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Baltic health

A landscape in the East: Beautiful, but with disease and social problems as a shadow. (From the Kishi islands in Lake Onega, Republic of Karelia, Russia.) (Photo: Ø. Larsen 2003)

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City structure from the past in downtown Vilnius, Lithuania.
(Photo: Ø. Larsen 2002)

Soviet style housing area, Kaunas, Lithuania.
(Photo: Ø. Larsen 2002)

Baltic health and European cooperation

Michael 2004:1: 363.

This issue of *Michael* looks east. It has a focus on health conditions in the region around the Baltic Sea. Here, in many countries major changes have taken place in the life of the populations since the collapse of the Soviet Union. A political and economic turmoil followed the breakdown in nearly all fields of the former Soviet society.

The process also exerted a profound effect on health and health conditions. Changes to the better simply had to take place rather swiftly. For some of the countries, joining the European Union on May 1, 2004 became a breakthrough and a preliminary goal in the efforts to achieve Western living standards.

However, at the same time the waves of neo-liberalism which have flooded Europe during the last decades, also have put strain on traditional public health and welfare state thinking. This concurrent development has been a concern in countries on both sides of the previous iron curtain.

In the Baltic region the *differences as such* perhaps have been a special challenge. Especially noteworthy among medical issues are the differences in perception and approach for diseases which become a more general threat when the region opens up. Free travel and easy contacts over the borders give new dimensions to handling of e.g. the communicable diseases. The practical strategy in preventing and treating infections, as well as the general attitudes towards communicable disease have to be harmonized.

The articles in this number of *Michael* take up these problems, e.g. by describing the activities within the comprehensive multinational Task Force project, which was designed to curb the infectious diseases in the Baltic region, but also to enhance multilateral cooperation as such on the political level.

Michael also covers the twelfth annual EUPHA conference in Oslo. This meeting of the European Public Health Association confirmed that European collaboration in the public health field has a blooming for the time being. Perhaps this is one of the consequences of a general internationalisation. But more likely it is a response to the growing necessity for cooperation in health matters.

Øivind Larsen

Autumn in St. Petersburg: Flowers for sale at the Moscow Railway Station. (Photo: Ø. Larsen 2003)

The prevention of alcohol abuse in the former Soviet Union constitutes a problem which should be solved. However, traditions may be hard to turn. The picture shows a sales kiosk for beer and tobacco strategically placed just outside the main entrance of the University of Petrosavodsk. (Photo: Ø. Larsen 2003)

Olga S. Toungoussova

Infections, infection control and social change in the countries of the former Soviet Union[1]

Michael 2004: 1; 365–75.

Introduction

The history of the spread of infectious disease in the countries of the former Soviet Union is closely related to the political and economic conditions. The topic can be characterised within geographic and time frames. The Soviet Union experienced isolation from the rest of the world during approximately 70 years of its history; most information was kept secret, data on infectious diseases were considered confidential and not available to the scientific community. The situation changed shortly after the breakdown of the Soviet Union. The statistical data available are, however, fragmentary and not consistent from publication to publication.

Transmission of infectious diseases during the past century depended on social, economic and political processes. The history of the Soviet Union provides good examples of how political and economic change in a country precedes the emergence of infectious diseases. Any crisis in a society brings socio-economic change, including low income, unemployment, crowded housing and improper nutrition. Socio-economic change is associated with a range of health problems including impairment of the immune system leading to increased susceptibility to infectious diseases. Behavioural changes and reluctance to use condoms gives excessive exposure to infectious agents. Problems in the health care system are caused by insufficient financial funding and include shortages of essential drugs, delayed diagnosis, inadequate vaccination and treatment. All these factors make patients infected for prolonged periods of time, increase exposure of susceptible individuals to infectious agents, hence providing the necessary conditions for the emergence of infectious diseases.

[1] Trial lecture April 1, 2004 on the occasion of the author's defence of her doctoral thesis at the University of Oslo.

Regular emergence of infectious diseases in a particular area provides an opportunity to analyse causation. The epidemic peaks in the incidence of infectious diseases evidently occurred after political and economic changes during the past century. The first wave of epidemics came shortly after the October Revolution in 1917; the next one was caused by the consequences of the Second World War. In the early 1990s, an increase in the incidence of infectious diseases started with the disintegration of the Soviet Union and was accelerated by the economic crisis in August 1998.

During Soviet times, the country comprised 15 socialistic republics that became independent states in 1991. Five of them (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) are located in the Central Asia. Armenia, Azerbaijan and Georgia in the Caucasus, Ukraine, Moldova and Belarus are in the west, while Estonia, Latvia and Lithuania are in the Baltic region. Russia is one of the world's largest countries with a population of approximately 145 million and an area of 17 million km^2, spanning seven geographic zones, ten time zones and three climatic zones. This diversity, in addition to socio-economic change, substantially influences epidemiological indicators of infectious disease in this country.

Socio-economic changes and the history of infectious disease control in the Soviet Union

The modern history of Russia and the new independent states may be divided into two periods: the Soviet era and the post-Soviet era. The Soviet era began in 1917 with the October Revolution and the Communist Party founding the Union of Soviet Socialist Republics. This political change resulted in crises in the economy and in the standard of living and created conditions for the spread of infectious diseases. At the time, about 2 million people, roughly 2% of the population, died from tuberculosis[7]. Syphilis and diphtheria also lead to high morbidity.

The post-revolution Soviet Union started rebuilding its industry and agriculture. A growing economy improved socio-economic conditions and people were provided with adequate housing and proper nutrition. Adequate housing decreased the number of persons sharing the same room, hence reducing the risk of exposure to infections agents. Improved nutritional status strengthened the immune system's ability to fight back infection.

The Soviet government showed great commitment to a reorganisation of health and medical services, which were available to everyone free of charge. It provided the necessary funding for infectious disease control, or-

ganised a specialised system consisting of centralised clinics or dispensaries, opened departments for infectious diseases in medical universities, designed vaccination strategies and programmes, and organised epidemiological monitoring of infectious diseases.

In 1985, Soviet economy and society experienced a dramatic change when Mikhail Gorbachev introduced the policy of glasnost and perestroika. His initiatives released forces that by December 1991 had split the USSR up into 15 independent states. Since then, Russia and the other states have struggled to build a democratic political system and a market economy. Political changes resulted in economic crises that threatened living standards and made for the spread of infectious diseases; 20% of urban families lived in crowded accommodation, as the state system of housing distribution broke down and people had to afford their own accommodation [3]. Young singles usually lived in crowded hostels or student dormitories; young married couples with their parents. Because of the economic crises and declining purchasing power, the average diet was insufficiently balanced. Vegetables were for the most part only available in rural areas, fruit was not an important element of the diet, and the consumption of meat decreased [3].

In the early years of the decade, a crisis developed in the health care system because of insufficient government funding, falling numbers of medical personnel, and lack of equipment and technology. Medical establishments were not supplied with all essential drugs because the Soviet system of drug distribution had broken down, with no good alternative in its place. In addition, the health care system did not run educational programmes for the population, for example on hygiene and a proper diet. All these factors were accompanied by mass media campaigns criticising the health care system, warning against adverse effects of vaccination and drugs, leading to people loosing faith in public medicine. At this time the government established an obligatory health insurance system. Several private clinics were organised to provide treatment on an anonymous basis and private pharmacies sold drugs, including antibiotics, without a doctor's prescription.

Re-emergence of infectious diseases in the former Soviet Union

During the past few years, Russia and other new states have experienced the re-emergence of old diseases such as tuberculosis, diphtheria, syphilis, hepatitis B, and the emergence of new diseases such as HIV infection. The re-emergence of the old diseases was accompanied by genetic changes in

pathogens leading to drug resistance and increased virulence[8]. Infectious diseases occur as a result of an interaction between the human host and the micro organism. Social and economic factors can decrease the host's ability to fight back the pathogen while at the same time increased virulence and drug resistance make progression to active disease more likely and patients remain infectious for a prolonged period of time. Antibiotic resistance increased when drugs became available without a prescription. It was combined with a massive shortage of drugs in clinics, especially those in the prison system, and frequent self-medication. Self-medication often included inappropriate selection of drugs, leading to insufficient treatment and emergence of drug-resistant micro-organisms. That is why these diseases have become the most urgent threat to public health[8].

Diphtheria

Diphtheria is normally a disease of childhood, but the history of the Soviet Union shows that a non-immune adult population can be affected. Diphtheria was a highly endemic disease in the early 20th century (600/100 000)[16]. The decrease in the incidence of diphtheria in the Soviet Union in the early 1920s was associated with improved living standards and the introduction of vaccination in some areas. After the first fall in incidence (100/100 000), there were periodic waves of epidemics. It is difficult to identify the factors that governed diphtheria periodicity between 1930 and 1950. A universal childhood immunization campaign began in 1958; by 1963 the incidence was down dramatically (25/100 000). The disease was successfully controlled during 30 years by a good vaccination programme[16].

In early 1990s, diphtheria started to re-emerge in the countries of the former Soviet Union. For the first time in the history of infectious diseases, most cases of diphtheria occurred in adults. In 1994, the diphtheria epidemic was reported from all states except Estonia, as most of its adult population had been vaccinated between 1985 and 1987. The cases were concentrated in Russia (26.41/100 000), though a similar epidemiological trend was observed in the countries of Central Asia (5.41/100 000), the Caucasus (7.02/100 000), the Western countries (5.35/100 000), and the Baltic countries (3.69/100 000) [16].

Several factors might explain the emergence of diphtheria in the post-Soviet period. Changes in the immunization schedule during this period resulted in less intensive vaccination of children. The number of conditions considered temporary or permanent contraindications to vaccination was

increased. In addition, the mass media made people fear adverse reactions to vaccination. This resulted in a drop of vaccination coverage and, hence, inadequate vaccination. Re-emergence of diphtheria was also associated with a biological change in the pathogen: a change in the predominant circulating biotype from gravis to mitis was documented[16]. The peak of the epidemic came in 1995, then a massive vaccination campaign was implemented and the incidence started to decrease steadily, reaching its initial level in the late 1990s.

Sexually transmitted diseases

The system for the control of sexually transmitted diseases (STD) in the Soviet period was free of charge but lacked confidentiality. Shortly after the revolution a committee for the control of venereal diseases was set up. In 1921 it started to develop a network of centralised and specialised dispensaries for the treatment of STD on an inpatient basis[13]. The official opinion on STD was negative, they were held to be morally undesirable. Persons diagnosed with syphilis and gonorrhoea were seen as having a morally corrupted capitalistic behaviour. Under criminal law, persons found to be infected and who refused treatment or who had sex after being notified about the infection, could be prosecuted. Patients and contacts were prevented from accessing a variety of municipal facilities, taking up new jobs or go abroad until they were cured. The system had a good screening for syphilis and gonorrhoea organised for certain occupational groups, including cooks, medical personnel, school and hotel staff, patients admitted to hospitals, and pregnant women. Doctors were under legal obligation to report all cases by name and address[13].

After the glasnost period and the disintegration of the Soviet Union, historical data describing the occurrence of syphilis have become available. The notification rate for syphilis in 1921 was 550/100 000 population. Introduction of penicillin and STD control helped to reduce it to 2.45/100 000 by 1963; it reached a new peak of approximately 30 in the mid-1970s (30/100 000) and declined again in the late 1980s (2/100 000)[12].

After the break-up of the Soviet Union, there were dramatic changes in STD control; first, because of lower government funding, and secondly because many doctors began to move towards the idea that STD control should be addressed by combining social education and by means of information through the primary health care system[13]. The contemporary STD service is based on voluntary attendance and partner notification. It became very clear that many people preferred to be treated in the private sec-

tor in order to avoid the stigma of STD. In response to these changes, the Russian Ministry of Health issued new instructions for screening, diagnosis, contact tracing, licensing of private practitioners, social care, providing medical supplies and for research[13].

The incidence of syphilis has increased sharply in the states of the former Soviet Union since the early 1990s, in 1996 reaching the level of 263/100 000 [12]. Approximately equal numbers of men and women were affected. The incidence among young people was significantly higher. For example, the notification rate of syphilis among women aged 18-19 exceeds 1/100. The epidemical situation in the western countries (Belarus 210/100 000, Moldova 200/100 000 and Ukraine 144/100 000) and Central Asia (Kazakhstan 231/100 000, Kyrgyzstan 137/100 000) was similar in the mid-1990s; in 1996 it was more favourable in the Baltic states (Latvia 117/100 000, Lithuania 99/100 00; and Estonia 70/100 000)[12].

The situation in the countries implied changing patterns of sexual behaviour[2], partly because of the opportunity of going abroad after the complete isolation during the Soviet era. This increased possibility of having sexual contacts and made sexually oriented products widely available[13]. A rapid decline in the age at first sexual intercourse has been described in Russia and the other new countries. It is also believed that adolescent prostitution has increased. Low social background made people reluctant to use condoms. It is documented that between 1985 and 1995 there was an increase in syphilis among the unemployed from 18% to 50.4%. The health care system had problems tracing contacts because of private clinics that provided treatment on an anonymous basis without reporting cases[13]. The incidence of syphilis and other sexually transmitted diseases in the region may be underestimated.

Hepatitis B

Rates of hepatitis B in Russia increased steadily, reaching peaks in 1996 (35.8/100 000) and 1999 (43.3/100 000)[8]. The reasons are the same as those for STDs. They include changes in sexual behaviour, low social background, frequent change of partners, and reluctance to use condoms[2]. Moreover, increasing intravenous drug abuse has been documented, especially among young people. Along with higher incidence, lower average age at infection was documented. In 1994, the majority of patients were about 24 years of age; in 1999 it was down to 22 years[1]. It is an interesting fact that men contracted hepatitis B at a significantly younger age than women. Men were primarily infected by other men through shared infected sy-

ringes and homosexual intercourse, while women were infected by men through heterosexual intercourse. Infection among women can be also due to injection drug use, but to a smaller extent than infection among men[1]. The health care system did not always provide disposable syringes for treatment. Some cases resulted from transfusion of infected blood. Children born from mothers with hepatitis B were at great risk to be infected and become chronic carriers[2].

HIV infection

HIV is a new emerging infection in the region. A mass HIV screening programme was introduced in 1987, which is towards the end of Soviet period [4]. It was targeted at low risk groups: pregnant women, blood donors, medical personnel, and hospital patients, foreigners arriving and planning to stay in the country for an extended period of time, and persons that had spent more than one year abroad. HIV was diagnosed in the Soviet Union early in 1987; the first infected person had been infected in Africa through sexual contact. In 1989, an outbreak of nosocomial HIV infections occurred among 250 children in the southern Russian republic of Kalmykia. It was followed by an epidemic among adults; around 40% of the cases were caused by homosexual transmission[4].

From 1990 to 1999, the number of HIV-infected persons in Russia increased dramatically, from 95 in 1990 to 10 900 in 1999[8]. Official statistics on HIV reflects only 10% of the actual number of infected persons. The majority (60%) of HIV-infected persons were intravenous drug abusers. The highest incidence was found in the big central cities and sea ports of Russia. The city of Kaliningrad, located in the west part of the country and isolated geographically from Russia by the Baltic states, was the most affected region[4]. Other cities with rapidly spreading HIV epidemics are Krasnoyarsk, Nizhniy-Novgorod, Rostov, Tver and Saratov. Smaller numbers were reported from several other cities and regions, including Siberia and the far north.

The former Soviet Union has the fastest growing HIV epidemic in the world. HIV prevalence varies widely in Ukraine, Belarus, and Moldova. In Ukraine, only 40 to 80 new cases were registered each year from 1988 to 1994 [4]. These were mainly among foreigners infected through sexual contacts. In March and April 1995, more than 1000 intravenous drug users in two main cities in Ukraine were found to be HIV positive. A year later, HIV infection among intravenous drug users was reported from all 25 regional centres in Ukraine. The total number of diagnosed cases rose to

more than 25 000 in 1997. Few HIV infections had been reported in Belarus until May 1996, when mass screening of intravenous drug users revealed that 632 (50% of those tested) were infected by HIV. By the end of 1997, the total number of HIV infections had increased to 1800 cases[4]. HIV is less prevalent in Baltic states, in particular in Lithuania, and in the states of Caucasus and central Asia[5].

Several factors are associated with the HIV epidemic[2,4]. They include intravenous drug abuse becoming prevalent among young people. Sharing of needles was very common among drug abusers in Moscow, Kaliningrad and Poltava. HIV infection might also result from the process of the preparing the drug for injection. There are reports from several cities, including Moscow and Kaliningrad, which indicate that blood was added to the drug before injection[4] because of a belief that the blood cells neutralise toxic reagents. Change of sexual behaviour patterns, low social background and reluctance to use condoms were other important contributing factors. Some data suggested spread of HIV infection among pregnant women, children born from HIV positive mothers, and blood donors. Blood donation is based on a voluntary system, though donors receive incentives such as payment, free food for the day, and two additional days off work. The HIV epidemic is also fuelled by the policy of distributing HIV-infected prisoners around the country. Until recently, all HIV-infected prisoners were kept in one prison, now they are allocated to different prisons around the country. Intravenous drug use has increased among prisoners; HIV is spreading in the prisons through shared infected needles and unprotected sex. Very few prison health services offer needle exchange and condoms, which would reduce the risk of infection. Migration from highly endemic countries also fuels the current epidemic.

Tuberculosis

The centralised dispensary system for tuberculosis prevention and treatment was introduced in the Soviet Union in 1918 and streptomycin and PAS has been used for treatment of tuberculosis since the 1940s. Isoniazid, cycloserine and thiacetazone were introduced in the 1960s; rifampin was available from the early 1970s. As a result of a good control programme and the introduction of specific antibiotics, the incidence of tuberculosis fell steadily from 119 per 100 000 inhabitants in 1965 to 34 per 100 000 in 1991. From 1991, however, the incidence started to rise sharply, reaching 90.3 per 100 000 in 2000[9,14].

In Estonia, after a decline in tuberculosis incidence from 417/100 000 in 1953 to 26/100 000 in 1992, there was a steadily increasing incidence, reaching 52/100 000 in 1999[6], accompanied by an increase in drug-resistant tuberculosis, particularly multidrug-resistant (MDR) tuberculosis, that is resistance to rifampin and isoniazid[17]. In 1998, MDR tuberculosis accounted for 14% of new pulmonary cases. The majority (87.5%) of these patients were infected by a highly virulent strain of the W-Beijing genotype [6].

The incidence of tuberculosis in Latvia has followed a similar trend, up from 1991 to a rate of 74/100 000 in 1998[15], since then remaining at about the same level. MDR was found in 8.6% of new cases and in 34.5% of all tuberculosis patients in 2000. The most dramatic increase has been observed in Georgia, where reported notification rates increased from 29.8/100 000 in 1989 to 194.7/100 000 in 1996[11].

Prison systems are known to create emergence of tuberculosis. Epidemiological indicators in the prison system are several times higher than in the community at large; there is, for instance, an extremely high incidence of tuberculosis (4667/100 000) in the prison system of Azerbaijan[10].

The increasing incidence of tuberculosis has been attributed to social changes after the political and economic crisis. The health services had less medical personnel and lacked equipment, technology, funding and of supplies of all essential drugs. The treatment regimens for tuberculosis were individual and usually consisted of three drugs, including second-line medication. Severely ill patients were prescribed four drugs. No supervision of treatment was provided; this allowed patients to take their drugs on an irregular basis. Interrupted treatment and inadequate regimens increased the infectious period for many patients and the probability of healthy individuals being exposed to and infected by tuberculosis. Up until the 1990s, all patients with tuberculosis were hospitalised for the entire duration of treatment, hence there were good opportunities for preventing interruption of treatment. However, the re-emergence of tuberculosis resulted in a lack of resources and unavailability of hospitalisation for all patients.

The epidemic was also fuelled by the situation in the prison system. Tuberculosis originating in the prison systems of the former Soviet Union affected inmates, personnel, and also those outside the walls. Nowadays, tuberculosis has new features: increased incidence of antibiotic resistance and the emergence of a new virulent genotype called W-Beijing; it causes high morbidity and mortality from tuberculosis.

Conclusion

The history of the Soviet Union provides strong evidence to the effect that economic, social and political change made for the emergence of infectious diseases. Political, economic and social transitions have brought changes in the health situation of the population, causing an emergence of new and re-emergence of old infectious diseases. The consequences of changes and the extent of infectious disease spread vary from country to country. Infectious diseases have similar epidemiological patterns over the past decades in the countries of the former Soviet Union. The threat of these diseases is well recognised, and improved social and economic conditions in these countries as well as research aimed at analysing new biological features of pathogens will allow us to improve the situation and combat infectious diseases.

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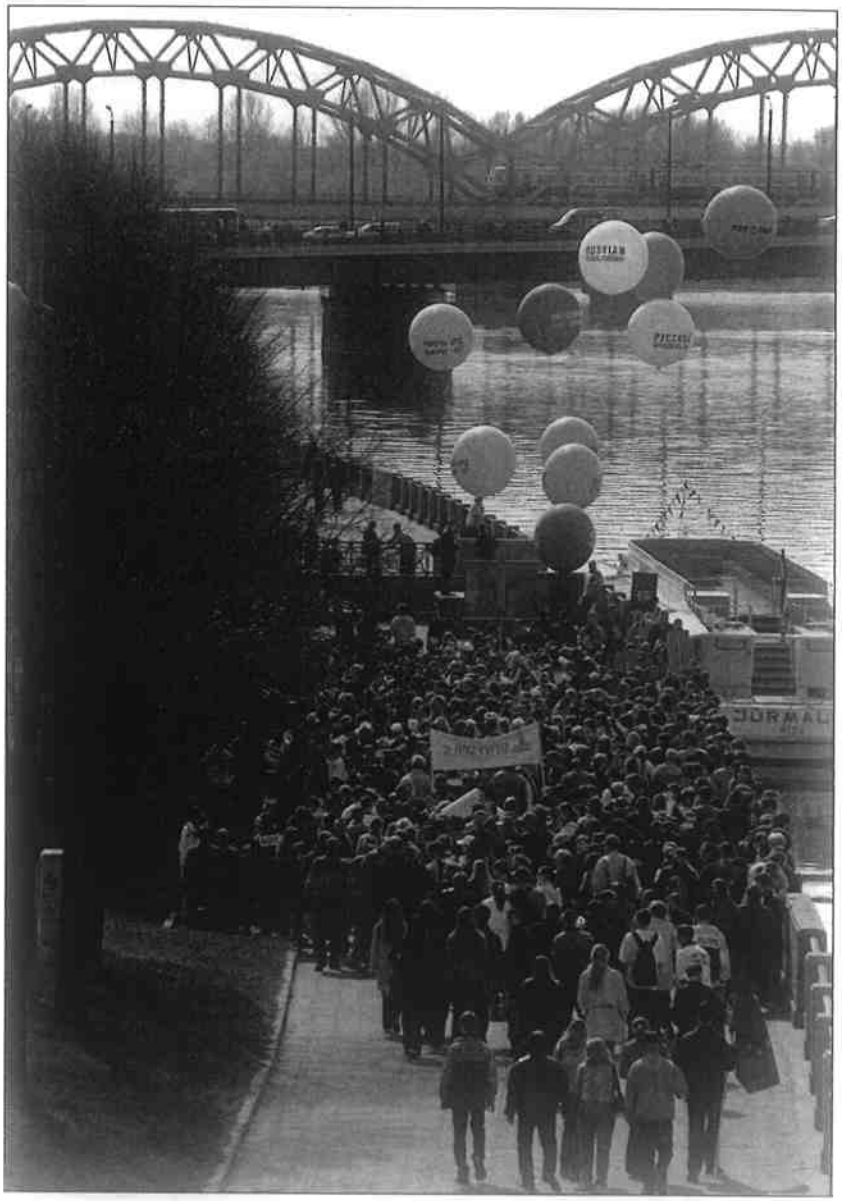

May 1, 2004 was an important day for the three Baltic countries Estonia, Latvia and Lithuania: joining the European Union. However, the minds of the people were not unanimous. An example: At the same time as celebrations were going on all over old Riga in Latvia, ethnic Russians passed the embankment of the river Daugava on their way to a demonstration to support schooling in Russian language. (Photo Ø. Larsen 2004)

Guntis Kilkuts, Øivind Larsen
and Elin Olaug Rosvold

Health and social change in Latvia 1991–2001 – a modern piece of medical history

Michael 2004: 1; 277–85.

Health and social changes in Latvia

Latvia, the small country at the Baltic Sea had been part of the Soviet Union since 1940, but regained its status as an independent state in 1991. At this point, health and social conditions resembled those in other former Soviet states in the Western parts of the Union, and the infrastructure of the society, including the health care system was Soviet style.

Latvia has a population of 2.42 million, and around half of them live in the capital of Riga. The ethnic composition in the country is 56.5% Latvians, 30.4% Russians and 13.1% others. Life expectancy is 73.7 years for women, 61.2 years for men. Gross domestic product per capita in the year 2000 was USD 2420.

For a comparison, another Nordic country, Norway, has a population of 4.50 million which is composed of 94.1% Norwegians and 5.9% immigrants of different origins. Life expectancy is 81.1 years for women and 75.6% for men. Gross domestic product per capita (2000) was USD 35004, of which 8.0% were total expenditures on health.

Since 1991 the Latvian society has undergone profound social changes, partly because of its political objective to join the European Union, where changes were required in order to qualify for application. By 2002, many traits of the Latvian society were much like in any Western European country. To achieve this goal and the further progress which is to be expected, the country has passed through a development which has been to the benefit of many groups of the population. But it has created problems in social conditions and health for others, e.g. pensioners and elderly people, or people employed in industries which were closed down due to the new market situation. The replacement of the Soviet system with a Western system in

many parts of daily life, at least for a while left parts of the population in a sort of limbo which led to social difficulties and even could harm their health.

The curative part of the Soviet style health care system was mainly hospital and specialist oriented with no functioning primary health care system as such. District internists and district pediatricians were placed in policlinics together with specialists and were responsible for preventive work. After 1991 and under new financial skies, this system among other weaknesses showed to lack the required cost-effectiveness, even if e.g. its preventive potentials were quite good. The first Western style general practitioners were trained in 1992, but the political decision that a primary health care served by general practitioners should be the first line system of choice, was taken only in 1996. The process of replacing the first line specialists with trained general practitioners is long and cumbersome, and is accompanied by a process of restructuring the payment procedures for medical services.

Aims of the study

During the decade starting in 1991, the social catch-up with the Western neighbours has been so rapid, that processes lasting for many years in other countries here could be studied in compressed version. So there were two distinctive objectives: In the first place to monitor and interpret what really was going on, and in the second place to discuss the present situation in relation to the social and medical history of other countries.

Material and methods

Since 1993 the authors have had the opportunity to observe the process going on in Latvia rather closely, one of us (GK) as an internist in a Riga hospital with out-patient services, later as a general practitioner in Central Riga, the second of us (ØL) teaching medical history and community medicine at the University of Oslo with special responsibility for student outplacement in Latvia and USA, and the third (EOR) as a student tutor.

In the years 1995 to 2001 a total of 93 medical students from Oslo in groups of 4-6 twice a year stayed four weeks in Latvia as part of their training in general practice and community medicine. In the period 1996-2001 38 students had corresponding stays in the United States of America (La Crosse, Wisconsin).

Each group got to examine a given topic related to health and social change and had to write a report on their findings. They were instructed to collect as much of relevant statistical information as possible, and to supplement this with own observations and with interviews of informants and key persons in the field. In order to take care of the comparative perspective in time and space, the reports were written when the students came back to Norway and could collaborate in an evaluation of the prevalent conditions in Latvia and Norway, respectively Latvia, Norway and the United States.

However, as the reports were completed in the course of six years, the information given there is not updated beyond the year they were submitted. The outplacements were discontinued in 2001.

To provide a common background for their studies, all students took part in a standardized teaching programme in Latvia, set up by GK, presenting them to a wide series of public health issues.

The material gathered in the reports (1-12) under the guidance of the authors makes up a material fit for elucidating a piece of modern medical history – the changes in social conditions and health in Latvia.

Results – some medical and social indicators

A change in culture

In the first years following the Latvian independence, the society basically was a Soviet society, yet challenged by strong nationalistic forces urging for change. This dichotomy led to a puzzling cultural situation, as the rapid breakup from the old system on the one hand could be painful in daily life, whilst on the other hand the introduction of a Western lifestyle also could be painful, especially when resources were scarce (1). This ambiguity of course influenced the attitudes of the informants, and e.g. their evaluation of the past and their prospects for the future have to be interpreted in light of the social context:

Wrote a group who had a Latvian family as their informants in 1996 (2):

"This family lives on the eight floor in a suburb apartment building, built in the Soviet period. They have a small apartment (50 square meters) and a veranda where they dry their laundry even at minus 10 degrees Celsius. Some of the windows have synthetic curtains, and everywhere are the green plants looking more healthy than the people living there. Beneath the concrete you can easily see the rusty reinforcement. One of their children, Janis is looking at television. The Dynasty is on channel one. Krystle speaks Latvian and the subtext is in Russian. The rooms are small and the interior is dark, and Christmas decorations are everywhere even though this is late

January. Migra, the grandmother, is sitting on the coach knitting mittens for sale at the market next Saturday. Unfortunately, the Latvian Cabinet recently approved new charges on electricity and hot water. However, needy elderly people like Migra have the right to receive free firewood if necessary. The pipe system is old and makes a lot of noise when the water is turned on. Often the pressure is so low that there is no water at all. The family boils their drinking water as they are recommended to do because of the spreading hepatitis A, but fruits and vegetables are eaten without washing them in advance. Chlorine is added to the drinking water, in order to prevent transmittable diseases. ..."

On Ilze (i.e. the housewife and breadwinner of the family, having broken up with her husband, who is suffering from cancer of the bones following having been sent to Tsjernobyl as a cleaning up worker at the 1986 catastrophe), after describing all her worries:

"One might wonder how she is able to stand on her feet. Virtually she has no spare time, teaching and housework takes all her time. She is very pleased with her job (as a teacher), even though it is poorly paid. To us it seems peculiar that she has not developed "fibromyalgia". We tried to ask physicians about psychosomatic diseases, and they raised their eyebrows and shook their heads. They seemed to have no interest in this matter. Or could it be that patients do not complain about such problems?"

The experiences from the field work clearly show that not only the social conditions and the health priorities change rapidly, but also the attitudes towards the problems.

As can be seen from the reference list, the reports take up a series of medical topics, each of them serving as an indicator or a proxy pointing at the running medical and social processes. Important problem fields as diabetes (3), asthma (7), arterial hypertension (8), hormone replacement therapy (9) and sexually transmitted diseases (12) also were among the topics studied. Here, some examples are taken out for further presentation and discussion.

Vaccination – the rise and fall of preventive medicine?

An overview and evaluation of the vaccination programmes in the three countries was given in the report «Vaccination of children in Norway, Latvia and the United States» (6). The programmes were compared to the guidelines given by the World Health Organisation. All countries were found to have adequate vaccination schedules that were in line with their respective disease panoramas. There was, however, a need to improve the coverage level.

In the case of Latvia, coverage had been fairly good in the Soviet period, not least due to the authoritarian system. However, the new democracy had as a side effect that people did not feel as obedient and responsible as before, also when it came to following vaccination programmes.

From the Soviet time it existed a long list of contraindications, mostly due to low quality vaccines. Besides that, a diphtheria epidemic in 1994 showed that the vaccination status had not been satisfactory. Because of the new situation, supplies of vaccines to cope with the situation were not sufficient. Using new vaccines, the list of contraindications should be reduced, although new contraindications emerge, such as allergy, which in general is an increasing problem connected to the increase in living standards. Increased efforts should also be made to localize all those in need of immunization.

However, the new health care system of Latvia does not seem to support or promote vaccination as a preventive measure. As the responsibility for establishing the required degree of coverage is not clear, people have problems to respond adequately to the system changes in this field.

Tuberculosis – a proxy when studying social development

After 1990, Latvia experienced an increasing incidence of tuberculosis (4). This coincides with economic problems, such as can be shown by the inflation rates, which at the outset were around 900 per cent a year, but soon stabilized on a three percent level. However, multi-resistant strains of tuberculosis bacilli have been a special problem in Latvia, and so have the health care systems for tuberculous patients, where the staff in the hospitals are particularly exposed to be infected.

In 1995 the directly observed treatment, short course therapy (DOTS) was introduced, but Latvia has no legislation that forces patients to be treated.

Availability of antimicrobial drugs as part of freedom

In Soviet times, antibiotics and other drugs against infections were not covered by the strong regulation of drug dispensing, because they were not regarded as harmful. The use of them was in principle following the advice given by a doctor. However, the use was rather widespread, not least because antimicrobial drugs also were recommended against viral infections, such as common colds.

After 1991, this practice continued and antibiotics and related drugs could be bought over the counter without any regulations at all. At the same time there were no guidelines for the perusal, and e.g. expensive broad spec-

tre antibiotics could be bought at the choice of the patient for minor diseases.

The students studied antibiotic practice in upper respiratory tract diseases in 1997, especially worrying about the risk of developing drug resistance in the population (5). Although Latvia seemed to pursue the same scientific objectives on use of antibacterial drugs as e.g. in Norway and the USA, i.e. a restrictive policy, the free trade in the dispensaries caused a problem, especially when economy became better: More money was available for buying expensive and fancy drugs, which might have a special harmful potential.

In 2001 prescription of antimicrobial drugs by a doctor was introduced again in Latvia.

Depression suppressed?

Depression as a primary health care problem in Latvia and Norway was discussed in a report in 2000 (11). The students found only a limited amount of literature about depression in Latvia, and there seemed to be less concern about mental health issues in Latvia as compared to Norway.

Unlike in Norway, there were no guidelines for diagnosing and treatment of depression in primary health care in Latvia.

Latvia maintains till this day a full-name register of psychiatric patients treated by specialists. A concern about patients' anonymity was expressed. Being entered into the register may have unpleasant consequences, e.g. by application for a driver's license. This may lead to a certain under-representation of psychiatric diagnoses. The register is by many regarded as a reminiscence of the totalitarian state.

On the other hand, there is another factor which might be of importance: In Soviet times it was a virtue to conceal one's feelings and mental distresses. This is obviously going to change, and illnesses like depression are more likely to come to surface.

Dyspepsia as a social indicator

The report «Dyspepsia. The present status» aimed to study dyspepsia as a health problem in Latvia as compared to Norway and the USA (10). This included definition and diagnostic criteria, treatment, and distribution of risk factors, where obvious differences were to be found. Alcohol, smoking, and helicobacter pylori infection seemed to have a greater impact as risk factors in Latvia than in Norway and the USA. Relatively low prices on alcoholic beverages, and traditions for heavy drinking of strong liquor were regarded as a risk factors at hand, and so were prices, availability and habits when it came to tobacco.

Due to low cost, endoscopies were frequently performed early in the investigative process in Latvia, whilst HP-serology and urea breath test were more widely used in the other countries studied.

From a viewpoint of community medicine, the risk factors for dyspepsia deserve a closer study: Even if the old risk factors are getting less importance because of changes in habits, psychosomatic dyspepsia probably would be likely to increase. As a social indicator, dyspepsia thus points in at least two directions.

The report also focused on the research problems arising from a lack of a universal definition of dyspepsia, which among other consequences preclude more precise comparative studies.

General discussion – lessons to be learnt

The material which has been collected and interpreted, covering Latvia in the years 1993-2001, reflects a development where the country left the totalitarian order of the Soviet time, rapidly approaching standards and life style corresponding with what could be expected from a country applying for membership in the European Union.

In the field of health care, this has led to a change from a specialist and hospital oriented care to general practitioner based family medicine first line services. More and more medical guidelines are adopted guiding daily medical work, in line with in Western medicine. Increased interest in health topics may be noted in the population, but also a shift towards medical problems which were not so apparent before, partly because they belong to another stage in the development of a society, but also for reasons having to do with biology, e.g. allergy. The reports were written during a series of years when the development was going on, and the sliding of problems, solutions and attitudes can clearly be noted.

However, what has been monitored and discussed during the period covered, has to be seen as part of a larger pattern: The previous balance between personal autonomy and regulations from the authorities has been shifted, but in health matters there obviously is a need not to avoid all sorts of authoritative control and it is not possible to rely entirely on personal freedom and integrity. A new balance has to be established. The authors claim that their experiences may have bearings in time and space also for other societies undergoing changes.

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Finland: Waning welfare? (Helsinki 1997, photo: Ø. Larsen)

Minna Harjula

Sick Finland? – The crisis of Finnish health policy in the 1960s

Michael 2004: 1; 287–99.

Introduction

A basic target for health policy [is] staying alive. In Finland this target is poorly reached.[1] Our health care proves to be peculiarly backward. We stick out sharply from the other Nordic countries and mostly join the poorest nations of our continent.[2]

(...) how and why do the healthiest babies in the world grow up into the sickest adults in Europe?[3]

The achievements of Finnish health policy were subjected to severe criticism in the 1960s and 1970s. The basis for and the focus of post-war health policy were rigorously questioned by both public authorities and experts. It was even provocatively argued that as a result of the unsuccessful policy the entire nation was sick.[4] However, as late as the 1950s, the health policy of the twentieth century was considered to be a great success in Finland: mortality rates declined, contagious diseases were brought under control and tuberculosis was gradually beaten.[5] How is it possible that the views on Finnish health policy changed dramatically in a single decade?

This article examines the origins of the health policy crisis of the 1960s in Finland and its contributory factors. The crisis launched an extensive debate on the means, goals, content and possibilities of health policy. Presumably, changing definitions of health and health indicators, as well as health risks, played a significant role in the crisis. Studying a period during which the direction and form of health policy were reformulated, makes it possible to analyse the conditions, consistencies and changes in health policy in general.

Finland is characterised by the central position of government in health policy. In other words, health services are organised and supervised by the government, and even voluntary organisations work in close relationship with the government.[6] Therefore, my focus is on official health policy, which was organised by the state and the municipalities and led by the Na-

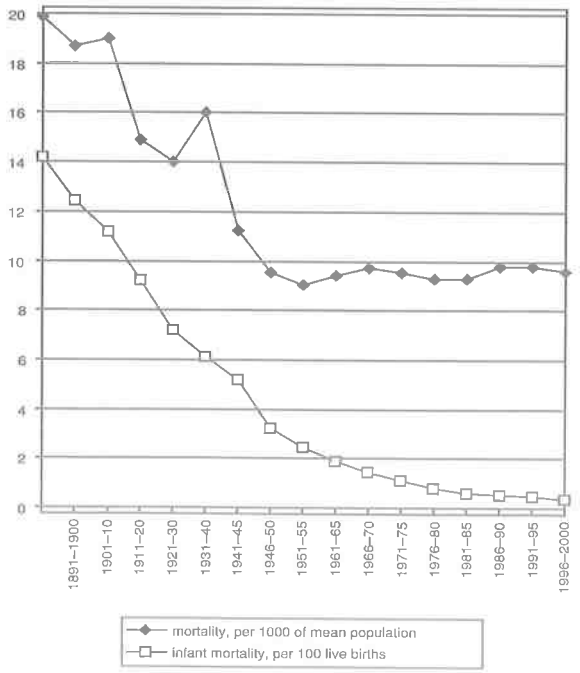
tional Board of Health. The main sources consist of the documents of the National Board of Health. Additionally, the study is based on an analysis of the health debate in national medical journals and public health literature.

Finland in the 1960s was transformed by a rapid change from an agrarian country to an industrialised and urbanised one. This entailed internal migration and emigration, rising living standards, changing living conditions and ways of life, increasing free time, and breaks in social patterns and traditions.[7] The structural change of society, which, compared to other Scandinavian countries, was notably delayed, provides a societal frame for analysing the field of health policy.

The crisis

As the development of mortality was considered the most unambiguous indicator of the success of health policy, a remarkable feature in Finland in the 1960s was the rise of mortality rates (Fig. 1). During the twentieth century the mortality rates had been constantly declining and the only in-

Fig. 1. Mortality and infant mortality in Finland 1891-2000

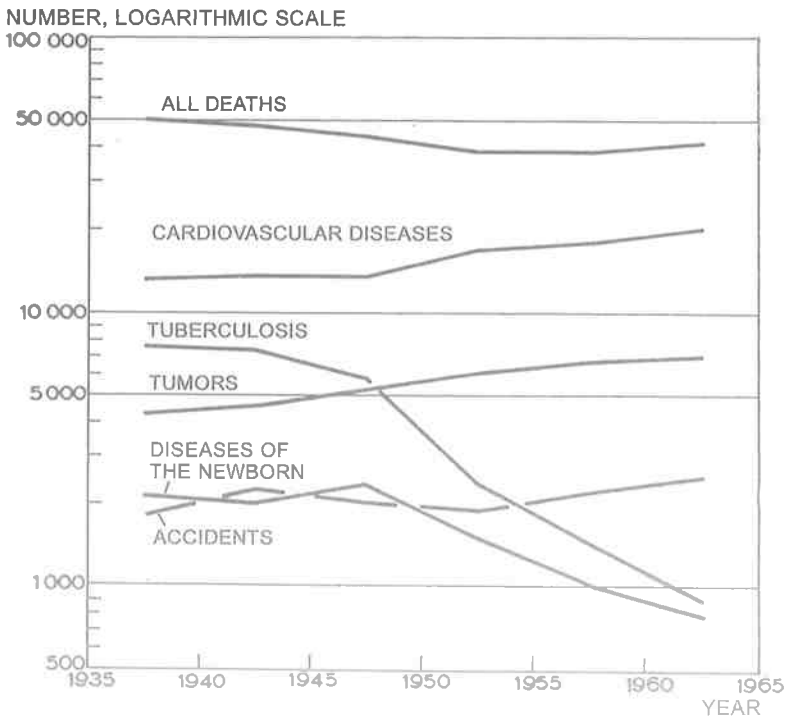


Sources: Statistical Yearbook of Finland 2002, p. 125, 144; Suomen väestö (1994),p.323; *http://www.stm.fi/kvt/suomi/ykhuippumaaliite1.htm#Liite%202*

creases had occurred during the Civil War of 1918 and during the Second World War in the early 1940s. Therefore, a rise during peacetime was an exceptional situation.

Additionally, the statistics showed that it was no longer acute epidemic diseases, tuberculosis or diseases of newborn children which brought the Finns to their graves. The favourable development in infant mortality especially was a source of national pride (Fig.1.).[8] Instead, the increased incidence of new fatal diseases – cardiovascular diseases and cancer – was evident. (Fig. 2.) Beating this novel, chronic major diseases – in Finnish kansantaudit meaning people's diseases or national diseases – became a new concern for the authorities.

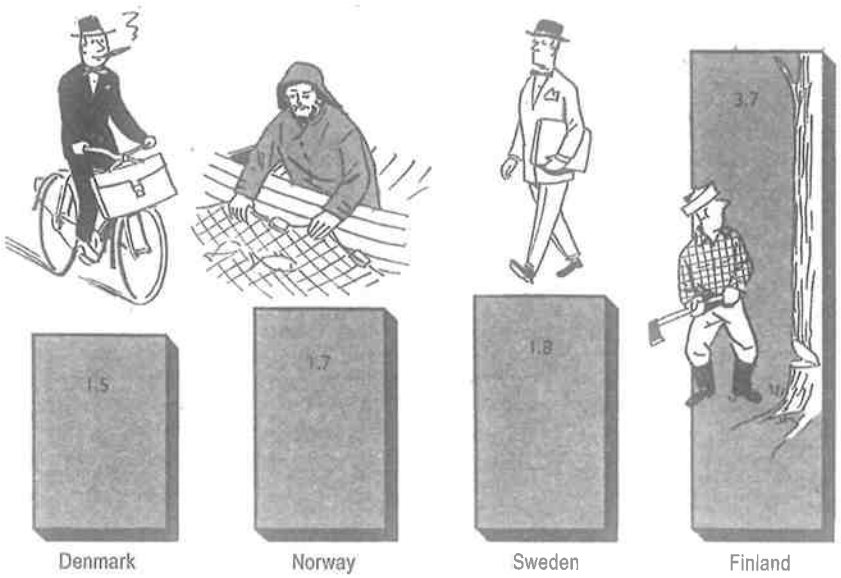
Fig 2. Main causes of death in Finland in 1936-65



Source: L. Noro, Sosiaalilääketieteen perusteet 1968, p. 61.

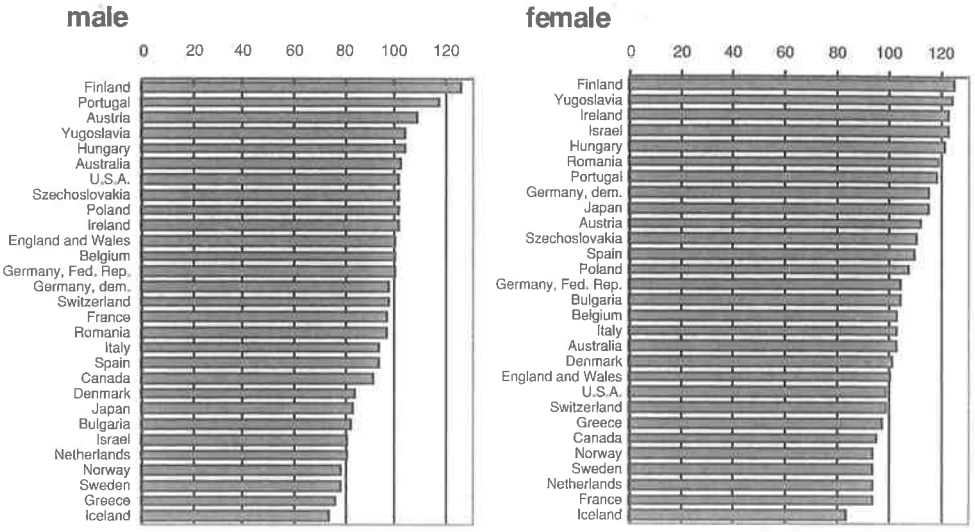
The statistics showed that Finnish men especially died prematurely: the mortality among Finnish men was observed to be twice as high as in other Scandinavian countries (Fig. 3). Accordingly, the result of a comparison among 29 countries in 1965 was even more shocking, for Europe's highest death rates were found in Finland. (Fig. 4.) It was even stated that for a 40-year-old man the situation was worse in Finland than it was in Costa Rica or Albania. This fact was considered to be a national disgrace: how was it possible that our country had failed in the basic task of keeping its citizens alive? How was it possible that the healthiest babies grew up to be the sickest adults?[9]

Fig 3. Mortality of 35-39-year-old men in the Scandinavian countries in 1956, per 1000.



Source: Kuusi, P., 60-luvun sosiaalipolitiikka (1961), p. 263.

Fig. 4. Standardised mortality as index in selected countries in 1965 (England and Wales = 100)



Source: Official Statistics of Finland XI: 70-71 1967-68, p. 26.

Since the late nineteenth century – and especially since independence in 1917 – health policy was seen a part of the nation-state building project in Finland. While being a part of the civilized word and keeping up with the development of the Western Europe had become a central goal, falling into the same category with developing, poor countries was considered a national and cultural crisis.[10] The crisis was also a demographic and an economic one, as the nation lost a substantial number of citizens in their prime, which also meant a huge loss of workforce. [11]

In addition to that, the crisis in health policy had a regional aspect. The expectation of life of a newborn baby boy was found to be three years shorter in Eastern Finland than in Western Finland. The situation pointed to the conclusion that there had to be serious regional inequalities in health and health services in Finland.[12] As democracy, social equality and economic growth were seen as tightly interrelated factors in the development of modern society in the 1960s, so also inequalities in health were considered to be both morally unacceptable and economically detrimental.[13]

Emphasis on population policy – a delayed reaction

The unpreparedness for the changing mortality and health patterns in Finland can partly be explained by a lack of comparative statistics. Detailed analyses of the causes of death only became possible in Finland in 1936, when the statistics were based on medical certificates and were brought into line with international statistics.[14] The first introductory studies based on these statistics were published in the late 1940s and 1950s.[15]

However, a more substantial factor in the process seems to be the fact that Finnish post-war health policy strongly emphasized population policy, which gave priority to children's and mothers' health. A municipal system of maternity and child welfare clinics was built up in the 1940s. Furthermore, preventive health care services and social policy were successfully combined: in order to be eligible for maternity allowance pregnant women had to attend the maternity clinic.[16]

Concentration on children meant, on the other hand, that the need for health care for other age groups was overlooked. Although the new Finnish term for public health, kansanterveys – which became common in the 1930s and 1940s as an equivalent to the Swedish term folkhälsa, literally meaning people's health [17] – suggested as its scope the whole nation regardless, for example, of age or gender, it was particularly the care for mothers and children which was defined as a matter crucial to the survival of the nation. It was, for example, explicitly stated that chronic diseases were population politically irrelevant, because those who suffered from these diseases were usually old people.[18] Besides, there was no tradition in health policy for coping with chronic non-contagious diseases, as ever since the late nineteenth century, health policy interest had been based on hygienic thinking and focused on suppressing acute epidemics.[19]

Health services as a solution

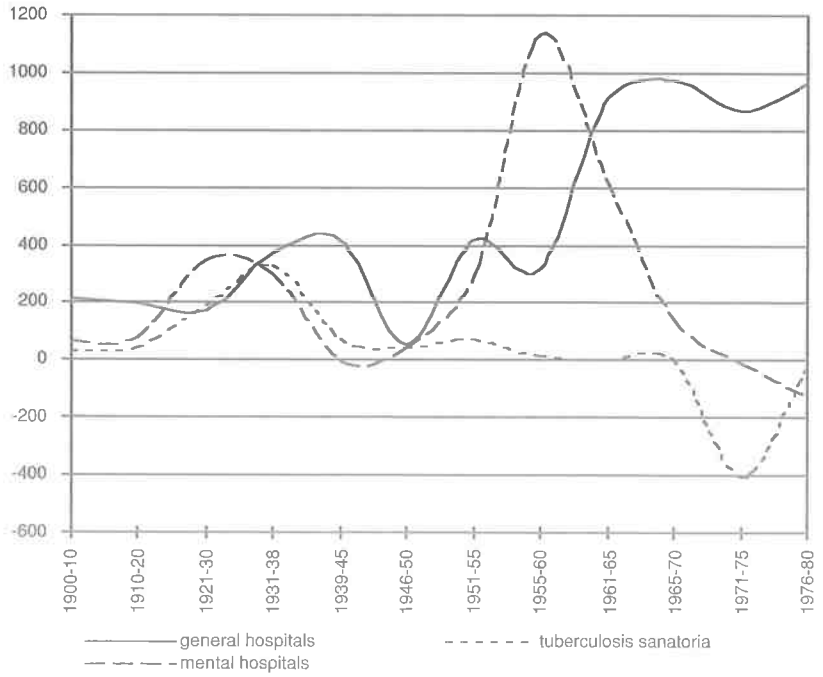
The discourse of health policy changed in the early 1960s and the emphasis on children and mothers was replaced by a concern for adult Finns. The Public Health Committee, which was appointed in 1960, stated that death rates clearly showed the preferential status of young age groups within health care services. Now it was necessary also to include the older citizens in the sphere of health care. All Finnish people became the target group of health policy. [20]

To guarantee a sufficient supply of health services became the main goal. In Social Policy for the Sixties, a seminal work guiding the development of Finnish society in the 1960s and 1970s, it was argued: 'The growth of the supply of medical services as such will nowadays usually guarantee an improvement in the health of the nation'.[21]

International comparisons did indeed show that Finland had fallen behind in health service development: the number of medical staff per capita was the lowest in Europe and the number of hospital beds was below the average European standard.[22] The need for medical doctors was gradually met by creating new training arrangements in Finland and abroad.[23] After a massive building project of general and mental hospitals, which can be seen in Fig. 5, Finland reached the top of the world in the number of hospital beds in the late 1960s. In contrast to the other hospital sectors, the separate tuberculosis sanatoria could gradually be closed down as the morbidity from tuberculosis declined, and the sanatoria could be used for patients suffering from other diseases.

In addition to the urge to offer every citizen everywhere in the country equal access to health services, another goal was to remove the financial barriers to using the services. People's slowness in seeking medical care as well as the plenitude of untreated diseases was seen as the results of inadequate

Fig. 5. Changes in number of hospital beds 1900-1980, annual means



Sources: Vauhkonen 1961, p. 50; Official Statistics of Finland XI: 72-73 1969-70, p. 228, 244; Official Statistics of Finland XI: 78 1982, p. 178.

compensation for medical costs.[24] Nationwide sickness insurance was finally put into practice in 1964, after a discussion of no less than 50 years. In the name of equality between the rural and urban population, the insurance was not restricted to wage earners but extended to all Finns, which meant a significant step in creating a comprehensive system of social welfare in the country.[25]

Despite these reforms the situation was not, however, considered satisfactory. The building of hospitals consumed most of the public resources put into health services. Due to the rapid technical development the costs rose unforeseeably. Besides, it was noticed that elderly and chronic patients occupied most of the hospital beds, and waiting lists were long.[26] The results and efficiency of the hospital-based system were called into question. 'People's health doesn't conclusively improve by the mere fact that good doctors cure bad patients in modern hospitals', it was argued.[27]

Outpatient care and preventive care were declared the new solution to the cost crisis of the hospital-based service system in the late 1960s. In fact, the importance and economic efficiency of preventive health care was already clearly stated in the health policy plans of the 1940s and the positive results of maternity and child welfare clinics could be seen as irrefutable proof of the benefits of preventive care.[28] With the passing of new Public Health Act in 1972, the local practices of municipal medical officers and public health nurses were replaced by an extensive municipal health centre system. The idea was to prevent disease by medical checkups and health education. It was hoped that the social differences in the use of health services would disappear with efficient cost-free primary health care.[29]

The growing supply of health services raised the question of how to motivate people to use the services. On the one hand it was argued that fostering health was a part of human nature and no extra incentive was needed. On the other hand it was even suggested that sickness insurance would only be paid on condition that the person attended regular health checkups.[30] The latter idea, which perceived it as the obligation of individuals to avail themselves of services provided by the state in the interest of safeguarding the health of the nation rather than respecting the autonomy of the individual, was introduced in the maternity services of the 1940s.[31] However, in the 1960s the idea of shepherding the uneducated public did not concur with the emerging discussion on the rights of the individual in social and health policy.[32]

Social development policy: Health policy as a part of social policy

A new wave a criticism emerged in the late 1960s. The critics now argued that investments in health services would no longer improve the health of the nation. Until then, the rising standard of living had furthered the efforts of health policy, but now economic growth was perceived to result in new 'welfare diseases'. Because it was society itself that caused diseases, it was society that should be changed. Therefore, health policy, which only concentrated on health services and operated in isolation from other sectors of society, was considered useless. It was underlined that, instead of health services, it would be more rational to invest in other sectors of society. In other words, health should become a decisive argument, for example, in housing policy, environmental policy and taxation policy. In summary, health policy had to be a part of social development policy.[33]

The new discourse on health policy related to the cultural and political radicalism of the late 1960s. Even the health administration experienced a change to a new, radical generation.[34] In addition, the criticism reflected the powerlessness of medicine to treat the new people's diseases. 'We have to admit that the ways to beat (...) the people's diseases are not adequately known', stated the annual report of National Board of Health in 1969-70.[35] As the epidemiological profile had changed, instead of microbes new complicated factors, which were closely linked to people's social environment, were found to cause diseases.[36] Besides medicine, social sciences gained ground in defining health. The mortality rate as such was considered an inadequate measure of health, because it ignored many significant diseases – for example mental illness, rheumatic disease – and failed to consider the social aspects of health.[37]

This new emphasis on the social nature of health contributed to administrative changes: the health administration was transferred from the Ministry of the Interior to a new governing body, the Ministry of Social Affairs and Health.[38] Another significant reform was the creation of a permanent statutory planning system in 1972. Instead of temporary and case-specific committee-based planning, Finnish health policy became based on regular five-year plans.[39]

One of the main achievements of the new health policy was new legislation on occupational safety (1973) and on the restrictions on smoking (1976).[40] Among these structural, macro level measures an indicator of new; more individually based approach to health was the launching of the North Karelia Project (1972), which aimed at reducing cardiovascular diseases by interventions in lifestyles.[41] Hypotheses were evinced that the high mortality was attributable to detrimental smoking and eating habits rather

than factors such as the harmful effects of the Second World War, occupational structure and low standard of living. Nevertheless, the researchers admitted that the exceptional mortality rates remained essentially a mystery.[42]

Conclusion

The crisis of Finnish health policy in the 1960s was a reflection of a change in a successful health care development lasting half a century. Statistics and international comparisons had a crucial meaning in the crisis, showing the trend from success to failure. The rise of mortality rates and the excess mortality of Finnish men especially, gave rise to claims about the erroneousness and backwardness of the health policy.

A basic factor in the crisis was the changing definition of health and health risks. Beside acute, fatal, infectious diseases, chronic diseases were also brought into the focus of health policy. A new emphasis on preventing diseases gradually gained ground, and in the late 1960s, health was defined as a broad concept connected to society.

In practice, the focus of health policy of the 1960s changed from the building of hospitals to primary health care and preventive health care and finally to the structural development of society to be more conducive to good health. Considering the role of individuals versus society, the health service policy of the early 1960s was distinctively system-orientated: people's lifestyles and living conditions became invisible and people were perceived as passive users of the services. During the late 1960s and 1970s the emphasis on socio-economic structures contributed to recognition of the importance of living conditions to health. Subsequently, promoting healthy lifestyles and underlining the ideas of individual freedom and responsibility for one's health became key concepts in the health policy discourse of the 1980s and especially after the severe economic crisis of the 1990s.

Placing the crisis of the 1960s in the context of Finnish health policy development of the twentieth century shows that it was not an isolated phenomenon. Throughout the century, Finnish health policy can be outlined as a chain of health projects, which have consisted of changing views on health, health risks, as well as measures and conditions to maintain and achieve good health. Judged from each new point of view the achievements of the health policy of previous periods have seemed to be inadequate. During the 1960s, the ideas of hygiene and population policy, which date from the late nineteenth and early twentieth century, were considered inappropriate to modern challenges and replaced by new projects focusing on the

health service system and health policy as a part of social development policy. What was exceptional for the 1960s was the intensity of the debate, which can be explained by the simultaneous rapid changes in the epidemiology, demography and society.

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5. For example: *Official Statistics of Finland* XI:58 1955; *Official Statistics of Finland* XI:62 1959.
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7. H. Waris, *Muuttuva suomalainen yhteiskunta* [Changing Finnish Society] (Porvoo 1968).
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9. Kuusi, *60-luvun sosiaalipolitiikka*, pp. 256, 262-3; Leppo and Puro, 'Sairas Suomi', pp. 3-5; *Official Statistics of Finland* XI 70-71 1967-68, p. 26.
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Helsinki 1997. (Photo: Ø. Larsen)

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Electrical safety administration as an intermediate form of private and public operation

Michael 2004: 1; 301–14.

Summary

This paper discusses the development of Finnish electrical safety governance. The case of electrical safety governance is interesting in that the authority that answered for electrical safety administration in Finland for nearly seven decades was arranged as an association: Inspection Centre for Electrical Installations 1929-1980 and Inspection Centre for Electrical Apparatus 1980-1995. In the early 20th century it was the government's will that electrical safety inspections be delegated to the trade guild. Since the 1970s at least, the will of interest groups to affect the market situation was also involved. Since the EEA agreement in 1994 the operation of the electrical safety authorities in Finland has been separated from the commercially arranged inspection operations. The new system was feared at first to weaken electrical safety. However, the fears were not materialized as the number of fatal electric accidents has been constantly declining since the 1950s.

Introduction

The governance of electrical safety means a combination of regulations, procedures, and practices for organizing and managing surveillance within the field. It is also a question of organizational solutions and cooperation arrangements that have been affecting the administration of electrical safety. Governance is based on an administrative model put forth in the regulations and norms of the field, including both legislation and standards. Governance entails the factors guiding the operations, which should implement the principle of good governance (see e.g. Aarrevaara 2001, 11-12). By public regulation we mean the different sets of norms stipulated and controlled by the public authority.

Research on administration focuses on the regulations and processes, and the behaviour of authorities. The objective of the development of governance is good governance that is responsible and effective. Good gover-

nance may produce economic results but, above all, it produces trust and authority in the citizens' eyes, and promotes the effectiveness of the operation. This paper describes how electrical safety administration has evolved in Finland. We also present our estimate of its effectiveness. The paper is based on document and interview material gathered during 2002.

By the governance of electrical safety we mean the combination of regulations, procedures, and practices used for organizing and managing surveillance within the field. It is also a question of organizational solutions and cooperation arrangements that have been affecting electrical safety governance in Finland. Governance concentrates on regulations, processes, and the behaviour of authorities.

The central objective of our paper is, however, to explain the development and the current situation in electrical safety. Our work has involved studying the main turning points in electrical safety and the search for an explanation to their emergence.

Social capital in the governance is particularly manifested in trust and reciprocity. On the basis of our material it is fair to say that it has proven a methodologically challenging task to identify the trust and reciprocity related to the networks, operators, operations, and reciprocal relations concerning social capital (see. Stenvall 2001). For instance, when drawing up documents and plans, good administrative practices often include the principle that they do not bring forth contradicting arguments and compromises made in the spirit of reciprocity. Until mid-1950s, the operating culture within the field was such that even severely conflicting arguments were not shown outwards and all presentations were made in unison. The interpreting and identifying of social capital in the administrative practices is, indeed, one of the central requirements of our paper.

Intermediate form of public and private organization

What is particularly exceptional in the history of the administrative model of Finnish electrical safety is that the electrical safety authority has been based on an association model. The system was in use over a period of almost 70 years, from 1928 to 1995, after which the administrative model was incorporated with the government administration by establishing a government office, the Safety Technology Authority (Turvatekniikan keskus, TUKES) and transferring the tasks of the earlier association-based organization under its authority.

The active juvenile phase in the promotion of the electrical safety system starts with the establishing of Inspection Centre for Electrical Installa-

tions (Sähkötarkastuslaitos) and continues to the 1960s. The phase of maturity stretches from the 1960s to 1985, when criticism towards the system begins to increase. The system lived its declining phase from mid-1980s to mid-1990s, when many of the central operators within the field failed to see the need for change. It was difficult to let go of the long-established system in which so many individuals had made great personal efforts for creating and developing the system.

The association-based system has included numerous unique features. The responsibility for electrical safety was largely carried by the operators within the field. At the same time, the administrative model meant that the surveyed companies and other operators had the possibility to control the contents of surveillance. However, there was no public criticism against the administrative model questioning the ethics of its operation.

A strong network of associations, companies, and the surveying authorities has prevailed within the field of electrical safety, and this explains the development of the administrative model. In electrical safety, social capital is a force comparable to institutions, maintaining continuity and explaining the established practices and solutions.

The authority of the association-based electrical inspection institution Inspection Centre for Electrical Installations was extensive especially after 1957 when the ministry enforced their right to issue binding application instructions.

Typically, changes in regulations and organization have especially caused crises in the discussion within electrical safety governance. The threats have not materialized. However, on the basis of our material, at least the changes in the governance made so far have actually improved rather than deteriorated electrical safety. Discussions on electrical safety were lively in conjunction with the transfer to market control in mid-1990s. In this respect it can also be said that the threats have not been put forth.

With Finland's EU membership the electrical safety administration model became merged with the international system. It should be noted, however, that from the point of administration even more important than EU membership was the EEA agreement. Through regulations it defined, for instance, the conditions of entering the market in a way that ended the system based on preliminary inspections. The changes in governmental regulation and operating principles have been adopted almost as such among those working within electrical safety governance, without any significant changes in social relations. For instance, the stricter regulations introduced in the 1980s were primarily considered an existing fact. The Finnish electrical safety governance is not a passive, receiving party in the

EU system. It participates in the development of directives, but also affects other member states through the example of its organizational solutions.

The EEA agreement defined the introduction of products to the market of the area. Free movement of products within the market was allowed after ensuring their conformity to the requirements through initial inspection that is the manufacturer's responsibility. The system is based on initial inspection of products and on market control as well as control of use and conditions. The starting point of the EU system is that due to effective initial inspections there are only safe products on the market. Initial inspection requires, however, complementary operations. Therefore, the authorities have been secured the possibility to intervene in case of such safety risks that have not been possible to foresee in the manufacturing stage.

Some product risks are not revealed until the product has been in use for some time. The products conforming to the requirements of the Community can be identified by the CE label attached to them by the manufacturer (TETAKO 1992, 24-25). The CE label does not, however, offer information for the consumer but for the authorities. It is the manufacturer's indication that the product meets the EU requirements.

Segregated control responsibility

In the EU system, initial inspections are carried out by independent institutions notified by the states, and their actual technical inspection operations are open to competition. The government is responsible for the competence of the notified institutions, and this can be verified using, for instance, accreditation. Thus, the inspecting institutions can be public or private. In Finland, the development of technical infrastructure belongs to the Ministry of Trade and Industry (vnp 3.12.1992). These include calibration and metrology systems, test laboratories, inspection and certification institutions, and systems for verifying competence. The basic systems are complemented by technical standards.

Market control, on the other hand, means the procedures used by authorities for supervising the operation of initial inspections through examining products that already are on the market. Preventing the access and movement of non-conforming products on the market is in the EU system the responsibility of the member states that nationally organize the authority for market control.

With the responsibility of initial inspections transferred to the manufacturers, the role of the authorities in market control is emphasized. The responsibility for market control is, thus, with the authorities, but market surveillance is also participated by, for instance, the competitors, citizens'

organizations, and customers. In Finland the system for market control had to be created by the time the EEA agreement came into force, i.e. by 1994.

In market control the authority plays a central role in building up the consumers' confidence in products. This did not call so much for a tight decision-making system based on interaction and social capital but more so a control system that is functional, independent, and reveals deficiencies. During 1994, the market control system was started off by making about 3000 business visits and actively informing the consumers. Being a new EU member state Finland was a pioneer in market control practices. The Finnish system was not directly based on the system of any other member state.

The control of use and conditions means all other surveillance included in technical inspection operations except product control. It is directed to installations, working and environmental conditions and use, as well as the pursuit of operations. The control of use and conditions is a task for the authorities and it includes technical inspections that can be transferred to public or private inspection and test institutions with verified competence (TETAKO 1991, 3).

Segregating commercial and authoritative tasks

The Finnish Government concluded in 1992 a decision of intent that the authoritative tasks and the technical inspections and testing shall be segregated. *Technical tasks* can, according to the committee, be limited to operations that are presupposed in regulations or decrees. These include approvals and inspections for ensuring the products' conformity to the requirements or for implementing the control of use in different production processes and machineries. A company or institution carrying out technical tasks may act as a 'third party', and is not using public authority. This enables the user of services to decide, which of the companies or institutions with verified competence they will choose.

Authoritative tasks, on the other hand, have always been stipulated by laws in Finland. These tasks are ordered to be carried out by an organization, and the authority cannot transfer any tasks to a third party. An organization carrying out authoritative tasks is using public authority, and it possesses the necessary authority and coercive means. Also the fees they collect are based on stipulated regulations.

An administrative procedure enforced by law is followed in authoritative tasks. The objective is that the citizens' rights and obligations will in the decision-making of the administrative authority be given the form intended in the law. Authoritative operations may be given other kinds of re-

quirements regarding the gathering of information needed for decision-making, ensuring impartial handling, and implementing the service principle. (Cf. e.g. Syrjänen 1996, 147-148).

Regarding Inspection Centre for Electrical Apparatus (SETI), the committee delegated to review the case defined their authoritative tasks as follows: preparation and issuance of norms, control of use regarding the holders of electric machineries and elevators, surveillance of the installation inspections by electricity boards, granting of qualification certificates to supervisors of electric work and use, and market control. Furthermore, it defined SETI's authoritative tasks to include the granting and revoking of certain permits to electric designers as well as electric and elevator contractors, as well as the surveillance of contracting and the maintenance of registers.

The technical tasks are significantly different. Several companies and institutions may have the required competence and it is usually verified by accreditation or certification. This enables competition in the implementation of technical tasks. The supplier of services may be a private or a public institution, and they set the prices of their services independently.

A committee defined the technical tasks of SETI to include the commissioning inspections of electric and elevator contractors, the periodic inspections of the holders of electric machineries and elevators, the testing, certification, and type inspections of electric appliances, as well as the inspection of lifting devices and ski lifts.

Angle of view shifting from safety to efficiency

A law that came into force early in 1902 presupposed that "electric plants operating with electric current of so high voltage or otherwise of such quality, or being located in a such a place that the plant may cause danger to life or property, shall be provided with special surveillance" (translation). In the current laws on electrical safety from 1966, the same objective is expressed so that "electric appliances and machineries shall be designed, constructed, manufactured, and repaired, and they shall be maintained and used in such a way that they do not cause danger to anybody's life, health, or property" (translation).

After the Second World War industrialization was rapid in Finland. An indication of this is that the volume of industrial production in Finland grew almost sixfold in 1948-1979. The increase in the use of electricity followed the development of industrial production, and in the course of the same period the electrification of all households was practically completed. The development was accompanied by a strong structural change. The per-

centage of those working in agriculture and forestry dropped by ten percent in the 1950s, and by seventeen percent in the next decade. The public administration system aimed at guiding, regulating, and building up an infrastructure for the society and the economy.

Common to the laws from these different periods is their aim to manage electrical safety. According to Veli-Pekka Nurmi, electrical safety is created through the identification and prevention of hazards, and even with the development technology the basic factors are unchanged. The hazards are electric shocks and electrical fires, and their occurrence can be affected by the actions of human beings. According to Nurmi, electrical fires may be caused by faults in design or manufacture, incorrect installation, insufficient maintenance, and wear, or improper and careless use. Poor connections and components are also sources of hazard. (Nurmi 2001, 7-17).

Market control in Finland today involves all products in the country on equal grounds, which had a part in defining the centralization solution implemented in mid-1990s. Legislation has been further developed so that the authorities have the possibilities of surveillance and the necessary coercive means at their disposal. Market and customer guidance has strengthened, which was one of the objectives filed by the committee.

From the point of electrical safety, this development has meant a shift in emphasis from the surveillance of safety towards securing the competitiveness of companies and ensuring the access of Finnish products to the European market. On the other hand, the reliability of the system shall ensure the safety of products, which is a prerequisite for Finnish products' access to the market. Thus, the objectives of competitiveness and safety can be simultaneously realized. At least three factors can be found for the development of electrical safety governance.

The first factor is the securing of the position of Finnish industry with trade political means. The emphasis on trade political angle of view is understandable in the social situation of the early 1990s. Finland was in deep recession, and the trade political angle of view guided the legislative solutions. Finland did receive an inspection system conforming to the EEA agreement so that Finnish products could compete on the common market. Objectives in accordance to it were also valid when Finland joined the EU in 1995.

The second factor is the search for solutions that are in line with the changes in administration. The amendments aimed at a solution where the ministries no longer would act as the surveying authority, and the task of surveillance would primarily be transferred to local administrative authorities or other units of the central government.

During 1990s there were repeated attempts to develop the ministries into strategic centres and headquarters of the government. Therefore, administrative routines should be carried out either in units of the central government separate from the ministry, or in local administration. If the operation in the field requires specialization and unified practices, a centralized solution is founded. According to the idea of decentralization, decisions should be made as close to the customer as possible, and unnecessary handling of issues in multiple stages should be avoided. What speaks for a local solution is that the operation requires local expertise or close connections to the customers. Of the guiding systems especially output guiding has also decentralized administration. In other words, there have been major plans for renewing central government, such as the proposal on transferring to a single stage administrative model, and the state corporate project, but the big plans have shrunk to smaller practical development operations.

Thirdly, besides external factors, reasons for the solutions that were made can also be sought in the very nature of the operations. The reason behind the reformation in the mid-1990s was partly the general aim to make the operations more effective through organizational solutions. On the other hand, the financing structure of SETI was more and more based on commercial operations. Alongside this it was necessary to maintain the authoritative operations that were clearly distinct from the commercial side in decision-making as well as budgeting.

The basis for the present system lies in the EU directives enforced through national legislation. Each EU member state defines independently what kind of organizations are taking care of the obligations to implement the Community laws in their own country. This is a central principle because according to the founding agreement of the Community the implementation of Community level decisions belongs to the member states. The TETAHO report on electrical safety also puts forth the general principle that the member states can decide themselves how they administratively arrange the implementation of their responsibilities arising from Community laws. A member state cannot, however, deviate from the distribution of tasks between the controlling authorities and the notified institutions as stated in the directives.

The European Union directives do not define what kind of organizational model is used for implementing the union's objectives; it is an internal matter of each member state. The Community directives presuppose only that each member state arranges surveillance in a proper manner (CIM).

In the new situation, the organizational solution for segregating the control and inspection operations was created first, and the new Electrical Safety Act was passed after that. The law on TUKES was passed in 1995, and the new Electrical Safety Act in 1996. Central to the arrangement of authoritative operations, the law on the CE marking (1376/1994) was passed already in 1994.

The second paragraph dealing with the level of electrical safety[1] contains the objectives placed for electrical safety and they are described briefly as follows (source: Safety Technology Authority TUKES):

> **Section 5**
>
> Electrical equipment and electrical installations shall be designed, constructed, manufactured and repaired, and serviced and used in such a manner that:
>
> 1) they are not hazardous to life, health, or property;
> 2) they do not cause excessive electric or electromagnetic interference; and
> 3) their functioning is not easily disturbed by electric or electromagnetic interference.
>
> **Section 6**
>
> The Ministry shall issue the provisions and regulations necessary to eliminate the risk of interference referred to in Section 5.
>
> **Section 7**
>
> The Ministry may provide that the provisions on electrical equipment contained in this Act be applied to certain electical installations comparable to electrical equipment because of its method of manufacture or use.

The Electrical Safety Act of 1996 was passed as a general act in the way presented in TETAKO (1992, 29) so that the enforcement and amendments of the technical contents of the directives could be implemented using statutes and decrees of lower level than acts. This was necessary because the

[1] The requirement included in 5:1 § of the law is extremely strict. It contains the idea that all hazard situations caused by electricity are considered to be against the law. This applies even to situations where nothing happens. Merely to cause a hazard is forbidden by the law.

EU directives could be divided in legislation between several acts and statutes, decisions by the Council of State, ministries, central administrations, and inspection institutions, as well as standards approved by the Finnish Standards Board. And, indeed, SESKO published in 1999 in co-operation with the Finnish Standards Association (SFS) the SFS standards concerning low voltage installations and electrical safety. They replaced the earlier regulations by Inspection Centre for Electrical Apparatus. The preparation of laws and the issuance of regulations binding the electric field of operation was now a task of the Ministry of Trade and Industry.

Founded on 1.11.1995, the Safety Technology Authority (TUKES) was a new Government office for handling tasks concerning electrical safety and other matters of technical safety, and all the authoritative tasks previously handled by Inspection Centre for Electrical Apparatus and The Centre of Safety Engineering were transferred to it (Parliament HE 89 – 1995 vp). According to its authoritative task, TUKES surveys the realization of electrical safety in Finland and the operations in the electric field of business. Among the central tasks transferred from SETI to TUKES were the surveying and authoritative tasks concerning electrical safety and the issuance of administrative instructions clarifying the regulations.

The technical inspection tasks related to electrical safety are carried out according to the decisions of the Ministry of Trade and Industry (Cf. TETAHO 2002, 68). They define the aimed level of safety, but the models of solution for reaching the level of safety are defined elsewhere, primarily in standards.

An evaluating institution notified by the Ministry of Trade and Industry grants qualification certificates. TUKES grants qualification certificates that give the right to operate within the area of qualification stated in the certificate (MTI 516/1996)

Return to remote government control

In the Grand Duchy of Finland the use of electricity spread rapidly from the 1880s onwards. The needs of industry and households began to emerge and they created a market for new products. In this sense the "Tsarist Age" was not at all stagnant. This is reflected in many details in our material. Since the 1890s documents are widely written using a typewriter, and at least since the 1910s the central terminology is beginning to be established in administrative use. The authorities responsible for electrical safety administration allow the operators within the field to define their own ways of operation, and public administration secures the practices with legislation using very general terms. The authorities are not in any significant way

preventing the transfer of international influences to electrical safety work. What is said above contains many features that are characteristic to electrical safety governance in Finland in the early 21st century. Electrical safety is largely based on practices created within the field itself, and these are secured by general legislation.

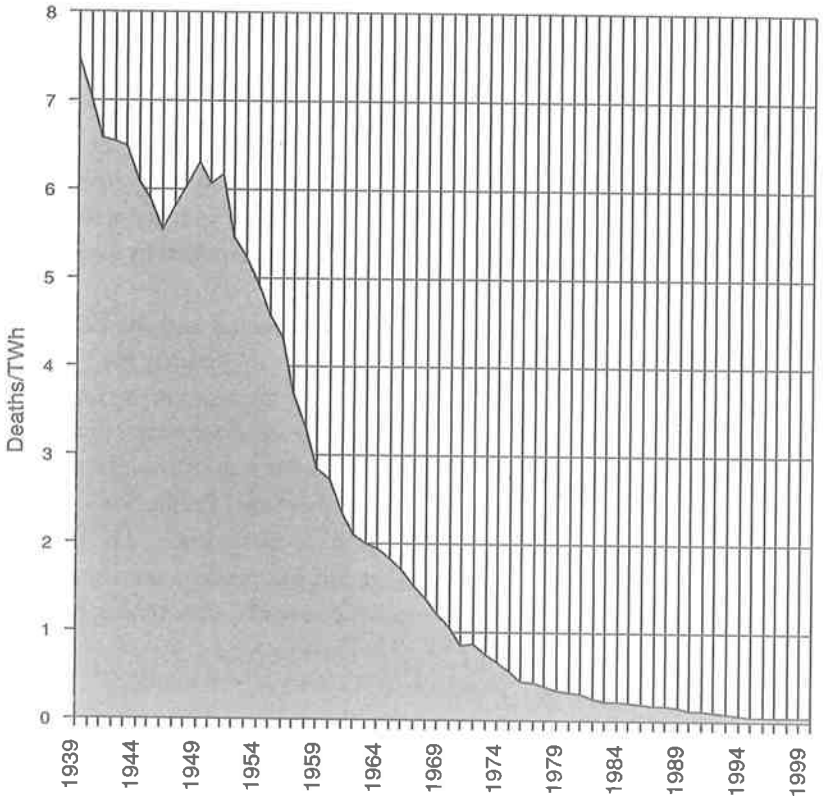
The electrical safety system in Finland has clarified since mid-1990s, when authorities lower than the ministry were deprived of the right to issue obliging norms. In practice, the norms that had been issued by lower than ministry level authorities and that were desired to stay in force were transferred into decisions by the ministry. The other norms issued by authorities lower than the ministry were revoked.

In questions of electrical safety the State of Finland and the European Union represent the public authority. The means they utilize for reaching the objectives are not restricted to legislation but means of many levels can be used for control. The means of the Community are statutes, directives, decisions, and recommendations. Executive power and the right to issue norms, on the other hand, lie with each member state. Public control is directing the choices of companies and citizens at many levels. The amount of controlling material is so extensive that it is not possible for a single operator to handle and fully manage even the material concerning his own field of operation (Cf. Harisalo 1997, 12-13, 65).

Alongside legal norms, standardization and quality policies complement legislation by creating comprehensible and applicable entities out of extensive objectives. Standardization and quality policies are, thus, promoting the objectives of good governance. However, Governance in the early 21st century starts with the paradigm that to achieve objectives, quality management is a more effective and faster way than obliging regulations. In the development of inspections you can see how enterprising reflects industrial corporatism and the tendency towards self-regulation on the basis of guilds. This is where standardization system and quality policies are needed today. The Electrical Safety Act of 1996 passed as a general law, and the extensive self-regulation within the field have created the framework for modern corporatism.

EEA membership and Finland's possible EU membership, and the development necessary for the field forced the centralized organization of Inspection Centre for Electrical Apparatus to be dissolved. Other than administrative factors have also affected the number of fatal electric accidents, as shown in the attached diagram. Of the isolated factors we can mention that the construction work related to the 1952 Olympics increased the number of fatal accidents. The reason was partly the use of unskilled labour

Fatal electric accidents in Finland 1939-1999 (Source: TUKES).



in construction work. Similarly, the increasing number of mobile cranes in the early 1960s also resulted in more fatal electric accidents. Increasing awareness of electric hazards, the decrease of downright negligence, and technical solutions increasing electrical safety have decreased the susceptibility to accidents over the whole century. In the past 50 years, the number of fatal electric accidents has not increased under any model of electrical safety governance.

During the different models of electrical safety governance safety has, however, increased if the number of deaths and accidents caused by electricity is used as the indicator. Electrical safety seems to have developed for a number of reasons irrespective of administration.

The Governance in Finnish electrical safety generated during 1990s returned to its roots a hundred years back if we consider the fact that cooperation between and voluntary action of operators within the field, i.e. a

model of operation based on social capital, is again emphasized as the basis for organizational solutions. This tendency is supported by the general law of 1996 that does not go very deep into detail.

New governance emphasizing effectiveness and consumer's status

The essential feature of the present system is that the evaluation results by notified institutions are also acknowledged in other member states according to the reciprocity principle. Thus, a member state cannot prevent the introduction of products that have been properly evaluated and verified to conform to the requirements as demanded by the relevant directive. The system promotes the movement of goods within the union and also enables competition between the inspection institutions notified by the member states. The institutions notified by the Finnish government are able to offer their services in other member states and the institutions notified in other member states can do the same in Finland. In addition, the EU and countries outside it have reciprocity agreements based on the so-called MRA agreements and PECA protocols. Thus, the evaluating institution can be located, for instance, in the Czech Republic, Hungary, the United States, Canada, Australia, or Japan (TETAHO 2002, 33).

In the early 21st century one of the tasks of the surveying authority is that the operators within the field trust each other through following the electrical safety regulations. The authority will also observe the consumers trust in electric products. This presupposes not only functional surveillance but also the distribution of more and more information on electrical safety among operators as well as consumers within the field. The above means that the authority has the responsibility to promote electrical safety using the available means, although the main responsibility for ensuring the safety of the devices has been transferred to the manufacturers.

At the moment, sovereignty of the consumer and efficiency are the central factors forming the governance of electrical safety. The consumer's views are esteemed in all respects, in the foundations for decision-making as well as in service practices in the form of customer-orientation. Arguments will change with the times, and the governance receives its foundations from new factors. It is also clear that risks are involved in the system in a situation where high consumer safety and, in accordance to market control, the producers' own responsibility are simultaneously emphasized. There is a threat, that if hazardous products enter the market in great numbers, the credibility of the whole system will be jeopardized. Typically such situations are tackled by increasing the strictness of control or by adopting higher sanctions for breaches.

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Harald Siem

Task Force on communicable disease control in the Baltic Sea region

Michael 2004: 1; 315–9

Enormous changes have taken place over a relative short period of time in the former Soviet states. The transition in the economy, the disappearance of old authorities, in part a loss of law and order and poverty were reflected in a fall in life expectancy, and increases in morbidity rates, for example a rise in the incidence of tuberculosis. This gave reasons for concern, also in the Baltic Sea region. In addition, the HIV virus made its entry into former Soviet states in the nineties.

The concern that was expressed by the professional community led to an extraordinary move. Eleven prime ministers and the president of the European Commission, at the biennial summit in Kolding, Denmark in April 2000, decided to establish a Task Force on communicable disease control in the Baltic Sea region, of special representatives for the prime ministers and the president. Its mission was through concerted action to reduce the risk and burden of communicable diseases in the region. Norway, then chairing the Council of the Baltic Sea States, CBSS, volunteered to chair the Task Force, and to establish a secretariat.

It took the Task Force half a year of consultations and deliberations to decide on a work programme, which then became the basis for project development. Six programme groups, on surveillance, HIV, tuberculosis, antimicrobial resistance, primary care development and prison health support were established, and technical advisers mobilized. Standardized projects were designed and implemented in all six programme areas, all monitored through a common database. The Task Force initiated collaboration on training in public health, and on health sector reforms. In all, 138 projects were under implementation or completed in the spring of 2004. Direct project support was close to 10 million Euros. The same estimated amount of funds are used for networking, training, technical advisers, secretariat and evaluation.

More information is available at the homepage *www.baltichealth.org*.

On the 6th Nordic-Baltic congress on infectious diseases in Palanga, Lithuanid 3-6 June, 2004, there was a session where the Task Force activities were summed up. The picture shows Ambassador Harald Siem in front of his audience. (Photo: Ø. Larsen)

Lithuania is a country with obvious potentials, not only on the regular tourist market, but also as a place for international conferences. Still, the international airport in Palanga, near the city of Klaipeda and the famous sandy shores, look rather domestic. (Photo: Ø. Larsen 2004)

What did the Task Force achieve?

The incidence rates for HIV and tuberculosis have flattened out or are declining at the end of this period (Fig 1 shows the incidence rates for TB). The direct impact of the Task Force can not be quantified; the changes to the better happened after strengthened efforts from the local authorities, and coincide with overall improvement of socioeconomic indicators. But the added effect of the Task Force is plausible.

National guidelines have been changed on tuberculosis control and antimicrobial resistance, surveillance has been strengthened, primary health care professionals have developed wide networks and collaborated on guidelines in the field of communicable diseases, and prison health improved, both as to improved routines in prisons, better hygiene and collaboration with the civilian sector. A permanent secretariat for the Council of the Baltic Sea Public Health Training Network is established in Estonia, work is underway to establish pilot areas for health sector reform in Lithuania, Poland, Russia and Norway. Extensive training in project planning and management has been given.

The Task Force has contributed to high political awareness of the problem in respective countries, of HIV/AIDS, tuberculosis or other communicable diseases, to changes in national neighbourhood cooperation policies and funding, and to increase in national budgets to combat communicable diseases.

One further aspect of the work was related to the enlargement of EU in May 2004, when the 'political geography' of the whole area changed. In this sense the activities of the Task Force have been guided to support accession priorities as well as encouraging the collaboration with the Russian Federation, as the frontier with EU became longer.

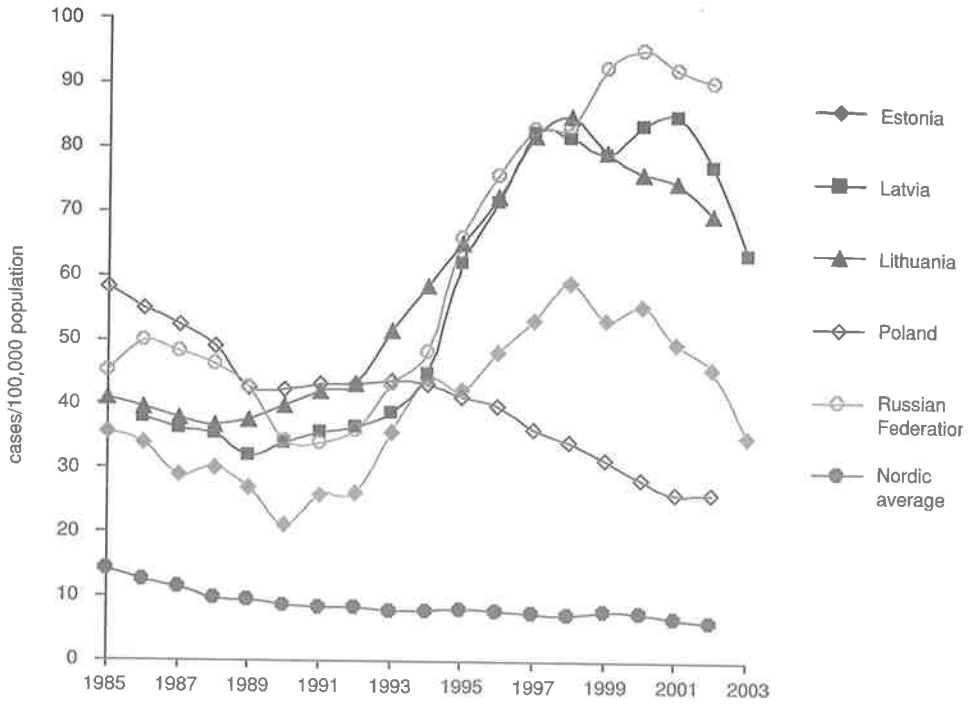
Evaluation

The Task Force collaboration has been evaluated under the oversight of a Steering Committee, with members from the London School of Hygiene and Tropical Medicine, The Moscow Medical Academy (Sechenov) and the Fridtjof Nansen Institute in Oslo. The evaluation has taken three approaches, looking at the political context, the programme areas and selected projects. The use of the database, and the monitoring of the database is a forth element (1, 2, 3, 4,).

What will be the follow up after the Task Force?

The available information on the burden of communicable diseases in the Eastern part of the Baltic Sea region strongly suggests that more needs to be

Figure 1: Tuberculosis incidence in the Eastern Baltic Sea countries per 100,000 populations. Early data for Russia for 2003 give an incidence rate of 70, confirming the positive development.



Source: (WHO Europe 2004); 2003 data provided by chief epidemiologists. Note: 2003 data are provisional.

done to contain these epidemics. Although the number of new cases may now be falling, the number of people living with HIV/AIDS continues to rise. The registered rates of new tuberculosis cases have stagnated, but are still unacceptably high.

A wide and well functioning network has been established, on the political level as well as the practical and professional level. These networks must be maintained, and preferably widened. The future collaboration will probably be less in the shape of project support and funding, as the economic indicators improve. Technical collaboration, common understanding and mutually supportive strategies, and acting through established

networks, will probably be the core of the future collaboration of communicable disease control in the region.

The Task Force has also laid the basis for collaboration at the political level, and this is already reinforced through the initiative of EU Northern Dimension Partnership in Public Health and Social Well-being, in which the networks created within the Task Force framework are of importance. The partnership framework will cover future expert groups on HIV/AIDS, antimicrobial resistance, primary health care, prison health, and possibly tuberculosis. The Council of the Baltic Sea Public Health Training Network and the work on health sector reform will also fall under the Partnership. The Task Force database for project oversight will be adapted and used in the future collaboration.

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Book review:

Health as international politics

Hønneland G, Rowe L. Health as International Politics. Combating Communicable Diseases in the Baltic Sea Region. 119 pp. Aldershot: Ashgate, 2004.

Health as International Politics tells part of the story of one of the many Western initiatives to help countries in the former Soviet Union combat communicable diseases, in the present instance tuberculosis and HIV/AIDS, besides improving primary health care. The countries involved were Estonia, Latvia, Lithuania, Poland and Russia, and the initiative was properly named the Task Force on Communicable Disease Control in the Baltic Sea Region (the Task Force for short), launched by the Council of Baltic Sea States, of which Norway is a member. By coincidence, which is explained in the book, the initiative and the driving force happened to come from Norway, not least due to the efforts of Mr. Jonas Gahr Støre, who drew on his experience from the World Health Organization. The enterprise lasted from 2000 to 2004, with a final report to be presented at a meeting in June 2004. As the present book was written toward the end of 2003, the overall verdict has to be sought elsewhere, but the book still contains enough interesting observations and discussions to make reading it worth while. It does not give an overall view, as the authors Geir Hønneland and Lars Rowe of the Fridtjof Nansen Institute made up one of several evaluation teams. Their contribution is the so-called "contextual evaluation", or the sociological approach to the international relations inherent in the Task Force efforts.

Following an introductory chapter, the authors go on to describe the establishment and organisation of the Task Force, emphasising that its purpose was not solely medical, but also an attempt to help "build up" the Baltic Sea region by promoting inter-regional collaboration, and not least to strengthen Norwegian foreign policy, which needs this kind of boost in its relative isolation outside the European Union. The Norwegian dominance in the Task Force turned out to be an impediment, as the collaborating partners and potential donors were reluctant to contribute substantially to what they perceived as a lopsided enterprise. Consequently, most

of the money came from the Norwegian government. To obtain funding for each of the nearly 200 individual projects proved to be difficult. Another problem concerned with recruiting Task Force and local project collaborators from the target countries was the condition of mastering the English language, which precluded otherwise qualified persons.

The authors based their evaluation on interviews with 96 persons who were directly involved in Task Force establishment and activities, most of them from Russia and the three Baltic countries. The methodology is described as qualitative research. In the presentation, the identity of the individual interviewee is not revealed. In the chapters on Western versus post-Soviet medicine and the Task force impact in the post-Soviet area, different opinions are voiced and in some instances quoted verbatim. This is the most interesting part of the book, the core example being how a new strategy for detection and treatment of tuberculosis was received and implemented. The acronym is DOTS, a WHO-inspired approach which stands for Directly Observed Treatment with Short-course chemotherapy. This requires increased effort on the part of the primary health care sector and a corresponding down-playing of the sanatorium philosophy with supplementary use of lung surgery, which is still the basic approach in Russia. Another clash of the cultures was apparent when the Task Force attempted to extend its strategy to prisons, where spread of serious contagious diseases is rife, but which is a world within a world, governed by its own rules and regulations. Why waste money on criminal outcasts when it can be spent on law-abiding citizens? The authors display the whole set of reactions, ranging from rejection-in-disguise to enthusiastic acceptance and willingness to collaborate. The latter was more noticeable in the Baltic Sea states, whereas the Russians had a more reserved attitude to Western attempts to change traditional systems. An overriding reaction was to view the problems addressed by the Task Force as an imposition.

Network building proved to be an unanimous success. Closer contact with people from other parts of the region led to exchange of ideas and expertise among medical communities with different traditions. Sustainability is another key word in this kind of activity. Will the efforts to change things remain, have a snowball effect, or will people and things revert to old traditions? Time will show, but since the Task Force was not the only outside enterprise of its kind, it will certainly be difficult to sort out cause and effect.

The authors confined themselves to evaluating the organisational aspects of the Task Force. I found the book interesting reading, but missed a description of single projects, if only confined to titles and number and ori-

gin of collaborators, which would have enriched the contents and understanding of what actually happened during the four years of Task Force existence. Four years is a short term for a multi-targeted programme embracing five countries, two of them with vast expansion and multiple regions. Any impact, however small, is to be congratulated.

Style and language are good. I presume that Health as International Politics will first and foremost appeal to political and social scientists plus historians. Among the medical community, it may interest those engaged in international health. Representatives of prospective donors, whether governments or non-governmental organisations, may avoid future mistakes by reading it.

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The ruin of the cathedral in Tartu, Estonia, is a proof that it is possible to stand upright even if all support and suspension have been taken away. Something for a political interpretation? (Photo: Ø. Larsen 1994)

Juris Salaks

Book review:

Task Force as seen from the Baltics

Hønneland G, Rowe L. Health as International Politics. Combating Communicable Diseases in the Baltic Sea Region. 119 pp. Aldershot: Ashgate, 2004.

The book *Health as International Politics* is a result of an evaluation of a major health initiative recently undertaken in the Baltic Sea Region – the work of the Task Force. The public health situation in Russia and the Baltic countries is sending out alarming signals to bordering countries, e.g. when it comes to communicable diseases. *Perestroika* changed not only the political map of the region, but also revealed old and generated new public health problems which alerted monitoring institutions in Western Europe. The initiative for combating communicable diseases that resulted in the creation of the so called Task Force for Combating Communicable Diseases (Task Force) in the Baltic Sea Region, was taken and supported on the highest political level ever seen before in the countries involved.

The introductory chapter in the book *Health as International Politics* by Geir Hønneland and Lars Rowe provides an overview of international collaboration in the field before the Task Force initiative was launched, and describes current regional activities, as well as gives an overview of health as a public good – particularly focusing on the DOTS concept.

Chapter 2 contains a description of the establishment and organisational structure of Task Force. Inception of this health care initiative was done by Norwegian prime minister Jens Stoltenberg on March 17, 2000 and resulted in signing of the agreement between all governments heads in the Baltic Sea Council, with Norway making the largest contribution. Finances for start-up were allocated and a secretariat with high level political support opened its office in Oslo. The secretariat provided all necessary support and sat out objectives for all experts involved. The Task Force itself was managed by the Secretariat and the so called Group of Senior Health Officials.

Initially, five programme groups were established for the fields Surveil-

lance, Tuberculosis, HIV/AIDS, Antibiotics and Primary Health Care. Due to alarms regarding communicable diseases in prisons of the former Eastern block, the Prison expert group was also established.

International Technical Advisors (ITA) were introduced into the organisational structure of Task Force. ITA ensured technical and logistic support to the members of programme groups and to the projects.

Health as International Politics by Geir Hønneland and Lars Rowe includes comments giving insight to the perception of the commitment within Task Force. These comments are based on interviews with members of Task Force and project leaders.

The chapter on *Western vs. Post-Soviet Medicine* includes the feedback to the initiative in Russia and Baltic countries, where e.g. the DOTS (Directly Observed Therapy Short course) strategy faces criticism by leading Russian experts. They claim that such strategies are not acceptable for Russia's setting and they are reluctant to mnemonics like DOTS. Considering DOTS as a starting point, we can explain the distrust of Russians, when they disapprove of 'magic formulae' of the West, but this points to a different understanding of public health issues in general.

Next chapter describes the impact of Task Force activities in the post-Soviet area. Interviews conducted in Baltic countries indicate that the Task Force initiative came in the right place at the right time. However, the health care systems of three countries were marred by fifty (not seventy as stated in the text) years of Soviet rule. Moreover, the emphasis is put on the description of the new strategies of the primary health care system, which is strongly believed to be the main tool for future control of communicable diseases.

As mentioned above, the book *Health as International Politics* is based on interviews performed in 2003 when Task Force activities were yet to finish, and the interviews were aimed to evaluate Task Force operations. The conclusions are found in the final chapter, and they assess the results as very intriguing and interesting.

Two distinct categories of informants are defined and described, providing the reader with the broad range of attitudes held by people involved in Task Force activities, followed by their interpretation of revisiting regional relations, East-West relations and of Task Force itself, to evaluate the development and impact following the initiative by prime minister Jens Stoltenberg, which induced the other government leaders of Baltic Sea Region countries to join in.

Being an outside observer of the Task Force and its activities in the Baltics, I have got a clear impression that we must not underestimate the

impact of Task Force activities by any means. It has definitely been one of the major events in the history of medicine in the region, first of all by creating new networks for further collaboration.

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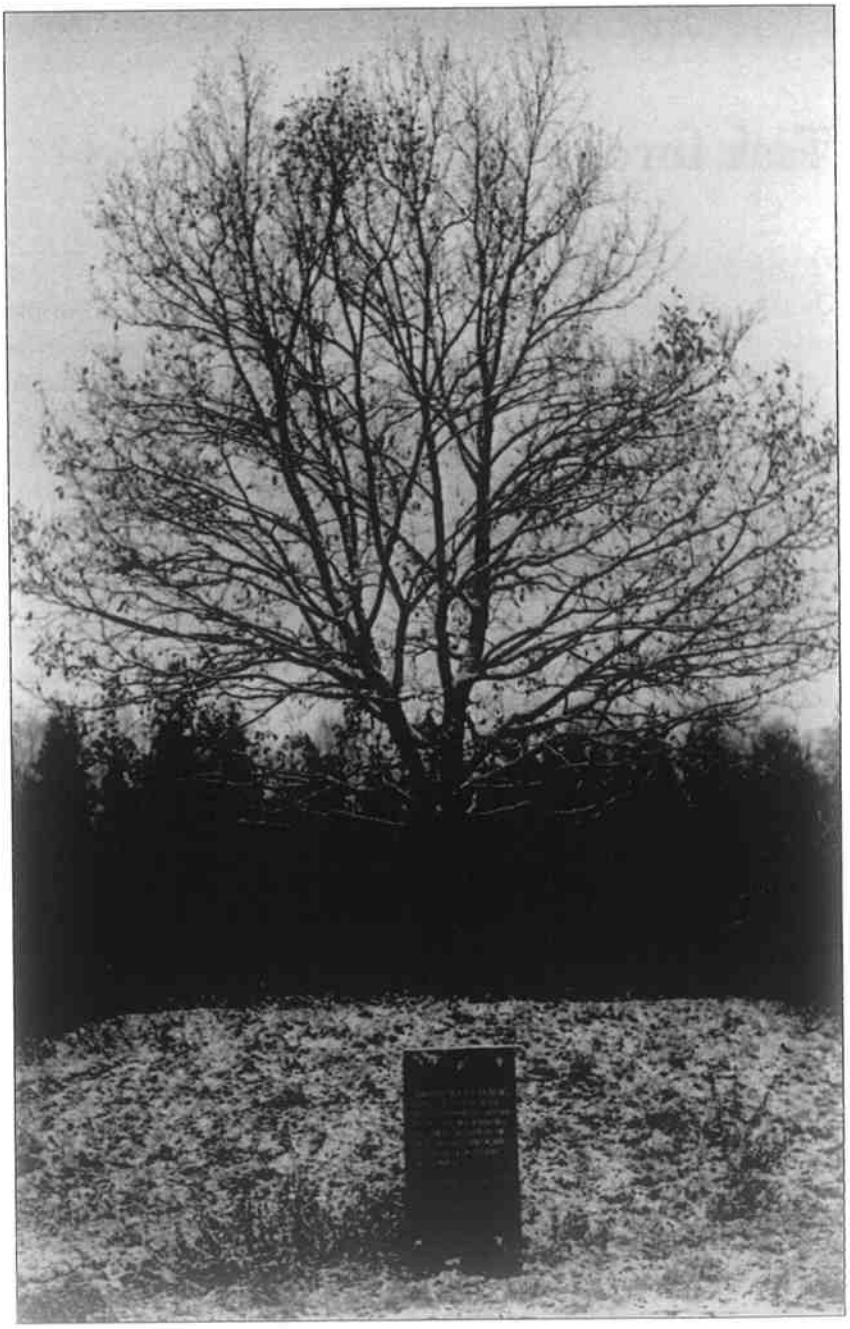
Borders

Borders in Eastern Europe have opened up, offering new potentials for development. However, when seen from the outside, it is easy to forget that borders still are there. And some of them even have gained in importance after the split up of the Soviet Union. Therefore, this picture of a small artificial elevation on the ground with a tree growing on the top in a sort of a park, situated deep in a forest, should have special interest. The place is called Draudzibas kurgans, which in Latvian means the friendship mound. Here monuments commemorating partisans of the Second World War have been erected, and veterans gather every year. But just where the tree stands, the borders of Belarus, Latvia and Russia meet. Now these borders in the former Soviet wilderness separate three countries with quite different political systems. (Photo: Ø. Larsen 2003)



Øivind Larsen

Task force evaluation revisited

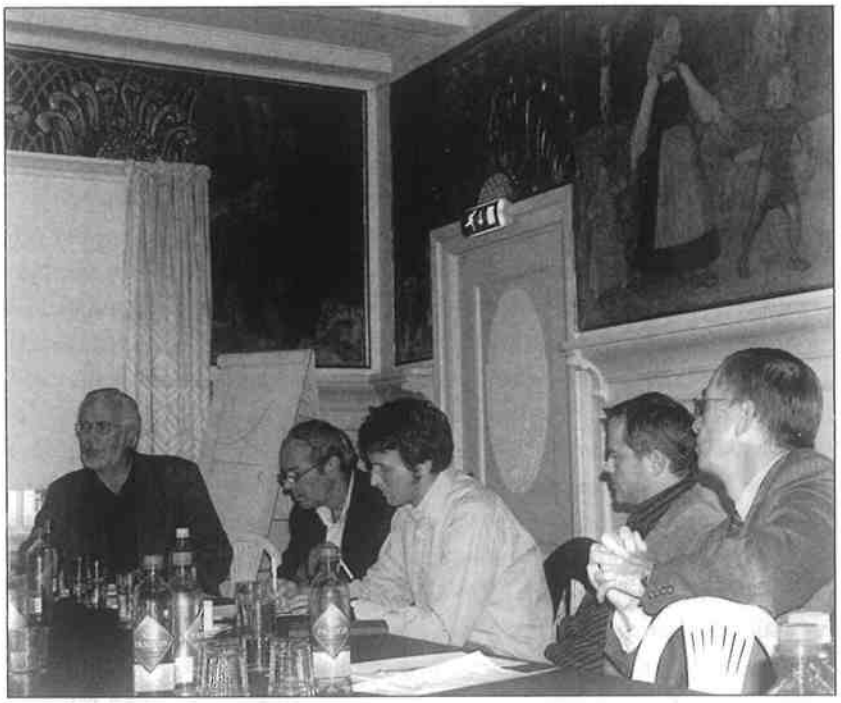
Michael 2004:1; 328–31

On crisp and sunny September 30, 2004, fifteen people gathered in the subdued light of the halls of prestigious Fridtjof Nansen Institute outside Oslo. The agenda was to discuss the Task Force on communicable disease control in the Baltic Sea region, a three year venture including eleven countries and engaging more than one thousand collaborators (1). The institute has its premises in the old villa Polhøgda where the explorer, scientist, diplomat, politician and Nobel laureate Fridtjof Nansen lived and worked. The venue of the meeting was his dining room, a hall lavishly decorated in 1907 with fairy-tale motives by the famous painter Erik Werenskiold. It was probably unintentional that the group had allegories above their heads which easily could be reinterpreted according to the topic of the meeting: A Nordic looking lady guiding small children with a brown bear lurking in the background.

The organisation and administration of the Task Force had in some ways been different from that of other collaboration efforts, aiming at a strong and committed local participation. And in fact, 223 small projects had been locally proposed by means of a standardised system, the so called Logical frame Approach (LFA) (2). A large number of the projects, 138, were really successfully carried through, many with obvious lasting value and bearings for future work.

The Task Force had been subject to thorough evaluation during the process (3-6), so that ample material was at hand when the work was concluded and the final report could be presented to the prime ministers in the Baltic Sea region, who had taken the original initiative (7).

The Task Force report can also be seen as a contribution to discussions about organisation and outcome in international collaboration; this meeting being one of the arenas. There were three introductions. The first was given by the Task Force leader Harald Siem. He gave a short outline of the project and the differences between traditional organisation and the Task Force principles. The general idea of the Task Force was to secure a system where on the road from supplier to receiver, most of the resources were spent on the receiving side, not on the donor side or lost to local bureau-



Under the fairy-tale: From left are seen: Peter Johan Schei, director of the Fridthjof Nansen Institute and chairman of the meeting, Steinar Andresen, Lars Rowe, Geir Hønneland and Anders Seim. (Photo: Øivind Larsen)

crats in between, a fate often experienced in international work. His sketch illustrating this point can be seen on our photograph just below the bear, no comments on that.

Lars Rowe, historian and researcher from the Fridthjof Nansen Institute and co-author of the principal evaluation (6), summarised the interview-based evaluation of the large project, where 20 million Euros had been spent, (8,4 million on direct project support!), 65% of this covered by Norway. His well-balanced talk concluded by giving the project, its organisation and its administration a mark from the Norwegian schooling system, M-, which should be compared to a B with a minus attached. The obvious strength of the Task Force idea was its close contact with the people on the ground and its successes here. The project had been launched as a priority on highest political level by the prime ministers of the countries involved, but the top support later had been weak, a clear disadvantage as compared to traditional organisation with tight top steering and follow up.

Steinar Andresen, senior researcher from the same institute, reviewed for a comparison of the evaluation process a similar assessment, which he had carried through on changes in WHO administration and its outcomes during the Gro Harlem Brundtland leadership 1998-2003. Especially relevant for the Task Force case were his general elaborations on what a success really is like, and in what way it should be measured, and when.

The subsequent discussion among the audience became somewhat varied, as different aspects were addressed: Task Force organisation, administration, outcomes, the evaluations performed, evaluation in general, and principles for setting up international development or relief work as such, competition among providers on the donor side, and among authorities and organisations on the side of the receivers. Examples: Stein Andresen of the Norwegian National Institute of Health expressed his preference for a more predictive bureaucratic model as opposed to the Task Force delegation principles; Stein Inge Nesvåg, Ministry of Foreign Affairs, favoured models where support was given to strengthen the national plans, while Marianne Monclair from the Red Cross missed the focus on non governmental organisations and their local networks.

However, Anders Seim, a seasoned development worker with massive experience in preventing some specific tropical diseases, deflated much of the criticism of Task Force by pointing out that the Task Force was different from most other programmes, as it was initially a political collaboration issue materialized as a medical project which even had to prove efficiency and results in a mere three year period, for then to be ended.

It was announced that this short seminar under the fairy-tale paintings was to be reviewed in a forthcoming report, and people engaged in the topic look forward to that.

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The EUPHA conference 2004: A quest for context

Michael 2004;1: 332–6.

When the European Public Health Association (EUPHA) met to its twelfth annual conference 2004, the scope was broad. Fresh ideas for a revival of a comprehensive social hygiene were present in all plenary sessions and in most of the very varied parallel sessions, where papers from all over Europe and even beyond were presented. Throughout the whole conference there was a positive atmosphere, what also only could be expected, when people meet and all share the same view: i.e. that public health work is the main road for coping with present and future group level health problems.

The venue of the meeting was the Oslo conference centre in downtown Oslo, where auditoriums and nearby hotels accommodated almost 700

The speech by Gro Harlem Brundtland was met with great interest and expectations. (Photo: Ø. Larsen)

participants. The keynote speakers had been carefully selected and the quality of their lectures could only be ranked on a scale from brilliant to excellent.

Often epidemiological papers on public health conferences vary between mere counting to inspiring results of lasting value, emerging from exciting materials and new methods. Or they range from confirmations of commonplace knowledge to studies staged to give scientific support to political decisions already taken. Tendencies of this sort could be observed also here, but the scientific committee had obviously done a good job to compose an attractive programme of good quality. Abstracts were published in European Journal of Public Health 2004;14: number 4 (Supplement, December 2004.)

The main title of the conference was "Urbanisation and health". Perhaps the outcome of the conference more was about the challenges of globalisation, and this was also the title of the introductory keynote speech given by the former Norwegian prime minister and WHO Secretary General, dr. Gro Harlem Brundtland.

The plenary session speech by professor Johannes Siegrist from Düsseldorf covered the ever pending questions on social inequalities in health in Europe with a challenging subtitle: from explanation to prevention. In this and in other speeches a clear and strong wish came to sight; to shift from an

The conference was framed with music: Here from one of the performances by the soprano Bodil Røinaas. (Photo: Ø. Larsen)

internal medical perspective to an active approach to society and to the physical and social context of medical issues. So e.g. themes like health aspects in modern city planning and the usefulness of historical experiences from the European 19th century urbanisation were on the agenda.

The shift in public health in direction of active health promotion also was a core issue at the conference. Graz in Austria will host the 2005 EUPHA conference on November 10.-12., and then health promotion will be a main topic.

New president of the EUPHA is professor Gunnar Tellnes from Oslo.

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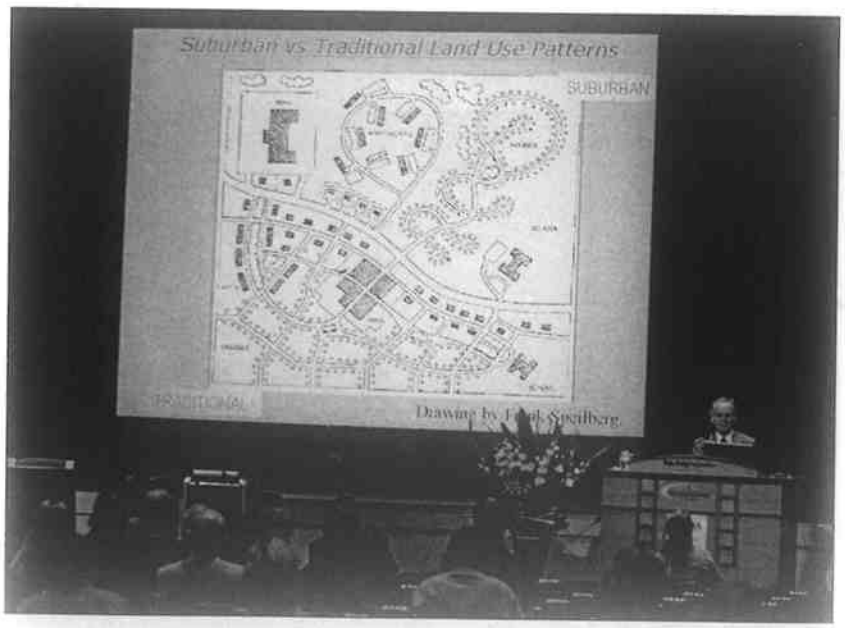
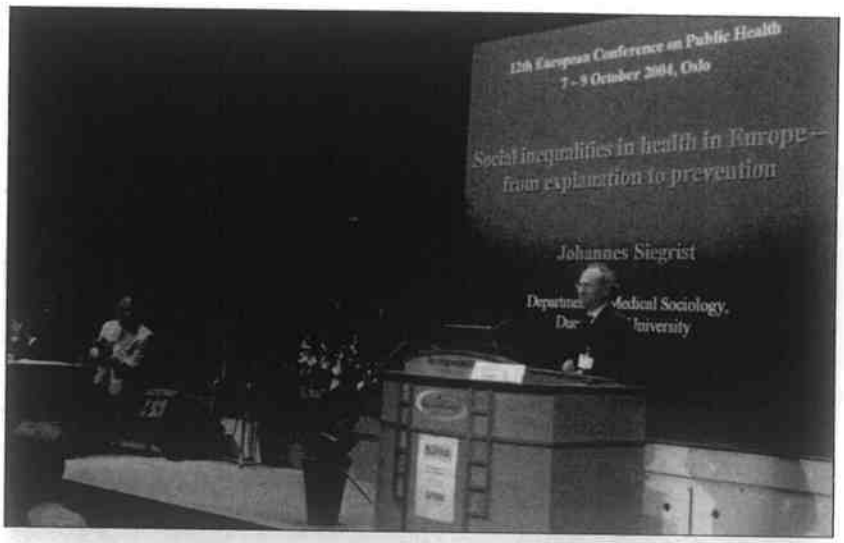


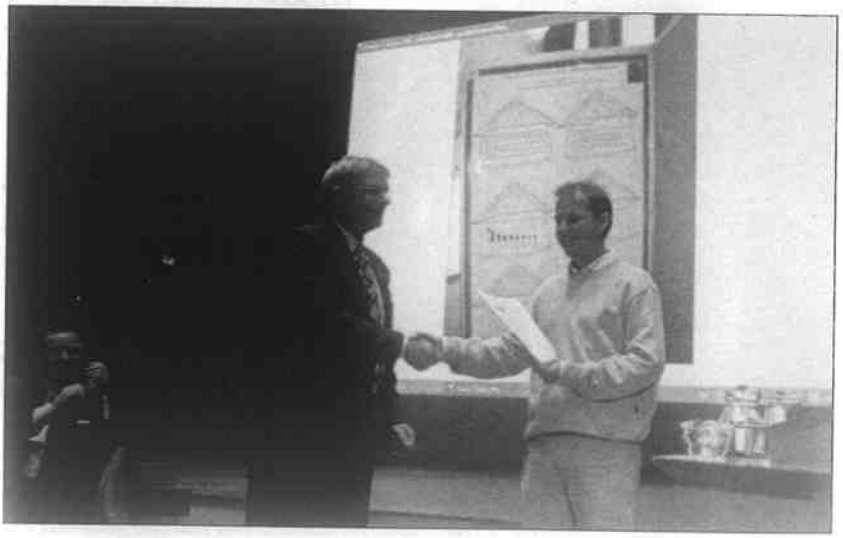
Public health arguments should also be heard in city planning. Here from a paper on "walkability" of cities and the possibility for everyday physical activity. The speaker was Jim Sallis (Photo: Ø. Larsen)

Professor Gunnar Tellnes addressed the conference participants in the Oslo City Hall. To the left Per Ditlef-Simonsen, mayor of Oslo. (Photo: Ø. Larsen)

To the right Camilla Stoltenberg, Norway, who gave a sparkling and foresighted keynote speech entitled "Predisposed for illness? The human genome, environmental exposure and public health", in conversation with the chairperson of the session, Alena Petrakova from Prague, now working in the WHO in Geneva, and Heidi Lyshol, Oslo, the efficient secretary and manager of the conference. (Photo Ø. Larsen)



The argument from professor Johannes Siegrist to prevent social inequalities in health was strong. (Photo Ø. Larsen)



The poster prize was awarded to Thomas Clausen, Oslo for the presentation entitled "Health inequalities in older persons in Botswana, a sub-Saharan African country in transition", co-authored by Gerd Holmboe-Ottesen, Oslo. (Photo: Ø. Larsen)