

# THL International News



## Let's welcome 2010, the European Year for Combating Poverty and Social Exclusion!

Poverty is often associated with developing countries, where a lack of food and clean water can be a daily challenge. Europe is also affected by poverty and social exclusion. It may not be as severe, but it is nonetheless unacceptable. On a global level we can see the effects of the current economic downturn, combined with rising food and energy prices. This development is seriously threatening the efforts to achieve the first of the Millennium Development Goals; to halve the 1990 proportion of people living in extreme poverty and hunger by 2015. There is no miracle solution to put an end to poverty and social exclusion. Each one of us can, however, do something to renew our commitment to solidarity, social justice and greater inclusion.

As a research and development institute we at THL are committed in our work to combat poverty and social exclusion. This work is done through public awareness by providing

research data and good practices in areas such as living conditions, social and health policies, health and welfare economics, lifestyle and participation, mental health and substance abuse services. Our operations are premised on scientific knowledge, which lays the foundation for practical operational models and the development of health and welfare. This framework allows us to engage in interesting development projects all over the world. The year 2009 was no exception. We have been kept busy and motivated by new projects starting in e.g. Lesotho, Mongolia, and Romania, along with our ongoing commitments.

This year we have enjoyed real winter weather around Christmas and more in the New Year here in Finland. It has been a time to take time off and enjoy the company of families and friends. I would like to take this opportunity to thank our staff, our partners and all the stakeholders for the good and positive collaboration during 2009. Looking forward to seeing you again in 2010!

Director JUTTA IMMANEN-PÖYRY,  
THL International Affairs Unit



THL International Affairs practising collaboration : canoeing in Southern Finland in September 2009.

## Update on the Finnish national immunization programme and pandemic influenza vaccinations

The government has long played a strong role in health care in Finland. Public health interventions, vaccinations included, have received a fair deal of attention. In addition, trust has mostly prevailed between lay people and health professionals; open lines of communication between public health nurses and parents have laid the foundation for a high vaccination coverage of the national immunization programme (NIP) vaccines. The latest figures show vaccine coverage at over 90% for all the childhood vaccines except

for influenza, a recent addition to NIP starting at the age of 6 months (Table 1).

Table 1. The National Childhood Immunization Programme of Finland in 2010

Age	Vaccine
6 to 12 weeks Last dose before 26 weeks	Rotavirus
3 months	DTaP-IPV-Hib and PCV*
5 months	DTaP-IPV-Hib and PCV
6 – 35 months	Influenza
12 months	DTaP-IPV-Hib and PCV
14-18 months	MMR
4 years	DTaP-IPV
6 years	MMR
14-15 years	dtap

\* to start in fall 2010

From early on, the development of the NIP has been guided by scientific evidence. THL (into which the internationally known National Public Health Institute, KTL has merged) has done front-line research in vaccine preventable diseases, vaccine immunology and clinical development, especially to prevent measles and diseases caused by Haemophilus influenzae and Streptococcus pneumoniae. Finland was actually the first country in the world to eradicate measles.

In recent years, the four-steps approach in national decision-making has been applied. In short, in order for Finland to introduce a new vaccine into the NIP, there must be (1) a considerable disease burden, and (2) an efficient and safe intervention, which (3) does not have anticipated large scale negative impacts, and which at the same time is (4) reasonably cost efficient. Using this decision-making model, the rotavirus vaccine was introduced in 2009.

The pneumococcal conjugate vaccine (PCV), on the other hand, was not introduced in 2001, as it did not pass the 4th step, i.e. the costs were too high in comparison to the direct and indirect returns. In a recent repeat analysis which took into consideration the potential herd immunity impact of the vaccine, PCV appeared reasonably cost-effective, and it will be introduced into the NIP later this year.

In the light of the generally high acceptability of vaccinations by Finnish people, it came as a surprise that the adjuvanted pandemic influenza vaccinations (PandemrixR), which were ordered in sufficient amounts to be given to all Finns, were received with quite a bit of criticism even by health professionals. The main aim of the vaccination was to avoid as many A(H1N1)v related deaths and severe cases as possible. It was considered not possible to stop the transmission of the virus by vaccination at that point. The pandemic hit Finland in early October (weeks 41-42), reaching its peak in Northern Finland during weeks 43-45, and in Southern Finland a bit later during weeks 45-48. By the end of 2009, there were a total 36 influenza A(H1N1)v infection related deaths (median age 56 years; range 1-88; of these 4 were children, 23 were men, and 23 had a known underlying illness).

A turning point in the critical attitudes towards A(H1N1) vaccinations was the death of a previously healthy child in early November, which was given a lot of media coverage. Immediately the vaccine demand sharply increased, creating logistics problems in several communities as vaccines were available only to the agreed risk groups and according to the recommended risk-analysis-based order (Table 2). At present,

a total 1.9 million doses of A(H1N1) vaccines have arrived in Finland. Most of the defined risk groups have received the intended single dose. The vaccinations of those above 65 years of age belonging to the medical risk groups are being invited to receive the vaccination. Once more A(H1N1) vaccine doses arrive, vaccination of the rest of the population will start, most likely in January-February 2010.

HANNA NOHYNEK, MD PhD, Academy Fellow, Professor of International Health

Additional reading  
Nohynek H. The Finnish decision-making process to recommend a new vaccine: From vaccine research to vaccination policy. Eur J Publ Health 2008;16:275-80.



High vaccine coverage is achieved through local maternity and child health clinics. Photo: Tommi Anttonen

Table 2.

Target group	Comment
1. Health, and social care personnel taking care of infectious patients or patients susceptible to infections.	Also family members taking care of such patients when the patient cannot receive the vaccine. Ambulance drivers and pharmacy personnel included.
2. Pregnant women	Regardless of state of pregnancy
3. Those 6 months to 64 years of age with a defined medical risk which would place them in danger when contracting A(H1N1)v	
4. Health children from 6 to 35 months of age	
5. Healthy children and young adults from 3 years to 24 years of age	
6. Those 65 years of age and older with a defined medical risk condition which would place them in danger when contracting A(H1N1)v	Based on antibody analyses, this age group is best protected by previous H1N1 infections
7. The rest of the population	

## Whose global health? Towards EU communication on global health

In the autumn of 2009 the European Union launched an open consultation on its role in Global health to collect views from the relevant stakeholders on the rationale, scope and strategic objectives of the EU. The purpose of the consultation was to build a base for the related Communication of the Commission planned for spring 2010.

The call for consultation was accompanied by an 'Issues paper' of 17 pages to frame the ideas and areas relating to global health. The major challenges identified are health inequities, incoherent external and internal policies, and weak equity and ownership of global health research. The EU clearly wishes to enhance its impact and values globally, and for that purpose, health and foreign policy are seen as crucial for alliances, for reputation and for trade issues. The paper thus implies that individual national global health strategies may no longer be desirable (pg. 12).

The concept of global health has generated lots of debate recently. The issue is not novel, however, as the international community has for decades created initiatives to protect and promote the health of all the people of the world, such as principles aiming at 'health for all in 2000' through the Declaration of Alma-Ata in 1978, or the Millennium Development Goals for 2015. Instead, the number of policy-makers and foundations funding health initiatives has increased in magnitude. WHO Maximising Positive Synergies Collaborative Group reported in 2009 on the abundance of separate and partly competing actors in the global health arena, on the lack of studies looking at the effects of global health initiatives on health systems, and on the plurality of ideas and policies (Lancet 2009;373:2137-69). Indeed, the editorial in the Lancet in 2009 asked who runs global health (Editorial, Lancet 2009;373:2083) and some have demanded a common definition (Koplan et al., Lancet 2009;373:1993-95).

THL International Affairs Unit gathered the views of THL's experts to draft a contribution for the consultation. THL experts reminded that health has a social dimension, and referred to, for instance, the Health in all policies -approach and Social determinants of health. Furthermore, sustainable health development starts from building local capacities rather than performing narrow single target actions. More emphasis should be paid on non-communicable diseases. National health information systems and their compatibility with international surveillance systems clearly need more attention. Without accurate and available data it is difficult to assess the status of health and the burden of diseases, or to respond to the health needs both locally and internationally.

In addition, THL proposed that the EU research agenda would include public health and health system research. However, THL holds that crucial to the successful launch of any research programme are adequate and practical informational meetings and assistance in the local setting. Given the overburdened health-workers in their triple role also as

researchers and teachers, they tend to lack capacity to learn about the complex calls and instructions attached to applications.

In general, THL suggested that instead of trying to develop a purely EU agenda, the EU should seek more collaboration and synergy with international organisations, such as WHO, UNICEF, UNESCO and other UN agencies. For instance, a highly relevant UNESCO report on Social Responsibility and Health was approved in November 2009. Key experts of the global community were involved in drafting the report for many years.

The Call for consultation attracted 104 actors to send their contributions, which can be accessed at the webpage of DG Development at <http://ec.europa.eu/development>

SIRPA SOINI, Senior Expert, Legal Advisor  
THL International Affairs Unit

## New publications in Russian

Several publications in Russian have been recently produced by THL projects.

Social Work Addressing Children and Families in the Republic of Karelia project prepared two publications. Mentoring Handbook intends to improve the quality of social work and strengthen the professionalism within the field. It presents the basics and models of mentoring practices in social work, where mentoring is used to a lesser extent. The Early Intervention and Early Support to Children and Families Manual describes how to work in multi-professional teams and how to use early intervention as a method. This manual is targeted to different experts providing social and health care services for children, adolescents and families, and can be used in the sphere of professional training as well.

Psychological and Social Support to HIV Infected Women in Leningrad Oblast project published a manual on medico-social management of HIV cases. Prevention of HIV in the Republic of Karelia project produced a manual on HIV pre-



Photo Sirje Vaittinen

Boy from Boxitogorsk, Leningrad Region.

vention for specialists working with the youth which was published in Russian in December 2009.

Fear-Hope-Trust publication, originally produced in Finnish, is published in Russian as well. Articles contributed by both Finnish and Russian experts describe the recent changes of the HIV epidemic in North West Russia. The articles bring a more sensitive approach to the HIV thematic, which often receives less attention. This THL publication is available at our website <http://www.thl.fi>

## New projects in Lesotho, Mongolia and Romania

In November 2009, THL began implementing the project Health Systems Strengthening Technical Assistance (HSSTA) in Lesotho. The project is funded by the Millennium Challenge Corporation, with a budget of USD 7.5 million. The duration of the contract is 44 months, running up until May 2013. The four task areas of the project are: human resources capacity development, support of effective decentralized health service delivery, strengthening the use of health management information in the health sector, and strengthening the Ministry of Health and Social Welfare's capacity to oversee health research activities. The other partners in the project are the Health Systems Trust (South Africa) and InDevelop-IPM (Sweden).



HSSTA team in Maseru, Lesotho. In the front row from left: Dr. Katito (Team Leader, Senior Decentralisation Advisor), Mr. Byleveld (HMIS Advisor), Mr. Rimmelzwaal (Training Advisor). Back row from left: Ms Koski (Training Coordinator), Mr. Muchinouta (MCA Lesotho), Mr. Sorsa (Project Director, THL Finland), Dr. Lerotholi (Decentralisation Advisor), Ms Halonen (Project Coordinator, THL Finland)

THL is also participating in another MCC financed health sector project. The Prevention and Control of Major Non-Communicable Diseases and Injuries project in Mongolia will be implemented in 2009–2013. Mongolia has rapidly increasing rates of non-communicable diseases and injuries (NCDI), including cardiovascular disease, diabetes, cancers and injury-induced trauma. The project aims to enhance behaviour change to reduce NCDI and to improve the medical treatment and control of NCDI by increased awareness of NCDI risk factors, early detection,

and increased access to efficient interventions. The leading consultant in this project is EPOS Health Management from Germany.

THL started a new EU Twinning project in Romania. Support for the Completion of the Integrated Mental Health Service System project is a continuation of mental health projects implemented by Dutch and Austrian experts. The main emphasis is on capacity building. The project implements a supplementary, multidisciplinary training curricula with a duration of eight months and prepares a number of toolkits and guidelines for local level planning of mental health services, rehabilitation and occupational therapy.

SANNA VESIKANSA, Communications Officer,  
THL International Affairs Unit



Jacarandas of Johannesburg.

## Swine flu response on focus at IANPHI annual meeting

The 4th annual meeting of the International Association of National Public Health Institutes (IANPHI) took place at the National Institute for Communicable Diseases (NICD) in Johannesburg, South Africa, 1–4 November 2009. The H1N1 pandemic and national public health institutes' responses to it were given a global overview at a plenary session, where member institutes from different countries presented their experience on the outbreak. It was concluded that the threat of the avian flu pandemic few years back has increased the national level of preparedness and cooperation between the NPHIs worldwide to meet the present challenges.

IANPHI serves as a platform for international cooperation, and as the General Assembly unanimously favored four new institutes proposed as members, the total number of IANPHI member institutes is now 67. IANPHI Secretariat is jointly located at Emory University, Atlanta, and at THL. IANPHI's website [www.ianphi.org](http://www.ianphi.org) has been renewed, and the new site was launched in December.

KATJA HEIKKILÄINEN  
Project Manager  
THL International Affairs Unit



## Getting more for less : Serbian capitation methodology

THL is implementing the EU-funded project 'Support to the Implementation of Capitation Payment in Primary Health Care in Serbia'. The project is due to run until the end of 2010.

The total value of the Project is EUR 5 000.000 out of which EUR 2.5 million is designated as technical assistance and EUR 2.5 million is a donation in IT hardware for PHC Pilot institutions.

Republic Institute for Health Insurance (HIF) is a key stakeholder in the project.

### Toward performance-based primary health care

Developed western countries introduced the capitation model of payment of primary healthcare services mostly to establish the mechanism for controlling costs in situations when service-based payment was running out of control.

Former communist countries had completely different starting points, hence decision to adopt a capitation payment model, with Serbia no exception either.

The health insurance system in Serbia is organized on the basis of the Bismarck solidarity model. A single institution in Serbia, the Republic Institute for Health Insurance (HIF) operates as the national, non-profit organization for health insurance. HIF is funded through health insurance contribution payments, which finances healthcare services for around 7 million citizens in Serbia. Unfortunately, the funds allocated for healthcare are rather modest and at 280 EUR per capita per year, Serbia is among the countries at the bottom of the list of the European countries.

Healthcare funding is linear and done on the basis of a pre-determined budget in accordance with set items, such as salaries, medicines, sanitation material, energents and so on. Physicians' salaries and the salaries of healthcare professionals in general are defined according to salary classes based on professional qualifications, with small adjustments possible only on the basis of years of service, managerial bonus and clinical title.

The advantage of this funding method is reflected in the impossibility of exceeding the budgeted funds. The weakness of this funding method is in not distinguishing between those who work better, longer and to a higher standard. To put it simply, if a physician examines 10 and another 70 patients a day on average, there is no mechanism for rewarding the one who works better than the other one since they will be paid the same guaranteed salary. It is simply destimulating.

While the western countries used capitation to switch from one output-based payment system to another, in Serbia the idea would be to switch from an input-based system to a performance-based payment system. It is a payment system where the ones whose performance exceeds the average are recognized and rewarded.

The HIF developed a powerful information system as a preparation for capitation and agreed with all healthcare services providers on an electronic invoicing format for services rendered. As of 1st January 2009, the HIF began collecting information with respect to each healthcare service (over 10 million services a month) including a physician that gave it, time and place, a recipient and type of services.

In addition, five years ago, a similar system was developed, which pharmacies now use to invoice medicines dispensed (amounting to around 5.5 million prescriptions a month) by primary healthcare physicians. These data form the basis for measuring and comparing the performance of physicians in Serbia.

As of 1st January 2010, a health professional salary will consist of two parts: a fixed and variable part in a 70:30 ratio respectively. The fixed part will include what the classifications of salary classes used to include, while the variable part will depend on performance.

The performance will be assessed in 4 categories: registration, rationality, efficiency and quality. One key indicator is chosen for each of the categories

that will be monitored so that the performance appraisal would be easier to conduct. The category of registration refers to the number of patients that have chosen a particular physician, while rationality refers to the average value of prescribed prescription drugs per insuree.

The category of efficiency includes the number of services provided, while the category of quality includes the proportion of preventive examinations from the total number of examinations. It is clear that each category could include more indicators to underpin the performance appraisal, but we must start with the most important ones.

The key issue is that the HIF did not want to set any limits and standards during the assessment and it simply let the physicians impose them on their own.

The performance appraisal of physicians against the categories is actually comparing the physicians with each other. Thus the physicians in each category can get a higher performance appraisal because their performance exceeds the average performance of all the physicians in that category. The sum of grades per categories is the basis for calculating the variable part of the salary.

This is just the first step and we are looking forward to future reforms after decades of waiting for changes in this field.

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Executive director, Republic Institute for Health Insurance

ZORAN KALJEVIC, M.Sc.E.E.  
CIO, Republic Institute for Health Insurance



## THL provides also advisory services with a government perspective

THL works also as a Government think tank in providing policy analysis and appraisal functions particularly to the Ministries of Social Affairs and Health, the “owner” of THL, and the Ministry for Foreign Affairs. With the latter, a cooperation contract has been functional a number of years. On the basis of this contract, THL experts provide expertise to the Ministry in the fields of health, population and social policy.

In social policy, the focus areas have been to provide expert support to the work of the Ministries in their work with the UN in social development issues, the World Bank in social protection and social development and the OECD - DAC preparatory work through its subsidiary bodies such as the poverty reduction network (POVNET) task teams.

The purposes of Finland’s cooperation with intergovernmental agencies and bodies is, as for any other Government, both to keep up to date and to have an influence on global affairs and decisions. Many THL experts have a long and wide background in networking with Government circles and in identifying and elaborating information from a perspective of and in “the language” of Ministry staff and decision makers.

The actual running of some processes as far as the participation of Finland is concerned, are done by THL staff. An example is the Global Forum on Migration and Development (GFMD).

This longstanding cooperation between the Ministries and THL may differ from a consultancy approach. It is an advisory function with a nature of an insider - with civil servant responsibility and accountability to the current Government - naturally without compromising an evidence-based approach.

Some specific topics elaborated during these years of cooperation have included e.g. the social dimension of sustainable development including a comprehensive approach to social policy (<http://info.stakes.fi/ssd/EN/index.htm>).

Another issue outsourced largely to THL has been the facilitation of the mainstreaming of disability issues into development strategies. This is done by supporting the work of the Global Partnership on Disability and Development (GPDD) (<http://www.gpdd-online.org/>).

GPDD is a multi-stakeholder partnership with some 50 members. The THL expert is charged with the responsibility of keeping visible the Government perspective in the dialogue with civil society stakeholders participating in the network.

RONALD WIMAN, Development Manager  
THL

## People behind the success of THL – get to know Teija Kulmala



Teija Kulmala

THL International Affairs Unit is happy to welcome a new member of staff: Teija Kulmala joined us in November 2009 as a Senior Expert in Health. As a Medical Doctor with wide international experience in both research and development collaboration, Teija will strengthen the health sector expertise at THL International Affairs.

Teija’s PhD on Maternal Health and Pregnancy Outcomes in Rural Malawi was published in 2001. Throughout her career, she has had a special interest in reproductive health in the international context. Before THL she worked at the Family Federation of Finland (Väestöliitto) as Medical Adviser and as Senior Researcher and Teacher in the University of Tampere. Teija has also been involved in clinical work to some extent throughout her career.

“I see THL as a new challenging multidisciplinary institution to join and I see lots of possibilities to utilize my professional experience from different fields”.

“Even though the new job is going to draw lot of my attention, I hope I can find some time with my family especially my three kids aged 6, 8 and 13 years, as well as for my favorite hobby which is local politics in my home municipality Kangasala near Tampere. However if I you see that I sometimes a bit restless, then it is just because of a lack of skiing, which I am addicted to. I can eagerly recommend skiing to everyone during this wonderful wintertime!”

SANNA VESIKANSA, Communications Officer,  
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## The National Institute for Health and Welfare (THL)

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