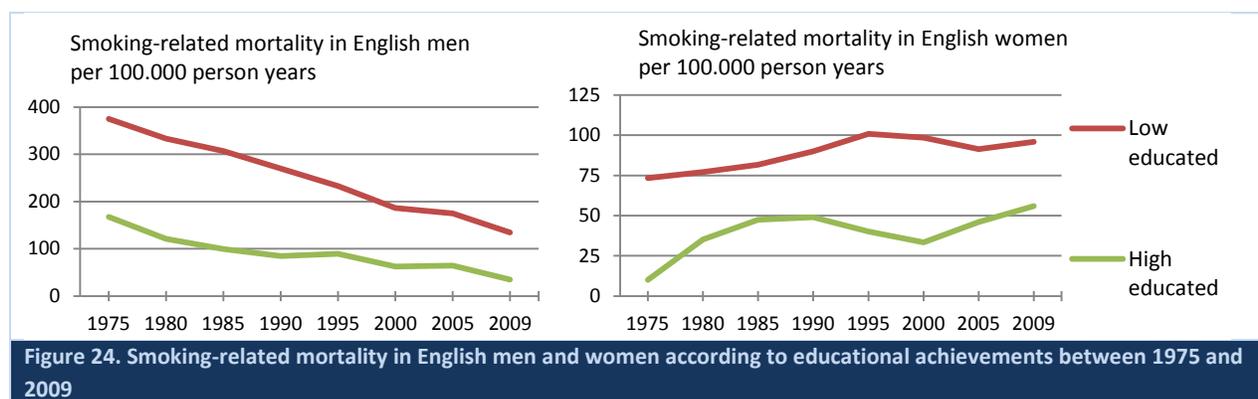
Figure 25 shows increasing trends in alcohol-related mortality in both men and women. This prevalence in men is approximately twice as high as in women. It is striking that mortality here, in contrast with all other available indicators, is nearly similar in high and low educated groups, although differences have grown since 1995. In low educated men we see that this increase has lessened slightly since 2005, while in high educated men the increase stopped after 2000 and mortality remained at the same level for the next ten years. We see that the increase in high educated women continued after the start of the Tackling Health Inequalities in 2003, while mortality remained at the same level in low educated

women. These findings indicate that the strategy might have some positive effects on alcohol-related mortality in men and low educated women. However, as was the case in -smoking-related mortality, the question is to what extent these effects are caused by the strategy since the long time lapse between excessive alcohol consumption and alcohol-related mortality. However, some of these effects might be caused by prevention of binge-drinking (which can lead to immediate alcohol-related mortality), and improvements in healthcare services and technologies.
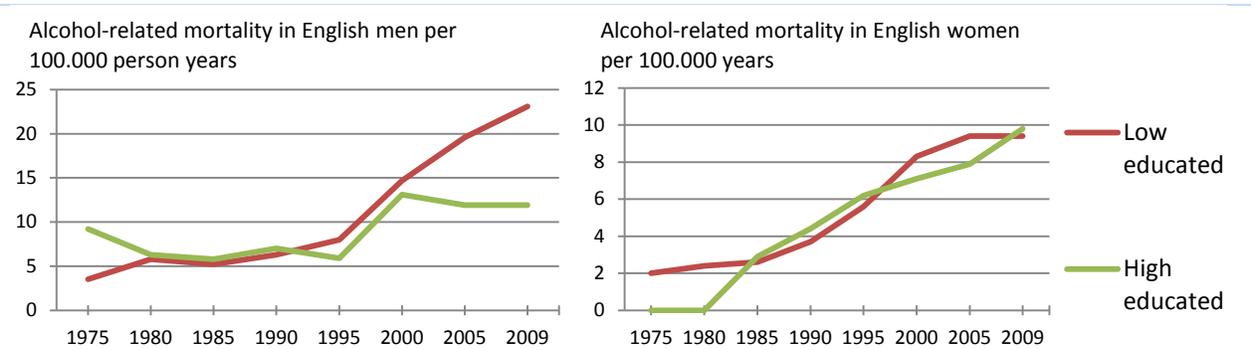

Figure 25. Alcohol-related mortality in English men and women according to educational achievements between 1975 and 2009.

In Figure 26 we see that total mortality has been declining in both men and women, and that through time rates have been almost twice as high in men as in women. Since the start of the Tackling Health Inequalities strategy this trends does not seem to have changed, indicating that there was no positive effect on total mortality. However, as was the case in other categories, for many of kinds of mortality, such as cancer and CVD-mortality, it takes time for the effects to become visible. However, for other kinds of mortality, such as mortality caused by accidents or suicide, effects might become visble on a much shorter time span. Overall, we can say that at this point the data does not indicate that the national strategy reduced total mortality.
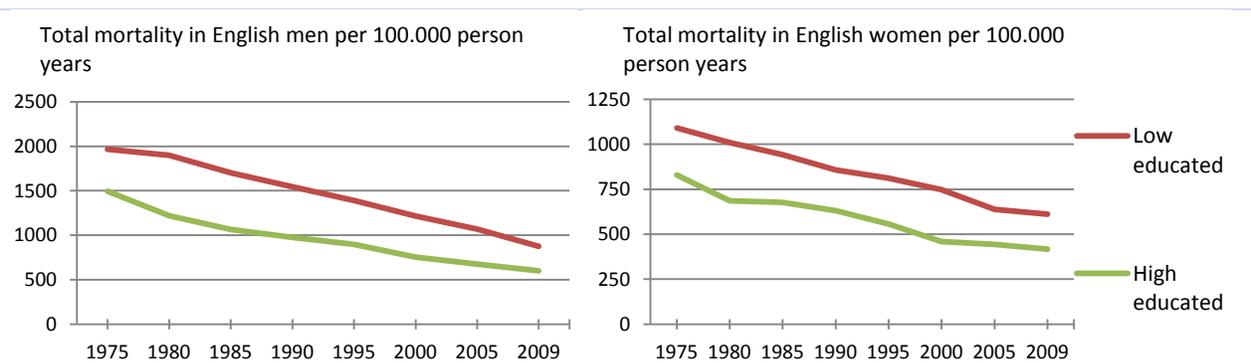

Figure 26. Total mortality in English men and women according to educational achievements between 1975 and 2009

Figure 27 shows the amenable mortality in men and women. This is a very good indicator for health inequity, as more vulnerable groups are often exposed to more hazards, unhealthy environments, and worse circumstances, which accumulate to higher levels of preventable deaths. We see that amenable mortality in both men and women have been decreasing ever since 1975, and that this decrease has been stronger in low educated than high educated groups. In general, health inequities have decreased, but unfortunately, these trends do not seem to have changed since 2003, the start of the Tackling Health Inequalities. However, similarly to some of the previous indicators, changes in amenable mortality might require some time to become visible. Overall, the findings indicate that the Tackling Health Inequalities strategy has not reducing amenable mortality, but these findings might change if more information becomes available.
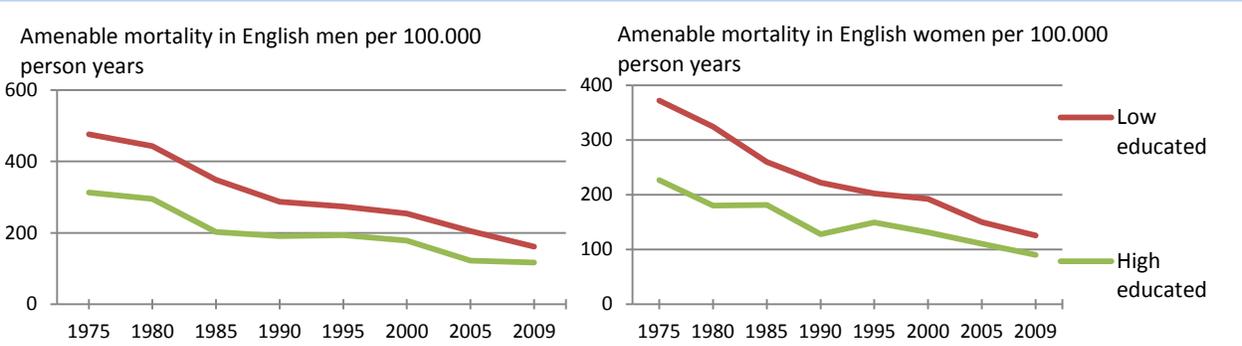
Figure 27. Amenable mortality in English men and women according to educational achievements between 1975 and 2009.

Finally, Figure 28 shows trends in the mortality caused by road accidents. This is an indicator in which results of the strategy might relatively quickly be visible. While mortality is steadily decreasing in low educated men and women, it shows quite some fluctuations in high educated groups. In low educated men and women there appear to be no changes in trends since 2003, the start of the Tackling Health Inequalities strategy. In high educated men, however, we see a sharp decrease in road accident mortality, but this might be just one of the fluctuations. In high educated women we see that road accident mortality increased and stabilized after the implementation of the strategy, but again, this could just as much be one of the fluctuations. Overall there is little evidence that the national strategy positively affected road accident mortalities.

Mortality caused by road accidents in English men per 100.000 person years

Mortality caused by road accidents in English women per 100.000 person years
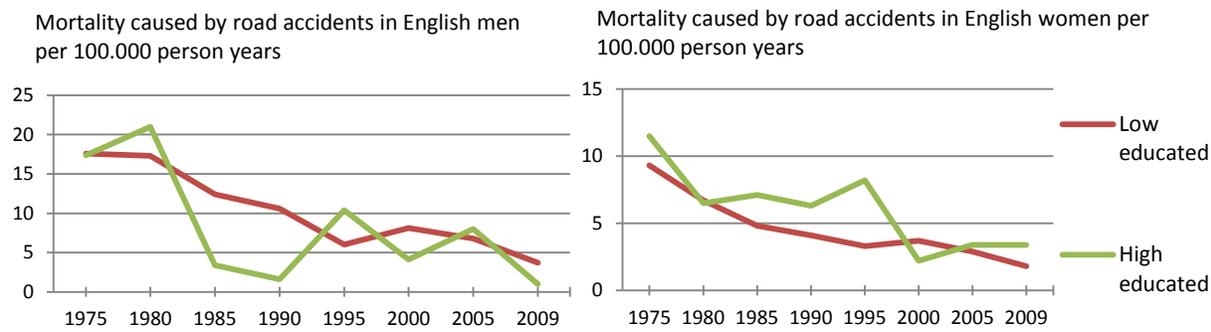
Figure 28. Mortality caused by road accidents in English men and women according to educational achievements between 1975 and 2009.

6.4.2. Health indicators and the effectiveness of the policy categories

For the policy category Lifestyle & Health Choices the logic model predicted that the relevant available health indicators were self-assessed health, longstanding limiting health problems, alcohol-related mortality, and smoking prevalence. The strategy seemed to have positively affected self-assessed health in the whole population, and in some extent alcohol-related mortality in men and low educated women. No effects were found for smoking prevalence and longstanding limiting health. However, for longstanding limiting health problems it might not be realistic to expect to find results at this point. For alcohol consumption, drug abuse, physical activity, nutrition, total morbidity, and the prevalence of overweight and obesity unfortunately no data was available. These indicators could have been useful to assess this category, as they are quite changeable and therefore might already show the results of this strategy. In general, some positive effects were found for this category, although more data for the relevant indicators is needed in order to draw a conclusion.

For the policy category Neighbourhoods & Physical Environment, which focused specifically on vulnerable groups, the relevant indicators are total morbidity, self-assessed health, longstanding limiting health problems, the prevalence of GP visits, and mortality caused by road accidents. For total morbidity we unfortunately have no data. For GP visits no clear positive effects were found, and for longstanding limiting health problems, there were even some indications that the Tackling Health Inequalities strategy had a negative effect. For self-assessed health, however, we found that the national strategy might have improved the situation, but no specific effects were found in vulnerable groups. In general this policy category seemed to have little effect, although it might have improved self-assessed health.

For the policy category Healthcare & Social Services it was predicted that the relevant indicator are self-assessed health, longstanding limiting health problems, prevalence of GP visits, amenable mortality, and total mortality. Moreover, possible results should be specifically visible in vulnerable groups, as this category focuses specially on these groups. Again, self-assessed health is the only relevant indicator which seem to be positively affected, but no specific effects were found in vulnerable groups. There were some indications that longstanding limiting health problems was negatively influenced by the strategy, although the prevalence decreased in high educated groups. Overall this category seemed to have some positive effects on self-assessed health, but not so much on vulnerable groups.

For the fourth category, Employment & Working Life, only two available relevant indicators were predicted: self-assessed health and longstanding limiting health problems. This policy category focused exclusively on people of working age, but unfortunately no specific data is available for this group. We already discussed that self-assessed health seemed to be positively influenced, while it might have increased the prevalence of longstanding limiting health problems. Unfortunately we did not have data for quality of life, the prevalence of suicide, and overall morbidity. Especially quality of life and prevalence of suicide could have been valuable because they might show results on a short term. Overall we find that this category might have improved self-assessed health, but that not enough information is available to draw a conclusion about the effectiveness.

For the policy category Equal Treatment & Opportunities the logic model predicted that the available relevant indicator are prevalence of GP visits, amenable mortality and total mortality, and that actions were specifically targeted at vulnerable groups. Unfortunately we found that the strategy did not affect any of these indicators, and that there were no specific effects in vulnerable groups. However, it might not be realistic to expect that amenable mortality and total mortality already showed results at this point. A very relevant, but unavailable indicator was total morbidity, which might have been able to show results at this point already. At this point it seems that this category was not effective, although many of the effects might not be visible at this point.

For the sixth policy category, Provision of Basic Needs, the predicted relevant available indicators were self-assessed health, longstanding limiting health problems, amenable mortality, and total mortality, and efforts were mainly directed at vulnerable groups. For self-assessed health it was found that the strategy might have had positive effects but not specifically in vulnerable groups, while for longstanding

limiting health problems there were indications that the Tackling Health Inequalities strategy might have had negative effects. For amenable mortality and total mortality no effects were found yet, although it might be that not enough time has passed for effects to be visible at this point. At this point it seems that this policy category did not improve well-being in vulnerable groups, but this might change if more data is available.

Finally, in the category Well-being of Children, Youth & Families the relevant available indicators are self-assessed health, longstanding limiting health problems, and total mortality. As we have seen in several categories before, self assessed health seemed to have been positively influenced, longstanding limiting health problems might have been negatively affected, and for total mortality no effects were found. For quality in life and total morbidity, two other relevant indicators, unfortunately no data was available. Moreover, actions were directed at children, youth and families, but no data was available for children. For morbidity indicators data was extracted from people aged 30 to 79, and for mortality indicators the age group was 35-79. Therefore, this data is not presentable for a large part of the target groups that was targeted in this population. In general there are some indications that self-assessed health improved, while longstanding health problems might have increased. However, at this point the data is insufficient to draw a conclusion about the effectiveness of this category.

6.5. Overall results for Tackling Health Inequalities.

The British Tackling Health Inequalities strategy's aim, as the title suggests, was to decrease inequalities in the British population. The strategy was build on four themes and five principles, and ran from 2003 until 2007. Actions were initiated on the national level, but required local and regional contributions from a white range of actors.

Based on the initial strategy and the logic models that were introduced in chapter four, expectations were created about the targeted groups in society and the targeted social determinants of health. Concerning target groups we expected that children and families, vulnerable groups, and working people would be targeted specifically. These expectations were realized, although vulnerable groups were not often specifically targeted. Efforts were mainly directed at groups with general low SES, and should be more often directed at more specific vulnerable groups, such as immigrants, homeless people,

and disabled people. For children and families we found that the programmes created a very comprehensive framework to improve well-being, although no actions were specifically directed at mothers and pregnant women. The social determinants of health that were targeted by the programmes were compared with the expectations that the logic models . These expectations were not completely met. In many cases not all relevant determinants were tackled, or they were tackled in a quite narrow manner. Determinants which should be targeted more often or more comprehensively were alcohol consumption, physical activity, smoking prevalence, working life, homelessness, poverty, participation, social inclusion, and discrimination.

Lastly, we used data from the Demetriq project in order to evaluate whether the different policy categories were effective in improving well-being and health. Self-assessed health improved in the population as a whole, and alcohol-related mortality declined in men and high-educated women since the start of the Tackling Health Inequalities strategy. For the other indicators no positive effects were found, although the prevalence of longstanding limiting health problems might have been negatively affected by the strategy. Self-assessed health and longstanding limiting health problems were relevant indicators for quite some policy categories, leading to the conclusion that these categories positively affected self-assessed health, but possibly negatively affected longstanding limiting health problems. At this point it is not possible to assess which of these categories really influenced this health and these indicators, and which did not. Therefore, our findings about (partially) effective policy categories are less reliable.

The Tackling Health Inequalities strategy aimed to reduce inequalities in health outcomes by ten percent as measured by infant mortality and life expectancy at birth by 2010. Moreover, it aimed to reduce both the gap in mortality between routine and manual groups and the population, and the gap between the areas with the lowest life expectancy at birth and the population with at least ten percent. Unfortunately the Demetriq data did not provide for data on any of these indicators, nor did it provide data for the different regions in the UK. Therefore we cannot say if these goals were realized.

7. Conclusion: findings and discussion

In this study we discussed the Finnish Health 2015 and the British Tackling Health Inequalities strategies as they were planned by governments, and the programmes that were created in order to implement these strategies. In essence we evaluated whether or not the promises that the Finnish and British government made to tackle inequalities and inequities were actually followed up by concrete actions, and whether the effects of the strategy were visible at this point. The different programmes were categorized according to their theme, and for each of the categories a logic model was created. These models predicted the relevant target groups and social determinants of health which should be targeted by the programmes, and the relevant health indicators for success of the policy category.

In Table 7 we see an overview of the findings of this study. Finland, with its decades of experience in health policies, created the most comprehensive strategy, but was vague about the specific actions that should be taken. This strategy paid lots of attention to children, people of working age, and vulnerable groups. However, often these groups were targeted in a in a rather narrow way. The strategy also tackled a very wide range of social determinants of health. However, efforts to reduce smoking prevalence, alcohol consumption, homelessness and poverty were pretty slim, and should be expanded in future strategies. We also found that some programmes made big promises about the determinants that would be tackled, but did not back these promises up with concrete action points. Overall, the Health 2015 programme seemed to be pretty well translated through the different programmes. However, our data did not show many effects at this point in time. It was solely self-assessed health and the prevalence of smoking in lower educated groups that seemed to have improved because of the strategy. We found little to no evidence that indicators improved more in lower educated groups and thereby decreased inequity. Moreover, because self-assessed health is relevant for many categories, we cannot say much about the effectiveness of the different policy categories, and we can only conclude that there are indications that Health 2015 helped improve self-assessed health and reduce smoking prevalence in low-educated groups.

In the United Kingdom, the Tackling Health Inequalities programme was the first comprehensive strategy to reduce inequalities and inequities. This strategy tackled a more narrow range of target groups than Finland, and lacked efforts to target specific vulnerable groups, such as homeless people

Table 7. Summary of the findings of this study for Finland and the United Kingdom		
	Finland	**United Kingdom**
Lifestyle & Health Choices	• Expectation about target groups were met • Efforts on smoking, alcohol consumption, and substance abuse were missing • Positive effects on self-assessed health and smoking prevalence in low educated groups • Data for important indicators was missing	• Expectations about target groups were met • Efforts on alcohol consumption and physical activity were missing • Positive effects on self-assessed health and alcohol-related mortality in low-educated groups • Data for important indicators was missing
Neighbourhoods & Physical Environment		• Expectations about the target groups were met • Efforts on income security, social cohesion, poverty, discrimination, and participation were missing • Positive effects on self-assessed health • Negative effects on longstanding limiting health problems
Healthcare & Social Services	• Expectations about target groups and determinants were met, but programmes should more clearly define actions • Positive effects on self-assessed health	• Expectations about the target groups and determinants were met • Positive effects on self-assessed health • Negative effects on longstanding limiting health problems
Employment & Working Life	• Expectations about target groups and determinants were met but more efforts to tackle equality en the work environment is desired • Positive effects on self assessed health • No data for people of working age	• Expectations about target groups were met • Efforts to target education, working conditions, gender equality, discrimination and social inclusion were missing • Positive effects on self-assessed health • Negative effects on longstanding limiting health problems • No data for people of working age
Equal Treatment & Opportunities	• Expectations about target groups were not met • Expectations about determinants were met, but programmes should better define their actions • No effects were found	• Vulnerable groups were targeted limitedly. • Efforts to target social networks and cohesion, and equality were missing • No effects were found
Provision of Basic Needs		• Vulnerable groups were targeted limitedly • Expectations about targeted determinants were met, but determinants should be targeted more thoroughly • Positive effects on self-assessed health • Negative effects on longstanding limiting health problems
Well-being of Children, Youth & Family	• Expectations about target groups were met • Efforts to tackle homelessness, poverty, smoking, and alcohol consumption were missing • Positive effects on self-assessed health • No data for children	• Expectations about target groups and determinants were met, but more efforts to target smoking, homelessness, poverty, and working life are desired. • Positive effects on self-assessed health • Negative effects on longstanding limiting health problems • Data for important indicators were missing
Overall Health	• Expectations about target groups and determinants were not met • No effects were found	• Expectations about the target groups and determinants were not met • No effects were found

and immigrants. However, children and families were targeted in a very comprehensive manner, in order to establish a healthy start of life for children. The social determinants of health that were tackled

by the Tackling Health Inequalities strategy, were less wide spread than in the case of Finland. Efforts for improvement were especially missing in the area of social life, as poverty, homelessness, discrimination, participation, and social inclusion were inadequately tackled. These determinants are often worst in vulnerable groups, and are therefore important underlying factors of inequity. However, the social determinants that were tackled, were most often tackled in a very comprehensive manner, approaching the issue from many different angles, and therefore might really improve in the long term. Overall, the British Tackling Health Inequalities strategy was less well translated into theory than the Finnish strategy, but a small number of determinants were tackled very well. However, at this point, the effects of the strategy look similar to the effects of the Finnish Health 2015 strategy. There were indications that self-assessed health and alcohol-related mortality improved because of the British health strategy. However, as self-assessed health was a relevant indicator for many categories, we cannot prescribe this effect to a specific policy category.

7.1. Discussion

In this study we found that Finland and the UK set different priorities in their national health strategies. We found that Finland puts great efforts in ensuring equal treatment of all genders and background, and tries to improve social inclusion, participation and eliminate discrimination, while the UK mostly focuses on ensuring a good start in life for children. These differences might be guided by different initial health situations in the two countries, but also by different institutional and cultural backgrounds. For example, Finland's focus on equal treatment and opportunities can possibly be explained by a situation in which women and minorities still do not receive the same opportunities as other groups, or by a culture and background in policy making where equal treatment of every person in society is greatly valued.

 As Finland and the UK are both countries with high alcohol consumption levels, it was striking that for both strategies it was found that efforts to reduce alcohol consumption were inadequate. Moreover, for Finland we expected that there would be efforts to reduce mental health problems and suicide, because of the specific geographic conditions. Our study found that Finland's efforts to improve mental health were only limited, and that suicide was not targeted at all. We also expected to find that Finland involved municipalities and local actors to provide services, because of the many sparsely populated areas. We found that this expectations was met, but that, unexpectedly, the same was true for the UK.

Both strategies seemed to assume that municipalities have great potential in improving the health of their population, as they know their people better than national governments do. As the UK dealt with big health inequities, we expected to find that vulnerable groups were specifically targeted. In reality, the health strategy made some efforts to tackle people with low SES and disabled people, but efforts were only small. Finland, on the other hand, made great efforts to improve well-being in vulnerable groups, and tackled many specific vulnerable groups, such as the homeless, immigrants, and disabled people.

At this point we were not able to find many results for the effectiveness of the two national strategies, but we found an improvement in self-assessed health in both Finland and the UK, which seems to be linked to the national strategies. This improvement might not seem very impressive at first sight, because it does not lead to a direct decrease in morbidity, mortality, or healthcare costs. However, it can be seen as quite an accomplishment, as improved self-assessed health might seriously contribute to improved quality of life and well-being. Moreover, if people feel healthier and happier, this might positively affect health, as stress might be reduced and suicide rates might decrease.

The Health 2015 strategy will end in 2015, and the Tackling Health Inequalities strategy ended in 2010. Therefore it might be too soon to find any results at this point, as changes in population health take a while to become apparent. Moreover, the data which was available for this study is probably too limited to find any effects. Data on a wider range of indicators and differentiated according to more factors, such as age, SES, gender, and ethnic background might shape a clearer image of the true effects of the national strategy, and especially the effects on inequity. Furthermore, the education population division might have changed over the years, as people have become higher educated. It is likely that twenty years ago the share of the population with a low education level was much bigger than it is today. Therefore, we cannot be sure if trends in the health of different educational groups are caused by the health strategy, or by changing educational divisions. Future studies should try to control for these changes in order to properly assess the results of the strategies. Because the strategies are still so recent, we need data on the determinants that were targeted by the programmes to find results at this point. For examples the effects of a reduction of homelessness might not be visible right now, but might have affected the number of homeless people in Finland. A reduction in the prevalence of homelessness, might indicate health improvements in the future. Moreover, adequate access to healthcare services is likely to lead to improved health, but not in the short term. Data of the number of

hospital visits, might predict the effects of a national strategy, long before these health effects become visible. Because this data is not available at this point, and since the effects of health strategies are not visible on the short term, a future study should evaluate the success of the Finnish and British health strategies.

Not many studies have evaluated whether or not national governments have properly implemented their health strategies. This evaluation is an important part of the total evaluation of strategies. After all, if strategies are not implemented as promised, expectations are not realistic and evaluations might not evaluate reality. However, besides the facts that it might be too early to see the effects of the strategies, and that the data is very limited, there are some other factors that influence the validity of this study. The literature included in this study as well as the findings were largely based on the interpretation and judgment of the author. We attempted to make this research more objective by creating a framework of logic models to assess the policy categories. Moreover, the target groups and targeted determinants of the programmes were presented in tables, in order to create a more quantitative presentation and to be able to have a clear overview of the strategy. However, we saw that Finland and the UK have very different institutional and cultural backgrounds, different initial health situations, and different time spans and priorities for their national strategies. Therefore, ultimately the question remains how comparable these two countries actually are.

7.2. Policy recommendations

For both countries we found that some determinants were tackled quite often, while others were not. Although at first sight it might seem obvious that determinants that are tackled more often show better results, in practice this might not be the case. It can even be argued that it is more efficient to tackle a problem by just one programme, since that takes away the need for coordination of efforts and division of resources. Action might be more effective and resources might be spend more efficiently in such a situation. In policy making, policy makers should consider if creating new programmes is better than extending existing programmes, in order to avoid that different programmes aim to tackle the same factors. Moreover, to avoid gaps in strategies, proper evaluation of proposed programmes, and possibly the involvement of other actors, is needed. The importance of policy evaluation was demonstrated by the findings of this study. Although these results are very preliminary, we found that the strategies had only limited influence on population health. As such strategies require large amounts of resources, and

policies are often experimental, evaluation is needed in order to avoid the continuance of inefficient and ineffective policies. However, since it often takes a very long time before the effects of policies are visible, it might not be conceivable to extensively evaluate past policies before creating new once. In order to enable proper evaluation, data collection should be continued and expanded to be stratified according to more social factors, such as SES and ethnic background. Moreover, the health sector should be concerned not only with health indicators, but also with social indicators such as homelessness, quality of housing, and unemployment, in order to be able to predict and recognize the results of policies at an early stage, and to better understand population health. Finally, policy makers should clearly define the actions that are to be taken in policy documents, in order to create a clear task division in which every actor knows his responsibilities.

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- Social work as a tool for wellbeing policy 2015
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APPENDIX III- Lines of actions of Health 2015

Health 2015 Statements of Lines of Action

Lines of action for child health
1. Cooperation between central and local government, NGOs and industry to support families and better reconcile the needs of families with children with those of working age.
2. In cooperation with parents, furthering the role of day-care, preschool, and comprehensive school in promoting child health.
3. Helping children and families with children who are at risk of marginalization by providing financial assistance and psychosocial services, as part of municipal welfare policy programmes. Ways must be found in which the health and social services and the social security system can promote child health, and in particular improve the home background and education opportunities of children in the most disadvantages categories and risk groups.
4. Indicators of psychosocial wellbeing among children must be devised and a monitoring system built up based on them. Mental health care for children must be safeguarded.

Lines of action for young people's health
5. Collaboration between schools and other educational institutions, social and health services, municipal sports and youth departments, organizations and the media in reducing educational marginalization and poor health, e.g. by developing support functions, increasing information provision on life management and health, and influencing exercise habits.
6. Cooperation in municipalities throughout the country between various authorities, organizations, schools, business and industry, parents and young people themselves aimed at reducing drinking and experiments with drugs, and properly dealing with social and health problems related to alcohol and drug use.

Lines of action for health during working life
7. 3.In order to reduce alcohol-related accidental and violent deaths and injuries among young adult men, the Ministry of Social Affairs and Health will agree on an action package with other ministries and local authorities, unions and industrial organizations, and will extend existing traffic and occupational safety and health programmes.
8. Every effort must be made to reduce problems related to human and family relations, domestic violence, and loneliness by developing services and training related to family life, e.g. by increasing the skill base of family counseling clinics and through special groups to combat male violence.
9. Every effort must be made to prevent social exclusion, ensuring that the unemployed and people in atypical jobs and workplaces have the same opportunities as others to get health services and health promotion. Occupational safety and health and occupational health services are crucial here.

10. 10. The Ministry of Social Affairs and Health, Ministry of Labour and labour market organizations must intensify present efforts in line with the goals of the National Programme for Ageing Workers to ensure that employer demands can be reconciled with employee ageing and physical and mental capacities. The Government must itself show the way by ensuring that its personnel policy and strategies help its employees to cope at work.

Lines of action for health in old age

11. Ageing people must be ensured opportunities for functioning actively in society, for developing their knowledge and skills, and the ability to care for themselves, and for continuing to live an independent quality life with an adequate income for as long as possible.
12. Residential, local service and transport environments must be developed for ageing population groups that will safeguard the conditions for an independent life even when their capabilities deteriorate. Local authorities should work for these targets through an old age strategy incorporated into the municipal plan, as part of their welfare programmes, in traffic planning, and in developing and adding to housing areas.
13. A programme of services for old people should be worked out with the municipalities, aimed at developing care services needed in daily life and long-term care, incorporating informal care, voluntary work, commercial services and government action, and utilizing modern technology.

Lines of action for municipalities

14. The municipalities must be supported in their health promotion and in improving monitoring and evaluation, e.g. as part of their welfare programmes, by providing expert assistance. Innovative local development projects must also be supported on a national basis, using budget appropriations for the purpose. In order to ensure high quality health care for all residents, municipalities should be encouraged to cooperate with each other more closely.
15. Expert bodies within the Ministry of Social Affairs and Health's sphere of government will work in closer cooperation with the municipalities and improve their potential for implementing the targets of this programme through research and development.

Lines of action for the health care system and health promotion

16. Health care must be developed in a way that will guarantee everyone equal, sufficient and high-quality services, so that regional and socioeconomic status does not limit access to the necessary services.
17. Social welfare and health care services must be developed so as to ensure that everyone, regardless of socioeconomic status or origin, is able to get understandable information about both their rights and their responsibilities in health care, and general information about health and its promotion, together with the chance to influence decision-making concerning their own health.
18. The health promotion viewpoint must be taken into better account in all health services, partly also through personnel development at workplaces. Sufficient resources for health promotion must be guaranteed in order to meet the need, also when services are outsourced.
19. The principles for calculating central government contributions to municipal social welfare and health care must be revised to ensure that central government subsidies also take municipal action to promote local health into account.

20. The Ministry of Social Affairs and Health must work with other relevant ministries and with universities and research centers to provide expert assistance and forums for cooperation in order to strengthen and accentuate the health-promoting role of business and industry, thereby ensuring that people have a better chance of making healthy choices. Business operations that cause health risks, such as the alcohol business, must be regulated and should be encouraged to help combat health hazards, e.g. through self-regulation.

Lines of action for NGOs and civil action

21. In implementing this programme, evaluating its achievements and reshaping it in response to changing. circumstances, care must be taken to involve and listen to individuals, NGOs and public health organizations both nationally, locally and in all administrative sectors involved in the programme. Central and local government also carries some responsibility for ensuring and furthering ways in which NGOs can exert influence and operate. Individuals must be encouraged to be active in promoting their own health.

Lines of action for research and training

22. The Academy of Finland, the ministries and other parties will carry out a research programme on health promotion jointly with universities and State research institutes. The availability of research findings supporting health promotion must be improved.
23. The standing of health policy research at universities and research centers, and in WHO and EU research programmes, must be strengthened.
24. The health promotion viewpoint must also be taken into more account in the training of all health care professionals, from basic training upwards. A national public health training and research network must be set up between the universities and institutes within the Ministry of Social Affairs and Health's purview. Familiarity with health impacts in working life will be improved in health care training by developing the network education model.
25. State research funding must be allocated to work on health disparities between social groups and the reasons for them, and especially into the identification of groups at risk of poor health or premature death, and the development of means to alleviate these problems.

Lines of action for international activities

26. Initiative and inputs in the health-promoting activities of international organizations must be increased. Finland is still an active member of the WHO, one of its aims being to achieve an international framework convention on tobacco control.
27. In accordance with Article 152 of the Treaty of Amsterdam, assessment of health impacts must be incorporated into preparations for all EU decision-making, and similar practices proposed for other intergovernmental organizations. Health targets should be promoted specifically through the EU's agricultural, transport, food, consumer and environmental policies
28. Active cooperation with neighboring areas must continue in the field of public health and in combating contagious diseases, and emphasis placed on the health content of the Northern Dimension.
29. Cooperation between the various responsible ministries must be increased in planning international activities so that national impact can be assessed as early as possible.

Lines of action for assessing health impacts

30. Every fourth year an external assessment should be made of the health impact of activities in various sectors of policy, utilizing, for instance, the Social and Health Report. Using this assessment, the Government will decide on any necessary action.
31. The Ministry of Social Affairs and Health must work with the Prime Minister's Office to produce guidelines for procedures for advance assessment of the health impacts of central government policies and decisions. All the ministries concerned will be ensured sufficient resources to develop and maintain the necessary assessment methods.
32. Models will be compiled jointly with the municipalities for assessment of the health impacts of measures at the municipal level, permitting this to be incorporated into municipal operational and financial planning.
33. The Ministry of Social Affairs and Health and the other ministries should draw up operating models for promoting health impact assessment in decision-making by business and industry.

Lines of action for monitoring and updating of Heath 2015

34. Monitoring comprehensively covering various sectors and levels of government will take place in connection with the Social and Health Report made every four years.
35. An external assessment of health promotion structures, resources and activities will be carried out jointly with the WHO in 2001.
36. An external evaluation of national health policy will be made during the present decade.
37. The Ministry of Social Affairs and Health and the other ministries should draw up operating models for promoting health impact assessment in decision-making by business and industry.

Lines of action for monitoring and updating of Heath 2015

38. Monitoring comprehensively covering various sectors and levels of government will take place in connection with the Social and Health Report made every four years.
39. An external assessment of health promotion structures, resources and activities will be carried out jointly with the WHO in 2001
40. An external evaluation of national health policy will be made during the present decade.