

**Pekka Puska**  
**Pääjohtaja**  
**Terveyden ja hyvinvoinnin laitos (THL)**

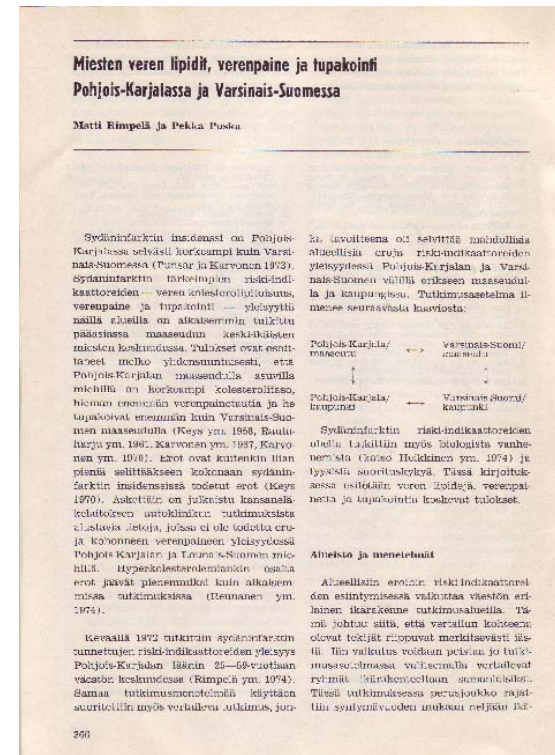
# **KROONISTEN KANSANTAUTIEN EHKÄISY 2010-LUVULLA – MITÄ OLEMME OPPINEET? NELJÄN VUOSIKYMMENEN AIKANA?**

Väestön terveyden edistäminen tutkimuksen  
ja päätöksenteon haasteena –seminaari  
Säätytalo, Helsinki 3.2.2009

NATIONAL INSTITUTE FOR HEALTH AND WELFARE



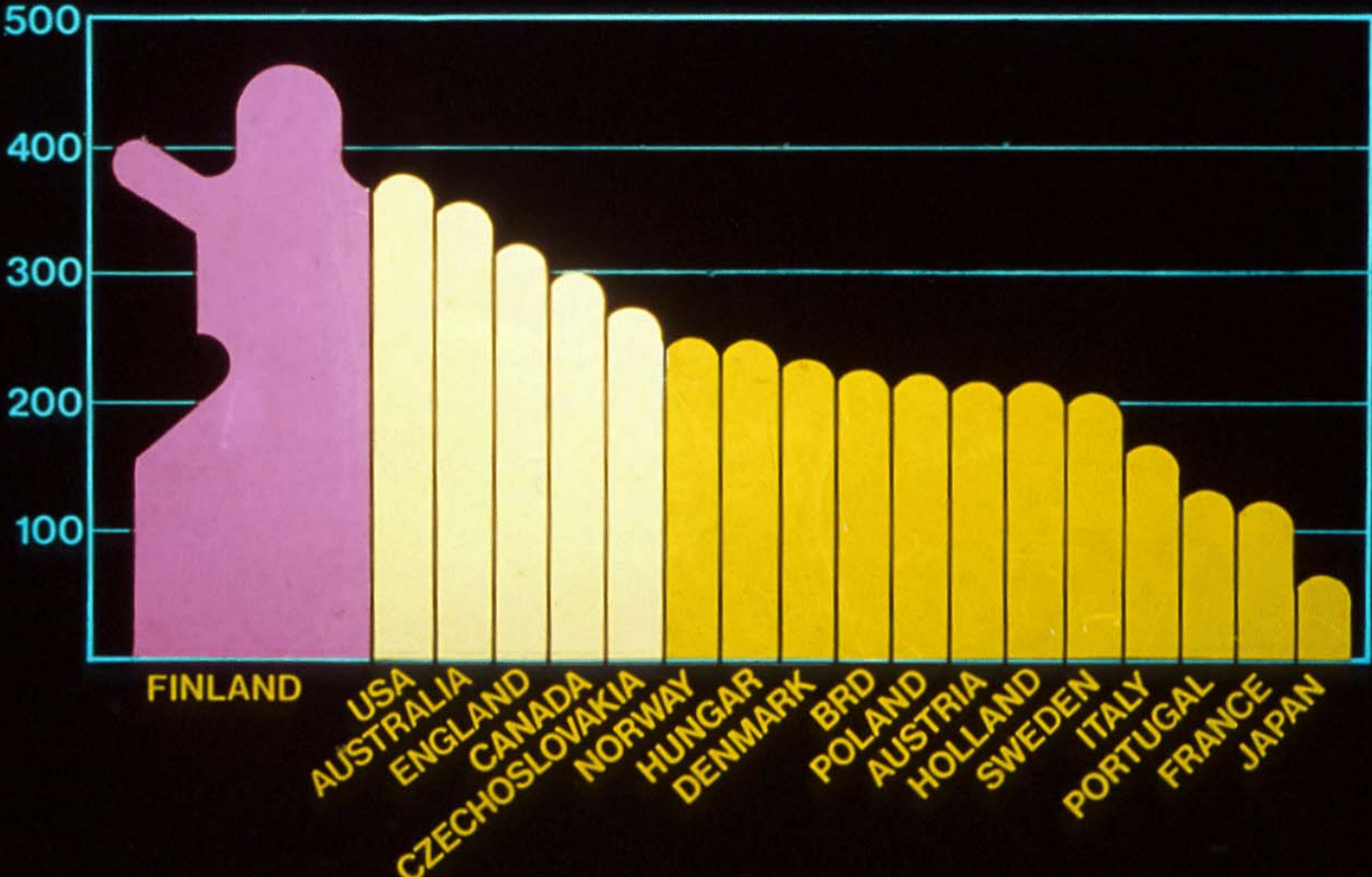
# Matti Rimpelä



# MORTALITY RATES OF ISCHAEMIC HEART DISEASE AMONG MEN IN SELECTED COUNTRIES



CHD mortality per 100.000 men in 1973



# NORTH KARELIA PROJECT FINLAND



National Public Health Institute



# North Karelia Project Principles for Defining the Intermediate Objectives



- Due to the chronic nature of CVD, the potential for the control of the problem lies in primary prevention
- The risk factors were chosen on the basis of best available knowledge:
  - previous studies
  - collective international recommendations
  - epidemiological situation in North Karelia
- Chosen risk factors:
  - smoking
  - elevated serum cholesterol (diet)
  - elevated blood pressure



# From Karelia to National Action



## Major Elements of Finnish National Action 1.

- Research & international research collaboration
- Health services (especially primary health care)
- North Karelia Project, other demonstration programmes
- Health Promotion Programmes (coalitions, NGO's, collaboration with media etc.)
- Schools, educational institutions



## Major Elements of Finnish National Action 2.



- **Industry, business – collaboration**
- **Policy decisions, intersectoral collaboration, legislation**
- **Monitoring system: health behaviours, risk factors, nutrition, diseases, mortality**
- **International collaboration**

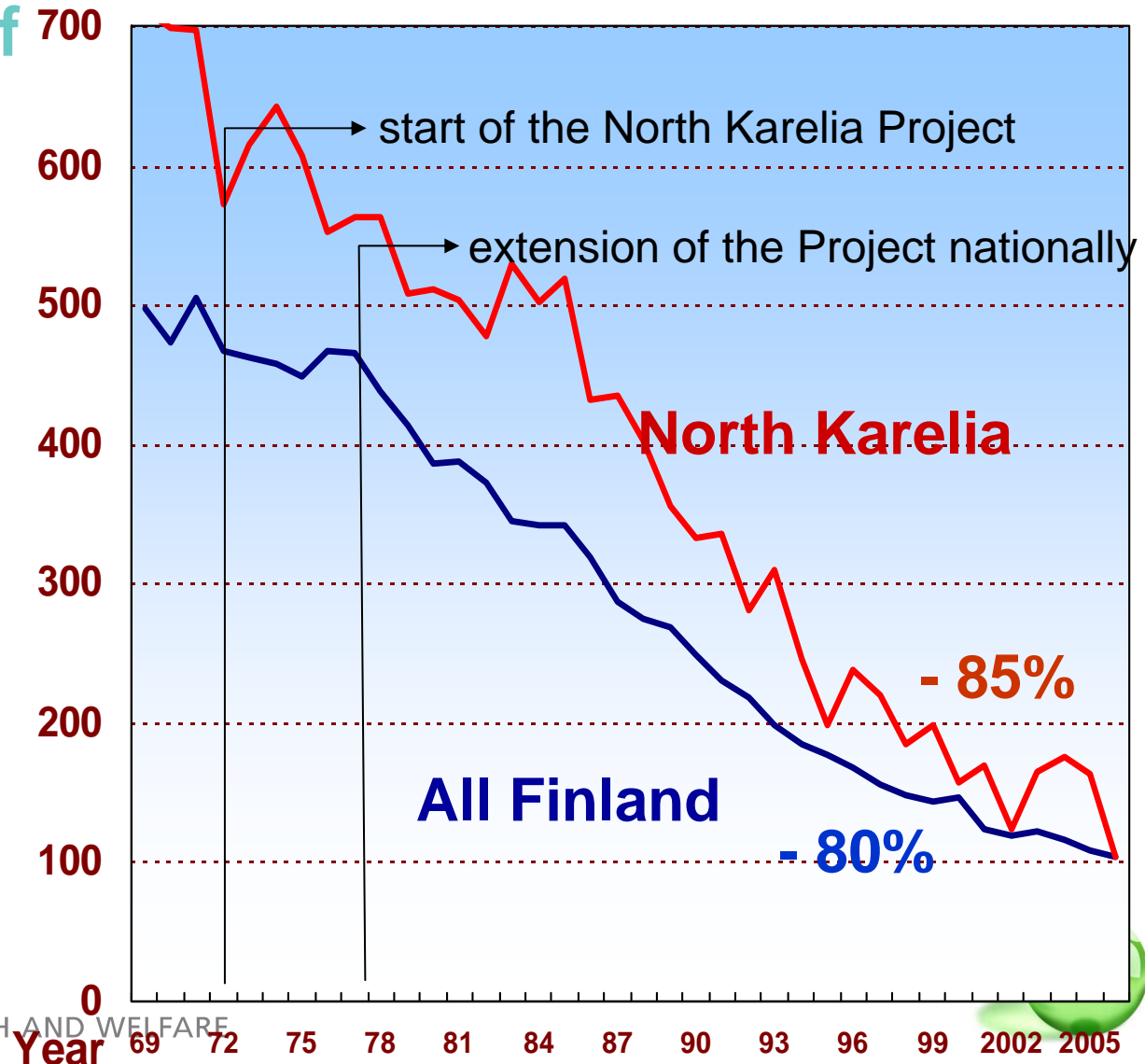


# Age-adjusted mortality rates of coronary heart disease in North Karelia and the whole of Finland among males aged 35–64 years from 1969 to 2006.

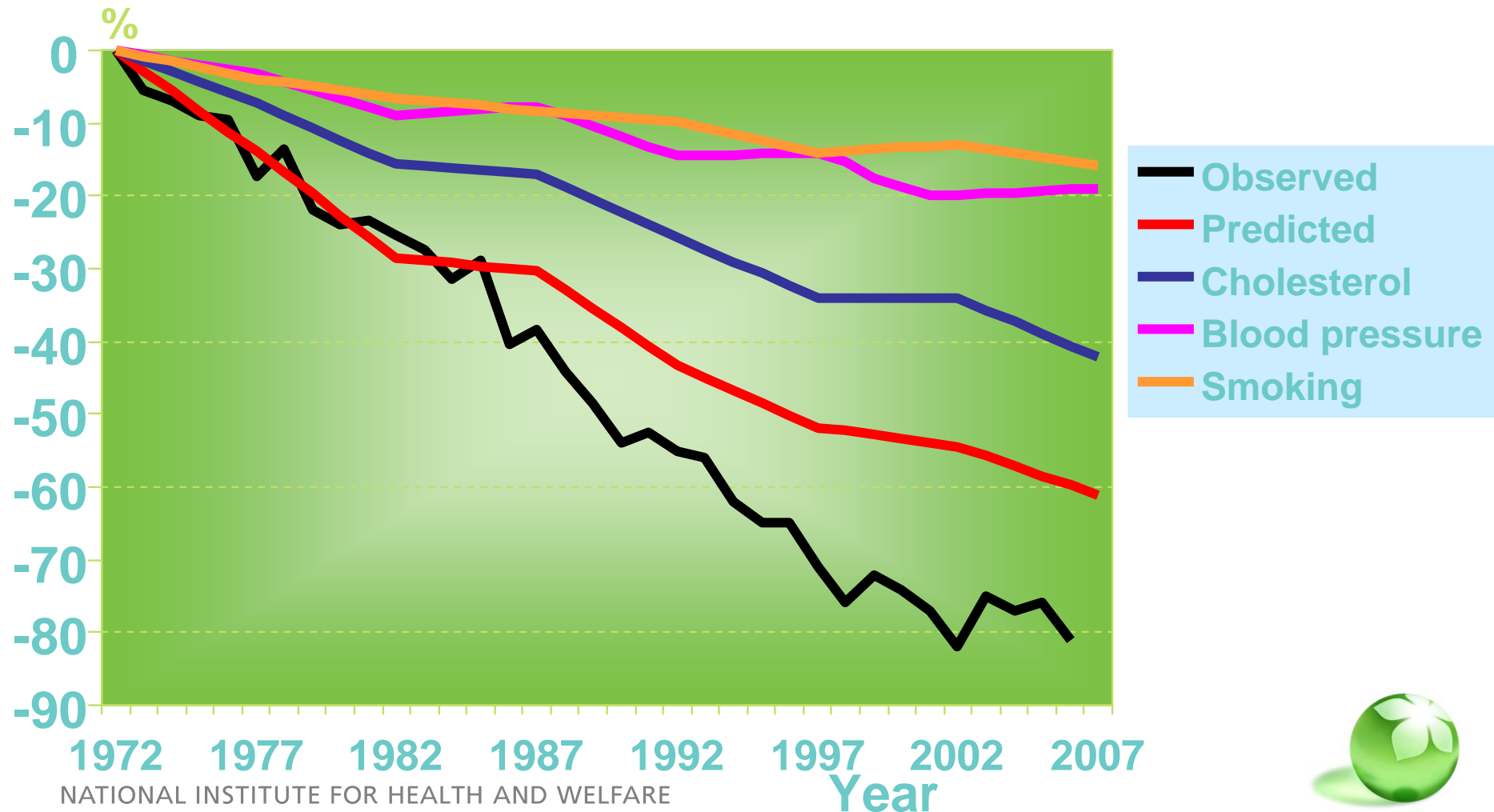
and the whole of Finland among males aged 35–64 years from 1969 to 2006.

Mortality per 100 000 population

Age-standardized to European population



# Observed and Predicted Declines in Coronary Mortality in Eastern Finland, Men



# Mortality Changes in Finland from 1969–71 to 2006 (Men 35–64 Years, Age Adjusted)

	Rate (per 100.000)		Change from 1969–71 to 2006
	1969–71	2006	
All causes	1328	583	- 56%
All cardiovascular	680	172	- 75%
Coronary heart disease	489	103	- 79%
All cancers	262	124	- 53%



# Finland Has Shown



- Prevention of major chronic diseases is possible and pays off
- Population based prevention is the most cost effective and sustainable public health approach to chronic disease control
- Prevention calls for simple changes in some lifestyles (individual, family, community, national and global level action)
- Influencing lifestyles is a key issue
- Many results of prevention occur surprisingly quickly (CVD, diabetes) and also at relatively late age
- Comprehensive action, broad collaboration with dedicated leadership and strong government policy support

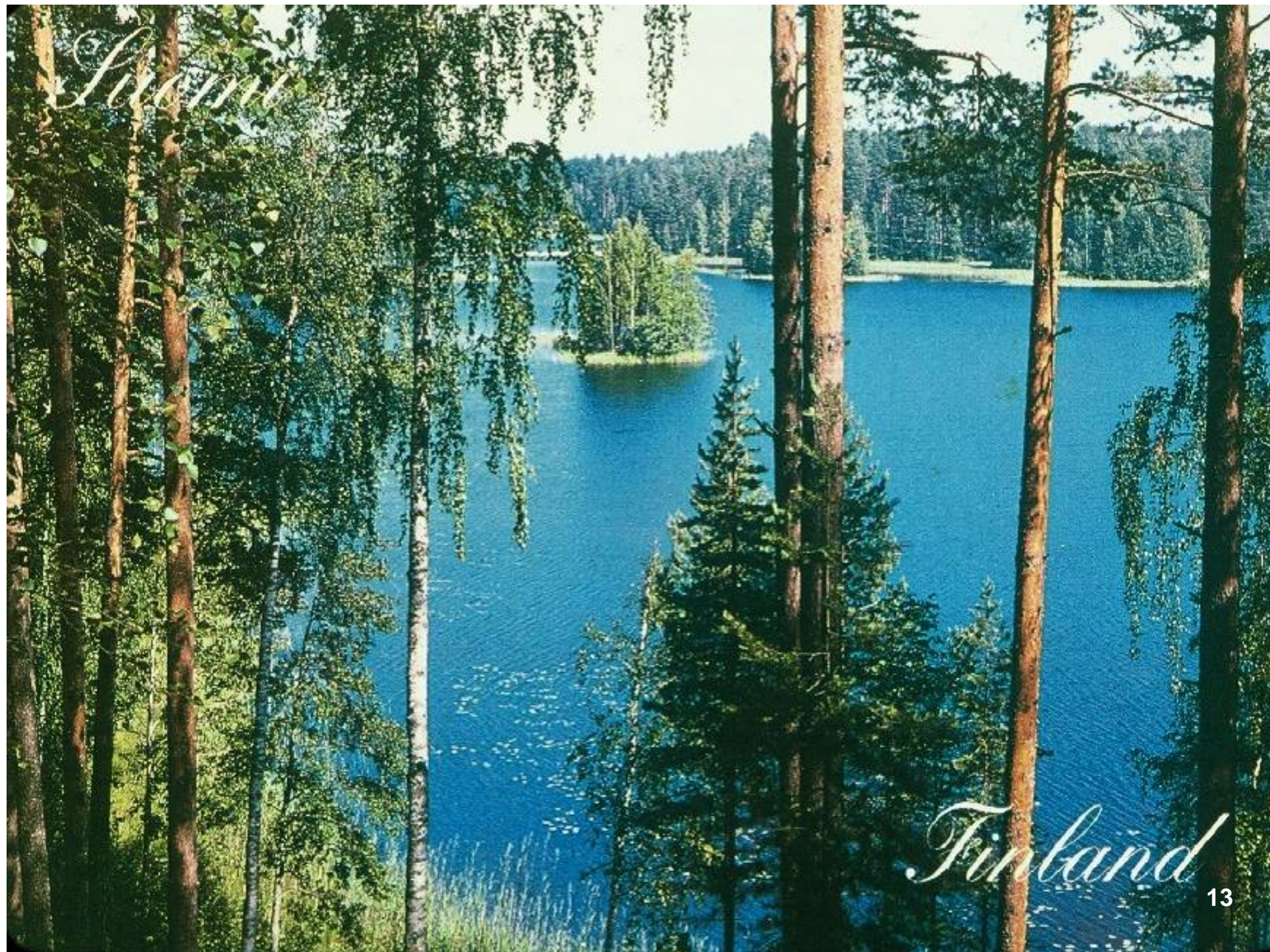


# Why success in North Karelia



- Appropriate epidemiological and behavioural framework
- Restricted, well defined targets
- Good monitoring of immediate targets (behaviours, process)
- Flexible intervention
- Emphasis in changing environment and social norms
- Working closely with the community
- Positive feedback, work with media
- International collaboration, support from WHO
- Close interaction with national health policy, integration with National Public Health Institute
- Long term, dedicated leadership

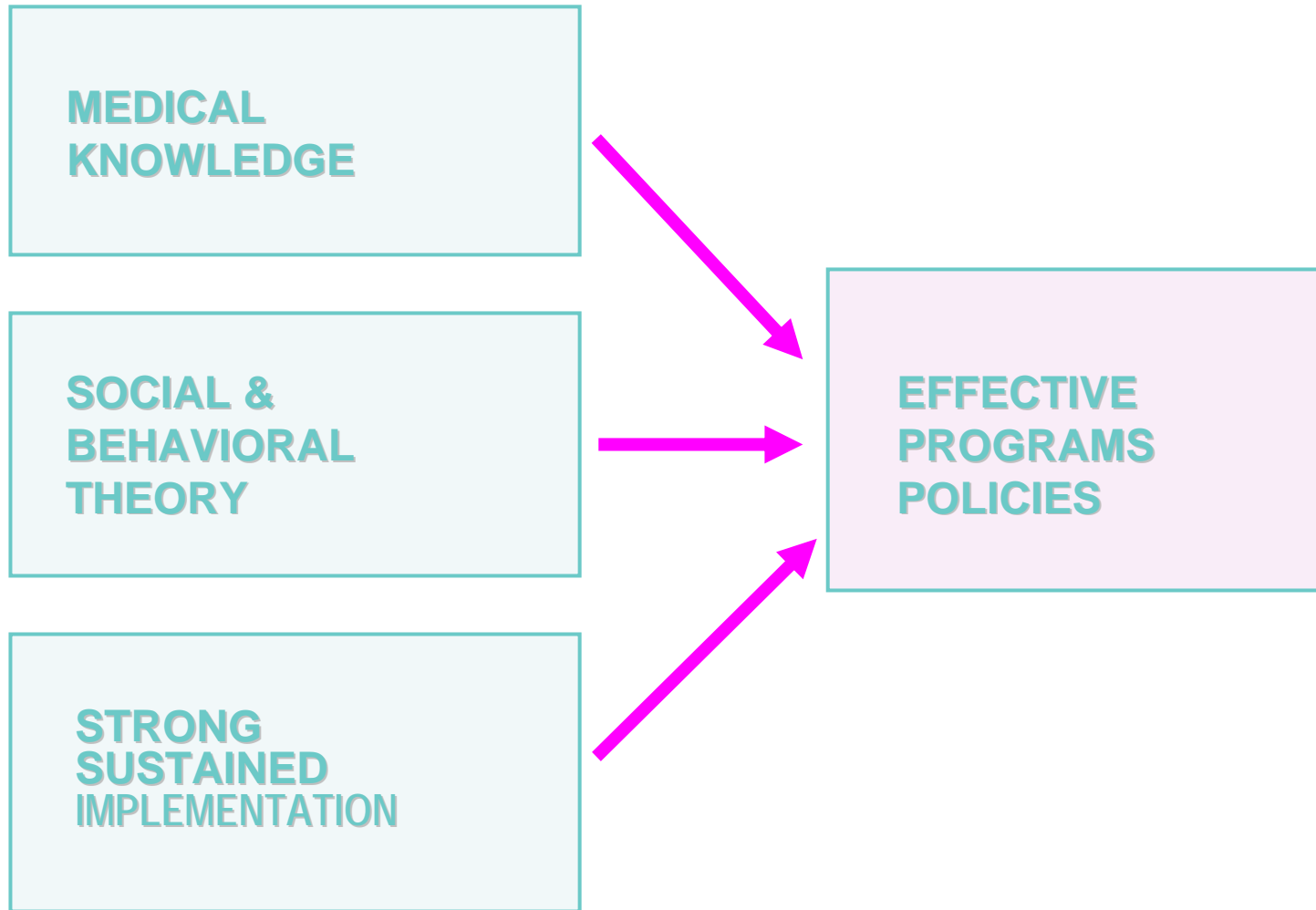




*Suomi*

*Finland*

# Theory + Action



# Lifestyles in Key Position

- Individual health
- Population health

➔ **ATTENTION TO DETERMINANTS OF  
LIFESTYLE CHANGES**



# Two Prevention Strategies

- 1) High risk strategy (individual)
- 2) Population strategy (public health)



# Whose Responsibility

- **Personal Responsibility**

**”Nobody can take better care of your health than yourself”**

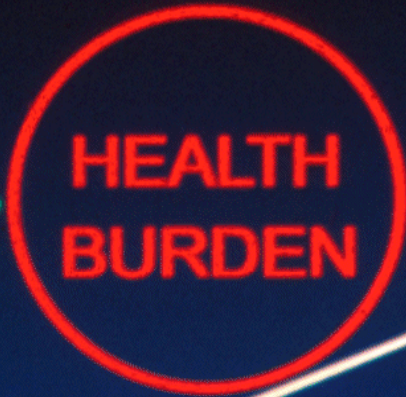
- **Public Responsibility**

**”Make the healthy choices the easy ones”**

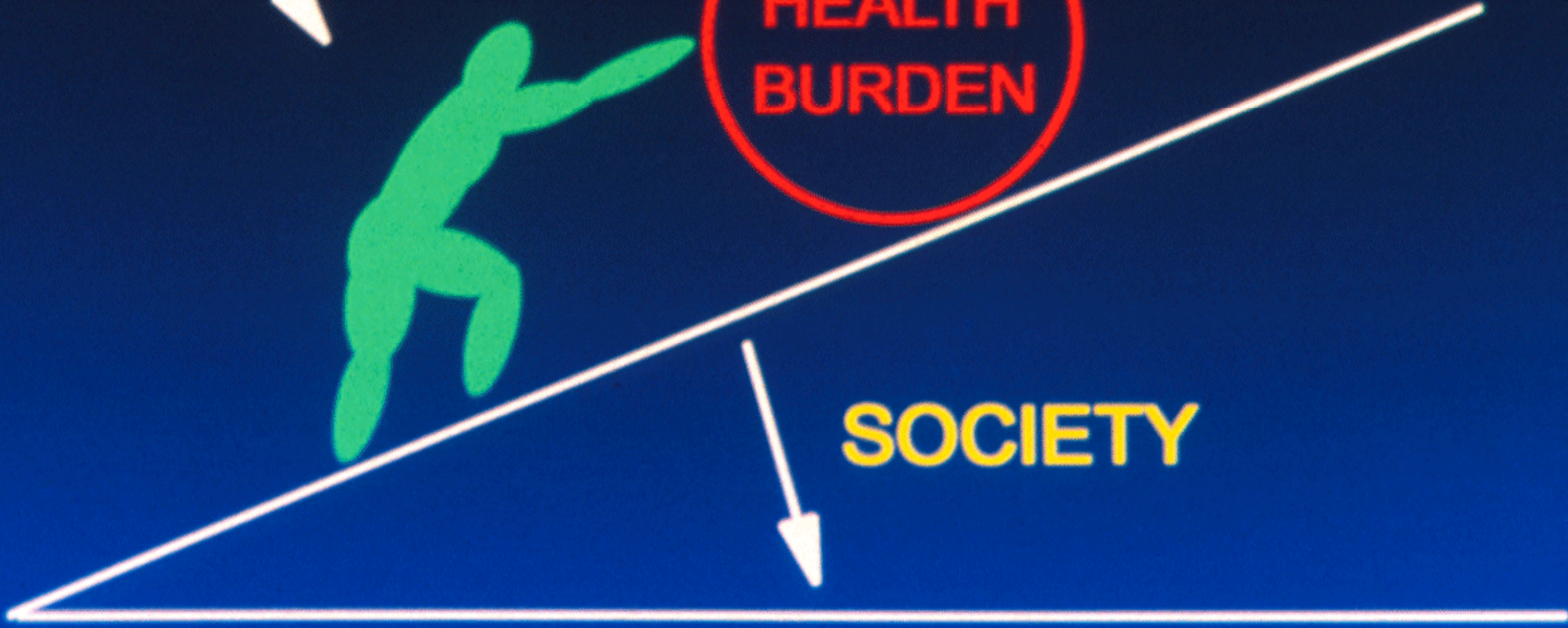
*(Ottawa charter)*



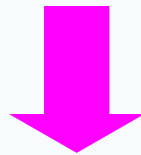
**INDIVIDUAL**



**SOCIETY**



**PUBLIC RESPONSIBILITY**



**POLICY INTERVENTIONS**



# Contents of Policies

## ”Stick & Carrot”

- **Restrictions and enabling actions**
- **Good mix**



**THE MAIN CHALLENGE IS NOT WHAT TO DO, BUT HOW TO DO!**

**➔ ATTENTION TO THEORY BASED BUT PRACTICAL IMPLEMENTATIONS.**

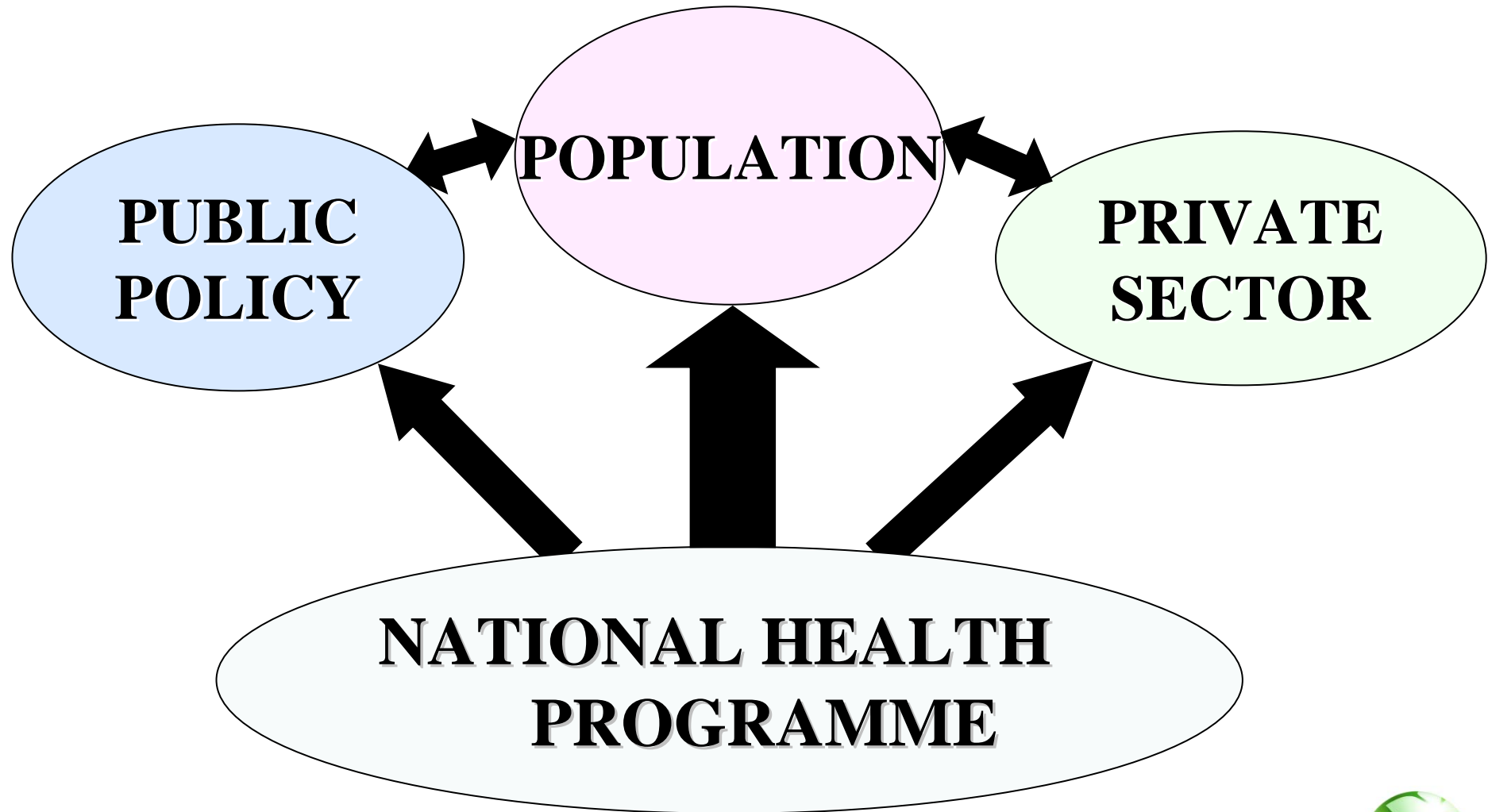


**During the last few years there has been produced a great number of strategies and plans for evidence -based, effective health promotion and health policies.**

**MANY IMPORTANT PRIORITIES  
HAVE BEEN IDENTIFIED.**



# How to Promote Policy Changes?



# Complex Process of Social Change

“Usually, environmental and policy decisions are key, but such can often be achieved only in health promotion activities that influence the public agenda and people’s intentions. At the same time, the human factor is crucial: persistent and dedicated work is needed, combining enthusiastic and credible leadership with also involvement of, and ownership by, the population.”

*Puska 2005. In Coronary Heart Disease Epidemiology (Marmot & Elliott, eds.)*



# CHALLENGES FROM GLOBAL TO LOCAL



**PUBLIC HEALTH IN ANY COUNTRY  
IS INCREASINGLY DETERMINED BY  
GLOBAL INFLUENCES:  
communication, trade, people's  
movements, marketing, media, etc.**



**THINK GLOBALLY –  
ACT LOCALLY**



# Global WHO Development

- **FCTC (Framework Convention on Tobacco Control) – 2003**
- **Global strategy on diet, physical activity and health – 2004**
- **Global strategy on alcohol**

***(under preparation)***



# Development within EU

- EU public health strategy
- Health in all policies



# Nationally

**Governments have a  
basic responsibility  
for public health**



# Partnerships

- **Governments (national, local)**
- **Civil society (NGO's)**
- **Private sector**
  
- **International collaboration**



# Health Services

- **Good primary health care with in balance with hospital care**
- **Health services in interaction with other community activities and general health promotion**
- **Availability and training of health personnel**
- **Use of IT technology**



# Private Sector

- **Commercial issues of increasing impact to public health**
- **Health is increasingly important business argument**
- **Product development, marketing**
- **Social responsibility? Regulation? Market push?**



# Civil Society

- **The role of civil society increasing in most countries**
- **NGO's: mobilize people, serve people, watchdogs, etc.**



# Health Promotion 1.

- Top down?
- Bottom up?
- Blended model?



# Health Promotion 2.

## Entry points

- 1) Diseases, health problems
- 2) Risk factors (behavioural, biological)
- 3) Determinants



# Health Inequalities as Challenge

- **Positive developments in lifestyles and service use greater in higher SES**
- **Many determinants put lower SES in disadvantaged position**
- **Attention to structural intervention (policies) + specific programmes in disadvantaged groups**



# Evidence for Policy

- Evidence on causes of diseases
  - risk factors
  - disease mechanisms
  - determinants of risk factors
- Evidence on intervention effectiveness
  - "clinical interventions"
  - health promotion interventions
  - policy interventions
- Evidence is not the only driver of healthy policy!



**PUBLIC HEALTH DOES  
CHANGE AND CAN BE  
CHANGED!**



# Final Recommendation

- 1) DO THE RIGHT THINGS AND DO ENOUGH OF IT
- 2) COMBINE LEADERSHIP WITH BROAD PARTNERSHIP





*Suomi Finland*