Experiences from the Swedish determinants-based public health policy

Bernt Lundgren

Promotion & Education 2008 15: 27
DOI: 10.1177/1025382308090345

Vol 15(2), pp. 27-33
DOI: 10.1177/1025382308090345

Original article

Experiences from the Swedish determinants-based public health policy

Bernt Lundgren[1]

Abstract: A comprehensive Swedish public health policy was adopted by the Swedish Parliament, the Riksdag, in April 2003. It pushes health up on the political agenda and affords equity in health high priority. The first phase of implementation of the policy, 2003–5, is described in the 2005 Public Health Policy Report published by the Swedish National Institute of Public Health (SNIPH). For the purpose of investigating the implementation, SNIPH has monitored the development of 42 determinants and used reports from 22 central agencies and eight county administrative boards together with interviews with all Sweden's county councils (21) and a questionnaire sent out to all municipalities (290). The experiences from the implementation of the policy are that: the determinants approach – focusing on structural factors in society, people's living conditions and health behaviours that affect health – is in general well understood and emphasises the role of other sectors in public health; the use of indicators to follow up exposures to determinants is of key importance; the support to actors outside the health service is needed to identify their public health role; a continuous steering from the government and other political bodies is of vital importance; public health promotion on the regional level needs a higher level of co-ordination; municipalities need more skills development; Sweden has a new government that was elected in September 2006; the new government has retracted the former government's public health policy communication submitted to the Riksdag in the spring of 2006, but does not intend to change the public health policy. (Promot Educ 2008;15(2): 27-33)

Key words: policy, multisectoral, dialogue approach, indicators, implementation

Key Points

- The article summarises and discusses the first phase (2003–2005) of implementation of the Swedish public health policy.
- Through quantitative and qualitative data collection, the study shows that national, regional and local actors researched have increased awareness of their remit's health dimension.
- Capacity building in the field and government and political bodies' continuous steering needs to be strengthened in order for the policy to be effective.

Introduction

A comprehensive Swedish public health policy was adopted by the Swedish Parliament, the Riksdag, in April 2003 (1). It pushes health up on the political agenda and affords equity in health high priority. The overall aim of the policy is to 'create societal conditions for good health on equal terms for the whole population'. To help achieve this aim through multisectoral efforts, the government has established 11 'domains of objectives' (areas of public health where efforts are to be concentrated):

1. Participation and influence in society.
2. Economic and social security.
3. Secure and favourable conditions during childhood and adolescence.
4. Healthier working life.
5. Healthy and safe environments and products.
6. A more health-promoting health service.
7. Effective protection against communicable diseases.
8. Safe sexuality and a good reproductive health.
9. Increased physical activity.
10. Good eating habits and safe food.
11. Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in harmful effects of excessive gambling.

The policy, presented in the government's Public Health Objective Bill (2) is based on the work of the Swedish National Committee for Public Health, which existed between 1997 and 2000 and proposed national public health goals and strategies in the report 'Health on equal terms – national goals for public health' (3,4).

An important crossroads has been reached with the new public health policy (5). Where objectives had previously been based on diseases or health problems, health determinants were now

1. Public health policy expert, Swedish National Institute of Public Health. Correspondence to: bernt.lundgren@fhi.se
(This manuscript was submitted on November 9, 2007. Following blind peer review, it was accepted for publication on January 9, 2008.)

chosen instead. The benefit of using determinants – structural factors in society, people's living conditions and health behaviours – as a basis is that the objectives are more open to political decisions and can be influenced by certain types of societal measures.

Also important is that the new policy stresses the need for long-term, goal-oriented and multisectoral public health work, and better co-ordination, and it capitalises on our increasing knowledge of the evidence-based effects of interventions.

The institutional set-up

According to the government's bill, many actors on all levels of society shall be responsible for the implementation of the new comprehensive public health policy. Central government agencies, whose tasks and activities have a direct impact on public health, are obliged to consider the effects and to monitor their own work. Municipalities ($N = 290$) and county councils ($N = 21$) have their own tax-levying powers and a significant degree of autonomy vis-à-vis the state. For them the domains of objectives, according to the central government, 'show how their activities can be incorporated to help achieve the overall national public health aim'.

A national steering committee, under the leadership of the Minister of Public Health and directors-general of concerned agencies, has been established to improve co-ordination on the national, regional and local level. The Swedish National Institute of Public Health (SNIPH) co-ordinates the national monitoring and evaluation of the policy. A Public Health Policy Report was delivered to the government in 2005 and a new one is to be completed in 2009. The reports provide a basis for the government to communicate with the Riksdag regarding public health issues.

Aim of the article

The primary aim of this article is to give some insight into the processes of implementation, monitoring and evaluation of the broad, determinants-based Swedish public health policy during the first phase of its implementation (2003–5). The focus is on the challenge of engaging the relevant agencies in other sectors of society and creating understanding among them for the health dimension of their remit.

Methods

SNIPH was commissioned by the government in 2002 to develop a monitoring system with indicators related to the new public health policy, and in 2003 and 2004 to support selected state agencies in the understanding of their roles as regards public health (6). To achieve this, SNIPH needed to formalise some normative starting points for the work. SNIPH developed a strategy (7) emphasising that actors outside the health service sector must:

- consider which determinants are important within their own spheres of activity and for which groups;
- establish indicators to follow up;
- build capacity for interventions, make Health Impact Assessments (HIA) and act on the determinants;
- monitor the effects of the interventions;
- suggest new steering mechanisms and interventions;
- report to stakeholders.

A monitoring system with indicators

The process was initiated because of the need to develop indicators to monitor progress (6). SNIPH was commissioned by the government in 2002 to propose indicators for the 11 domains of objectives. A proposal from SNIPH was submitted to the government in March 2003. This proposal was circulated by the Government Offices to 45 central state agencies for comments. Through this, a process of communication was started between SNIPH and more than 20 central state agencies, from agriculture to education. One result of this communication was 38 principal indicators adopted by SNIPH in November 2004; this was later reduced to 36 principal indicators when preparing the 2005 Public Health Policy Report (2005 PHPR). Besides the principal indicators, the report also contains 47 sub-indicators. The principal indicators and the sub-indicators are related to 42 determinants connected to the 11 'domains of objectives'.

A dialogue approach to support the state sector agencies

At the same time as the work with the indicators was being followed up, a dialogue approach to support the state sector agencies regarding their roles in public health (6) was adopted. The government commissioned 17 central state agencies in 2004, five central state agencies and eight county administrative boards (regional state agencies) in 2005 and 13 county administrative boards in 2006 (the latter ones were not included in the 2005 PHPR) to:

> identify their roles in the field of public health and report on the measures they are taking and intend to take to reach Sweden's overarching public health aim and the objectives specified in the eleven domains of the Swedish Public Health Policy.

Concurrently, SNIPH was commissioned to 'stimulate and support' the agencies. A prime challenge for SNIPH was to use the above-mentioned strategy, and engage and create understanding among the agencies for the health dimension of their remit.

The dialogue process started with meetings between SNIPH and agency directors-general and county governors about the normative starting points. This was followed by multi- and bilateral meetings with agency representatives about following up the determinants and reporting initiatives and achievements. To help central state agencies to report to SNIPHa a frame with questions was formalised and sent out (8). The frame was said to be a means of assistance, focusing on four principal questions (the task of the agency, activities that have significance for people's health, the effects of the activities on health determinants and development needs and proposals for future actions). The same questions were put to the county administrative boards but in a qualitative form during meetings with each one of them. Reports with answers to the questions were sent to SNIPH from the 22 central state agencies and eight county administrative boards during 2004–5, and from the rest of the county administrative boards (13 agencies) during 2006.

Support to municipalities and county councils/regions

In the government's Public Health Objective Bill, the municipalities and county councils are regarded as the most important actors in public health. Support to them from SNIPH has primarily been given in the form of seminars, participation in strategic groups, knowledge reviews and reports (6). SNIPH has also compiled what are known as Basic Public Health Statistics (BPHS), for Local Authorities to help the municipalities plan and monitor their public health work. BPHS contain public health-related data on all municipalities and on the city districts of the three main Swedish cities. To obtain information for the 2005 PHPR, SNIPH conducted telephone interviews in 2004 with all 21 county councils/regions, and also distributed an electronic questionnaire to all 290 municipalities and to the city

districts in the three biggest cities. The questions to both county councils and municipalities focused on the organisation and governance of public health work, activities, planning and monitoring, resources and development needs in the field of public health (9). The response rate was 100% for county councils and 84% for the municipalities and the city districts.

Analysis of data

The focus of analysis in this article is not on the development of the chosen indicators, but on the implementation process in terms of different actors' public health roles. Reports from central state agencies in 2004 were analysed by SNIPH in a 'review report' in December 2004 (10). This review report was used as a basis for the 2005 PHPR. The analysis of answers from the other questionnaires and interviews mentioned was made directly for the 2005 PHPR. Later – after the publication of the 2005 PHPR in October 2005 – a separate report was compiled in 2006 with an analysis of how public health work was organised in the municipalities (9) and also a report in 2007 about the public health role of the county administrative boards (11). To incorporate information about primary healthcare, SNIPH has also used reports from the National Board of Health and Welfare for the analysis.

The experiences of the implementation process, summarised below, are all described in the 2005 PHPR (6). The use of other sources of information is given special mention.

Results

Central state agencies

The remits of the central agencies[i] contacted by SNIPH during the communication process cover a vast array of different policy areas, including the labour market, work environment, housing, integration, equality, education, social security, environmental protection, road traffic, sports, medical care, food and taxation.

The meetings with directors-general started the process and resulted in a consensus on the normative approach to public health and support to the idea of deepening the dialogue between SNIPH and each agency. There was a marked interest among the directors-general in synergy effects, for example: environmental interventions that also had a positive effect on health; a decrease in alcohol consumption that also helps to meet transport policy targets to minimise traffic injuries; and city planning that supports physical activity. There was also a demand for a booklet of determinants and indicators related to each domain of objectives to make it easier for agencies 'not in the health business' to understand the determinants-based approach and their own relation to health (12).

Direct and indirect effects

The central agency reports to SNIPH showed that many agencies regarded their activities as having a direct impact on people's health. According to the Swedish Chemicals Agency, for example, everything the agency does is aimed at preventing personal injury and environmental damage caused by the use of chemicals. Similar answers were given by the Swedish Work Environment Authority, the National Board of Housing, Building and Planning, the Swedish Environmental Protection Agency, the Swedish Radiation Protection Authority and the Swedish Road Administration.

Others regarded the effects as more indirect in that their activities influenced local actors. One example is the Swedish National Council for Crime Prevention, which finds it is difficult to separate the effects of what it does in relation to the work of other actors. Several agencies, among them the Swedish National Council for Crime Prevention, pointed out that they work within domains of objectives other than those declared in the government's Public Health Objective Bill (2).

Greater awareness of the health dimension

A summary of what happened shows that the process challenged the established domains of central agencies. Using a dialogue approach, however, increased awareness of the health dimension of their remit, and obstacles could be overcome. Most agencies involved in the process became actively engaged and contributed to the development and monitoring of indicators; statistics were sent over to SNIPH for monitoring or the agencies did the monitoring by themselves (in a few cases). They also reported initiatives, achievements and suggestions related to health determinants within their respective domains. Typical suggestions (here related to domains of objectives 1, 2 and 3) were for example: people overburdened with debt should have better support from society, bearing in mind the correlation between economic problems and ill-health; the labour market should be more flexible and inclusive for individuals that have less than full working capacity; more attention should be paid to public health aspects in the physical planning of municipalities; access to adequate transportation should be seen as an important part of people's economic and social security; the situation of children should be afforded more attention from a public health perspective – for example: the size of preschool groups; the working climate in schools; staff skills; children's influence at school; and the quality of anti-bullying campaigns. Related to the suggestions were proposals on more resources for analysis, co-operation and actions.

Regional state agencies

The most important task for the regional state agencies – the county administrative boards – is to promote regional development in accordance with goals decided by parliament and government. This task incorporates overall issues like equality, diversity and accessibility, promotion of sustainable environmental and social regional development, adaptation of the Swedish environmental quality objectives to the regional level, environmental supervision including environmental impact assessment and social supervision in the areas of social services for disabled persons and alcohol. It also includes animal and food protection, road traffic issues, etc.

Need for a clearer public health role

According to the 21 county administrative boards,[ii] their work has both a direct and an indirect effect on all the domains of objectives, except domain 6 (the health service). Several of them also report that their co-ordination responsibility on the regional level, experiences from the area of environmental policy implementation and broad contact networks on the regional level provide good prerequisites for deepening and strengthening their role within the public health area. Therefore they want to be given a clear public health role by the government and to have resources for implementation.

County councils/regions

The main responsibility of Sweden's county councils is to run the health service. They also have a long tradition and an important role as centres of excellence with regard to health and ill-health among the citizens. The Health and Medical Services Act (HSL Sections 2 and 3) stipulates that the county councils shall work to prevent ill-health and – even in other ways – promote good health throughout the entire population.

County councils/regions and the national public health policy

To obtain information, SNIPH conducted telephone interviews with all 21 county councils. These interviews show that the national public health policy has impacted on the work of the county councils/regions. All county councils have adopted an overall action plan for public health work. In nine county councils, the plan has been adopted in partnership with other actors, primarily the municipalities. Most of the plans relate to objective domain 6 (a more health-promoting health service), health-related lifestyles, the health situation among children and young people, as well as the health-promoting work done by colleagues in the health service.

Organisation and governance

Public health issues on which political decisions are to be taken by the county council are firstly prepared by some kind of healthcare committee prior to being adopted by the county council assembly or by the county council executive board. Six county councils have a special standing committee on public health. Seventeen have special public health/social medicine departments or units and, in 11 of them, public health strategy/the social medicine function falls directly within the remit of the county council executive or central office.

The 17 county councils with a department for public health/social medicine support public health promotion within the county council and in the county, mostly for epidemiological monitoring, public health reporting and knowledge support. These play a supportive role. The Public Health Policy Bill makes reference to how these departments should work as a regional link in public health promotion between the national and local levels and provide support to the municipalities and information to SNIPH.

There are currently three examples of how the scope of this support to the municipalities has been reduced – bringing objective domain 6 more and more into focus at the expense of the other objective domains – and how the support varies across the country. This raises questions about the ability of these departments to manage the role given to them by the legislator.

Co-operation

The outreach public health activities of the county councils are performed in different forms of co-operation. There is co-operation on the political level in various county boards, public health committees, etc. Common forms of co-operation include youth clinics, family health clinics, tobacco and alcohol prevention programmes. There is also co-operation among different counties as regards public health reporting and there is also formal co-operation, regulated by agreements between council councils and municipalities, to co-finance (e.g. public health planners).

Programmes within primary healthcare centres

Sources other than SNIPH's own questionnaires and interviews give insight in health-promoting and preventive measures implemented in primary healthcare.

Routines/programmes for prevention vary considerably among primary healthcare centres: successful preventive measures have been implemented within parts of the health service for a long time, for example in the maternity and child healthcare services, youth guidance centres, dental care, school healthcare and company healthcare. Infection control and vaccinations, along with other forms of screening, are also examples of well-developed preventive activities. Certain obstacles to health-promoting and preventive measures have been identified in previous government commissions: primarily a lack of time caused by a general shortage of resources and resultant increased workload (13).

According to the National Board of Health and Welfare, the focus has increasingly been on medical care/treatment within primary care throughout the 1990s while preventive activities have decreased. A new survey of primary healthcare centres by the National Board of Health and Welfare (14) shows that systematic health-promoting work in terms of routines/programmes to reduce smoking (64%) and overweight (45%) and to increase physical activity (48%) is being done, but that this is less usual when it comes to alcohol habits (30%) and stress-related problems (21%). A majority of primary healthcare centre directors (70%) said that they were co-operating with, for example, local public health advisory committees (64%) and helping to develop health-promoting programmes in local communities (47%). Only a small minority of them have specific programmes offering citizens medical examinations (17%).

It has been calculated by SNIPH in the 2005 PHPR that the majority of resources go to treatment and rehabilitation; only about 5% of total health service costs go towards disease-preventing measures – too low a share, according to SNIPH.

Municipalities

Municipalities are responsible for activities that affect a number of health determinants, e.g. social services, childcare, planning and building issues SNIPH distributed an electronic questionnaire to all 290 municipalities in 2004. The questionnaire contained 24 questions about the current situation as regards organisation, governance, activities, planning, monitoring, resources and development needs in the field of public health. Some comparisons were made with SNIPH surveys in 2003 and 1995.

The 2004 questionnaire was answered by 239 municipalities including the cities of Göteborg and Malmö (not Stockholm) and 41 of 49 city districts in Stockholm, Göteborg and Malmö. The response rate was 84% for both the municipalities and the city districts. The overall conclusion was that both the municipalities and the city districts were reasonably well organised in terms of their public health promotion and that the organisation of the municipalities had improved since the first survey in 1995.

Action plans

There were overarching action plans in 116 of the municipalities. This was 100% higher than in 1995. Public health was also mentioned in other overarching plans within 33 municipalities, for example in plans for sustainable development or democracy. Another 50 municipalities were also in the process of drawing up public health plans. Similar to earlier findings, sparsely populated municipalities had the least well-established organisation for public health promotion.

Conditions during childhood and adolescence, physical activity, tobacco and alcohol were in focus, compared to illicit drugs, allergy and environment/Agenda 21 in 1995.

Public health committees

As many as 76% of the municipalities – compared to 60% in 1995 – had some form of public health committee for organised co-operation with other actors such as county councils and NGOs. Most public health committees came directly under the municipal executive board, but it was also usual that they were linked to a local governmental committee. Both politicians and civil servants were on the public health committees. Co-operation was most common among industrial and rural municipalities and least common among other large municipalities.

Planning and monitoring

According to findings in the 2004 questionnaire, public health promotion was systematically monitored in half the municipalities. Municipalities usually monitored their activities using their own indicators/key ratios and using the Swedish Basic Public Health Statistics for Local Authorities. Both the large cities of Göteborg and Malmö said they systematically monitored their public health promotion efforts. More than half the municipalities said they used the SNIPH knowledge base when planning and implementing various public health promotion measures.

The percentage of municipalities with a public health co-ordinator remained unchanged (69%) compared to the 1995 and 2003 surveys and the majority of these offered a higher education public health science programme.

A growing interest

The municipalities are showing a growing interest in public health issues. At the same time, however, there is striking uncertainty as regards how the ambitions are to be met practically. Only a few municipalities can be said to have come far in the development of systematic public health work based on an analysis of epidemiological data, and of a systematic planning and monitoring process integrated into the planning and monitoring activities of the municipalities. Knowledge of key health determinants within different domains of objective and effective methods of intervention, and a clear division of roles and responsibilities between different parts of the administration are generally lacking. Both civil servants and politicians need deeper knowledge.

According to both county council and municipality representatives, the national public health policy has most definitely helped to reinforce the mandate for pursuing public health issues both locally and regionally.

Discussion

Proposals in the 2005 Public Health Policy Report

The experiences during the first phase of implementation (2003–5) are described in the 2005 PHPR together with the presentation of time series data for 42 important health determinants. In the report, SNIPH also puts forward 29 priority proposals related to health threats in the areas of mental ill-health, working life, air pollution and accidents, communicable diseases, overweight and physical activity, tobacco, alcohol, violence against women and inequalities in health. There are also 13 proposals related to policy and capacity for public health work, such as the need for the involvement of more actors, better co-ordination of regional public health work, and more support to municipalities regarding competences in the field of public health (6).

Proposals suggested in the 2005 PHPR as regards capacity for public health work are based on the investigations referred to in this article. The quality of the investigations varies from on occasion rather vague answers by state agencies to more precise answers by county councils and municipalities. One reason for this could be that questions put to state agencies are more difficult to answer (the direct and indirect impact and effects on determinants of interventions, and development needs related to present interventions and effects) than questions put to county councils/municipalities (the organisation and governance of public health activities, but no questions about interventions and effects). It is important, however, that the answers are sufficient to serve as a basis for proposals from SNIPH to the government.

It is also important that both the questions and the answers are part of and reflect the processes of implementation, monitoring and evaluation of this broad, determinants-based public health policy. To further improve future policy reporting, the questions need to be reviewed.

As regards capacity for public health work, SNIPH points out that agencies have generally shown considerable interest in public health and have identified their potential for having a positive impact on it. New central and regional agencies should therefore be involved in the process in a similar way. It should be clarified, however, that the responsibility of the agencies for contributing to a positive health development by making efforts in their own areas of responsibility also includes monitoring the development of health determinants and establishing relevant indicators in the area. Data used by the agencies when monitoring should be reported annually to SNIPH for input into the database that has been built up during the compilation of the 2005 PHPR.

The regional level needs to be developed in order both to cement the standing of public health issues in regional development planning and to support the municipalities and other local actors. SNIPH proposes that the county administrative boards – provided no other regional body takes on the responsibility – should co-ordinate the efforts to develop regional public health objectives, increase awareness of the national public health policy in the county and monitor the regional objectives and public health promotion in the county. A second proposal regarding the county administrative boards is that they should report on an annual basis to SNIPH on how the public health policy and improvements in the county are progressing, since there is a lack of public health reporting from the local and regional level to the national level.

Another proposal regarding the regional level is that regional public health centres should be developed and be connected to SNIPH. The collaborative partners for these centres should primarily be municipalities, county councils, universities and university colleges, along with county administrative boards, the business sector and various non-governmental organisations (NGOs). Activities should aim to stimulate public health promotion and support local and regional actors, compile knowledge and act as public health R&D centres, develop practical methods and help to evaluate public health measures. It is furthermore important, according to SNIPH, for public health/social medicine departments at county councils/regions to have the resources and skills needed to be able to provide support for the implementation and monitoring of public health efforts made within all 11 objective domains of the public health policy.

Municipalities want more skills development. Politicians would like to see more strategic and method support in order to be able to convert public health plans into concrete measures. They also express a need for health economics data that shed light on the financial profitability of public health measures and the need to bridge the gap to universities and university colleges in order to develop more 'down-to-earth' or reality-based forms of research. SNIPH proposes, among others, that skills development is offered to municipalities and county councils in the form of short, in-service training programmes; the proposed initiator of this measure is SNIPH in co-operation with SALAR, the Swedish Association of Local Authorities and Regions.

The government communication to the Riksdag

The government submitted a communication 'Public health policy for equality in health and sustainable development' (15) to the Riksdag in the spring of 2006. This communication is the first follow-up of the Public Health Objective Bill (2) in

terms of a government communication to the parliament. The 2005 PHPR and considerations by 100 relevant actors are used as the basis of the communication, along with the public health report by the National Board of Health and Welfare, and communications and bills submitted after the 2005 PHPR have been published.

The communication states that the public health policy shall remain in place, with one overarching national aim, domains of objectives, a four-year 'evaluation cycle', determinants, indicators, a spread responsibility and interventions that combat the most common health problems and inequality in health.

In the communication, the government emphasises that more work is needed to specify some of the indicators, that health impact assessments (HIA) should be used by more actors and that health economic analysis should be developed to provide good arguments for investing in health. The government is in favour of continued implementation, involving more state agencies. Increasing the number of 'role assignments' which were given to 22 national and 21 regional state agencies during 2004–6, and the number of 'HIA tasks', which have been given to 13 national and 21 regional agencies in 2005–7, is one of the aims. The government finds it difficult to reach a consensus about co-ordinated regional public health promotion among county councils and county administrative boards and feels more discussion on this subject is needed.

The communication also points out that support for more competence in public health matters among the municipalities is needed. Successful public health promotion presupposes the integration of public health aspects into the activities already being carried out by municipalities and county councils. Research and method development, the dissemination of experience, evaluation and support to networks of elected representatives and public sector officials, e.g. Forum folkhälsa (Public Health Forum), are, according to the Public Health Policy Bill, the most important issues when it comes to encouraging the ongoing process.[iii] In partnership with the relevant actors, SNIPH shall take a supporting role in this process.

The integration of public health issues into the efforts being made to achieve sustainable development not only requires intersectoral co-operation but also a broadened knowledge base. In addition to knowledge that helps them to make decisions regarding various programmes, for example parent support, municipal representatives also need knowledge about how these methods can be implemented in a systematic and high-quality fashion. Knowledge about quality assurance and implementation therefore needs to be further developed.

Signals from the new government elected in September 2006

A new centre-right coalition government came into power after the general election in September 2006.

The new government retracted the former government communication to the Riksdag, but has also decided that there shall be no amendments made to the public health policy. More focus shall be put on the domains of objectives related to children, the health service and health behaviours (domains 3, 6, 7–11). A new government bill shall be submitted in 2008. The bill will focus on the need for new investments in the area of preventive efforts regarding children and adolescents, support for parents and prevention of suicide and obesity. Increased taxation on cigarettes, oral smokeless tobacco and beer has been announced as another important area. More money is also likely to be made available for investments to decrease the use of alcohol and abuse of illicit drugs consumption, together with more money being raised to hinder pandemics, for HIV/aids prevention and other public health problems.

Conclusions

The determinants-based Swedish public health policy is very new; it was only adopted by the Riksdag in April 2003. We have not been able to build up extensive experience in such a short space of time. However, a brief examination of the first phase (2003–5) of the implementation process shows the following:

The determinants approach – focusing on structural factors in society, people's living conditions and health behaviours that affect health – is in general well understood and emphasises the role of other sectors in public health.

The use of indicators to follow up exposures to determinants is of key importance. To be useful for municipalities and organisations on the local level, statistics should be locally based as much as possible.

Support to actors outside the health service is needed to identify their public health role. SNIPH has a core function in this respect, but other bodies, especially on the regional level, are also of great importance and should have more resources for this task. Two solutions, not competing with each other, could be relevant: 1. all public health/social medicine departments at county councils/regions should have the resources to provide support within all 11 objective domains of the public health policy; and 2. new regional public health centres could be developed for the purpose of stimulating public health promotion and supporting local and other regional actors. Those centres could come under SNIPH or be established as an arrangement between municipalities, county councils and universities as the driving partners.

Continuous steering from the government and other political bodies is of vital importance. Without distinct steering from the government vis-à-vis the state agencies on the central and regional levels, the processes will slow down. Continuous steering is also needed in relation to agencies that have been involved in 2003–6, and are still involved in 2007 and 2008, but new agencies should also be engaged in the process. It needs to be clarified that efforts should be made in their own spheres of responsibility, including monitoring the development of health determinants and establishing relevant indicators in the area. This is a key to transferring the 'ownership' of the public health issue to the agencies.

Public health promotion on the regional level needs a higher level of co-ordination. The county councils/regions and SALAR (Swedish Association of Local Authorities and Regions) are not in favour of the SNIPH proposal, according to which the county administrative boards act as co-ordinators of public health issues on the regional level and report to SNIPH every year on how the public health policy and public health work are being implemented.[iv] The former government has also said it is important to have more of discussion on this subject. In any case, it is important that this issue be resolved as soon as possible.

Municipalities need more skills development. Successful public health promotion presupposes the integration of public health aspects into the activities already being carried out by municipalities and county councils. Research and method development, the dissemination of experience, evaluation and support to networks of elected representatives and public sector officials, e.g. *Forum folkhälsa* (Public Health Forum), are, according to the Public Health Policy Bill, the most important issues when it comes to encouraging the ongoing process. In partnership with the relevant actors, SNIPH shall take a supporting role in this process. SNIPH proposes that skills development is offered to municipalities and county councils in the form of short,

in-service training programmes; the proposed initiator of this measure is SNIPH in co-operation with SALAR.

The new Swedish government, which came into power after the election in September 2006, has retracted the former government communication to the Riksdag, but does not intend to change the public health policy. The new government intends to focus more on the domains of objectives in the policy related to children and adolescents, the health service and health behaviours (domains 3, 6, 7–11). A new government bill shall be presented in 2008.

i. State sector central agencies in the public health communication process: Swedish Labour Market Administration; Swedish Work Environment Authority; National Board of Housing, Building and Planning; Swedish Integration Authority; Swedish Consumer Agency; National Food Administration; Swedish National Agency for School Development; Swedish Environmental Protection Agency; Swedish Rescue Services Agency; Swedish Police; Social Insurance Office in Sweden; Swedish Institute for Infectious Disease Control; National Board of Health and Welfare; Swedish Board of Agriculture; Swedish Arts Council; Swedish National Agency for Education; Swedish Radiation Protection Authority; Swedish National Board for Youth Affairs; Swedish Road Administration; Swedish National Council for Crime Prevention; Medical Products Agency – Sweden; Swedish Customs; Swedish Gaming Board; Swedish Chemicals Agency; also 21 county administrative boards.

ii. Reports from eight of the 21 county administrative boards were included in the 2005 Public Health Policy Report. The answers from all 21 county administrative boards do not change the picture given by the eight first ones, but enhance the description and provide more suggestions.

iii. Forum folkhälsa (Public Health Forum) is a national forum for local public health promotion, the aim of which is to ensure the exchange of experience and the dissemination of knowledge within the field of public health for municipalities and county councils/regions as well as other NGOs on the national level who are actively involved in public health issues. Forum folkhälsa is jointly run by the Swedish Association of Local Authorities and Regions (SALAR) and SNIPH.

iv. This is shown in considerations by county councils and SALAR on the 2005 Public Health Policy Report (16).

References

1. Govt. Report 2002/03:SoU7, Riksdag Communication 2002/03:145 [in Swedish].
2. Swedish government's Public Health Objective Bill 2002/03:35 [in Swedish]. Extended summary in English available from: http://www.fhi.se/templates/Page____4835.aspx
3. The Swedish National Committee for Public Health. Health on equal terms – national goals for public health. English version of SOU 2000:91. Stockholm: Fritzes; 2000. Also in: The Swedish National Committee for Public Health. Health on equal terms – national goals for public health. Scand J Public Health. 2001;29 Suppl 57:1–68.
4. Hogstedt C, Lundgren B, Moberg H, Pettersson B, Ågren G, editors. The Swedish Public Health Policy and the National Institute of Public Health. Scand J Public Health. 2004;32 Suppl 64. Available from: http://www.fhi.se/templates/Page____4835.aspx
5. Ågren G. Sweden's New Public Health Policy, National Public Health objectives for Sweden. Stockholm: Swedish National Institute of Public Health; 2003.
6. Swedish National Institute of Public Health. The 2005 Public Health Policy Report. Stockholm: Swedish National Institute of Public Health; 2005. [in Swedish]. Summary in English available from: http://www.fhi.se/templates/Page____6725.aspx
7. Swedish National Institute of Public Health. Communication (20–03–1108) to the Swedish government on 30 January 2004 entitled "A strategy for stimulating and supporting central agencies and other authorities that have a special responsibility in the field of public health" [in Swedish].
8. Lundgren B. Template for reporting activities/interventions. Swedish National Institute of Public Health (working material); 2004 Jun 3.
9. Noor B. How the municipalities are organised as regards public health issues (2004). Swedish National Institute of Public Health; 2005 [in Swedish]. Summary in English available from: http://www.fhi.se/templates/Page____7949.aspx
10. Lundgren B, Moberg H, Branting Elgstrand M. SNIPH's review of agency reports on indicators and statistics and on interventions that influence public health determinants: final report. Swedish National Institute of Public Health (working material); 2004 Dec 6 [in Swedish].
11. Swedish National Institute of Public Health. The role of the county administrative boards (CABs) in public health: a summary of the CABs' reports about their role in the public health field. Swedish National Institute of Public Health; 2007 [in Swedish].
12. Lundgren B, Branting Elgstrand M, Schaerström A. Public health determinants and indicators: background material to the ongoing Public Health Policy Report. Swedish National Institute of Public Health (working material); 2005 Feb 10 [in Swedish].
13. National Board of Health and Welfare. Healthcare status report 2003. Stockholm: National Board of Health and Welfare; 2004 [in Swedish].
14. National Board of Health and Welfare. A health-promoting health service? A survey of health-promoting and disease-prevention interventions. Stockholm: National Board of Health and Welfare; 2005 [in Swedish].
15. Swedish government communication 2005/06:205. Public health policy for equality in health and sustainable development; 2005 [in Swedish].
16. Swedish Government Offices, Ministry of Health and Social Affairs, consultation report 2006 31 May, S2005/7557/FH [in Swedish].