

The th Nordic  
Public Health  
Conference

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Report

The status of the Public Health Programs  
in the Nordic Countries

## **The Icelandic National Health Plan to the year 2010**

During the years 1996-2000 a committee appointed by Iceland's Minister for Health and Social Security worked on the revision of a health plan which had been in effect since 1991. This revision has taken into account the policy of WHO on Health for All and the health plans of other countries on the one hand, and the public policy and revising of many aspects of health matters in Iceland on the other.

The National Health Plan will apply until 2010, but a special revision will be performed of its main targets in 2005. The Ministry of Health and Social Security will conduct the administrative implementation and revision of the targets of the Plan, and the Directorate of Health will make provisions for the collection and processing of information and professional monitoring. District physicians, health care employees and boards, as well as directors of institutions, will work towards reaching the set targets and ensure the monitoring of the implementation of the plan at a local level.

During the revision of the health plan from 1991 a decision was taken to specifically define seven priority areas until the year 2010. Apart from this, its basis is formed by the 21 targets of the WHO European plan.

Priority projects of the Health Plan until 2010 cover the following seven areas:

1. Alcohol, drug, and tobacco
2. Children and adolescents
3. Senior citizens
4. Mental health
5. Cardiovascular Disease and Stroke
6. Cancer
7. Accidents

In the year 2004 a report on the status and progress of the projects covered by the National Health Plan was published.

This year, 2005, the main targets of the Health Plan are being revised.

## **Healthy throughout Life – the targets and strategies for public health policy of the Government of Denmark, 2002–2010**

### **Common responsibility**

Health is a common responsibility – for individuals, for communities and for the public sector. No one can carry out the task of improving health alone. Joint efforts and cooperation are required. This is what the Government of Denmark states in its Public Health Policy, entitled Healthy throughout Life.

### **Coherence in promoting health and preventing disease**

Healthy throughout Life is a comprehensive policy on public health; the overall targets are to increase life expectancy, improve people's quality of life and minimize social inequality in health.

In addition, Healthy throughout Life establishes targets for several risk factors, target groups and efforts in the major settings for health promotion.

Healthy throughout Life has a special focus on the major preventable diseases and disorders. The quality of life of many people can be improved substantially by more systematic efforts in counselling, supporting and rehabilitating patients.

### **Common challenges**

Healthy throughout Life lists challenges for the future common efforts to promote health and prevent disease for every risk factor.

### **Responsibility for disadvantaged and vulnerable groups**

The Government emphasizes the need for special attention and efforts in relation to several high-risk groups.

A catalogue of health indicators will ensure the regular documentation of trends in public health, health behaviour and the efforts to promote health and prevent disease.

Eleven ministries are behind Healthy throughout Life.

A key aspect of Healthy throughout Life is partnerships, which can be created between actors at many levels:

- individuals; families; and local social networks; communities; nongovernmental organizations; and child-care institutions, schools, workplaces and health care services; and the state; counties; and municipalities.

### **Elements of Healthy throughout Life**

#### *Risk factors:*

Tobacco smoking - Alcohol consumption - Diet - Physical inactivity - Obesity  
- Accidents - Working environment - Environmental factors.

#### *Target groups:*

Pregnant women - Children (0–14 years) - Young people (15–24 years) - Distressed adults - Elderly people (65 years or older) - Chronically ill people.

*Major preventable diseases and disorders:*

Non-insulin-dependent diabetes - Preventable cancer - Cardiovascular disease – Osteoporosis - Musculoskeletal disorders - Hypersensitivity disorders (asthma and allergy) - Mental disorders - Chronic obstructive pulmonary disease.

*Settings for promoting health:*

Child-care institutions and schools – Workplaces - Health care services.

## **A New Health Law and a New Structural Reform**

From 2007 Denmark transfers to a new reform of the framework for public tasks and public service. 14 counties turn to 5 regions. 271 municipalities turn to 99 municipalities. Regions will not be able to deduct taxes.

A new health law has been passed in June 2005. The regions should have responsibility for the hospitals, the general practitioners and other health insurance schemes as well as psychiatric treatment.

The regions will have uniform conditions for solution of tasks within the health care sector. Health care services will primarily be financed through a block grant based on objective criteria for expenditure need, a smaller state activity pool, and local co-financing.

The municipalities will be responsible for prevention, care and rehabilitation that do not take place during hospitalisation. The municipalities should be able to find new solutions especially within prevention and rehabilitation, e.g. in the form of health care centres.

The municipalities and regions will be obliged by statute to cooperate about treatment, training, prevention and care. Obligatory health care agreements should include agreements on the discharge procedure for weak, elderly patients and for prevention and rehabilitation.

The municipalities will pay a contribution for financing of the health care service which gives them further incentives to make an extra effort within prevention, training and care.

- The local co-financing consists of a basic contribution per inhabitant and an activity-related contribution.

## Norwegian public health strategies

- What is new since the 7th nordiske folkesundhedskonferencen in Odense, Danmark in 2002?

### Prescriptions for a healthier Norway

In January 2003 the minister of health Dagfinn Høybråten, on behalf of the coalition government (Høyre (conservative), Venstre (social-liberal) and Kristelig folkeparti (Christian democratic)) presented the White Paper *Prescriptions for a healthier Norway- a broad policy for public health* (St. meld nr 16, 2002-03). The white Paper draws up the Norwegian public health strategies for the next years.

The White Paper defines public health work as “reducing factors that entail a health hazard and strengthening factors that contribute to better health”. The objective is a healthier Norway through a policy, which contributes to:

- More years of healthy life for the population as a whole
- A reduction in health disparities between social classes, ethnic groups and the sexes.

The “diagnostic” part of the White Paper points out three major public health challenges. First, Norway is facing major lifestyle and health challenges. Second, mental problems and disorders are becoming the great new challenge (in Norway as in other western countries). Third, to achieve further improvement in the health of the population, Norway has to improve the health of the group with the lowest education and income. Children and young people are pointed out as an important target group for the public health strategy.

Given these challenges the Government put particular emphasis to the following four “prescriptions” for public health:

1. Make it easier for people to take responsibility for their own health
2. Build alliances to promote public health
3. Encourage more prevention and less cure in the health service
4. Build up new knowledge

In addition, five special areas of concentration were pointed out: physical activity, nutrition, smoking, alcohol/drugs and mental health. Other important elements in the strategy of the White Paper are more knowledge about social inequalities in health; the development of health impact assessment tools, local health profiles and a stronger focus on health in public planning.

*Prescriptions for a healthier Norway* emphasizes that the determinants of health are in all sectors and levels, and points out opportunities on the local and regional levels. In accordance with this, the White Paper introduced partnerships for health between the Government, the county municipalities and the local municipalities, together with private voluntary organizations, universities, colleges and more. Most of the counties are today working in and with partnerships for health. This work will be presented on the conference on Iceland.

## **Other policy documents**

The White Paper is a framework for public health policy, and as part of the plan several action plans have been presented in its aftermath:

- The Norwegian government's action plan to combat drug- and alcohol related problems 2003-2005 and 2006-2008
- Action plan for preventing unwanted pregnancy and abortion (2004-2008)
- The Government's strategic plan for children and young peoples mental health ...together for mental health
- Together for physical activity. Action plan for physical activity (2005-2009)
- Preventing injuries and accidents – a strategic plan for transsectoral co-operation
- The challenge of the gradient. The Norwegian Directorate for Health and Social Affairs' plan of action to reduce social inequalities in health

## **The public health policy for Sweden – building a strategy based on wider determinants of health**

In April 2003, The Swedish Parliament approved the first comprehensive national public health policy. It was the result of an intentionally long and extensive process actively involving a wide range of stakeholders at all societal levels. Managing such a time consuming process required fuel to keep the momentum up, which was done through public debates, the involvement of politicians and professionals, all making footprints in the final proposal. An important point was to prepare for the implementation phase already at the start of the policy-building process.

After very thorough considerations it was agreed by consensus to build the public health policy on the wider determinants of health and link it to existing responsibilities and policies within different sectors, instead of setting up different health outcome targets. By doing this the inter-sectoral nature of public health became evident and the political implications of health more apparent. Politics is indeed more about creating prerequisites for good and equal health, than delivering specific health outcomes.

Given the existing health disparities, the policy is first and foremost focusing on how to reduce inequalities in health. Its overall aim is to create social conditions to ensure good health on equal terms for the entire population. The determinants are grouped into eleven target areas interconnected to one another and ranging from societal structures, environments, settings and life-styles. The different areas cannot be viewed isolated from one another, so measures in one area have implications on the other areas.

In implementing the policy the Swedish government emphasizes on four key features:

1. The nomination of a special Minister of Public Health with an inter-sectoral mandate and establishing a National Public Health Steering Group.
2. Spelling out clear responsibilities for national state agencies to promote health by actively tackling health determinants within their specific sectoral responsibilities.
3. Appointing the Swedish National Public Health institute as a hub for facilitating the implementation and coordinate monitoring and evaluation.
4. Produce a Public Health Policy Report every 4<sup>th</sup> year to monitor and evaluate to what extent policies have been implemented and their impact to fulfil the objectives of overall public health policy.

By taking a 'determinant approach' it becomes almost self-evident that protecting and promoting public health is moving 'up-stream'. By putting the wider and social determinants at the forefront, health inequalities become the overall priority. The monitoring and evaluation of the policy is not going to present 'average data', but the state of the art and trends for different socio-economic groups and separately for women and men over the life span.

We are all facing a more inter-connected and globalized world. For many reasons this is beneficial to health. Therefore health must be recognized as the key driving force for economic and social development and must thus be considered duly in global trade, in internationalized labour market, in human reproduction, in sustainable investments and so forth. This is also one major reason why there is an urgent need to strengthen the position of health in human development through the Millennium Development Goals.