

Summary, conclusions and recommendations

Introduction

This chapter gives an overall summary of the report, highlighting some of the issues and conclusions of particular interest for both Finland and other countries. Following a general overview, the issues related to policy formulation, implementation and monitoring and evaluation are summarized, as is adherence to the HFA principles. The value and future of such policy reviews is briefly outlined. Finally, a number of recommendations are made.

Characteristics of the country under review

Examinations of the health sector in countries often ignore the overall policy environment. This report has tried to highlight the main aspects of the situation in Finland, many of which were favourable to the development of an HFA policy. These can be summarized as follows.

- Finland is a small, rather homogeneous country, which has enjoyed a high degree of prosperity, stability and social cohesion for a considerable period of time.
- The HFA policy was very much a continuation of past health policy developments in Finland.
- There was strong political commitment to HFA.
- Senior Finnish experts had been closely involved in the elaboration of the European regional HFA policy and targets.
- A high-quality health care system was already in place.

- There were a comparatively good research and information base for health policy development and very highly trained health planners.
- The comparatively strong economic growth, enjoyed until about 1989, allowed shifts in the allocation of financial resources to priority areas without cutbacks in others. The recent very rapid deterioration in the economy, however, makes such an option unlikely in the immediate future.
- The guiding role of the state was accepted and respected, and the political and cultural environment was strongly conducive to searching for consensus or compromise. More recent pressures for decentralization and increased local power have led in some instances to quite extreme positions, which could endanger equity in health.

Overview of the achievements and the prospects

In the field of health care provision, Finland has a reputation of being a model to be emulated. In the development of the HFA strategy, the Finns have once again lived up to their reputation. The purpose of the review was to make a critical assessment of that development, and in doing so, a number of shortcomings have been highlighted. As the first in the field, Finland practised "state-of-the-art" HFA policy formulation in the middle 1980s. It is only with hindsight that the review picked out not only the substantial successes but some of the weaknesses of that pioneering effort.

Finnish economic and social policy since the Second World War has been highly successful in improving the health status of the population. This is evident from trends in mortality and morbidity data. In some instances, such as maternal and child health, Finnish achievements are amongst the greatest in the world. Health policy as developed in the 1970s and early 1980s, however, is being overtaken and perhaps threatened by fundamental changes in Finnish society. These include population trends that affect the need for health care and the capacity to provide it; the rise of consumerism and the decrease in solidarity in the people, which threaten the principles that have guided health policy; and new assumptions about quality of work life that affect the staffing of health services. This is accompanied by a move towards greater autonomy in political and bureaucratic decision-making at the local level. While improving the chances of wider participation, this weakens the strategic planning

system, which was one of the strongest tools for building Finland's success in reorienting health services towards primary health care.

The fundamental challenge for Finland is to revise its health policy, preserving the best of past achievements, while taking account of the basic demographic, economic, political and social trends in the country that present challenges for the future.

The Finnish HFA strategy was clearly based on sound scientific and strategic conclusions. By now, however, it has been recognized that the preparation of the plan was not sufficiently consultative. The closer involvement of other governmental departments, local authorities, health workers, voluntary organizations, private enterprise and the general public would have been beneficial. The lack of such consultation is reflected in current problems of implementation.

In many ways the Finnish HFA strategy was a forerunner of the global and European movements. In addition, the international collaboration and exchange of experience was valuable for developments at the national level. There seems to be agreement that such discussion confirmed the best of the policy trends already established in Finland in the 1970s. It also gave Finland the opportunity to widen the horizons and consider new options, broadening policy thinking in areas such as equity and intersectoral action.

Outside a limited group of advocates, however, views on these broader issues are still not strong. This is probably a symptom of the fact that the policy was not given high visibility outside Parliament when it was introduced. Little use was made of the mass media to bring the discussion to the grassroots level, and HFA was not raised for discussion at the local level. Furthermore, the ensuing strategy was not converted into a set of explicit tactics for implementation, with designation of responsibility. This is not to say that nothing was done at the local level. On the contrary, much was going in the right direction without actually being labelled as HFA policy implementation.

Clearly, an open discussion of the future of health policy in Finland at this time will raise very fundamental questions. These focus on the nature of health and how it can be maintained and improved, the relevance of the medical model to current health issues, the relationships between various professional groups and the role of the public sector, the voluntary sector and the private sector in health.

The HFA policy development process

Policy formulation

The Finnish HFA policy was clearly based on that of WHO. The WHO policy was used as a means of "legitimizing" rather than "initiating" the national HFA policy formulation process. Despite

the Finn's very strong commitment to and involvement in the formulation of the European regional HFA policy, it would not have been culturally acceptable to formulate a national policy because of the WHO decision. It was better to see this clearly as a Finnish activity, backed by international opinion.

Many developments in the health sector were already in line with such HFA principles as the reorientation of health services towards primary health care and the emphasis on equity. In Finland, as in other countries, however, these developments had been seen in a fragmented way until the middle 1980s. Improvements were made to different parts of the system as and when they were thought to be needed. In formulating an HFA policy, Finland departed from this fragmented approach to look at the whole rather than its parts, and to look at the long term, rather than dealing only with short-term crises. From this point of view, the formulation of a comprehensive policy for health was a completely novel idea. Finland was the first country in the European Region to formulate such a national HFA policy document. This whole process of participating in the formulation of the European regional HFA policy and adapting that policy to national needs has been an opportunity without precedent in the development of health policy in Finland.

The initiative for the formulation of a HFA policy in Finland came from the top, having the strong support of the then Minister for Social Affairs and Health, key civil servants and experts with experience of international developments. There was, however, no opposition to the introduction of this innovative approach to health policy; on the contrary, the main political parties were supportive. This was partly a reflection of the overall policy environment, which includes a tradition of seeking consensus or compromise and a willingness to listen with an open mind to reasoned discussion.

Like the other Nordic countries, Finland has a strong civil service tradition of reliance on expert opinion, with both the advantages and disadvantages that this entails. Furthermore, civil servants move easily between positions in the Ministry of Social Affairs and Health and the National Agency for Welfare and Health (the unified National Boards of Health and Social Welfare), thus gaining experience and understanding of administrative issues and those related to planning and research. This reliance on experts is coupled with a confidence in the state and a respect for political rules and regulations that are not so strong in some other countries.

Until very recently, there was broad acceptance of central authority and the civil service hierarchy, although this was counterbalanced by a belief in decentralization and a demand for a greater autonomy at the local level. This respect for the centre facilitated the acceptance of the

HFA policy, but was not conducive to the development of the sense of ownership at the local level that is essential for its successful implementation. Consequently, there was an expression of agreement with the HFA principles at all levels of decision-making, but not always a clear understanding of what they meant in practice, particularly the concept of intersectoral action for health.

This was largely due to the fact that an insufficient attempt was made at the policy formulation stage to bring together the central and local levels to define and adopt a health policy agenda, and to consider what this would mean in terms of the central/local relationship. This was unfortunate, since the respect enjoyed by the central level was tempered by a long tradition of strong local communities, and there was ample experience of their feel for autonomy. In some cases, for example, there had been difficulty in getting small and fiercely proud local communities to work together in federations.

At the policy formulation stage, participation was largely restricted to the health sector, and dominated mainly by experts in public health with medical training. The content of the policy was broad and innovative for its time, because of the vision and talents of the highly educated and motivated civil servants and academics responsible for its formulation. The well tried mechanisms of policy formulation, firmly based in the health sector and on expert opinion, were not questioned, despite the intention for a radical broadening of the scope of health policy. As a result of this failure to involve other sectors at the policy formulation stage, the sectors other than health felt a lack of ownership similar to that at the local level, which had to be overcome at a later stage.

Planning by objective was not new to Finland, but the formulation of the HFA policy focused renewed attention on this and on the setting of quantified targets. The focus on objectives and targets — many of which are related to health outcomes, whether quantified or not — has had two main effects. It has further shifted the emphasis of planning from health services to health. It has also provided long-term guidelines for health policy, on which broad political consensus could be obtained. With such guidelines, even incremental steps can at least be taken in the right direction. A change in government does not necessarily entail a change in these long-term objectives, as has so far proved to be the case in Finland. Thus, a high degree of commitment and stability has been assured.

The Finnish HFA strategy does not define quantified targets for most of the policy statements. The decision for this approach, which differed from that of the WHO regional HFA policy, was based on both a belief that it would be scientifically difficult to support such quantification in some areas, and a political position that more importance

should be given to the direction of policy measures than to the level of their achievement. This did not exclude the quantification of some targets felt to be scientifically sound and politically feasible. Furthermore, quantified targets are traditionally set through the strategic planning process, but these relate more to resource allocation than to health outcomes.

The choice of when to define or not to define quantified targets, although explained in general terms in the HFA strategy document, is not always quite clear. In Finland, as in other countries, quantified targets are set on the whole in areas in which there is a feeling of control over the outcome, particularly through the strategic planning process, or in which target setting is a tradition. This can mean that quantified targets are not set for what might be important policy areas, perhaps giving them an appearance of comparatively lesser significance. The development of quantified targets could be usefully reconsidered, as a means of both encouraging the scientific community to put more effort into supplying the necessary sound argumentation for intersectoral action for health, and focusing attention more precisely on certain issues. The quantification of targets is not, however, sufficient, and the means of achieving them must also be specified.

As in most countries in the Region, inequities in health have proved very persistent in Finland, despite a long tradition of egalitarian socioeconomic policies. It would appear, therefore, that something is needed in addition to the traditional universal approach. The setting of specific objectives and targets for vulnerable groups in society, along with clear policy measures for their achievement, would provide increased potential for closing some of the gaps in health status and access to health services.

The relative priorities of the 34 policy statements outlined in the HFA strategy were not very clearly defined in the strategy document, although priorities were determined for some of the subareas within them. In practice, the policy statements were too many to handle at one time, a problem that other countries have also encountered. The setting of priorities was left very much to the bureaucratic process, with ensuing political approval. It would have been more effective, and more in line with wider participation in decision-making, if the priority setting process had had the transparency of the discussion of the original policy statements; these were open to political debate at the highest level. A more formal process, with wider participation, might also be conducive to shaking off a rather linear way of thinking and to searching for innovative solutions. In addition, the explicit setting of priorities for the short, medium and long terms, would entail the designation of responsibility for policy implementation in priority areas within a defined time.

Policy implementation

More attention could have been given at the policy formulation stage to pinpointing possible problems of implementation, including provisions for the process and mechanisms to ensure that the policy was carried out. As was the case in most countries in the Region that formulated an HFA policy document, the Finns seem to have assumed that, once the policy was formulated and ratified, the implementation process would largely take care of itself.

Specific resources were not designated for the activation, coordination and monitoring of the implementation process. These tasks were entrusted to the same small group of civil servants that had been mainly responsible for the formulation and drafting of the policy document, but they did not receive extra human resources or relief from their other duties. It is to their credit, and a testimony to the civil service tradition mentioned above, that they included these tasks in their regular developmental, monitoring and evaluation activities.

The implementation of an HFA policy calls for the collaboration of numerous partners in different sectors and sometimes with conflicting interests. The process of consultation and negotiation that begins at the policy formulation stage continues throughout the implementation and evaluation stages. The coordination of such a complex process as HFA policy implementation is a full-time job. In Finland, as could only have been expected, the people attempting to carry out this task in addition to already heavy workloads suffered a partial and natural burn-out. There was a lack of human and financial resources to market the policy widely and take advantage of the initial enthusiasm generated by the parliamentary discussion, to build and use networks of new partners, and to take the policy, even at that late stage, to the local level. This was particularly unfortunate, given the conduciveness of the policy environment in Finland to constructive discussion and a search for compromise, and the eagerness for the exchange of experience.

This situation, however, was not unique to Finland. In the Netherlands, for example, the other pioneer country in the Region, the same type of problem arose with the first HFA consultative document. In revising that document, the Netherlands engaged in a broad consultative process with the many partners designated to undertake responsibility for implementation of various parts of the policy. In addition, a special unit was set up within the administration to monitor the implementation of the HFA policy.

It is hoped that, in revising the HFA policy in Finland, ways of marketing it to the general public will be considered so that the people both understand and feel a sense of ownership for it. Individual

responsibility for changes in lifestyles is necessary for the implementation of the HFA policy, but so is a general understanding of the need for certain sometimes unpopular policy measures, such as changes in fiscal policies. As to food and nutrition policy, for example, pressure from the public succeeded in changing agricultural production towards healthier products. It might be exactly this type of informed pressure from below that is needed to push politicians at the local level, and even Cabinet members, to make resource allocation decisions conducive to the achievement of HFA.

Although the strategy document expanded on the policy document discussed in Parliament, it did not designate responsibility for policy implementation, pinpoint key partners in the process, or set a timetable for the implementation of the various stages of this long-term effort, which was to cover 15 years.

Since priorities had not been fully set at the policy formulation stage, they were implicitly defined through the existing bureaucratic process. This did not allow a systematic search for opportunities to put health on the agenda of other sectors. As was perhaps natural in these circumstances, attention focused mainly on areas that had been the traditional responsibility of the health sector and in which effective intervention was seen to be more easily feasible.

The whole range of policy instruments that could have been used for the implementation of the HFA policy was not fully explored and exploited. The strategic planning process received by far the greatest weight. It had the advantage of being centrally controlled, and was very successful in gradually shifting posts for health personnel and investment to primary health care. The strategic planning process was also reasonably successful in shifting resources towards particular parts of the policy, such as care for specific groups. Its weakness was its greater emphasis on numbers of staff and on bricks and mortar than on the content of care. In order to affect the content of care, the other types of policy instruments, particularly training and the provision of incentives, would need to have much more relative weight.

The strategic planning process, as it was used, was more conducive to a traditional services-oriented approach than to an intersectoral approach. The Finns were clearly conscious of the limited value of the process and attempted to improve it. Consequently, the field of strategic planning for health was enlarged to include policy for the social welfare services in 1984, and environmental protection in the late 1980s. Other forms of coordination were preferred for other sectors. An example is the joint committee on nutrition, set up and chaired by the Ministry of Agriculture; it produced an excellent health-oriented programme, which both the agricultural and the health sectors have implemented. Nevertheless, the strategic planning

process could be a potentially powerful tool for intersectoral action if, for example, the allocation of certain resources were used as an explicit incentive for this purpose and the necessary links were made to the strategic planning processes in other sectors.

Monitoring and evaluation

Finland's commitment to international collaboration was reflected in the tremendous effort made to reply to the monitoring exercise for the regional HFA policy, and in its active role in the attempt to monitor progress in the Nordic countries, and to improve the indicators used for this purpose. This contrasted with the lack of resources designated for monitoring the implementation of their national policy. This seems to be explained by the fact that initially, Finland assumed that the regional monitoring system could be used or adapted for monitoring and evaluating its national policy. It may also be a symptom of the lack of a strong implementation strategy.

The effort made to monitor progress for the European HFA policy could have had an important impact if it had been directed towards the Finnish national policy. The question could be asked as to whether it is preferable to try to use the WHO HFA indicators for national monitoring, or to put much more effort into developing effective indicators to monitor the national policy, and then discuss these at the international level for possible use in monitoring the regional policy. What is certain is that the monitoring of such a complex process as HFA policy development calls for a system that is more comprehensive and flexible than those of the past. In addition, any monitoring system developed should assess progress both in the past and for the future.

Attempts were made to develop new tools for monitoring progress, particularly in the use of health care. Furthermore, improvements in the database continued, particularly in relation to the reflection of socioeconomic inequities, and an attempt was made to channel more research to serve policy-making purposes. Excellent statistical data exist for monitoring many of the main areas covered by the HFA policy. For example, changes in health-related behaviour are monitored annually in some detail. In addition to the health data traditionally compiled, information on environmental pollution is rapidly increasing, and there has been some improvement of the analysis of the health care system. More effort could be made, however, to study the impact of the policy measures implemented. Particularly in the case of a long-term policy, which requires perseverance, politicians need to see proof of results, if they are to be persuaded to continue their support. In recognition of the never-ending cycle of policy development, evaluation in Finland was intended from the start to

lead to the revision of the policy. The present review was clearly intended to complement the internal revision process.^a

Adhering to the principles of HFA

Equity

Upholding the focus of social policy for many years, the Finnish HFA policy was based on equity. Certain vulnerable groups — such as the elderly, the disabled and people suffering from mental illness — were singled out in subareas of various policy statements to be given priority. The policy of the 1970s to improve equity in access to health care has largely succeeded, although there are some important gaps in, for example, access to dental care, rehabilitation and physiotherapy.

These remarkable achievements now appear to be threatened, however. The proposed changes in the system of financing local services, as outlined in the Hiltunen proposals, will probably create regional inequities. Some of the suggestions being made for greater autonomy at the local level would also endanger equity in health. A notable example is the suggestion that the level of user charges should be decided at the local level. The change in the mix of public and private services and the increases in the cost of health care being met by private households could endanger any further moves towards equity.

Specific outreach policies for high-risk vulnerable groups — that is, positive discrimination for the achievement of equity in health status — does not yet appear to be a strong focus of health policy. Part of the reason may be that, despite a political ideology in favour of equity, too little is yet known in Finland, as in other countries, about the extent and causes of inequities, and how far they are amenable to change.

Nevertheless, the reflection of inequities in research and statistical data has improved. On the whole, data collected for other purposes seem to have been used to explore the extent of inequity in health. Steps remain to be taken towards specifically investigating inequities and their causes with a view to designing policies for their reduction. For example, some experts have singled out the level of education as the main single determining factor of inequities in health in Finland,

^a A preliminary draft of this report has already proved to be an excellent way of focusing discussion of the main issues in Finland, and of taking that discussion to a level beyond purely local interests. Furthermore, the Minister of Social Affairs and Health decided in June 1991 to set up an intersectoral steering group to revise the HFA policy and coordinate and monitor its implementation (see Appendix 9.1). She also decided that the finalized report of the review group should be presented for wider discussion following a national meeting to be held in August 1991.

while in Sweden particular emphasis is given to employment and the work environment. A definition of the most effective entry point has obvious policy implications.

Participation

Participation in policy formulation has been partly summarized above. It should be reiterated here that decision-making on choices for society seems to rely partly on expert opinion and partly on the process of political representation through parliament and the local authorities. Although there is now an obvious awareness that participation in the policy development process has not been sufficiently broad, even recent attempts to broaden it have occurred mainly at the level of experts. This strong cultural tradition is difficult to break. As in other countries, the step towards the participation of lay people in the definition of problems in societal choices appears to be particularly painful in Finland and has not yet been taken. The predominant view is that the experts must first put the problem on paper to form a focus for discussion, despite a growing number of successful examples in other countries of participatory research leading to changes in policy measures. Notable among these would be the long experience in Sweden at the workplace and with vulnerable groups, and the Edinburgh experience with families living in poor housing.

The health professions were consulted informally, that is, high-ranking members of professional associations took part in policy formulation as experts. Apart from this step, however, the potential for strengthening formal channels of consultation does not seem to have been exploited. Formal consultation gives recognition of status and can make allies out of possible enemies. Perhaps even more important, it allows the designation of responsibility and accountability.

Full advantage does not yet seem to have been taken of the potential power and resources of nongovernmental organizations for the implementation of the HFA policy. Neither has the potential of the mass media been exploited to involve the general public in policy development. In Finnish terms, participation in decision-making remains largely a question of experts talking to experts.

The progress made in other sectors in developing techniques of consultation and negotiation, including advances in management techniques in the private sector, do not seem to have been explored. This has implications for dealing with conflicts in the complex environment of HFA policy development, and for the improvement of the teamwork that is essential for HFA.

As to participation and involvement at the case level, some attempts have been made to secure the participation of patients and their families in decisions about care.

A re-examination of the whole policy development process would therefore appear to be useful. A clearer definition of the consultation process might be attempted, to search for an appropriate balance that would both make the best use of the excellent channels of informal consultation in Finland, which are extremely valuable and, through innovative ways of achieving participation, assure responsibility and accountability for the implementation of the HFA policy. Ways of involving lay opinion would also have to be considered, in addition to their representation in local and national political bodies.

Intersectoral action for health

The formulation of a national HFA policy, and its discussion in Parliament, was a considerable step forward, since it constituted the first overall political discussion of health policy development in Finland. The HFA policy document takes a broad intersectoral approach, in that it covers most of the 38 European targets. Its formulation and ensuing ratification facilitated intersectoral action on issues that had hitherto been difficult to promote.

Some innovative action has also been taken to implement the policy. As could be expected of the first attempt at the national level to take such a radically new approach to health policy development, this has been very much a learning process. In some cases, the HFA policy brought planners in the health sector, for the first time, to the same table as those in other sectors, such as the Ministry of Finance, to discuss wider health issues. This gave them the opportunity to uncover areas of mutual interest.

Skills in redefining the problems in order to clarify the role of the health sector in negotiating, and in looking for common objectives and trade-offs between sectors have undoubtedly been improved, as seen in the case of the food and nutrition policy. Efforts, however, have concentrated only on specific issues. It is not clear how the search for opportunities for intersectoral action will be handled on a systematic, continuing basis.

The bodies with the main power for resource allocation — the Cabinet, Parliament and the Ministry of Finance — do not, however, seem to have taken on a permanent role in the HFA effort, and there is no watchdog mechanism to assess the possible impact on health of policies in other sectors. A systematic examination is therefore needed of the processes and mechanisms for achieving intersectoral action for health. This would mean looking at how potential opportunities for intersectoral action for health could most effectively be picked up, and then how to best translate them into action.

On the one hand, the move towards decentralization and the use of block grants to subsidize health, welfare and education at the local

level should increase participation in decision-making. On the other hand, the possible impact of the loss of central control and the ensuing weakening of the leadership role of the centre in the achievement of overall health objectives that require intersectoral action are still unclear. Greater freedom for decision-making at the local level will create greater capacity for implementing differentiated combinations of solutions to suit local needs and to use local assets. There will, however, be a need for training in intersectoral planning for health at all levels and particularly in the use of information systems at the local level.

Participation in consultation and negotiation on an issue-specific basis appears to have been successful when the opportunity and field for action were clear, as was the case of food and nutrition. This issue-specific approach is less effective, however, in the search for opportunities. To ensure an effective watchdog function there is perhaps a need for a more permanent intersectoral body to discuss policy issues, or for cross-representation on existing bodies, such as the representation of the health sector on the Council for Economic Affairs or of the Ministry of Finance on the Board of the National Institute for Public Health. The role of the parliamentary health committee might also be considered.

Reorienting health services

In terms of the preferential allocation of resources, posts for health personnel and investment, the move towards primary health care that started in the 1970s has continued successfully. The planned moderate growth of health professional posts was achieved. Regional access to primary health care services improved greatly, even for small islands that are difficult to reach, and equitable access has been achieved to a large extent across socioeconomic groups. In contrast with many other countries, Finland has had reasonable success in attracting health personnel to rural areas, owing to a strong tradition and the strength of the Centre (agrarian) Party, and the resulting development of all public services in such areas, so that health personnel find good housing and good schools for their families.

There are excellent examples of good preventive programmes with very high take-up levels. The necessary step from prevention and health education to a more proactive and intersectoral health promotion approach has still to be fully taken. The prevention of disease and promotion of health have become the domain mainly of the nursing profession, with less interest and input from physicians.

At the time of the review there were shortages of primary health care physicians, although these seem now to be decreasing. Other categories of personnel, such as physiotherapists, remain in short

supply in the public sector, owing to competition from the private sector. In some urban areas, particularly Helsinki, the shortage of nurses is severe. The present increased rates of unemployment notwithstanding, the age distribution of the population, the dwindling growth of the labour force, growing opportunities for work in the private sector and a sickness insurance system that facilitates the growth of the private sector are likely to make the human resource issue a fundamental challenge to the primary health care system and the development of community-based care in the long run.

The education and training of health personnel are still based largely on the traditional medical model. More emphasis needs to be given to disease prevention and health promotion. Although significant differences between primary health care centres in the quality of service delivery were attributed mainly to differences in the quality of leadership, management training and development have received little attention.

For many years, there was a reasonable balance between the pressure of demand for primary health care and increasing resources to meet it. Consequently, the population could compare the care in the public sector favourably with what they had previously received. In recent years, however, waiting lists in some health centres have been growing, along with patient dissatisfaction with a lack of continuity of care. Response to the pressure for more personal attention and continuity of care was rather quick and apparently effective. It has taken the form of a very serious effort to reform the orientation and method of work within the primary health care system, and the new population-based system (or personal doctor system, as it is also called) has already been extended to about one sixth of the population. Less attention has been paid to the teamwork needed in new models of care than to the conditions of work and remuneration of physicians. It is unclear whether the wide implementation of the personal doctor system will facilitate or hinder a shift in emphasis towards health promotion and intersectoral action.

The preferential allocation of resources to primary health care over a number of years has restricted the rate of growth of hospital care. At the same time, as in many countries, the pressure for high technology medical care has been building in Finland. Such pressure will be even more difficult to control in the proposed decentralized situation. International experience has shown that local politicians can be swayed more easily towards high-visibility technical equipment than to less visible health promotion activities. If the present strategic planning system in Finland is disestablished, other forms of control will be needed to deal with ethical issues such as the proportion of resources allocated to high-cost services for the few. In

Finland in particular, one of the difficulties in moderating uncontrolled access to specialized, high-technology services is that the general practitioner does not really act as the gatekeeper to such services. At present, the system offers very liberal direct access to specialist services.

This fact also makes the system a "sellers' market" for specialists in the private sector. Unless waiting lists in the public sector are reduced, and a clear policy on the complementarity of the public and private sectors is developed, there could be serious unplanned consequences in the development of the private sector, with an undesirable effect on the supply of health personnel in the public sector and on equity of access to care. The policy of the Social Insurance Institution and the HFA policy obviously need coordination. This would include the necessity for a decision on whether the present system of uncontrolled access to specialized care is economically feasible or desirable.

It is interesting that, notwithstanding the fundamental challenge to the capacity of the health care system to deliver good care, some of the strategic options have not yet been seriously considered. These might include the development of a clear strategy for the public/private mix of health services, making more effective use of the voluntary sector and developing a strategy that more explicitly takes account of self-help and mutual aid endeavours.

Although the buildings are in place and, in many areas, so are most of the staff, little consideration has been given to the management and operation of health services: their efficiency and effectiveness. In a country with such a highly developed system of education, management in the health services sector is approached on what might be called an amateur basis.

The concept of teamwork, which is so essential to HFA, has received insufficient attention. This is not a problem unique to Finland. The development of a team approach has been much discussed. Although there are some scattered examples of teamwork development in countries with very different systems of health care (such as the Federal Republic of Germany, Sweden, the United Kingdom and Yugoslavia), there appears to have been no generalized development of this approach.

In Finland, emerging conflicts between the medical and nursing professions over leadership roles and between different levels of the nursing profession remain unsolved. Some of the symptoms of managerial inefficiency are to be seen in the lack of awareness of policy objectives and of professional roles, and in the length of waiting lists.

One of the main factors in the creation of these has been the lack of a policy for the development of human resources for HFA. So far

policy has covered only the level of expansion of the health professions, the number of posts in different areas of health care and in the welfare services, and their distribution in the country.

A systematic approach to human resource development will be one of the priority areas for the 1990s. Ways must be considered of putting HFA on the curricula for the health professions; this entails much closer cooperation between the Ministry of Social Affairs and Health and the Ministry of Education and the universities. Many health professionals have not been adequately prepared to meet the emerging needs of the elderly, particularly those with dementia, for example. Physicians' knowledge of lifestyle issues does not meet today's needs, particularly since the public is increasingly well informed. Many health professionals need more skills in helping patients and families to cope with terminal or chronic illness. In some European countries such skills have been developed in the framework of the hospice movement.

Furthermore, the health professions are important opinion formers at the local level. Their influence on public opinion and aspirations for the future shape of health services and overall policies for health can be quite significant, and may gain importance with increased decentralization. Their training strongly affects the way they exercise this influence. The attitudes of future generations of health professionals can only be changed if the universities become strong allies of HFA. Given the traditional autonomy of universities, the change will be most effective if it comes from within them as a result of critical self-assessment in relation to tomorrow's needs. Some of the best known medical schools in North America, for example, have successfully carried out such self-assessment.

The time needed for the education of medical and nursing personnel dictates a focus on in-service training for faster results. Various possibilities could be explored. The National Agency for Welfare and Health, for example, usually has funds that could be used to finance such training. The collective agreements between employers and employees, which make provision for career development and training, provide a possible ready-made framework for the development of such in-service training. The professional associations in Finland have a long tradition of providing training courses and seminars for their members, and offer another obvious option. Training in management skills is also essential for those in post, but this should not be the exclusive preserve of the medical schools if it is to follow a non-medical model and take advantage of the advances in management development methods outside the health sector. In addition, continuing support for management development should follow such training.

Human resource development is not, however, only a matter of education and training. The needs of the health sector must be seen in the context of the overall demand for human resources and the competition from other sectors. The health sector must offer more attractive employment opportunities. The relative lagging behind of salaries in the health sector, particularly for nursing personnel, in comparison with other sectors can be expected to create considerable pressure for higher pay. This will come at a time when the increase of resources for the health sector is slowing down, and could cause serious conflicts of interest. The need to consider possible trade-offs to increased pay could be constructively used to re-examine the work environment, including issues of job satisfaction, flexibility, teamwork, alternative mixes of team members, leadership roles and the interface between professional and informal caregivers. This issue will be of considerable concern for most Member States, and a search for innovative solutions in Finland can only help the international dialogue. It should be noted that a marginal financial input to action-oriented research, which would represent only a minute proportion of the cost of health services, could frequently overcome the obstacle to innovation.

Human resource development will be less effective if it is a one-off attempt. The responsibility for human resource development for HFA must be established on a more permanent basis.

Finally, the current resource-based planning system for health services, while extremely effective in some ways, does not address issues of quality, effectiveness and efficiency in either the primary health care system or the hospital sector. As a consequence, Finland's considerable fund of knowledge on health care delivery is not effectively used. A multidisciplinary pilot project to devise such a planning system, supported by a relevant research and development strategy, might be a good way for Finland to make an early start.

Value and future of health policy reviews

Collaboration on the development of the HFA policy for the European Region, and the adaptation of that policy to national needs changed Finland's approach to health policy development. There will be no going back from this broad approach of planning for health through an intersectoral policy. The present review has given the opportunity of confirming the best of what has been achieved and of noting areas in which more could have been done.

As mentioned, a preliminary draft of this report has already been discussed at an informal meeting of about 50 experts from all over Finland, and this final report is expected to be widely distributed and discussed. Participation in the review process through interviews or

the submission of documentation has also opened up the HFA discussion. Considering the preliminary views of the review group has already given the Finns the opportunity to step back and take a fresh look at where they are going. It is hoped that this final report will open this discussion even further.

The HFA policy was launched in the early 1980s. Those were the years of creating a vision, selling an idea. Ten years later, almost all the Member States of the European Region are well into the business of implementing the regional HFA policy. The HFA concept has developed rapidly throughout the Region and, perhaps even beyond expectation, is still gathering momentum at both the national and the subnational levels.

Policy development is a dynamic, cyclical process. Even while countries implement and evaluate policies based on HFA principles, as has been done in Finland, they are reassessing the processes of policy formulation.

The policy environment of the 1990s, however, is totally different from that of the 1980s. The most dramatic changes have been in central and eastern Europe, where the whole structure of socioeconomic and political development is being reformed. In addition, most countries in the Region are undertaking various forms of health care reform. The need for an extensive discussion of policy issues and an assessment of progress is urgent.

The information necessary as a background to this discussion can be obtained only by the type of in-depth examination carried out in the Finnish review. Not unexpectedly, many of the issues found to be difficult in Finland are also of concern to other Member States. It is hoped that Member States will be able to compare their own experience to that of Finland and thus gain a deeper understanding of the health policy development process and an insight into possible solutions to their own problems. Even the recognition of common problems can be conducive to mobilizing the will to deal with what might otherwise be considered to be overwhelming, country-specific issues.

The review of the Finnish HFA policy both highlighted the opportunities offered through the development of such a policy and examined the difficulties of managing such a complex process. The need has been demonstrated for patience and perseverance, for revitalizing the process and sustaining enthusiasm to keep health high on the political agenda, when a host of other issues are jostling for position and resources. There is a clear need to reassess and redefine the rules when power shifts, as in a process of decentralization, or when new partners come into the game and the balance between the public and private sectors changes. Old and tested ways can be used

and improved, but they are not always the most appropriate for such a complex process as HFA.

Much of the social policy debate in the early 1990s in the European Region centres on the reform of health care. The review reflected the importance of integrating such reforms into an HFA framework; this offers important lessons, particularly for the countries of central and eastern Europe.

This initial review already shows that the review of health policies in countries opens up a potential new role for WHO. A review by a neutral body enables a country to stand back from the special interests of the various partners in policy development, and to see the issues through the eyes of disinterested observers. WHO can provide this neutral channel, and the forum for an exchange of the ensuing experience.

Recommendations

Strategic planning

1. Finland has been extremely successful in using strategic planning to reorient health services by the preferential allocation of resources to primary health care.

The review group recommends that Finland safeguard and build on this effective tool. The responsibility of the central government for strategic planning and that of local authorities for tactical planning should be clearly distinguished, and the strengths of both should be built upon.

This means that the responsibility of the central level for the allocation of human and investment resources in accordance with overall policy guidelines should be retained. At the same time, the strategic planning system should be further developed so that it is conducive to:

- sustaining desirable change;
- promoting innovation;
- furthering opportunities for the implementation of health policy objectives in all sectors.

While protecting health policy principles such as equity in health, this would allow maximum flexibility for tactical planning at the local level, in accordance with local needs and aspirations.

Priority setting

2. The 38 regional targets for HFA have proved extremely valuable as a checklist for determining long-term policy in most countries in

the European Region. In many of the countries, such as Finland, that have formulated a broad and comprehensive health policy document, however, it has proved difficult in the short and medium term to deal with so many issues at the same time.

The review group recommends that, while retaining the broad, long-term vision and guidelines for health policy, Finland should set explicit priorities for short-term and medium-term action.

Public discussion of such priorities would focus attention on and clarify the possible and the desirable futures in health policy development.

Target setting

3. Finland has based its HFA policy on qualitative policy statements, with few quantified targets. In this respect, the experience in the European Region in the formulation of similar policy documents has been extremely varied.

The review group recommends that, in revising the HFA policy, Finland re-examine the utilization of quantified and non-quantified targets, and the balance between them. Consideration should be given to the possibility of defining separate targets for certain population groups, particularly vulnerable groups.

Coordination

4. The public sector in Finland has succeeded in bringing a wide range of high-quality health and welfare services to the entire population, including people in remote rural areas. At the same time, the National Sickness Insurance, by partially reimbursing the costs of ambulatory care in the private sector, including occupational health care, has brought within reach certain services that were in short supply in the public sector, or for which there is a consumer preference for greater freedom of choice. This rather liberal system, however, endangers the role of the general practitioner as the first source of primary care, and encourages the ad hoc, uncontrolled growth of the private sector. Furthermore, the possible introduction of block grants at the local level could lead to double funding of some services from the public sector, if local authorities use the block grants to buy from the private sector, services that are also covered by the National Sickness Insurance.

The private sector plays a legitimate role in supplementing the public sector, and in meeting consumer demands for freedom of choice and the demands of health professionals for greater freedom in their work. The disadvantage in the long run, however, is that a failure to control such developments will undermine the basis of the Finnish HFA policy, which rests on the principle of equity.

The review group recommends that Finland:

- carefully examine the development of the public/private mix of health services, to sustain and build upon the gains made in equity, health promotion and the accountability of publicly managed services; and
- ensure the long-term coordination of the policies of the central health authorities and the National Sickness Insurance, with regard to the allocation of financial and human resources, in line with the HFA principles.

Such coordination could be achieved in a number of ways, such as transferring clear authority over the National Sickness Insurance to the Ministry of Social Affairs and Health, establishing a parliamentary committee for the purpose, annual reporting mechanisms or other negotiating arrangements.

Human resource development

5. Finland is in the fortunate position of enjoying health services staffed by highly trained and motivated health professionals. The complex demands of the HFA policy, however, require increased emphasis on building the capacity for health promotion and intersectoral action, and for managerial skills.

The review group recommends that a permanent system be established for human resource planning and development to support HFA.

This would entail forecasting future needs for human resources and the development of the capacity to meet them, taking account not only of past trends but also of possible alternative staffing patterns for the future and the competing demands of other sectors for new personnel. This means that training should be very high on the agenda, in terms of both changing the content of university education to meet the health needs of the population and providing continuing in-service training to meet the challenges of the future. The development of human resources for health must also deal with the work environment, and with issues such as professional roles and teamwork. The development of management skills should not be restricted to the classroom, but should include support in actual management situations.

The initiative in taking such a broad approach to human resource planning and development cannot come only from the top. It should involve the universities and training institutions in self-assessments of the education they offer, in relation to the needs of the twenty-first century; it should motivate not only the teachers but also the students

to assess the demands for change, and should build on the strengths and motivation of the professional associations of health personnel.

Management practices

6. Insufficient attention has been given to the management of health services, the way they operate, and their efficiency and effectiveness.

The review group recommends that Finland undertake a programme for the continuing review and revision of management practices in primary health care and the hospital sector.

This should provide a basis for addressing the complexity of the HFA approach, the demands for better service and for the improved quality of work life in the health care sector.

Accountability

7. There is a move towards decentralization and greater responsibility at the local level. Planning for health rather than only for health care creates a complex new environment for management. The private sector is developing in new areas. Health professionals are taking on changing responsibilities. In the current process of reform, the old-fashioned methods of management by activity, of focusing solely on balancing income and expenditure, do not suffice.

The review group recommends that Finland take steps to establish political and managerial accountability for outcomes, the use of resources and consumer or public satisfaction, among the various partners responsible for policy formulation and implementation.

This entails a clear definition of accountability not only for outcomes but for processes. It also entails consideration of the most suitable mechanisms for ensuring accountability.

Quality of services

8. The high quality of the staff and the physical facilities in the Finnish health services has been unquestioned for many years. On the whole, the population has been satisfied with the quality of care in the technical sense. Until recently, however, comparatively little attention has been paid to the quality of care in terms other than those of people and buildings, and this has created dissatisfaction with the quality of the services offered. It is already clear that the aspirations of increasingly well educated patients and their families will demand that more attention be given to the preparedness of health and welfare services to meet their needs.

The review group recommends that urgent attention be turned to this issue, particularly as this relates to training needs, standard monitoring systems, peer review and participatory research.

Monitoring

9. In comparison with many countries, Finland is fortunate in having a well developed information system and a rich body of research, much of which is relevant to policy development. There is a pool of highly skilled experts in the field of epidemiology and public health. In monitoring the HFA policy, however, Finland gave priority to responding to the system set up to monitor the European HFA policy. In the event, this did not meet the needs for national monitoring and decision-making.

The review group recommends that Finland utilize its outstanding information and expertise to develop a monitoring system that provides a clear understanding of the achievements and problems of HFA development. This system should include quantitative and qualitative information related to both processes and outcomes.

Possible approaches might include the development of a set of essential indicators and the preparation, presentation and discussion of periodic reports on the public health. Particular attention should be given to monitoring issues of equity in health. It is hoped that this experience could then be shared with the WHO Regional Office for Europe, and be instrumental in improving the regional monitoring system, so that it becomes more relevant for national policy-making.

Research and development

10. Finland enjoys a very well trained research community and has formulated a research policy for HFA. This has not been sufficient, however, to bring about the desired results.

The review group recommends that Finland allocate personnel and financial resources for the preparation and implementation of a research and development strategy with a capacity comparable to that in other sectors using similarly complex systems and similar levels of technology.

The efficacy of this type of research and development has recently been proven by several projects, such as the personal doctor scheme, hospital utilization analyses applying new mapping techniques, and economic analyses of cost variations between areas and units.

Equity

11. As seen in the review, Finland has made great strides in the achievement of greater equity in health status and access to health care. There are, however, as in all countries in the Region, very persistent gaps.

The review group recommends that urgent attention be turned to specifically investigating inequities in health and their causes, with a view to designing strategies for their reduction. Socioeconomic policy

initiatives and proposals for resource allocation in sectors relevant to health should be examined for their possible implications for equity.

Intersectoral action

12. Intersectoral action for health is one of the basic elements of the HFA policy. Finland has had significant success in achieving intersectoral action, as seen in this report in relation to the closer link of the health and welfare services and in the area of food and nutrition policy. The development of an intersectoral approach has proved challenging in all countries, and care must be taken not to miss possible opportunities for putting health on the agenda of other sectors.

The review group recommends, therefore, that the mechanisms and incentives for achieving intersectoral action for health at all levels of policy-making (central, provincial and local) be re-examined and strengthened.

It is suggested that, in searching for opportunities for an intersectoral approach, comprehensive mechanisms might be examined, such as establishing an intersectoral body (for example, a Cabinet committee) or mechanisms related to population groups (whether geographical groups such as the population within the area of responsibility of a municipal council or specific groups such as the elderly or disabled). In taking steps for intersectoral action, an issue-specific approach such as that already used in Finland, might be more appropriate.

Participation

13. The achievement of wider participation in the processes involved in policy formulation, implementation and evaluation has financial, personnel and time implications. The trade-off in effective policy implementation and evaluation, however, makes these costs very much worth while.

The review group recommends that Finland provide the opportunities and support for achieving wider participation throughout the policy formulation, implementation and evaluation processes.

This will call for innovations in consultation and negotiation processes.

Food and nutrition

14. The approach taken in Finland for the development of a food and nutrition policy is one of the outstanding examples in Europe of an intersectoral approach based on sound scientific knowledge.

The review group recommends that Finland confirm this approach and continue to strengthen the progress made.

Care for the elderly

15. Care for the elderly and chronically ill can be expected to pose one of the major challenges for the future. There has been a great deal of strategic thinking about this issue but a gap appears to remain between the formulation and implementation of policy.

The review group recommends that the health and welfare services and other sectors be further encouraged to strengthen their contribution to meeting the HFA policy objective of maintaining and enhancing the functional capacity of the elderly and chronically ill.

This is partly a resource issue, in terms of the allocation of the necessary financial and human resources to ensure a continued shift from institutional to community care, and partly a question of consultation to ensure the readiness of services in the public, private and voluntary sectors to meet the special needs of these groups of the population.

International implications

16. The experience of the present review has proved to be of immense value in understanding the process of HFA policy development in a particular country. The issues examined are crucial for other countries. International reviews of policy development in sectors such as education and the environment have proved to be extremely valuable both to the countries reviewed and to the international community. Given the challenges to the health sector in the twenty-first century, it is vital that information that can only be collected and presented through processes such as those used in this policy review be gathered, analysed and discussed widely.

The review group recommends that:

- consideration be given to carrying out similar policy reviews in other countries of the Region;
- international consultation be undertaken as soon as possible on the issues raised in the recommendations in this report; and
- Member States and WHO consider a system of financial and technical aid to support the policy review and information exchange process.

This implies that WHO and Member States should consider establishing a system of technical and financial support, which is essential for carrying out such reviews. It is also hoped that Finland, which has agreed once again to act as a pilot country in this project, will share its experience, and contribute to the development of country health policy reviews as a tool for policy development at the national and international levels.

Appendix 9.1

Decision of the Minister for Social Affairs and Health

Helsinki, 4 June 1991

A Steering Committee for the "Implementation and follow-up of the HFA 2000 programme" has been set up for the period 1 June 1991 to 31 December 1995.

The terms of reference for the Steering Committee are to:

- supervise the implementation of the HFA programme for health policy, and health oriented public policies in other sectors;
- assess the progress made in implementation, taking particular account of the report made by the WHO expert group;
- make a proposal for revision of the programme by 31 March 1992; and
- monitor, develop and coordinate the activities of different sectors for achieving programme objectives.

The Steering Committee comprises:

(a) as Chairperson, the Permanent Secretary of the Ministry of Social Affairs and Health;

(b) as members:

- Director-General for Health and Welfare Service, Ministry of Social Affairs and Health;
- Director, Health Promotion and Disease Prevention, Ministry of Social Affairs and Health;
- Director, Planning, Ministry of Social Affairs and Health;
- Director-General, National Agency for Welfare and Health;
- Senior Councillor, Ministry of Education;
- Deputy Director, Ministry of Agriculture and Forestry;

- Director, Ministry of Trade and Industry;
- Permanent Secretary, Ministry of Transport and Communications;
- Director, Ministry of the Environment;
- Member of the Finnish Academy;
- a representative of the Social Insurance Institution;
- a representative of the National Public Health Institute;
- Director, Health Institute;
- Director, Association of Finnish Cities;
- a representative of the Association of Finnish Rural Communities;
- a representative of the Association of the Swedish Speaking Communes;
- a representative of the Finnish Medical Association;
- a representative of the Association of Nursing Personnel;
- a representative of the Centre for Health Education;
- Professor of Social Policy, University of Lapin;
- Chief Physician, Turku; and
- Director, Health Promotion Institute, Tampere.

The Steering Committee is to be supported by a preparatory working group, consisting of:

- Director-General for Health and Welfare Services, Ministry of Social Affairs and Health;
- Director, Health Promotion and Disease Prevention, Ministry of Social Affairs and Health;
- Director, Planning, Ministry of Social Affairs and Health;
- Director-General, National Agency for Welfare and Health; and
- Director, National Public Health Institute.

The Steering Committee may appoint three part-time secretaries. Most of the work of the Steering Committee will be done during office hours, without extra compensation.

Signed: Minister of Social Affairs and Health
Eeva Kuuskoski

