# Monitoring local level implementation of Health in All Policies in Finland – foundation for enhancing the four HiAP pillars

Towards Sustainable Societies - Health in All Policies and Social Determinants of Health Seminar
6-7 September 2023, Tampere University, Tampere, Finland

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# Content

1) Key elements for HiAP in Finland’s legislation
2) Monitoring the HiAP implementation on local level – health promotion benchmarking system, TEAviisari
3) Lessons learned

# Act on Organizing Healthcare and Social Welfare Services 612/2021

## Defines 5 key HiAP elements* on local and regional level (municipalities and wellbeing services counties), §6 and §7

### Objectives and measures

1. In the strategic planning, the objectives for the promotion of health and wellbeing of the inhabitants must be set
2. Measures to achieve the strategic objectives need to be identified

### Responsibilities and co-operation

3. Body that is responsible for the promotion of health and wellbeing of the inhabitants needs to be appointed.
4. Obligation for co-operation between administrative sectors, with other local actors, private enterprise and NGO's

### Impact assessment (prospective)

5. Decision making – impacts of the decisions on the health and wellbeing of the inhabitants must be considered

### Monitoring and reporting

6. Yearly a short report, once in four year a comprehensive report on status of health and wellbeing by population groups, factors influencing the health and wellbeing and measures conducted -> given to the council (municipalities / wellbeing services counties)

### Cooperation between Municipalities and Wellbeing services counties

7. have the obligation to cooperate with each other and support one other with their expertise

*have been set in legislation since 2010

# Monitored elements by checklist of operational characteristics and outcomes of HiAP approaches (Box 5, pp 16-17)


## Box 5. Checklist of operational characteristics and outcomes of HiAP approaches

### Inputs

#### Governance

- ~~Existence of endorsement at the political level of explicit HiAP approach or multisectoral action that could advance addressing SDH~~.
- Existence of formal or informal multisectoral coordination mechanism specific to SDH, health equity and broad HiAP; or integrated with other issues (e.g. noncommunicable diseases, antimicrobial resistance, One Health, COVID-19).
- ~~Existence of national policy or strategy specific to HiAP or SDH~~.
- ~~Existence of national health plans that embed and mention HiAP or multisectoral action~~.
- Existence of priorities in addressing SDH for advancing equity.

#### ~~Finance~~

- ~~Resources allocated or mapped to HiAP through separate or integrated budget lines.~~
- ~~Government spending on HiAP as percentage of government health spending~~.
- ~~Source of spending~~.

#### Health workforce

- Number of dedicated full time equivalent personnel working on HiAP or multisectoral

#### ~~Monitoring and evaluation~~

- ~~Existence of system to capture best practices, lessons learnt and innovation related to HiAP~~.

### Processes

- Occasional or ongoing regular collaboration to address one issue or social determinant or multiple issues or determinants with a single partner or multiple partners.
- Existence of multisectoral and multistakeholder mechanisms with clearly defined roles and functions.
- ~~Interventions at community level in support of HiAP.~~

### Outputs

- ~~Frequency of meetings of multisectoral and multistakeholder coordination mechanism.~~
- ~~Representation (types, seniority, numbers) of ministries or departments involved in multisectoral and multistakeholder coordination mechanism.~~
- Other stakeholders and sectors involved in multisectoral coordination mechanism.
- Inclusion of health considerations in the work, policies and programmes of non-health ministries, independent of health sector input.
- ~~Improved community perception, knowledge and access to information on HiAP approaches.~~

### Outcomes

- Existence of reporting structures or accountability measures that address policies impacting on determinants of health.
- ~~Level of engagement with different types of sectors as a result of collaborative work, indicating level of engagement of economic, home affairs/interior/local government, labour, finance, and infrastructure ministries, compared with social sector ministries~~.
- ~~Characterization of the problem of inequity explicitly framed in terms of SDH (essential conditions for health – good-quality and accessible health services; income security and social protection; decent living conditions; social and human capital; decent work and employment conditions)~~.

### Impact at policy level

- ~~Improved public policies aligned to evidence on SDH~~.
- Systematized mechanisms for HiAP implementation.
- ~~Improved outcomes for other policy sectors (co-benefits)~~.
- Improved equity in health or in SDH.

”Has the implementation of HiAP been successful in Finland?”

# How to collect data indicating success of local level HiAP implementation?

# TEAviisari – a system for benchmarking health promotion capacity building

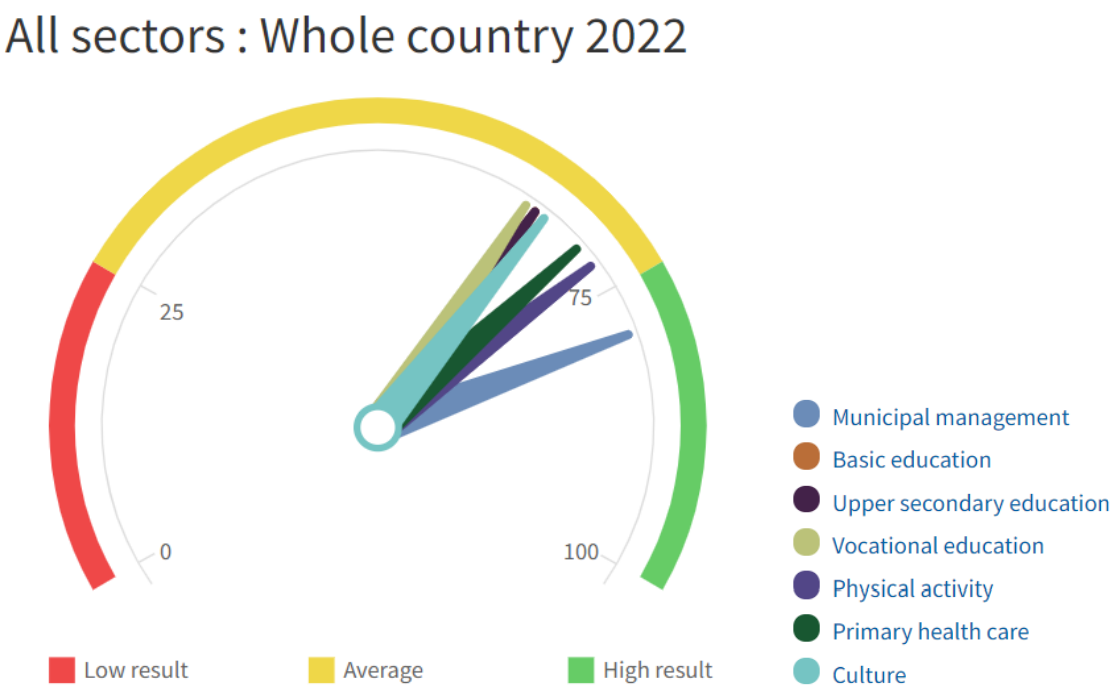
The key is to measure and assess
health promotion capacity and activity
of an organization
in a **comparable** way
across sectors of the local government

➡ Database for monitoring the HiAP implementation

www.teaviisari.fi

# TEAviisari - Generic framework

- Based on literature on health promotion capacity-building, quality management and organizational theories
- Seven dimensions under which sector specific indicators are built:
  1. **Commitment** of the organization to the promotion of population health
  2. **Management** of health promotion
  3. Population health **monitoring**, **needs assessment** and **evaluation**
  4. **Resources** for health promotion
  5. **Common working practices**
  6. **Public participation**/partnership in the planning and evaluation of health promotion services
  7. Other **core health promotion functions**



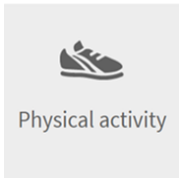
# Datasets - collected biennially from municipalities

## Primary health care

- 2008: 191 (83 %) health centres
- 2010: 155 (89 %)
- 2012: 158 (100 %)
- 2014: 154 (99 %)
- 2016: 152 (96 %)
- 2018: 142 (97 %)
- 2020: 120 (90%)
- 2022: 123 (93 %)


## Promotion of physical activity

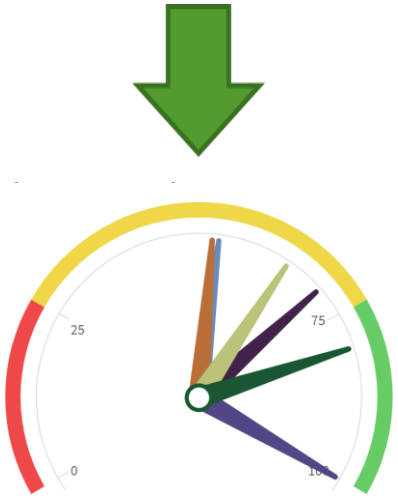
- 2010: 268 (79 %) municipalities
- 2012: 230 (68 %)
- 2014: 249 (78 %)
- 2016: 271 (91 %)
- 2018: 282 (96 %)
- 2020: 286 (97%)
- 2022: 288 (98 %)




## Municipal management

- 2011: 195 (58 %) municipalities
- 2013: 214 (67 %)
- 2015: 250 (79 %)
- 2017: 270 (92 %)
- 2019: 273 (93 %)
- 2021: 271 (92%)
- 2023: 286 (98%)


**Over 800 indicators**




+ national registers

## Basic education

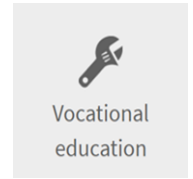
- 2009: 1803 (63 %) schools
- 2011: 2078 (73 %)
- 2013: 2023 (74 %)
- 2015: 2013 (80 %)
- 2017: 2335 (88 %)
- 2019: 2057 (91 %)
- 2021: 1868 (86 %)


## Upper secondary education

- 2012: 343 (86 %) schools
- 2014: 323 (82 %)
- 2016: 335 (90 %)
- 2018: 343 (94 %)
- 2020: 345 (95%)
- 2022: 328 (92%)

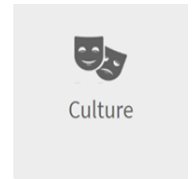

## Vocational education

- 2012: 158 (92 %) schools
- 2014: 133 (90 %) schools
- 2016: 317 (90 %) units
- 2018: 303 (76 %) units
- 2020: 336 (96%) units
- 2022: 319 (88%) units




## Culture

- 2019: 283 (96 %) municipalities
- 2021: 279 (95%)
- 2023: 290 (99%)



# To what extent HiAP implementation has been successful?

## Inputs – Governance (Box 5)

➡ Existence of formal or informal multisectoral coordination mechanism specific to SDH, health equity and broad HiAP

**SOURCE**

**QUESTION**

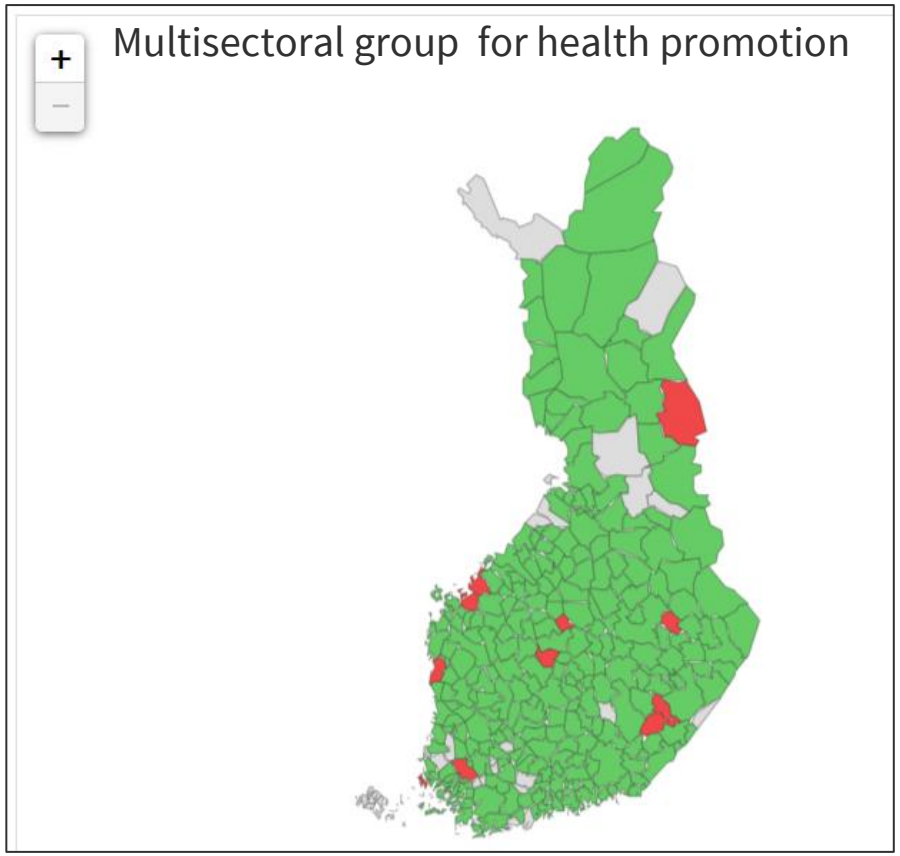
16. Does your municipality have a working group for health promotion?

| Score | Response |
|---|---|
| 0 points | No working group |
| 100 points | Cross-sectoral working group |
| 100 points | The (extended) municipal management group |
| 100 points | Regional welfare team |
| 100 points | Other group |

**DATA COLLECTION**

DATA COLLECTION FOR MUNICIPAL MANAGEMENT on the promotion of population health and welfare 2021

| | % |
|---|---|
| 2023 | 98 |
| 2021 | 95 |
| 2019 | 97 |
| 2017 | 96 |
| 2015 | 92 |
| 2013 | 63 |
| 2011 | 24 |

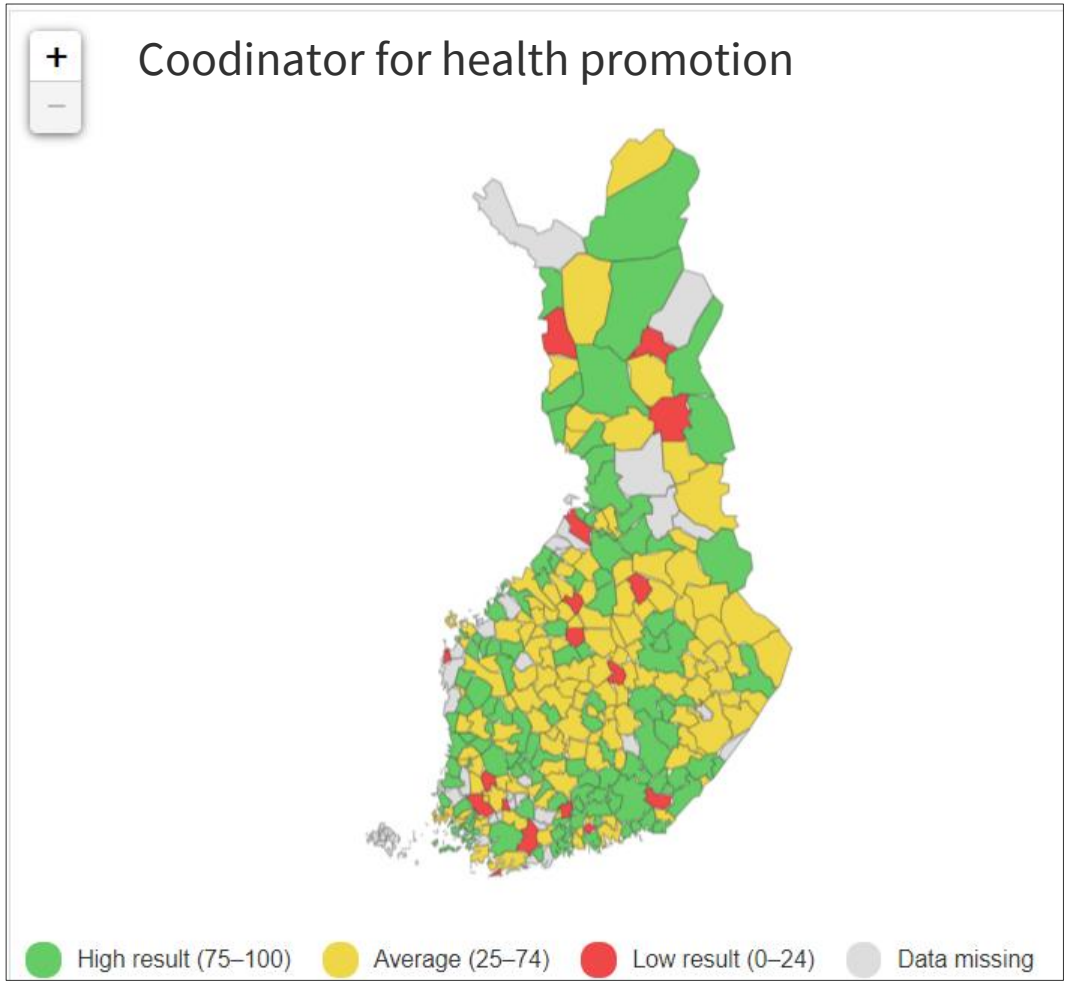


# To what extent HiAP implementation has been successful?

## Inputs – health workforce (Box 5)

➡ Number of dedicated full time equivalent personnel working on HiAP or multisectoral action, or working on other issues but with HiAP elements integrated in the job description.

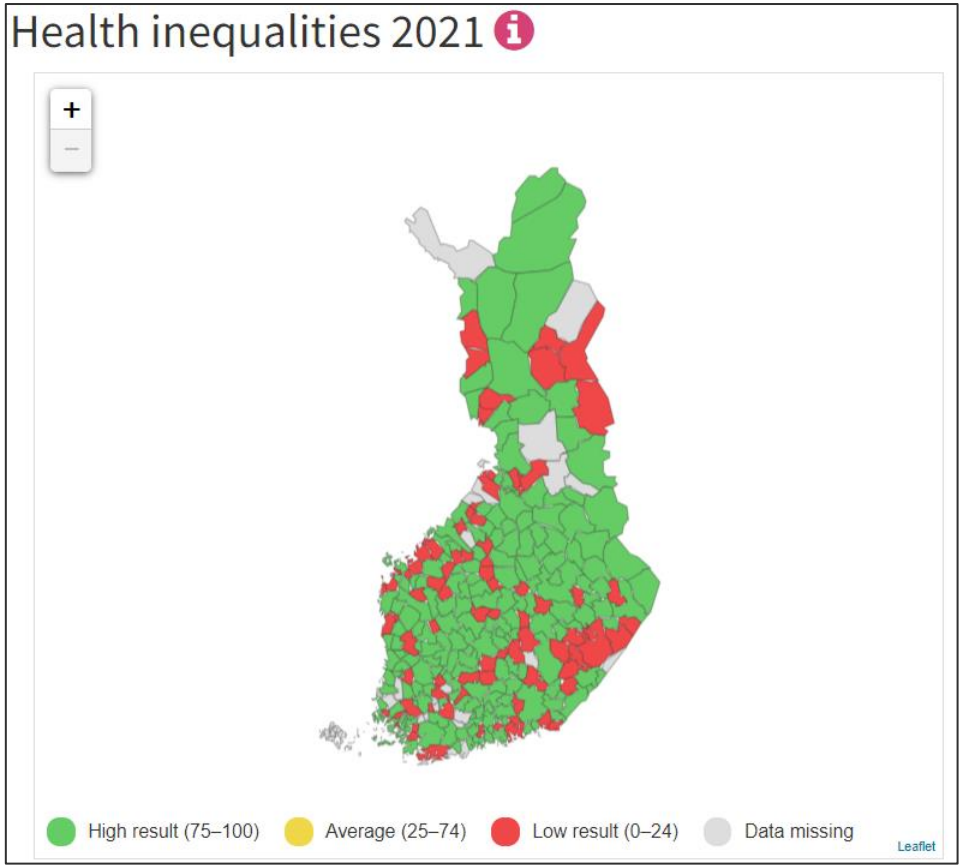
| SOURCE | |
|---|---|
| QUESTION | |
| 26. How large contribution does the welfare coordinator, planning officer or similar have in welfare and health promotion in your municipality? | |
| **Score** | **Response** |
| 0 points | Not at all |
| 50 points | 0.01-0.29 man-years/10000 inhabitants |
| 100 points | 0.3 man-years or more / 10000 inhabitants |
| 100 points | More than one full-time professional |



# To what extent HiAP implementation has been successful?

## Impact at policy level (Box 5)

➡ Improved equity in health or in SDH.


SOURCE

QUESTION

23. Did the **management group** discuss the following changes in population health and welfare or their determinants during 2020? Health inequalities

| Score | Response |
|---|---|
| 0 points | No |
| 100 points | Yes |

# Lessons learned

1) It is possible to collect comparable data indicating how well the key elements of HiAP have been implemented
2) Publishing relevant, interpreted information online
   - serves local decision-makers in assessment and planning
   - makes municipal actions transparent to the residents
   - provides information for national-level policy-making, also enabling the assessment of law enforcement
3) Monitoring the progress and publishing the results in online benchmarking system facilitates HiAP implementation – peer learning and pressure

# Thank you!

## Further reading and sources: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