

HEALTH MONITORING IN FINLAND AND THE BALTIC COUNTRIES

Examples and experiences

Toward a surveillance system on the health objectives in Italy
A discussion with international and national experts

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STRUCTURE OF THE PRESENTATION

- 1) Health monitoring system in Finland**
- 2) Behavioural monitoring in Finland and the Baltic countries**
 - origin**
 - method: sample, data collection, questions**
- 3) Examples of results and uses**
- 4) Practical aspects**
- 5) Problems and solutions**

Health Monitoring system in Finland

1. Health Examination survey (Health 2000)

- every 10th year, first in 2000
- random sample of population over 18 years
- health examination, interviews, questionnaires
- health, diseases, functional capacity

2. Finrisk survey

- every 5th year, since 1972
- regional samples, stratified by age, 25 -74 years
- some measurements, interview, questionnaire
- risk factors of chronic diseases

3. Health behaviour survey

- every year, since 1978
- random sample of population, 15-64-years
- self-administered mailed questionnaire
- health behaviours, self-assessed health
- separate questionnaire for the elderly (65-84), every second year

Behavioural monitoring in Finland and the Baltic countries - FINBALT Health Monitor

- The origins of the FINBALT are in the North Karelia project
- Surveys on health behavior and related factors among adult population

-Finland	1978-, annually
-Estonia	1990, 1992, 1994, 1996, 1998, 2000, 2002, 2004
-Lithuania	1994, 1996, 1998, 2000, 2002, 2004
-Latvia	1998, 2000, 2002, 2004

Methods of behavioural monitoring

- random sample of adult population, based on registers
- sample size 3000-5000
- data collected by mailed self-administered questionnaires
- annually or every second year, April/May
- core questions repeated in every survey
- some local or temporal questions allowed

MAIN DOMAINS IN THE QUESTIONNAIRE

- 1) Background information**
- 2) Health services and health status**
- 3) Smoking**
- 4) Food habits**
- 5) Alcohol consumption**
- 6) Other (physical activity etc.)**

Criteria for choosing the core questions

- relevance for public health and health policies – chronic diseases, analyses in subgroups
- measurability (all important problems cannot be measured by a survey)
- nature of the phenomenon (Is it changing rapidly?)
- expectations of the stakeholders

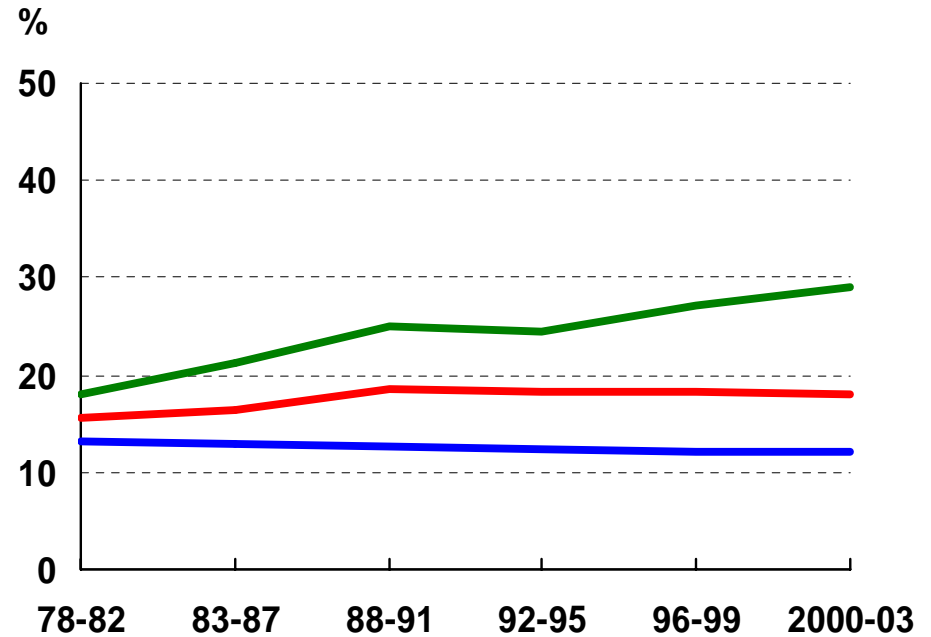
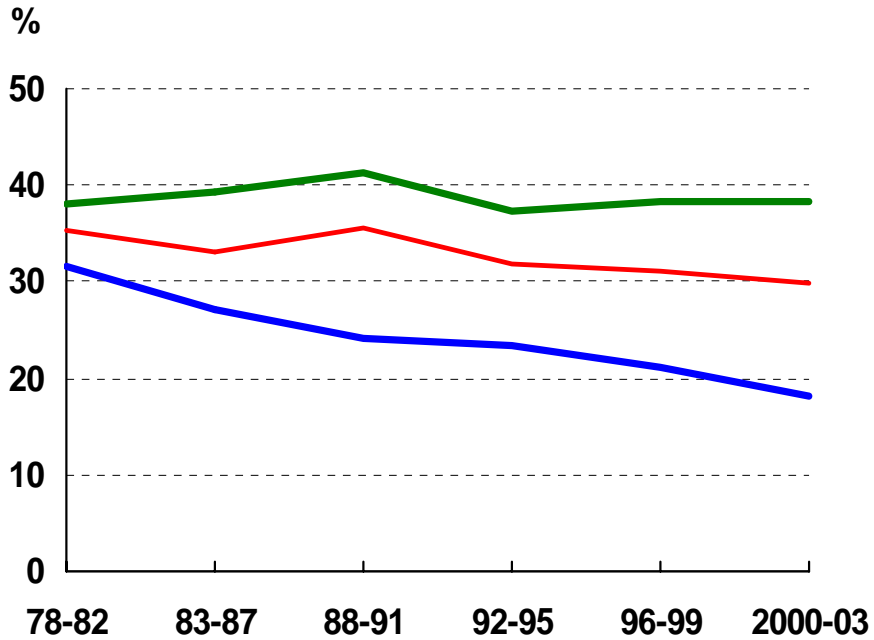
Higher educational groups smoke less

Differences are increasing

Prevalence of daily smoking by educational level (Helakorpi ym. 2003)

Men

Women



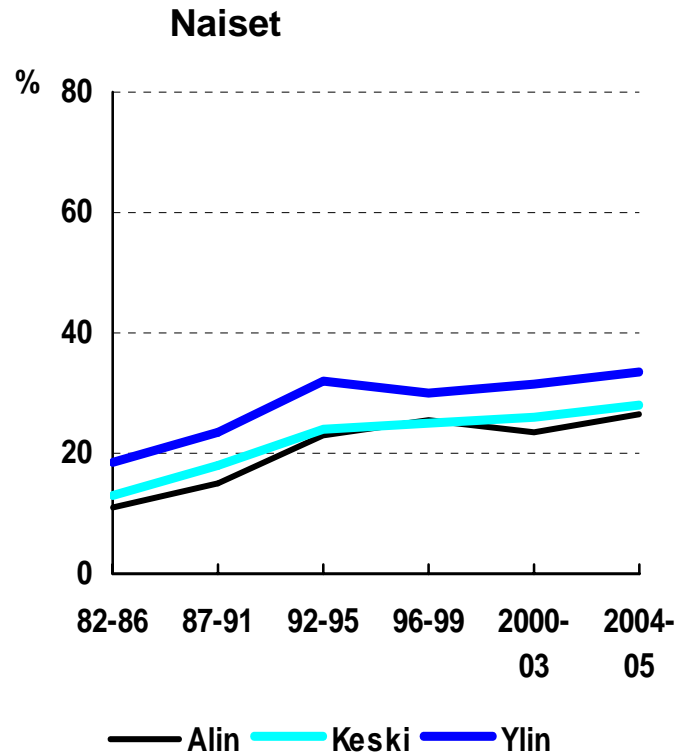
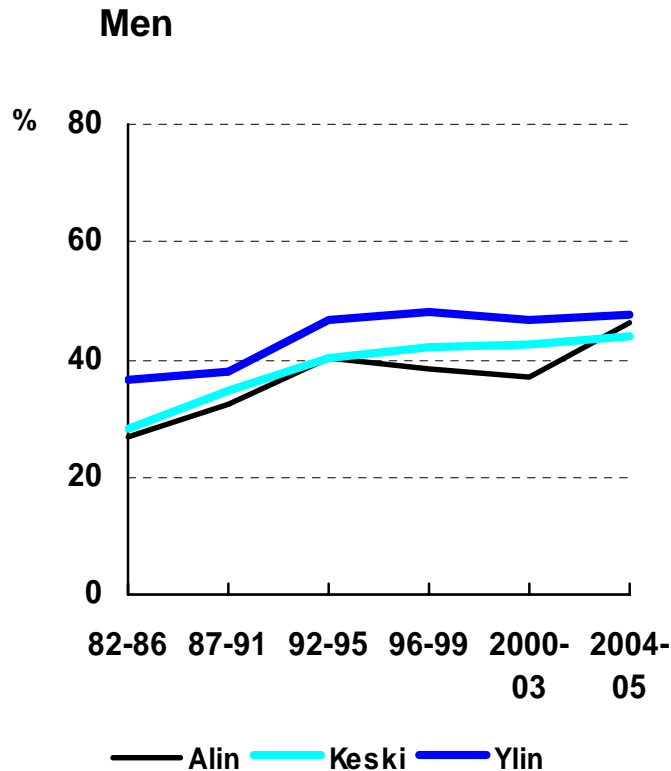
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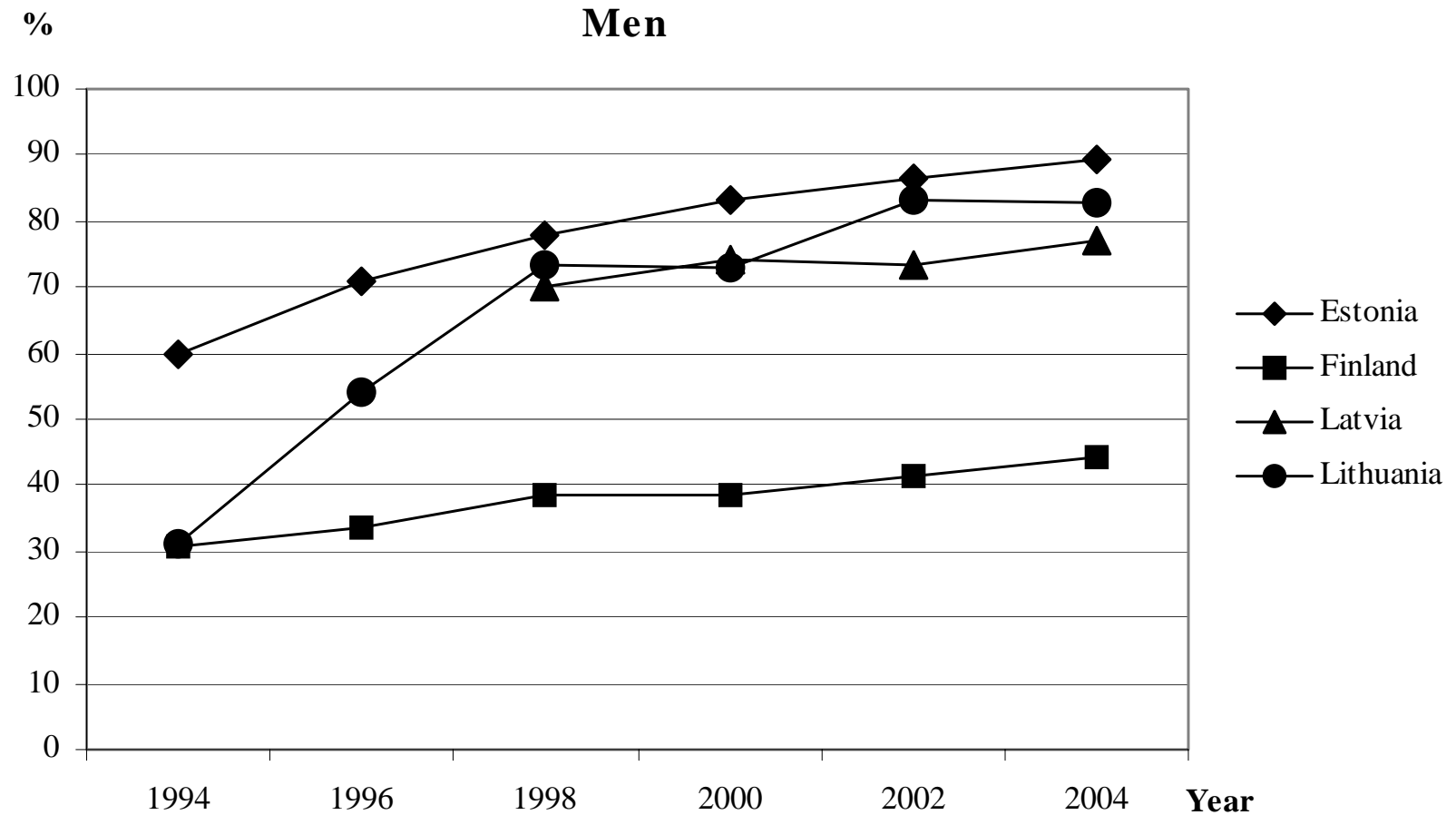


Men of lower educational groups have increased their alcohol consumption most.

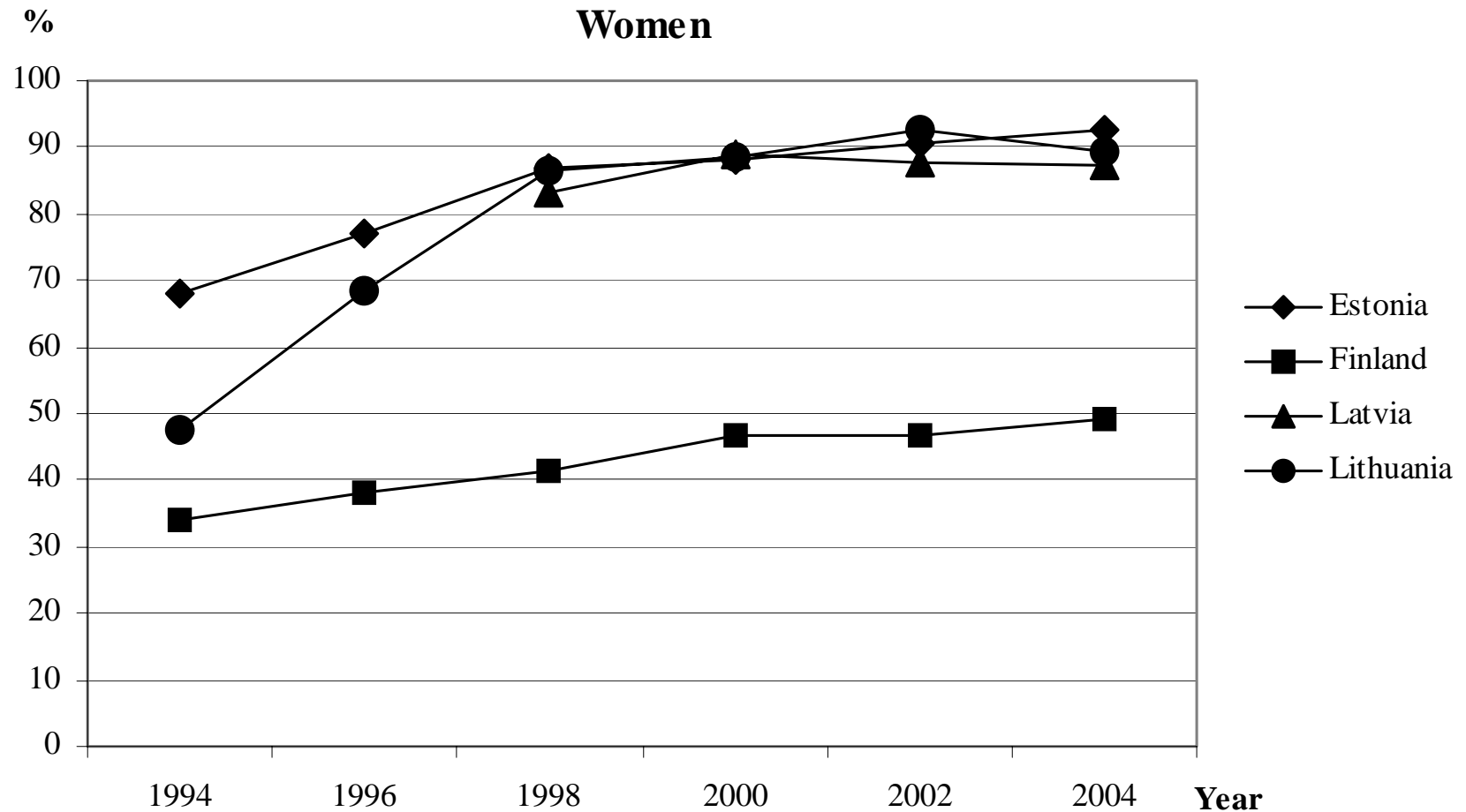
Use of alcoholic drinks (portions/week, men ≥ 8 , women ≥ 5) by educational level.



Use of vegetable oil for cooking increased



Use of vegetable oil for cooking increased



USE OF HEALTH MONITOR DATA

- Monitoring trends in different population groups (tool for encouraging changes)
- Information for health **policy decisions** (justification of anti-smoking legislation, consequences of EU-alcohol policy)
- **Research** (changes, variations and mutual associations of health behaviours, contribution to health inequalities, international comparisons)
- **Development of health policies** (results presented in national nutrition and health reports)
- Increasing **public information** (regional results in Finland, media contacts)
- **Education** and training of professionals (master's theses, use in textbooks)
- Development and evaluation of **interventions** (Quit & Win, North Karelia project)

Practical aspects of behavioural monitoring

Comparability and representativeness

- **Comparability - over time, between countries and population groups**
- **Alcohol, tobacco and food products change over time - Trends will be lost if questions change**
- **Nationally representative random sample**
- **Non-response is a growing problem**
- **Increase of sample size does not diminish response bias**
- **1-3 reminders to non-respondents**
- **Substitution of non-respondents not allowed**

PROBLEMS AND SOLUTIONS BASED ON FINBALT EXPERIENCES

Problem: No results in 2 years

Solution: Wait, normal time frame 5 - 10 years

Problem: Key partners change

Solution: Work with partners from more than
one organization

PROBLEMS AND SOLUTIONS (cont.)

Problem: Lack of knowledge on scientific methodology

Solution: Patience, allocate resources for scientific experts, joint papers

Problem: No agreement on goals

Solution: Face-to-face- contacts, regular meetings, collectively written rules and plans

PROBLEMS AND SOLUTIONS (cont.)

Problem: Lack of long-term funding

Solution: Political will (interest in public health)
Good contacts with health officials
Support from neighbouring countries
Media visibility, publicity
Coordinating organisation (methodology)
Good collaboration with academics
Scientific publications based on the data

Multiple uses of the data