

Hjelt Institute, Department of Public Health
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HEALTH PROMOTION IN LOCAL CONTEXTS AND ENABLING FACTORS

**A STUDY OF PRIMARY HEALTHCARE PERSONNEL,
LOCAL VOLUNTARY ORGANIZATIONS AND
POLITICAL DECISION MAKERS**

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ACADEMIC DISSERTATION

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LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following original publications, referred to in the text by their Roman numerals (I-IV), as well as some additional unpublished findings.

- I Simonsen-Rehn N, Laamanen R & Suominen S. Paikallisyhdistysten rooli ja merkitys terveyden edistämisessä kunnissa. [The significance and role of local voluntary associations in health promotion in municipalities] *Kunnallistieteellinen Aikakauskirja* 2004;2:95-117.
- II Simonsen-Rehn N, Øvretveit J, Laamanen R, Suominen S, Sundell J, Brommels M. Determinants of health promotion action: comparative analysis of local voluntary associations in four municipalities in Finland. *Health Promotion International* 2006;21(4):274-283.
- III Simonsen-Rehn N, Laamanen R, Sundell J, Brommels M, Suominen S. Determinants of health promotion action in primary health care: comparative study of health and home care personnel in four municipalities in Finland. *Scandinavian Journal of Public Health* 2009;37(1):4-12.
- IV Simonsen-Rehn N, Laamanen R, Brommels M, Suominen S. Determinants of effective health promotion actions in local contexts: a study of the perceptions of municipal politicians. *International Journal of Public Health* 2012;57(5):787-795.

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ABBREVIATIONS

EM	Eastern municipality
HPH	Health-promoting hospitals
LVAs	Local voluntary associations
MSAH	Ministry of Social Affairs and Health
OR	Odds ratio
PHC	Primary healthcare
SD	Standard deviation
SM	Southern municipality
SWM	South-western municipality
WHO	World Health Organization
WM	Western municipality

ABSTRACT

Municipalities are important arenas in health promotion as many of the determinants of health relate to, and exert their influence in, local contexts. Accordingly, one key question in public-health work is how to support health promotion on the local level. The present study explores and compares health promotion actions in four medium-sized municipalities, with an emphasis on factors influencing engagement. The point of departure is the health promotion strategies described in the Ottawa Charter (WHO 1986) – the focus being on community action for health, health-promoting health services and healthy public policy – and the multilevel health promotion model (Rütten et al. 2000). The overall aim is to further enhance understanding of health promotion action in local contexts. The specific aims are to explore the role of local voluntary associations in health promotion, to compare the emphasis on health promotion in four municipalities with different forms of primary healthcare service production, and, especially, to identify factors associated with comprehensive health promotion action and with health policy impact (effective health promotion actions).

The study – part of an evaluation of the production model of primary healthcare in four municipalities in the southern part of Finland – is based on cross-sectional surveys conducted in the four municipalities in 2000, 2002 and 2004 and including all registered local voluntary associations (LVAs), primary healthcare (PHC) personnel (including services for older people) and local politicians. The data were analysed by means of descriptive statistics as well as logistic and linear regression analysis.

The findings suggest that a fair proportion of LVAs are interested in action for community health and could be seen as a resource for health promotion in local contexts. There was agreement that the promotion of residents' health requires cooperation between municipal agencies and LVAs, although cooperation was not particularly strongly emphasized in municipal budget and action plans according to the politicians. Cooperation with municipal agencies was independently associated with LVA engagement in health promotion.

PHC personnel appear to be engaged in health promotion primarily on an individual basis. On all three levels (individual, group and population) it was most prevalent in ambulatory care. This was also true in the case of comprehensive action, as well as when health promotion was conceptualized as addressing risk behaviour. There were some differences between the municipalities in terms of level of engagement; the respondents' focus in health promotion and varying opportunities for cooperation are two potential explanations for these differences.

Moreover, variables reflecting all the proposed determinants (organizational values, competence and opportunities) were independently associated with the PHC personnel's engagement in comprehensive health promotion action. These included working conditions that are conducive to health promotion such as being able to use one's skills and knowledge, and having possibilities for reflection and learning as well as collegial support; knowledge about residents' health and living conditions; and opportunities to cooperate with partners outside the organization.

Similarly, perceived competence and a value orientation towards health as well as opportunities for community participation were independently associated with LVA engagement in comprehensive health promotion action. In addition to the determinants in the theoretical model, the municipality had an influence.

There were no inter-municipality differences in the politicians' evaluations of health promotion actions and their effectiveness (health policy impact). In terms of impact, an emphasis on promoting health and quality of life among older people and the resources (in the form of capacity of PHC and care for older people) were among the most significant elements of health promotion policy on the local level. Contrary to expectations, opportunities for community participation were not associated with the evaluations.

The findings reinforce the value of empowerment, community participation and intersectoral cooperation – in other words the principles of health promotion – in the context of Finnish municipalities, providing further evidence as well as highlighting their significance for engagement in health promotion action. The study also provides novel empirical confirmation concerning the applicability of the multilevel health promotion model to the actions of different actors in municipalities, in other words in local contexts. In support of action on the local level, the findings – the equally strong associations of organizational values, competence and opportunities with engagement in health promotion – suggest the need for a multilevel approach. However, local policy makers may need more evidence concerning the impact of cooperation and community participation.

TIIVISTELMÄ

Väestön terveyden edistäminen on keskeinen terveystoimintapolitiittinen tavoite Suomessa. Kunnilla on tärkeä rooli tämän tavoitteen saavuttamisessa, sillä monet terveyden määrittäjät vaikuttavat väestön terveyteen lähiyhteisöissä. Näin ollen kansanterveystyön yksi tärkeä kysymys on se, miten terveyden edistämistä voidaan tukea paikallisella tasolla. Terveyttä ja hyvinvointia ja niihin yhteydessä olevia tekijöitä tutkitaan paljon. Sen sijaan vähemmän on tutkittu terveyden edistämisen toteuttamista ja toteutumista sekä niitä tukevia tekijöitä. Tässä tutkimuksessa tarkastellaan ja verrataan terveyden edistämistä sekä siihen yhteydessä olevia tekijöitä neljässä suomalaisessa keskikokoisessa kunnassa. Lähtökohtana ovat Ottawan julkilausuman (WHO 1986) terveyden edistämisen toimintalinjat sekä Rüttenin ja työtovereiden (2000) monitasoinen terveyden edistämisen malli. Tutkimuksen tavoitteena oli tarkastella paikallisten vapaaehtoisjärjestöjen roolia kuntien terveydenedistämistyössä ja verrata terveyden edistämisen suuntautumista ja painopisteitä eri kunnissa. Lisäksi tavoitteena oli tunnistaa niitä tekijöitä, jotka tukevat terveyden edistämistä ja jotka ovat yhteydessä paikallisten päättäjien näkemyksiin terveyden edistämisestä ja sen tuloksellisuudesta (terveyspolitiikan vaikuttavuus).

Tutkimuksen aineistot koottiin neljästä eteläsuomalaisesta kunnasta osana perusterveyden- ja vanhustenhuollon palvelujen kokonaisarviointia. Tutkimusaineistoja kerättiin postikyselynä kolmesta eri lähteestä: paikallisten vapaaehtoisjärjestöjen edustajilta (vuosina 2000 ja 2002), perusterveyden- ja vanhustenhuollon ammattihenkilöiltä (vuonna 2002) sekä kunnallisten luottamuselinten poliittisesti valituilta jäseniltä (vuonna 2004). Kysely lähetettiin kuntien kaikille rekisteröidyille yhdistyksille, joista oli osoitetiedot yhdistysrekisterissä. Vuoden 2000 järjestökyselyyn vastasi 183 ja vuoden 2002 kyselyyn 182 järjestöä. Vastausprosentit olivat 46 % ja 40 %. Terveystyön ammattilaisten kysely lähetettiin kaikille perusterveyden- ja vanhustenhuollon työntekijöille (n= 986), joista 57 % vastasi kyselyyn. Poliittisten päätöksentekijöiden kysely lähetettiin kaikille kunnanvaltuustojen, kunnanhallitusten ja sosiaali- ja terveystalokuntien jäsenille (n= 195), joista 52 % vastasi kyselyyn. Tutkimus on poikkileikkaustutkimus, ja tilastomenetelminä käytettiin kuvailevia menetelmiä sekä logistista että lineaarista regressioanalyysiä.

Tutkimuksen tulokset osoittivat, että kohtuullisen suuri osuus paikallisyhdistyksistä oli kiinnostunut toiminnasta yhteisön terveyden hyväksi, ja ne voidaan siten nähdä voimavarana terveyden edistämässä paikallisella tasolla. Kunnissa oli yksimielisyyttä siitä, että väestön terveyden edistäminen edellyttää kunnallisten toimien ja paikallisten vapaaehtoisjärjestöjen yhteistyötä.

Poliittisten päätöksentekijöiden mukaan yhteistyötä painotettiin jonkin verran kuntien talous- ja toimintasuunnitelmissa. Järjestöjen kannalta yhteistyö on tärkeää: yhteistyö kunnan eri toimien kanssa oli yhteydessä paikallisyhdistysten korkeampaan terveyden edistämisen aktiivisuuteen.

Perusterveyden- ja vanhustenhuollon henkilöstö teki terveydenedistämistyötä pääasiallisesti yksilötasolla. Terveydenedistämistyötä tehtiin varsinkin terveysasemilla (ml. kouluterveydenhuolto). Verrattuna muuhun terveydenhuoltoon, terveysasemilla tehtiin enemmän yksilö-, ryhmä- ja väestötason terveydenedistämistyötä sekä osallistuttiin enemmän laaja-alaiseen terveydenedistämistyöhön sekä riskikäyttäytymisen ehkäisemiseen. Kuntien välillä oli jonkin verran eroja henkilökunnan terveyden edistämisen aktiivisuudessa. Mahdollisia selityksiä näille eroille ovat vastaajien kohderyhmät terveyden edistämässä sekä mahdollisuudet tehdä yhteistyötä eri toimijoiden kanssa kunnassa.

Tutkimustulokset ovat sopusoinnussa Rüttenin ym. (2000) monitasoisen terveyden edistämisen mallin kanssa. Terveydenhuollon ammattilaisten terveydenedistämistoiminnan aktiivisuutta lisäsivät organisaation arvot, oma osaaminen (tieto kuntalaisten terveydestä ja elinoloista) sekä mahdollisuudet yhteistyöhön organisaation ulkopuolella. Organisaation arvoihin liittyen, tulokset osoittivat, että työn koettu monipuolisuus ja haastavuus (työ jossa voi käyttää taitojaan ja tietojaan ja joka vaatii osaamista, harkintaa ja päätöksentekoa sekä uusien asioiden oppimista) sekä kollegoiden sosiaalinen tuki olivat yhteydessä terveydenedistämistoiminnan aktiivisuuteen.

Myös vapaaehtoisjärjestöjä koskevan tutkimuksen tulokset tukivat monitasoisen terveyden edistämisen mallin oletuksia. Paikallisyhdistysten terveydenedistämistoiminnan aktiivisuutta selittivät yhdistyksen pätevyys, yhdistyksen arvot – orientoituminen erityisesti lasten, nuorten ja aikuisväestön hyvinvoinnin edistämiseen – sekä osallistumisen mahdollisuudet (mahdollisuus tehdä yhteistyötä kuntatoimien kanssa ja seurata kuntalaisten terveydestä käytävää keskustelua sekä vaikuttaa päätöksentekoon). Näiden ohella kunnalla oli vaikutusta.

Kuntien välillä ei ollut eroja siinä, miten luottamushenkilöt arvioivat terveydenedistämistoimintaa ja sen tuloksellisuutta (terveyspolitiikan vaikuttavuutta). Vaikuttavuutta selittivät, oletusten mukaisesti, tavoitteet ja resurssit. Oletusten vastaisesti yhteisöosallistumisen mahdollisuudet eivät olleet yhteydessä terveydenedistämistoimintaan ja sen tuloksellisuuteen. Vaikuttavuuden näkökulmasta tärkeimmiksi elementeiksi paikallispoliittisesti nousivat vanhusväestön terveyden ja elämänlaadun edistäminen sekä perusterveyden- ja vanhustenhuollon toimivuus.

Tutkimuksen tulokset vahvistavat terveyden edistämisen periaatteiden eli voimaantumisen (empowerment), yhteisöosallistumisen ja sektorien välisen yhteistyön merkitystä suomalaisissa kunnissa. Tulokset antavat lisänäyttöä ja korostavat näiden periaatteiden merkittävyyttä terveydenedistämistoiminnan

tukemisessa. Tutkimuksessa saatiin uutta tietoa teoreettisen mallin soveltuvuudesta eri toimijoiden terveyden edistämisen toimintaan kunnassa. Kun halutaan tukea terveyden edistämistä paikallistasolla, tämän tutkimuksen tulokset – organisaatioarvojen, osaamisen ja mahdollisuuksien yhtä vahvat yhteydet terveydenedistämistoimintaan – painottavat monitasoista lähestymistapaa. Poliittiset päättäjät tarvitsevat mahdollisesti enemmän näyttöä yhteistyön ja yhteisöosallistumisen vaikuttavuudesta terveyden edistämisessä.

1. INTRODUCTION

“Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one’s life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.”

The Ottawa Charter for Health Promotion (WHO 1986)

Good health is among the most important things in life – it is a resource for everyday life. The promotion of health therefore has, or should have, a key role in society and in decision-making on different levels and in all areas. According to the ecological view of health and health promotion, the responsibility rests not only with individuals but also with communities and society, and its authorities. In the Finnish context, an evaluation by the World Health Organization (WHO) of the Finnish health promotion system of the 1990s concluded that, although the standards were high on the national level and in national policy documents, on the municipal level there was too much emphasis on health services instead of systematic health promotion (WHO 2002a). The municipalities, specifically, are key actors in this context, given that local government, in line with the decentralized Finnish administration model, has a high degree of autonomy and is responsible for local conditions and health policy. Even though municipal decision makers value health highly (Perttilä 1999), recent studies suggest that the promotion of health still does not have as high priority in Finnish municipalities as recommended in the national health policy (Uusitalo et al. 2007; Rimpelä et al. 2009; Lindfors et al. 2010). Thus, a key question in public-health work is how to motivate and support health promotion in municipalities, or local contexts (cf. Guldbrandsson 2005).

On the general level, public health has improved considerably in Finland as in most developed countries, and in fact to a greater extent than in many other Western European countries (Teperi & Vuorenkoski 2006). The rapidly rising level of education in Finland, which is high by international standards, structural changes and a growing general emphasis on health have contributed to improving the population’s health (Lahelma et al. 2006). However, some problems remain, some have grown worse and new challenges have emerged: mental health problems, alcohol-related problems, obesity, diabetes, population ageing, inequity in health and the growing costs of healthcare constitute some of the challenges to the nation’s health (Koskinen et al. 2006). ‘Health promotion’ has been recognized as an essential aspect of health development (WHO 1997). Health is multidimensional in nature, and is influenced by a range of different factors – not only personal characteristics

but also social, cultural and structural elements. Hence, a broad approach to the promotion of health has been advocated (WHO 1986; 1997; 2005). Such an approach, and especially the Ottawa Charter for Health Promotion (WHO 1986), has had a significant influence on the debate on public health and the formulation of health policy in many countries (Kickbusch 2003), including Finland. Consequently, there is a need for more knowledge about health promotion based on the strategies and principles of the Ottawa Charter.

Health promotion, as conceptualized in the Ottawa Charter (WHO 1986), works to enable people to increase control over their health and its determinants through five action strategies: building healthy public policy, creating supportive environments, strengthening community action, reorienting health services and developing personal skills. In terms of the effectiveness of these strategies, a recent synthesis of eight reviews proposes that they be combined and complemented with certain supporting actions or principles (Jackson et al. 2006); the strongest evidence related to one strategy only was found for investment in building healthy public policy. In addition, as political commitment turned out to be a central principle supporting health promotion effectiveness, the vital role of policymakers in general and political decision makers in particular, seems obvious. Moreover, the authors concluded that although the effectiveness of the community-action strategy still appears to be unclear, community engagement and participation in decision-making and planning are vital to the effectiveness of health promotion (Jackson et al. 2006). Raeburn and colleagues (2006) strongly support the view that the most powerful instrument for health promotion in the future will be action centred on capable communities.

The strategy of 'creating supportive environments' has been referred to as a cross-cutting strategy (Jackson et al. 2006; Pettersson 2007). It initially focused on the physical environment, gradually evolved to become more comprehensive (Nutbeam 2005), and now studies have shown the importance of creating supportive environments and conditions on different levels – the individual, the social and the structural (Jackson et al. 2006). Supportive environments are essential for the other strategies to be effective: for example, personal skills development does not seem to work in isolation. Moreover, there is evidence that awareness of the socio-environmental context is a central principle behind the effectiveness of health promotion (Jackson et al. 2006). The review covering the effectiveness of the Ottawa Charter's strategies did not include that of reorienting health services, which thus far has not been addressed consistently (Jackson et al. 2006; Wise and Nutbeam 2007) despite the perceived need for a reorientation with a more explicit concern for the population's health (Wise and Nutbeam 2007).

Although there is growing evidence of the effectiveness of health promotion strategies, there is a lack of research focusing on the conditions and factors that might enable health promotion actions (Guldbrandsson 2005). This need for knowledge about enabling factors relates, in part, to the discussion on sustainability, and the

importance of building capacity to create on-going action for health (Smith et al. 2006). The main interest in capacity building lies in the health promotion system, or the organizations doing the actual health promotion work and their capacity to develop and embrace new forms of action (Hawe et al. 1997; Rimpelä 2010).

Given that the different health promotion strategies tend to relate to different research contexts, Rütten and colleagues (2000) suggest that it would serve both theoretical and strategic purposes to involve two or more of them in studies. Levin and Ziglio (1996) emphasized some years ago that a better understanding of the relationships among the strategies would be helpful for decision-making. In addition, there is growing recognition of the need for theoretical approaches in health promotion research to provide an explanatory focus. The present study intends to address these aforementioned issues. It explores health promotion actions in local contexts from different actor or organizational perspectives, the point of departure being the strategies and principles of the Ottawa Charter (WHO 1986) and the multilevel health promotion model (Rütten et al. 2000), and its application to policy-making (Rütten et al. 2003a; 2003b). The model proposed by Rütten and colleagues is based on von Wright's (1976) general 'logic of events' model, and is assumed to be applicable to different strategies and actors (Rütten et al. 2000; 2003a; 2003b). The overall aim of this study is to enhance understanding of health promotion action, and especially its enablement on the municipal, or local level.

This study was part of a larger evaluation of the production model of primary healthcare (PHC) in four municipalities. Politicians in one of the municipalities had decided to contract out all PHC services (including services for older people) to a non-profit organization that emphasized health promotion and community participation as central values in its operations. This guided the outline of the study: with the Ottawa Charter (WHO 1986) as the point of departure, the focus was set on the strategies of strengthening community action, reorienting health services and building healthy public policy. The approach was comparative – comparing health promotion actions in four municipalities in Finland – thus taking into account the context.

2. LITERATURE REVIEW

The aim of this study is to contribute to current knowledge about health promotion on the local level and how it is enabled. The following literature review therefore starts from the concept of health promotion, including the principles and approaches. Thereafter the significance of health promotion on the local level is explored, and the Finnish health policy context is briefly described. Attention then turns to the three health promotion action strategies. Given the broad scope of the study and the use of a novel theoretical approach to explore the determinants of health promotion action, the review focuses more strongly on conceptual than on empirical issues.

2.1 Health promotion – the concept

Interest in the protection and promotion of public health is not new. However, health promotion as an ‘organized field’ is quite a recent phenomenon, which is commonly considered to date from 1974 and the Canadian document ‘A new perspective on the health of Canadians’ written by Marc Lalonde, Canada’s health minister at that time. This was the first national governmental policy document to identify health promotion as a key strategy (Rootman et al. 2001; Rimpelä 2010). Growing interest in the concept and the strategy led to the first international conference on health promotion, which was held in Ottawa in 1986. The conference delegates endorsed the Ottawa Charter of Health Promotion (WHO 1986), which with its values and strategies has provided a basis for much of the development of health promotion on the global level (Rootman et al. 2001).

The Ottawa Charter defines health promotion as “*the process of enabling people to increase control over, and to improve, their health*” (WHO 1986). New definitions have been suggested from this starting point. Nutbeam (1998a) expanded the original one to include control over the determinants of health: “*the process of enabling people to increase control over the determinants of health and thereby improve their health*”. Ziglio and colleagues (2000) expanded it further: “*the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health*”. The Bangkok Charter (WHO 2005) defines health promotion as “*the process of enabling people to increase control over their health and its determinants, and thereby improve their health*”. These are not the only definitions. Rootman and colleagues (2001) analysed some of them and concluded that although they differ, they share basic elements: the ultimate goal of improved health or wellbeing, objectives that focus on the individual and/or the environment, and the processes or activities.

Nevertheless, the Ottawa Charter definition (WHO 1986) has gained special recognition: it is used extensively in professional as well as scientific literature (Rootman et al. 2001; Kickbusch 2003), and the principles and actions set out in the charter have influenced the frameworks and national policies of many countries (Kickbusch 2003; Scriven and Speller 2007). According to Kickbusch (2003), the aim of health promotion as understood in the Ottawa Charter was to expand the health promotion work from an individual, disease-oriented and behavioural model to cover different levels of society and different settings - it shifted the focus to the determinants of health.

The determinants of health

The determinants of health are the factors that have been found to have the greatest influence on it – either positive or negative. Health could thus be understood as the outcome of individual and collective action (MSAH 2009) and of several determinants (Ollila 2006). The Finnish quality recommendations for health promotion conceptualize these determinants as individual, social, structural and cultural factors that can strengthen or weaken health (MSAH 2009). According to these recommendations, the population's health can be influenced through these determinants; moreover, it is stated that their influence is mediated by factors such as attitudes, health behaviour, health-supportive resources, the ability to interpret health-related information and access to services (MSAH 2009).

Dahlgren and Whitehead (2006) conceptualize the determinants of the population's health as rainbow-like layers of influence. In the centre are rather stable characteristics of individuals such as sex, age and constitutional factors. Beyond this, however, are influences that are theoretically modifiable by policy and actions, in other words individual lifestyle factors (first layer), social and community networks (second layer), living and working conditions (third layer), and general socioeconomic, cultural and environmental conditions (the most far-reaching fourth layer). Furthermore, Dahlgren and Whitehead differentiate between positive health factors, protective factors, and risk factors or risk conditions, all of which can be influenced by individual, political, organizational and commercial decisions.

A further and significant aspect of the aforementioned model is the emphasis on the interactions between the layers – a view that is common today. Ståhl and Lahtinen (2006), for example, describe how lifestyle factors are determined by social and community influences, living and working conditions, as well as general socioeconomic, cultural and environmental conditions. Similarly, as Beaglehole and colleagues (2011) state, although tobacco use, an unhealthy diet, physical inactivity and harmful consumption of alcohol comprise major threats to public health all over the world, forces largely outside the control of individuals influence their choices regarding these lifestyle factors. Thus, measures such as policies and actions that

make healthy lifestyles possible are needed – and these are the action strategies of health promotion. Before turning to the strategies, the following section discusses some of the principles on which they are based.

2.2 Principles and approaches in health promotion

The WHO health promotion ideology reflects several principles. The key principles of a broad view of health, intersectoral cooperation, participation, and empowerment of individuals and the community (WHO 1986; Rootman et al. 2001) are highly relevant from the perspective of the current study. The following two sub-sections review these principles, after which various approaches to health promotion are briefly described.

A broad view of health

The World Health Organization initially defined health in 1948 (WHO 2006) as: “*A state of complete physical, social and mental wellbeing and not merely as the absence of disease or infirmity*”. This definition has been criticized as being too abstract and utopian. Moreover, with the changes in demographics and in the nature of disease since 1948, ageing and chronic illnesses are now among the major challenges facing society and the healthcare system (Huber et al. 2011). In the view of Huber and colleagues, the reference in the WHO definition to ‘complete wellbeing’ is counterproductive because it categorizes people with chronic illnesses as definitively ill. Nevertheless, they acknowledge the value of the three dimensions of health – physical, mental and social – it delineates. Huber and colleagues (2011) describe a conceptual framework of health – the outcome of a discussion among experts – that is based on the capacity to cope and to maintain or restore equilibrium and a sense of wellbeing. They conceptualize health as “the ability to adapt and to self-manage”. Similarly, the Ottawa Charter (WHO 1986) states: “*To reach a state of complete physical, mental and social health, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment*”. If the word ‘complete’ is replaced with ‘optimal’, the two conceptualizations come closer to each other in meaning, although the inclusion in the Ottawa Charter of the environment and what it offers seems valuable. Moreover, in the general context of health promotion, health has been conceptualized more as a means than as a state (WHO 1986; Nutbeam 1998a): “*Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.*”

The adopted view on health is significant given that it is both a goal of health promotion and has consequences in terms of how it is approached. Kickbusch

(2003) describes the strengthening of resources for health in general as the objective of health promotion. Nutbeam (1998b), however, distinguishes various types of outcomes associated with health promotion activities. He presents a hierarchy in which health and social outcomes constitute the top level, and this includes the quality of life, functional independence and equity and, related to these, outcomes such as physical and mental health. On the second level he places intermediate health outcomes, in other words the determinants of health and social outcomes: healthy lifestyles, healthy environments (physical, economic and social) and effective health services. The determinants of these outcomes are the outcomes on the third level, which he defines as the actual outcomes of health promotion: health literacy, healthy public policy and organizational practices, and social influence and actions (Nutbeam 1998b). Huber and colleagues (2011) also suggest, in relation to health policy, that a more relevant outcome measure than health gain in survival years might be societal participation.

Participation, intersectoral cooperation and empowerment

Nutbeam (1998b) describes participation and partnership as processes in health promotion, and the empowerment of individuals or communities as outcomes. According to various evaluations, intersectoral cooperation as well as community participation and engagement in planning and decision-making are vital for the effectiveness of health promotion strategies (Jackson et al. 2006). Intersectoral cooperation is understood as a relationship between different sectors of a community or society, the aim of which is to act on specific issues to achieve health outcomes (Nutbeam 1998a) – thus including, one might argue, community organizing, another related concept. Community participation, in turn, is defined as a “*process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change*” (WHO 2002b). Different stages, steps or levels of participation have been described (Eklund 1999; Tones & Green 2004). Tones and Green (2004) suggest a relationship between degrees of participation and empowerment – a low degree of participation (or exclusion) being related to a low degree of empowerment, and a high degree of participation to a high degree of empowerment.

Political will has been described as a key facilitator of participation (Wallerstein 2006). Zakus and Lysack (1998) concluded from their review that community participation has to be supported by health professionals and managers and by the political and administrative system in order to be effective and long lasting. Gillies (1998), reviewing the effectiveness of different types of partnership in health promotion, found that the more extensive the community involvement/

participation, the greater was the impact and sustainability. She stressed the impact of community involvement both in setting agendas and in the practice of health promotion.

With regard to empowerment, in the context of health promotion it has been defined as a process through which people gain greater control over actions and decisions that affect their health (Nutbeam 1998a). Furthermore, an empowered community is a community in which organizations and individuals “*apply their skills and resources in collective efforts to address health priorities and meet their respective needs*” (Nutbeam 1998a) – the community has gained greater control over decisions and actions affecting their health. According to Eklund (1999), generating community empowerment requires long-lasting external and supportive mechanisms, systematic cooperation and changes in prevailing organizational structures.

Wallerstein (2006), in a review of the effectiveness of empowerment, states that participatory processes constitute the basis of empowerment, but that they are insufficient in themselves if the strategies do not build capacity in community organizations and individuals: sustainability and empowerment occur as people ‘create their own momentum’, improve their skills and advocate changes they perceive are needed. Key factors seem to be ‘authentic participation’, autonomy in decision-making, a sense of community and local bonding, as well as psychological (individual) empowerment among community members. Moreover, health literacy and life skills are crucial for participation as well as for empowerment (WHO 1997; Nutbeam 1998a). Although empowerment is considered an outcome in itself, it is seen as a significant intermediate step to long-term health-status outcomes (Wallerstein 2006). Dalgard and Lund Håheim (1998), for example, having found that social participation was better than social support at predicting survival, suggest that, by implication, social participation is related to control over one’s life; that is, empowerment (Nieminen et al. 2010).

Apart from individual empowerment, outcomes of community empowerment – participation and bonding measures such as social capital and a sense of community (Wallerstein 2006) – have also been found to be associated with health outcomes. Parker et al. (2001) found in separate analyses that a greater perceived sense of community, neighbourhood control and neighbourhood participation were positively associated with self-reported health and negatively with depressive symptoms. When all these ‘community social dynamic’ variables were included in the same model, a sense of community emerged as the only significant variable, suggesting that it might be the most comprehensive of these measures. In terms of social capital, for example, Nieminen et al. (2010) concluded that, measured as social participation and networks, trust and reciprocity, it contributed to good self-rated health and psychological wellbeing. Social support, another dimension of social capital in their work, turned out to be a much weaker measure, and not significantly related to health and wellbeing when the other dimensions were controlled for.

The authors also suggest that a person's own contribution to social capital might be more important for her/his health than support from other people.

The principles of a broad view of health, intersectoral cooperation, participation and empowerment could be considered distinctive traits of health promotion. In addition, however, it would be helpful to acknowledge different approaches.

Approaches to health promotion

According to Rootman et al. (2001), health promotion in practice encompasses a range of activities aimed at improving the health of individuals and communities. There is some general agreement about the importance of principles such as participation and empowerment – although health professionals, for example, may vary in their understanding of how broadly they view health and health promotion (Buetow & Kerse 2001).

One way of conceptualizing the different approaches is in terms of *content* (e.g., substance use, physical exercise, nutrition, mental health, healthy and safe environments), *target group* (e.g., population strategy, risk-group strategy, a certain age group), *context* (e.g., a certain environment or policy segment) and *working methods and practices* (e.g., political influence, community action, preventive service practices and cooperation) (MSAH 2009).

On the basis of the above conceptualization, a comprehensive health promotion approach could be said to address multiple behaviours or contents (e.g., tobacco use, physical inactivity and mental health) and target populations in several community locations or contexts (e.g., schools, workplaces, healthcare settings), and to use a variety of population-based approaches or working methods (e.g., community-wide education, environmental and policy initiatives) (Riley et al. 2001). In terms of content, the concept 'general health promotion' has also been used, referring to addressing general determinants of health and disease such as tobacco and alcohol use, nutrition, physical activity and psychosocial issues (Groene & Garcia-Barbero 2005).

The interest on the level of actors in the current study lies primarily in the content of health promotion, although the focus in terms of different population groups is also explored to some extent. The principles of health promotion are evident in that the broad view of health is reflected in the conceptualization of health promotion action, resembling 'general health promotion', and intersectoral cooperation and community participation are seen as factors enabling health promotion action. The study context is four municipalities, in other words the local level. The next section therefore focuses on the importance of health promotion in such contexts.

2.3 Health promotion in local contexts

The World Health Organization emphasizes the significance of health promotion on the local level (e.g., WHO 1986; WHO 2005). Many factors that have an impact on people's health relate to community settings and social structures in the community (Jackson et al. 2006; Wimbush et al. 2007; Jansson and Tillgren 2010). According to some estimations, more than 75% of health determinants exert their influences on the population in the community setting (Hancock 2009): these determinants include the social, cultural and economic environment, the physical environment and the health services. In addition, the conditions needed for health are largely created locally (Hancock 2009). Children in particular, together with young and older people, the unemployed and people with disabilities, are dependent on the local environment and the opportunities it offers (Holmila 1997; Vertio 1992).

The rationale behind emphasizing health promotion in local contexts, moreover, lies in the fact that, as Swerissen and Crisp (2004) point out, individual action takes place within a social context and is maintained by it. Interventions that focus on individuals outside of their social context are therefore not likely to produce health gain that is sustainable; changes in the social context, or in the conditions that constitute it (institutional, organizational and community conditions), are also needed (Swerissen & Crisp 2004). It has been suggested that one reason why community engagement initiatives have failed is the lack of real engagement with the community, in other words with the social context in which its members live (Blomfield & Cayton 2010). One key component of the community approach, and of the setting approach overall, is the possibility to cooperate and to form partnerships (Jackson et al. 2006). The partnership approach to local public-health promotion entails local government with its different agencies, non-governmental organizations and other actors acting together to create healthier communities (Fröding et al. 2008).

Jansson and Tillgren (2010) suggest that studies on the promotion of health in the context of municipalities are particularly valuable, one reason being that there seem to be differences between national and local policies as well as in local practices (WHO 2002a; Jansson et al. 2011). Although Eyles et al. (2009) found no differences in health-policy discourse between different levels of the system, they did identify a gap between national and provincial policy and local practice. They suggest that this partly reflects resource investment in shaping implementation. Develin (2010) also found, in relation to health promotion within health services, that area services shared the state policies' vision of a greater focus on health promotion in their strategic plans, although this was not realized in practice. Local needs, interests and resources appear to influence local health promotion processes more than external factors such as national health policies (Jansson and Tillgren 2010). Guldbrandsson (2008), however, found that international and national policy

documents had an influence on local public-health action, although this may be on more of a confirmatory level than giving rise to new actions and paths.

Other researchers (Fröding et al. 2008) describe national public-health objectives as crucial for the development of local health promotion, notably in the form of a greater emphasis on public-health issues in local government and the support and structure it gives to local planners and coordinators. On the local level, public officials, politicians and non-governmental organizations have been identified as key actors in the development of health promotion in different phases of the policy process (Guldbrandsson 2005; Jansson & Tillgren 2010).

Reflecting how Dahlgren and Whitehead (2006) picture the determinants of health, health promotion can be conceptualized on different levels in a rainbow-like form. Starting from the outer layers, there is health promotion on the global and, in the case of Finland, European level, continuing towards the centre with the national, the municipal and the community level and finally reaching, in the centre, the individual level. These different levels or layers interact: they influence and are dependent on one another. Although the focus in this study is on the municipal and community level, it is acknowledged that the inner (e.g., individuals and relations) and outer (e.g., Finnish national policies, national non-governmental organizations) layers influence and are influenced by health promotion on this local level.

2.4 The Finnish health promotion policy context at the turn of the 21st century

The WHO 'Health for All' policy frameworks and the principles and actions set out in the Ottawa Charter have influenced the framework and policy of national health in Finland. The 'Health for All' philosophy on which the Ottawa charter is based indicated a shift in perspective from input to outcomes, meaning that governments were to be held accountable for the health of their populations and not only for the health services they provided (Kickbusch 2003). Health became a national priority in Finnish politics as early as in the 1970s., but a significant step forward was taken when its status and government's responsibility for it were confirmed in the revised constitution (Melkas 2013; The Constitution of Finland 731/1999): the Constitution of Finland and additional, more specific, legislation state that public authorities shall guarantee adequate social, health and medical services for everyone, and promote the health of the population (MSAH 2001).

A guiding principle in Finland is that the promotion of health and wellbeing should be incorporated into all policies, which Finnish representatives have also promoted on the EU and global levels as a 'Health in All Policies' approach (Ståhl et al. 2006; WHO, MSAH 2013). Nevertheless, the Ministry of Social Affairs and Health (MSAH) plays a central role in initiating and coordinating health policy, having the responsibility to guide and oversee health promotion in Finland,

supported by different agencies. The policy instruments used include legislation, recommendations, national programmes and support of local action. The National Institute for Health and Welfare (formed through a merger of the National Public Health Institute with the National Research and Development Centre for Welfare and Health in 2009) is a research and development institute that is responsible to MSAH but serves decision-makers in central and local government, actors in the field, as well as broader society. The aims are to promote the health and welfare of the population, to prevent diseases and social problems, and to develop social and health services. Recent examples of its activities include monitoring health promotion in municipalities and developing a good practice model for its management. The Finnish Institute of Occupational Health is also working on issues concerning health promotion in the field of occupational health and safety. In addition, national non-governmental organizations are active in the promotion of health and wellbeing (Melkas 2013) initiating, for example, nation-wide health promotion strategies and programmes and becoming involved in decision-making on the national level.

MSAH points out on its homepage how the importance of health promotion in Finnish public policy is evident in legislation on primary healthcare, temperance work, and alcohol and tobacco control. Furthermore, the Social Welfare Act stipulates the obligation to promote the welfare of the population. Moreover, MSAH refers to legislation concerning occupational safety and health, environmental healthcare and the role of municipalities.

The topicality of health promotion is underscored in the revised Finnish Public Health Act (Primary Health Care Act 928/2005; Rimpelä 2005): it is included as a central concept and is described as a challenge for the whole municipality. The municipalities are obligated to work in cooperation with other municipal actors in promoting public health, monitoring the local population's state of health and related factors, and ensuring that health considerations are taken into account in all local government activities.

The Local Government Act (365/1995) stipulates that the municipalities have to promote both the welfare of their inhabitants and sustainable development. Furthermore, new joint municipal boards are obliged to promote health, functional capacity and social security according to the framework legislation in the reform of local government and services (169/2007). According to the Local Government Act, the council decides the direction of the municipal policy. The municipal operational and budgetary documents are the principal instruments of governance in the municipalities.

The Government Resolution on the Health 2015 public health programme (MSAH 2001) outlines the targets for Finland's current national health policy. The focus of the strategy is on health promotion. The programme lists challenges at different phases of life, and challenges facing different actors, the targets for different age groups being: an increase in child wellbeing and health and a decrease in symptoms and diseases attributable to insecurity; a reduction in smoking among

young people and appropriate responses to health problems associated with alcohol and drug use; a reduction in accidental and violent death among young men; an improvement in working and functional capacity among people of working age and in workplace conditions; and enhanced average functional capacity among people over 75. The targets for everyone include an expectation of more healthy years and maintaining satisfaction with health-service availability and functioning at least on the present level, and reducing inequality. Most of the targets stipulate exact figures to be reached by 2015. The main preconditions state that: all sectors and levels of government, the private sector and civil action must make the population's health a key principle guiding choices, and also be given better preconditions for its promotion; moreover, everyone will be given the right to a healthy environment and opportunities to influence decision-making concerning life arenas such as schools, workplaces and leisure environments.

The Health 2015 public health programme (MSAH 2001) highlights the key role of the municipalities and, furthermore, the need to strengthen cooperation among different actors in municipalities to promote health. For example, it is stated that municipal health departments can influence the population's health by working with local actors such as non-governmental organizations. Related to this, the programme emphasizes that both central and local government carries a certain responsibility for furthering non-governmental organizations' possibilities to operate and exert influence. Moreover, individuals are to be encouraged to be active in promoting their own health. According to a recent evaluation of the programme, further development with regard to the promotion of health and wellbeing in municipalities is needed, especially in the areas of competence, leadership, structures and good praxis (MSAH 2013).

However, although the national administration defines general health-policy guidelines and directs the health care system on the state level – such as in drawing up development plans for social and healthcare services – steering on the national level is quite weak (Teperi et al. 2009). In fact, local governments have a high degree of autonomy and responsibility for local conditions and health policy: Finnish municipalities have more authority than local authorities in other European countries (Ryynänen 2003). The municipalities are responsible not only for local public goods such as basic environmental and technical services, water and electricity, but also for healthcare, social welfare, and most education and cultural services (Loikkanen and Nivalainen 2011). The crucial role of municipalities in health promotion as emphasized in international literature (Jackson et al. 2006) is thus especially evident in Finland.

Health centres in Finnish municipalities have traditionally had a key role in health promotion and disease prevention (Teperi et al. 2009). The Primary Health Care Act of 1972 required the municipalities to establish health centres that would provide PHC services, and the emphasis was to be on preventive work (Melkas 2013). PHC in Finland includes a number of services (Laamanen et al. 2008a): school

healthcare, and maternal and child healthcare, which are free of charge (Teperi et al. 2009), non-urgent medical care, emergency services, inpatient services, care related to substance abuse, home care and care related to mental health (Laamanen et al. 2008a). Accordingly, the health centres employ a wide range of professionals, including general practitioners and physicians with other clinical expertise, public-health nurses, nurses, physiotherapists, psychologists and social workers (Laamanen et al. 2008a; Teperi et al. 2009). As part of the reform of the state subsidy system in 1993 the municipalities were given new options in the provision of health and social services: they could be produced in-house and in cooperation with other municipalities, organized as a municipal federation, or purchased from a public or private for-profit or not-for-profit provider.

There are differences across municipalities in the scope of services (within the general limits set in national legislation) and in the volume, with regard to primary-care visits and mental healthcare, for example (Teperi et al. 2009). Moreover, even after needs adjustment, significant differences in resource allocation for healthcare delivery persist. It has been suggested that these differences relate to differing developments of care-delivery structures, financial resources, the availability of health professionals and the population's need for healthcare as perceived by municipal decision makers. (Teperi et al. 2009) With regard to health promotion, recent studies suggest that there may be significant differences across municipalities in their commitment to health promotion in primary healthcare (Rimpelä et al. 2009), and also generally in terms of capacity building (Ståhl & Rimpelä 2010). Differences in municipal health promotion policies have also been reported (Uusitalo et al. 2007).

Local governments in Finland are responsible for local health policy, and thus for how health promotion issues are prioritized and how community participation is supported. Accordingly, there is a need for knowledge about health promotion on this governmental level. Moreover, given the apparent differences between the municipalities in their commitment to health promotion, further knowledge about health promotion on the local level, comparing different municipalities is warranted.

2.5 Health promotion strategies and enabling factors

This study focuses on three of the health promotion strategies set out in the Ottawa Charter (WHO 1986), namely strengthening community action, reorienting health services and building healthy public policy. It does so, by studying actors in local contexts representing community action, health services and public policy. The actors in question are local voluntary associations (LVAs), PHC personnel and local-level political decision makers. The strategy of creating supportive environments is included as part of the content of the health promotion actions of the different actors (cf. Jackson et al. 2006). The strategy to develop personal skills is acknowledged as

being a basis for individual action to take care of one's health and wellbeing. This is not explicitly studied, but is assumed to be included as a working method in the health promotion actions of the actors, especially the PHC personnel.

2.5.1 STRENGTHENING COMMUNITY ACTION

“Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of the process is the empowerment of communities, their ownership and control of their own endeavours and destinies”

Ottawa Charter (WHO 1986)

Strengthening community action is one strategy for achieving better health in local contexts. As discussed earlier, ‘community participation’, ‘empowerment’ and ‘community empowerment’ are considered key components of health promotion (e.g., WHO 1986; Israel et al. 1994; WHO 1997; Laverack & Labonte 2000), and partnership-based community effort has been seen as the only way to ‘produce’ the determinants of health (Kickbusch 1997). Earlier, ‘communities’ were primarily seen as venues through which one could reach large numbers of people to bring about changes in health behaviour (Nutbeam & Harris 2004). The current view in health promotion is of communities as dynamic systems with strengths and capabilities that can be influenced and supported so as to improve the health of their members (Nutbeam & Harris 2004). The WHO health promotion strategies describe community action and empowerment as prerequisites for health (WHO 1986; 1997; Wallerstein 2006). One approach to studying community action is through the activities of local voluntary organizations.

A major challenge in the coming years, according to the Jakarta Charter (WHO 1997), will be to release the resources for health promotion that reside in different sectors of society, and to establish co-operation between the different sectors, including non-governmental, governmental, and public and private organizations. The Bangkok Charter (WHO 2005) emphasizes the role of communities and civil society in initiating and shaping, as well as undertaking, health promotion. Scriven and Speller (2007) also conclude in their overview of the development of health promotion in Europe that community and civil-society involvement will be crucial components in the future.

One reason for the effectiveness of community engagement is that an individual's behaviour is shaped by the patterns of behaviour, norms and attitudes in their living context (Blomfield & Cayton 2010) as the rainbow picture of health determinants implies as well (Dahlgren & Whitehead 2006). Writing about the lack of effectiveness of community interventions, Blomfield and Cayton (2010) suggest that many fail to engage with communities on a deeper level and do not attempt to mobilize them

for action as a group. They see a need to engage communities in taking on the role of co-producers of health.

Focusing on factors supporting health promotion action, Zakus & Lysack (1998) identified a number of predisposing conditions for community participation: 1) a political climate that accepts and supports active community participation and interaction; 2) a socio-cultural and political context that supports individual and collective public awareness, knowledge acquisition and discussion of issues and problems affecting individual and community wellbeing; 3) sufficient awareness of social organization and health-related issues, and the relevant knowledge and skills, as well as previous successful experience of community participation; and 4) the prioritization of health issues in the community.

Moreover, community capacity is regarded a key factor influencing community health promotion efforts (Goodman et al 1998; Merzel & D’Afflitti 2003), and is one way of conceptualizing the potential to act (Baker & Teaser-Polk 1998). Community capacity has been defined as the “*characteristics of communities that affect their ability to identify, mobilize and address social and public health problems*” (Goodman et al. 1998 p. 259). Community engagement is believed to develop community capacity (Dressendorfer et al. 2005), which according to Goodman and colleagues (1998) comprises the following dimensions: participation, leadership, skills, resources, values, social and inter-organizational networks, community power, critical reflection and a sense of community, as well as an understanding of community history.

Furthermore, from another field, there are the concepts self- and collective efficacy, which are part of Bandura’s (1998; 2004) social cognitive theory. Collective efficacy is interesting in relation to this study: according to Bandura’s theory and the extension of the concept of human agency to collective agency, people’s belief in their collective efficacy to achieve social change could be regarded as a determinant of health promotion action.

On a more general level, Raeburn and colleagues (2007) argue that the ‘inner layer’ determinants of communities and individuals are still crucial to health promotion in a globalized world, although policy and regulatory matters have also become critical. The authors view the concept ‘community capacity’ as related to assets and strengths, and as an empowering or bottom-up approach to health promotion as opposed to a deficit and top-down approach. They refer to closely related concepts such as empowerment, participation, social cohesion, social capital, social networks and civil society, and especially non-governmental organizations. They also point out that when it comes to community capacity building, it is essentially a community-determined process: the communities are in control and ‘use’ professionals as they see fit and find appropriate and useful. They conclude from their review that self-determined community action in an environment of supportive policies and cooperating key actors might be the key to health promotion, also in a globalized world. Thus, the present study addresses community engagement in

health promotion through an investigation into the role of local-level voluntary organizations, their resources and the factors that influence their engagement in health promotion action.

The role of local voluntary associations in health promotion in Finland

Voluntary organizations have a relatively limited role in the core areas of welfare services in the Nordic countries as compared with other EU countries, focusing instead on activities related to culture, recreation and advocacy (Helander & Sivesind 2001; Lundström 2001). Nevertheless, in the case of Finland, voluntary organizations operating in the welfare sector have greater economic capacity than others, on average (Helander & Sivesind 2001; Helander 2003), and in this respect are comparable with most EU countries (Helander & Sivesind 2001). Moreover, the proportion of voluntary work within the core areas of welfare is about a fifth of all voluntary work in Finland, and much higher than in Sweden (7%; Helander & Sivesind 2001).

With regard to Finland, much has been and is expected of the voluntary, or third, sector in general. For example, the severe economic recession in the early 1990s forced municipalities to find new ways of offering welfare services and new cooperation partners, including third-sector actors, in order to produce them (Helander 2003). The inclusion of local women's associations at the beginning of the 1970s was important to the success of the North Karelia health promotion project (McAlister et al. 1982), for example. Voluntary organizations have also been called upon in connection with unemployment, loneliness and promoting social cohesion and democracy (Niiranen 1998; Hokkanen et al. 1999; Helander & Laaksonen 2000). Furthermore, the discussion about social capital has highlighted the role of voluntary organizations in society (e.g., Putnam 1996; Loranca-Garcia 2000; Kaunismaa 2000; Siisiäinen 2002). All of these issues can be considered to be related to health and wellbeing. Moreover, from the viewpoint of local-level voluntary organizations, Trojan et al. (1991) in Germany, found that many community groups were interested in action for health, although their main goal might have been something else.

Voluntary associations are the most prominent representatives of the third sector in Finland, and as regards voluntary work it has been shown almost entirely to comprise activities of the local-level associations (Helander 2003). The voluntary sector is highly structured, however, with national, regional and local levels. Four out of five LVAs are affiliated with federations operating nationwide; these federations increase the capacity of the local-level associations by providing information and advisory services (Helander 2003). At the time of this study there were about 100,000 registered associations (Rönneberg 1999; Helander & Laaksonen 2000), of which about 90,000 operated on the local level: this means that there were, on

average, 200 local-level associations in every Finnish municipality (Helander 1997). However, not all of them function actively: at the beginning of 2000 it was estimated that 50,000 – 60,000 were active (Rönnerberg 1999; Helander & Laaksonen 2000). The numbers are growing, and in 2007 there were about 67,000 active registered associations in Finland (GHK 2010a). Although there have been more studies related to the voluntary sector in Finland since the 1990s, there is still little research related to the significance of volunteering (GHK 2010a). Moreover, the role of local-level voluntary associations in health promotion and the factors that support their actions in this regard has not been a topic. However, Kokko et al. (2006; 2009; 2011) report in a recent study of youth sports clubs and their health promotion profiles that they were fairly health promoting.

2.5.2 REORIENTING HEALTH SERVICES

“The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.”

Ottawa Charter (WHO 1986)

Reorienting health services is the action strategy in the Ottawa Charter that has received the least systematic attention (Wise and Nutbeam 2007). The purposes of this strategy were to achieve a better balance between prevention and treatment, and to focus more explicitly on health outcomes on the population as well as the individual level (WHO 1986; Wise and Nutbeam 2007). Wise and Nutbeam (2007) suggest two main reasons why this strategy has attracted so little attention:

- 1) The main focus in health promotion has been on the social and environmental determinants of health, and the role of the health services in addressing these determinants has been considered marginal.
- 2) The political and public focus with regard to the health services has been strongly on issues related to tertiary services, and to their cost, access and affordability.

The European WHO network for Health Promoting Hospitals (HPH) works to promote the reorientation of hospitals and, today, also of health services in general (WHO 2007). The WHO HPH movement focuses on four areas: promoting the health of patients, promoting the health of staff, changing the organizational setting to focus on health promotion, and promoting the health of the community in the catchment area (Groene & Garcia-Barbero 2005). Related to this, Johnson and

Baum (2001) point to the role of cooperation, stating that if health services strive to be health-promoting settings and to improve the health of the community, cooperation with patients and their families, other service providers and the broader community is needed. HPH initiatives have been implemented in different ways, however, and success seems to be dependent on the implementation of reforms that embrace the whole organization and its culture and therefore influence all health professionals (Whitehead 2004a).

Whitehead (2004a) argues further that, there is an overall need in the health services to turn the emphasis towards public health, meaning that health professionals should also focus on the broader determinants of health in their activities. A recent study among Swedish health professionals found that the majority held the belief that health services had a key contribution to make in health development on the level of the population (Johansson et al. 2010a). Furthermore, the study revealed strong support for a health-oriented strategy as a prerequisite for effective healthcare. However, although the majority believed that the entire health service had responsibility for health promotion and disease prevention; over half perceived that the main responsibility lay within PHC (Johansson et al. 2010a).

It seems that health services in most countries need to expand their health promotion and disease-prevention activities in order to improve population health outcomes (WHO 1986; Wise and Nutbeam 2007; MSAH 2008). Moreover, health promotion in PHC does not seem to be realized on the level recommended in national policy goals (e.g., Ewing et al. 1999; Miilunpalo et al. 1995; Rimpelä 2004; Hogg et al. 2009). Empirical studies suggest that personal characteristics such as gender, age, specialty, self-perceived health status, critical reflection, knowledge and skills, as well as attitudes and beliefs (Benson and Latter 1998; Nolan et al. 1996; Ewing et al. 1999; Liimatainen et al. 2001; Delnevo et al. 2003; Joffres et al. 2004a; Javanainen-Levonen 2009), may play a role in the delivery of preventive and/or health promotion services. Jacobsen et al. (2005), for example, found that although general practitioners believe they have an important role to play in preventing lifestyle-related illness, they are sceptical about the effectiveness of intervention and have ethical concerns about giving lifestyle advice. Practice nurses have been found to be involved more in health promotion activities organized on an individual basis, and health visitors more in group- and community-wide activities (Nolan et al. 1996). Midwives seem to prefer societal approaches to health promotion but focus on the individual in their work (Furber 2000). Compared to hospital personnel, PHC personnel have reported a higher willingness to focus more on health promotion and disease prevention than they were currently doing in their work, and women seemed to be more willing than men (Johansson et al. 2010a).

According to Beaglehole et al. (2004), a workforce with a broad view on public health and an ability to work cooperatively across sectors, and with the skills to influence policy making, is required to face the health challenges of today. Workforce development is thus needed. However, the proponents of capacity building, a

relatively recent interest in the literature on health promotion, emphasize the fact that although workforce-development strategies are an important component in building the capacity of an organization, institutional capacity should also be expanded (Tang et al. 2005). Similarly, Hogg et al. (2009) point out the importance of organizational structures, stressing the need for those that support the practice of health promotion if the policy of the organization is to improve in this respect.

On the empirical level it has been found that factors related to the organization are associated with health promotion activities (Delnevo et al. 2003; Hogg et al. 2009). The following barriers to health promotion have been identified: lack of time and work overload, insufficient staffing, a lack of financial incentives, too low a value placed on the continuity of care, contradiction among recommendations, a lack of guidelines and unclear objectives (Hudon et al. 2004; Joffres et al. 2004a; Johansson et al. 2010a). A recent study from Canada reports that personnel in community health centres engage in health promotion activities to a higher degree than personnel engaged in other kinds of primary care (Hogg et al. 2009). The important attributes in community health centres include a higher proportion of female family physicians, more nurses, longer booking intervals and a smaller panel size. Joffres et al. (2004a) describe the following facilitating factors for health promotion in different kinds of organizations: support from management and from the boards/municipal councils, partnerships and overall organizational interest. Robinson et al. (2006), in turn, found that a lack of interest and competing priorities were among the major barriers to health promotion action, whereas committed and appropriately skilled people were the key facilitators. Delnevo et al. (2003) further argue that organizations can promote a culture of disease prevention and health promotion by making health a priority. Earlier, Benson and Latter (1998) referred to the need for nurses to be empowered in order to empower others, and highlighted the organizational climate or philosophy as an influential factor for nursing practice. Similarly, Germann and Wilson (2004) state that one cannot expect health professionals to facilitate emancipatory processes if they themselves do not experience these kinds of processes in their workplaces.

Finally, Robinson et al. (2006) point to external factors such as partnerships and cooperation, demographics and the political context as possibly influencing health promotion action in different organizations. However, thus far few studies have focused on the particular factors in health-service organizations and their environments that support health promotion action and therefore this issue is still not well understood (Riley et al. 2001; Robinson et al. 2006).

2.5.3 BUILDING HEALTHY PUBLIC POLICY

“Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.”

Ottawa Charter (WHO 1986)

Healthy public policy – a key strategy in health promotion – reflects the role of government and the public sector in creating conditions that support health (WHO 1988; Tones & Green 2004): the main aim is to create a supportive environment that enables people to lead healthy lives (WHO 1988). The importance of this strategy has been highlighted many times (e.g., WHO 1988, 2005; Wismar et al. 2006; Jackson et al. 2006): such a policy establishes the environment that makes the other strategies possible (WHO 1988; Jackson et al. 2006). Moreover, recent overviews of health promotion strategies point to the essential role of political commitment for the development of health promotion (Scriven & Speller 2007) as well as for its effectiveness (Jackson et al. 2006). In other words, health should be high on the agenda of policy makers. The recent approach of ‘health in all policies’ is similar in terms of agenda to the strategy of building healthy public policy (Sihto et al. 2006), and is seen as a third policy wave of horizontal health governance (Kickbusch 2010): the starting point is the vital role health plays in the economy of societies (Kickbusch 2010; Wismar and Ernst 2010).

Aside from the broad determinants of health and local government’s role in that respect, another policy issue concerns people’s possibilities to control, as far as possible, the determinants of health, in other words the core principle in health promotion of community participation and empowerment. Community participation is considered crucial to the concept of a healthy public policy (WHO 1988; Fosse 2003). According to Rütten (2001), it is especially important on the local level given that citizens’ knowledge and perspectives are decisive in shaping healthy public policies. As Zakus and Lysack (1998) point out, community participation has to be supported by the political and administrative system in order to be effective and long lasting on the local level. It has also been stated in the Finnish context that the national and local governments shape the conditions under which voluntary associations succeed in their work, for example (Saarelainen 2003).

Although many policy decisions in Europe nowadays reside on the European or even the global level, the responsibility for health policy and for the implementation of many other policy decisions still, in practice, remains on the national and local levels (Ollila et al. 2006). Consequently, the development of healthy public policy is as important on the local governmental level as it is on higher levels (WHO 1988; Sihto et al. 2006). Local government, with its mandate, has a significant role in creating a supportive environment for health promotion given the need for multiple strategies and actions on multiple levels and in many sectors to make the actions

effective (Jackson et al. 2006). There still seem to be barriers in the development of healthy public policy, or health promotion policy, however, and it has been suggested that such obstacles are to be found in the political and administrative structures (Fosse 2003). Nevertheless, whereas much effort has been put into studying the determinants of health and the causes of disease, and how to influence these factors, far less is known about the impact of politics on health policy (Ritsatakis et al. 2000; Navarro 2008). Furthermore, in view of the key role of politicians in the development of health promotion, there is good reason to focus research on their views (Ashley et al. 2001; Cohen et al. 2001).

The current study concerns the health promotion policy of local governments and its impact from the viewpoint of local-level political decision makers. Some general reflections on the issue of policy-making and policy change are therefore warranted.

Policy-making and policy change

Policy has been defined as agreement or consensus on issues to be addressed in order to achieve a desired result or change. In other words, a policy is an agreement about goals and objectives, the priorities among these objectives and the main directions for achieving those (Ritsatakis et al. 2000). Milio's (2001) definition is similar, but emphasizes resource allocation. Fosse (2003) defines health promotion practice as the outcome of policy, and policy as the policy decision, i.e. output. However, she also emphasizes that public policy is more than the programmes of government: it is a guiding principle as much as an outcome. De Leeuw (1993) points to the fact that the making of policy is connected to implicit assumptions, interests and power positions. Policy-making and target setting thus constitute a political process that is constrained by values and principles (Ritsatakis et al. 2000; Ritsatakis & Järvisalo 2006). In addition, as de Leeuw (2001) states, communities and institutions always play a role in policy development. Policy decisions are influenced by practices in the implementing organizations, and these practices can become statements of policy (Guldbrandsson 2005).

The policy-making process has been described as either 'rational' or 'incremental' – according to two broad schools of thought (Tones & Green 2004). The incremental view is said to be typical of a pluralist, democratic approach, of 'muddling through' and the 'consensus model' of policy-making, whereas the opposite of the consensus model is the 'conflict model', meaning that groups have their own interests and compete to achieve their goals (Tones & Green 2004). Related to this, Sabatier and Jenkins-Smith's notions about different policy subsystems and policy learning, as described in Sabatier (1998), is interesting in the context of this study. According to Sabatier (1998), policy subsystems are vital in terms of understanding policy processes: the actors in a subsystem can be grouped in a number of 'advocacy coalitions' with shared sets of policy core beliefs, meaning that different coalitions

perceive the world differently – through ‘different lenses’. Moreover, the ‘belief system’ includes deep core beliefs, policy core beliefs and secondary aspects. Deep core beliefs represent an individual’s basic ontological and normative beliefs (e.g., on the left/right-wing scale), which are quite resistant to change; policy core beliefs represent normative commitments and causal perceptions, which are less strictly held and constitute the glue of a coalition; and the secondary aspects include large sets of ‘narrower beliefs’ that are more easily adjusted (Sabatier 1998).

According to Sabatier, ‘policy-oriented’ learning within and between coalitions is a crucial aspect of policy change. However, major changes in policies – that is in the core – tend to derive from external events such as socioeconomic change and change in public opinion, whereas policy-oriented learning can lead to secondary changes in public policy, which he defines as instrumental decisions (Sabatier 1998). Thus, changes in policies are, in general, small (Guldbrandsson 2005), and changes on the policy periphery are easier to introduce than changes closer to the core (Sabatier 1998; Guldbrandsson 2005).

Vrangbæk and Christiansen (2005) discuss two sets of theories explaining stability in policy: path dependency and institutional inertia, which lead to the following of paths set in accordance with choices made earlier and with social and cultural norms in institutions. Political institutions and processes seem to reinforce path-dependent development because of the collective nature of politics, the central role of formal and change-resistant institutions, and the complexity and ambiguity of political processes (Pierson 2000; Vrangbæk and Christiansen 2005). Pierson explains path-dependent development in terms of processes of ‘increasing returns’, which he describes as positive-feedback or self-reinforcing processes (Pierson 2000).

In line with that path of thought, Guldbrandsson (2005), discussing an actor-structural approach to analysing policy, points to the interrelationship between actors and institutions or structures, both influencing each other. Actors’ and institutional preferences can change over time to coincide with what has been found possible for the institution to accomplish. Moreover, actors belonging to the same structure are more likely to be ‘socialized’ in similar ways as they receive the same information and face similar opportunities and restrictions (Lundqvist 1993; Guldbrandsson 2005).

Like Sabatier (1998), Vrangbæk and Christiansen (2005) discuss changes in policy, especially in health policy, and identify four sets of factors that may influence and change path-dependent development: socioeconomic developments, such as economic factors, demographic change and national socioeconomic policies; new knowledge and ideas via policy learning or the spread of fashion; changes in the political climate and the composition of policy coalitions; and disasters, accidents and scandals. They also suggest that many gradual changes may eventually lead to more radical changes.

Empirical studies related to health promotion policy in local government

Earlier studies on health promotion policies within local governments have often approached the issue through content analysis of local governmental reports, plans, strategies and interviews with policy makers (e.g., Perttilä 1999; Andersson et al. 2003; Guldbrandsson 2005; Uusitalo et al. 2007; Jansson & Tillgren 2010). In the case of Finnish municipalities, it seems that health promotion is still not well established (WHO 2002; Uusitalo et al. 2007; Lindfors et al. 2010). The theoretical literature review suggests that the changes in policy that take place tend to be small. However, one possibility for change is in policy learning, which is proposed to take place among coalitions with different beliefs and values (Sabatier 1998; Gagnon et al. 2007). Some differences in beliefs related to health promotion have been reported. For example, Perttilä (1999) found that municipal decision makers' views on health affect how the role of health promotion is understood. If health is understood narrowly the responsibility for its promotion is seen to be borne by individuals themselves, and in terms of decision-making the issue seems to relate mainly to health services. However, when there is a more comprehensive understanding of health its promotion could be seen as a strategic issue for the local government as a whole (Perttilä 1999). Furthermore, studies based on surveys among municipal managers, health-centre managers, and chairs of municipal councils and executive boards (Rimpelä 2004; Poikajärvi & Perttilä 2006) suggest that there might be differences among decision makers as to their views on the state of health promotion in the municipality.

One way of exploring the dynamics of local government is to study the perceptions of all local-level politicians. As mentioned earlier, there is a recognized need for public-health research focusing on the views of politicians (Ashley et al. 2001; Cohen et al. 2001). Moreover, it is not known whether there are differences between municipalities in their health promotion policies and in the impact of these policies as perceived by local-level politicians. Findings from Canadian studies indicate that there may be differences in the view of health promotion based on political-party affiliation (Ashley et al. 2001; Cohen et al. 2001). On the other hand, it has been suggested that first-term councillors' 'utopian' ideas are hindrance factors for boards in their decision-making (Laamanen et al. 1994). Accordingly, in addition to differences by political ideology there may be tension and differences in perception between first-term politicians and those who have been serving as councillors for a longer time. In terms of policy learning (Sabatier 1998; Gagnon et al. 2007), studies focusing on possible differences in perception among local-level politicians based on party-political affiliation and length of council service could give valuable knowledge and help to determine how issues related to health promotion are best discussed in local councils, thus facilitating policy change.

2.6 Health promotion action, principles and approaches in the current study

This study, which is based on the Ottawa Charter (WHO 1986) and its health promotion action strategies, explores community action for health, health-promoting health services and healthy public policy through the actors 'representing' these strategies in local contexts. The focus is on the third level in Nutbeam's (1998b) health promotion outcome hierarchy, and on three actors in municipalities – namely the health services (i.e. the personnel), the local voluntary sector (i.e. LVAs) and local government (i.e. municipal politicians) – and their actions aimed at creating supportive environments and support healthy lifestyles.

Health promotion action (or comprehensive health promotion action) is understood here as reported action among LVAs and PHC personnel to address the multidimensional nature of health, including the promotion of healthy lifestyles, mental and social health, healthy and secure environments and/or the scope for action. With regard to municipal politicians, the study explores their perceptions of a) how much emphasis is given to the above-mentioned aspects of health promotion in municipal policy (health promotion policy), and b) the impact of health policy in terms of effective health promotion actions. Thus, the interest lies primarily in the content of health promotion, although its focus, meaning different population groups in the municipalities, is explored to some extent. Moreover, some additional aspects of health promotion are explored; the term 'comprehensive' is included in the conceptualization of health promotion action as described in the beginning of this paragraph, in order to make a distinction. Chapters 5.3, 5.4 and 5.6 give detailed descriptions of the applied measures of health promotion action (including the different aspects), the impact of health policy and health promotion policy, respectively.

Furthermore, the aim of the study is to identify factors that support or enable health promotion actions on the local level. According to the principles of health promotion, one focus area concerns intersectoral cooperation and community participation. In this context, community participation is understood as the LVAs' opportunities to cooperate with municipal agencies and be involved in decision-making related to health issues. The approach adopted is described in more detail in Chapter 3 below.

3. THE THEORETICAL FRAMEWORK OF THE STUDY

Health promotion relies on several theories or theoretical frameworks, most notably those covering health behaviour and behavioural change. Other relevant sources include theories or models on change in communities and communal action for health, models for communication, models for change in organizations and for the creation of health-supportive organizational practice, and models for the development of healthy public policy (Nutbeam & Harris 2004). Theories and models on change in individual behaviour are generally more highly developed than those related to environmental change, such as models for community mobilization, organizational change and policy development. By and large, the terms conceptual or theoretical framework or model are better suited to many of the ‘theories’ of health promotion (Nutbeam & Harris 2004; Rimer & Glanz 2005): these models provide practical frameworks for working with communities and organizations, and are not so suitable for structured study or theory development (Nutbeam & Harris 2004).

One way of classifying theories is to define them as explanatory or change-related (Rimer & Glanz 2005). In the area of health promotion, current explanatory theories and/or models relate to health behaviour on an individual or interpersonal level, whereas those on the community level could be described as change models. The present study was explanatory in its approach, and the focus was on the actions of different actors in the municipalities. In this regard, one potentially fruitful explanatory model is the multilevel health promotion model introduced by Rütten et al. (2000) and based on the Finnish philosopher von Wright’s (1976) general ‘logic of events’ model.

According to von Wright (1976), human actions are intentional and the determinants of intentions, and action could be described in terms of ‘wants’, ‘duties’, ‘abilities’ and ‘opportunities’. Changing situations create new opportunities for action, thus intentions to act emerge based on existing wants, duties and perceived abilities – this is the ‘logic of events’. Rütten and colleagues (2000) based their multilevel health promotion model (Figure 1) on von Wright’s general model and on previous empirical research: they conceptualize the determinants of health promotion action as *values* (wants), *competence* (ability) and *policy* (opportunities).

Rütten et al. (2000) categorize research aimed at developing the model as follows: a) studies reflecting environmental and policy approaches to the promotion of health, and findings that *policies* (*opportunities*) can create opportunities for developing personal skills and community participation and could therefore relate to both competence and action; b) Bandura’s social cognitive theory (1998) concerning people’s belief in their efficacy (*competence*) to accomplish social change as a predictor of action, and Antonovsky’s (1987) work on sense of coherence suggesting

that participation in ‘socially valued decision-making’ (*health promotion action*) could affect competence, and vice versa; c) insights related to the work of Syme (1988), for example, suggesting that infrastructures that enhance control can promote health, in other words create a pathway from opportunities to competence and furthermore to health; d) research related to community participation and empowerment, and their relation to health; and e) concerning the effect of *values*, the literature on the supposed role of shared values in health promotion action (Rütten et al. 2000). The findings of Riley et al. (2001) confirm the importance of shared values, suggesting that a shared commitment to organizational priorities has a direct impact on the implementation of health promotion.

Rütten et al. (2000) used their theoretical model in an international population study and found that the competence of individual actors, their values and the opportunities that policies provided were significant determinants of participation in health promotion action. In addition, this participation was associated with self-rated health. The researchers concluded that health promotion policies could facilitate the creation of opportunities that enable people and communities to increase control over the determinants of health, and thereby to improve their health.

Given the importance of policies, Rütten et al. (2003a) studied policy making in more detail, applying the same framework in a study of health promotion policy and its impact among European policy makers. They conceptualized the determinants in this context as policy goals (wants/values), resources (abilities/competence), obligations (duties) and opportunities (Rütten et al. 2003a; 2003b). The results of the empirical study indicated that perceived obligations and organizational opportunities predicted policy output, whereas resources, goals’ concreteness and public opportunities were associated with the policy outcome (Rütten et al. 2003a).

The multilevel health promotion model (Rütten et al. 2000; 2003a; 2003b) is generally consistent with the socio-ecological perspective, which emphasizes the interaction and interdependency of factors within and across different levels. Rimer and Glanz (2005) identify two main concepts in the ecological perspective, ‘multiple levels of influence’ and ‘reciprocal causation’. The first of these highlights the fact that behaviour and health are subjected to many levels of influence (individual, interpersonal, institutional, community and public-policy factors, for example). Reciprocal causation, on the other hand, implies that people simultaneously influence and are influenced by different factors around them.

Von Wright (1976) discusses his general ‘logic of events’ model in relation to the actions of individuals, but states that it could just as well be used to describe historical events and the actions of governments and other institutions, for example. Rütten and colleagues (2000; 2003a; 2003b) also suggest that the model is applicable to different levels of action. Given that the intention in the present study was to analyse health promotion actions from the perspectives of different municipal actors, the multilevel health promotion model was chosen as the common theoretical framework: it seemed to offer a fruitful approach to building on current knowledge

of factors that influence health promotion action, and a novel approach to using the same theoretical framework to chart the actions of different actors in local contexts.

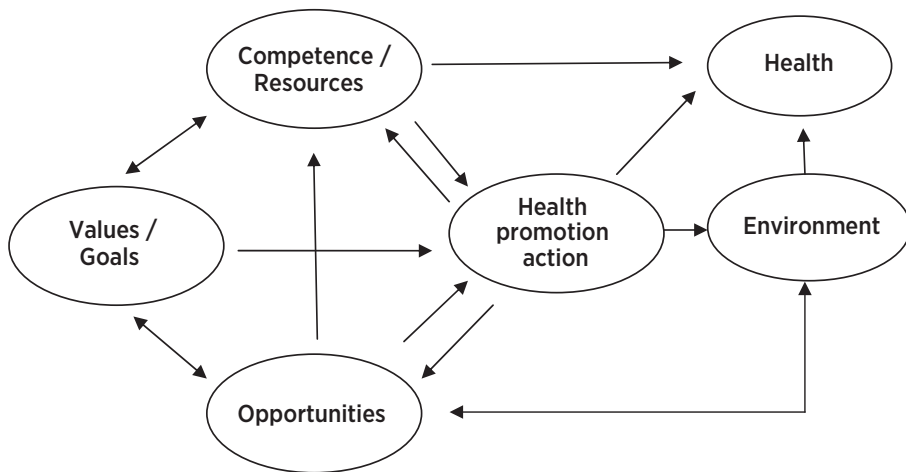


Figure 1. The multilevel health-promotion model (adapted from Rütten et al. 2000)

In addition, the study drew on research related to capacity building, community capacity and organizational capacity, which provided useful starting points for finding factors that enable actors to participate in health promotion, as discussed in the literature review. In fact, the common features of health promotion models concerning community building and organizational change (including intersectoral action) relate to the concepts of capacity and capacity building, as well as empowerment (with regard to community building). With regard to models of organizational change, also the concept organizational climate or culture was useful for this study: the climate and culture of an organization can influence its capacity to function effectively (Nutbeam & Harris 2004).

‘Capacity building’ has attracted growing interest in health promotion internationally (Hawe et al. 1997; Smith et al. 2006), and in Finland (Ståhl & Rimpelä 2010). The term appears in the Jakarta Declaration on Health Promotion (WHO 1997), and is emphasized as a priority theme in the Bangkok Charter (WHO 2005). The focus is on issues that enable effective health promotion actions (Smith et al. 2006), taking into account the different levels – the individual, the organizational and the community, and recently also the national level. Hawe and colleagues define capacity building as “an approach to the development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over” (NSW Health Department 2001). Four general approaches to capacity building have been identified: top-down organizational (e.g., changing policies and practices), bottom-up organizational (e.g., skills development among staff), the

partnership approach (strengthening relationships between different organizations or professional groups) and the community-organizing approach (Crisp et al. 2000). Crisp et al. (2000) suggest that change in one domain tends to have an impact on the other domains, and that changes in more than one domain might be needed before one could argue that capacity building has taken place.

One of the strengths of the multilevel health promotion model is its parsimony (Rütten et al. 2000). This study – drawing on the background literature including research on capacity and capacity building – thus aims to develop understanding of health promotion in local contexts in identifying determinants of health promotion action based on the theoretical model. Chapter 4 presents the aims of the study, the hypotheses and the outline.

4. AIMS

The overall aim of this study was to further develop understanding of health promotion action and the enabling of it on the municipal, i.e. local, level. With the Ottawa Charter action strategies as the point of departure, the focus was on community action for health, health-promoting health services and healthy public policy. The specific aims, addressed from a comparative perspective in four municipalities with different forms of primary healthcare provision, were as follows (the Roman numerals refer to the original publications):

1. To explore the activities and role of local voluntary associations in health promotion in municipalities, i.e. local contexts (I, II, IV);
2. To compare the emphasis on different aspects of health promotion across municipalities from the viewpoint of selected actors, i.e. local voluntary associations (LVAs), primary healthcare (PHC) personnel and local-level politicians (I, II, III, IV);
3. To explore the associations between comprehensive health promotion action and its proposed determinants, with a focus on LVAs and PHC personnel (II, III); and
4. To explore the associations between the impact of health policy (effective health promotion actions) and its proposed determinants, as perceived by local-level politicians (IV).

Hypotheses

In accordance with the multilevel health promotion model (Rütten et al. 2000) and its application to policy-making (Rütten et al. 2003a; 2003b), it is posited that the determinants of health promotion action include values, competence and opportunities. It is further proposed that municipal goals, resources and opportunities for community participation influence politicians' evaluations of the impact of health policy. The approach in using the multilevel health promotion model was different in the study of LVAs on the one hand and PHC personnel and politicians on the other. The aim in the former case was to identify and build composite measures of the determinants, whereas in the latter it was to find the specific factors that were the most important in terms of engagement in health promotion action and the evaluation of the health policy's impact (effective health promotion actions), respectively.

The common factor across all actors relates to opportunities, conceptualized as the possibility to cooperate within the community and including the principle of community participation. The context, in the form of four municipalities, is also taken into account, as are the different work units (home care, in-patient care and ambulatory care) in health services and, party affiliation and experience among the politicians.

The following hypotheses derive from the chosen theoretical framework and the background literature.

Health promotion action by a) LVAs and b) PHC (including care of older people) personnel is influenced by:

- 1) The **values** of
 - a. LVAs (reflected in a focus on different population groups)
 - b. Health-service organizations (reflected in a job environment that is conducive to health promotion and an emphasis on workplace health promotion)
- 2) The **competence** of
 - a. LVAs (reflected in perceived capability)
 - b. Health professionals (i.e. knowledge about the population/community and perceived competence)
- 3) **Opportunities** for health promotion action for
 - a. LVAs (reflected in opportunities for community participation)
 - b. PHC personnel (i.e. a reasonable workload and the possibility to cooperate within and outside the organization).

Local politicians' evaluations of the impact of health policy (effective health promotion actions) are influenced by:

- 1) **Goals** (i.e. an emphasis on different aspects of health promotion in the municipal budget and operational plans)
- 2) **Resources** (i.e. PHC, care for older people and LVAs)
- 3) **Opportunities** for community participation

The research question addressed in the current study is, as outlined in aims 3 and 4, whether the proposed determinants are associated with health promotion action and the impact of health policy.

Outline of the study

Table 1 gives an overview of the study. It briefly describes the focus and method, gives details of the four sub-studies (the years the surveys were conducted, the study population and the response rate), sets out the approach and the principles

of health promotion, which are common to all the sub-studies, and finally lists the aims of the study, indicating which of the sub-studies addresses each one.

Table 1. Health promotion in local contexts and the enabling factors – study outline

Focus:	Health promotion action – community action for health, health-promoting health services and healthy public policy – and its enabling			
Method:	Comparative study in four municipalities. Questionnaire surveys of LVAs, PHC personnel (including care for older people) and local-level political decision makers.			
Sub-studies:	Study I	Study II	Study III	Study IV
study populations and response rates	LVAs (2000) n= 397 46%	LVAs (2002) n= 457 40%	PHC pers. (2002) n= 986 57%	Politicians (2004) n= 195 52%
Approach:	the content and focus of health promotion			
Principles:	a holistic view of health, community participation and intersectoral cooperation			
Aims:				
LVAs' activities and role in health promotion	X	X		X
Emphasis on health promotion in local contexts	X	X	X	X
Determinants of health promotion action – values, competence and opportunities		X	X	
Determinants of health-policy impact – goals, resources and opportunities				X

5. DATA AND METHODS

5.1 The context of the study – four municipalities

The study was part of a larger-scale evaluation of the production model of primary healthcare, comprising comparisons between four municipalities in the southern part of Finland, namely the Southern (SM), Eastern (EM), South-western (SWM) and Western (WM) municipalities. They were all situated close to a larger city, were similar in size (7,000-12,000 inhabitants), population structure and services offered to their inhabitants, and represented medium-sized municipalities in Finland, of which there were about 75 at the time of the study. Over half of the population in SM and SWM had Swedish as their mother tongue, whereas Finnish was the mother tongue among the majority in EM and WM. In addition, SM and SWM were so-called ‘densely populated areas’, with a still rather low population density (45/44 persons/km²), whereas EM and WM were more urban with a higher population density (169/161 persons/km²). SM was included as a special case: in 1998 the local politicians took the decision to outsource its primary healthcare services, including services for older people, to a non-profit organization operating in Finland.

Thus, the production of services differed between the municipalities in that the services were produced mainly publicly in the other three. A municipal federation produced the primary healthcare services in EM, and the municipality provided services for older people, whereas the municipality was the main provider in SWM and WM. The service-provision model in SM was the first, and to date the only one carried out in Finland, in which all service production in primary healthcare is contracted out to a non-profit organization.

The most prominent social and health problems and problems related to the inhabitants’ environment in the four municipalities, as perceived by the politicians were: the economic situation of the municipality, including the high cost of healthcare, especially of secondary care; the aging population; and issues related to organizing and providing healthcare services. In addition, unemployment was frequently mentioned in three of the municipalities (SM, EM and WM), as well as problems related to alcohol and/or illicit drug use, especially in WM, but also brought up in the others. Problems related to young people and children, and to mental health, were also mentioned. The respondents made occasional statements concerning unhealthy lifestyles in general, marginalization, divorce and social cohesion, for example. Fourteen per cent of the political decision makers in SM referred to the emphasis on health promotion in making the choice of service provider in 1998. The proportion of politicians reporting a high emphasis on health promotion in the choice of health service provider in the other municipalities ranged from 27%

Table 2. Some characteristics of the population in the municipalities under study, 2002

	SM	EM	SWM	WM
<i>Population density; residents/km²</i>	45	169	44	161
<i>Population</i>	8897	7444	11984	8208
- aged 0-15 years (% of total population)	18.5%	15.9%	19.6%	18.4%
- aged 75 years and over	8.9%	9.6%	8.1%	8.3%
Swedish-speaking	60.3%	39.6%	54.6%	0.1%
Education; aged 15 or over				
Completed qualification or degree	52.3%	52.0%	58.7%	54.1%
- upper-secondary education	60%	59.9%	55.9%	66.2%
- higher-education qualification	40%	40.1%	44.1%	33.8%
Families with children; % of families	44%	37%	42%	41%
Single-parent families; % of families with children	21%	25%	16%	20%
Households with one person	39%	44%	35%	38%
Unemployment rate	9.5%	12.6%	7.8%	14.5%
<i>Health and lifestyle (population aged 15–64):</i>				
Perceived health: good (rather good/good)	71%	65%	72%	64%
poor (quite poor/poor)	6%	9%	6%	8%
Vigorous physical activities for at least half an hour and two times a week	53%	64%	54%	59%
Alcohol use: more than six portions at one time once a month or more frequently	32%	35%	37%	37%
Smoking daily	41%	44%	44%	43%

Source: Stakes SOTKANet; Laamanen et al. 2004 unpublished report

in EM to 12% in SWM (20% in WM), and the corresponding figures concerning services for the elderly from 31% in WM to 6% in SWM (17% in EM).

5.2 Data sources and participants

The data used in addressing the aims of this study included mail surveys among local voluntary associations (in 2000 and 2002), primary healthcare personnel (2002) and local-level politicians (2004) in the four case municipalities.

Local voluntary associations (Studies I and II)

We conducted mail surveys in the four municipalities in 2000 among all registered voluntary associations with accurate contact information in the Register of Associations (n=397, see Table 3). Freedom of association is secured in the Finnish Constitution, but only registered associations have legal capacity. Furthermore, making a complete list of voluntary associations in the four municipalities was

deemed beyond reach. The questionnaires (in Finnish or Swedish), and one reminder if necessary, were addressed to the chairs or the secretaries of the associations. The response rate was 46%, ranging from 58% in WM to 42% in SM and EM (45% in SWM). The final sample comprised 183 voluntary associations (Study I). The same procedure was applied in 2002. The number of registered voluntary associations had increased and 457 associations provided accurate contact information in the register. The response rate in 2002 was 40%, ranging from 45% in WM to 34% in SWM (41/40% in SM/EM). The final sample comprised 182 voluntary associations (Study II).

Table 3. Local voluntary associations (LVAs) in the municipalities in 2000 and 2002

	SM		EM		SWM		WM	
	2000	2002	2000	2002	2000	2002	2000	2002
LVAs in the register of associations (n)	238	245	241	249	238	246	188	194
LVAs with accurate address information (n)	97	99	118	134	101	122	81	102
“LVA density” (LVAs/ 1000 citizens)								
- All registered LVAs	27	28	32	33	20	21	23	24
- LVAs with accurate address information	11	11	16	18	8	10	10	12

The voluntary associations were classified into seven categories based on their names: associations for a) culture and recreation (25% in 2000 / 30% in 2002), b) business, professionals and politics (26/24%), c) public health (16/17%), d) sports (14/10%), e) patients (10/10%), f) the retired and elderly (8/7%), and g) other (1/1%). The mix of types of association was similar in all the municipalities.

Primary healthcare personnel (Study III)

Questionnaires (in Finnish or Swedish), and one reminder if necessary, were sent in 2002 to all personnel working in primary healthcare, including care for older people, in the four municipalities (n=986). The response rate was 57%, ranging from 59% in SWM to 54% in SM and WM (58% in EM). For the purposes of Study III, office staff, maintenance and cleaning staff were excluded from the dataset. Dental-care personnel and social workers were also excluded in order increase comparability: those in dental care because the questionnaire delivery failed in one of the municipalities, and social workers because those in SM were employed by the municipality and not by the non-profit organization. The final sample comprised 417 employees, of whom 98% were women, with a mean age of 44.9 (S.D. 9.4). All

the respondents in WM were Finnish-speaking, whereas over half of those in SM and SWM were Swedish-speaking. The Swedish speakers were sent a questionnaire in Swedish. Half (50%) of the respondents in EM worked in ambulatory care, the largest professional group being registered nurses, whereas 42-48% of those in the other municipalities worked in in-patient care, the largest group being practical nurses. Of the respondents, 54% had a vocational college or polytechnic degree, and 60% assessed their health as good. (Table 4; Table 1 in Study III)

Table 4. The work characteristics of participating health personnel across the municipalities in 2002 (%)

	SM	EM	SWM	WM
Work unit (***)				
In-patient care	48	33	42	42
Home care, service houses	30	17	26	25
Ambulatory care	22	50	33	33
Occupation (***)				
Physician	4	4	5	7
Head nurse/nurse manager	9	8	7	4
Public-health nurse	7	20	8	12
Registered nurse or equivalent	24	34	22	23
Practical nurse or equivalent	49	26	40	33
Home-help staff	7	8	18	21
Professional education (ns.)				
Training courses or less	8	5	6	5
Vocational school	36	23	40	42
Vocational college/polytechnic	51	67	48	46
University	5	5	6	7
Managerial position (ns.)				
Upper management	2	3	3	2
Middle management	13	11	9	6
Not in management position	85	86	88	92

Statistical analyses based on chi-square tests. ns. $p > 0.05$, *** $p \leq 0.001$

Local-level politicians (Study IV)

Surveys of local-level politicians in the four municipalities were conducted in 2004 (n=195), which was the last year of the four-year term for which the councillors had been elected. The questionnaires (in Finnish or Swedish), and two reminders if necessary, were sent by mail to all members and deputy members of the municipal councils, the executive boards, and the boards of the social and health services. The response rate was 52%. After excluding questionnaires that were almost empty, the response rates ranged from 67% in SM to 34% in EM (39% in SWM and 53% in WM). The final sample included 94 politicians, of whom over half were men (59%), 18% held the position of chair or vice-chair and 46, 44 and 10%, respectively represented centre/right-wing, left-wing and other parties including the Greens and the independents. The average age of the respondents was 55.4 years (S.D. 10.2),

being lowest in SWM (49.8, S.D. 9.2) and highest in EM (60.9, S.D. 7.2; $p < 0.05$). For 51% (48 persons) of them it was their first term in the municipal council: they are referred to as first-term politicians hereafter, although 19 of them reported having been a board member for more than one term. For the remaining 49% it was at least their second term on the council, and they are referred to hereafter as senior politicians. There were more first-term politicians in EM (69%) and SWM (73%) than in SM (36%) and WM (42%; $p < 0.05$). Otherwise the respondents did not differ between the municipalities in terms of background factors (sex, political party, position in the political organs).

5.3 Measures of health promotion action

LVA engagement in health promotion action (Studies I and II)

The LVAs' engagement in health promotion action was the outcome variable in Study I. We measured this engagement by five items rated on a Likert-type scale and assessing the extent of emphasis on: a) promoting healthy lifestyles, b) promoting a healthy environment, c) promoting a secure environment, d) creating scope for action, and e) building social contacts. The question posed was 'To what extent does your association emphasize the following issues in its activities?' the response alternatives ranging from 'not at all' to 'very much' (range 1-5). The action scale was constructed by sum-scoring the responses on the five items (range 3-25; Cronbach's alpha .75). Responses with more than two missing items were excluded.

In addition, in assessing the different aspects of health promotion we explored the emphasis on the promotion of healthy lifestyles in more detail (six questions): acting for promoting physical exercise, promoting healthy dietary habits, reduction of smoking, reduction of alcohol abuse, prevention of drug use/distribution, and sexual education. The response alternatives ranged from 'not at all' to 'very much', as in the questions mentioned above. The focus in health promotion – that is, on different population groups in the community – was assessed as shown in Chapter 5.5 on the determinants of health promotion action.

The LVAs' engagement in health promotion action was also the outcome variable in Study II, although it was a more detailed measure than in Study I. We assessed engagement in (comprehensive) health promotion action by fourteen items under the question: 'To what extent does your association emphasize in its activities the following issues promoting health and wellbeing?' Six items assessed the *promotion of healthy lifestyles*: a) promoting physical exercise, b) promoting healthy dietary habits, c) acting to reduce smoking, d) acting to reduce alcohol abuse, e) preventing illicit drug use/distribution and, f) sexual education. Three items assessed the *promotion of mental wellbeing*: a) developing personal abilities, b) strengthening self-confidence and c) promoting subjective wellbeing. Finally, five items assessed

giving social support: a) material support, b) practical support, c) knowledge, d) emotional support and e) spiritual support. The response alternatives ranged from 'not at all' to 'very much'. The health-promotion-action scale was constructed by averaging the responses on the 14 items (Cronbach's alpha 0.89; range 1-5). A minimum of 70% of the items had to be answered. The scale was dichotomized into high versus low action groups according to the median (2.3).

PHC personnel's engagement in health promotion action (Study III)

Ten items under the following question measured engagement in (comprehensive) health promotion action among PHC personnel: 'To what extent are the following health-promoting activities emphasized in your work?' Six items assessed the emphasis on *promoting healthy lifestyles*: a) activities to promote physical exercise, b) promoting healthy dietary habits, c) promoting non-smoking, d) preventing alcohol abuse, e) activities to prevent illicit drug use, and f) sexual health counselling. Two items assessed *promoting mental and social health*: a) promoting mental health and b) paying attention to and supporting social networks. Finally, two items assessed *promoting supportive environments for health*: a) promoting healthy environments and b) promoting safe environments. The response alternatives ranged from 'not at all' to 'very much'. The health promotion action scale was constructed by averaging the responses on the 10 items (Cronbach's alpha 0.89; range 1-5). A minimum of 70% of the items had to be answered. The scale was dichotomized into high versus low action groups according to the median (2.4).

Focus in health promotion was measured, using the same question as above, with six items: improvement in the health and life quality of older people, supporting harmonious development in children, supporting harmonious development in youth, promoting the health of adults of working age, promoting the health of people with different illnesses and mitigating the negative effects of unemployment. The response alternatives ranged from 'not at all' to 'very much' (range 1-5).

Additional aspects of health promotion included a question regarding the extent of engagement in health promotion on the a) individual, b) group and c) population levels, with the same response alternatives as above. Moreover, the ten items of the comprehensive health promotion scale were subjected to principal component analysis (PCA), which resulted in the following two factors: the 'addressing risk behaviour' scale (acting to promote non-smoking and reduce alcohol abuse, prevent drug use and sexual health counselling) and the 'promoting health' scale (acting to promote physical exercise, healthy dietary habits, mental and social health, a healthy environment and a safe environment). The internal consistencies of the scales were good (Cronbach's alphas 0.92/0.84). The scales were dichotomized into high vs. low groups for the analyses, using the medians as cut-off points (1.8/2.8).

5.4 Measures of health-policy impact

Local politicians' assessment of health promotion actions and their effectiveness in the municipalities, in other words the impact of the health policy, was the outcome variable in Study IV. We measured this using two items on a scale ranging from four (fail) to ten (excellent), as used in the Finnish school-marking system. The respondents were asked, 'What grade between four and ten would you give health promotion in your municipality using elementary-school marking system?' The items assessed were a) health promotion action and b) the effectiveness of health promotion action. The health-policy impact scale was constructed by averaging the grades given to the two items (Cronbach's alpha 0.89).

5.5 Measures of the proposed determinants of health promotion action

LVAs (Studies I and II)

The first study concerning the activities of LVAs in health promotion (Study I) was explorative. The general aim was to investigate how these associations perceived their actions and role in the municipalities from a health promotion perspective. The specific aims were to study LVAs with regard to their: a) resources, b) target groups, c) efforts to promote health, d) cooperation with different municipal authorities and e) significance for the population's health and wellbeing. The nature of the second study (Study II) was explanatory, the general objective being to develop theoretical understanding of the determinants of health promotion action in local contexts. The specific aims, related to the actions of LVAs, were to a) identify factors representing the determinants of health promotion action and b) compare the actual health promotion actions with the proposed determinants.

The variables in Studies I and II

– The population groups emphasized in health promotion

We identified the population groups on which the LVAs were focusing in their health promotion activities on four items in response to the question 'To what extent does your association emphasize the following issues in its activities?': 1) improvement in the life quality of the retired and elderly, 2) improvement in the life quality of people with disabilities, 3) supporting harmonious development among children and young people and 4) mitigating the negative effects of unemployment. The questionnaire used in 2002 also included 5) improvement in the life quality of

people with illnesses and 6) improvement in life quality among adults of working age. The response alternatives ranged from one ('not at all') to five ('very much').

– *Measures of cooperation*

Cooperation with different municipal authorities was measured on six items concerning the extent of cooperation with healthcare services, social services, municipal departments of education, and youth and cultural services. The respondents were asked to 'Assess how much cooperation there was last year between your association and municipal authorities'. The response alternatives ranged from one ('none') to five ('very much'). In addition to analyses of the separate items, a cooperation scale was constructed by sum-scoring the number of cooperation partners (range 0-6; Cronbach's alpha .82 in 2000).

– *The role of the LVAs in health promotion*

The LVAs' perceptions of their role and influence in health promotion was assessed on statements related to a) the need for cooperation between voluntary associations and municipal authorities in the promotion of citizens' health and wellbeing (only Study I) and b) the impact of their own activities in this regard; c) their interest in following discussions about residents' health and wellbeing; d) and whether they wanted to influence decision-making related to these issues in the municipality; and e) their actual influence on decision-making concerning health matters in the municipality. We also asked a) to what extent was the LVAs' expertise taken into account in the decision-making in the municipality (Study I), b) whether cooperation with other voluntary associations promoted their own work (Study I), and c) whether the municipality appreciated the work done by the association. The 2002 questionnaire also included a statement on whether the LVAs perceived that their activities promoted feelings of affinity among residents. The response alternatives ranged from one ('do not agree at all') to five ('fully agree').

– *Background variables*

The main background variables were the LVA's home municipality, name and resources. The questions related to resources concerned the number of members, the number of members taking an active part in organizing the activities and how this rated on a sufficiency scale ('way too little', 'too little', 'enough'); the number of citizens taking part in activities organized by the association; whether the association had employed personnel, and if so, how many. We also assessed the LVAs' need for support from the municipality (in the previous year) (Study I) in the form of money, meeting and other facilities, expert help and education, and asked if they received this kind of support and if so, to what extent. The response alternatives were 'we did not need support', 'we did not get support', 'we received support but not enough', and 'we received enough support'.

Identification of the proposed determinants of the LVAs' health promotion action in Study II

The theoretical framework in the second study focusing on LVAs was the multilevel health promotion model proposed by Rütten and colleagues (2000). Accordingly, the suggested determinants were competence, values and opportunities.

The 12 items (described earlier under the headings: population groups emphasized, cooperation measures and the LVAs' role in health promotion) that were to represent the determinants of the LVAs' health promotion action, that is, values, competence and opportunities (Rütten et al., 2000), were subjected to principal component analysis (PCA; extraction criterion: Eigen value > 1). One of these items, the cooperation scale, was constructed as a sum-score of six statements indicating whether the voluntary association cooperated with the municipal authorities (municipal agencies responsible for healthcare services, social services, education, sports, youth and culture, no-yes scale; sum-score ranging from 0-6). To make it compatible with the other items the sum-score was changed to a five-class scale: 0, 1, 2, 3-4 and 5-6 cooperation partners. The PCA resulted in a four-factor structure (see Table 1 in Study II, which also gives the wording of the items for each factor). Based on this structure four scales were constructed: one each for competence (perceived capability and appreciation from the municipality; three items) and opportunities (following discussions about residents' health, having influence on decision-making and cooperating with municipal agencies; three items), and two for values, labelled orientation towards health (values 'health'; three items) and orientation towards the vulnerable (values 'vulnerable'; three items). These variables reflect the LVAs' focus on the wellbeing and life quality of different population groups in the municipalities – children and young people, adults of working age and the unemployed, respective, the retired and elderly, people with disabilities and people with different illnesses. The scales were constructed by averaging the responses to the items defining the respective scale (one missing value per scale was allowed). The Cronbach's alphas were, respectively, 0.73, 0.73, 0.66, and 0.87. For the further analyses the scales were dichotomized into high versus low groups according to the median of the respective scale.

Proposed determinants in the study of primary healthcare personnel (Study III)

The theoretical framework in Study III was the multilevel health promotion model (Rütten & al. 2000), and the determinants were proposed to be values, competence and opportunities.

– *Values – Job characteristics conducive to health promotion*

Based on the literature review, the assumption was made that workplace values played a crucial role in health promotion work. These values were conceptualized as a work environment that was conducive to health promotion action, and the indicators were measures of the psychosocial work environment and one measure of the perceived sufficiency of workplace health promotion. The measures of the psychosocial work environment included Karasek's (1979) constructs 'skill discretion' and 'decision authority', as well as a measure of experienced social support from co-workers. In order to measure *skill discretion* the respondents were asked to answer four questions measuring a) opportunities to use one's skills and knowledge, b) having a job that requires learning new things, as well as c) reflection and decision-making and d) having a job that includes a variety of tasks. The response alternatives in the first three questions ranged from 'very little' to 'very much', and in the fourth question from 'very varied' to 'very monotonous'. *Decision authority* was measured on seven items in response to the question 'How much influence do you have over the following aspects of your job?': a) the variety of tasks you carry out, b) the order in which you carry out your tasks, c) the pace of your work, d) the methods you use in carrying out tasks, e) decisions concerning which co-workers you work with, f) decisions concerning which individuals do which tasks, and g) the availability of supplies and equipment you need for your work (response alternatives 'none at all' – 'very much'). Further, *social support* from co-workers was measured on a question probing whether one gets enough support when needed with regard to a) knowledge, guidance and advice, b) practical help and) emotional issues. The response scale ranged from 'never' to 'always'. In addition, *sufficiency of workplace health promotion* was assessed on eight items based on the question 'To what extent has your workplace invested in promoting the personnel's health and wellbeing?': a) healthy meals at the workplace, b) the opportunity to exercise, c) emotional wellbeing, d) the physical work environment and working conditions, e) health campaigns and lectures, d) health checks, e) screening and f) recreational activities for the staff. The response alternatives ranged from 'absolutely insufficiently' to 'completely sufficiently'.

The four value scales were constructed by averaging the responses on the items defining the respective scale (range 1-5). A minimum of 70% of the items had to be answered. The Cronbach's alphas in the data were 0.74, 0.82, 0.84, and 0.85, respectively. For the analyses, the aforementioned scales were categorized into three groups based on quartiles, combining the cases in the two middle quartiles in a medium category in order to focus comparison on the upper and lower ends of the dimensions. However, given the uneven distribution the social-support scale was dichotomized by the median, and the categories low respective high social support groups were used in the further analyses.

– *Measures of perceived competence*

The indicators of competence were self-assessed *knowledge about the municipal residents' health and living conditions* and *perceived competence*. The personnel's knowledge was measured on four items assessing self-assessed knowledge about a) the socioeconomic situation of the population, b) health problems and morbidity, c) social problems and d) problems related to the environment. The response alternatives ranged from 'not at all' to 'very well'. The perceived competence scale was adapted from the 'Perceived Competence Scale' (Williams et al. 2003) and included four items: 'I feel confident in my ability to manage work demands', 'I feel able to meet the challenges in my work', 'I am able to manage my daily duties at work', and 'I am capable of handling even more demanding tasks'. The response alternatives ranged from 'do not agree at all' to 'fully agree'. The two competence scales were constructed by averaging the responses to the items (Cronbach's alpha 0.89 and 0.72, respectively; range 1-5: one missing value per scale was allowed). For the further analyses, the scales were categorized into three groups based on quartiles, combining the cases in the two middle quartiles to a medium category.

– *Opportunities*

Opportunities were conceptualized as having the opportunity to cooperate both inside and outside the organization, and having a reasonable workload. Six items were used to measure the extent of cooperation on a response scale ranging from 'none at all' to 'very much' (range 1-4). A principal component analysis of these items identified two factors in the data, which were labelled *cooperation within the organization* (two items measuring cooperation inside the work unit and cooperation with other work units; Cronbach's alpha 0.62), and *cooperation outside the organization* (four items measuring cooperation with voluntary organizations, non-health municipal agencies, political decision makers and managers; Cronbach's alpha 0.66). The two cooperation scales were constructed by averaging the responses to the respective items. No missing values were accepted for cooperation within the organization, and one for cooperation outside the organization. Given the uneven distributions, the cooperation scales were dichotomized roughly between those in the highest tertile, that is, those who reported cooperating most, and the rest. *Workload* was measured on a question probing whether excessive work was demanded. The five response alternatives ranged from 'never' to 'constantly'. Responses to the workload question were divided into three categories in which 'often' and 'constantly' represented the high work-demand (reference) group, 'every now and then' the medium group and 'never' and 'seldom' the low group.

– *The background variables* registered were age, professional education, mother tongue, occupation, work unit, managerial position and perceived health.

5.6 Measures of the proposed determinants of health-policy impact

Study IV was based on investigations into the making of health policy (Rütten et al. 2003a: 2003b), the aim being to explore to what extent councillors' evaluations of effective health promotion actions in the municipality (i.e. health-policy impact) were influenced by municipal *goals* for health promotion, *opportunities* for community participation and *resources*, as well as the *political variables*.

With regard to *goals*, emphasis on health promotion was assessed on a 10-item scale in response to the question, 'To what extent have the following activities to promote health and wellbeing been emphasized in the municipal budget and operational plans during the last years?' The response alternatives ranged from 'not at all' to 'very much' (range 1-5). A principal component analysis of the ten items (with three factors set) identified the following dimensions: 1) *emphasis on the promotion of healthy and safe environments* (four items: the promotion of healthy and safe environments, physical exercise, and work against illicit drug use); 2) *emphasis on the promotion of mental and social health* (three items: the promotion of mental health, paying attention to and supporting social networks, and sexual health counselling); and 3) *emphasis on the promotion of healthy lifestyles* (three items: promoting healthy dietary habits, promoting non-smoking and preventing alcohol abuse). The health promotion goals scales were constructed in accordance with this structure, averaging the responses to the items defining the respective scale (range 1-5). The Cronbach's alphas were 0.87, 0.73 and 0.86, respectively. In addition, emphasis on promoting the health and wellbeing of different population groups was assessed on six items in response to the question mentioned above. The items included supporting the harmonious development of children, supporting the harmonious development of young people, promoting the health of adults of working age, improving the health and life-quality of the retired and elderly, mitigating the negative effects of unemployment and promoting the health of people with various illnesses.

Opportunities for community participation were conceptualized as an emphasis in the municipality on cooperation between the municipal authorities and the LVAs, and a general assessment of the LVAs' influence in the municipality. A six-item scale assessed the extent of the emphasis on cooperation in the budget and operational plans with regard to the question: 'To what extent has cooperation between the different municipal authorities and the LVAs been emphasized in the municipal budget and operational plans in recent years?' The response alternatives ranged from 'not at all' to 'very much' (range 1-5). Two dimensions of cooperation were constructed based on a principal component analysis: *cooperation between LVAs and primary care authorities*' (municipal sectors responsible for healthcare services, social services and education), and *cooperation between LVAs and leisure*

authorities' (municipal sectors responsible for sports, youth and culture). The councillors' perceptions of the LVAs' *influence* in the municipality were assessed on two statements ('LVAs have an influence on decision-making in health matters in the municipality' and 'the municipality appreciates the work done by the LVAs'). The response alternatives ranged from 'totally disagree' to 'totally agree'. All the scales were constructed by averaging the responses on the items defining the respective scale (range 1-5), and the Cronbach's alphas were 0.81, 0.87, and 0.56, respectively.

Resources for health promotion included in this study were the *capacity of primary healthcare* and *care for older people*, and the LVAs' *role in health promotion* in the municipality, as assessed by the politicians. The respective capacity measures were based on five items (comprehensiveness, effectiveness, quality, accessibility and efficiency; Cronbach's alpha 0.79/0.91) rated on a scale ranging from four (fail) to ten (excellent) in accordance with the Finnish marking system for schools. Assessment of the LVAs' role in health promotion focused on their *activity in health issues* (three statements: 'LVAs actively follow discussions about residents' health and wellbeing', 'LVAs want to influence the decision-making concerning health issues in the municipality', 'LVAs have a positive influence on residents' health and wellbeing'; Cronbach's alpha 0.64), and their *significance in promoting residents' health*. The responses to the latter question were dichotomized into those reporting quite or very considerable significance, and the rest (no or little significance or could not say). The other scales (range 1-5) were constructed by averaging the responses on the items of which 70% had to be answered (a principle that concerns all scales).

Political engagement was assessed in terms of political-party affiliation, and the classification left-wing, centre/right-wing, and other (i.e. the Greens and the independents) were used in the analyses in the present study. *Political experience* was determined on a question concerning the number of terms the politicians had served on the municipal council: the respondents were classified as senior politicians if the current term was at least their second one; otherwise they were classified as first-term politicians.

Knowledge about residents' health and living conditions served as a proxy measure for interest in health issues, and was included as a control variable. It was assessed on four items concerning knowledge about the socioeconomic situation of the population, health problems and morbidity, social problems and problems related to the environment. The Cronbach's alpha for the sum scale (constructed by averaging the responses) was 0.82. In addition, municipality, age, and sex were registered.

5.7 Further statistical methods

The study was both explorative and explanatory in nature: possible differences between the municipalities in health promotion action, as well as in the factors influencing this action (Study I, II, III), or influencing its evaluation (Study IV), were analysed in all the sub-studies. Descriptive statistics as well as linear and logistic regression analyses were the main statistical tools used. In addition, principal component analyses were employed, as indicated in the section describing the study variables. The SPSS statistical package for Windows was used in all the statistical analyses.

Descriptive statistics, e.g., cross-tabulations and Pearson Chi-square tests were used in Study I, in addition to the background variables, to explore the differences between the municipalities and the different LVA types regarding engagement in health promotion action and in the promotion of healthy life styles. The associations between the potential determinants and health promotion action were assessed by means of univariate and multivariate linear regression analysis.

The health-promotion-action scale was dichotomized into low and high action by the median in Studies II and III. In addition, cross-tabulations and Pearson Chi-square tests were used to measure differences in health promotion action among the municipalities as well as by the explanatory variables. The associations between the background variables and health promotion action were similarly investigated in Study III. The proposed determinants of health promotion action, including the municipality, were assessed by means of univariate and multivariate binary logistic regression analysis. All the variables were included in the multivariate analysis in Study II, whereas only those with significant associations in the univariate analyses were used in Study III. The results of the regression models were presented as odds ratios (OR) and their 95% confidence intervals (CI). The determinants were entered step by step into the multivariate analyses. The municipality variable was also included, as was the work unit in Study III.

Univariate and stepwise linear multivariate regression analyses were used in Study IV to measure the associations between the proposed determinants and health-policy impact. All the proposed determinants were included in the multivariate analyses. Furthermore, the associations of political party and experience with the reported emphasis on the three dimensions of health promotion were assessed by means of multivariate binary logistic regression analysis, the dimensions being dichotomized at the median.

6. FINDINGS

6.1 The role of LVAs in health promotion and their resources

Almost all the LVAs (92%) and the municipal councillors (95%) were of the opinion that cooperation between municipality authorities and LVAs was needed in the promotion of the population's health. Moreover, of those, the majority (60% and 57%, respectively) were *completely* of this opinion. Half of the responding councillors perceived the LVAs' significance in promoting residents' health to be considerable: in general, senior politicians were more likely to be of this opinion than first-term politicians (61/39%; $p < .05$). Of the voluntary associations surveyed, 76% perceived that their activities had a positive impact on residents' health and wellbeing. The LVAs saw their current role in the municipality in general as being complementary to (59%) or completely apart from (36%) the roles of municipal functions and services. (Studies I, IV, Simonsen-Rehn et al. 2008 abstract) There were no statistically significant differences between the municipalities.

About half of the LVAs reported that they actively followed discussions about residents' health and wellbeing (51%) and wanted to influence decision-making concerning health matters (47%). However, only 20% of them thought that they had a real influence on political decision-making concerning health matters in the municipality: mainly voluntary associations for the retired and the elderly (50%) and patients' associations (39%). The politicians recognized these interests: over half of them believed that LVAs followed discussions about residents' health and wellbeing actively (51%) and wanted to influence decision-making concerning health matters (65%). However, less than half (42%) reported that LVAs had any such influence in the municipality. In the opinions of the majority of both councillors (71%) and LVAs (75%), the expertise of the voluntary associations was not sufficiently taken advantage of in municipal decision-making. (Study I, IV, Simonsen-Rehn et al. 2008 abstract)

Cooperation opportunities - between the municipal authorities and the LVAs - were, according to the councillors, emphasized to 'some extent' in the municipal policy plans: cooperation with 'leisure authorities' (culture, sports, youth) was emphasized more than cooperation with 'primary care authorities' (healthcare, social services, education) (3.3/2.6; range 1-5; Study IV). There were no differences in policy between the four municipalities, and 66% of the councillors thought that there was too little cooperation between the municipal authorities and the LVAs (Simonsen-Rehn et al. 2008 abstract).

The majority of the responding LVAs (70%) reported that they cooperated with municipal or other agencies: on average they worked in cooperation with 2.5

municipal agencies, somewhat more in WM (3.0) and SWM (2.8) than in EM (2.0) and SM (2.2.). More than half of them cooperated with municipal departments of education (60%) and cultural services (56%), whereas an average of two out of five cooperated with the other municipal agencies surveyed. There were some differences between the municipalities: cooperation with departments of education was more prevalent in SWM (76%) than in EM (44%; $p < .01$), and cooperation with healthcare services more prevalent in WM (58%) compared with EM and SM (33/31%; $p < .05$). (Study I) According to the 2002 survey, the proportion of LVAs cooperating with healthcare services in SM had risen to 65% (33% in 2000; $p < .05$).

LVA resources

A minority of LVAs (13%) employed salaried personnel. Of those, 77% had at most three persons on their wage list and 41% only one person. On average, 11% of the members, that is 15 persons (median 10) per association, participated actively without pay in organizing activities; two out of three associations reported that too few people were actively engaged. On average, 267 citizens (median 100) per association participated in their activities. This figure was higher than the average number of members in the associations (134 with a median of 75). (Study I)

Most LVAs reported needing support from the municipality for their operations, mostly in the form of money (69%) as well as premises and materials (61%). The municipalities also granted this kind of support: 44% of the LVAs had received financial support, and 45% support in the form of premises and materials. Furthermore, almost half of them needed support in the form of expertise (48%), which one fifth had received, and education (42%), which one tenth had received. Over half of those needing this kind support did not receive it from the municipality (see Table 5). (Study I)

Table 5. Support needed by the LVAs and granted by the municipalities in 2000 (%; Study I)

	Financial support	Premises etc.	Expertise support	Education
Municipality				
Southern Municipality (SM)	74	53	41	32
Eastern Municipality (EM)	59	53	36	36
South Western Municipality (SWM)	68	61	58	50
Western Municipality (WM)	74	77	57	51
Support granted by the municipality for those in need of it				
Did not receive support	36	27	54	71
Received support but not enough	37	17	18	13
Received enough support	26	56	28	16

6.2 Population groups emphasized in health promotion

Among the LVAs

In the first study year, 27% of the LVAs emphasized (strongly or very strongly) supporting the harmonious development of children and young people, and 24% improvement in the life quality of retired and older people. A lower proportion focused on people with disabilities (16%) and the unemployed (10%). (Study I) Figure 2 shows the focus in 2002; that year also included an emphasis on the improvement in the life quality of adults of working age and people with illnesses. No statistically significant changes appeared during the two years: the strongest emphasis in 2002 was also on the retired/older people (33%), children and young people (30%) and, as a new group included in the questionnaire, adults of working age (31%). There were no statistically significant differences concerning the focus on different population groups between the municipalities.

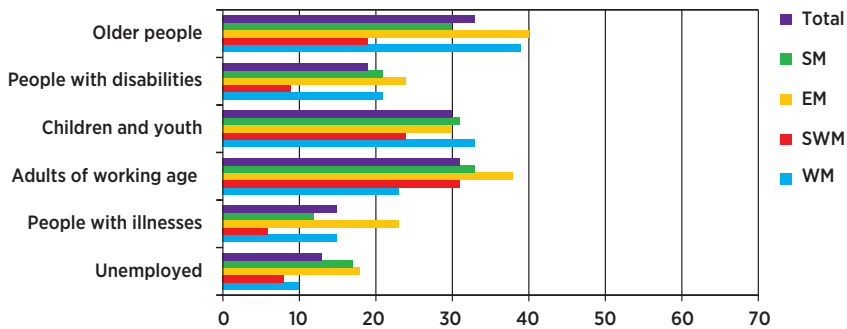


Figure 2. Emphasis in health promotion on different population groups by LVAs across municipalities in 2002 (proportion responding 'much' or 'very much';%)

In primary healthcare, including care for older people

The majority of the responding PHC personnel reported that they emphasized (strongly or very strongly) health promotion with a focus on older people in their work (71%). People with illnesses (47%) were quite often the target group, whereas a smaller proportion focused on children and young people, adults and the unemployed (Figure 3). (Simonsen-Rehn et al. 2006 abstract)

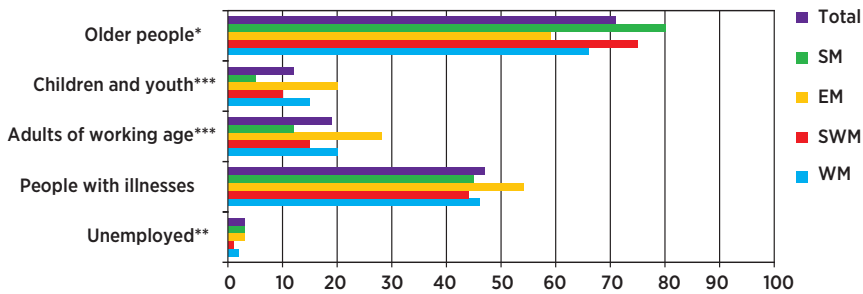


Figure 3. Emphasis in health promotion on different population groups in PHC across municipalities (proportion of personnel responding ‘much’ or ‘very much’; %; *p < 0.05, ** p < 0.01, *** p ≤ 0.001)

The health and life quality of older people was emphasized especially in home (85%) and inpatient (87%) care, and by 41% of the personnel in ambulatory care (Figure 4). Over half of the ambulatory-care personnel (58%), almost half of home care personnel (46%) and 39% of the personnel in inpatient care emphasized health promotion focusing on people with illnesses. Supporting harmonious development among children and young people, and promoting the health of adults of working age was emphasized foremost in ambulatory care.

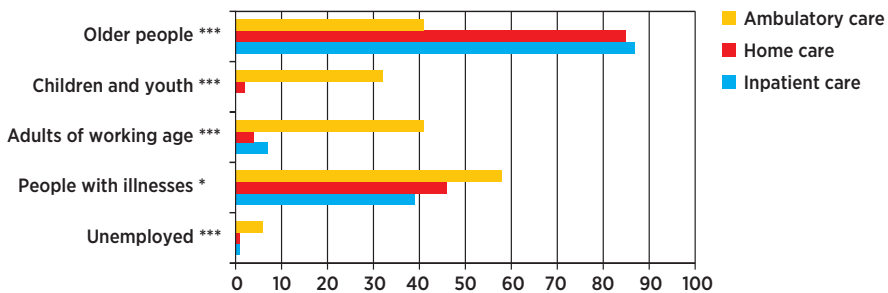


Figure 4. Emphasis in health promotion on different population groups in PHC across work units (proportion of personnel responding ‘much’ or ‘very much’; %; *p < 0.05, *** p ≤ 0.001)

In municipal policy plans

In the view of the politicians, the strongest emphasis in the municipal policy plans was on promoting the health and life quality of older people, and supporting harmonious development among children and young people (Figure 5). Those in WM reported a significantly stronger emphasis on health promotion among adults compared with those in SWM (Figure 5), and senior politicians, compared with first-term politicians, a stronger emphasis on the health of people with illnesses and the unemployed (Table 2 in Study IV).

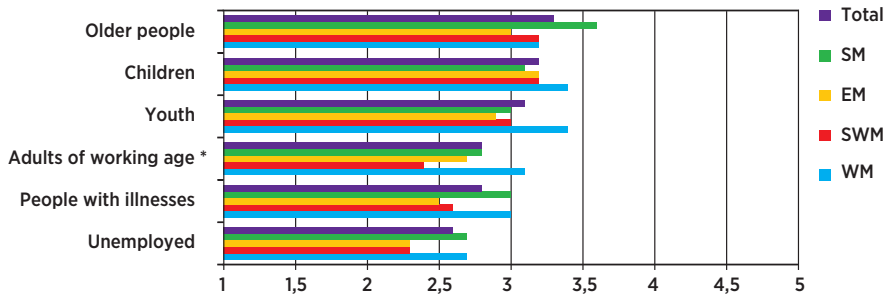


Figure 5. Emphasis in health promotion on different population groups in municipal policy plans across the municipalities (1= not at all – 5= very much; means; Study IV; *p < 0.05)

6.3 Additional aspects of health promotion

Among the LVAs

Study I explored different aspects of health promotion action with regard to separate variables (Figure 6). The LVAs engaged in health promotion most of all through actions to build social contacts (62% emphasized this to a high degree) and creating scope for action (42%). Moreover, 29% emphasized promoting a healthy lifestyle and one fifth promoting a healthy (22%) and safe (21%) environment. LVAs in WM were the most active in health promotion with a focus on the environment (combining the healthy and safe-environment variables), to a statistically significantly different level than those in EM (5.5/4.1; p < 0.05).

When the promotion of healthy lifestyles was examined in more detail (Figure 6), it turned out that the LVAs engaged most of all in promoting physical activities (32% emphasized this to a high degree), especially those in EM (45%). Moreover, one fifth emphasized the prevention of drug use/distribution and about one seventh promoting healthy dietary habits (14%), and reductions in smoking (14%) and alcohol abuse (13%).

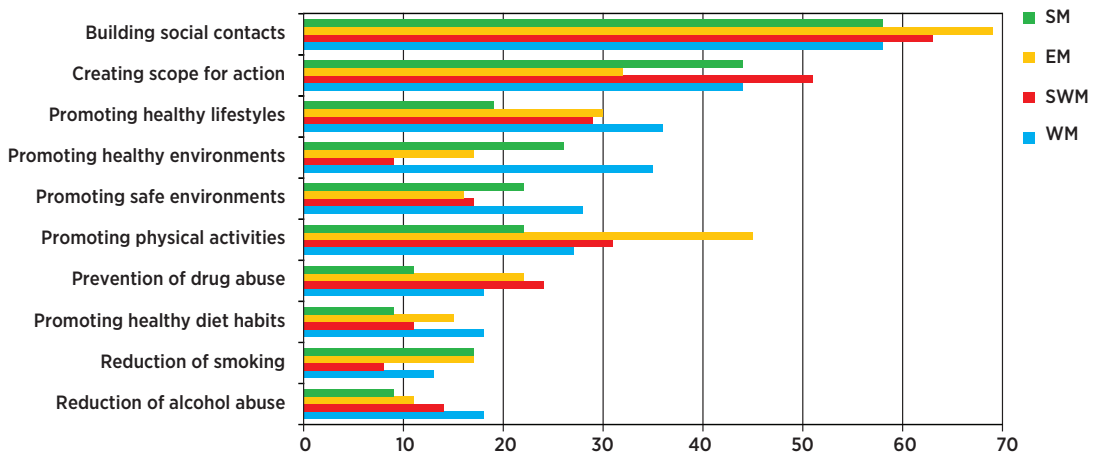


Figure 6. LVA emphasis (strong or very strong) on different health promotion activities across municipalities (%; Study I)

In primary healthcare, including care for older people

Nearly half (48%) of the PHC personnel reported engaging to a high degree in health promotion action focusing on individuals, and 17% focused to a high degree on groups: more in WM (27%) than in SM and SWM (11%; $p < 0.05$), and 22% in EM. Moreover, 7% reported engaging to a high degree in health promotion on the population level (Figure 7). Engagement on all three levels (individual/group/population) was most prevalent in ambulatory care: to a high degree in 62, 28 and 11% of the personnel, respectively. The respective figures were 47, 8 and 6% for those involved in home care, and 37, 12 and 5% for personnel in inpatient care. The differences between the work units were statistically significant ($p \leq 0.000/0.000/0.05$).

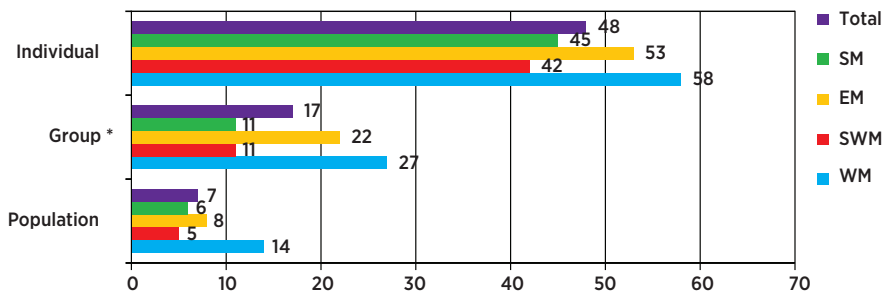


Figure 7. Health promotion action in PHC with a focus on the individual, group and population levels across municipalities (proportion of personnel engaging 'highly or 'very highly'; %; * $p < 0.05$)

With regard to the two aspects of health promotion that emerged from the principal component analysis and were interpreted as ‘addressing risk behaviour’ and ‘promoting health’, healthcare personnel working in ambulatory care (73%) were more highly engaged in ‘addressing risk behaviour’ than those working in home (28%) and inpatient (36%) care (Table 6). There were no differences between the work units on the ‘promoting health’ scale. Those who reported emphasizing health promotion with a focus on children and young people, adults, and/or people with illnesses were also more likely to engage to a high degree in both aspects of health promotion. However, the findings suggest that personnel emphasizing health promotion with a focus on older people engaged to a lesser extent in both aspects compared with those reporting that they did not emphasize health promotion among the elderly. ‘Addressing risk behaviour’ was more prevalent in EM than in SM, even following adjustment for the work unit (OR 1.85; 95% CI 1.06-3.23). There were no differences between the municipalities regarding ‘promoting health’. (Simonsen-Rehn et al. 2006 abstract)

Table 6. The correlates of high engagement in ‘addressing risk behaviour’ and ‘promoting health’: odds ratios (OR) and 95% confidence intervals (CI) from the univariate logistic regression analyses

Focus in health promotion on:	Addressing risk behaviour		Promoting health	
	OR	95% CI	OR	95% CI
Children and young people				
Low	1.00		1.00	
Medium	4.11***	(2.38-7.10)	1.71*	(1.01-2.91)
High	21.17***	(10.01-44.79)	2.77***	(1.62-4.73)
Adults of working age				
No	1.00		1.00	
Medium	6.55***	(3.88-11.06)	1.53	(0.98-2.38)
High	15.14***	(7.56-30.32)	3.32***	(1.81-6.09)
Older people				
No	1.00		1.00	
Medium	0.56	(0.19-1.67)	0.30*	(0.11-0.81)
High	0.20**	(0.07-0.56)	0.65	(0.25-1.65)
People with illnesses				
No	1.00		1.00	
Medium	6.48**	(1.91-22.01)	7.50***	(2.21-25.44)
High	17.68***	(5.22-59.88)	25.21***	(7.41-85.80)

*p < 0.05, ** p < 0.01, *** p ≤ 0.001

In municipal policy plans

According to the political decision makers, health promotion was emphasized to some extent in the municipal budget and operational plans. There were no differences between the municipalities and the priorities were similar (Figure 8): the promotion of healthy and safe environments was the aspect that was given the highest priority. First-term politicians perceived that there was significantly less emphasis on health promotion than senior politicians (Table 2 in Study IV), although

the ranking was the same. The difference in emphasis on the promotion of mental and social health and healthy lifestyles was still statistically significant when the municipality was controlled for: that is, first-term politicians perceived that there was significantly less emphasis on these aspects of health promotion in the municipal policy plans (Table 3 in Study IV). The only significant party-political difference to emerge was that members of centre/right-wing parties perceived a stronger emphasis on the promotion of healthy and safe environments than members of left-wing and other parties (Table 2 in Study IV), even when the municipality was controlled for (Table 3 in Study IV).

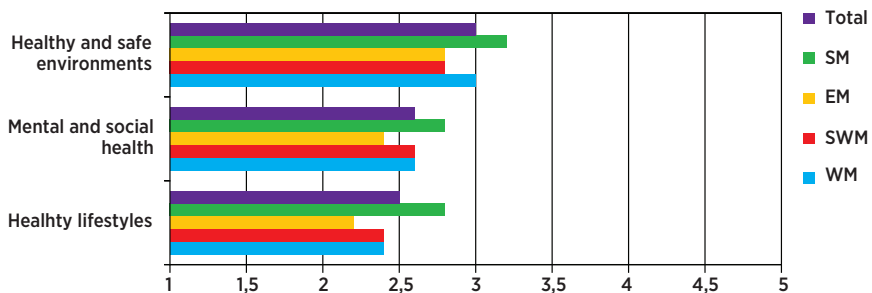


Figure 8. Emphasis on different aspects of health promotion in municipal policy plans across municipalities as perceived by political decision-makers (Means; range 1-5; Study IV)

6.4 Comprehensive health promotion action and its determinants in local contexts

Comprehensive health promotion action among the LVAs

Almost 60% of the LVAs in EM (59%) and WM (57%) engaged in a high degree in comprehensive health promotion action in 2002 compared with about 40% of the responding LVAs in SM (38%) and SWM (35%; Study II). The differences were not statistically significant, however ($p = 0.07$). The findings were quite similar in both study years, although health promotion action was defined slightly differently. Nevertheless, in the first study year, 2000, WM was the only municipality in which over 50% of the LVAs engaged in a high degree, the percentages in the other municipalities being 40 or less (Study I). The difference between the two years in the case of EM could have been attributable to the ‘promotion of physical activities’, which was emphasized somewhat more there than in the other municipalities in both years (although not statistically significantly more), but was not part of the health-promotion-action scale the first study year.

The determinants of comprehensive health promotion action among the LVAs

All the proposed determinants, in other words values (i.e. values ‘healthy’ and values ‘vulnerable’), competence and opportunities, were associated with engagement in health promotion action (Study II, Table 2). Over 60% of the LVAs that rated their competence, opportunities and/or values as high participated in a high degree in such action.

There were no statistically significant differences between the municipalities with regard to the proposed determinants of health promotion action (Figure 9).

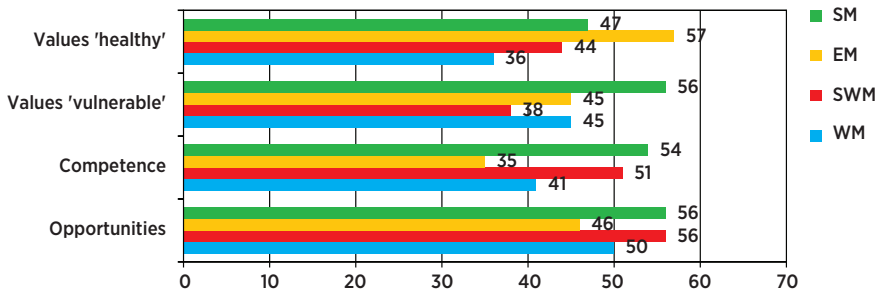


Figure 9. The proposed determinants of health promotion action across the municipalities (proportion of LVAs giving high ratings, %; Study II)

All the proposed determinants were entered stepwise into the multivariate analyses (Table 7). Both value indices made a unique contribution in the first step of the analysis. However, when firstly competence and secondly opportunities were then entered the association between the values on the ‘vulnerable’ scale and health promotion action disappeared. Removing the scale from the multivariate model produced a better model fit. The final model showed strong independent associations between the three determinants – values on the ‘healthy’ scale, competence and opportunities – and engagement in health promotion action. Furthermore, the municipality variable had an additional effect in that the LVAs in EM and WM were more likely to engage in health promotion action than those in SM when the proposed determinants were controlled for.

Table 7: The associations of the proposed determinants with high participation in health promotion action: multivariate logistic regression analyses, odds ratios (OR) and 95% confidence intervals (Study II)

Proposed determinants	Model 1 OR (CI 95%)	Model 2 OR (CI 95%)	Model 3 OR (CI 95%)	Model 5 OR (CI 95%)
Values 'healthy'				
Low	1.00	1.00	1.00	1.00
High	6.32*** (2.98-13.44)	5.68*** (2.55-12.65)	5.24*** (2.31-11.89)	6.61*** (2.71-16.14)
Values 'vulnerable'				
Low	1.00	1.00	1.00	
High	2.23* (1.05-4.74)	2.17 (0.97-4.82)	1.60 (0.68-3.78)	
Competence				
Low		1.00	1.00	1.00
High		4.65*** (2.09-10.37)	3.87*** (1.69-8.86)	6.31*** (2.39-16.67)
Opportunities				
Low			1.00	1.00
High			2.71* (1.16-6.33)	4.13** (1.69-10.11)
Municipality:				
SM (= reference)				1.00
EM				5.32* (1.42-19.88)
SWM				0.77 (0.21-2.78)
WM				7.25** (1.84-28.47)

*p < 0.05, **p < 0.01, ***p ≤ 0.001

Comprehensive health promotion action in primary healthcare, including care for older people

Table IV in Study III shows the proportion of PHC personnel engaged in comprehensive health promotion action (=higher than median engagement) across all background variables, and Table 8 below across work-related characteristics. There were statistically significant differences in engagement in terms of municipality, professional education, occupation and work unit: 60 and 66%, of the responding personnel in EM and WM, respectively, were involved in comprehensive health promotion action compared with less than half of those in SM (47%) and SWM (46%; Table 8). The higher the level of professional education the higher was the proportion involved. All the public health nurses and almost all the physicians (85%) reported engagement in health promotion. Of the personnel working in ambulatory care, 65% were engaged in health promotion action compared with 44 and 52%, respectively, of those working in inpatient and home care. When the work unit was controlled for it turned out that PHC personnel in WM were more highly engaged than those in SM. (Study III)

Table 8. The proportions of personnel reporting engagement in ‘comprehensive health promotion action’ (CHA), ‘addressing risk behaviour’ (RB) and ‘promoting health’ (PH) by municipality and work characteristics (%)

	CHA	RB	PH
Municipality	*	***	ns.
Southern municipality	47	40	49
Eastern municipality	60	64	57
South-western municipality	46	34	48
Western municipality	66	53	58
Work unit	**	***	ns.
Inpatient care	44	36	46
Home care, service houses	52	28	60
Ambulatory care	65	73	54
Occupation	**	***	***
Physician	85	90	55
Head nurse/nurse manager	27	27	33
Public health nurse	100	96	94
Registered nurse or equivalent	49	49	41
Practical nurse or equivalent	42	36	48
Home help staff	54	23	61
Professional education	**	***	ns.
Training courses or less	35	24	40
Vocational school	43	33	50
Vocational college/polytechnic	59	56	55
University	77	82	50
Managerial position	ns.	*	ns.
Upper management	67	78	67
Middle management	39	32	45
Not in a management position	54	48	51

*p < 0.05, ** p < 0.01, *** p ≤ 0.001

The determinants of comprehensive health promotion action in primary healthcare, including care for older people

According to the univariate analyses, most of the variables proposed as determinants of health promotion action were associated with the personnel’s engagement (Table V in Study III). This was the case for all the variables reflecting organizational values, whereas concerning competence, the perceived-competence variable, and concerning opportunities, the excessive-demands variable, showed no association with the personnel’s engagement in health promotion action.

A higher proportion of the personnel in EM than in the other municipalities reported high skill discretion and cooperating to a high degree within the organization. In addition, a higher proportion of the personnel in both EM and WM reported a high level of knowledge about the residents’ health and living conditions compared with those in SM and SWM (Table 9; Study III).

Table 9. Distribution of the proposed determinants across municipalities (% , Study III)

Proposed determinants	SM	EM	SWM	WM
Organizational values:				
Skill discretion **				
Low	29	15	23	26
Medium	39	38	52	40
High	32	48	26	33
Decision authority ns.				
Low	22	26	25	27
Medium	48	46	54	57
High	30	28	21	16
Social support at work ns.				
Low	42	42	33	47
High	58	58	67	53
Workplace health promotion *				
Insufficient	24	13	20	32
Medium	45	50	58	45
Sufficient	31	37	22	23
Competence:				
Perceived competence ns.				
Low	19	27	15	30
Medium	44	41	55	40
High	37	32	30	30
Knowledge ***				
Low	30	13	27	28
Medium	46	46	56	28
High	24	41	17	44
Opportunities:				
Cooperation within org. *				
None or low	70	53	63	67
High	30	47	37	33
Cooperation outside org. ns.				
None or low	77	65	67	62
High	23	35	33	38
Excessive work demands ns.				
Often	29	32	28	36
Every now and then	39	36	36	33
Seldom	32	32	36	31

*p < 0.05, ** p < 0.01, *** p ≤ 0.001

All the proposed determinants showing a statistically significant association with health promotion action in the univariate analyses were chosen for the multivariate analyses and entered stepwise into the models, as shown in Table 10. According to the result of the first multivariate model (Table 10, Model 1), PHC personnel in WM engaged somewhat more in health promotion work than those in SM, and personnel in ambulatory care more than those working in inpatient care. When the organizational values variables were entered in the next model, the difference between work units disappeared. Including the competence variable (knowledge about the population) did not change the other associations, although it made a strong independent contribution. When including the opportunity variables

(cooperation inside and outside the organization) in the last, fully adjusted, model, the statistically significant difference between municipalities disappeared. The fully adjusted model showed strong independent associations for organizational values (skill discretion) and competence (knowledge) with health promotion action: the higher the perceived level, the more likely was the person to be engaged in comprehensive health promotion action. Moreover, those reporting high levels of social support at work and opportunities to cooperate to a high degree with partners outside the organization were more likely to engage in health promotion action.

Table 10: The associations of the proposed determinants with high levels of health promotion action in primary healthcare: multivariate logistic regression analyses, odds ratios (OR) and 95 % confidence intervals (Study III)

Correlates	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)
Municipality:				
SM (reference)	1.00	1.00	1.00	1.00
EM	1.14 (0.66-1.97)	1.08 (0.60-1.94)	0.85 (0.46-1.58)	0.78 (0.41-1.49)
SWM	0.75 (0.43-1.33)	0.75 (0.40-1.38)	0.73 (0.39-1.39)	0.62 (0.32-1.19)
WM	1.99 (1.00-3.95)*	2.43 (1.15-5.13)*	2.29 (1.05-4.99)*	2.01 (0.91-4.44)
Work unit:				
Inpatient care	1.00	1.00	1.00	1.00
Home care	1.39 (0.81-2.39)	1.09 (0.60-1.99)	0.95 (0.50-1.78)	0.91 (0.48-1.73)
Ambulatory care	2.39 (1.46-3.93)***	1.05 (0.58-1.92)	0.90 (0.48-1.68)	0.90 (0.48-1.71)
Organizational values:				
Skill discretion				
Low		1.00	1.00	1.00
Medium		2.20 (1.17-4.13)*	2.31 (1.20-4.44)*	2.37 (1.20-4.68)*
High		6.27 (3.01-13.09)***	5.83 (2.70-12.60)***	5.12 (2.32-11.29)***
Decision authority				
Low		1.00	1.00	1.00
Medium		0.96 (0.54-1.71)	0.89 (0.49-1.61)	0.88 (0.48-1.62)
High		1.17 (0.58-2.32)	1.05 (0.51-2.14)	0.95 (0.45-2.00)
Social support at work				
Low		1.00	1.00	1.00
High		1.93 (1.20-3.12)**	2.00 (1.22-3.28)**	1.84 (1.09-3.10)*
Workplace health pro.				
Insufficient		1.00	1.00	1.00
Medium		1.98 (1.07-3.64)*	1.96 (1.04-3.69)*	1.82 (0.96-3.45)
Sufficient		1.11 (0.56-2.20)	1.01 (0.50-2.04)	0.92 (0.45-1.90)
Competence:				
Knowledge				
Low			1.00	1.00
Medium			3.02 (1.61-5.66)***	2.62 (1.38-5.00)**
High			4.96 (2.44-10.07)***	3.82 (1.83-7.95)***
Opportunities:				
Cooperation within org.				
None or low				1.00
High				1.16 (0.68-1.99)
Cooperation outside org.				
None or low				1.00
High				2.77(1.56-4.93)***

^a ORs for high health promotion action
*p < 0.05, **p < 0.01, ***p ≤ 0.001

6.5 The impact of health policy and its determinants in local contexts

Politicians' evaluations of the impact of health policy (score given to health promotion actions and their effectiveness) were similar in all the municipalities (Figure 10): 6.8 on average (range 4-10; 95% CI 6.5-7.0; SD 1.0). Politicians belonging to left-wing and other parties gave lower scores than those in centre/right-wing parties, although the difference was not statistically significant when analysed by municipality.

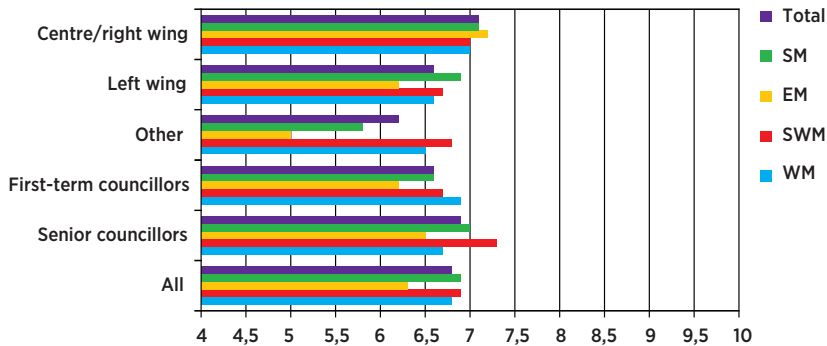


Figure 10. Politicians' evaluations of the impact of health policy by terms on the council and party affiliation across municipalities (means; Study IV)

All health promotion *goals* – in terms of the emphasis on different aspects of health promotion – and all the variables measuring *opportunities for community participation* were significantly and positively associated with the impact of health policy. Furthermore, most of the goals concerning an emphasis on health promotion with a focus on different population groups were also significantly associated. Exceptions included goals related to children and the unemployed, which were not significantly associated with the impact of health policy. Moreover, all the variables measuring *resources* for health promotion, except LVA activity in health issues, were significantly associated with the impact of health policy. Of the background factors, only the political party showed an association: members of the centre/right-wing parties gave significantly higher assessments.

The only difference between the municipalities with regard to the proposed determinants of health-policy impact was that the politicians in SM perceived the LVAs as more active in health issues than those in EM did (4.0/3.3; $p < 0.05$). Furthermore, although there were differences in perceptions of health promotion goals according to terms in office and political-party affiliation, the only difference with regard to opportunities for community participation and resources was that senior councillors were more likely to perceive the LVAs' significance in promoting residents' health as considerable (Table 2 in Study IV).

The politicians' knowledge about residents' health and living conditions was on an average level, with a mean of 3.4 (range 1-5; median 3.5). The computed proxy measure of interest in health issues (higher than median knowledge) showed no difference by municipality or terms in office. However, politicians from 'other' parties tended to have a higher interest in health issues than those representing centre/right-wing and left-wing parties ($p < 0.05$).

According to the stepwise linear multivariate regression analysis, the goal of promoting the health and quality of life of older people, the capacity of PHC and the capacity of care for older people explained 49% of the variance in health-policy impact. Adjusting for the municipality and for interest in health issues did not change the picture.

Some differences emerged in the analyses conducted in the same way as above but separately for first-term and senior politicians, and controlling for the municipality and interest in health issues, respectively, in the last step. Assessments of health-policy impact among both groups of politicians were influenced by a good capacity of care for older people: however, whereas the senior politicians' assessments were influenced by a perceived emphasis on healthy lifestyles, a perceived emphasis on promoting healthy and safe environments influenced the first-timers. Furthermore, first-term female politicians gave lower assessments. Goals related to an emphasis on different population groups were excluded from these analyses in order to restrict the number of variables.

7. DISCUSSION

The general aim of this study was to further enhance understanding of health promotion action and its enablement on the municipal, or local, level. Based on the Ottawa Charter (WHO 1986) health promotion strategies, the study focused on community action for health, health-promoting health services and healthy public policy. The specific aims were to explore the role of LVAs in health promotion, to compare the emphasis on health promotion in four municipalities with different forms of PHC service production and, specifically, to identify factors associated with health promotion action and its evaluation (in terms of effective actions). The data set included cross-sectional questionnaire data on LVAs, PHC (including care for older people) personnel and municipal politicians from four medium-sized municipalities in the southern part of Finland. This chapter begins with a presentation and an interpretation of the main findings. It continues with a general discussion about the differences and similarities between the municipalities, and of the enabling factors for health promotion on the local level. The final section focuses on methodological issues.

7.1 Main findings

There was agreement on the part of the LVAs and the local-level political decision makers that the promotion of residents' health requires cooperation between the municipal authorities and LVAs. Nevertheless, the emphasis on cooperation in the municipal budget and operational plans was rather weak, especially concerning LVAs and 'primary care authorities' – that is healthcare services, social services and education. There was an independent association between the LVAs' actual engagement in health promotion and cooperation with municipal authorities.

Regardless of their main activity, the majority of the responding LVAs found that their activities had a positive impact on the health and wellbeing of the residents. Moreover, about half of them actively followed discussions about residents' health and wanted to be involved in the decision-making related to health matters in the municipality, whereas a minority felt that they were able to influence decision-making. Local-level politicians thought that the LVAs' expertise was not sufficiently utilized in municipal decision-making. However, half of those who responded, especially the senior politicians, perceived the LVAs' significance in promoting residents' health as considerable. Above all, the LVAs emphasized establishing social contacts, scope for action and physical activities in their health-promoting activities.

Physical activities were also emphasized in the municipal budgets and operational plans as part of the 'healthy and safe environments' aspect of health promotion, which had the highest priority in all the municipalities. Politicians from the centre/right-wing parties tended to report a higher emphasis on promoting healthy and safe environments than those representing left-wing and other parties. Social and mental health and healthy lifestyles were given a lower priority than healthy and safe environments. Moreover, first-term politicians more so than senior politicians tended to perceive that these aspects were given even less emphasis.

PHC (including care for older people) personnel engaged in health promotion action primarily on an individual basis, and action on all three levels (individual, group, population) was most prevalent in ambulatory care. Moreover, 'addressing risk behaviour' and comprehensive health promotion action were more prevalent among personnel working in ambulatory care. There were some differences between municipalities in terms of level of engagement.

Variables reflecting all the proposed determinants were independently and strongly associated with the PHC personnel's engagement in comprehensive health promotion action. The variables concerned were: perceived skill discretion and social support at work (*organizational values*), knowledge about the health and living conditions of the population (*competence*) and cooperation with partners outside the organization (*opportunities*). The differences between the municipalities in terms of engagement in health promotion action disappeared in the multivariate analysis.

Perceived *competence* and a *value* orientation towards health were the factors that were statistically the most strongly associated with LVA engagement in comprehensive health promotion action. Moreover, perceived *opportunities* (to cooperate with municipal agencies as well as to follow discussions about residents' health and have an influence on decision-making) had a strong independent association with health promotion action. In addition to the determinants in the theoretical model, the municipality had an influence.

Local-level politicians evaluating health promotion actions and their effectiveness (health-policy impact) in the four municipalities gave 'passable grades', with no differences between the municipalities. An emphasis on promoting the health and quality of life of older people (*goal*), and the capacity of care for older people as well as of PHC (*resources*) turned out to be the most significant elements of health promotion policy in terms of impact. The politicians were not entirely consistent in their views on the municipal health promotion policies, the length of time in office explaining more of the differences than party-political affiliation.

7.2 Interpretation of the main findings

The role of voluntary associations in health promotion in local contexts

Practically all the LVAs and councillors surveyed perceived a need for cooperation between municipal agencies and voluntary associations in the promotion of residents' health. There was some variation, however, in that over a third did not fully share this opinion. In terms of LVAs' actual engagement in health promotion, cooperation with municipal authorities was independently associated with their engagement. Intersectoral cooperation and community participation are considered guiding principles in health promotion and have proven to be essential for its effectiveness (Gillies 1998; Jackson et al. 2006): with regard to community engagement and participation in decision-making and planning in particular, the evidence seems to be conclusive (Jackson et al. 2006). The current study shows the importance of cooperation from the viewpoint of local-level community organizations.

About half of the responding LVAs actively followed discussions about residents' health, and also wanted to be involved in the decision-making concerning health issues in the community. Only a minority felt that they had been able to have an influence, however. The views of the political decision makers differed on the question of LVAs' influence on the decision-making; nevertheless, less than half perceived that LVAs had an influence. At the same time, the majority of the politicians felt that the expertise of the voluntary associations was not utilized sufficiently, as did the majority of the LVAs. These findings suggest the need for more discussion and interaction among politicians and other decision makers, and the community. However, the findings could also point to a potential conflict for political decision makers in listening to the views of particular actors in the community at the same time as having the responsibility to consider the overall picture. Thus, the mechanisms through which different actors can become involved in discussions and decision-making related to the promotion of residents' health and wellbeing should be developed. Gillies (1998), having reviewed the effectiveness of partnerships and alliances in health promotion, suggested that durable structures such as local committees are needed to facilitate both planning and decision-making in a successful way. It has been proposed that intersectoral committees, which could also include representatives of voluntary organizations, should be set up to facilitate the strategic management of health promotion in Finnish municipalities (THL 2010). According to a recent study, there is a need to develop practices and to supplement legislation so that intra-municipal organs are not merely forums for dialogue, but can also offer opportunities for residents to participate in and contribute to local matters (Pihlaja & Sandberg 2012).

The majority of the responding LVAs that were active in the municipalities perceived their activities as having a positive impact on the health and wellbeing of the residents. This was the case regardless of their main activity. This finding is

in line with those of Trojan et al. (1991) that community organizations in general are interested in action for health. Two of five voluntary associations included in the present study engaged in health promotion action on a broad scale, defined as achieving a score of over 15 out of a maximum of 25, and comprising actions related to the promotion of healthy lifestyles, healthy environments and safe environments, broadening the scope for action and establishing social contacts (Study I). Likewise, two of five perceived their actions as very or quite significant for the residents' health and wellbeing, and as many thought they were of some significance (unpublished findings). There are no similar studies with which to compare these findings; however, a recent study on health promotion in Finnish youth sports clubs indicates that they do engage in promoting health, although only about a quarter of them recognize health promotion comprehensively (Kokko et al. 2009). Moreover, a third of the sports clubs were active in giving guidance on alcohol, drugs, tobacco and nutrition (Kokko et al. 2011). These results are fairly comparable with the finding in the current study that about a quarter of the sports associations emphasized these issues strongly or very strongly in their activities, although only one tenth emphasized the promotion of healthy dietary habits (Study I). According to studies on local-level voluntary associations within the social and health sector – which 'by their nature' are involved in promoting health and wellbeing as well as preventing problems – leisure, recreation and voluntary work as well as peer-group and guidance activities are their core fields of action (Peltosalmi et al. 2012). It is suggested in earlier studies conducted in the Nordic countries that the voluntary sector's main role has been in areas such as culture, recreation and advocacy (Helander and Sivesind 2001; Lundström 2001). Recent Swedish studies concerning health promotion processes in municipalities have highlighted the importance of non-governmental organizations as actors in health promotion, as perceived by decision makers (Guldbrandsson 2005; Jansson & Tillgren 2010). In general, the distinctive feature of citizens' organizations seems to be their action in areas in which there is a real need (Matthies 1997).

The emphasis on cooperation between municipal authorities and voluntary associations was rather low in the municipal budget and operational plans. According to the councillors it was, on average, emphasized 'somewhat', but especially with regard to cooperation between the LVAs and the 'primary-care authorities' – in other words healthcare services, social services and education – the emphasis was low. It has been suggested that the cooperation activity in municipalities is associated with the number of residents, the authorities in smaller municipalities cooperating less with other actors than those in larger municipalities (Eronen et al. 1995). In line with this finding, the results of a recent study focusing on Finnish municipal management (Tukia et al. 2011) indicate a perception among respondents in city-like municipalities in particular that the cooperation with voluntary organizations functions fairly well. These findings may relate to the possibilities for cooperation in terms of available partners, however, also to the fact that there may be better

opportunities for cooperation in the organizations in the larger municipalities. Moreover, cooperation in smaller municipalities may be more informal in nature. The anticipated active role of municipal health departments in cooperating with different local actors to promote health, highlighted in the national Health 2015 public health programme (MSAH 2001), is dependent on the opportunities available to the personnel, which in turn is at least partly dependent on the municipal health policy. The discrepancy in politicians' views concerning the need for cooperation between LVAs and municipal agencies, and its rather low priority in the municipal budget and operational plans, may mirror the barriers that studies on citizen participation in decision-making have identified: an ambiguous attitude among councillors, a lack of concrete measures for enhanced citizen participation, and the power of the local bureaucracy (Niemi-Iilahti 2003; Kettunen 2003).

However, there was a stronger focus on cooperation between the LVAs and the 'leisure authorities': it may be that the LVAs' role in the promotion of residents' health and wellbeing is seen mainly in relation to these kinds of activities. Although health and welfare promotion as well as preventive activities in the policy plans of Finnish municipalities seem to be connected foremost with health and social services, these activities are mentioned also in relation to sport, leisure and youth services (Uusitalo et al. 2007). According to a recent Finnish study on the role of voluntary organizations in rural municipalities, the municipalities expect them, above all, to work on strengthening social networks and the sense of community (Pihlaja 2010). The LVAs surveyed in the current study most strongly emphasized, apart from, physical activities, the need to establish social contacts and broaden the scope for action in their health-promoting activities. Social participation as well as social capital – measured as social participation and networks, trust and reciprocity – appears to be related to better health outcomes (Dalgard & Lund Håheim 1998; Hyyppä & Mäki 2003; Nieminen et al. 2010). Thus, creating these kinds of opportunity on the local level could be considered important health-promoting activities.

There were no differences between the municipalities in their emphasis on cooperation in their policy plans; however, the first study-year the voluntary associations in WM reported cooperating with the health services to a larger extent than did voluntary associations in the other municipalities. Furthermore, according to the 2002 survey, a higher proportion of voluntary associations in SM were cooperating with the health services than in the first study: one aim of the healthcare service provider in SM was to enhance community participation in health promotion. In general, the LVAs cooperated, above all, with municipal departments of cultural services and education. Earlier research points to the large step between policy and implementation, in other words operations do not always reflect the current policy (e.g., Guldbbrandsson et al. 2009); moreover, the influence may sometimes go in the other direction in terms of incorporating common practices into the policy (Guldbbrandsson 2005).

The LVAs operated mostly without salaried personnel, and about ten per cent of the members, on average, were actively involved in arranging activities. In average, over two hundred residents (median 100) per association engaged in these activities. It has been found in earlier studies that although voluntary associations in larger cities are more likely to have salaried personnel than those in smaller cities, this applies to less than one third of them (Helander & Pikkala 1999). Two thirds of the associations surveyed in the present study reported having too few active members taking part in organizing events and activities, reflecting findings from other studies regarding the shortage of active actors in LVAs (Pihlaja 2010; Peltosalmi et al. 2012). Pihlaja (2010), for example, questions their role as producers of services in rural municipalities, mainly due to the shortage of active actors and the ageing of those who are involved, and uncertainty related to funding.

Less than half of the LVAs surveyed in the current study had received financial support and/or support in the form of premises and materials from the municipality, although this kind of support was the most common. Almost half of them were in need of support in the form of expertise and education; however, they received such support more seldom. The Ottawa Charter (WHO 1986) states that funding support, full access to information and learning opportunities are necessary if communities are to take an active role in the promotion of health and wellbeing. Moreover, the provision of common meeting places might facilitate cooperation among voluntary associations acting in the municipality, as well as between them and both municipal agencies and residents. Successful cooperation among voluntary associations seems to be associated with their engagement in health promotion action (Study I). In the Finnish context, Möttönen (2002) suggests that municipalities could foster relations with voluntary associations when it comes to operations related to 'activating' residents, and, moreover, that the cooperation could be close.

According to the findings from the present study, a fair proportion of LVAs are interested in action for community health, and could be seen as a resource for health promotion in local contexts. However, support in the form of cooperation with different municipal agencies seems to be needed to facilitate LVA engagement in health promotion action. The role of voluntary work and how it is supported generally in society is a question in its own right. In fact, during the first decade of the 2000s the role of volunteering has been higher on the policy agenda in Finland in terms of national strategies and programmes. It has been suggested that EU policies on active citizenship have had a key impact in this regard (GHK 2010a).

Enabling factors for comprehensive health promotion action among LVAs

Common factors across the LVAs that led to greater involvement in health promotion on the local level included the degree to which the voluntary associations had a value orientation towards health (focusing on the wellbeing of children and young

people, adults and the unemployed), the degree to which they perceived they had the competence (reflected in the municipality's appreciation of their work and their belief that it had an impact on residents' health and wellbeing, and promoted feelings of affinity), and the degree to which they perceived they had opportunities to follow discussions about residents' health and wellbeing, influence the decision-making and cooperate with municipal departments. The theoretical framework of this study, the multilevel health promotion model (Rütten et al. 2000), has been found to apply as conceptual framework on different levels of action. The findings from the current study – consistent with the hypotheses – give some empirical confirmation of its applicability to the organizational level of LVAs.

The overall findings of this study are in line with the theoretical literature related to community building, community capacity and community participation (Zakus & Lysack 1998; Baker & Teaser-Polk 1998; Goodman et al. 1998; Merzel & D'Affliti 2003; Nutbeam & Harris 2004). Community capacity is a key concept in the community-building model (Nutbeam & Harris 2004) and, as mentioned in the literature review, could be a main factor influencing engagement in health promotion (Goodman et al. 1998; Merzel & D'Affliti 2003). Community capacity is a multidimensional concept incorporating values, skills and resources, a sense of community and networks, for example (Goodman et al. 1998). The predisposing factors for community participation in health that Zakus and Lysack (1998) propose focus more on conditions related to the context, and whether they support participation, include awareness and discussion about issues affecting individual and community wellbeing, and give priority to health issues. The current study includes similar dimensions to those mentioned above, but views them as separate constructs, in other words as values, competence and opportunities rather than the multidimensional concept of capacity (cf. Riley et al. 2001).

The finding in the present study that the LVAs' values related to health – as part of their overall activities – were a major determinant of engagement in health promotion action was expected, given that LVAs choose their activities based at least partly on their own interests and the perceived needs of the community. Priorities might, in part, originate from regional or national organizations. Riley et al. (2001) suggest in their study on public-health agencies that what is important is a shared commitment to organizational priorities, and that this has a direct impact on implementation. Moreover, studies related to heart health promotion among different organizations, including non-governmental bodies, have found that an overall organizational interest is a facilitator (Joffres et al. 2004a). The extent to which LVA members differ in their priorities concerning health promotion and how these differences affect the activities, as well as how many priorities (cf. Riley et al. 2001) voluntary associations can address, would be worth further study.

It seems that the population groups with which the voluntary associations work also matter. Namely, the findings suggest that LVAs focusing on 'vulnerable groups' in the community (people with disabilities, people with illnesses and older people),

engage in health promotion to a larger extent through being involved in decision-making as well as through cooperating with municipal authorities. In fact, the first study year it was the voluntary associations for the retired and elderly, as well as patient associations that, in the main, felt that they had an impact on decision-making concerning health issues in the municipality (Study I). However, in the second study year only a few associations for the retired and elderly (8%) felt that they were able to influence decision-making, whereas half of the patient associations (47%) were still of this opinion (unpublished findings). There were elections to the municipal councils in the first study year, thus the 'political life' in the municipalities was probably different as compared with the second year. Nevertheless, the findings suggest that patient associations may have more channels for influencing decision-making than other types of voluntary associations, and advocacy activities might also be more pronounced in their operations. Overall, it seems that local-level voluntary associations still perceive the possibility of influencing decision-making in the municipalities as quite poor (Peltosalmi et al. 2012).

The differences in action found between voluntary associations working with different population groups could also be related to the comprehensive health-promotion-action variable. Of the three dimensions included – the promotion of healthy lifestyles and mental wellbeing as well as social support – voluntary associations might focus on emotional and social wellbeing more than healthy lifestyles in relation to older people and people with illnesses or disabilities. For instance, almost all associations for the retired and the elderly strongly emphasized building social contacts, and although almost half of them emphasized physical activities, the other lifestyle issues were not particularly highly prioritized (Study I). Earlier studies on older people discuss aging stereotypes in society, and point to the effect of lifestyle changes in the elderly (Ory et al. 2003). There may be a need for more knowledge in the community about health promotion in relation to different population groups.

The promotion of social and mental health is just as important as the promotion of healthy lifestyles; moreover, advocacy is an essential health promotion approach. Nonetheless, according to the findings of the present study, voluntary associations focusing on the wellbeing of children, young people and adults in particular seem more likely to engage in activities related to comprehensive health promotion action, including promoting healthy lifestyles as well as social and mental wellbeing. What kind of strategies various LVAs use in the promotion of health and wellbeing merit further study. Moreover, given their expressed need for expert help and education (Study I), it would be useful to explore exactly what kinds of needs voluntary associations have in relation to health promotion in municipalities. More is known about the strategies and needs of associations within the social and health sector. It has been shown, for example, that the support they receive from their national organizations in the form of information and material is important; however, almost

half of those surveyed expressed the need for more or different kinds of support (Peltosalmi et al. 2012).

Perceived competence was strongly associated with LVA engagement in health promotion action. The competence construct included the perceived ability to accomplish health and social effects as well as perceived appreciation from the municipality. It thus resembles 'collective efficacy' (Bandura 1998; 2004), which is suggested to play a key role in health promotion action. One would also expect reciprocal associations between competence and engagement in health promotion, meaning that competence facilitates engagement in health promotion action and participation in health promotion action improves LVA competence in this regard. Longitudinal studies are needed to confirm this. Moreover, the correlation between competence and opportunities was quite strong. On theoretical grounds, the opportunity to participate in decision-making and to have an influence on decisions related to health issues in the municipality should lead to empowerment (Israel et al. 1994), which could suggest a higher level of competence in health promotion action. In the analysis, the odds ratio for competence decreased slightly when opportunities were brought into the multivariate model, but there was still no clear indication of any mediating effects. These issues merit further study.

A valuable finding in its own right was that, even after controlling for the determinants of value and competence, opportunities still had an independent effect on engagement in health promotion action. The literature on health promotion stresses the need for partnerships and community participation, as well as for normative and policy-change interventions, in strengthening resources for health in communities (Gillies 1998; Zakus & Lysack 1998; Merzel & D'Afflitti 2003; Jackson et al. 2006). This study confirms the value of these strategies. Moreover, as opportunities are considered a crucial factor in the dynamics of the 'logic of events' and the multilevel health promotion model (von Wright 1976; Rütten et al. 2000), in other words new opportunities arise through changes in external situations, the implication is that municipalities can enable LVA participation in health promotion through their policies.

Enabling factors for comprehensive health promotion action in primary healthcare

In line with the hypotheses and according to the multilevel health promotion model (Rütten et al. 2000), variables reflecting all the proposed determinants (organizational values, competence and opportunities) independently contributed to the healthcare personnel's engagement in health promotion action. The variables showing the strongest associations were the personnel's perceived skill discretion (measure of organizational values), knowledge of the health and living conditions of residents (competence) and cooperation outside the organization (opportunities).

Moreover, there was a positive independent association between social support at work, also a measure of organizational values, and engagement in health promotion.

The multilevel health promotion model (Rütten et al. 2000) has not previously been applied to health promotion actions in the health services. The present study gives some empirical confirmation of its applicability in this context. An interesting finding was the equally strong associations of variables reflecting organizational values, competence and opportunities with engagement in health promotion action in the final multivariate model. This finding implies a need for a multilevel approach to reorienting health services to focus more on health promotion.

Findings from a recent qualitative study on the experiences and views of Finnish public-health nurses about the promotion of physical activity among children below school age support this kind of multilevel approach (Javanainen-Levonen 2009). According to the results, the determinants of physical-activity promotion included the nurses' personal characteristics and abilities, the nature of child health-clinic work, cooperation, and information on service delivery in the community with regard to physical activity.

Moreover, the findings from the current study, taken as a whole, are in line with the results of studies emphasizing the importance of cooperation and partnerships (Gillies 1998; Riley et al. 2001; Jackson et al. 2006), the organizational climate and the empowerment of health professionals (Benson & Latter 1998; Germann & Wilson 2004) and knowledge about the community (Riley 2003; Germann & Wilson 2004) for health promotion action.

Organizational values were conceptualized in this study as a work environment that was conducive to health promotion work. In the final multivariate model, skill discretion was the variable with the strongest association with engagement in health promotion action. To my knowledge, skill discretion has not previously been studied in relation to health promotion work; however, this finding is consistent with the results of a Swedish study indicating that the personnel perceived both time for reflection and learning and freedom of action as decisive for developing a health-promoting role in the work unit (Johansson et al. 2010b). Earlier studies have also implied that 'critical reflection' is essential for an empowerment approach in health promotion work (Liimatainen et al. 2001; Germann & Wilson 2004). Moreover, Germann and Wilson (2004) concluded on the basis of interviews with community-development workers and leaders that the core values supporting a community-development approach to health promotion in health services include reflection, learning, risk taking and innovation. Skill discretion reflects the psychosocial work environment, and specifically refers to being able to use one's skills and knowledge as well as to having a job requiring learning, reflection and decision-making (Karasek 1979). Furthermore, in the current study, social support from co-workers – also a measure of organizational values – had an independent association with engagement in health promotion action. Social support and group coherence among employees are considered critical in converting challenging strategies into action and achieving

set goals (Arneson & Ekberg 2005). Comprehensive health promotion practice therefore needs a work environment that is conducive to this kind of work.

The finding in the current study concerning the importance of competence, in the sense of knowledge about the health and living conditions of the local population, is in line with the emphasis in the literature on capacity building: this kind of knowledge is seen as a necessary resource for a community- or population-based approach to health promotion (Riley 2003; Germann & Wilson 2004). However, perceived competence in one's work in general was not associated with engagement in health promotion. The personnel referred to in the Swedish study (Johansson et al. 2010a) mentioned above did not perceive a lack of competence to be an issue or a barrier to their health promotion work. However, the health-service personnel suggested that the development of a more strongly health-promoting service would require higher levels of competence among the managers. Management interest in the health of co-workers was also deemed necessary (Johansson et al. 2010a). This could be interpreted as a need for an overall interest in health and how it is valued in health services. Moreover, Johansson et al. (2010a) mention the vital role of managers in giving opportunities, in the form of time and other resources, and supporting the personnel in prioritizing work and achieving a balance between health-promoting, preventive and curative care. In the light of the findings of the current study, it would be worth exploring the role of middle management and the opportunities available: less than 40% of them reported engaging in health promotion action.

The finding that opportunities – in the form of cooperation with non-health municipal agencies, voluntary organizations, managers and political decision makers – were strongly associated with the personnel's engagement in health promotion actions reflect the key principles of health promotion, which include participation and cooperation (Rootman et al. 2001). Various reviews refer to the effectiveness of partnerships in this context (Gillies 1998; Jackson et al. 2006). However, there is little empirical evidence concerning the association between cooperation and health promotion implementation in relation to health services (Riley et al. 2001). Related findings in recent empirical studies confirm the importance of partnerships and cooperation in health services: Reuterswärd and Lagerström (2010), for example, found in their qualitative study on school health nurses that cooperation in a network of professions was essential for successful health promotion work. Moreover, Javanainen-Levonen's study (2009) on public-health nurses found cooperation to be a determinant of the promotion of physical activity, and studies on the organizational level of public-health agencies reveal that participation in community networks is a key factor influencing the implementation of health promotion (Riley et al. 2001; Riley et al. 2003).

Contrary to findings from other studies, a heavy workload (excessive work demands) was not associated with engagement in health promotion action in the current study. Insufficient time and work overload have been reported as key

barriers to engagement in health promotion (Hudon et al. 2004; Joffres et al. 2004a; Casey 2007; Johansson et al. 2010a). Moreover, decision authority was only weakly associated with engagement in comprehensive health promotion action, and only in univariate analyses. Decision authority reflects the control dimension in the control-demand model (Karasek 1979), and refers to the authority to make decisions about different aspects of one's job as well as the work of the whole team. It emerged as an explanatory factor for 'promoting health' in supplementary analyses related to the two different aspects of health promotion action, but not for 'addressing risk behaviour' (unpublished findings). This finding implies the need for a higher decision-making authority especially when working towards the goal of promoting mental and social health as well as health-supportive environments. Thus, there might be different needs, as relates to working conditions, for different kinds of approaches in health promotion. These questions warrant further study.

Health promotion policy and its impact in local contexts – the views of political decision makers

In the view of the local councillors, the *goal* of promoting health and quality of life among older people and *resources* in the form of capacity with regard to care for older people and the PHC were the most significant elements of the local health promotion policy in terms of impact. According to earlier studies on the impact of health policy, policy makers' evaluations of outcomes are influenced by goal concreteness and a sufficiency of resources, and also by public opportunities (Rütten et al. 2003a). In the current study, opportunities for community participation were associated with health-policy impact in regression analyses before adjustments. However, contrary to the hypotheses, neither the opportunities for community participation nor the variables reflecting LVAs as resources for health promotion were associated with effective health promotion actions in the multivariate model. These findings could indicate that public opportunities in the form of community participation – both in decision-making and in opportunities for cooperation – should be highlighted more on the local level. Moreover, there did not seem to be a fully consistent view on the current health promotion policy – time in office more than party-political affiliation explained the differences in the councillors' views.

The municipalities emphasized, to some extent, all three aspects of health promotion. However, in general, the politicians perceived it as being emphasized only 'somewhat' in the municipal budget and operational plans. Whether this finding is attributable to the fact that health promotion had not been high on the politicians' agenda, or that health promotion had not been realized in local policy plans is an open question. Nevertheless, a recent report describing the state of health promotion in Finnish municipalities from the perspective of municipal management (Tukia et al. 2011) concluded that, although further development on the local level is still

needed, there seems to be a positive trend in including the promotion of health and wellbeing in municipal strategies and action plans.

The promotion of healthy and safe environments, including the promotion of physical activity and work against illicit drug use, was the aspect of health promotion that was given the strongest emphasis in all the municipalities, according to the councillors. Analyses of Finnish municipal policy documents point in the same direction (Uusitalo et al. 2007): physical activities and substance abuse in particular are prioritized. Jansson et al. (2011) found that public-health policies on the local level in Sweden focused on lifestyle issues; the municipalities prioritized physical activity, and the prevention of alcohol and drug abuse specifically among children and young people. One reason for this, the researchers suggest, is that lifestyle issues seldom involve political conflict (Jansson et al. 2011). In Canada, as well, traditional risk factors such as physical activity, but also smoking and a poor diet, have been prioritized locally (Anderson et al. 2008). However, Allender et al. (2012) found that local governments in Victoria, Australia, were in favour of creating supportive environments for physical activity but gave little support to changes aimed at promoting healthy eating: competing priorities and lack of relevance were reasons for not supporting policy interventions. With regard to the current study, there was no specific stress on promoting healthy lifestyles, including activities related to smoking, alcohol abuse and healthy dietary habits. One possible explanation for this is that local governments consider the measures already in place as well as those taken on the level of national policy to be sufficient. It might also be the case that illicit drug use as a 'new' risk factor was higher on the local agenda, and therefore prioritized in municipal policies. In fact, the politicians raised the issue of illicit drug use, but also alcohol abuse, as a local-level problem. According to the analysis, senior politicians perceived that goals related to healthy lifestyles had led to effective health promotion actions locally.

Taken as a whole, the politicians' evaluations of effective health promotion actions in the municipalities were influenced most strongly by the goal of (a perceived municipal emphasis on) promoting the health and quality of life of older people, and by capacity of care for older people. Moreover, PHC capacity was significantly associated with the evaluations. Capacity and priority given to health have been found to be the major determinants of health promotion implementation from the organizational perspective – however, external factors such as participation in networks also play a role, primarily through improving capacity (Riley et al. 2001). The perceived importance of promoting the health of older people is understandable in the context of an ageing population and the discussions related to it. This issue was one of the main concerns of the councillors with regard to residents' health. There is a focus in Finland, as in Europe overall, on demographic change in societies, which are ageing (Wismar and Ernst 2010). Furthermore, financial concerns, especially related to the rising costs of specialized care, were another main issue for the councillors. Between 70 and 80% of the expenditure of Finnish municipalities is

assigned to education, social services and healthcare, the latter two having become the main focus since the 1960s (Loikkanen & Nivalainen 2011). Thus, it is possible that these concerns – the ageing population and expenditure – have brought health promotion particularly related to older people higher on the local agenda. Indeed, local governments have referred to savings and better living conditions for residents in justification of their decisions related to health promotion (Uusitalo et al. 2007). Moreover, goals concerning health promotion among older people might have been more clearly stated in the municipal policy documents and hence were perceived to have had a stronger impact (cf. Rütten et al. 2012).

The councillors' views on the significant role of health services in local-level health promotion are in line with earlier findings (WHO 2002; Uusitalo et al. 2007). The impact of health policy certainly depends a great deal on the efficacy of the public sector, and also in SM the municipality had official responsibility for the services. Finnish municipal politicians have prioritized home nursing and care since the 1990s (Lammintakainen & Kinnunen 2004), and the municipalities have developed these services and increased outpatient care for the elderly as a response to rising healthcare costs (Loikkanen & Nivalainen 2011). The current strong national-level focus on health promotion may have been adjusted in the municipalities to follow choices made earlier in accordance with theories explaining stability, such as path dependency (Vrangbæk and Christiansen 2005). Local needs and conditions, more than external factors, appear to have influenced the development of health promotion on the local level (Jansson and Tillgren 2010; Jansson et al. 2011). However, the equation of health policy with health services has been criticized. Bambra and colleagues (2005), for example, point to the fact that it seems like health is often reduced to and misrepresented as healthcare: the politics of health becomes the politics of healthcare. It should be remembered that the resources included in this study were PHC and care for older people in addition to the LVAs. Including other resources might have yielded different findings. Nevertheless, given that health promotion was apparently not a central issue when local governments chose their service providers (Laamanen et al. 2005), the findings from the current study confirm the need for a more systematic health promotion strategy on the local level.

A community approach, including partnerships with community organizations, has been considered vital in promoting the health of residents. It has been found in studies among European policymakers that perceived public support predicted the health outcomes of specific health promotion policies (Rütten et al. 2003b). In the current study, opportunities for community participation were no longer related to the impact of health policy in the multivariate analysis. It may be that politicians perceive LVAs' actions as separate measures that should not be evaluated as part of public policy, or they might not have enough knowledge about their activities. Alternatively, the councillors do not consider the LVAs' activities relevant enough in terms of promoting the health of residents: only 50%, including more

senior than first-term councillors, reported that their significance in this regard was considerable.

There did not seem to be a consensus as to the current emphasis on the promotion of health in the municipalities. Terms in office turned out to explain more of the differences in local politicians' perceptions than party-political affiliation did. Earlier studies conducted in Canada report differences in views on health promotion based on political affiliation (Ashley et al. 2001; Cohen et al. 2001). Local-level decision makers in Finland in the 1990s perceived health promotion as a 'neutral' rather than a political issue, meaning that there were no political disagreements in relation to health and its promotion (Perttilä 1999). However, Jansson et al. (2011) suggest that issues that do not involve political conflict tend to be in focus on the local level. Pettersson (2007) further argues that inequality, as well as issues concerning responsibility for health and whether it is the individual or society that carries it, have brought health promotion onto the political agenda. This may be one explanation why, in the current study, left-wing politicians, compared with centre/right-wing politicians, perceived that there was significantly less emphasis on the promotion of healthy and safe environments in the municipalities. Given that this was also the aspect of health promotion that was emphasized the most on the local level, it might have been discussed more thoroughly in local councils than the other aspects, which could also explain the party-political difference. With regard to inequalities, there were a few comments suggesting that marginalization was a problem on the local level, but the politicians did not specifically comment on health inequalities in the open question on key issues regarding the health of residents. The same applies to leading officials in interviews conducted as part of a recent study in two major Finnish cities and concerning health promotion as a municipal task (Lindfors et al. 2010). These findings are similar to those reported in a Swedish study (Jansson et al. 2011) in which there was no mention of health equality in local policy documents or in interviews with local decision makers. This could be a question of terminology, but it nevertheless seems that the issue could be higher on local agendas.

First-term councillors perceived significantly less emphasis on health promotion in the municipal budget and operational plans than their senior colleagues. The biggest disagreement was related to the promotion of social and mental health. The reasons for the differences in views could lie in the complexity of health promotion and possibly vague goals. One interpretation from an actor-structural approach (e.g., Guldbrandsson 2005) is that senior politicians have been 'socialized' to interpret matters in a similar way. Related to this, path dependencies and institutional inertia (Vrangbæk and Christiansen 2005) may offer further explanations. First-term councillors may perceive both needs and solutions differently: whereas the senior councillors' evaluations of the impact of health policy were influenced by goals related to the promotion of healthy lifestyles, the first-term councillors' evaluations were influenced by goals related to the promotion of healthy and safe environments. Policy learning has been proposed to take place between coalitions

with different values and views (Sabatier 1998; Gagnon et al. 2007). It may be that such ‘coalitions’ in local health promotion policy do not primarily follow the respective party affiliations. This suggests that health promotion policy on the municipal level could be furthered in discussions in local councils without the need for party-political consensus. However, the differences in views among councillors regarding the current policy in the municipality might indicate the need to strengthen local governments’ institutional capacity for health promotion.

7.3 Health promotion in local contexts and enabling factors – general discussion

Similarities and differences between municipalities

The municipalities in this study were quite similar in terms of population (the numbers varied from 7,444 to 11,984 in 2002), age structure and health. EM and WM were more urban with higher population densities (169/161 persons/km²), whereas SM and SWM had a lower population density (45/44 persons/km²). The proportion of Swedish speakers in SM and SWM was over 50 % (60/55), and 40 and 0.1%, respectively in EM and WM. The population in SWM were the most highly educated among the municipalities. The density of LVAs was highest in EM (33 LVAs/1000 inhabitants in 2002) and lowest in SWM (21), with 28 and 24 in SM and WM, respectively. Health promotion was the core value of the contracted healthcare provider organization in SM, and one of its goals was to integrate it into all communal and voluntary activities.

The present study showed some differences between the municipalities in that the LVAs in the more urban areas (EM and WM) engaged more in health promotion action than those in SM when the other determinants were controlled for. It may be that an urban environment is more fruitful in this respect. Earlier studies report that geographical, demographic and socio-economic factors influence health promotion practice with regard to the measures taken by different actors (Robinson et al. 2006; Guldbrandsson et al. 2009). Robinson et al. (2006) found that geographical characteristics were perceived as barriers to health promotion, whereas according to Guldbrandsson et al. (2009), densely populated town districts with a high proportion of adults with more than 12 years of education tended to have more measures in place. There is thus an apparent need for studies on LVAs and their health promotion actions in different kinds of municipalities and, in the case of larger cities, in different districts. Moreover, the LVAs in EM seemed to engage somewhat more actively in promoting physical activities than those in the other three municipalities, which could be one explanation for the finding that a larger proportion of the adult population in EM engaged in physical activities than in the other municipalities. Apart from the above contextual factors, community history

(Goodman et al. 1998) and municipal support might also explain the differences in the actions of LVAs.

No differences in health promotion activities were found between the LVAs registered in Swedish and Finnish in the Register of Associations. Nevertheless, those registered in Swedish were slightly more strongly convinced of their significance for the health and wellbeing of municipal residents, although the difference was not statistically significant ($p = 0.065$) (Study I). One reason for this could be the better health of Swedish speakers observed in some studies, attributable to, among other things, more active participation in activities of voluntary associations (e.g., Hyypä & Mäki 2003). These studies have also been referred to in the mass media. There were no differences in health promotion actions between the Finnish- and Swedish-speaking healthcare personnel.

The PHC personnel in WM engaged more actively in comprehensive health promotion action than those in SM, even following adjustment for the work unit. There was a higher tendency in WM to take a group approach to health promotion, although following adjustment for the work unit there were no statistically significant differences between the municipalities. According to the analyses of the two dimensions of health promotion action, employees focusing on the elderly, engaged in both dimensions of health promotion action to a lesser extent than those who did not focus on older people. The responding PHC personnel in SM engaged somewhat more in health promotion with a focus on older people and less with a focus on children and young people, which may be one contributory factor in the lower engagement of SM than WM personnel in comprehensive health promotion. Moreover, although the largest professional group among the respondents in both municipalities, practical nurses comprised nearly half of the respondents in SM compared with a third in WM, thus differences in job description might be an explanation for the finding. Further, the statistically significant difference between municipalities identified in the multivariate analyses of comprehensive health promotion action disappeared in the last step when cooperation outside the organization was included. Thus, opportunities for cooperation outside the organization explain some of the differences in health promotion action. In terms of actual cooperation activity, the personnel in WM seemed to be cooperating somewhat more with partners in the community: almost 40% reported a high level of cooperation outside the organization as opposed to 23% of the personnel in SM. This difference was not statistically significant, however.

As far as the LVAs were concerned in the first study year, over half of those in WM cooperated with health services compared with about a third in the other municipalities. Cooperation activity between the voluntary associations and the health services, as well as with the social services (although to a lesser extent) increased in SM during the two study years in that more LVAs reported that they had been cooperating with health services and social services (not statistically significantly more) during the second study year than in the first. Moreover, the

proportion of healthcare personnel cooperating with voluntary organizations in SM increased from 36 to 52% (unpublished findings). However, over 70% of the personnel in WM were cooperating with voluntary organizations and over 60% of the personnel in the other two municipalities (unpublished findings; detailed data not shown; $p \leq 0,001$ both study years). The political decision makers in SM (in 2004) reported higher activity in health issues among LVAs than those in the other municipalities, which could imply that LVA interest and involvement in health matters had continued to grow.

The differences in actions could be attributable to variation in health policies in the municipalities. Health promotion policies are one way to create opportunities that enable individuals and communities to increase control over the determinants of health (WHO 1986). Furthermore, they give work in the health and social services a direction. The only difference in the local-governmental health policies as perceived and reported by the politicians was the higher priority given to promoting the health of adults of working age in WM than in the other municipalities under investigation (only statistically significantly related to SWM). Moreover, as discussed above, the politicians in SM had the impression that voluntary associations were more active in health issues, which in this study is included in the resource dimension of health promotion policy. Andersson (2003), in turn, found only small differences between Swedish municipalities when analysing health promotion targets in annual reports. She concluded that national laws and regulations guided the work in local government, and that there may be inter-municipality differences further out in the organizations, such as in home care and schools.

However, some studies do report differences in health promotion policy between municipalities. Uusitalo et al. (2007), for instance, found variation in the extent to which health, welfare and preventive activities featured in municipal documents related to strategic and financial planning. Jansson and Tillgren (2010) also identified differences when they analysed the development of health promotion on the local level in Sweden on the basis of policy documents and interviews, mostly with officials but also including politicians. It seems that health promotion was not prioritized on the political agenda until the beginning of the 2000s. Before that the initiatives and activities remained primarily on the departmental level and with non-governmental organizations, for example, which produced differences between the municipalities. However, also later on differences between municipalities in emphasis on health promotion arose, and in how explicit and wide reaching the goals were: local needs and champions had been the main influencing factors (Jansson and Tillgren 2010). The varying research methods might explain the differences in findings. In the current study, the municipality variable was not retained in the multivariate analysis of health-policy impact, implying that although the production of services differed, the policy environment, as relates to health promotion, was quite similar in the four municipalities. Furthermore, there were no differences between them in the politicians' evaluations of health promotion action and its

effectiveness. However, the study findings indicate that there may be differences among political decision makers in the same municipality as to which factors of the policy they perceive to be important.

In terms of capacity building, studies suggest that policy making, or organizational “will”, is not enough to support health promotion action, and that major developments in both leadership and infrastructure are needed as well (Dressendorfer et al. 2005; Anderson et al. 2008). The timeframe is also of significance. With regard to health promotion, especially health promotion with a community approach, Moulton et al. (2006) suggest that it takes more than three years to get programmes established, whereas according to Riley (2003), setting up and preparing for the change to a new public-health agenda takes at least 10 years. Thus, although the health-service producer in SM had been successful in reaching goals such as achieving a positive development in the working conditions of the health service personnel, a higher level of trust in PHC among residents and a higher level of satisfaction among clients (Laamanen et al. 2008b), as well as in strengthening community participation, given the timespan and the study approach the emphasis on health promotion was not otherwise seen as higher commitment in the actions of the PHC personnel and the LVAs or in policy plans as compared with the other municipalities.

Values, competences and opportunities in health promotion action in local contexts

Opportunities are a major component in the dynamics of the multilevel health promotion model, and changes in external situations create new opportunities (von Wright 1976; Rütten et al. 2000). In this study, the emphasis concerning opportunities was on cooperation and community participation. In the context of health promotion, a partnership approach to strengthening resources has been widely advocated (Kickbusch 1997; Roussos & Fawcett 2000; Lasker & Weiss 2003; Jackson et al. 2006). Rütten (2001) points out that community participation appears to be especially important on the local level where citizens’ knowledge and views are required in shaping healthy public policies. Gillies (1998) concluded in her review of the effectiveness of partnerships in promoting health that the more involved the community is in agenda setting and health promotion action, the greater is the impact. Indeed, an association was found in the current study between cooperating with different partners in the community and higher levels of health promotion action among the LVAs and the healthcare personnel.

Thus, one question regarding the development of health promotion action on the local level concerns the enhancement of cooperation between municipal agencies, including health services and partners in the community. However, cooperation or partnerships have not been at the forefront in all studies related to health professionals and health promotion. Casey’s (2007) study on nurses’

understanding of health promotion in the context of acute care made no mention of cooperation outside the organization, although a few nurses mentioned the lack of follow-up when patients were discharged from hospital. Johansson et al. (2009) identified three types of health promotion roles among health professionals, which they labelled the 'demarcater', the 'integrater' and the 'promoter': only the promoters described health promotion strategies related to cooperation and working in the local community. The study did not analyse the roles according to different healthcare settings; however, one might assume that the two are related to some extent. Ribera et al. (2005) identified similar roles among physicians and nurses in PHC: the 'active promoters' were those who created links with community institutions such as neighbourhood associations, community centres, fitness centres and city councils. In terms of breadth, the community approach in health promotion certainly differs in different parts of the health service. There appears to be a need for discussion concerning the role in and interpretation of health promotion among different personnel groups and work units (cf. Whitehead 2004b; Germann & Wilson 2004; Irvine 2007; Johansson et al. 2009). Thus, the health promotion strategies and roles of professionals in different health-service settings should be clarified.

The results of the current study and earlier empirical findings related to the importance of partnerships and cooperation in health promotion (Riley et al. 2001; Joffres et al. 2004a; Robinson et al. 2006) point to the influence of external factors. Healthcare personnel need opportunities to cooperate as well as cooperation partners in the community. Overall, the level of cooperation outside the organization identified in the current study was rather modest. Regular meetings, sharing premises and geographical proximity have been found to facilitate intersectoral cooperation (Edvardsson et al. 2011). Other influential factors in successful cooperation include necessity or dependency, opportunity, trust and the organizational infrastructure, meaning a skilled workforce, adequate resources and organizational support (Nutbeam & Harris 2004). Bearing in mind that a relatively small proportion of PHC personnel work with children and young people, especially with regard to health promotion, it is vital for them to have the opportunity to work in cooperation with other actors and in other settings in the municipalities. Moreover and as indicated in the findings from the current study, the personnel in ambulatory care, especially public-health nurses, are in a high degree involved in addressing risk behaviours and health promotion. Therefore, their competence could be taken advantage of in other parts of the health service. According to the multilevel health promotion model, opportunities affect engagement in health promotion action both directly and indirectly through their effect on competences (Rütten et al. 2000). Working in cooperation could thus enhance competence among all cooperation partners, including health professionals and LVAs.

It was found in the current study that competence among health-service personnel in the form of knowledge about residents' health and living conditions was related to higher engagement in health promotion action. Local healthcare

and health promotion planning requires the monitoring of health (Knesebeck et al. 2002) and an awareness of the socio-environmental context (Jackson et al. 2006). Knesebeck et al. (2002) suggest on the basis of their evaluation of an intervention that adequate data on the population's health and health needs as well as innovative structures concerning the management of health services would facilitate health promotion on the community level. As noted in the current study, taking part of discussions about residents' health fostered the LVAs' engagement in health promotion. Thus, the obligation of Finnish municipalities to monitor health and related factors (Primary Health Care Act 928/2005) has the potential to strengthen health promotion action locally if these issues are discussed in the municipality.

Further findings from the current study indicate the significance of organizational values. Perceived skill discretion and social support at work were the value variables associated with engagement in health promotion action in the health services. Skill discretion refers to the possibility to use one's knowledge and skills, and a job that involves learning, reflection and decision-making, whereas the social support operationalization includes informational, practical and emotional support. Others have analysed work environments more deeply, and suggest that a good emotional climate as well as trust and respect create opportunities for learning, skills development and innovation (Södergren 2009). Moreover, perceived skill discretion seems to be related to the quality of care (Pekkarinen et al. 2006). Knowledge, social support and skill discretion in combination appear to reflect empowering processes at the workplace (cf. Kanter 1993; Laschinger et al. 2000). Thus, the findings from this study empirically confirm earlier suggestions that an organizational climate that facilitates empowerment is beneficial as far as health promotion work is concerned (Benson & Latter 1998; Germann & Wilson 2004).

Similarly, concerning empowerment related to LVAs, the findings, besides opportunities for cooperation, suggest the importance of opportunities to follow discussions about residents' health and wellbeing, and being able to influence decision-making regarding which health issues are prioritized locally. These findings can also be seen to confirm the value of an empowerment approach to facilitating engagement in health promotion action.

According to Frankish et al. (2006), values are the foundation for health promotion in primary healthcare: they should be reflected in the structures, which in turn should create the right environment for health promotion. A possible barrier for a health promotion approach in health services might be the focus on acute care (Rimpelä 2010; Develin 2010). Others have pointed to a possible discrepancy between the view on health among the personnel and the general view steering operations in the health services. It is reported in a Swedish study that the vast majority of the health personnel surveyed held holistic views on health; however, 40% were of the opinion that, on the whole, the perspective on health in the health services was biomedical (Johansson 2010). The finding in the current study that cooperation with actors outside the organization was associated with engagement

in health promotion action suggests a broader view to health promotion among the personnel than relying, only, on a health education or individual approach. Such an approach, according to recent international studies, appears to prevail in practice in acute care (Casey 2007), in primary-care settings among clinicians (Flocke et al. 2007) and among district nurses (Irvine 2007). Reuterswärd et al.'s (2010) findings suggest that cooperation with other professions – in addition to knowledge and an organization in which the need for health promotion is understood – facilitates health promotion work on a general level as opposed to a, merely, individual approach. Cooperation could thus be advantageous for health promotion in terms of influencing the approach used.

The finding that personnel in ambulatory care were the most actively engaged in comprehensive health promotion action was expected given that outpatient departments in Finnish health centres provide most of the preventive services, including healthcare at school and for mothers and children. In the case of Sweden, primary healthcare personnel seem to be more willing than hospital personnel to focus even more strongly on health promotion than they do currently (Johansson 2010a): nevertheless, there was strong overall support among health personnel for a reorientation of the services to focus more on health promotion. Such a reorientation seems to require its integration into the work of all health professionals (Johnson & Baum 2001). About half of the personnel surveyed in the current study reported being highly involved in health promotion on an individual level, compared with less than one fifth on the group level and less than 10% on the population level. Barriers to health promotion in health services include time and work overload, as mentioned previously, but also unclear goals, a lack of guidelines, unsupportive structures and competing organizational priorities (Robinson et al. 2006; Johansson 2010a). Work overload was not associated with engagement in health promotion in the current study, and although the time issue is important, it may be that structures such as working conditions facilitating skill discretion and social support, together with organizational priorities are more significant variables. Further studies are needed to confirm this.

Competing priorities and lack of time have also been identified as barriers to health promotion work with older people (Runciman et al. 2006). The finding from the current study that a focus on the health and quality of life of older people was negatively associated with the two dimensions of health promotion – addressing risk behaviour and promoting health – might suggest that there is a need to develop health promotion practice in healthcare services for this age group. In the case of home care, for example, it has been suggested that stronger consideration of the broader determinants of health is needed. In this regard, trials among frail older home-care clients have shown bigger improvements in health-related quality of life in the case of nurse-led health promotion and disease-prevention interventions that with ordinary home care, at no additional cost to society (Markle-Reid et al. 2011). However, the findings from the current study stressing the importance of

enabling working conditions and opportunities for cooperation with other partners should also be highlighted.

This study supports evidence from earlier studies that an appropriate organizational environment is vital for a health-promoting health service. In terms of achieving a reorientation of services in this direction – in other words more capacity for health promotion – leadership, partnership and commitment have been identified as key elements in enabling structural change, workforce development and resource allocation (Yeatman & Nove 2002). As Joffres et al. (2004b) state, capacity building, for a reorientation to take place, is both a complex and a dynamic process, especially because organizations are influenced by diverse social systems – such as community, regional and national environments – at the same time as they comprise a variety of systems. The authors found resistance to be the main challenge to capacity building, primarily based on competing organizational priorities and perceived incongruence related to objectives, working procedures and values (Joffres et al. 2004b). In this regard, components of organizational change such as the function of senior and middle managers as role models and catalysts, effective communication and the need to involve personnel on all levels in the change process have been highlighted (Yeatman & Nove 2002). Other studies point to the importance of developing strategies to enhance the organizations' public-health leadership at the same time as promoting community partnerships, and to focus on the organizational structure and employee skills and their interaction (e.g., creating multidisciplinary teams), in order to achieve a reorientation (Riley et al. 2003).

On a more general level, Frankish et al. (2006) suggest that a starting point for developing a reorientation framework of health promotion in primary healthcare would be a community-wide common vision of values and related structures. The values they propose include a broad view of health and its determinants, optimal health and quality of life for all, empowerment, social justice and equity, as well as social capital and healthy communities (Frankish et al. 2006). They further suggest structural characteristics based on these values that create a supportive health promotion environment (e.g., organizational culture, resource allocation, committed personnel, human-resource development, intersectoral cooperation, multidisciplinary teams, governance and decision-making). Germann and Wilson (2004), in their conceptual model of a community approach to health promotion within health authorities, also emphasize the fundamental constituents of values and beliefs among organizational leaders, which are then reflected in structures and processes on the levels of the organization, the work unit and the individual health workers.

The findings of the current study related to organizational values, competences and opportunities point to certain features of health-service organizations that facilitate health promotion work. However, the above-mentioned frameworks offer a complementary organizational approach to developing stronger health promotion in health services. Whereas the current study focuses on the work-unit level, these

frameworks incorporate the organizational level, as well as the role of organizational leaders and the crucial role of values and beliefs in favour of health promotion. These dimensions could be included in the theoretical framework of the current study, together with perceived obligations. Moreover, the policy framework developed by Rütten et al. (2003a; 2003b) could be helpful with regard to organizational policies: this would entail pursuing spelled-out goals related to health promotion, including obligations for health promotion action, securing the necessary resources and taking into account organizational (e.g. the views of the personnel) and public opportunities (e.g. the views of local residents).

This discussion reflects the proposed view of health promotion as taking place on different, interacting levels: the role of individual professionals is dependent on the values of the organization, municipal health policies and values in the community/society and, not least, the expectations of patients and residents. Wise and Nutbeam (2007) argue that health-service reorientation would require changes in professional and public opinion about the function of health systems. One reason for this is that political decision makers are influenced by community demand. When it comes to public opinion, the mass media has been seen to have a vital role (Wise & Nutbeam 2007). Thus, a reorientation of health services to a stronger focus on health promotion would appear to go hand in hand with strengthening community action for health.

The finding in the current study related to the determinants of health promotion action among LVAs suggests that – in addition to providing opportunities for cooperation and involvement in discussions and decisions related to health and wellbeing – emphasizing the value of health and enhancing competence could facilitate community engagement. Showing appreciation and recognizing the work of LVAs is one way of strengthening perceived competence, given that appreciation from the municipality was a component of the competence scale. Appreciation from decision makers might thus support health promotion action through increasing perceived competence. Awards and certification are used to recognize voluntary work, and further expansion of the system has been called for (GHK 2010a) to complement other competence-building efforts.

In terms of capacity building, Dressendorfer et al. (2005) identified similar process elements in a study carried out in Canada: the development of a community vision and political will, creation of partnerships and cooperation, mobilization and communication within the community, and use of the systems and resources of the community health sector. The authors integrated these elements into three dimensions they labelled leadership (e.g., the process of developing partnerships), policy-making or will (e.g., the process of developing vision) and infrastructure (e.g., the process of developing a supportive system in the health sector). They found that involving existing leadership, policy-making and enhancing existing infrastructures facilitated community development and the implementation of sustainable health promotion interventions. Moreover, two recent reviews of capacity building in

communities (Liberato et al. 2011; Kendall et al. 2012), the latter focusing specifically on strategies for building cooperative capacity, identify key domains for community capacity and community-based health partnerships as well as strategies for action. Parsimony is a strength of the multi-level health promotion model and these frameworks might be useful in facilitating scale development regarding variables to include, thereby benefitting research and supporting community action.

One avenue worth exploring in strengthening the value of health in a community relates to the need for a stronger focus on building a sense of social cohesion across the population (Kickbusch 1997; Wise and Signal 2000). The findings from the current study suggest that this could also apply in Finnish municipalities in terms of health policy: fewer than 20% of the local politicians thought that social networks were given a lot of attention, and furthermore, the promotion of social and mental health did not stand out as a determinant of the impact of health policy. Health promotion measures directed at mental and social health might not be as easy to implement and evaluate as measures concerning healthy lifestyles, for example. Egan et al. (2008) concluded from their meta-review of psychosocial factors in community settings and homes and their associations with public health, that factors such as empowerment, participation and control within communities were under-researched in comparison with research related to social support and networks. They found the issue of control in the community interesting, especially because of the good evidence related to control in workplaces and its effect on health. With regard to LVAs, it seems from the current study that control, in the sense of being able to influence decision-making regarding the way in which health issues are addressed, facilitates engagement in health promotion action. In terms of empowerment, it is suggested that empowerment on the organizational level (i.e. LVAs) influences individual empowerment, and both appear to be positively associated with health and quality of life (Israel et al. 1994). However, it has to be acknowledged that not all issues can be dealt with on the local level, or in the community, and that volunteers are potentially susceptible to work overload. Moreover, whereas in the view of Hunter et al. (2011) actions to build and increase social capital through enhanced social networks, trust and reciprocity, could be one way of reducing the negative effects of the social determinants of health on the local level, Eriksson (2011), for example, points to the need to be aware of the potential risk of exacerbating social inequality in the mobilizing of social capital in local communities.

Community involvement, intersectoral partnerships, political commitment and healthy public policy are all considered building blocks for creating a healthy community – and, by linking them, a strategy for improving population health (Hancock 2009). In this sense, an asset-based approach to community development is seen as a key mechanism. An approach focusing on assets – as opposed to deficits – is based on the strengths and capacities of people, organizations and institutions (Hancock 2009), which is also the approach in community capacity building (Raeburn et al. 2006). However, the role of voluntary work in society today, in the

sense of working without pay for the good of others, maybe needs to be attended to. Most of the LVAs involved in the present study reported a shortage of people prepared to organize activities. Again in the Finnish context, Grönlund (2012), having investigated the role of volunteering in the lives of young people, suggests that the public sector and political decision makers should emphasize volunteering as an opportunity for ‘exercising beneficial values, communality and trust’. She further notes that outsourcing core welfare responsibilities to the voluntary sector could reduce the extent or the value of volunteering, which in turn might reduce the beneficial impact of the voluntary sector on society (Grönlund 2012). However, differences in the voluntary sector, such as the fact that national-level and local-level organizations have their separate roles, also need to be taken into account. There have been calls to clarify the roles of different third-sector organizations, such as those based on voluntary activities and those involved in service delivery (GHK 2010a).

Nevertheless, Grönlund (2012) argues that volunteering could be used more, thereby increasing the benefit to volunteers and to people who use their services. The level of volunteering in Finland has been shown to be quite high by European standards, especially in sport, and there seems to have been a slight upward trend in the number of volunteers in the past decade. Nevertheless, the levels are higher in Sweden and the Netherlands, for example, meaning that over 40% of adults do voluntary work compared with a good third in Finland. (GHK 2010b) It should be noted, however, that the figures reported in different studies vary, and are therefore only indicative.

The national governance of health promotion in Finland was pushed a step further in a hierarchical direction in the revised Public Health Act (928/2005) and the new Health Care Act (1326/2010), both of which set out obligations for the municipalities. Questions have been raised concerning the adequacy of management by supervision and audits (Melkas 2010), in other words the managerial practices that were introduced in the reform of the state subsidy system in 1993. There have been proposals to include some kind of financial incentives for health promotion work in municipalities, however, the subsidy system is not to be changed for the time being (Melkas 2010). An alternative view is that the present structure favours prevention in that the municipality carries the responsibility for paying the costs of a patient’s healthcare (Teperi et al. 2009). However, according to Rimpelä (2010), for example, primary healthcare in Finland is focusing more than ever on medical care. This seems to apply in most industrialized countries and their health services – biomedical interventions make up a substantial proportion of investments, and public-health interventions have been marginalized (Nutbeam and Wise 2009). Recent reports nevertheless suggest that interest in health promotion in Finnish health centres is growing stronger (Kokko et al. 2009). The proposed implementation of the chronic care model (Wagner et al. 2008) in ambulatory care in health centres, as part of the National Development Programme for Social

Welfare and Health Care (MSAH 2010), for example, could be seen as one way of strengthening the focus on health in PHC, and also with regard to chronic diseases, through both workforce development and structural change.

On the level of local policy, commitment to health promotion in Finland seems to be stronger nowadays with the increasing tendency to include health promotion goals in municipal plans (Tukia et al. 2011) – although not in all municipalities – possibly because of the national hierarchical management tools in use. With regard to policy making in local councils, the theoretical framework proposed by Rütten et al. (2003a, 2003b) suggests that perceived obligations as well as organizational opportunities predict policy output. In terms of organizational opportunities, an understanding of the value of health promotion through enhancing institutional capacity within the framework of the Ottawa Charter (WHO 1986) might influence perceived obligations further. According to Perttilä (1999), a comprehensive view of health is needed if it is to have a place on the agenda of the most influential decision makers in the municipalities, and a strategic role. Given the findings of the present study, organizational opportunities could include the discussion of health promotion issues on local councils without the requirement of party-political consensus, thus facilitating policy-oriented learning. Moreover, the continuous monitoring of health promotion activity in municipalities (health promotion capacity building) could serve as a resource for planning and management (Ståhl & Rimpelä 2010).

Furthermore, it might be worth acknowledging and further studying the implications of Rütten et al.'s analysis (2003a) concerning different outcome orientations. The authors point to the 'risk' that if obligations are high but resources are low or the policy goals are unclear, the result might be a situation in which the output in terms of different programmes or services is more important than the health outcome on the population level. Studies in both Finland (Wilskman et al. 2008) and Sweden (Jansson et al. 2011) report that decision makers on local levels perceive national goals to be too diffuse. Vague objectives as well as a lack of resources are considered hindering factors for the development of local health promotion in Sweden (Jansson and Tillgren 2010). In the case of Finland, tools and measurement instruments as well as resources for health promotion have been requested on the local level (Wilskman et al. 2008). Moreover, commitment to health promotion in the municipalities appears to be only weakly associated with resources for health promotion action (Ståhl & Rimpelä 2010). Jansson et al. (2011) suggest the need for clearer management and negotiation regarding the content and purpose of national policies. Thus, the theoretical policy model (Rütten et al. 2003a; 2003b) could also be applied in policy making regarding the relationship between national and local levels, as well as in studying the policy. The implication is that if the national level is to support health promotion policy making on the local level, goals, resources, and organizational as well as public opportunities need to be considered.

In terms of public opportunities, at the beginning of the 2000s, the expectations of the Finnish population concerning the need for stronger health promotion measures

on the municipal level reflected, above all, the need for further measures by health services as well as measures related to physical and leisure activities (Nikula et al. 2006). However, over 50% saw no need for additional measures. The highly educated were more likely to perceive such a need, although their expectations had decreased the most compared with the situation at the beginning of the 1990s (Nikula et al. 2006). The researchers suggest that in the future these views will be mirrored in the views of political decision makers. On the other hand, it could be a question of how health promotion is perceived – as special measures or as encompassing all decision-making.

Finally, given the likelihood that policy processes will change and that a much larger group of actors will become involved in health policy developments in society (De Leeuw 2001; Walt et al. 2008), the role of local politicians will, it is argued, increasingly involve coordinating an organizational system that is fragmented, and their responsibility, specifically, will be the whole community (Bogason 2004) and the health of all residents. This might be especially true given the current reforms in Finland, as well as elsewhere, which are producing larger municipalities. Nevertheless, a criterion for good local governance is the active involvement of residents in both promoting and implementing local initiatives, and local authorities need to create these opportunities in order to promote social cohesion (Saarelainen 2003).

7.4 Methodological considerations

This study – as part of a larger evaluation of the PHC production model in four medium-sized municipalities in Finland – explored health promotion action in local contexts from different actor perspectives, at the same time as taking a comparative approach. Its strength lies in its theory-based approach. It applies, in a novel way, the ‘multilevel health promotion model’ (Rütten et al. 2000) to the organizational level of voluntary associations and to the actions of PHC personnel. Based on the model and the conceptual background, the analyses identified ‘determinants’ of health promotion action. On account of the cross-sectional survey design, no conclusions about direction of influence can be made. However, the theoretical model assumes reciprocal associations as well as strong relationships between the determinants. Path analyses and a longitudinal design could give further information about the relationships among the determinants as well as the direction of the influence.

The corresponding policy model (Rütten et al. 2003a; 2003b) was applied to explore, and find, the determinants of effective health promotion actions in local contexts from the perspective of local-level politicians. It has to be acknowledged that the associations between action and determinants identified in this sub-study, as well as in the others, might reflect consistency in perception and reporting rather than the role of the factors as determinants of health promotion action. Moreover,

data that is self-reported does not necessarily reflect actual practice or circumstances. With regard to the responses from the LVAs, it is not known whether one person (e.g., the chair or secretary) or the whole executive committee in the respective LVAs filled in the questionnaires. There may be differing views concerning the significance and role of voluntary associations in health promotion. Furthermore, responses from only one or a few individuals representing an organization may be more unreliable in terms of correspondence with actual practice than clearly individual responses.

The exploration of health promotion in local contexts from different actor perspectives could be seen as strength of the study, although at the same time it may be a limitation in that the phenomenon was explored on quite a general level. Thus more detailed studies of health promotion are needed, also those taking a qualitative approach, especially with regard to LVAs. Nevertheless, the sub-studies confirm the conceptual background, and the study as a whole was able to give some empirical confirmation of the theoretical model's applicability to health promotion actions on different levels of action. Including perceived obligations in studies of healthcare personnel could further enhance knowledge about engagement in health promotion action, and including perceived obligations as well as organizational opportunities in studies of health policy could enhance understanding of commitment to health promotion in local government.

Data sources

The study was based on data from questionnaire surveys of LVAs in 2000 and 2002, PHC personnel (including care for older persons) in 2002, and local-level politicians in 2004. The survey of politicians was conducted during the last year of the four-year term the councillors had been elected to serve, which could be seen as a strength given that first-term councillors had also gained in experience.

The survey response rates were 46% and 40% in the two LVA sub-studies. Earlier studies on voluntary associations in Finland have achieved response rates of between 42% (Helander 2004) and 54% (Helander & Pikkala 1999). The lower response rate in the second sub-study could be attributable to 'survey fatigue' given that there were only two years between the surveys. Both of them focused on questions related to health promotion, and were sent to all registered associations in the municipalities. A more selective inclusion policy might have yielded a higher response rate. However, the aim was to explore the overall interest in community health among LVAs, and the assumption is that those with no interest in health issues were the ones that in a higher degree did not respond. Moreover, the study only reached associations with correct contact information in the Register of Associations, which was about half of the registered associations. It has been estimated that approximately 50-60% of the associations in the register are active (Rönnerberg 1999; Helander &

Laaksonen 2000). It is probable that the survey did not reach all associations that were active at the time of the study, and that some of the ones receiving it were no longer active. The response rates were considered sufficient given the explorative nature of the first sub-study and the focus on associations between the proposed determinants and health promotion action in the second one.

The 57% response rate in the study of PHC personnel is consistent with earlier studies in health services (Cook et al. 2009) and could be considered satisfactory. There were differences between municipalities related to the proportions of answers from different work units: this was controlled for in the multivariate analysis. However, non-response bias cannot be ruled out because it was not possible to carry out a non-response analysis given that not all the municipalities were able to send background information regarding the personnel. The questions concerning health promotion were not in the main part of the questionnaire, which was related to work wellbeing and health. Thus, it does not seem likely that non-response was related to interest in engagement in health promotion.

The response rate to the survey of local-level politicians was 52%, which is consistent with earlier studies (Laamanen 1998; Ashley et al. 2001). It varied from 67% in SM to 34% in EM. In addition to the low response rate in EM, analyses of non-response (Laamanen et al. 2008a) showed differences between respondents and non-respondents related to party-political affiliation, meaning that left-wing politicians were overrepresented. It is therefore possible that the findings for EM are not as reliable as those for the other municipalities, in which there were no differences between respondents and non-respondents or the target population with regard to party-political affiliation. On the whole, there were few inter-municipality differences with regard to politicians' perceptions. The questionnaires, in the main, comprised questions about outsourcing healthcare services. Thus, it is probable that politicians with an interest in healthcare issues were more likely to have responded. A further reason for responding may have been a desire to be more visible.

Measurements of health promotion and its determinants

The study, based on the Ottawa Charter (1986), explored three key health promotion strategies on the municipal level: community action for health, health-promoting health services and healthy public policy. On the level of actors, the explorations concentrated on health promotion actions in terms of content and, to some extent, focus (MSAH 2009). The study did not explore the actors' working methods and practices, which might have given another picture of health promotion action in local contexts. However, cooperation with other partners and influence on decision-making were included as determinants of health promotion action. It cannot be assumed in studies of engagement in health promotion action across different actors that there is a shared understanding of health promotion. Moreover, there is no

'gold standard' tool with which to measure such engagement. The measurement of health promotion used in this study was based on the principle of a broad view of health and was conceptualized as self-reported action (LVAs and PHC personnel) and a perceived emphasis in municipal policy (political decision makers) to promote healthy life-styles, mental and social health, healthy and safe environments and/or scope for action – thus aiming at content validity. The measurement's ability to differentiate work units and professional groups, for example, offers some evidence of validity. The constructed health promotion sum scales had good internal reliability, with Cronbach's alphas of between 0.73 and 0.89.

The choice of determinants regarding health promotion action was based on the multilevel health promotion model, the principles of health promotion and earlier studies. The study of healthcare personnel included some well-recognized and widely used measurement tools related to the psychosocial work environment (Karasek 1979). However, most of the proposed measures were self-developed or developed from existing measures. Sum scales were used for almost all of the determinants, the reliability being acceptable to good (Cronbach's alpha). Nevertheless, some of the scales had low consistency, which could have been attributable in part to the small number of items, and further scale development is needed. Insufficient sensitivity among the measures could also have contributed to the lack of association between the proposed determinants and health promotion action or health-policy impact.

In terms of generalization, it is assumed that the findings of this study describe situations in medium-sized municipalities in Finland, with similar population density and structure, fairly well. However, on account of the non-response, although the identified associations between the variables probably hold, the levels of health promotion could be considered only approximate. The theoretical framework – the multilevel health promotion model – is based on a general model, and has been applied in international studies. The novel way of using the multilevel model in this study, as well as the explorative approach as regards the determinants, means that the findings need to be confirmed in other studies and contexts, taking the need for further scale development into account. Moreover, different approaches to health promotion could be studied in order to discern possible differences in the corresponding determinants.

8. SUMMARY AND CONCLUSIONS

Health promotion has become a major goal in Finnish public policy, the new Health Care Act (1326/2010) that came into force in May 2011 being one example of this. Municipalities play a crucial role in this context in that many of the determinants of health relate to and exert their influence in local contexts. Thus, a key question in public-health work is how to support health promotion on the local level. The present study explored and compared health promotion actions in four medium-sized municipalities, particularly emphasizing the factors that influence engagement in health promotion. Based on three of the Ottawa Charter (1986) action strategies, the investigation focused on the actions of selected municipal actors, i.e. local voluntary organizations, primary healthcare personnel and political decision makers. The multilevel health promotion model (Rütten et al. 2000), which guided the study, is assumed to be applicable to different levels of action. The current study gives some novel empirical confirmation of its applicability to the actions of different actors in municipalities, and contributes to the understanding of health promotion in local contexts. In terms of support on the local level and given the equally strong associations of organizational values, competence and opportunities with engagement in health promotion action the findings revealed, a multilevel approach would be called for.

Opportunities are a key component of the multilevel health promotion model (von Wright 1976; Rütten et al. 2000). According to the findings from the current study, opportunities, in the form of cooperation with different partners in the community are associated with higher levels of health promotion action; this was true for healthcare personnel and for local-level voluntary associations. Thus, in terms of developing action on the local level, efforts should be made to enhance cooperation between the health services and other municipal agencies on the one hand, and between municipal agencies, including the health services, and voluntary associations as well as other partners in the community on the other. Both empirically and theoretically there are suggestions that working in cooperation might influence health promotion action not only directly, but also through its influence on competence and organizational capacity. Path analyses would give further information about the relationships among the determinants in the theoretical model. For now, the findings of the current study empirically highlight the value of cooperation on the local level.

The results also point to the value of the empowerment approach to health promotion in local contexts. Namely, they highlight the importance of not only cooperating with LVAs but also offering them the opportunity to follow discussions about residents' health and wellbeing, and to influence the decision-making

concerning these issues on the local level. With regard to PHC personnel, the findings highlight factors that appear to reflect empowering processes at the workplace: access to information about the community and organizational values reflected in the working conditions such as possibilities for development, skill usage and reflection, and collegial support. Consequently, in the same way as health promotion works to enable people to increase control over their health and its determinants, the actors working with health promotion need a supportive environment that facilitates empowerment and encourages engagement. Thus, an empowerment approach to health promotion in general could be highlighted on the local level and according to the findings might need further development on the level of local policy.

Competence, another proposed determinant, was strongly associated with engagement in health promotion action. For healthcare personnel this meant having sufficient knowledge about residents' health and living conditions. With regard to voluntary associations, perceived capability and appreciation from the municipality were the main measures of competence, whereas following discussions about residents' health fell within the opportunity dimension. Thus, it appears from the findings that the obligation for Finnish municipalities to monitor health and related factors (Primary Health Care Act 928/2005; Health Care Act 1326/2010) has the potential to enhance health promotion action locally if these issues are discussed on the municipal level. Moreover, the findings point to a need for appreciation and possibly for competence building among the LVAs.

In the view of the local politicians, the goal of promoting the health and quality of life of older people, and resources in the form of capacity of health services – i.e. services for older people and primary healthcare – were the most significant elements of health promotion policy in terms of impact on the local level. In terms of policy-making, improving the impact of the various health promotion goals would, in theory, require, in addition to resources, concrete and specific goals as well as public opportunities (Rütten et al. 2003a) or community participation. However, as the study findings imply, local policy makers might need more evidence as to the impact of cooperation and community participation in health promotion. In general, enhancing organizational opportunities in terms of developing the institutional capacity of local government within the framework of the Ottawa Charter (WHO 1986), and encouraging discussion about health promotion issues in local councils without demanding party-political consensus, could produce a stronger focus on health promotion in local councils. Since the findings from this study suggest that possibilities for interaction among politicians, other decision makers and healthcare personnel as well as the community are needed, it would be beneficial to develop further the mechanisms for involving different actors in discussions and decision-making related to the promotion of health-supportive environments and the health of local residents.

Overall, there were few differences between the four municipalities. Within the timespan and given the research approach of the study, the health promotion

emphasis of the producer of health services in one of the municipalities was not observable as stronger commitment to health promotion in terms of the PHC personnel's or LVAs actions, or the politicians' evaluations than in any of the other municipalities. These findings support the need for longer timespans in the evaluation of comprehensive health promotion implementation.

The findings of the current study are in line with key principles of health promotion and confirm the value of intersectoral cooperation, community participation and an empowerment approach on the local level in the Finnish context. Findings contribute with new knowledge with regard to the theoretical model and its applicability to the organizational level of local voluntary organizations as well as to the health promotion actions of healthcare personnel. Further contributions include enhancing knowledge related to interest among LVAs in action for community health, and confirming the importance of cooperation from the viewpoint of local-level community organizations. The need for a work environment that is conducive to health promotion is also highlighted.

Research on enabling factors with regard to health promotion action (i.e. health promotion work) from a socio-ecological perspective is a growing field and there are many potential research directions. In the light of the findings from and the limitations of the current study, three focus areas are proposed here: the first relates to the need for more detailed knowledge, the second to cooperation and the third to the need for replication studies.

First, in order to strengthen the findings from this study it would be useful to clarify the health promotion priorities, strategies and roles of professionals in different health-service settings, one potential focus being on middle and higher management. The possibility that there may be different enabling factors depending on the approach to health promotion also warrants further study. A further need relates to LVAs and the kind of health promotion strategies they employ, as well as the relations between them and the national federations. Furthermore, more detailed knowledge about the different kinds of LVA and their health promotion actions in different settings would enhance understanding of their role in promoting health. Their expressed need for expert help and training also warrants exploration in terms of how this relates to health promotion and how the need can be met.

Second, the findings confirming the importance of cooperation in health promotion action imply the need for studies focusing in more detail on intersectoral cooperation among different partners on the local level. The theoretical framework used in this study could help in identifying factors that support cooperation, meaning that common values, competences and opportunities with regard to cooperation in municipalities would be explored. Furthermore, studies on the impact of cooperation – including community participation – on competence and organizational capacity would provide policy makers with valuable knowledge.

Third, further studies based on the same theoretical framework in different contexts – keeping in mind the need for further scale development – would

complement current understanding and result in additional implications for both practice and theory. Path analyses and a longitudinal design would give further information on the relationships among the determinants as well as the direction of influence. With regard to the motivational aspect, studies could include perceptions of obligations. Future studies would be strengthened by longer timespans as well as taking into account the quality of health promotion, including equity.

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