Reducing health inequalities in Finland: progressing or regressing?

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ABSTRACT
The health of the population in Finland improved dramatically during the 20th century, but differences between socioeconomic groups prevail and have even widened during the past decades. Reducing health inequalities has been the goal for health policy since the 1970s. One instrument for addressing the problem has been public health programmes. However, they have not proven to be very powerful in reducing inequalities. This is connected with the nature of socio-economic health differences, which are generated in a wider societal context and are linked to social and economic inequalities. By the turn of the 1990s, Finland was one of the most egalitarian countries but after the economic depression of the 1990s the basis of the welfare state was weakened. Improving the conditions and health-related habits of the more disadvantaged groups has been articulated in the programmes of the present government and a major healthcare reform is underway, but it seems that the root causes of inequalities do not receive the attention needed to reduce health inequalities.

Keywords
Health inequalities, public health, health policy, welfare state
INTRODUCTION

In Nordic comparisons, Finland has until recently often been a slightly deviant member of the Nordic welfare state family because of its poorer health outcomes as well as higher health inequality indicators (see e.g. Mackenbach et al., 2003). Yet by the turn of the 1990s, Finland was one of the most egalitarian countries in terms of income distribution. The social welfare system had ‘matured’ more or less to the level of other Nordic welfare states during the past few prosperous decades, and the unemployment rate was low. The changes in the overall political environment in the early 1990s, however, had a profound effect on Finnish society and the social conditions that are connected with the distribution of welfare and health. The Soviet Union collapsed in 1991 and Finland joined the European Union in 1995. The economic depression of 1991-1993 left marks in Finnish society which persist even today. For example, the unemployment rate and the at-risk-of-poverty rate rose and have remained on a markedly higher level than before the depression. Cuts were made in social security that have not been fully returned even today (e.g. Blomgren et al., 2012). Tax rates were lowered (in order to stimulate work) and a fixed lower tax for capital income was introduced. These changes were conducive to one of the fastest increases of income inequality after the recession in the OECD countries (Blomgren et al., 2012). A retrenchment of the welfare state seemed to follow almost immediately after the welfare state had been ‘achieved’ in Finland.

In the present article, we will highlight some of the controversial elements in the developments in Finnish health policy aiming to reduce health inequalities. The article draws on results of epidemiological research, Finnish health policy documents, as well as our earlier report on the role of social determinants in Finnish health policy (Palo- suo et al., 2013). First, we present an overall description of health inequalities in Finland and then describe briefly how health inequalities have been addressed in public health programmes and some other policy documents. In the discussion, we will consider some explanations for the present development and point to some controversies in current health policy.

HEALTH INEQUALITIES IN FINLAND

Finland is usually somewhere between its Eastern and Western neighbours in mortality statistics, and normally lagging behind Sweden in almost all welfare indicators. Yet life expectancy was not always higher in Sweden than in Finland. In 1751-90 the life expectancy at birth for Finnish men was 1.5 years higher (35.2 years) than that of Swedish men, and for women 0.8 years higher (37.4 years) (Turpeinen & Kannisto, 1997, 19). Living conditions were probably not better in Finland which was part of Sweden at that time, but the country was sparsely populated and people lived in relative isolation, which was an advantage in relation to contagious diseases. By the early 20th century, when Finland had been a Grand Duchy under the Russian Empire for about 100 years, the life expectancy of Swedish men was more than ten and Swedish women more than nine years longer than that of Finnish men and women respectively (Koskinen & Martelin, 2007, 172). In 2015, Swedish men still exceeded Finnish men (78.3 years) by 2.4 years, but Finnish women (with 83.8
years) were only 0.2 years behind Swedish women. A phenomenal improvement in welfare had taken place during the 20th century as life expectancy almost doubled. However, there are considerable socioeconomic differences in health, and they are also considerably larger in Finland (mainly among men) than in Sweden.

Health inequalities were a concern in Finnish social and social medical research as early as the 19th century, but the interest declined in the first part of the 20th century (Lahelma et al., 1996). Shortly after the Second World War, regional and socioeconomic differences in mortality, as well as a very high level of mortality in North Karelia were noted in studies by Väinö Kannisto. Some decades later in the 1970s, the North Karelia project was launched to tackle the high mortality in the deprived area of North Karelia (Lahelma et al. 1996). Research on socioeconomic differences in mortality was retrieved in the late 1970s and conducted more regularly since the 1980s, when Tapani Valkonen and his group made calculations for the Finnish Health for All by the year 2000 national programme (MSAH, 1986). At present, there are good data bases and substantial research on health inequalities in Finland (see e.g. Gissler & Martelin, 2013; Palosuo et al., 2009).

Socioeconomic differences have been found in almost all studied health indicators and also often in the use of health services and outcomes of treatments. Differences in health and illness have also tended to persist, as shown in a large follow-up study in 2000 and 2011 (although differences in chronic illness between the lowest and middle level educational groups had narrowed; Talala et al., 2014). However, differences in life expectancy have since the 1980s clearly increased between educational and social groups (Valkonen et al. 2009), and especially between income groups (Tarkiainen et al., 2012). The gap between the highest and lowest income quintiles increased from 7.4 to 12.5 years for men, and from 3.9 to 6.8 years for women (at 35 years), between 1988 and 2007. One of the important contributing factors to this gap was the increase in alcohol-related mortality.

Inequalities in health have often been more pronounced among Finnish working-age men compared to other West-European men, whereas women tend to be in the middle range in such comparisons (depending on the indicator, age-groups and study period; e.g. Mackenbach et al., 2003; Mackenbach et al., 2008). Comparing Finland and Sweden, the difference in life expectancy (at 25) between high and low educational groups was 6.4 years among Finnish men, but 4.6 years among Swedish men (in 2007-2010). Women were close to each other: in Finland the difference was 3.5 and in Sweden 3.2 years. (Koskinen & Martelin, 2013, 62.) In a recent study of the trends in both relative and absolute inequalities in mortality in Europe between 1990 and 2010, Johan Mackenbach et al. (2016) found that while relative inequalities in mortality had mostly grown everywhere, absolute inequalities had in fact decreased in most European countries, except in Finland and Norway. The stagnation and even decline of life expectancy in the lowest income group in Finland has also been shown by calculating the contribution of amenable causes of death to the increase in differences in life expectancy by income deciles (Manderbacka et al., 2013). Alcohol-related mortality was the single most important contributor to the increase of differences

1. The difference in life expectancy between Finland and Russia is still very large, even if it has narrowed in the past decade, as the life expectancy has increased more rapidly in Russia (and was 64.7 years for men and 76.3 years for women in 2015; World Health Statistics 2016). However, in the mid-1960s life expectancy was practically on the same level in Finland and Russia (Palosuo 2003, 9-10).
in life expectancy between the highest and lowest income decile (between 1996-97 and 2006-07). The researchers concluded that more than half of socioeconomic differences in life expectancy (at 35) were amenable through health policy action (such as alcohol and tobacco policies) or health care, and that this share had increased from the mid-1990s.

PUBLIC HEALTH PROGRAMMES AS A POLICY INSTRUMENT

“When the government is subjugated for serving the citizens, leveling out the living conditions comes to the fore everywhere” wrote Pekka Kuusi (1963, 6) in a book that became the cornerstone of Finnish social policy for the 1960s and 1970s. According to him, everything that prevented ill health was central for health care policy. This meant looking at other fields than just medicine and health care (Kuusi, 1963, 264; see also Sihto & Keskimäki, 2000). Very influential was also the report of the health policy working group of the Economic Council (1972), which stated that the goal of health policy was the best possible health for the population plus its even distribution. The goal was divided into health care and prevention of ill health, and the causes of ill health were to be looked at in the natural sphere and the social sphere. This implied the inclusion of a vast variety of relevant policy areas other than health policy.

Finland has attempted to promote health and equity in health by launching national public health programmes. There have been three national health policy programmes, all of which were linked to the worldwide WHO initiatives and had the reduction of health inequalities as one their main goals. The first was the national Health for All by the year 2000 (MSAH, 1986, in English 1987). Finland was a pioneer country (among some others) for the WHO in the HFA process, partly because of having successfully shifted the emphasis in health (care) policy from hospital-based specialised care to primary health care in the 1970s. One of the instruments in this shift was a system of multifunctional health centres at the municipalities. The Finnish HFA-programme was evaluated by a WHO expert group and revised in 1993, in order to meet better the equity goal, which had not been sufficiently addressed (e.g. Sihto & Keskimäki, 2000, 279; Leppo, 2013).

The third programme, Health 2015 (MSAH, 2001) for 2001-2015 followed the WHO Health 21–programme. For the first time a quantitative target was set for reducing “mortality differences between the genders, groups with different educational backgrounds, and different vocational groupings by a fifth” (MSAH, 2001, 18). The programme was supported by a National Action Plan to Reduce Health Inequalities in 2008-2011 (MSAH, 2008; Melkas, 2013). The aim of this Action Plan was to draw attention to the social determinants of health and appropriate social policies to reduce inequalities through them (for example, by means of improving income security and education, and reducing unemployment and poor housing). However, the actual measures on such determinants were few and were left to the responsibility of other sectors. According to evaluations concerning the Action Plan, it was successful in raising awareness among relevant actors and was perhaps instrumental in a few policy decisions (such as increasing tax on alcohol and tobacco).2 The socioecon-

2. Health 2015 has been evaluated in three and the Action Plan in two separate evaluation reports and commented in several other health policy assessments (e.g. Rotko et al. 2011; Mikkonen 2012; Palosuo et al. 2013). It is not possible to summarise the conclusions from the different evaluation reports in a concise way in this article.
omic target of Health 2015 has not been reached, as the trend has been in the opposite direction (Tarkiainen et al., 2012). However, the gender difference in mortality has narrowed.

REDUCING INEQUALITIES IN HEALTH IN OTHER PUBLIC PROGRAMMES AND STRATEGIES

For the moment, there is no separate national public health programme. However, the objective to reduce health inequalities has been expressed in several strategies and other programmes of the Ministry of Social Affairs and Health (e.g. Sihto et al., 2009). Reducing health inequalities was kept on the agenda in two extensive development programmes coordinated by the Ministry of Social Affairs and Health, with sub-areas directed at regional and municipal level (KASTE I in 2008-2011, KASTE II in 2012-2015) (see e.g. Mikkonen 2012).

All government programmes since 2003 (2007, 2011 and 2015) have raised health inequalities on their agenda during their four-year government terms. One of the key projects of the present government (2015-) concerns promotion of health and welfare and reducing health inequalities. Its three sub-projects focus on 1) good practices (targeting low-income families, low-income workers with low-level education, lonely pensioners with low pension, and persons with mental health and substance abuse problems), 2) healthy buildings and 3) forming permanent structures for cooperation in welfare and health between different ministries. In contradiction to the aims of this government key project, the government is planning to liberate alcohol policy considerably in ways (for example, allowing sales of strong beer and mixed alcohol beverages in groceries, extending the hours for alcohol sales and loosening control in restaurants) that are likely to increase alcohol consumption and alcohol-related harm, and subsequently also health inequalities.

The third sub-project is related to a central strategic approach in Finnish health policy, ‘Health in All Policies’, which reminds all policy sectors of their influence on and responsibility of people's health and emphasises the need for cooperation and intersectoral action (see e.g. Melkas, 2013). Intersectoral cooperation has indeed been successful in Finland in policy areas targeting nutrition, exercise, taxes on consumption, occupational safety and environmental health, but the equity goal has mostly not received special emphasis in those contexts (see Melkas, 2013). At the same time, the old instruments for multisectoral cooperation (multisectoral Advisory Committee for Public Health and a regular social and health care report to the Parliament which has given an account on such activities) have been discontinued.

The present government³ is also preparing a major reform of the social and health care system. The aim is to organise social and health care ‘on broader shoulders’ than the over 300 municipalities that are currently responsible for social welfare and primary health care locally in Finland. According to the government proposition, a new county level electorate will be legislated to manage the services on the county/regional level. One of the aims of the reform is to integrate social services and health care better with each other, which is expe-

³ The present majority government (2015-) is formed by the Centre Party, Conservative Coalition Party, and Finns Party.
cted to reduce welfare and health inequalities. All services will have to be formed into companies (county level social and health centres), in order to ensure full transparency of the costs. The various public, private and third sector producers will have to compete both for the public finances (provided mainly by the state), and for the ‘customers’. The key concepts in the reform are competition and freedom of choice. An important aim of the reform is to reduce the ‘sustainability deficit’ which is expected to develop with the aging population and the increasing social and health care costs, but also to improve access to public health services by increasing the supply and choice of services (MSAH & Ministry of Finance, 2016). The Swedish health care reform with its emphasis on freedom of choice has been one of the sources of inspiration in the Finnish planning, but the criticisms that have appeared in Sweden concerning the negative consequences for equity of such a reform (e.g. Dahlgren, 2014; Burström, 2009) have not been widely discussed.

**DISCUSSION**

The rather poor state of the population health and also its uneven distribution were a great concern in the 1960s and 1970s in Finland. This situation stimulated considerable innovations in developing public health policies and their systematic evaluation during those decades (e.g. Leppo, 2013). In an international context, Finnish researchers were among the first to study health inequalities and mortality differences after the Second World War. Since the 1980s, Finland has attempted to promote public health and reduce health inequalities through public health programmes. During these decades, the overall health has improved and life expectancy has increased in all social groups, except the lowest income quintile. Differences in mortality between the social groups have widened. Finland is not alone in this development. It has been considered something of a paradox that the Nordic egalitarian welfare states have similar health inequalities as less egalitarian welfare states (e.g. Hujts & Eikemo, 2009; Mackenbach, 2012). The reasons for such a development are not self-evident. In Finland the lagging behind other West European countries in life expectancy and the greater health inequalities might be connected with the history of an exceptionally rapid structural change of the society after the II World War, the relatively late development of the welfare state and its almost immediate weakening since the 1990s, and the smoking and drinking habits that may be Finnish or Nordic, but also connect Finland culturally with its East European neighbours and history.

The long line of the Finnish health policy may be at the cross-roads. The experiences and lessons from the history of health policy programmes in Finland or elsewhere have not lent much faith in their power specifically to reduce health inequalities (e.g. Mackenbach, 2010; Mackenbach, 2012). This may be understandable, considering how such programmes tend to be split into numerous small projects, lack sufficient coordination, and leave the root causes untouched. It may, nevertheless, be important to repeat and keep the goal of a more even distribution of health on the political agenda in some form, and per-

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4. This is a huge reform and it has been on the agenda of several governments in some form and has so far taken different turns.
5. It is not yet known in exactly what form the health and social care reform and the new alcohol law will take after they have passed through the parliamentary decision process.
haps become more sophisticated and clear about the mechanisms of how inequalities in health are produced.

The work and initiative of the Commission on Social Determinant of Health (CSDH, 2008) has been a source of inspiration worldwide in this respect and has brought back the ethical issues of social justice that were expressed already in the Constitution of the WHO in 1946. The main message of the CSDH is that health inequalities can be reduced by reducing social inequalities and addressing social and structural determinants of health. This requires political decisions that would deal with economic inequality, unfair division of labour, poor working conditions, deficiencies in health and social care and other unfair conditions and policies.

Finnish health policy has in many respects been in accordance with the views presented by the Commission on Social Determinants of Health, at least rhetorically, and has underlined the social conditions that have direct or indirect impacts on health and health inequalities (Palosuo et al. 2013). However, the power-related and ideologically sensitive questions of the redistribution of resources have not been directly and clearly addressed in health policy documents and action, not even in the Action Plan to Reduce Health Inequalities (MSAH, 2008). The actual conditions in society have become less favourable to health equity, and the Finnish welfare model has become less universal and less generous than it used to be in the early 1990s (Blomgren, 2012, 119). As Blomgren and her colleagues (2012, 119) have noted, Finnish society appears to have shifted from politics of redistribution to “politics of responsibility”, which does not refer to collective responsibility but individual. This development seems to be rather opposite to the recommendations of the CSDH. Also, the Commission was not in favour of increasing and letting the market decide on health care services, which now seems to be an important thread in the Finnish health care reform.

Many analysts connect changes like these to the larger picture of shifting the focus from a national welfare state or a planning state to a competitive state (e.g. Alasuutari, 2006; Heiskala, 2006). Another umbrella term for this shift is neoliberalism, by which we refer to the economic and political changes which had started within the OECD, the United States and Great Britain earlier (e.g. Julkunen, 2006; Patomäki, 2007). The health care reforms of the current government as well as the plans to pursue a more liberal alcohol policy seem to fit a neoliberal framework as well (see also Leppo, 2010; Melkas, 2013).

CONCLUDING REMARKS

In politics and health policy, it is easy to agree on the value of health, which is one of the least arguable values in people’s minds. However, when dealing with health inequalities, it is necessary to understand, how social inequalities evolve and are produced in the pro-

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6. Neoliberalism is a contested concept, but there seems to be agreement on some of its characteristics in comparison to classical liberalism. In neoliberal ideology the state is not something to get rid of, but rather, the state is being used for the protection of private ownership. A large public sector is accepted in a way which allows the market to operate within the public sector – which seems to be the line for the health and social welfare reform at present. “New public management” is the doctrine for neoliberalism, emphasising objective unambiguous accounting and detailed management. Thus, while operating within democracy, neoliberalism tends to narrow its limits (Patomäki 2007, 27-30).
cesses of social stratification (e.g. Mackenbach, 2012). When narrowing health inequalities is a policy goal, inequality needs to be addressed through the social determinants of health, which will necessarily raise questions of the distribution of resources and social justice. This means that conflicts of interest between different power groups, as well as ideological disagreements have to be dealt with (CSDH, 2008; Palosuo et al., 2013). It is something of a challenge for health and welfare policies to understand the long chains of causality in social epidemiology and convert and apply this knowledge to practical policy measures. It also means an epistemological jump from causal to finalistic logic: in the field of policy it is the ends that need to be defined (in more or less complicated political negotiations) and the task is to find appropriate means to those ends.

In our study on the barriers that hamper policies to reduce health inequalities in Finland, we ended up proposing continued efforts to improve the position of the poor and marginalised groups, tackling unemployment and working conditions, correcting inequalities in health services, and conducting stricter alcohol policies (Palosuo et al., 2013). Some of these seem to be on the agenda of the present government, while some initiatives like those aiming to liberate alcohol policies are clearly opposite to health and equity goals.

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