Abstract: Swedish public health policy clearly illustrates how the concept of the Ottawa Charter for health promotion can be utilized at a national level. The impact has been more implicit than explicit. Public health has a long history in Sweden and much of the present and future is, and will be, linked to traditional values and structures. International input, however, has been essential to prompt new approaches and change. Health inequalities remain the major shortcoming. The Swedish system offers universal access to healthcare in a decentralized system. Still, primary healthcare, and the health services as a whole have not yet sufficiently embraced the idea of health promotion. Political attention to modern public health at the Prime Minister level was established in late 1980s. Since, continuous initiatives in terms of organization, infrastructure and funding have taken place. With regard to funding, a vast majority of the resources allocated to health promotion will be found outside the health sector. An interesting observation is that the Swedish public health policy with its 11 objective domains remains the same, also after a change of government. Future challenges include maintaining and developing an intersectoral mechanism for implementation, allocating more resources for intervention research to strengthen knowledge-based health promotion, and developing tools for coping better with the challenges of globalisation identified in the Bangkok Charter. (Promotion & Education, 2007, XIV (4): pp 244-249)

Key Words: health determinants, governance, implementation, welfare

Résumé en français à la page 286. Resumen en español en la página 280.

There is at least a 300-year history of organized public health in Sweden, which in parts links to today’s health promotion concepts. This history had been led by the governing and public structure, formally represented by the King but since the beginning of the 20th century by a pluralistic democratic structure. The State Church, and the popular movements represented by the free churches, trade unions, workers movement, temperance organisations and sports movement have also been significant influences (Sundin et al., 2005). During the Swedish manufacturing and industrial development in late 19th and dawn of the 20th century, the workers and their families health became an issue for the proprietors of local industrial communities, mainly in mining, forestry, iron and steel production, and hydro power plants. Local enterprise-based systems included medical services, basic education, food supply and recreational activities.

Social reforms paved the way during the 1930s for the foundation for what became a welfare society. The guiding principle was to establish an inclusive society. Different views on whether this was top-down social engineering, paternalistic governance for peoples own good or the outcome of a democratic bottom-up process is still an issue for debate, politically as well as scientifically. Part of this social reformation was the institutionalisation of new national state agencies, and among them a national institute of public health (Statens institut för folkhäl- san), which existed up to 1969, and can be seen as a predecessor of today’s Swedish National Institute of Public Health (SNIPH).

Health and medical care in Sweden is based on a national framework legislation (HSL, 1984) combined with a decentralized, tax-based system guaranteeing universal coverage for the delivery of services, but a state transfer of funding for maintaining equal access to and equal standard of the services. All citizens are covered by a comprehensive public social insurance guaranteeing them universal access to the general welfare system and care on equal terms. Health services are provided by 21 regional bodies. Those County Councils/Regions are autonomous, publicly governed and elected with taxation rights and are held accountable for the delivery of these services. Caring of the elderly is further decentralised to the municipalities, 290 autonomous local authorities, with their own taxation rights. Also at the local level there is a state transfer of funding to enable equal opportunities for citizens, regardless of where they are living.

Over the past 40 years the Swedish population has changed significantly. A stable and continuous growth occurred in the 30 largest cities and municipalities. An increasing proportion of immigrants from all over the world are represented. Sweden has become both multi-cultural and multi-lingual, facts posing new challenges to society at large and for health promotion to manage complex contextual issues. The total population in 2006 exceeds 9 million citizens of which 15 percent were born abroad. People of Finnish ethnicity are the largest subgroup.

Hospital or primary care approach, conflict with physicians

After World War II the development in public health came to a crossroad. One road pointed toward an extensive develop-
Correlation

Figure 1. Principal model for the Swedish national public health policy

The Swedish public health policy overall aim and objective domain

THE SWEDISH PUBLIC HEALTH POLICY
One overarching aim: To provide societal conditions for good health on equal terms for the entire population

11 Objective domains in brief

9-11: Physical activity
- Eating habits and safe food
- Tobacco, alcohol, illicit drugs, doping, harmful gambling

Lifestyles and health behaviours

4-8: Healthier working life – Sound and safe environments & products – A more health promoting healthcare system – Effective protection against communicable diseases – Safe sexuality and good reproductive health

1-3: Participation and influence on the society – Economic and social security – Safe and favorable growing-up conditions

Societal structures and living conditions

International inspiration and domestic surprise

A catalyst for public health was the launch of Health for All in the World Health Assembly of 1977 and the Alma Ata declaration in 1978 (WHO, 1978). The new Health and Medical care act of 1985 gave disease prevention legal status (HSL, 1984). The 38 WHO European health for all targets (WHO, 1985) and the Lalonde report (Lalonde, 1974) became triggers for disease prevention among County Councils, which had started in 1979 to develop comprehensive regional health promotion plans. The Ottawa Charter was published in Swedish (Socialstyrelsens h-nämnd, 1987) and was repeatedly referred to in regional health programmes and plans. In the mid 1980s, the state level was activated by the National Commission on Health services (SOU, 1984:39), which, among other priorities, highlighted the need for more and better prevention. In light of this, the first modern Public Health Report (PHR) since 1910 was published in 1987 (Socialstyrelsen, 1987), revealing surprising socioeconomic differences in what was perceived as one of the most egalitarian countries of the world. PHRs are now published regularly, and the latest (Persson et al., 2006) revealed a continuation of health inequalities. The inequalities issue has prompted governmental action, firstly by establishing the Governments Public Health Group, proposing the re-establishment of a national public health institute (Folkhälsorganisationen, 1991). Before this time health promotion and disease prevention were issues at the margin of the political agenda (Ekulund & Pettersson, 1987). The National Public Health Committee was appointed and delivered the proposal for a national public health strategy for Sweden in 2001 based on 18 measurable objectives (SOU, 2000:91, 2000).

All representatives from parliamentary parties in the Commission, with the exception of the Moderaterna lend in principal their support for the policy. Sweden can be considered a fairly homogeneous and stable political society. Since the 1930s the Social Democratic Party has had majority power, sometimes in a coalition, or agreed collaboration with other parties, with the main features of a general welfare society remaining. The new Alliance government, a four party coalition (New moderatearna, Christian Democrats, Centre Party and Liberal Party), taking office from 2006, has proposed and started to implement profound changes in social welfare benefits concerning the unemployment insurance, pre-retirement allowances and sickness leave compensations. There are comprehensive efforts to increase employment opportuni-
The function of a special Public Health Minister in the Cabinet remains but is now renamed as the Ageing and Public Health Minister.

The funding is increasing and will be allocated for alcohol and illicit drug prevention, and a general increase of 115 SEK annually over the next three years is also proposed, (Prop 2007/2008:1, 2007) giving priority to mental health, improved food habits, physical exercise, and parental support among others. The core funding of the SNIPH remains about the same.

Initially statements were made from the new government about changing the structure and foundation of the public health policy. Currently, a new public health bill is in preparation, building on the present structure, but putting stronger emphasis on a limited number of priorities and emphasising more concrete actions. A possible interpretation is that public health in Sweden is not a controversial subject from an ideological point of view.

To sum up, health promotion stays on the political agenda, but the change of Government will determine the extent to which political ideologies and values will impact on existing public health policy. The new Public Health Minister has announced in public speeches some changes in the public health policy concerning the need for more quantitative targets that can be more accurately monitored, and a better response to evaluation of the impact and efficiency of different interventions. Repeatedly gathered information from County Councils/Regions and municipalities indicates strongly that public health continues to be a priority on the regional and local levels (Hammerslag, 2004; Noor, 2005). Health policy is cutting across many sectors and government departments. In order to make this work a number of steps have been taken. Within government there is a long held procedure with a joint cross-departmental preparation of new political initiatives in order to align all proposals. This is necessary since all decisions by the Swedish government are made collectively, and not by single Ministers. The SNIPH was appointed as the focal point for the monitoring process and to provide support for the implementation of public health policy (SFS 2001:309, 2001) to be presented in the first Public Health Policy Report in 2005 (Statens Folkhälsoinstitut, 2005a). It embraces 30 health related policy areas out of a total of approximately 50 officially recognized areas of policy. For those 30 policy areas, objectives and targets already exist and include the determinants covered by the 11 objective domains. Therefore, no new targets were introduced, something that was intended to facilitate other sectors' commitments and to integrate the implementation into everyday business.

The government has also commissioned responsible sectoral state agencies at national and regional level to report on the PHPR about their fulfilment of the strategy. Finally, a national steering committee was established under the Minister of Public Health with Director Generals representing the 20 most concerned state agencies, together with a representation of the powerful Confederation of Regional and Local Authorities, with all 21 County Councils/regions and 290 municipalities as members.

A thorough and intensive consultative process took place over nearly two years in preparation for the PHPR. It was initiated from the top executive management level in order to create the highest possible legitimacy. During this process alliances were created among involved professionals.

Strong efforts were made during the whole process from the Public Health Committee to the first Public Health Policy Report, to link the policy with best available evidence and make it as operational as possible by translating policies into concrete actions. Such an approach relates to the ongoing discussion about what is evidence in health promotion and how to put it into practice. This means that evidence must influence the practice, but also the reverse. The same two-way relationship is valid for evidence into policy and policy into practice, which is illustrated in figure 3.

**National health promotion intersectoral policy established**

In April 2003, the Swedish Riksdag, adopted a national public health strategy for Sweden (Hogstedt et. al, 2004) which was supported by all political parties, except the Moderaterna, although some details caused debate. The policy has one overall aim and 11 objective domains (see figure 2). What makes it different from most other public health policies is that it is solely based on the determinants of health, and not on different health outcomes. Its upstream approach (see figure 1) and overall concept link it to the Ottawa Charter, even if this is not explicitly expressed.

The 11 objective domains in the policy address structural and wider social determinants, settings, environments products and services, as well as lifestyle risk factors, with an interconnection between these determinants on different levels (see figure 2).

The change in political power in 2006 has seen the new Alliance government in its political mission statements shifting the focus from societal to more emphasis on individual responsibility for health, where the role of the family and civic society is highlighted. The following observations on continuity can be made:

- The mission statement from the new government highlighted public health as a priority.
- The function of a special Public Health
Figure 4. HEPS - The health promotion staircase for building local capacity

..."
such as teachers and environmental protection inspectors. During the first part of the economic recession in the early 1990s the impression was that health promotion funding remained the same, while cuts were made in the health and medical care services. Later cuts were also made in health promotion. Consequently, to get value for money by optimal health outcomes, an increasing interest is paid to evidence-based and efficient health promotion activities. Some reviews of reviews have been published but the level of implementation is difficult to judge. The adoption of the Swedish public health policy was not linked to a general increase of monetary resources. Nevertheless, some substantial earmarked funding was raised for alcohol, tobacco and illicit drug prevention and to a lesser extent to counteract harmful gambling. Within health and related budgets, estimates have been made (Landstingsförbundet, 2004), pointing at a figure between 5-7 percent spending on health promotion, which falls within the interval 3-5 percent as presented by OECD (OECD, 2004). After a period of incremental increase in Sweden up to the mid 1990s, this development seems to have levelled out. However, the new Alliance government in its state budget proposal bill for 2008 is targeting illicit drug prevention, with 260 million SEK allocated to this annually over the coming three years. Likewise, another 115 million SEK annually over three years is proposed for mental health, improving eating habits and physical exercise, parental support and strengthened tobacco prevention (Prop 2007/08:1, 2007). However, the main issue about the total volume remains unanswered. To make progress in this respect requires an operational definition of health promotion. One measure to enable this could be the inclusion of health promotion as an item in national health accounts.

Community participation in health

The strategy in the Ottawa Charter to strengthen community action is understood and implemented in Sweden. Following the WHO European Health for all strategy and the introduction of the Healthy Cities concept in the late 1980s, there was a break through for health promotion. The greater Stockholm was formally appointed a WHO Healthy City, represented by the County council. The former Association of Local Authorities built an extensive national Healthy Cities network with more than 100 municipalities subscribed to the agreed criteria and assured political commitment. This development has continued, and currently more than 130 municipalities are politically committed to the Public Health Forum (Forum folkhälso, 2007). A core Healthy City network including 11 municipalities has taken the lead to develop further health promotion on the local level (Nationella Healthy Cities Nätverket, 2007). A book presenting good practices based on implemented health promotion programmes following the Swedish public health strategy has been published (Meiton, 2007). There are also examples of systematic social mobilisation and participation in sustainable social neighbourhood planning. The major problem in the field of community participation is the segregation in sub-urban areas in the larger cities in Sweden including Stockholm, Gothenburg, Malmö and others. In order to support and facilitate a more systematic approach to local health promotion, tools for management, planning and monitoring have been developed by SNIPH as a guide for health impact assessment (Statens folkhälsoinstitut, 2005c), Local Welfare Management Systems (Statens folkhälsoinstitut, 2005d), and Basic Public Health Statistics for Local Authorities (Statens folkhälsoinstitut, 2007). Experiences from the development of health promotion on the municipal level are a multi-step evolutionary process (see figure 4).

Research and information

A key strategy in the implementation of the Public health strategy is a systematic monitoring process. Part of the reorganisation of SNIPH from 2001 was that monitoring and evaluation of public health policies was stated as the Institutes prime remit, and was in place well ahead of the adoption of the national public health strategy. The proposal from the National Public Health Commission to develop a Public Health Policy Report, alongside the Public Health Report that has been published in regular intervals since 1987 on health and risk factor trends, was accepted by the Government and later confirmed by the Riksdag, as part of the adoption of the public health strategy. The PHPR aims at reporting on the fulfilment of the public health strategy, and is based on 36 principal indicators related to the 11 objective domains. This report was first published in October 2005 (Statens Folkhälsoinstitut, 2005a). As part of the monitoring of health behaviours SNIPH together with interested County Councils and has initiated a yearly population survey (60 000 random sample) on health behaviours and other data, which are reported for 2005 and 2006 (Statens Folkhälsoinstitut, 2006). All data can be broken down to the regional level and it is possible to also break it down to local data in those regions where the sample is enlarged.

Fulfilling the role as a National Knowledge Centre is the second remit for SNIPH. A number of reviews and other knowledge-based reports have been published during the past years. In order to support the evaluation of local health promotion activities and the implementation of knowledge-based health promotion practices, a manual is available (Hedin & Kallestad, 2004). To stimulate an active exchange on effective practices, consultations, seminars and workshops are arranged. However, the impression is that there is a long way to go before best practices are used more widely. There is also a lack of multi-disciplinary research on implementation of health promotion interventions in general, and on strategies to deal with social health determinants in particular. A review of Swedish public health research confirms some other results, namely that the vast majority is devoted to describing and analysing health problems (Swedish National Institute of Public Health, 2004).

Conclusions

The principles and concept of the Ottawa Charter are well reflected in Swedish public health policies and practices. In particular, the healthy public policy recommendation was instrumental in developing intersectoral approaches (WHO, 1988). However, the world is a different place in 2007 than it was in 1986. The focus on health determinants was implicit in Ottawa but is not bold enough for today’s world. The concept of supportive environments as developed in the 3rd International Health Promotion Conference in Sundsvall (WHO, 1991, and Haglund et al., 1996) has served as a bridge to a health determinants approach in Swedish public health policy making and in ensuring a balance between individual responsibilities for health and the role of society. Health promotion has entered a phase dominated by globalization, re-emerging and new communicable diseases and a demographic transition with rapidly increasing ageing populations, where countries cannot govern their future in isolation. The Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005) points to the essential roles and responsibilities of governments. The new Alliance government in Sweden will hopefully recommit to the ideas of Ottawa but also draw on Bangkok when it presents the imminent new public health bill.

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