LEENA TERVONEN-GONÇALVES

International Ideas and National Agendas of Public Health Policy

The Cases of Finland and Portugal

ACADEMIC DISSERTATION
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Preface

Comparisons have long played an important part in social sciences. There have always been different ways to do comparative research, but some of these ways have been considered more legitimate than others. In this study I compare Finnish and Portuguese public health policies. However, I also compare national agendas with international ones. I even compare the use of comparisons in policy-making. In spite of this clear comparative dimension in my research, it has not been unproblematic to locate myself in the field of comparative research. The problem continues to be caused in part by the persistent confusion over the right way to compare policies or the right way to be a comparativist (See Adcock 2006; Wrede 2010). In her recent article Katharina Paul (2009) calls for a broader methodological horizon for comparative research, especially in areas studying phenomena such as Europeanization, and argues that those who engage in policy discourse analysis *should not shy away* from comparative approaches, but instead, should take advantage of the specific tools that discourse theory offers.

The recent social science literature makes exacting demands of the comparativist. According to Linda Hantrais (1996, 5), "Cross-national comparativists are forced to attempt to adopt a different cultural perspective, to learn to understand the thought processes of another culture and to see it *from the natives's viewpoint*, while also reconsidering their own country *from the perspective of a skilled, external observer*. (italics added)." Marja Keränen (2001, 88) points out how this vision is quite far from the earlier understanding which positioned the researcher as an external observer, who from the office compared similar phenomena across countries.

But how to learn the *thought patterns* of different cultures? One should begin by asking what are they and how are they manifested. Thought patterns can be described as shared cognitive devices which are used to make sense of everyday life. They are essentially manifested in language. It has been argued that the task of social research is to unsettle and dislodge the certainties and orthodoxes that govern the present (Shore and

Wright 1996; Dean 1994; Saukko 2006; Kettunen 2008). According to Chris Shore and Susan Wright (1996, 17), this is not simply a question of "exoticizing the familiar", but rather it involves "detaching and repositioning oneself sufficiently far enough from the norms and categories of thought that give security and meaning to the moral universe of one's society in order to interrogate the supposed natural or axiomatic "order of things"."

Shore and Wright recognize the difficulty of standing outside one's own conceptual schemas. They recall that native speakers are usually quite unconscious of the metaphors and rules that make up "cultural meaning systems" or normative cognitive structures that shape their reality. Immigration and emigration can provide one perspective to the demand and dilemma of "native and stranger" described above.

Before beginning my journey as a PhD student, I had spent almost four years of my life living in Portugal. Personally, the whole process of immigration to Portugal and emigration from Finland has been significant in terms of gaining the sufficient familiarity with Portuguese culture and language as well as gaining distance from my own country and my own "conceptual schemas" molded by education and language. Having majored in social policy at Finnish university, I had become socialized to the concepts, vocabularies and discourses of "*comparative welfare state research*", "*Nordic model*", "*Finnish social policy*". In my master's thesis on the development of the Portuguese welfare state (2000), I approached the issue from the theoretical underpinnings of welfare state research and although I recognized the gaps in this scholarship in regard to studying Southern Europe and Portugal in particular, I was unable to abandon the established ways of describing the Southern European welfare state as mainly *rudimentary*. But over the years, my understanding of the contextual and local nature of these concepts, vocabularies and theories has grown. This has been a combination of growing criticism with the normative bias of research in favour of Nordic superiority and its hollow repercussions in recent media debates and in politics, and of becoming familiar with alternative literature on policy analysis, especially on interpretative and discoursive approaches.

If successful comparative research requires a double position of native and stranger in relation to the societies compared, a researcher analysing policies should adopt a a reflexive position outside the cognitive domain of the policy makers. (Hajer & Laws 2006) According to Maarten Hajer and David Laws, this way "he or she can get analytic leverage on how particular discourse orders the way in which policy actors perceive

reality, define problems, and choose to pursue solutions in a particular direction". The majority of experts and policy makers (i.e. civil servants in public administration) in the domain of health policy continue to have educational backgrounds in medical and health sciences. Coming to the field of health policy analysis from "outside" (social sciences) has put me in a priviledged position outside certain taken-for-granted rationalities and discourses that are characteristic of health sciences and the related public policies.

***

I began my PhD studies while working as a researcher on a project called *Finnish Health Promotion Policy from an International Comparative Perspective*. The project was funded by the Academy of Finland and based on collaboration between Stakes and the University of Tampere. I do not remember exactly how I got into writing a dissertation, but I believe it was the overall enthusiastic atmosphere created by the senior researchers Professor Juhani Lehto, Dr. Meri Koivusalo, Docent Eeva Ollila, Dr. Marita Sihto that inspired me to begin my doctoral studies in the field of public health policy. Thank you all for guiding me into the interesting world of health promotion policy. Particularly, I would like to thank Juhani for supervision, support and guidance, especially at the beginning of my journey. I am also grateful to Juhani for providing the material conditions for carrying out this work. I also owe special debt of gratitude to Eeva, my second supervisor, for being available whenever needed – to comment my papers and to encourage me on my journey. From the time spent in Stakes, in Helsinki, I remember with warmth my colleagues Riitta-Maija Hämäläinen, Minna Ilva and Ilpo Airio.

After moving to Tampere, the School of Health Sciences at the University of Tampere became my workplace and Pia Solin, who just like me had started writing her doctoral dissertation on the same Academy project, my closest colleague. Pia turned out to be a truly supportive and funny colleague in everyday work in the office, but especially a unique travel companion in our visits to various conference destinations. Thank you, Pia for your friendship. Academically I wish to thank the FF-seminar group for providing me with support especially in the first years in Tampere. Besides the group, I wish to thank the following colleagues and friends from the School of Health Sciences: Kirsi Lumme-Sandt, Annika Launiala, Outi Jolanki and Jutta Pulkki, as well as the

community of the upstairs coffee room and the SOTEPO-group, especially Riitta, Heli, Elina, Anne, Sari, Liina-Kaisa, Liisa, Helena, Pirjo and Heini, for all the support and good moments shared.

Since the beginning my research was focused on the interplay between national and international arenas and agendas. To approach this from a comparative discourse analytical perspective has been not only interesting but also a demanding topic and a lonely road. In 2010 I was able to join the seminar group of Academy Professor Pertti Alasuutari called "*Globaalin muutoksen hallinta* (Governance of global change)". It was very exciting to share the interest in this theme with an entire seminar group. I thank Pertti for his valuable guidance in the world of transnational governance and beyond, as well as for involving me truly with the work of his research group. I would like to thank all the participants of this group for commenting my papers, but I am especially grateful for Elina Mikola, Jukka Syväterä, Laura Valkeasuo and Marjaana Rautalin for making me feel welcome and at home in the Virta Building.

Another pervading theme in my dissertation has been the comparative approach. On this front I gratefully acknowledge the support and encouragement given by Dr. Eriikka Oinonen and Professor Emeritus Matti Alestalo and the group of the comparative research seminar in the School of Social Sciences and Humanities. The open and encouraging atmosphere of the seminar meetings made it possible to air tentative ideas and drafts, but on the other hand the group also challenged the thinking by asking the right questions. Especially towards the end of the process Matti and Eriikka offered their wisdom, comments and encouragement that truly helped me to finish the job. Thank you for that.

The official reviewers of my thesis Dr. Meri Koivusalo and Professor (acting) Johanna Lammintakanen offered valuable comments that helped me to improve the manuscript in the final stages. I want to thank Virginia Mattila for the skillful revision of the language of the present work and Sirpa Randell for editing the manuscript into a final form. I wish also to thank all the public health experts interviewed in Portugal and Finland for giving their time and sharing their valuable views with me.

For funding my research I thank Doctoral Programmes in Public Health (DPPH), The National Graduate School in Social and Health Policy, Management and Economics (SOTKA), University of Tampere, the Competitive Research Funding of Tampere

University Hospital, the Ministry of Social Affairs and Health, the Emil Aaltonen Foundation and the City of Tampere.

Finally I wish to thank my family for supporting me in this project. I am grateful to my parents, Taina and Esko, for having always supported me in my endeavors, including academic ones, and for providing high level child care during this process. My brother Lasse has always been important in keeping my spirits up. In recent years his whole family has continued on this important front. I am also grateful to my parents-in-law, Isabel and João, for having provided me with second home while in Portugal. Last but not least I want to thank my husband João and our son André, *os meus grandes amores*, for all the love, care and patience that has put the sometimes stressful work of writing a dissertation into the rightful place – it is just work.

Tampere 17.2.2012.

Leena Tervonen-Gonçalves

Abstract

This study explores, how the idea of health promotion, appearing on the global public health policy agendas in the end of 1970s, has been interpreted and adapted in Finland and in Portugal. In this research, which in geographical terms is limited to Western Europe and which focuses particularly on soft governance, European health promotion policy has been traced by analysing declarations, recommendations and programmes produced by the WHO and the EU as well as the related comparative practices, which have been used to guide and evaluate the desired policies. In temporal terms the study covers the period from the 1970s until the end of the 2010s.

The dissertation comprises a theoretically and methodologically oriented summary, that frames the study, and four articles based on empirical analysis. The research data obtained from the case countries consists of various texts, such as government programmes, public health strategies, programmatic documents of the majority churches of the case countries and newspaper articles. The theme pervading the entire dissertation is the movement, travel or transfer of ideas and policies from one place to another. Place refers here not only to geographical location, but also to more abstract localizations, such as epistemic communities, international organizations or different societal institutions (church, welfare state, media). The movement of ideas and programmes for its part is understood to occur between these places across borders and in all directions. Methodologically I have approached the movement of particular policy ideas and programmes in different ways in each original article.

The first article addressed the movement of key recommendations of the *Health for All* programme to the government policies of Finland and Portugal in the historical context of broader welfare state development. The study indicated that the application of the programme to the local context caused only minor changes in national policies. In the second article the state-centred perspective was broadened towards community actors by analysing the majority churches of England, Finland and Portugal as actors in

health promotion policy. The analysis of programmatic documents of the churches of England and Portugal revealed the transition from the treatment of sickness towards the promotion of health and wellbeing. The churches have interpreted and recontextualized the health promotion discourse mediated by the WHO as well as the core results of public health science into their own programmatic documents. The analysis showed how the main ideas of health promotion have spread over institutional, professional and disciplinary borders. Such a transnational diffusion can be taken as an indication of the rise of health and its promotion to be one of the metadiscourses that characterizes our era.

By analysing the use of comparisons produced by international organizations in national policy-making, the third and fourth articles demonstrate concretely and in detail how national policies are defined in relation to what is described to happen by means of comparisons in other countries. International comparisons and the related categorizations are actively and continuously used when defining what are perceived to be nationally significant problems and the (related) future objectives. The analysis of the use of comparisons as a one method of governance produced a novel perspective to comprehend the roles of the WHO and the EU in public health policy. The results of this study indicate that by authoring and producing comparisons the EU influenced the public health policies of its Member States long before gaining any formal competence in this area.

Studying texts can be perceived as studying policy agendas. However, in those models which describe policy-making as a rational and linear process, agendas are often perceived as a mere starting point for the actual implementation. From the point of view of constructivist policy analysis, policy programmes and texts are understood as a focal form of policy-making. One of the key results of this research is a conceptualization of health promotion policy as programmatic and declarative (as opposed to system based). Of the essence is also the international and transnational nature of this programmatic dimension. From this reason it is not very useful to approach health promotion solely from the perspective of national health care system research. This study provides a novel perspective on the Finnish and international debate in order to understand health promotion policy.

Abstract in Finnish

Tutkimus tarkastelee, kuinka globaalin kansanterveyspolitiikan agendoille 1970-luvun lopussa noussutta terveyden edistämisen ideaa on tulkittu ja sovellettu Suomessa ja Portugalissa. Tässä Länsi-Eurooppaan rajautuvassa ja nimenomaisesti pehmeään hallintaan (*soft governance*) keskittyvässä tutkimuksessa eurooppalaista terveyden edistämispolitiikkaa on luettu esiin WHO:n ja EU:n julistuksista, suosituksista ja ohjelmista, sekä niihin liittyvistä vertailevista käytännöistä, joilla politiikkaa on pyritty ohjaamaan ja arvioimaan. Ajallisesti tutkimus rajautuu 1970-luvulta 2010-luvun lopulle.

Tutkimukseen sisältyy teoreettisiin ja menetelmällisiin kysymyksiin keskittyvä yhteenvetoartikkeli, jossa kuvataan tutkimuksen viitekehys, sekä neljä empiirisen aineiston analyysiin pohjautuvaa artikkelia. Tutkimusmaista hankittu aineisto koostuu erilaisista teksteistä, kuten hallitusohjelmista, kansanterveysstrategioista, tutkimusmaiden enemmistökirkkojen ohjelmallisista asiakirjoista ja sanomalehtiartikkeleista. Eräänlaisena punaisena lankana läpi kaikkien artikkelien kulkee ideoiden ja politiikkojen liikkuminen, matkustaminen tai siirtyminen paikasta toiseen. Paikalla viitataan paitsi maantieteelliseen paikkaan, myös abstraktimpiin paikannuksiin, kuten episteemiset yhteisöt, kansainväliset organisaatiot tai erilaiset yhteiskunnalliset instituutiot (kirkko, hyvinvointivaltio, media). Ideoiden ja ohjelmien liikkuminen puolestaan on ymmärretty tapahtuvaksi näiden paikkojen välillä ylirajaisesti ja kaikkiin suuntiin. Menetelmällisesti olen tutkinut tätä politiikkaideoiden ja -ohjelmien siirtymistä eri artikkeleissa eri tavoin.

Ensimmäisessä artikkelissa tutkittiin WHO:n Terveyttä kaikille -ohjelman keskeisten toimintasuositusten siirtymistä Suomeen ja Portugaliin laajemmassa hyvinvointivaltiollisen kehityksen kontekstissa. Tutkimus osoitti, että ohjelman soveltaminen aiheutti vain vähittäisiä muutoksia kansalliseen politiikkaan. Toisessa artikkelissa valtiokeskeistä näkökulmaa laajennettiin yhteisötoimijoiden suuntaan tutkimalla Portugalin, Englannin ja Suomen enemmistökirkkoja terveyden edistämisen toimijoina. Englannin ja

Portugalin enemmistökirkkojen ohjelmien analyysi toi esiin siirtymän sairauksien hoidosta kohti terveyden ja hyvinvoinnin edistämistä. Kirkot sovelsivat WHO:n terveyden edistämisen diskurssia ja kansanterveystieteen tutkimustuloksia omiin ohjelmallisiin teksteihinsä. Analyysi osoitti, kuinka terveyden edistämisen keskeiset ideat ovat levinneet yli institutionaalisten-, ammatillisten- ja tieteenalarajojen. Tälläistä ylirajaista ja transnationaalista leviämistä voi pitää merkkinä terveyden edistämisen noususta erääksi aikakauttamme jäsentäväksi metadiskurssiksi.

Analysoimalla kansainvälisten organisaatioiden tuottamien vertailujen käyttöä kansallisessa poliitikanteossa, kolmas ja neljäs artikkeli osoittavat konkreettisesti ja yksityiskohtaisesti, kuinka kansallista toimintapolitiikkaa määritetään suhteessa siihen, mitä muissa maissa kuvataan vertailujen välityksellä tapahtuvaksi. Kansainväliset vertailut ja kategorisoinnit ovat jatkuvasti ja aktiivisesti mukana määritettäessä kansallisesti merkittäviksi ymmärrettyjä ongelmia ja tulevaisuuden tavoitteita. Vertailujen käytön tarkastelu yhtenä hallinnan keinona on tuottanut uudenlaisen näkökulman EU:n kansanterveyspoliittisen roolin ymmärtämiseksi. Tutkimuksen tulokset viittaavat siihen, että EU on tuottamiensa vertailujen välityksellä vaikuttanut jäsenmaidensa kansanterveyspolitiikkaan jo kauan ennen kuin se saavutti muodollisen kompentenssin tällä alueella.

Tutkittaessa tekstejä voidaan ajatella tutkittavan politiikka-agendoja. Agendat ovat rationaalisesti politiikkaprosessia kuvaavissa malleissa nähty usein vain alkuna varsinaiselle toimeenpanolle. Konstruktivistisen politiikan tutkimuksen näkökulmasta politiikkaohjelmat ja tekstit ymmärretään keskeisenä poliitiikan tekemisen muotona. Tämän tutkimuksen yhtenä keskeisenä tuloksena on terveyden edistämispolitiikan käsitteellistäminen *ohjelmalliseksi ja julistukselliseksi politiikaksi* (*vs. järjestelmäkeskeiseksi*). Olennaista on niin ikään ohjelmallisuuden kansainvälinen ja transnationaalinen luonne. Siksi terveyden edistämisen politiikkaa ei ole kovin hyödyllistä lähestyä esimerkiksi kansallisen järjestelmäkeskeisen terveydenhuoltotutkimuksen näkökulmasta. Tutkimus tarjoaa uuden näkökulman niin suomalaiseen kuin kansainväliseenkin keskusteluun terveyden edistämispolitiikan ymmärtämiseksi.

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List of abbreviations

COM	European Commission
EU	European Union
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organization

List of original publications

This dissertation is based on the following original articles:

I Tervonen-Gonçalves, Leena and Lehto, Juhani (2004) Transfer of Health for All Policy – What, How and in Which Direction? A two-case study. Health Research Policy and Systems 2: (8)
(http://www.health-policy-systems.com/content/2/1/8)

II Tervonen-Gonçalves, Leena (2006) Kirkollista terveyden edistämisen diskurssia etsimässä (In Search of Church Health Promotion Discourse). Diakonian tutkimuksen aikakauskirja, 1, 7–31.
(http://dts.fi/dokumentit/DT_nr1_2006_final.pdf)

III Tervonen-Gonçalves, Leena (2012) From Averages to Best Performers – Use of Comparisons in Identity-formation. Forthcoming in Critical Policy Studies, 6 (3), 304–323.

IV Tervonen-Gonçalves, Leena and Oinonen, Eriikka (2012) Vertailun valta (The Power of Comparisons). Yhteiskuntapolitiikka, 77 (1), 3–15.
(http://www.thl.fi/attachments/yp/2012/1/tervonen.pdf)

1 Introduction

> "Lose weight!" "Avoid fat!" "Stop smoking!" "Reduce alcohol intake!" "Get fit!" "Practise safe sex!" "Play safe!"
>
> (Petersen & Lupton 1996, 9)

> "Build healthy public policies." "Create supportive environments." "Reorient health services." "Enable, mediate and advocate health."
>
> (WHO, Ottawa Charter for Health Promotion, 1986)

The above two groups of quotations describe the imperatives of health promotion. While the sentences in the first group target individuals, the sentences in the latter group give advice to governments and community actors. Taken together these sentences shed light on the nature of health promotion from the point of view of *facilitation*. That is, individual citizens are expected to make the right (i.e healthy) choices, and governments are expected to make the making of these choices easy (Burrows, Nettleton & Bunton 1996). The sentences above do not only reveal the content of health promotion policies, but they also disclose its *imperative* tone. Not only are citizens *subjected to* promoting their health, but governments are also *urged to* act in the name of public health. This thesis studies how governments have been advised by two international organizations: the World Health Organization (WHO) and the European Union (EU), to promote population health and how these recommendations, advice and programmes have been interpreted nationally in two European countries, Finland and Portugal.

Although health has been cherished in different cultures and across societies for centuries, the importance attached to health has burgeoned to a whole new level in recent decades. Michel Foucault (1984) has used the notion of "imperative of health" to describe this ever-growing pervasiveness of health in conditioning our behaviour and choices via subtle methods of control and governance. (See also Lupton 1995.) This has

been the case especially in the Western advanced countries. It was in the latter half of the 20th century that the term *health promotion* appeared in international health policy agendas. It soon became a buzzword, a slogan, which was embraced both by leftist and rightist political parties across countries. This is understandable if we think of health as a universal value that all people need for their wellbeing. On the other hand the success of the discourse of health promotion is understandable in the context of the welfare state crisis in the 1980s. Health promotion offered a legitimate hope of cutting down the growing health expenditure. However, due to its imperative and political nature, health promotion has also encountered criticism. Debates on how we should relate to the all-embracing notion of health promotion have been heated.

The public health policies of Finland and Portugal are compared in the wider international, mainly European, framework. Drawing on the constructivist and interpretive tradition in policy studies, this research departs from the notion of language as constitutive of reality. (Fischer 1995, 2003; Hajer 1995; Hajer & Wageneer 2003; Yanow 2000; Risse 2000; Clarke 2004, Yanow & Shwartz-Shea 2006, Alasuutari 2011.) Constructivism implies that policies are understood to be essentially about meaning-making taking place through language in documents and debates. Policies are here studied by analysing different kinds of policy documents. Most of us agree that the analysis of government programmes can be perceived as the study of policy agendas. There is, however, disagreement in policy sciences on how to perceive agendas and what we study when we study policy programmes. These disagreements have their roots in different ways of perceiving policies. In the mainstream literature policies have mostly been reduced to numbers or cut into phases (Cf. Stone 1988). This way the messy domain of policies has been made to be neatly measurable and defineable. In those models which aim to describe the policy process rationally and linearly, programmes are comprehended solely as the first stage for the actual implementation of policies. It follows that in order to grasp the "true nature" or "real effects" of policies, a researcher should study the whole process of policy-making and preferably focus on implementation. I have chosen a different approach. Drawing on the constructivist and interpretive policy analysis, I understand policy programmes and texts as a central form of policy-making. By using certain terms, vocabularies and discourses either in debates or in documents we create social order and build rationalities (Hajer 1995). When studying the movement of ideas across national borders from this perspective the term implementation assumes

a different meaning. In the context of transnational governance the production of the national policy programme is itself a first indication of their implementation nationally. (Cf. Freeman 2006.) This is how global ideas, concepts and vocabularies are introduced and integrated into national agendas and policy-making.

Constructivism and sociological institutionalism are feasible approaches here since the most prominent international governmental organizations in this policy area, namely WHO and EU, have traditionally used the means of soft governance to influence their Member States. (K. Jacobsson 2004; Mörth 2004; Marcussen 2004; Armingeon & Beyeler 2004; Djelic & Sahlin-Andersson 2006; Mahon & McBride 2008.) Political actors have no binding policy instruments such as legislation at their disposal in soft governance. Instead regulations are created through norms, myths and ideas (Mörth 2004), through shared discourses, socialization and peer pressure (K. Jacobsson 2004). Coordination and surveillance are also part of soft governance. They are essentially practised by monitoring and evaluating the programmes and by building databases. (Jakobi 2009; Djelic & Sahlin-Andersson 2006; Mahon & McBride 2008.) Taken together, these soft methods of governance regulate the behaviour of the national actors and create an understanding of how we are related to others and how we behave as members of social communities. These are called constitutive effects. (Palola 2006, 49; Marcussen 2006; Kettunen 2006; 2008.)

This dissertation is based on the research presented in four original articles[1]. The first two articles address the interpretations of the concept of health promotion in different countries (Portugal, Finland, the UK) and by different institutions (governments, majority churches). The last two articles approach the governance practised by the international organizations (WHO, EU) in the form of comparisons and scrutinize their constitutive effects on the identity-formation and agenda-setting in the national contexts of Finland and Portugal.

Finland and Portugal are understood to represent different, historically and culturally distinct, traditions of welfare production. Welfare state understood as a material manifestation of these traditions has been an object of study for comparative social policy research from the early 1970s onwards. As a result of comparing certain important measurable political power relations and the functioning of market forces,

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1 The articles are referred to by their Roman numerals (I–IV) in the text. Articles I, III and IV focus on public health policies in Finland and Portugal. Article II, which addresses the majority churches as actors in health promotion policy, widens the comparative setting to include a third case: England.

different categorizations of welfare states have subsequently been created (e.g. Esping-Andersen 1990). After being repeated and reproduced by scholars and by the epistemic community, these categorizations have started to appear as static, real and natural. (Clarke 1996; Spicker 1996.) It has often been ignored, that besides representing reality, these categorizations and the associated vocabularies also construct it. These constitutive effects of comparisons are analysed in Articles III and IV.

Until the end of the last century the comparative welfare state research was mainly focused on reading out national, and to certain degree regional, stories of path-dependency and continuity. In the new century there has been growing concern about dynamics and change (vs. stability and continuity) and about international as well as transnational (vs. national) forces and pressures (Clarke 2004; Armingeon and Beyler 2004; Mahon & McBride 2008). In line with this recent tradition, the interest here is rather in the dynamics and trends linked to the processes of internationalization, transnationalization and Europeanization than on static categorizations. By approaching welfare states and their categorizations from the thematic perspectives of public health policy and the southern European welfare state, and from the theoretical perspective of constructivism, this research does not add to the body of mainstream research, but offers alternative ways of approaching the issue. (Cf. Clarke 2004; Kettunen 2006; Paul 2009.)

As the title suggests, public health policies are understood here to be constructed at the intersection of national and international. This intersection can be located in the area of transnational. Besides at the intersection of national-transnational-international, the public health policies are here seen to be formed at the disciplinary and practical intersections of social and health policy. Some of these intersections appear more organized and evident; some more latent or obscure. The seemingly more obvious intersections have been at least partly covered by research or administrative reports (e.g. the role of WHO or EU in international and national public health policy), while there are relationships and arrangements as yet unresearched (e.g. the role of the church institution in health promotion policy or the influence of international public health comparisons on agendas and self-images of the states). As the timeframe analysed extends from the present time back to the 1970s, some issues can be seen to belong to contemporary past (such as the diffusion of HFA2000 programme) while others are

decidedly topical (the role of EU in public health issues, or the labelling of Southern European countries in the context of the latest financial crisis that began in 2010).

This research examines the interpretation of a number of major European public health policy initiatives in the Finnish and Portuguese governmental policy documents from the 1970s until the first decade of the 21st century. It also examines the interpretation of these international ideas within another type of significant national institutions, the majority churches in Finland, England and Portugal[2]. In organizational terms churches are seen to pertain to the group of non-governmental organizations. During the time period analysed international organizations, namely the WHO and the EU, have put forward a series of new concepts, principles, and programmes to promote public health in their Member States. In order to be able to monitor and evaluate the spread and influence of the proposed policies, different comparative practices have been created. In this study the numbers, categories and labels provided by these comparative practices and common discourses are not taken merely as a description of reality. Instead, they are understood to construct the reality by conditioning the processes of agenda-setting and identity formation. These soft methods of governance are analysed by combining a comparative approach with a discourse theoretically oriented perspective. Thus the purpose here is not to describe the field of actors in any detailed and exhaustive manner, but rather to map the discourses and practices that characterize the field (Cf. Osborne 1997).

The research aims at 1) making visible the diverse modes of governance practised by the international organizations in the field of public health and 2) analysing how the ideas and policies advocated by international organizations are translated into the domestic context. 3) Thirdly the aim is to analyse the constitutive effects of transnational governance on agendas, self images and identity formation of the states in questions of health and welfare.

In order to locate health promotion into the domain of public health policy in historical and conceptual terms Chapter 2 begins by presenting some related and alternative concepts that emerged simultaneously to describe the changed orientation of public health policy. After presenting the key concepts considered to be the corner stones of the

[2] The Evangelical-Lutheran Church of Finland and the Anglican Church of England are Protestant churches while in Portugal the Roman Catholic Church is in the position of a majority church.

contemporary (hi)story[3] of public health, the chapter ends by presenting an alternative and novel way to comprehend health promotion (as a) policy. Chapter 3 summarizes the theoretical framework of this study. Chapter 4 presents the data analysed in the original articles as well as the key concepts and methodological considerations involved in the analysis of this data. The specific challenges and problems of comparisons and discursive policy analysis are discussed. The analytical frameworks applied and the core results of the original articles are presented in Chapter 5. While the empirical emphasis in the original articles has been on how global ideas and international policies have been interpreted in national policy-making, Chapter 6 discusses the regulatory ambient where nation-states make these interpretations. Public health policy is also set in the wider context of soft governance. The discussion continues in Chapter 7 by presenting the main findings of the individual publications in relation to the spreading of ideas and to changing policy agendas.

[3] The Finnish term "historia" refers to past time. It is also used to refer to a subject and a discipline. In Portuguese language the term "história", as in English the term "history", have, however, a second significance in everyday use. Besides referring to past time, these terms refer to a story. This second meaning puts the official histories into perspective. History is always a story and it is always told by someone. This same concern is explicitly addressed in the genealogical method (See page 42).

2 Public health policy

A significant shift in the history of public health policy has been traced back to the late 1970s and the 1980s, when the term *health promotion* was introduced in the international health policy forums (Macdonald & Bunton 1995; Parish 1996; Baum 2008; Awofeso 2004). Health promotion has been considered a basic component (Martin & McQueen 1989) or a central force (Bunton & Macdonald 1995) of the new public health movement. The main forum for the development of global level health promotion policy has been the WHO and especially it's *Health for All policy* (Baum 2008, 18, 31–43). To emphasize the policy dimension of health promotion the concept of *healthy public policies* was introduced (WHO 1986).

These four overlapping concepts are categorically defined in relation to each other and thus they form a web of entangled meanings. Empirically this is observable in intertextuality (See Article II, 15) which, simply taken, means texts refering to other texts. However, describing the terms as overlapping or as having a high degree of intertextuality might hinder their ambiguous and even contradictory relations. It has been argued that the ambiguity follows from the fact that the ideological basis of the concepts point in different directions (Stevenson & Burke 1991; Bunton 1995; Petersen & Lupton 1996) or that the terms are constructed in various policy documents drawn up in temporally and contextually different situations (Tervonen-Gonçalves & Lehto 2004; Awofeso 2004). This web of entangled and somewhat contradictory meanings poses a challenge for empirical research on the policy in question.

This chapter offers a concise explication of these interrelated concepts and locates them in the field of public health policy. As public health policy is not only a field of practice but also a field of research, this localization refers both to policy documents and scholarly texts. These are not two totally separate categories of texts, but rather form a continuum. While trying to comprehend this continuum the reader should keep in mind that following from the political (Bernier & Clavier 2011) and politicized (Helén

& Jauho 2003) nature of the issue at hand (i.e. health and its promotion) much of the research literature is political and prescriptive in nature (Bunton 1995, 137).

Sarah Nettleton and Robin Bunton (1996) have divided public health policy analysis into a research *for* and *of* policy. While the former aims at telling policy-makers what health promotion techniques or which policies work by making recommendations, the latter studies policies without no explicit aim of giving policy advice or developing health promotion techniques. Instaed of labelling the research for policy as "a political" Bunton (1995) has called this approach "a committed analysis of policy development". According to him, practically all the literature on healthy public policy falls into the category of committed policy analysis.

Committed analysis comes in many forms, from producing information for policy-making to policy advocacy and process advocacy[4]. (Bunton 1995, 136–137.) In the area of health promotion, the concepts of policy advocacy and process advocacy merge with the notion of health advocacy (WHO 1986; Awofeso 2004, 706), which means that health is advocated as a universally good and important thing to be promoted at all levels (individual, collective, global) and across policies. Together these advocacy streams call for health to be taken into account in *all* policies. This idea is at the core of health promotion policy and is manifested in the following policy initiatives of international organizations: healthy public policies (WHO) and Health in All Policies (EU) (Cf. Koivusalo & al. 1997; Koivusalo & Santalahti 1999; Ståhl & al. 2006; Ollila 2011).

Committed policy analysis is practised in government departments and in international organizations but also in research institutes (e.g. National Institute for Health and Welfare, Finland) and universities (Bunton 1995, 136–137). While it is commonplace and reasonable for many purposes to divide the field of public health into a research community and a policy community, I deem it appropriate here to introduce the concept of epistemic community, which emphasizes the connections and commonalities between the two communities. According to Peter Haas (1992, 3) epistemic community is "a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain

[4] According to Bunton process advocacy attempts to improve the nature of the policy-making system, particularly the machinery of government, through the development of planning systems and new approaches to co-ordination which involve analysts in pressing for specific options and ideas in the policy process, either on their own behalf or via a pressure group. Policy advocacy on the other hand is more concerned with the content of a specific policy and its ultimate goal to advance specific policies.

or issue-area". Haas (1992, 16–20) distinguishes epistemic communities from other groups such as: disciplines and professions, interest groups and social movements, legislators, bureaucratic agencies, and bureaucratic coalitions based on four features. In the following I present these features and locate each feature in the domain of health promotion policy.

Members of epistemic communities share:

1) Normative beliefs providing value-based rationale for action (e.g. health as human right, equity in health)
2) Causal beliefs, which are derived from the analysis of practices contributing to a central set of problems in their domain (e.g. distribution of wealth across society affects the people's health, different factors of human environment determine health) and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes (e.g. equity oriented action and healthy public policies),
3) Notions of validity, which is intersubjective, internally defined criteria for weighting and validating knowledge in the domain of their expertise (e.g. epidemiology), and
4) A common policy enterprise – that is a set of common practices associated with a set of problems to which their professional competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence (e.g. health promotion policy).

This field and its epistemic community are not only national, but also transnational (Haas 1992, 17). Drawing on the notion of epistemic community as presented by Haas, I see new public health as a social movement that took place in research communities and in policy-making communities by (1) enlarging the disciplinary basis to analyse the problem, (2) recognizing the causes of much ill health in human environments, (3) offering new solutions to solve the problem and (4) building bridges to policy making community in such a manner that a new epistemic community was formed. The next section discusses how the proposed shift from old to new public health has been conceptualized.

2.1 From old to new public health

The proposed shift in the public health policy refers to the interplay of the four concepts mentioned earlier: new public health, health promotion, healthy public policy and Health for All. Following Evelyne de Leeuw (1989, 4), I understand new public health as an umbrella concept in relation to the remaining concepts. The most significant difference in comparison to other terms is to be found on its abstract and non-operationalizable nature. It has been perceived as a movement (The Ottawa Charter 1986), as an approach (Ashton & Seymor 1988), as an era of public health policy and action (Baum 2008, 18) and also as a paradigm (Awofeso 2004, 708). Regardless of the form of conceptualization it suggests there is an old public health. How is the shift from old to new public health described? How is new public health defined?

Although the Ottawa Charter is famous for its definition and promulgation of health promotion, the banner of the Ottawa Charter (WHO 1986) announces it to be "The move towards a new public health". The preface to the Charter states: "This conference was primarily a response to growing expectations for a new public health movement around the world." Some scholars connect this movement to a larger societal movement taking place in many Western societies in the 1960s and 1970s, namely the women´s movement and the environmental movement (Macdonald & Bunton 1995, 11; Jones & Sidell 1997, 102). Others take a critical stance on calling new public health a movement (e.g. Petersen & Lupton 1996). Michael Stevenson and Steven Burke (1991) argue that the health promotion movement is politically largely confined within the state, rather than the expression of a social movement against the state.

In his health promotion glossary Don Nutbeam (1998) presented the following definition: "A distinction has been made in the health promotion literature between public health and new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the determinants of health, and the methods of solving public health problems. This new public health is distinguished by its basis in a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and a recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health."

According to the above definition, new public health differs from public health in two ways: 1) in approaches to describe and analyse the determinants of health and 2) concerning the methods used to solve the problems. While in the old public health the determinants were mainly found in the individual, the new public health brought structure and social organization to the fore. This has been called a structuralist approach (e.g. Baum 1990). The environmental approach is another common term to describe the same idea (i.e. the roots of health are increasingly found in the human environment). According to Andrew Long and Frada Eskin (1994–1995), this environment has several components, each of which has the potential to affect human health: physical, psychological, socioeconomic, political and cultural. John Ashton and Howard Seymor (1988, 21) specify the environmental argument present in all the above definitions by locating the root causes of health problems into existing policies either in local or national level. Following from this they take the view that the solution lies in making healthy public policies (i.e. "*policies in many fields which support the promotion of health*").

De Leeuw (1989, 48) describes the shift in the following terms: "an approach on health problems has shifted from a reductionist, single-factor, monodisciplinary approach to a more comprehensive approach". While the medical profession and clinical world are understood to have a prominent place in the old public health, the new public health recognizes a comprehensive disciplinary basis and intersectoral action as crucial to health. In terms of methodology, there has been shift from epidemiology to seeing many methodologies as legitimate. (Baum 2008, 37; Long & Eskin 1994–1995.)

Long and Eskin (1994–1995) among others argue that the new public health is not new at all, since the recognition of the complexity of factors affecting on health has existed for many centuries. Even in Ancient Greece environmental factors were taken into account when advising patients. Robin Bunton and Gordon Macdonald (1995, 8) claim that after a period of individually focused public health measures (e.g. vaccination programmes in the first half of the 20th century) new public health was actually a *return* to the more traditional 19th century public health approaches with concern about structure, environment and ecology. Others are more critical about building bridges between Victorian public health measures and public health policies of the contemporary time (e.g. Jones & Sidell 1997, 106–107).

Linda Jones and Moyra Sidell argue that while public health traditions have undoubtedly provided an inspiration for healthy public policy, the old public health measures were much more restricted in scope. According to Jones and Sidell what is truly new is the justification that the healthy public policy focus in health promotion has provided for public health. (Jones & Sidell 1997, 106–107.) Niyi Awofeso (2004, 708) writes that what is new in new public health is the manner in which the health promotion discourse has adapted core doctrines of previous eras to address the current public health problems. Frances Baum (2008, 36) also argues that the Ottawa Charter did not emerge from a vacuum in the 1980s, but reflected various social and health movements of the preceding 120 years. According to her its claim to be "new" came from the way it bound together "numerous and diverse movements to present a package that gave public health a more radical and cohesive direction than had been the case for some time. It also served to make health promotion a legitimate and respectable aspect of the health scene."

Alan Petersen and Deborah Lupton (1996) see many of the accounts of new public health as nostalgic. They argue that the new public health has been warmly embraced by people of diverse backgrounds and political persuasions. It has been presented as an answer to all kinds of problems linked to modern life. They criticize the uncritical acceptance of the basic tenets of the new public health as *disturbing* given the increased potential for experts to intervene in private lives. They conclude that this reticence indicates the power of the discourse of the new public health to shape public opinion. (Petersen & Lupton 1996, 9–10) It is in the context of this powerful discourse of new public health that I will now turn to the concept of health promotion by presenting the story told about it.

2.2 The (hi)story of health promotion

Health promotion as a phenomenon has existed for centuries, but under other labels such as sanitation and urban improvement. The way it is understood today was determined in the 1970s and 1980s. The story of contemporary health promotion is commonly told by referring to international declarations, meetings and programmes. When describing the

origins of health promotion, most scholars began by referring to the Lalonde Report[5], published in 1974 (e.g. de Leeuw 1989; 1991; Bunton & Macdonald 1992; Parish 1996; Kelly & Charlton 1996; Perttilä 1999; Rimpelä 2005). This report, originally called *A New Perspective on the Health of Canadians* and renamed after the then minister of health, Marc Lalonde, aimed at changing the direction of Canadian health policy from medical and hospital care towards the prevention of illness. It proposed the idea of health fields as determinants of health. These health fields were health care, environment, lifestyle and biology. The Lalonde Report suggested that improvements in the fields of environment and lifestyle could lead to the reduction of morbidity and premature mortality. The term health promotion and the broad vision of health were recognized beyond the Canadian context and health promotion soon became a catch-phrase in the international sphere. (Kelly & Charlton 1996, 80; Bunton & Macdonald 1992, 9.)

The next milestone in the history of health promotion is a declaration issued by the International Primary Health Care Conference held in Alma-Ata, Soviet Union, in 1977 (WHO 1978). The declaration states that "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." This goal is commonly known as "*Health for All by the year 2000*". It was a political statement for better world that appealed to governments and international organizations. The call for intersectoral action and a community based approach that are to be found in most of the subsequent health promotion programmes was introduced in the Alma-Ata Conference (WHO 1978, 17, 20, 24). It was already in the Alma-Ata declaration that a recommendation was given to all Member Countries to build their national public health strategies.

After the Conference of Alma-Ata, the WHO and especially its European Regional Office became a forum where the definition of the term and development of the health promotion strategy were advanced (de Leeuw 1989; WHO European Regional Office 1990; Kaprio 1991; Sihto 1997; Ziglio & al. 2000). Although *Health for All* was initially developed as a global level policy initiative, it was soon divided into two branches. While

[5] In the Finnish context the Report of The Economic Council (Talousneuvoston raportti) published in 1972 can be considered a seminal text on health promotion.

global strategy (1981) linked *Health for All* to primary health care, it was interpreted in the developed countries as an approach suitable for developing countries. In Western industrialized countries this approach was not found adequate since fairly stable systems of primary health care were already in place. (Kaprio 1991; de Leeuw 1989; Sihto 1997.) In European countries, but also in Canada and Australia, *Health for All* became more intertwined with the concept of health promotion policy. In this dissertation the focus is on the interpretation given to these concepts in Europe.

If the declaration of Alma-Ata can be perceived as the beginning of the *Health for All* movement, the culmination is located to the first international conference on health promotion organized in Ottawa, Canada in 1986. (Cf. Awofeso 2004.) This meeting and the related charter (WHO 1986) has become the core content of the past and present story told about health promotion policy. Even today the following quotation from the Charter offers a standard and commonly referred definition to health promotion.

> "Health promotion is the process of enabling people to increase control over, and to improve, their health… Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites." (WHO, Ottawa Charter 1986.)

The Ottawa Charter endorses the positive definition of health (i.e. health as a resource rather than the absence of sickness) and presents a call for extensive social policies in order to deliver the basic prerequisites for health. The extensive list of prerequisites has been taken as sign of the human rights approach to health promotion. (Bryan, Khan & Hyder 1997.) At the same time it is understood to have presented a radical agenda for change (Baum & Sanders 1995; Coombes 1997). The broad definition of health promotion and the emphasis given to healthy public policies in the Ottawa Charter legitimated *Health for All* policy as a viable solution also for developed countries (Cf. Kaprio 1991; de Leeuw 1989; WHO European Regional Office 1990, 4; Awofeso 2004).

According to the Ottawa Charter health promotion consists of five means of action: (1) building healthy public policy, (2) strengthening community action, (3) creating supportive environments, (4) reorienting health services, and (5) developing personal skills. Building healthy public policy is one of the five means but it is set as a precondition for the others (WHO 1986). The Charter states, that health should be put on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and accept their responsibilities for health. Healthy public policy is presented to combine diverse but complementary approaches such as legislation, fiscal measures, taxation and organizational change. It is defined as a coordinated action that "leads to health, income and social policies that foster greater equity".

Healthy public policy was set as a target of the European *Health for All* policy document in 1985 (WHO 1985). The debate on healthy public policies had earlier been on the agenda in European health promotion circles (de Leeuw 1989; Koivusalo & al. 1997; Koivusalo & Santalahti 1999; WHO European Regional Office 1990). Jones and Sidell (1997, 110) have observed convergence in the language and debate between healthy public policy, environmental movement, social welfare policy as well as old and new public health. According to Bunton (1995, 129–139) the term is intimately linked to the development of WHO programmes. In 1986 the WHO European Regional Office concluded in the Vienna Dialogue on Health Promotion that "the best health promotion policy is a good social policy" (WHO 1986). European scholars have also subscribed to this view. De Leeuw (1989, 21) writes that "social policy is the largest determinant of health… This means we are talking not just health care organization policy but over-all social policies with health consequences."

While the social policy argument is a relatively widely held view in European health promotion circles (Bunton 1995; Nettleton & Bunton 1996; Jones & Sidell 1997), only few have connected health promotion and healthy public policy to the welfare state context. In 1989 de Leeuw suggested that the concept of health promotion has been presented as a possible solution to specific health problems of the industrialized welfare states (de Leeuw 1989, 13). This idea appears in the report on the WHO meeting in Europe (WHO 1987, 4–5). Later on several scholars have empirically studied health promotion and public health measures in the different welfare state regimes (Navarro & Shi 2001; Navarro 2002; Lundberg & al. 2008). The research project *Finnish Health Promotion*

Policy from the International Comparative Perspective likewise aimed at studying health promotion policies in countries representing different welfare state types. (Tervonen-Gonçalves & Lehto 2004; Lehto & al. 2005.)

WHO has organized six international health promotion conferences since Ottawa (Adeleide 1988, Sundsvall 1991, Jakarta 1997, Mexico City 2000, Bangkok 2005, Nairobi 2009) The emphasis given to different aspects of health promotion in these conferences covering period of more than twenty years has varied (See Baum 2008, 38–43). Frances Baum (2008) argues that although each of them has added new dimensions to the debates on health promotion, none of the subsequent conferences has had the impact that the Declaration of Alma-Ata and the Ottawa Charter have had on the thinking about new public health.

In 2005 WHO established a Commission on Social Determinants of Health to produce information and give advice on how to reduce growing health inequities. The report produced by the Commission was published in 2008. (WHO 2012.) The latest core concept in the European health promotion circles is *Health in All Policies*. The concept was advocated during the Finnish Presidency of the EU in 2006 and was then included as one of three core principles of the EU public health strategy in 2007 (Ståhl & al. 2006; COM 2007). *The Health in All Policies* principle is considered to share the same values of universality, access to good care, equity and solidarity that have been central to the *Health for All policy*. The fundamental principles of *Health for All*, such as building healthy public policies or encouraging multisectoral action are also endorsed. (Wismar & al. 2006, 17, 27.)

2.3 The programmatic nature of health promotion policy

What most definitions of health promotion have in common is the references made to key policy documents. Health promotion as a practice and as a research area is defined repeatedly and across countries by referring to the Declaration of Alma-Ata (WHO & Unicef 1978) or the Ottawa Charter (WHO 1986), and to lesser extent to the declarations issued after the subsequent international conferences. These meetings (conferences, workshops, seminars, assemblies) and the documents (declarations, charters, reports and recommendations) are the corner-stones of the story (or milestones in the history) told

about health promotion policy. One key result of my research is the conceptualization of health promotion as programmatic and declarative policy.

I have argued that the story past and present of health promotion policy is told by referring to key policy documents. (Cf. Freeman 2006.) This may seem a trivial statement, applicable to any policy domain, and to an extent such is indeed the case. For example, the Beveridge Report (1942) is seen in many accounts as an origin of British social policy as well as a legitimation used for widening the social security agenda in many other countries (e.g. Abel-Smith 1992). The *UN Declaration of Human Rights* (1948) has been widely referred core document in the area of human and constitutional rights. The OECD report *Crisis of the Welfare State* (1981) attracted a lot of attention and has been a subject of many books, articles and conferences. The report and the subsequent publications have been pivotal in constructing the crisis of the welfare state.

However, the centrality of programmatic documents is, I argue, characteristic of health promotion and quite unique compared to its immediately related concepts and feeder disciplines of health policy and social policy. The history of health promotion policy is not told by referring to laws, system reforms or changing benefit and funding mechanisms as in social policy, nor in terms of medical-technical innovations as in public health policy (e.g. vaccines, screenings) or medical care policy (e.g. the invention of new medicines and treatments) in particular. Rather, it is told in terms of consensus statements, agreements, programmes and strategies. The key documents are used not only as a reference points while telling history of this policy; the present policies are defined and told in relation to them. Health promotion policy as programmatic policy consists of two different dimensions to which I now turn.

The declarative dimension

The first dimension is derived from the cultural conception that health is seen as a core value and human right and thus should be promoted. It is assumed and explicated in all the key documents. They *state, declare, preach, propose and promulgate* that health should be promoted and that all the decisions made either the individual or collective sphere of life should consider their impact on health. Health is defined in *holistic* terms (mental, social, physical, spiritual) and its promotion is seen to necessitate an *ecological* or *comprehensive* approach. The message conveyed in the documents of different societal institutions (e.g. governments, majority churches) is that health is valuable, and it belongs

to everyone. Health should be promoted, enabled and advocated through all possible actors, sectors and policies. Some have described this as healthism (Skrabanek 1994). Others have called the constant promotion of health a new form of pastoral power (Ryan 2003; Foucault 1988) or the representation of a new form of religion (Terveyskasvatuksen neuvottelukunta 1990, 44–45; Conrad 1992, 213–214).

This core message is communicated in various ways. Although the key documents in this study are perceived to be the primary vehicles for delivering this message, this is not to deny that the international meetings and the related debate provided a vehicle to raise awareness over the importance of health promotion. This is explicitly stated in the following quotation.

> "The first element of the WHO strategy for health promotion includes developing the concept of health promotion and making health promotion visible and accepted. In 1986 the health promotion programme began to set an agenda for the new public health and to build a consensus around this agenda, which has helped to develop a new approach to public health. Two international conferences on health promotion, undertaken by WHO and various co-sponsors, provided the vehicle for this process." (WHO Europe, Strategy for Health Promotion, 1990, 4.)

Focal for health promotion as a declarative policy has been to promote and communicate its ideas and build consensus around its agenda. Ideas have been knowledge; ideas have been normative perceptions about the best ways to promote public health. Ideas and agendas have been disseminated in texts. Key texts are used to define the field of operations, and to suggest how to act by making recommendations and setting standards, for example, in terms of different comparative references, such as averages or good and best practices. Together these discourses and practices also shape, structure and challenge national agenda-setting and identity formation.

The programmatic dimension

While the declarations, charters or papal encyclicas represent the first dimension of the programmatic nature of health promotion policy, the concrete policy programmes with neatly defined objectives and quantified targets represent the second dimension. There are global, regional, national and local policy programmes (*Healthy Cities*, *Healthy Schools*,

Health Promoting Hospitals, Healthy Workplaces) created in the spirit and framework of *Health for All*. These programmes suggest common or standardized programme models to be repeated. Although each government, municipality, city, hospital or school is in principle free to make its own interpretation of the model programme, the related coordinative and surveillance practices direct the actors' view towards certain factors and patterns. Coordinative practices can take the form of programme evaluation or building and maintenance of databases. Their explicit function is to evaluate the outcome of programmes and policies. These programme related surveillance practices are embedded in national and international organizations. The modes of soft governance used by the relevant international governmental organizations in the area of health promotion are described and set in a broader context in Chapter 6.

These documents have been central to health promotion not only due to their content but also due to their imperative tone and their declarative form. In light of analysis, I argue that the core of health promotion policy is to be found precisely in its declarative and programmatic nature (vs. system-based nature). Another essential feature of this policy, which is connected to its programmatic nature, is its international and transnational character. From this perspective the currently prevailing practice of studying health promotion interventions and the related policy from the premises of *national health care system* research does not seem very useful. By analysing health promotion in the context of some health care systems, these studies often conclude that health promotion rhetoric has failed to become reality and by studying *interventions in the health sector* they come to the conclusions that *health promotion policies* have not changed.

The conceptualization of health promotion as programmatic policy has been central to my research. This conceptualization offers an alternative to the concepts and perceptions advocated by system research, which continues to be the dominant approach in much of health policy analysis. Chapters 3 and 4, which describe the theoretical-methodological framework of this study as well as the data and the key concepts used to analyse the data, further clarify the theoretical and empirical underpinnings of this conceptualization.

3 Theoretical framework of the research

This study draws on the ideas of constructivism and sociological institutionalism, both of which emphasize the importance of meaning making, language, shared understandings and common discourses in policy-making. As indicated in the Introduction, constructivism and sociological institutionalism are appropriate approaches here since the most prominent international organizations of the policy field analysed – the EU and the WHO - have traditionally trusted in the above means of governance to influence their Member States. This chapter begins by locating sociological institutionalism in the wider map of new institutionalism and continues by describing how the individual publications are located to this map.

3.1 The rise of institutionalism

The term institutionalism refers to the importance attached to institutions (vs. individuals) in explaining how societies work. The so-called new institutionalism emerged at the beginning of the 1980s as a reaction to the behavioural perspectives[6] that were influential during the 1960s and 1970s (Hall & Taylor 1996). New insitutionalism is often divided into different schools of thought, which have been labelled rational choice institutionalism, historical institutionalism and sociological institutionalism (Hall & Taylor 1996; Schmidt 2005; 2008; Palola 2007). More recently two new approaches have been added to the theoretical map of new institutionalism: Scandinavian institutionalism[7] (Czarniawska & Sevón 1996; 2003) and discursive institutionalism (Schmidt 2005; 2008).

6 Or "in response to overemphasis on agency without structure" as Vivien Schmidt (2008, 313) has phrased it.

7 According to Boxembaum and Johnsson (2008) Scandinavian institutionalism does not represent the mainstream institutionalism, where US research predominates. According to them this is noteworthy since it addresses some of the shortcomings of mainstream institutional theory, such as excessive focus on mimetic processes, insufficient attention to the study of practice and limited use of qualitative methods.

All these different approaches are united by the importance attached to institutions, but divided along a number of other dimensions. These include the way in which they define the logic of political action. (Schmidt 2005, 4; Risse 2000.)

Rational choice institutionalism perceives actors as rational decision-makers whose behaviour is guided by utility maximization, strategic bargaining and rhetorical action. It focuses on strategic interactions in which actors participate on the basis of their given identities and interests and try to realize their preferences by behaving strategically. Their behaviour is understood to be guided by the *logic of consequentialism*. (Risse 2004; See also Kangas 1994; Saari 1994.) Although rational choice institutionalism is categorized as a variant of new institutionalism the other variants can be perceived to have emerged in reaction to it (Staniland 2010, 251). Historical and sociological institutionalisms challenged the logic of consequentialism, understood to be part of rational choice institutionalism but also part of old institutionalism (Powell & DiMaggio 1991), with the *logic of appropriateness*. According to the logic of appropriateness actors try to do the right or appropriate thing rather than to maximize their preferences. Behaviour is conceived to be rule guided and not purely rational.

While historical institutionalism in the field of welfare state research has emphasized path dependencies (i.e. the tendency of the institution to continue in the path once chosen) and continuity of national institutions (e.g. Pierson 2004), sociological institutionalism raises the analytical level from national to international. Secondly, although sociological institutionalism does not abandon normative rationality assumed in historical institutionalism, it considers that behaviour is not only and always reducible to norm-seeking, but is also guided by negotiation, argumentation and mutual consensus-seeking between the actors. This is called argumentative rationality. (Risse 2000; Schimdt 2008.)

Much of this debate has been taking place in USA and much of it is part of the overall battle between social constructivist and rational choice approaches in the social sciences, especially in the fields of international relations and comparative politics (Risse 2000, 1; Finnemore & Sikkink 2001; Keränen 2001; Wrede 2010). As the new institutionalism has not so far played any significant part in the Finnish university curriculum for social sciences, it has not been a self-evident point of departure for my research. I will now describe how I came across the variants of new institutionalism and how they have guided my research. Along with this reflective note on the research process, I will

introduce the main arguments of this broad debate on those parts which I consider relevant to my research.

Institutionalism became significant for my research from two different perspectives. The first has to do with the notion that the contemporary welfare state literature, with which I gained familiarity in the course of my master's studies, largely fitted the approach and limits of historical institutionalism. In historical institutionalism the methods were mostly quantitative time-serie analysis and the research was mainly concerned with describing the national or regional path dependencies and continuities in different domains of social policy or in entire "welfare state regimes". Qualitative data and methods were marginal and often overlooked in this tradition (e.g. Mahoney & Rueschemeyer 2003). In 2000 Alain Noël wrote how the emphasis that has been placed on the stability of institutions in the mainstream of welfare state research had been done the cost of analysing the role of policy debates and agenda setting in policy change. In response to these concerns he proposed a social constructivist research orientation. My data being policy documents and having an interest in agendas and questions of policy change, I found a suitable approach in social constructivism (Noël 2000; Hajer 1995; Risse 2000). Social constructionism or constructivism[8] takes the view that words do not only reflect or describe reality but also construct it. Accordingly language and texts are worth studying as they are seen to constitute reality (present or past) or to be part of "world-making" (Risse 2000; Fischer 2003; Paul 2009). Constructivist policy analysis fits the sociological institutionalism variant of new institutionalism (Finnemore & Sikkink 2001).

The second path to sociological institutionalism has to do with my research topic and the perception that national health promotion policies must be seen in the wider international and European context. While much of the earlier research approached the relationship of international organizations and their Member States in terms of hierarchical relationships and studied the influence of international organizations in terms of hard law instruments (e.g. laws, directives, financial aid) or in terms of rather mechanistic conception of programme transfer (Cf. Sevón 1996), sociological

[8] There is some variation in the terms used (Yanow 2006). Although social constructionism seems to be a more widely used term in social sciences, many authors in the specific field of policy analysis use the term constructivism and scholars of international relations oriented towards sociological institutionalism call themselves constructivists. (Risse 2000; 2004; Noël 2000; Finnemore & Sikkink 2001; Fischer 2003; Paul 2007; Wrede 2010.) I have used here the term social constructivism.

institutionalism framed the international-national relationship in terms of "world cultural models" (Mayer & al. 1997). According to this modern states have become increasingly similar as they have followed a shared world culture and its models (Mayer & al. 1997; Alasuutari 2009; 2011).

As much of mainstream sociological institutionalism was, however, based on quantitative analysis of a large number of countries, Scandinavian institutionalism offered deeper insights into the the local interpretation of these global ideas and models in small number of cases (Czarniawska & Sevón 1996). This on the other hand came very close to the interpretive approach to policy analysis, which also emphasizes meaning-making in the local context (Yanow 2000; Yanow & Peregrine-Shea 2006). Ultimately the research on transnational governance (discussed in Chapter 6) offered a framework where all these concerns were taken into account. Together new institutionalism, the constructivism and transnational governance approaches form the theoretical-methodological framework for my research. I now describe in more detail how my theoretical framework shifted from historical institutionalism towards sociological institutionalism in the level of individual publications. Transnational governance approach will be discussed in Chapter 6.

3.2 The shift from historical institutionalism towards sociological institutionalism

In Article I the transfer of *Health for All* policy was analysed in the context of the developmental phase of the welfare state. Studied from the premises of historical institutionalism it seemed that the launch of the *Health for All* policy did not result in any significant change, but the changes that occurred were of an incremental nature and made in accordance with earlier policy choices. The identification of historical phases or stages in the policy development is a common feature of historical institutionalism. Vivien Schmidt (2005, 6) writes how "historical institutionalism works best at delineating the origins and development of institutional structures and processes over time. It tends to focus on sequences in development, timing of events, and phases of political change." According to Pauli Kettunen (2008) the historical accounts based on phases tend to tell a story of progress, where a policy develops from immaturity towards maturity.

The problem with these stories is that they do not pay attention to the simultaneously available alternatives and contingent stories.

This concern is also shared by a genealogical approach to history. According to Paula Saukko (2003) genealogy is a method that investigates how certain taken-for-granted facts, such as scientific truths, are historical constructs that have their roots in specific social and political agendas. Genealogy can be used to analyse the historical formation of discourses and ideas. While the traditional history of origins legitimates the present by finding its roots in the past (e.g. calling Southern welfare states *ex-authoritarian*), genealogy on the other hand studies history in order to challenge the present (Articles III and IV). The genealogical method is characterized by a careful reading of historical details, not in terms of the truths they tell, but in terms of the truths they constitute. (Saukko 2003, 115–118.)

Article II about church discourse on health promotion was written from the constructivist point of view. On the basis of an analysis of majority churches' texts on health issues I identified a global metadiscourse on health promotion, which had travelled through different countries, institutions, professions, etc. This article also broadened the scope of the research from the state centred view to the societal perspective. By the time I came to write my third article the path-dependency of state policies as a built-in assumption of historical institutionalism began to look like a gridlock. Empirical accounts were harnessed by the theoretical assumptions of permanence and unchangeability (Look Greener 2002).

In new institutionalism, and especially in its sociological version, discourse and language are taken to constitute institutions (Paul 2009). Social norms and institutionalized knowledge (e.g. categorizations, comparative discourses with assigned subject positions) have constitutive effects, since they do not only regulate our behaviour, but also shape the identities of the actors and create an understanding who we are and how do we act as members of our social community (Palola 2007, 49; Risse 2004). Schmidt (2005, 9) writes how sociological institutionalism is understood to work best at "delineating the shared understandings ands norms that frame action, shape identities, influence interests. And affect what are perceived as problems and what are conceived as solutions." Risse writes how the value added of constructivism comes precisely from the constitutive role of ideational factors.

The constitutiveness of institutionalized ideas and discourses is taken as an explicit concern in Articles II, III and IV. Article II identified how the majority churches of the case countries share the key concerns of current health promotion policy with other societal institutions, namely radical health research, WHO and local governments. The churches do not position themselves in the field in a holistic manner, but have two different ways to locate themselves in the field of health promotion. In helping the poor, weak and marginalized, churches position themselves as a last resource, while in targeting action at substance abusers and women in fertile age, they position themselves as primary actors in giving the needed spiritual support, moral guidance and sexual education. In Article III the subject positions (e.g. laggard, forerunner) assigned to countries in the comparative discourses of international governmental organizations are taken to constitute the processes of identity formation and agenda setting. Locating countries in different comparative positions predisposes their future choices in terms of setting the objectives and defining the problems. Furthermore, after being positioned as a laggard or labelled as a periphery in different societal arenas (e.g. EU politics, welfare state research, media), these pejorative positions are also reproduced in the national policy-making. The Portuguese case exemplifies the constitutive power of these categorizations and demonstrates how difficult it is to break loose the positions assigned in the dominant discourses (Article IV). These findings are based on discourse analytical reading of different kinds of texts. The next chapter presents these texts as well as the applied methodological framework.

4 Research questions, data and methodological framework

This chapter presents the major methodological approach selected for my study. The first subchapter presents the core research questions of the study and the second is dedicated to the presentation of the research data. The last two subchapters describe the methodological underpinnings of the study as well as the key concepts used to analyse the data in the original articles. The purpose is not to repeat what has been said in terms of methodology in the original articles, but instead to locate my research in the wider methodological framework and to describe specifically those approaches that have guided the research process. I begin by presenting policy discourse analysis and continue by locating my research to the field of comparative social research.

4.1 Research questions

This study analyses the public health policies of Finland and Portugal in a comparative manner. Instead of delineating the national developmental paths of both countries, the analytical focus has been on their development in the interplay with the wider international and transnational context. By making visible the different means and channels of transnational governance, and by analysing their influence on public health policies of Finland and Portugal, the study offers new insights into European public health policies. Besides focusing on the national-international interplay, the study aims to broaden the scope of the state-centred view towards taking into account other societal actors, i.e. non-governmental organizations. Empirically this is done by analysing majority churches as actors in health promotion policy. On the other hand, by approaching the field of welfare state from the perspectives of public health policy and by means of discourse analysis, this research also contributes new knowledge on the borders of the welfare states.

The main research questions are:

1. How have the core ideas and practices concerning public health policies and health promotion policy advocated by WHO been interpreted in the national policy documents in Finland and Portugal? How has national health promotion policy changed in Finland and Portugal since the 1970s in relation to the ideas promoted in *Health for All* policy? (Articles I and III)
2. How is health perceived and how have the ideas concerning health promotion been interpreted by the majority churches of Finland and Portugal, and in UK the Anglican Church? What are defined as root causes of ill health and how do churches aim to tackle them? What are the component parts of the church health promotion discourse identifiable in all the case countries? (Article II)
3. How have governments used international comparisons authored by the WHO and the EU in the processes of identity-formation and agenda-setting in the specific domain of public health policy? (Articles III and IV)
4. How do policy comparisons and the related categorizations work? How do certain ways of thinking, which are often condensed into categorizations, become dominant and taken-for-granted in a certain historical period? How has the picture of southern Europe as rudimentary been formed in categorizations? (Article IV)

4.2 Data

The data consists of various kinds of written texts on public health policies from different countries (Portugal, Finland, the UK), international governmental organizations (WHO, EU), institutions (governments, ministries, churches) and different groups of policy-relevant actors (policy-makers, researchers, media, church). All the texts analysed are public, produced specifically to be widely read. They are also publicly accessible via the Internet. Even the older texts and historical archives (such as government platforms from the case countries or policy programmes and declarations of international organizations) have been digitalized and made available in the Internet, making it feasible for wider audiences to study contemporary history across countries. Almost all these texts were produced by a certain institution. The research literature is an exception. The scientific

texts analysed are written in English for international audiences and according to the tradition of scientific writing; they are published under the names of the authors. The idea of including such a wide variety of texts from different policy relevant actors was to grasp the phenomena of health promotion and its context (time and place) as widely as possible. The comparative and interpretive orientation of this study also requires a wide perspective on policy-relevant actors and specific emphasis on contextualization.

The time frame of the texts analysed is from the beginning of 1970s to the first decade of the 21st century. This period was chosen for analysis as it represents what has been called the era of new public health. As noted in Chapter 2, inherent in the notion of *new* public health is that of old public health, and alleged change. The core policy programmes promoted under the auspices of new public health, namely *Health for All by the year 2000* and *Health for All for the 21st Century*, were written for a time horizon of ca. 20 years. As such the suggested policy change is understood to take a relatively long time (Cf. Ziglio & al. 2000). By comparison, *Health in All Policies* is rather a principle than a programme (COM 2007, 7). Instead of a specifically defined time period it is assumed to be continuously taken into account.

The need to take a longer time horizon in research is also acknowledged by scholars studying the soft methods of governance used by international governmental organizations (e.g. Marcussen 2004; Ahrne & Brunsson 2004). This is taken into account in this study by analysing four decades of public health policy in order to see if and how policies have changed. In addition, extending the period to the beginning of 1970s enables an understanding of the emergence of the new public health thinking at the national level.

The data analysed can be divided into five categories:

1) policy documents[9]
2) programmatic texts
3) research literature
4) newspaper articles[10]
5) expert interviews[11]

9 The category of policy documents can be divided into two. While the first subcategory consists of different kinds of policy documents (e.g. declarations, programmes, recommendations, reports) produced by international organizations, the second subcategory consists of national policy documents. As the core international documents have been presented in Chapter 3, I will concentrate here on the national level policy documents.

10 Newspaper articles are used only in Article IV and since they are presented in detail in the original article, they are not discussed in more detail in this summary.

11 Semi-structured expert interviews conducted in Portugal were used as complementary data in Article I. See more on pages 52–53.

Most of data fall into the first two categories. It is common for national policy programmes and programmatic texts that the desired state of affairs is articulated in them by (a) producing definitions of the situation and (b) suggesting future objectives. This distinguishing characteristic apparent in all the documents analysed makes it possible to answer following questions: *To what problems, questions and situations does health promotion policy claim to respond*? *What are the objectives and goals of this policy*?

Besides the policy documents and programmatic texts, research literature (e.g. journal articles, reports, books) on health and social policy is analysed. As the research literature analysed is described and listed in the bibliography of the individual articles and their nature and status in relation to policy making is discussed in Chapter 2, they will not be presented in more detail here. However, it is worth mentioning that while in Article I the research literature is used to complement the analysis of policy documents in describing how the *Health for All* programme was adapted and interpreted in the case countries, in Articles II, III and IV research literature as well as the policy documents is analysed as one way among many others to present an account of the policy situation.

Policy documents

The bulk of data analysed consists of governments' policy documents from Portugal and Finland. I now describe this category of data in detail, likewise how the copies of relevant documents were obtained. At the end of this chapter I analyse the context of text-production.

The documents from Portugal include the Public Health Strategies (Ministério da Saúde 1999; 2004) and the following parts of the Government Programmes (I–XVII Governments) since 1976 and their annual and medium-term updates called *Grandes Opções do Plano* (*GOP*): the introductions, the Chapters on social, health, and environmental policy and the Chapters covering European issues. In Article I other government level policy documents were analysed, of which the most relevant were the *Reforma de Saúde e Assistência* (The Health and Asssistance Reform Bill) (1971), *Saúde XXI*[12] (Health XXI) (2000) and *Saúde de Mulher* (Womens' health) (1999).

Government Programmes are written for the mandate period of each government, which in Portugal is four years. In practice, however, the mandates may be shorter. This

[12] Saúde XXI is an operational health programme written for the 3rd Community Support Framework for the period 2000–2006.

was the case in Portugal especially in the years following the revolution[13]. Between 1976 and 1987 there were 10 governments. Based on Government Programmes the Parliament publishes documents called *Grandes Opções do Plano*. They can be loosely translated as major options of the plan: they have the status of law and they guide the actions of the ministries. The documents are published yearly, but sometimes also for the medium term (three to four years). As Government Platforms and *Grandes Opções do Plano* are printed in two columns in small letters and include hundreds of pages of texts, they can be described to be lengthy documents. Although *Grandes Opções do Plano* adhere to the government programmes and yearly published documents are in line with the medium term documents, there is variation among them. Texts have been updated, rewritten and amended. These documents can be understood to be strategic papers oriented towards the future but the amplitude and richness in the detailed description of sectoral policies also refers to their operationality. All the documents were accessible via open webpages.

From Finland the most important government level data were public health strategies (1986; 1991; 2001; 2008) published by the Ministry of Social Affairs and Health. As evaluations, commissioned from the WHO (1991; 2002) and published together by the WHO and the Ministry of Social Affairs and Health, have been widely disseminated and referred to in national programmes, they, too, have been used as data. Finnish public health strategies are medium-term programmes. They are a result of a lengthy preparatory process and until the strategy of 2001 they included extensive background information before the short policy recommendations. The programmes have been relatively lengthy, amounting 100–200 pages. The 2002 programme was not only shorter, but clearly more future oriented in its form. It also set clearer numerical targets than the earlier documents.

In Article III the Chapters covering health and social policy as well as European issues of the Government programmes since 1976 were also analysed. The Finnish Government programmes from the 1970s to the 1990s were very short and limited, having altogether 2–12 pages, and in most of them health policy was not discussed. Only since 2003 have these Government Programmes been more extensive. In Article

[13] The revolution which took place in 1974 ended the 48 years of an authoritarian and dictatorial regime in Portugal. Although the authoritarian regime (1928–1974) is in everyday language often referred to as fascism, political scientists have argued that conservatism, Catholicism and Christian democracy restrained the fascist elements (Almond & Powell 1966; Payne 1980). Manuel Braga da Cruz (1980) has called the regime baptized fascism (*fascismo baptizado*) to emphasize the influence of Catholicism in the Salazar regime.

I other governmental documents were also used, of which the most important were *Kansanterveyslaki* (Primary Health Care Act) (1972) and *Terveyspolitiikan tavoitteita tutkivan työryhmän raportti* (Report of the working group on health policy objectives) (1972).

While in Portugal the tradition has been to write extensive government programmes with specific sections covering public health issues from the early days of democracy, in Finland this tradition is relatively new. On the other hand, while Finland has a longer tradition in writing specific public health strategies, in Portugal this is a relatively new practice.

There are differences between the political systems of Portugal and Finland. However, as the present study is not concerned with political systems *per se*, I will comment them only as far as I consider them significant for my research and its intelligibility. First of all, I am interested in the political systems as a *context* for producing the texts analysed. Policy documents are produced in both countries mainly as expert work by ministerial level bureaucrats with support from researchers and experts.

In Finland, *Terveyden ja hyvinvoinnin laitos* (THL) (National Institute for Health and Welfare) is a sectoral research and development institution dedicated to health and welfare issues. It is a research institute for the Ministry of Social Affairs and Health and thus produces reports and information for the needs and interests of the Ministry. As a sectoral research institution it creates and maintains research networks with relevant university departments and other research bodies. THL was constituted in 2009 by the fusion of *Kansanterveyslaitos* (*National Institute of Public Health*) and *Stakes* (*National Development and Research Agency for Welfare and Health*). Stakes was constituted in 1993 from the remains of National Board of Social Welfare (Sosiaalihallitus) and that of Health (*Lääkintöhallitus*) in a process of major public sector reform. THL and its predecessors have traditionally had a central role in the creation of public health strategies and statistics.

In Portugal, the closest research institution to a Ministry of Health in terms of programme development is *Escola Nacional de Saúde Pública* (*ENSP*) (National School of Public Health). There is also a certain overlap as many of the civil servants of the Ministry hold positions in the *Escola Nacional de Saúde Pública*. Moreover, the *Observatório Português dos Sistemas de Saúde* (*Portuguese Health System Observatory*), which produces annual reports on performance and policy analysis, is organized in

ENSP. Besides these mention should also be made of the *Instituto Nacional de Saúde Doutor Ricardo Jorge* (*National Health Institute Doctor Ricardo Jorge*) as a provider of health information and a partner of cooperation.

These personal, institutional and knowledge based relationships around a common concern (such as public health), a cause (health promotion) or a project (drafting a national strategy, contributing to the maintenance of information systems) form communities. These networks and relationships can be called epistemic communities (See Chapter 2). Epistemic communities are to a large extent involved with the epistemic communities of other countries and result in transnational epistemic communities. Transnationality is partly overlapping with contacts and relationships created in the sphere of international governmental organizations. However, the former does not require the latter and they should not be confused.

In the latest health strategies the preparatory process is claimed to have been fairly open[14] in both countries and it is stated that large numbers of different stakeholders were consulted. While the latest Portuguese health strategy was in the making there was an opportunity to comment the draft via the Internet. In Finland the process involved hundreds of experts and advocates through a series of seminars, although not much of this preparatory work was ultimately included in the final document. This caused the WHO to criticize the preparation of the 2001 programme for being a closed expert oriented process (WHO 2002).

Although in both countries it is the community of policy makers together with the wider epistemic community that is responsible for writing the strategies for government or for the parliament (in the case of *Grandes Opções do Plano*) there is a difference in the relationship between the civil servants of the ministries and the government in office. In Portugal, the highest ranking civil servants in the Ministry of Health change when the government changes. In Finland, only one to three policy advisors of the Minister change when the government coalition changes. There is, however, another issue connected to this, which from the point of view of "policies as texts" is important and should be noted. Only two years after the first Portuguese health strategy for a medium term time horizon was published, the government changed and the newly appointed

[14] In the appendix 1 of the Finnish National Action Plan to reduce health inequities (2008) ca. 200 experts from various committees and different organizations that were consulted in the process are listed. Likewise the newest Portuguese health strategy mentions ca. 280 individuals who have given their contributions to the formation of the strategy.

Minister of Health withdrew the strategy. No new strategy of the same amplitude was developed; instead, a short booklet on public health issues was published (Ministério da Saúde 2001). The sudden withdrawal of the strategy was among the issues discussed in the interviews. One interviewee noted how "Health Strategy will anyhow continue its life as as new ways of thinking have been introduced".

Finland was the first country in the world to publish a national *Health for All* -programme 1986. In the language of organization research Finland together with the Netherlands acted as "pilot cases" for the WHO and its new programme format (*Health for All 2000*). The term pilot country soon became translated as "edelläkävijä" in the Finnish documents which is closer to "forerunner" or "pioneer" than "pilot". The pioneer position was keenly assumed and it has proved to be an essential part of self-description in the public health epistemic community. Part of the pilot case agreement was for a panel of international experts to evaluate the Finnish public health policy. This was done for the first time 1991. After the evaluation a second public health programme was published in 1993. A third national public health programme was published in 2001 and evaluated by a panel of foreign experts in 2002.

As a general notion about the audience for whom these papers were written, it is possible to argue that although the documents are public, they are primarily written for national and local level policy-makers and the field practioners of different institutions. This is certainly the case with the Portuguese government programmes and *Grandes Opções do Plano*, and for the public health strategies of both countries. The fact that all the Finnish public health programmes and their evaluations are published in English clearly indicates that international audiences are also taken into account. This is in part connected to the pilot country agreement the Finns made with the WHO. Obviously the *Saude XXI* also has specific international tone, as it was written in the sphere of EU's 3rd Community Support Framework.

Programmatic texts

While texts produced by national governments and international governmental organizations can be easily understood to fall into the category of policy documents, I had to ponder how to call the majority churches' programmes and statements on health promotion. Do churches produce policy documents? If policy is understood as *a statement of intent* of any given organization, then churches have policies, too. If we do not entirely

accept the state-centred vision regarding policy-making, one can assume that churches do indeed participate in policy-making. The same goes for the term agenda. Churches have their agendas, but also participate in the wider agenda-setting. Both words (policy and agenda) and especially the related terms (policy-making and agenda-setting) have become so widely associated with state policies, that their use in contexts other than formal state forums seems inappropriate or erroneous and would require an extensive explanation. So for the sake of clarity and in order not to be misunderstood I have here called these papers produced by majority churches "programmatic texts".

I chose those texts which took a stand on human health and well-being from the perspective of health promotion. The documents were not selected because of their potential "official status" as the voice of a church; rather, I picked out the documents where the churches define their own activities in relation to a broader field of actors and called them programmatic documents. They serve as references for longer-term action and presumably reach a wider audience than policy statements concentrating on one issue and drawn by the churches' central administration at the request of central government authorities. In addition, the formulation of programmatic documents can be regarded as an indication of the churches' desire to establish a profile in the area in question.

Expert interviews

Although the analysed data consists of texts, I used semi-structured expert interviews, conducted in the course of the research project *Finnish Health Promotion Policy from an International Comparative Perspective*, as offering background information and understanding. These interviews also served to ensure the identification and location of the relevant published and unpublished sources in the field.

Numerous documents were obtained in the two field visits made to Portugal in 2003 on the project *Finnish Health Promotion Policy from an International Comparative Perspective*. The purpose of the visits was to find so called grey literature[15] and carry out semi-structured interviews with public health experts. Altogether 20 interviews each 40–120 minutes long were carried out in Lisbon and Coimbra. Nine of the interviewees

[15] The term grey literature refers here to different kinds of texts which are not easily accessible from public sources, such as public libraries or which are not publicly delivered via the netpages of the relevant organizations, such background papers, unpublished evaluations and reports.

worked in the *Ministério da Saúde* (*Ministry of Health*) and four worked in *Escola Nacional de Saúde Pública* (*National School of Public Health*), three researchers from the *Instituto Nacional de Saude Dr. Ricardo Jorge* (*National Institute of Health, Dr Ricardo Jorge*) were interviewed. Further interviewees included: two academics outside the *Escola Nacional de Saúde Pública*, a local level healthy city coordinator, and a priest who had organized the *Pastoral da Saúde*[16] in Portugal. All the interviews were tape-recorded and transcribed afterwards. The interviews as such could not be used as data since no permission for this was requested at the time. Nevetherless they served as an introduction to Portuguese way of conceptualizing the field. These interviews also strengthened my conception of the role played by the *Grandes Opções do Plano* in public health policies. The number of interviewees provided different views and opinions on the issue at hand. In the Article I, the information gathered in the interviews was used as a complementary source to written documents while respecting the anonymity of the interviewees.

Although no expert interviews were carried out in Finland for the purposes of the research project *Finnish National Health Promotion Policy from an International Comparative Perspective*, in 2003 similar interviews with key actors were carried out for the purposes of evaluating *Health for All* policies in several European countries. This evaluation was commissioned by the European Regional Office of the WHO, and in Finland the interviews were conducted by myself and my fellow researcher, under the supervision of Professor Juhani Lehto. Besides these interviews I became acquainted with the Finnish way of conceptualizing health promotion by following the Finnish media and participating in seminars on national health promotion issues and policies.

The use of data and different methodological contexts

There are many different actors or interpretive communities (e.g. governments, media, churches, research communities) in the field of health promotion and each of them has their own understanding of policy, which is communicated through different means. (Yanow 2000, 26–27.) These different communications, of which I have focused particularly on policy documents and programmatic texts, but also on newspaper articles and research literature, exist without the researcher and as such they offer a

16 An institution of the Roman Catholic Church concerned with promotion of health.

natural data to analyse. The researcher does not sanitize or manipulate the data in any way, but has the power to choose whose and which documents to analyse. I approached health promotion policies by analysing the texts of different interpretive communities and by using different discourse analytical frameworks (See Table 1). Before describing the methodology in more detail in the following subchapter, I present some of the main notions of the interpretive tradition on analysing policy documents as data.

Given that policies have many artefacts, such as policy documents, speeches, buildings and monuments (Yanow 2000, 27), it is reasonable to ask why study policy documents in particular. According to Richard Freeman (2006, 52), government in general is a "text-based medium" and thus it works essentially by producing and communicating its ideas, suggestions, proposals and plans in the form of texts. In health promotion politics, in particular, the production of a key text is argued to be the case across countries. Elina Palola (2007, 44) has connected the increased production of texts to the ongoing processes of change in governance. While governance is constructed to be based on wider networks of actors, the significance of text in politics increases. Palola takes the view that the textual expansion in the EU in particular is facilitated by the fact that the politics of the EU are essentially rather programmatic than system-based. This notion of programmatic nature of policies is appropriate for health promotion in particular as it is by definition assumed to be multi-disciplinary, intersectoral and community based policy. Moreover the fact that it has been characteristically international in nature makes its interpretation as a programmatic policy very appealing. As a programmatic policy it has been essentially narrated into existence in these texts. (See Chapter 2.)

Besides the above argument on how texts are fundamental in health promotion policy and worth studying, they are relatively easily accessible data. However when texts are analysed from the premises of interpretive policy analysis, the process of data collection is not limited to securing the copies of the relevant documents. Dvora Yanow notes how the whole concept of data *collection* seems alien to this research tradition, which requires data to be treated *in their context* and not separated from their sources. According to Yanow "what is collected, if anything, are the *researcher's observations and interpretations* and *copies* of relevant documents. In this sense we might more properly speak of *accessing the local knowledge* that the analyst needs to make sense of a policy situation (italics added)." So to be more accurate, "data" for interpretive policy analysis are words, symbolic objects (here policy documents, programmatic texts) and acts (here

the act of agenda-setting or knowledge-building) of policy-relevant actors along with policy texts, and the meaning these artefacts have for them. (Yanow 2000, 26, 69–70.)

Table 1. Data and theoretical-methodological frameworks applied in the original publications

Original publications	Data	Theoretical and methodological framework
I Transfer of Health for All policy – What, How and in Which Direction? Two-case study	• Finland: Primary Health Care Act (1971), Health Report by Economic Council (1972), National Public Health Programmes (1986, 1993, 2001) and their evaluations (1991, 2002) • Portugal: Reform on Health and Assistance (1971), Chapters on social and health policy of Government Programmes and GOPs 1976–2003, National Health Strategy (1999), Saúde de Mulher (1999) Saúde XXI (2000) • Semi-structured expert interviews	• Theory oriented content analysis
II Search of Church Health Promotion Discourse	• Majority Churches' programmatic documents on health and welfare from Finland (1995, 2005), Portugal (1999, 2001, 2005) and England (1985)	• Critical discourse analysis, intertextuality
III From Averages to Best Performers: Use of Comparisons in Identity-formation	• Finland: National public health strategies (1986, 1993, 2001) and their evaluations (1991, 2002) National Action Plan to reduce health inequalities 2008–2011 (2008), Chapters on social and health policy of government programmes (1976–2009) • Portugal: GOPs and Government Programmes 1976–2009 (Introductions, European issues, social and health policy)	• Social interactive discourse theory
IV The Power of Comparisons	• Scientific publications on welfare state comparisons 1990–2000 • 5 EU reports and programmes on cohesion and regional policies • Social and health policy parts of Portuguese Government programmes and GOPs 1976–2009 • 88 Articles from the major Finnish newspaper *Helsingin Sanomat* 1.1.2011–30.7.2011	• Genealogy, discourse theoretically oriented policy analysis

The thematic interest in wide variety of international forums (WHO, EU, churches, the research community), the timeframe of four decades and the comparative research design (2–3 countries) resulted in an ample amount of data for analysis. I was able to complement the data during the research process, which ensured its topicality throughout the years. In evaluating the data in retrospect, it is possible to argue that

it provided a rich and broad basis for the analysis. Its strengths also lie in its diversity (published and unpublished documents, government documents and majority churches documents, national documents – international documents etc.). On the other hand, by analysing mainly government level documents, there is an obvious risk that only the governmental view is included. In this regard including also the parliamentary debates or wider variety of background papers produced by different policy relevant groups in the data could have made the data more representative.

4.3 Policy discourse analysis

Policy is a common term. It is used in everyday life but it is also part of the language of elites, such as politicians, businessmen or academics. The term has become ubiquitous in the parlance of governments and organizations, particularly in how these bodies represent themselves, define their goals, or present their *raison d'être* (Wedel & al. 2005, 36). But how is policy perceived[17]?

An instrumentalist view of government conceptualizes policy as a tool to regulate a population from the top down, through sanctions and restrictions, but also through rewards and incentives. According to this understanding policy is an "intrinsically technical, rational, action-oriented instrument that decision-makers use to solve problems and affect change" (Shore & Wright 1997, 5). Chris Shore and Susan Wright argue that when policies are objectified this way they acquire a seemingly tangible existence. But on closer inspection, policy fragments and it becomes unclear what is "a policy". While Dvora Yanow (2000) speaks of different artefacts of policy, Shore and Wright (1997, 5) ask if policy is found in the language, rhetoric and concepts of political speeches and party manifestos. Or is it the written document produced by government? Or is it embedded in the institutional mechanisms of decision-making and service delivery? They emphasize that policy can be all these, and in these various manifestations it may differ enourmously. In a more abstract vein three levels through

[17] Before explicating how policy is defined in the literature and how it is perceived in this study, one important observation should be made. Although it is relevant to discuss the political nature of policy in the English-speaking world, the issue is conceptualized differently in Finnish and Portuguese languages. The inherently political nature of policy is manifest in the fact that there exists only one term that refers primarily to *politics*, but accounts also for *policy* (term *política* in Portuguese, *politiikka* in Finnish).

which policy operates can be differentiated: structures, agencies and discourses (Wedel & al. 2005). Here the focus is on the third.

The anthropologists Shore and Wright (1997) write how, despite the fact that policy has become a major institution in Western and international governance it is treated ideologically and politically as neutral. It has also been argued how "policy is typically represented as something that is both neutral and rational: a mere tool that serves to unite means and ends or bridge the gap between goals and their execution – in short a legal-rational way of getting things done" (Wedel & al. 2005, 37).

The problem with the broad field of policy studies is that it continues to operate with a positivistic paradigm that treats policy as an *unproblematic given*, without reference to the sociocultral contexts in which it is embedded and understood (Wedel & al. 2005; Yanow & Peregrine-Shea 2006; Wrede 2010). In a rational system model policy is represented as a neat linear process of "problem identification", "formulation of solutions", "implementation" and "evaluation" (See also Hajer 1995; Paul 2009). Instead of using this model as an analytical device, many analysts have tended to treat it as a prescriptive framework so that the normative tone as to how policy *should* be made, implemented, and evaluated, creeps into the analysis (Wedel & al. 2005, 38; Compare the prescriptive nature of "committed policy analysis" introduced on pages 27–28).

Although the rational-linear model of policies continues to be dominant in policy studies, in social sciences, in modern governments, and in everyday life there are alternative ways of perceiving policies (Wedel & al. 2005; Risse 2004). Particularly prominent approaches have been developed in interpretive policy analysis (Yanow 2000; Yanow & Peregrine-Shea 2006), constructivist policy analysis (Fischer & Forrester 1993; Fischer 2003; Hajer & Wageneer 2003) poststructuralist discourse analysis (Hajer 1995: Hajer & Laws 2006: Paul 2009; Howarth 2000) and in the anthropology of public policy (Wright & Shore 1997; Wedel & al. 2005). These different approaches have guided my understanding on how to perceive policies and how to analyse them. They all focus on meaning and meaning-making in specific situational contexts, as well as processes of sense-making more broadly (Yanow 2006).

There are various definitions of discourse and various ways to conduct discourse analysis (Fairclough 1992; 2003; Hajer 1995; van Dijk 1997; Wodak & Mayer 2001; Wetherell, Taylor & Yates 2001; Holstein & Gubrium 2008; Vuori 2001; Paul 2009). Although the English term "discourse" refers to "discussion", and the Portuguese

concept "discurso" signifies "speech", in discourse analysis the concept refers to something the analyst infers from a situation. (Vuori 2001, 83.) Discourses can be described as patterned ways of thinking and arguing. Although various discourses operate concurrently, dominant discourses stand out by setting up the *terms of reference* and by disallowing or marginalizing alternatives (Seidel 1997). Especially in policy analysis the question of identifying the dominant discourses is important since it allows us to analyse who has power to define them, and by analysis making these discourses and their often axiomatic nature visible. I have identified the dominant discourses of different institutions, organizations or historical periods in the individual publications.

An interest in questions of power and dominance has led many researchers who study policies from a discourse analytical point of view to draw on French post-structuralist theory and specifically the work of Michel Foucault (1989; 1995). (Shore & Wright 1997; Hajer 1995; Vuori 2001; Hajer & Laws 2006; Rautalin & Alasuutari 2007; Paul 2008.) In this scholarship, discourses are seen as patterns of social life, which not only guide discussions, but are institutionalized in particular practices. These patterns and practices are contextual and discourses are connected to a certain historical time and place. Foucault used the term discursive formation to describe metalevel discourses that govern certain historical periods and go beyond particular themes, targets, expressions, institutions, professions, theories and disciplines. (Vuori 2001, 83; Foucault 1982.) This embeddedness of discourse in various different domains and across various boundaries is aptly described by Jaana Vuori (2001, 90–93), who defines discourse as "intertextuality chrystallized in repetiton". In Article II, I applied Vuoris's notion of discourse to identify the key texts and discourses of health promotion. Based on the empirical analysis of churches' programmatic documents I argue in Article II that health promotion, which has crossed institutional, organizational and professional boundaries, can be considered as one of the metadiscourses of our time.

Marten Hajer's (1995) social-interactive discourse theory and his later work on discourse as an ordering device (Hajer & Laws 2006; Hajer 2009) are especially suitable for policy analysis. I applied Hajer's theoretical-methdological considerations in Articles III and IV. Hajer describes the process of discourse analysis as follows "Analytically we try to make sense of the regularities and variations in what is being said (or written) and try to understand the social backgrounds and the social effects of the specific modes of talking. First by analysing in which context a statement is made or to whom statements

are directed… One may also point to a content of what is being said." Hajer himself combines these two levels and defines discourse "as an ensemble of ideas, concepts and categories that are produced, reproduced, and transformed in a particular set of practices and through which meaning is given to social and physical phenomena, and which is produced and reporoduced through an identifiable set of practices" (1995, 44). A key point of this approach is that linguistic utterances cannot *usefully* be understood outside the practices in which they are uttered. Hajer's analogy clarifies what is meant by *practice* in the context of discourse analysis: "If discourse analysis is the analysis of language-in-use, the practices are the sites where language is used." (Hajer 2009.)

The emphasis on analysing the sites where language is used bears a resemblance to Norman Fairclough's (1992) three dimensional notion of discourse. In his critical discourse theory, discourse consists of three interrelated elements: text, discursive practice and socio-cultural practice. These are all an essential part of discourse and should be taken into account in analysis. What is common to all these different terms – context, practice, setting, site-of-use, intertextuality – is the emphasis given to the contextualization of used language.

While in Article I I approached the data from the point of view of historical analysis and applied factual reading of the documents, in the rest of the articles I drew on different discourse analytical reading traditions. In the second article I draw on the critical discourse theory (Fairclough 1992) and the concept of intertextuality (Vuori 2001). In the third and fourth articles I analysed texts using Maarten Hajer's (1995, 2006) analytical devices. What unites these different ways of analysing the data is the emphasis given to contextualization and to the productive nature of discourses. But what does it mean that discourses are productive?

According to Richard Freeman (2006, 52) "policy documents are not only material objects or tools in technology of governance, but they are also important for the vocabularies and ways of thinking they generate, reproduce, translate and set in motion". Freeman writes how documents do not just *communicate knowledge and ideas*, but they serve to coordinate behaviour by linking the authors of the texts to each other (as a group using a common language) and to specific readership (by the chosen format and method of publication). In this process text becomes a source of authority (e.g. the Ottawa Charter), a vehicle by which influence is established and exerted. Documents do not only link authors and readers, but references, footnotes and other elements of

the document make links to other texts. Texts never exist in isolation, but always make references to other texts. This is called intertextuality. Epistemic communities are held together by a dense web of intertextuality.

Intertextuality does not only characterize the texts and their references; it is also part of the act of reading[18]. Through the concept of intertextuality it is possible to trace not only the key texts regarding certain phenomena, but also the discourses as a content of these texts as well as the key actors in the field. Freeman (2006), who analysed policy documents on health equity in several countries argues that the politics of health equity are expressed or realized in the research documents, and that intertextuality is actually the way that documents work.

The productivity of discourse also has another dimension. This aspect of productiveness is more conventionally called the constitutiveness of discourse. David Howarth (2002, 9) defines discourse as "historically specific systems of meaning which form the identities of subjects and objects". The constitutive nature of discourse is also present in the following definition by Shore and Wright (1997, 22): "discourse is a particular way of thinking and arguing which involves the political activity of naming and classifying, and which excludes other ways of thinking". Because dominant policy discourses shape the ways of classifying people, societies, nation-states and defining problems and solutions, they have material consequences. The idea of a strategic acting subject (rational choice institutionalism) is corrected by recognition that discourses come with subject positions that guide actors in their perceptions (See Chapter 3). Articles III and IV analyse the constitutive nature of the some of the core societal discourses empirically.

4.4 The comparative approach

This study is a case-oriented cross-cultural policy comparison. It has been argued that comparisons play such an essential part in our thinking and reasoning that all research is to some extent comparative. (Keränen 2000; Oinonen 2004.) But regardless of the overall human tendency to compare, there is a distinct branch of research called *comparative social research*. According to a common definition research is comparative

[18] In reading the text we try to discover its meaning(s) by tracing the textual relations. Reading becomes a process of moving between texts. (Freeman 2006, 52–53.)

when it "studies a particular issue or phenomena at least in two countries, societies or cultures with the express intention of comparing their manifestations in different socio-cultural settings in a systematic manner" (Hantrais & Mangen 1996, 1). However, there are different approaches to comparative social research. (Tilly 1984; Ragin 1987; Oyen 1989; Alestalo 1992; Hantrais & Mangen 1996; Keränen 2000; Wiener & Diez 2004; Anttonen 2005; Paul 2009; Wrede 2010.) One of the most common distinctions between different approaches is the number of cases compared. Research that compares a large number of cases is called variable oriented comparative approach and research which compares a few cases is known as case-oriented comparative research. (Ragin 1987.) This is a very sound distinction since many other distinctions, such as seeking generability vs. particularity, using theory driven vs. empirically oriented approach or quantitative vs. qualitative analysis are related to the number of cases compared. (Kautto 2001; Oinonen 2004.)

According to Linda Hantrais (1996, 1–2), cross-national comparisons have been used by social scientists since the 19th century to achieve various objectives. Some have used comparisons as a tool for developing classifications of social phenomena and establishing whether shared phenomena can be explained by the same causes. Research in this vein has aimed at building theories and testing them. (Adcock 2006.) In mapping the history of contemporary comparative social research Else Oyen (1990, 12–13) writes how the emphasis used to be on comparisons seeking *uniformity* and attempting to establish *generality* of findings across national borders in an attempt to imitate the "logic of experiment" (see also Adcock 2006). Citing Pjotr Sztompka (1988) Oyen concludes that by the 1990s the time had come "to search for uniqueness and comparisons that point to the peculiarities of a country". Back in 1996 Linda Hantrais and Steen Mangen also estimated that the shift was occuring "in emphasis away from descriptive and "culture-free" approaches back to a concern with critical case-studies and other explanations of social phenomena that are rooted in their social-cultural setting" (Hantrais & Mangen 1996, 5).

The turn towards an interpretative and culture-bound approach meant that linguistic and cultural factors were taken into account. In this tradition comparisons can be used either as an *analytical framework* for examining and explaining social and cultural differences and specificity or *as a means of gaining a better understanding* of different societies (Hantrais 1996, 1–3). Tom Mackie and David Marsh (1995) argue that the shift

towards contextualization has been taking place since the 1950s. They point out how the tendency has turned from comparisons of institutions and behaviour towards *policy comparisons*. On the wide map of comparative research this is the area where I locate my research.

Besides being a policy comparison, my approach bears similarities with both case-oriented (Oinonen 2004) and cross-cultural research traditions (Keränen 2000). Historically case studies have their roots in anthropology, but in the sphere of purportedly comparative social research the origins of case studies can be found in the criticism voiced about macro comparisons. According to Risto Alapuro (2004, 56–58) macrocomparisons tracing causalities and big structures have been critized since the 1980s as a result of the linguistic turn and the rise of cultural studies. This criticism gave rise to a new way of comparing countries.

Case studies emphasize the importance of the context as well as qualitative data and its empirical analysis (Wrede 2010). Marja Keränen (2000) argues for cross-cultural comparative research which focuses only on a few cases and uses the ethnographic approach. According to Eriikka Oinonen and Matti Alestalo (2006, 214–215) the benefits of comparing only a few cases are related to the ability to keep the research process open and reflexive. In practice this means that research questions can be adjusted in the middle of the process and new data collected. By focusing on only two countries I have been able to benefit from these features. Firstly, I was able to change the perspective from the historical reading of policy documents towards their constructivist analysis. Secondly, although the original purpose was to compare government policies, after identifying majority churches as relevant actors in health promotion, I was able to broaden the scope of actors from governments to non-governmental organizations. Article II addresses the majority churches' role in health promotion policy in Finland, Portugal and also in the UK, in order to avoid a simplistic view between the "Protestant North" and "Catholic South". Taking the UK along with Finland and Portugal made it possible to identify similarities across three different cases and to expose the common core of the church discourse on health promotion.

The core of comparative research is to locate the phenomena, structure or process to be analysed in the context of time and place (Oinonen & Alestalo 2006, 209; Alapuro 2004, 62). Time wise the era of new public health forms the context for this study. It is inextricably linked to the growing influence of international governmental organizations

in policy-making. In terms of comparisons, the first two articles were concerned with the national interpretation of international policies by emphasizing national particularities and specificities (e.g. the role of churches, or the interpretation given to the *Health for All* programme in the developmental phase of the welfare state). The last articles approached the issue more from above by analysing the constitutive power of transnational discourses and comparative practices of international governmental organizations.

The transnational context

It has been argued that the dominant approach in much of modern social science including policy studies and comparative research, has been rooted in "methodological nationalism" – the assumption that "all social relations are organized at a national scale or are undergoing processes of nationalization" (Brenner 2004, 28; Mahon & McBride 2008; Kettunen 2008; Alasuutari 2009). Pauli Kettunen (2008) recognizes how methodological nationalism rooted in comparative research makes it difficult to take into account the interdependency of the societies under analysis and that these units have been shaped as a result of international comparisons. Kettunen recognizes that methodological nationalism has also been built into the practices of comparative knowledge production of international organizations (Kettunen 2008, 17). Articles III and IV aimed at explicitly taking these issues into account by studying the constitutive power of comparative practices and discourses.

Although the debate on methodological nationalism has made the national view visible in recent years, the narrow view on the endogenous developmental paths of nation-states' policies had already been challenged. At the turn of the millennium the debate on the interplay of inter/national ideas and policies was conceptualized in terms of policy transfer (e.g. Dolowitz & Marsh 2000). It should not be forgotten that the question has been on the agenda of comparativists even longer for example in the form of convergence (i.e. the tendency for societies to become more similar).

The recent literature on transnational governance has, however, challenged the old ways of perceiving the interplay between national and international. (Mörth 2004; Djelic & Sahlin-Andersson 2006; Mahon & McBride 2008.) While states used to be treated as the central actors, transnational governance takes the view that "although nation states still make policy they do so in increasingly dense web of transnational networks, operating at different scales" (Mahon & McBride 2008, 3). In this perspective

international organizations are seen to function as nodes or forums in these networks. Rianne Mahon and Stephen McBride (2008, 5) also emphasize how nation-states still matter, but their boundaries are increasingly recognized as permeable. As stated above, the concept of transnational recognizes a wide variety of boundaries and scales. The modes of transnational governance practised in the sphere of international governmental organizations are discussed in Chapter 6.

The increased amount of research focusing on international fashions, structures and organizations has brought with it a growing number of concepts describing the relations of different actors. As a result besides the need to specify the unit of analysis (country, state, society, sector, policy) anyone involved in doing comparative research should also consider whether they want to approach the phenomena from a *transnational* or *international* point of view. (Hantrais & Mangen 1996; Smelsner 2003; Diez & Wiener 2004; Djelic & Sahlin-Andersson 2006; Mahon & McBride 2008.) There is a certain ambiguity as to how these terms should be understood and how they are used. Marc Evans (2004, 28–29) recognizes as international those structures and processes which inform *state-to-state relations* such as the United Nations and as transnational the increasing importance of *non-state actors* in policy-making. Following Ulf Hannerzt (1996) Morgan (2006) points out how many of the linkages in the so-called *international* sphere do not actually involve nations or, states, but instead the actors are individuals, groups or movements. In sum, while the term *international* is typically taken to refer to relations between states, the term *transnational* can encompass a wide variety of different types of actors and different sorts of connections across varying numbers of national boundaries (Morgan 2006, 140–141). The idea of health promotion has been transnational, likewise the epistemic community, but the WHO and the EU have offered international organizational forums for health promotion policy development and its diffusion to national contexts.

The welfare state context

As described in Chapter 2, public health policy, has since the 1970s, been known as new public health. This term entails an understanding that public health policies should be understood in the context of wider social policies. International welfare state research has studied national social policies from a comparative perspective (Arts & Gelissen 2002). In these studies Portugal and Finland are generally categorized as belonging to different

welfare state models, types or regimes. In short, Finland is understood to belong to the group of Nordic or Scandinavian welfare states (Erikson & al. 1987; Alestalo & Flora 1994; Kautto & al. 1999; Alestalo & Kuhnle 2000; Kautto 2001), while Portugal is taken to represent the Southern European welfare state model (Leibfried 1992; Kosonen 1994; Ferrera 1996; 2000; Rhodes 1997; Guibentif 1997; Palier 1997; Moreno 2000).

The Nordic model is known for its emphasis on universality and equality, and for its wide and mostly tax-financed public sector as a provider of the services. The recognized characteristics of the Southern model are fragmented and dualized social protection with a focus on occupational insurance, a universal health care system, familialism, particularism and clientelism. Although the focus of this study is not the welfare state *per se* but public health policy and its changes in the context of international policies, the classification of countries provided by welfare state research served as the selection criteria for country cases, since the public health policy is determined by broad social policies and since its contemporary variant is claimed to be understandable in the context of welfare state. (See Blank & Burau 2004, 16.)

Paul Spicker (1996, 72) locates policy comparisons in the wider welfare state regime modelling. He rejects the broad brush of modelling in regime analysis for the purposes of policy evaluation. Spicker argues that the models generally refer to overall systems, and when the focus shifts to subsystems, such as public health policy, the normative classifications are much less helpful. He points out how normative distinctions are not necessarily identified with clear differences in the approach to policy. Spicker also notes how categories are static, while policy-making is dynamic. However, these notions have not guided much of the subsequent comparative policy studies. If, for example, we look at the comparative treatment of public health policy in relation to welfare state models, researchers have taken the earlier categorizations as a self-evident starting point and tested the validity of proposed welfare state models in the area of public health by choosing certain measurable indicators. Vicente Navarro and Leiyu Shi (2001) chose child mortality rates and compared them in different welfare models. More recently Lundberg and co-workers (2008) compared how the family and pension policies of different welfare states are related to infant mortality and old-age excess-mortality.

What is accepted as a valid knowledge about social and health policies in different European countries and in European policy-making is largely based on research. Comparative research has established the vocabulary used to communicate in the

European context, to position us and our country on the European map, to understand our differences and similarities. Even when we do not explicitly set out to compare, we do it implicitly. According to Oyen (1990), the most prominent form of comparative research is actually a single-case comparison. Categorizations of Southern and Northern models have offered a solid base for understanding European differences, but at the same time they are also frustratingly reductionist (Luhtakallio 2010, 24) and surprisingly biased. This observed bias (Alestalo & Flora 1994; Hellsten 1995; Baldwin 1996; Spicker 1996; Hantrais & Mangen 1996; Moreno 2000; Keränen 2001; Kuisma 2007; Alestalo, Hort & Kuhnle 2009) in favour of Northern European or Scandinavian countries is at odds with one of the pronounced reasons for doing comparative research, which is to overcome provinciality. (Keränen 2000, 83.)

These observations can be taken as a call for greater reflexivity while doing research and to critically examine the theories and concepts used. Marja Keränen writes that only by comparing does the researcher gain an understanding of the parochialism of his/her world and thinking. Gaining awareness of our locatedeness is not something to be done once and then forgotten but is a continuous challenge throughout the research process. This challenge is endorsed by the observation that theories are always contextual or culture bound (cf. Baldwin 1996; Keränen 2000). By gaining an understanding of our locatedeness we could make visible the taken-for-granted assumptions in comparative social and health policy. (Kettunen 2008, 130.)

The purpose of the chosen approach is not to present an exhaustive description of public health policies in the case countries, nor in light of the expertise gained from the exhaustive description to prescribe future policies. By combining a comparative approach with discourse analysis and constructivist policy analysis I have aimed to get closer to interpretations of health promotion in different cultural contexts and to render comprehensible the framework where nation-states set their agendas and make their policies. (Cf. Osborne 1997, 75.) This is pursued by making visible the modes of governance used by international organizations. Empirically analysing comparisons from the discourse theoretical perspective has allowed me to reveal how comparisons work as governance instruments. The chosen approach has also made it possible to analyse their constitutive effect on identity-formation and agenda-setting.

5 Main results of the original publications

This dissertation consists of four original publications. This chapter provides short summaries of the individual publications. Each publication approaches the core questions of the dissertation from partially different perspectives. Article I is an introduction to the field of contemporary European health promotion policy. It approaches the issue by comparing the government policies of Finland and Portugal in relation to the *Health for All* policy advocated by the WHO. Article II broadens the state centred perspective towards a societal perspective by analysing majority churches of Finland, England and Portugal as actors in health promotion policy. By analysing the uses of international public health comparisons in national policy-making Article III sets out to shed light on the constitutive power of these comparisons. Article IV continues the analysis of international comparisons and traces how certain taken-for-granted categorizations have emerged and gained a dominant position in European public discourses. Because two of the articles were published only in Finnish, the main research questions, the key concepts and the major results of these are presented below.

5.1 Transfer of Health for All policy – What, How and in Which Direction? A two-case study (Article I)

Article I explores the transfer of the *Health for All* policy to the national contexts of Finland and Portugal. The *Health for All* policy is conceptualized as an *ideal policy model* constructed in different policy programmes. The intention was to analyse the national interpretation of the *Health for All* policy from the viewpoint of change and to find out how it challenged and altered national public health policies. Finland and Portugal were chosen for comparison as they represent different welfare state types and as the transition from the old to new public health is assumed to be related to the wider welfare state development. (de Leeuw 1989; Navarro & Shi 2001; Navarro 2002.) The

interpretation given to the *Health for All* policy in Finland and Portugal is analysed in the historical context of broader welfare state development.

The policy transfer approach (Dolowitz & Marsh 2000) is used as a conceptual tool to analyse the possible policy changes related to the adaptation of the *Health for All* policy to the national context. According to David Dolowitz and David Marsh (2000) policy transfer is a theoretical perspective that has been used to describe the spread of policy ideas from one political setting to another. While most studies have concentrated on studying the transfer between countries, here the transfer is assumed to be mediated through an international organization (WHO) to its Member States. Considering the WHO as a mediator and not as an initiator also makes it possible to take account of the idea transfer from Member States to the WHO.

The article departs from the recognition that *Health for All* is an ambiguous policy and not a coherent health strategy that can be interpreted neatly and consensually. Its ambiguity follows from the fact that it is constructed in many different documents, in temporally and contextually different situations. By focusing on the core contents of four repeatedly referred policy documents (The Declaration of Alma-Ata 1978, Targets in Support of the European Regional Strategy 1985, The Ottawa Charter 1986, Health 21 for Europe 1999) three dimensions of the *Health for All* policy were chosen for analysis: primary health care, the community approach and healthy public policies. By focusing on the analysis of these aspects Article I explores how health promotion policy has changed in Finland and Portugal since the 1970s in relation to the ideas put forward in *Health for All*.

In terms of the institutional context (e.g. laws, system reforms) the development had been similar in Finland and Portugal in relation to primary health care. In both countries laws were passed in 1971 dealing specifically with primary health care and having the goal of creating a nationwide network of health centres. The launch of *Health for All* with its primary health care emphasis did not change the nationally chosen path in this respect. In terms of interpretation it was observed that the concept of primary health care was not given a radical tone (Cf. Declaration of Alma-Ata 1978) in either of the countries of interest, but was translated into a more reduced concept of primary *medical* care.

The second dimension analysed was the community approach. A wide variety of setting-based projects coordinated by the WHO and understood to represent the local

level of the *Health for All* policy (e.g. Healthy Cities, Network of Health Promoting Schools, Healthy Workplaces) was iniatiated in Portugal in the 1990s. The model of community action adapted with these projects introduced a new ideology (i.e. universality) and forms of organization into the sphere of public health. In this respect a change took place in the course of the *Health for All* policy in Portugal. In Finland, the community approach was identified in the early 1970s under the concept of *North Carelia Project*. This project named after one of the north-eastern provinces of Finland introduced a novel approach to improve health in local communities. It was considered a success in terms of improving the health of the population and gained international recognition. No change followed from *Health for All* in this respect. Instead it has been suggested that the direction of the transfer was from Finland to the WHO and to other countries.

Thirdly the transfer of healthy public policies was analysed. In Finland, people's health was already improved through comprehensive planning systems in the early 1970s. The public health argument was advocated in different policy domains, for example in alcohol, nutrition, tobacco, environment and physical exercise. In this area, too, Finland has been claimed to be among the forerunners in Europe and the *Health for All* programme did not change the already chosen path. In Portugal, as of the 1970s, major effort was invested in preventive services (e.g. vaccinations) and on the improvement of environmental and housing conditions. The building of healthy public policies must be seen to have happened at the same time as the overall improvement of societal infrastructure in the aftermath of the Carnation Revolution (1974). No significant transfer mediated by the WHO was identified in the field of healthy public policies in Portugal.

In conclusion the analysis suggested that no significant change in health promotion policy resulted from the launch of the *Health for All* policy either in Finland or in Portugal. Instead, the changes that occurred were incremental, in accordance with earlier policy choices and the adaptation of the *Health for All* policy was mainly applied to the areas where there were national traditions.

5.2 In Search of Church Health Promotion Discourse (Article II)

The Article II focuses on the majority churches of Portugal, England and Finland as actors in health promotion policy. The agency of churches is addressed on a textual level by analysing the ways in which the programmatic documents of the churches talk about health and health promotion policy.[19] By employing critical discourse analysis (Fairclough 1992) and the concept of intertextuality (Vuori 2002) the article aims to identify and specify church discourses on health and health promotion. As the intention is to investigate the common core of the church health promotion discourse, the countries studied are mainly compared with regard to the similarities instead of their variations.

By approaching public health policy from the perspective of churches, this article provides one answer to the question how the idea of health promotion, originally launched in the 1970s on the agendas of global health policy, has diffused to different countries. The dominance of the state-centred perspective in research has led to neglecting potentially important community actors in health promotion policy. One of the neglected community actors is the church. Although churches and various religious actors are mentioned in the public health strategies of several countries[20], the research has rarely gone beyond identifying their existence. In order to take the call for community orientation in health promotion seriously, the research needs to address alternative health discourses and become aware of community actors on their own terms.

The following questions serve as the basis of analysis: what meanings, and how, have churches produced concerning health, the methods and targets of health promotion and underlying problems and their own position in the field of health promotion policy? After analysing the texts in the respective national contexts and highlighting the distinctive characteristics of each case, I move on to analyse the church institution as an actor in the broader field of health policy, trying to answer the question: what are the component parts of the church health promotion discourse?

[19] In the social policy literature churches and religious actors are taken into account as actors. Peter Flora (1986) has used the term *intermediate institutions* to refer to them; Stein Kuhnle and Per Selle (1992) refer to *non-governmental organizations*. Kees van Kersbergen (1995) has analysed the influence of Christian democracy on welfare state development.

[20] Apart from the government-level health strategies of the countries examined in this study; Finland (STM 1993), the UK (Secretary of the State for Health 1999) and Portugal (Ministério da Saúde 2004), the Swedish strategy (Ministry of Health and Social Affairs 2000) also mentions churches and religion as an actor in and resource for health promotion.

When outlining the way in which the churches talk about health promotion, I analyse how churches generally talk about health and what meanings they attach to it. Health is understood in the texts in a very comprehensive manner. The texts of the churches of Portugal and England start out with a holistic understanding of health as the basis for action, whereas in the document of the majority Finnish church, holistic health is set down as a goal. According to the analysis of the documents, the church health promotion discourse is constructed of two sub-discourses. The discourses construct the targets and methods of church activities and how the church defines its own position and partnership with the state in these areas. I have named the discourses as follows: *community solidarity as a resource for health* and *spirituality as a resource for health*. The first discourse has a powerful presence in the documents of all the countries while the spirituality discourse is limited to the Finnish and Portuguese documents.

Which health related issues are seen as problems requiring church action, depends, on the one hand, on church tradition and doctrine. On the other hand, churches do not act and produce its texts in isolation from the rest of the world but rather in interaction with society. This appears on the level of texts in the form of intertextuality. While presenting descriptions of churches as health policy actors, they interpret and apply the messages of other actors in their respective contexts. This process of adapting texts and discourses is called recontextualisation. (Linell 1998, 145.)

It has been said that health-related values have become increasingly prominent in western people's lives in recent decades. It has also been claimed that medicine has replaced religion as the dominant moral ideology and institution of social control in western societies (Conrad 1992, 213–214). Apart from the processes of secularization, individualization and medicalization, globalization has also shaped the field of health and welfare policy. Although the texts are primarily studied in the national socio-cultural context and mindful of the fact that the national policy environment conditions the textual practices of churches, the analysis also shows that their health promotion discourses are at the same time limited and conditioned by the health promotion discourse conveyed by the WHO. I call this approach characteristic of the new era of

public health policy the 'global metadiscourse on health promotion'[21]. The texts of the Comissão Nacional da Pastoral da Saúde (National Committee for Pastoral da Saúde) are hybrids in which the national tradition of the church institution is mixed with the texts of the Vatican and the WHO. The texts exemplify the spreading of the global health promotion metadiscourse to cover the church institution. The report of the Church of England, called *Faith in the City*, can also be read as an adaptation of a component of this global metadiscourse, namely critical health research. In comparison to the English and Portuguse texts with a high degree of intertextuality, it is not possible in the Finnish documents to observe any references made to relevant public health institutions (e.g. the WHO, the scientific community) and their discourses. Instead in the Finnish context Evangelical Lutheran Church repeatedly refers to the public sector as the principal provider of services and positions itself in the field as a partner to public authorities. Such a narrow approach to health and its promotion seems to be characteristic of the Finnish documents in the data.

The documents of *Comissão Nacional da Pastoral da Saúde* and the *Faith in the City* report refer to the WHO particularly when constructing the transition in church and state activities concerning health promotion. When using the health promotion discourse mediated by the WHO dominant in the public health policy debates of western European countries, churches become more legitimate participants in the public debates on health promotion. The mobilization of churches in health promotion policy may be an unrecorded observation in public health research, but from the perspective of recent history it is not a new phenomenon.

5.3 From Averages to Best Performers – Use of Comparisons in Identity Formation (Article III)

The third article examines the use of international comparisons in national policy-making in Finland and Portugal from the 1970s until the end of the first decade of the

[21] I have adopted the concept of metadiscourse from Jaana Vuori's study. According to her, the term 'discursive formation', originally introduced by Foucault, is a higher-level discourse, a metadiscourse, which crosses the boundaries between individual themes, targets, expressions, institutions, occupations, theories and disciplines. The concept of metadiscourse attempts to outline discursive processes that are characteristic of whole eras of time. (Vuori 2001, 83–84.) I will use the notion of metadiscourse to describe the era dominated by the theme of health promotion in international public health policy.

21st century. By analysing national policy programmes from a discourse-theoretically informed perspective this article addresses the question of how comparative discourses of international governmental organizations frame and shape the identity formation and agenda-setting of their Member States. Discourse is understood as "historically specific system of meaning which forms the identities of subject and objects" (Howarth 2000, 9). Instead of trying to sketch the formation of generic nation state identities, the focus is on the identity formation of the states in the specific domain of public health policy.

Public health policy is rendered comprehensible in this article by contrasting it to health care policy. Thus it is characterized by a population level (vs. individual) concern over a wide variety (vs. narrow focus) of issues determining health (vs. ill-health). As the majority of health determinants are nowadays understood, as in the above definition, to be found beyond the immediate scope of health care policies, it has been suggested that public health policy should be studied in the wider policy context of the welfare state (e.g. Navarro 2002; Blank & Burau 2004; Burau & Blank 2006; Lundberg & al. 2008). In this article asolution is proposed by analysing the national policy agendas of two different welfare states, Finland and Portugal.

However, since the national agenda setting takes place in an increasingly global context, the mainstream welfare state research does not provide a sufficient context for analysing it. In line with the sociological institutionalism which emphasizes the influence of the broader international environment in shaping and constituting social actors by defining their goals and identities, the comparative discourses of international governmental organizations are here taken to be the context in which national identity stories are told. (Schofer & al. 2009.) In this article the focus is on the European Union and the European Regional Office of the World Health Organization and their comparative discourses.

The comparative discourse built around the practices of the WHO is called "the Health for All discourse". The norm for a good public health policy is condensed in a morally binding idea of *Health for All*, which is then exemplified by measuring it using certain quantifiable factors (the Health for All database) and by evaluating it in different review practices. The comparative discourse of the EU is called "EU social policy discourse". Although *European Social Model* refers to one European model, the policy instruments used by the EU are based on making the differences visible in the form of comparisons. In the new millennium the comparative measurement results are

increasingly presented in the form of country rankings or clusters grouping the best and worst performers in groups.

The article departs from the notion that comparisons authored by the EU and the WHO in their authorative systems of categorization play a significant role in transnational governance by shaping national policy-making in a continuous manner. Earlier studies have suggested that not only are nationally perceived problems defined in relation to international comparisons (Sahlin-Andersson 1996), but future desires are also socially constructed by comparing them to those of other nation-states (Sevón 1996). By discussing the constitutive effects of international comparisons on national policy-making and identity formation, this article seeks to contribute to the comparative social and health policy debates that have been largely dominated by the positivist approach (See Paul 2009). The following questions are addressed: How has comparative information been used in the national policy-making in Finland and Portugal in the last three decades? How is comparative information used in the process of identity formation, particularly in the description of the situation and in setting the objectives?

The empirical research focuses on government programmes and public health strategies. These programmes have a basic narrative structure which consists of situational descriptions and statements of objectives and desired outcomes. What I look at in the national policy documents are the repeatedly used discursive elements – ideas, concepts and categorizations – where international comparisons are used to position the country in the European context and in relation to other countries. Following the basic narrative structure inherent in the documents, the uses of comparisons can be classified into situational descriptions (Who are we? What situation is this?) and definitions of future goals (What would we like to be? What is appropriate for us in this situation?). This division also presents the key processes of identity formation in terms of comparisons. Comparisons are used in the process of self-identification as well as in the construction of future desires. (Sevón 1996) The article is based on the premises that (1) programmatic government documents form a practice where nation-states explicitly answer the mentioned questions, and (2) the comparative discourses of international governmental organizations frame how to do so.

In the data used in this article the comparative information is mostly used to position the country at a disadvantage compared to the reference group. In the Portuguese documents the disadvantaged position is described in terms of a wide

variety of indicators. Compared to the broad use of different indicators (e.g. mortality, morbidity, system performance, costs) to position Portugal in the European context, positioning Finland is characteristically done on the basis of two mortality indicators: those of children and of adult men. While infant mortality is a one of the lowest in the world, the mortality of Finnish men is one the highest among the developed countries of the Western world. Besides using indicators to set them apart, both countries have been described as lagging behind the others. While Finland is typically claimed to lag behind the other Nordic countries, Portugal is claimed to lag behind European (Union) countries. In the typical argument, the "unfavourable position" or "lag" is a description of the actual situation and the objective is to overcome this lag in the future. While a desire to achieve the levels, patterns, models, requirements, values and the normative framework typical of "Europe" is presented in Portuguese documents, the desire to achieve Nordic levels is articulated in the Finnish documents. Nordic cooperation based on the idea of the Nordic welfare model is a pervasive theme in the data. The nordic welfare model is marketed as an export product for the public health policy of the EU. In temporal terms it is possible to conclude that the comparative reference turned from averages towards best performers at the turn of the century.

Yet the negative use of comparisons and assigned pejorative positions are also explicitly doubted. In the Portuguese data the label of "peripheral country" is explicitly questioned. Peripherality is described to be "a stagnant habit of thought" which should be contradicted. In these texts Portugal is positioned on the map of Europe in a positive way (e.g. reference point, pioneer, the new welfare state). Finland has been positioned on the map of Europe as a forerunner since the 1980s. After being nominated by the WHO as "a Health for All pilot country" in 1981, the agreed pilot position was systematically updated to "a pioneer country" or to "a model country" in various national policy documents. Later, the pioneer position assumed in relation to the *Health for All* discourse was successfully recontextualized into an institutional context of the EU and its discourse of *Health in All Policies*.

5.4 The Power of Comparisons (Article IV)

This article examines the current one-dimensional labelling of Portugal as a *crisis country* from the perspective of contemporary history and the genealogical approach. In order to

understand why pejorative labelling of Portugal and other Southern European countries has been so easily accepted in the European media and politics, the article describes how Portugal has been labelled in different societal arenas (welfare state research, media, the EU, national policy-making) in the last three decades. The analysis is not confined to categorizations and labels as such, but also pays attention to the identification of those mechanisms which made them effective.

This article departs from the notion of how the abundant and heated debate on the debt crisis of European states has been based on biased and oversimplifying categorizations, which tend to reproduce stereotypical divisions inside Europe. The editorial of the biggest Finnish newspaper *Helsingin Sanomat*, published on 18.4.2011, exemplifies the tone of this debate by stating: "The herd of black sheep is now rounded up and fenced off." Greece, Ireland and Portugal, which are having problems with their state debts, are now the black sheep of the Euro herd. Calling Portugal, Italy, Greece and Spain with the acronym *PIGS*[22] fits with this group of animal inspired metaphors used in the research community (by economists), but also in the media and politics.

Categorizations provide efficient means to simplify complex reality. The current oversimplifying and pejorative categorizations of southern European countries are not only a result of the latest debt crisis and its coverage by the media, but they have been constructed as such over a longer time period. The dichotomous division into "south" and "north", to "periphery" and "centre" has been made in many forums, including research. Although it is difficult and even pointless to try to point out the origins of certain categorizations, it is important to try to understand how certain categorizations become dominant and taken-for-granted.

Categorization can be considered to be taken-for-granted when its use goes without explanation. Succesful categorizations are easily understandable. This helps their diffusion from person to person, from research to politics, from country to country etc. When political decision-makers adopt a certain category this opens up possibilities for its wider diffusion. This often happens in cooperation with the media. (Czarniwaska & Joerges 1996, 31.) Although populism and superficial categorizations have in recent

[22] The term PIGS was first introduced in the sphere of economics, but it soon spread to wider audiences. One indication of its frequency is that the term and its history is described with a long list of references in Wikipedia (http://en.wikipedia.org/wiki/PIGS_%28economics%29). However, due to its strident and highly pejorative character it has also faced criticism and its use has been limited or banned in some media houses and in politics.

years regained ground in European politics, the demands for evidence-based policies continue. The evidence called for is scientific in nature, and researchers as well as the authority of science are called on to support political decision-making (Fischer 2009). But for what kind of knowledge is there a demand?

It seems that those studies that provide evidence in the form of categorizations are especially welcome. Welfare state research, which has produced comparative information and models, has responded to this challenge in Europe (e.g. Esping-Andersen & al. 2002). As a powerful and authoritative political-administrative institution, the EU formalizes the catergorizations produced by research. Comparative social research often produces categorizations and classifications that highlight differences or similarities based on statistical data. An important part of comparison is *labelling*, which can be understood as a tool to communicate and describe the outcomes of comparisons. Although comparisons are central to both research and European policy-making, the debate on labelling and categorizations and the associated power of comparisons have been scarce. According to Barbara Czarniawska and Bernward Joerges (1996) words are turned into labels by repeating them often in an unchanged form in a simalar context. On the other hand, successful labels spread from one context to another, ultimately becoming institutionalized categories (Czarniawaska & Joerges 1996, 32).

This article aims at stimulating discussion about the role and nature of comparisons and categorizations in constituting reality. Categorizations do not only reflect the diversity of European reality but constitute the Europe present and future in which we live. The empirical focus of the article is on how southern Europe and Portugal in particular have been described and labelled in the social scientific research literature, in the realm of EU policy and in the Finnish media and how these labels have been received in Portugal. The following examples from the data give one answer to the question why it has been so easy to label Portugal, for example, as a crisis country dependent for its survival on the benevolence of the others. More generally the analysis can be understood as an example of how certain ideas become self evident and taken-for-granted in a certain historical period.

Although welfare state comparisons are based on statistical measurement, the results are communicated in words. Researchers have used the following expressions to describe the southern European model of welfare state: *rudimentary* (Leibfried 1992; Gough 1997), *semi-institutionalized promise* (Leibfried 1992), *peripheral* (Kosonen

1995), *post-authoritarian* (Lessenich 1995), *distinct group of laggards* (Katrougalos 1996), *ex-fascist* (Navarro & Shi 2000), *immature* (Muffels & Fouarge 2004). The other extreme in welfare state comparisons is located in northern Europe, especially the Nordic countries. According to Peter Baldwin (1990, 43) the Nordic model is generally taken as an expression of the highest level of welfare state development. Researchers have mostly used either geographic terms (*Scandinavian, Nordic*) to describe the model or called it *social-democratic* (Esping-Andersen 1990). Social democracy on the other hand is linked to positively charged values of universalism, equality and solidarity (Kuisma 2007). Margitta Mätzke and Ilona Ostner (2010) call the Scandinavian countries as *forerunners* in relation to the problems of postindustrial societies.

The EU aims at diminishing the developmental differences between the Member States by means of "cohesion policies". In practise this has ment defining the goals and criteria of cohesion policies and the distribution of financial benefits based on the criteria defined. For the period 1988–1992 the main principle of cohesion policies was to focus on "*the most backward and undeveloped areas*" (European Commission 2011a). In the periods 1989–1993, 1994–1999 and 2000–2006 the primary objective in paying subsidies from the Structural Funds was for: "supporting development and structural adjustment of regions whose development is lagging behind" (European Commission 2008). For the period 2007–2013 the prime goal is to "support the development in less prosperous regions" (European Commission 2011b).

The Cohesion Fund direct subsidies to "those Member States, whose GDP per capita is lower than 90% of the EU average and that are following a programme of economic convergence" (European Commission 2001; Sapir 2004). In practise this has meant Greece, Italy, Spain and Portugal (e.g. Tsipouri 2002, 3). In the current period 2007–2013 there is a big group of new Member States categorized as cohesion countries (European Commission 2011a). Although the splendid idea behind cohesion policy is to increase cohesion and unity between countries and regions, the truth is that Spain, Portugal, Ireland and Greece are called cohesion countries mainly due to the subsidies they have received (e.g. Wallace 2000, 31). If academic language has constituted the political reality constructed in the EU, the message has also been internalized in Portugal. In the spirit of governance the discourse of "peripheral and lagging" country is taken into active use in political discourse (See Article III).

The latest categorization for southern European countries is *crisis country*. This has been used in political discourse as well as in the media to refer to the financial and economic crisis that southern European countries have fallen into. Here the empirical focus is on the categorization of Portugal as a crisis country in the Finnish media represented by the biggest Finnish newspaper *Helsingin Sanomat*. The search for "Portugal crisis country" in the electronic archive of *Helsingin Sanomat* resulted in 88 hits for the seven first months of 2011. For the sake of comparisons in 2010 the phrase appeared 27 times, while in 2009 there was only one hit. Besides becoming more common, the term spread from the economic articles and editorials to the pages covering national news. One means for the politics of labelling is dichotomization. In articles published in *Helsingin Sanomat* in 2011 and found using the search term "Portugal crisis country", the following dichotomizations were found, all of which reproduce the south-north division in the context of economic crisis talk:

weak and strong (Euro) countries
losers and winners; givers and takers
net payers and net receivers
crisis countries and countries offering help
the best Euro countries and countries in difficulties
indebted countries and countries with tight economic policies,
real crisis countries (Greece, Portugal and Ireland) and crisis countries (USA)
real crisis countries (Greece, Portugal, Ireland) and indebted countries (UK, Belgium, Italy, Spain).

Article IV does have a certain prescriptive tone, but instead of prescribing policy-makers, the message is targeted at researchers. The article encourages researchers to break the current trend of Scandocentrism (Alestalo & Flora 1994; Alestalo & al. 2009) and to question the deeply rooted assumptions related to this regional bias in European comparative research. As politics relies more and more heavily on knowledge or evidence, and researchers are called upon to lend their expertise and legitimize politics and its arguments, it is necessary to give more careful thought to the question of how to describe and label different ways of living and resolving social issues. Firstly, even though it is possible in research to make comments and specify conditional factors, they tend to disappear and categorizations and labels continue on their own in the spheres of

politics and public debate. Secondly, it is possible that the objects of politics ultimately begin to behave as they are expected to behave.

5.5 Main results

All the articles are concerned with how the ideas and policies advocated by international governmental organizations or shared by transnational epistemic communities are used and interpreted locally by national governments, majority churches, research communities or the media. To study the spread of ideas and policies across diverse borders different analytical approaches were applied in individual articles. After using a policy transfer framework in Article I, the concept of intertextuality was applied in Article II to trace the spread of health promotion. In the last two articles the literature on transnational governance provided a perspective to analyse the travel of ideas and policies. The theoretical and methodological underpinnings of the individual publications are discussed in more detail in Chapters 3 and 4. The core results of the original articles are presented in Table 2 below. The significance of the results is discussed below the table. More theoretical discussion on the basis of the results will be presented in the last two chapters.

Table 2. Main research questions and main results of the original articles

Original publications	Main research questions	Main results
I Transfer of Health for All policy – What, How and in Which Direction? Two-case study	• How has national health promotion policy changed in Finland and in Portugal since the 1970's in relation to the ideas promoted in HFA policy? • How have the following aspects of HFA been adapted into the national contexts: primary care, community approach and healthy public policy?	• No significant change of health promotion policy resulted from the launch of HFA policy neither in Finland nor in Portugal. • The changes that occurred were incremental, in accordance with the earlier policy choices and the adaptation of HFA policy was mainly applied to the areas where there were national traditions. • The interpretation of HFA policy must be seen in the wider context of welfare state development.
II Search of Church Health Promotion Discourse	• What meanings have the majority churches of Finland, Portugal and England produced concerning health and its promotion? What are the methods, targets and underlying problems of health promotion? • What are the component parts of the church health promotion discourse identifiable in all the case countries?	• Churches share a holistic approach to health (vs. disease-oriented curative approach). • The underlying problems of ill health are secularization, medicalization, individualization and hard market economy. • Two discourses were identified with common targets and modes of action: 1) Discourse targeted at poor, marginalized and vulnerable groups. Churches define themselves as a last resort compared to the other actors and the mean of churches' own action is the promotion of community solidarity. 2) Discourse targeted at substance abusers and women in fertile age. These groups require spiritual support and moral education, and demand active action in these areas.

III From Averages to Best Performers: Use of Comparisons in Identity-formation	• How has comparative information regarding public health policy been used in the national policy making in Finland and Portugal in the last three decades? • How is comparative information used in the process of identity formation, particularly in the description of the situation and in setting the objectives?	• Comparative information is mostly used to position the country at a disadvantage compared to others. Future objectives are set to overcome the disadvantage. The negative use of comparisons and assigned pejorative positions are also explicitly doubted and has opened the way for different self-identifications celebrating national originality. • Substantial change has occurred in the use of comparisons from averages towards best performers in the turn of the century.
IV The Power of Comparisons	• How certain ways of thinking become dominant and taken-for-granted in certain historical period? • How has the picture of South Europe as rudimentary been formed in categorizations?	• Reproduction of categories in different societal spheres (research, EU, media, national policy making) • Categorizations validated by using truisms, repetition, dichtomizations, numerical indicators, and by making reference to scientific authorities, evidence based policies and influential actors.

Although it is often emphasized that public health policy should be understood, planned and studied in the wider context of welfare policies, in practice this recommendation is rarely followed in the field of research. By empirically analysing health promotion in the wider context of welfare policies the research contributes to filling this gap and offers new knowledge about the borders of the welfare state. Secondly, and perhaps more significantly, the results of Articles III and IV provide new knowledge on the productive nature of comparative welfare state research discourse.

This research sets national public health policies into the wider transnational context by studying empirically what meanings have been attached to health promotion in different countries and by different institutions, and how international comparisons have been used in national policy-making. By approaching the EU's role in public health policy from a perspective of comparisons, it was possible to point out how EU indeed influenced national public health policies long before gaining any sort of hard law governance instruments (e.g. legislation, financial instruments). Conceptualizing

comparisons produced by the EU and WHO as governance instruments made it possible to demonstrate how these organizations have conditioned national policy-making and identity formation.

Due to the required format and limited length of the individual articles published in scientific journals, the contextual framework where health promotion policy as an international idea emerged is not explained in detail in the orginal publications. Although the significance of the term new public health is explicated in the original publications, the wider contextual framework which it emerged is not thoroughly explained. Chapter 2 set the term new public health in wider conceptual framework by discussing other relevant terms that have framed the debate and set the agenda for research and policy. Another core question not explicitly issued in the individual articles is the regulatory framework where nation-states set their agendas and make their policies. Chapter 6 summarizes the core modes of soft governance applied in the field of public health policy by international governmental organizations. Another core interest in this study was the spread of ideas across borders. Chapter 7 broadens the discussion of the results in relation to the movement of ideas and policies.

6 Discussion I: International governmental organizations and soft governance – the case of public health policy

This chapter discusses the broader regulatory ambient in which nation-states make their policies. The discussion begins by locating the core organizations of European public health policy in the framework of soft governance. While the programmatic nature of health promotion policy is explicated in Chapter 2, and while policy has been understood to be manifest in programmes and to be identifiable at the level of discourse in the original articles and conceptualized as such in Chapter 4; in this chapter these concerns are located in the framework of soft governance. Furthermore, by discussing the particularities of public health policy and the findings of original articles in dialogue with the existing literature on soft governance, the chapter sets public health policy in the wider contextual framework.

6.1 International governmental organizations and public health policy

The international governmental organizations studied here are the World Health Organization and the European Union[23]. There are some differences between them in scope and orientation. To begin with, while the WHO is dedicated exclusively to health

[23] Article II analyses the texts of the Roman Catholic Church of Portugal, but also refers to the Roman Catholic Church as an international organization which sets the framework for national churches by producing keytexts (e.g. Papal Encyclicas) and creating organizational structure (e.g. Committees of Pastoral da Saúde) to be followed. However, as the empirical emphasis is on the Roman Catholic Church of Portugal and I have not systematically analysed it in the international context, I will not discuss the Roman Catholic Church and its governance methods in this chapter. The role of the Roman Catholic Church in the processes of nation-building in Europe is discussed in detail by Stein Rokkan (1975).

issues, the EU has a wide variety of other concerns among its interests. Second, the EU has a large decision-making body and parliamentary system, and citizens of the Member States have their representatives in EU politics, while the WHO is an expert driven institution. It has a governing body called the World Health Assembly (WHA), where representatives of Member States' governments meet annually, but there are no mechanisms for direct citizen influence comparable with those of the EU. Third, while the EU is a European organization with limited membership, as a UN affiliation the WHO is a global institution and its membership is open to all states. (Koivusalo & Ollila 1997, 7–8.) However, it must be emphasized that the focus here is on their influence in Western Europe.

Besides the differences, these organizations also have important similarities. They are both meta-organizations. Meta-organizations are organizations having as members other organizations rather than individuals. (Ahrne & Brunsson 2004.) The EU and the WHO are typical examples of meta-organizations where states are members[24]. The EU and the WHO can also be called international organizations, as they also call to action and influence non-governmental actors. However, as the main focus in this dissertation, is on their influence on governmental public health policy, I have chosen to use here the term international governmental organization. International governmental organizations and international organizations have been conceptualized as nodes, sites or forums in the transnational networks of governance (Mahon & McBride 2008). In addition they have been called facilitators of policy learning (Grinvalds 2008) or purveyors of ideas (Mahon & McBride 2008). This plethora of metaphors emphasizes not only the recognized importance of international governmental organizations but also the nature of the policy-making carried out in and around these organizations.

Before going into the soft modes of governance analysed in this dissertation, a few words on the changed picture of politics and policy-making in general are appropriate. According to Maarten Hajer and Hendrik Wagenaar (2003), the *shift from government to governance* has been taking place since the 1990s. (See also Mörth 2006.) While government refers to overarching political authority and formal hierarchy, governance is characterized by networks of actors operating on multiple scales and developing a variety of regulatory mechanisms. It is precisely the absence of formal hierarchy that suggests the

[24] Other such organizations are OECD, World Bank and International Monetary Fund (Ahrne & Brunsson 2004, 179).

increased utilization of "soft" regulation (e.g. recommendations, standards) in addition to the "hard" regulation (e.g. formal laws and directives) (Mahon & McBride 2008, 3–4). The comparison of regulation based on soft rules with the laws and hard rules has led to the former being called *soft law*. The essential difference between hard and soft law is that soft law is not legally binding[25]. The most prominent international governmental organizations of public health policy, the WHO and the EU, have traditionally used the means of soft regulation to influence their Member States. However, only recently the perception has emerged that their policies and mechanisms of influence may be conceptualized in terms of soft regulation (e.g. Hämäläinen & al. 2004). This dissertation is an attempt to broaden the soft governance approach in the field of European public health policy. Empirically this was done by analysing the discursive dissemination of health promotion policy as well as the comparative discourses used by international governmental organizations.

Soft forms of regulation are particularly likely in meta-organizations. According to Ahrne and Brunsson (2004), there is often conflict about regulation in meta-organizations, and due to the relatively weak central authority in meta-organizations, these conflicts are difficult to resolve. Conflicting interests lead to the use of regulation at the soft end of the scale. In general soft regulation is desirable as it is considered to be a "modern" way to govern. Soft regulation is also appealing because it is apparently effective. As a result "metaorgnizations are rife with recommendations, guidelines, policies, bench-marking, ranking, codes-of-practice, conventions, protocols, white books, and green books, all of which constitute or contain rules that are not mandatory for the members to follow" (Ahrne & Brunsson 2004, 185).

By applying these non-mandatory rules regularly and by socially binding others to use them the *standards for appropriate behaviour* are created. According to the logic of appropriate behaviour, actors do what they believe is the appropriate thing to do in a given situation (March & Olsen 2008). Their behaviour is understood to be mainly guided by rule-following and norm-seeking. (Risse 2004.) Rules are followed because

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[25] Ahrne and Brunsson (2004, 171) make a valid point in observing how the concept of binding may at first glance seem to relate to the rule followers and their chances to avoid compliance, but that in fact the concept is used to describe the situation and activities of the rule setter. Soft law is issued by rule setters who do not have the right to formulate legally binding rules (the case of the WHO and in some instances also of the EU), or by rule setters who have that right but choose not to exercise it (the case of the EU in other instances). Ahrne and Brunsson point out that the effect on rule followers is another issue, although obviously related.

they are deemed to be natural, rightful, expected and legitimate (March & Olsen 2008, 689). In this context it is useful to present Francis Snyder's definition of soft law (1993; quoted in Mörth 2004, 6). According to him soft law can be defined as "rules of conduct which, in principle, have no legally binding force but which nevetherless may have practical effects". Mörth writes how the above definition suggests that law can have more meanings than the usual definition which conceptualizes law as only having to do with legal acts. This concurs with Cini's (2001) understanding according to which soft law lies somewhere between policy statement and legislation.

In the European governance literature the international governmental organizations that have been mostly studied empirically from the point of view of soft governance are the EU (Jacobsson 2004a; 2004b; Jacobsson & Vifell 2005; Savio 2001; Palola 2007) and the OECD (e.g. Jacobsson 2006; Marcussen 2004; Mahon & McBride 2008; Armingeon & Beyeler 2004; Alasuutari & Rautalin 2007; Alasuutari & Rasimus 2009). Mahon and McBride (2008, 21) have argued that the OECD has pioneered the inquisitive and meditative forms of governance, which other international organizations have more recently discovered. This inspiration is evident in the light of statement by WHO in 1991 while evaluating the Finnish HFA policy. In the review report it is explicitly stated that the WHO sought cooperation with the OECD in order to benefit from the vast experience of the OECD in conducting country reviews[26] and to find suitable research methods to carry out policy evaluation in Finland (WHO 1991, 7). In the sphere of the EU the specific policy-making mode resting on the use of expertise and accumulation of technical arguments in favour of developing shared approach has been called the *OECD technique* (Wallace 2000, 32–33).

The relationship of Member States and the EU has been analysed in recent decades from diverse perspectives (e.g. Diez & Wiener 2004). Tailored analytical approaches have been developed in specific policy areas. In the domain of social and health policies, the authority to decide on national policies remains with the Member States. It is often stated how in line with the administrative principle of subsidiarity, the EU has a mandate merely to *complement* national action on health (European Commission 2012a). This is a valid notion, but as it focused on what the EU cannot do, or the limits of its hard law competencies, research based on this notion does not pay attention *to what is actually done* in these policy domains under the auspices of soft governance (See also Mörth

[26] An annex on "OECD policy reviews" is attached in the publication.

2004, 3). After the initial phase of studying the EU's influence in national social and health policies by focusing on binding legislation and on hard law, in the latter half on 1990s and especially in the new millennium it has become more common to perceive the relationship of the EU and the Member States in the domain of social policy in terms of soft governance. (E.g. Savio 2001; Jacobsson 2004a; 2004b; Risse 2004; Jacobsson & Vifell 2005; Palola 2007.) The results of Articles III and IV indicate that both the WHO and the EU influenced the public health agenda-setting of the Member States long before they gained any hard law competencies or formal and explicit strategies to do so.

As the governance practised in the sphere of international governmental organizations is a topic of interest for a wide variety of scholars, (e.g. sociologists, political scientists, policy analysts, legal scholars, scholars of organizational studies) there is some terminological variation surrounding the phenomena across the disciplinary fields. Ulrika Mörth (2004, 5) observes how some legal scholars question altogether calling the soft methods of governance "laws". On the other hand, scholars in organizational studies do not find the division into hard and soft *law* meaningful, and prefer the terms hard and soft *regulation* (Ahrne & Brunsson 2004, 175–176). According to Djelic and Sahlin-Andersson (2006, 6–7), the term *governance* includes regulation but goes well beyond. As a broad term it permits the inclusion of different mechanisms of influence, such as comparative knowledge production, in the analysis. Furthermore, the term soft governance makes explicit the wider context and how the locus has shifted from governments to governance, from hierarchical law-like instruments to a network of actors (See Mörth 2006, 121).

6.2 Soft modes of governance

Researchers have created various categorizations concerning soft modes of governance. Bengt Jacobsson has divided the system of transnational governance into *meditative and inquisitive modes of regulation*. While meditative activities are mainly framed as discussions among experts about the best way or ways of doing something, inquisitive regulation involves the surveillance or monitoring of the actions of states (2006, 208). Bengt Jacobsson and Kerstin Sahlin-Andersson (2006, 253–262) have identified three different and intertwined modes of transnational regulation: *agenda-setting, rule-setting*

and *monitoring*. Anja Jakobi's classification[27] (2009, 33–37) of governance instruments used by international organizations bears a close resemblance to this by distinguishing among *discursive dissemination, standard-setting* and *coordinative activities*. Marcus Marcussen (2004) has also recognized soft governance to consist of three distinct modes. He has labelled them *cognitive*, *normative* and *legal governance*. I will now discuss governance modes in the context of European public health policy.

Discursive dissemination: establishment of ideas

According to Anja Jakobi (2009) the primary function of discursive dissemination is to establish ideas on national political agendas. This function has led Jacobsson and Sahlin-Andersson (2006) to call this mode agenda-setting. Ideas are disseminated in debates and documents, by publishing programmes, issuing declarations or by organizing meetings. This study has contributed to our understanding of how ideas can be and are disseminated through the comparative practices of international governmental organizations. As described in Chapter 2, Ottawa Charter is taken to be a key document in health promotion. The following quotation from *A Strategy for Health Promotion* (WHO Regional Office for Europe 1990, 5) sheds light on the importance of discursive dissemination in the case of Ottawa Charter:

> "… Ottawa Charter has received an enthusiastic response: at least 19 translations have been widely published. It is used as as basis for health promotion policy, programmes, research and training. Selected materials from the conference are available in special issue of Health Promotion (1986) and in the Canadian Journal of Public Health (1986) and in selected Conference Proceedings (1987)."

Currently the EU's public health policy can be identified with the *Health in All Policies* approach (e.g. European Commission 2007). Accordingly an effective health policy must involve all relevant policy areas, but especially social and regional policies, taxation, environment, education and research (European Commission 2012b). This way the imperative of health promotion is spread not only through Member States, but also across different policy sectors, professional and disciplinary borders. By disseminating

[27] In addition Jakobi identified financial means and technical assistance to form their own categories, but I will not discuss them here, as I have not included these dimensions into my analysis in the original articles either.

these documents, programmes or more loosely formulated policy ideas, and the related vocabularies, policy discourses are constructed.

For Marcussen (2004, 107) the *regular production of discourse* about the world and about the roles that international governmental organizations and the Member States play in it represents *cognitive governance*. In his words “it is a question of producing stories about the past, present and future challenges, visions, values and feelings”. The declarativeness of health promotion policy combined with long-term planning horizons painted in the relevant programmes has made it especially appropriate to produce these visionary and value-laden stories. As such they have offered an attractive and pervasive narrative and vocabulary for Member States and their civil servants with which to describe themselves, thereby socially constructing imagined communities (See also Anderson 1991).

The constitutive power of discourse is the subject of Articles III and IV. Positioning Finland as a model country in terms of health promotion policy, first in the institutional context of the WHO (*Health for All*) and now in the sphere of EU policy-making (*Health in All Policies*), is an example how one nation-state has participated in the production of these common European stories and to the dissemination of the related discourse. On the other hand the Portuguese case is a different example of how the commonly agreed reference level (e.g. average, best performers) and the distance to it constructs the logic of national agenda-setting. Those issues where a nation-state is positioned to lag behind the reference level are easily defined as problems. Following the logic of causal reasoning, the objective tends to be the achievement of the reference level. Thus the European level is set as a future goal, an ideal state at which to aim.

Standard setting: prescription of behaviour

Anja Jakobi (2009) writes that the primary function of standard setting is to prescribe behaviour. This is done by making recommendations, by prescribing ideal policy models, setting benchmarks or good and best practices. In a broad definition any explicit aims and rules that countries should comply with can be considered to be standard-setting. Jacobsson and Sahlin-Andersson (2008) have used the concept of rule-setting to describe the dominance of soft and voluntary rules in transnational governance.

In the case of public health policy experts and epistemic communities play an important role in the construction of standards. The concepts of “policy-relevant

research" and "the prescriptive policy studies" identified during the 1990s to characterize much of the public health research (See Chapter 2, pages 25–26) have paved the way for the current trend of evidence-based health promotion and the extended role of epistemic communities in defining what is the desired behaviour. However, international governmental organizations provide a formal forum for their diffusion.

By disseminating the ideal models, country comparisons and ranking lists international governmental organizations define the desired ways to behave and to argue. Marcussen (2004) calls this normative governance. He locates the development and diffusion of ideas to happen through various peer review processes and in a multitude of committees. It is through repetitive interaction, research and dialogue that the rules of appropriate behaviour are created, which national civil servants and other political actors tend to follow (Marcussen 2004, 106).

Coordinative activities: execution of surveillance

Different standard-setting practices have introduced auditing, comparison and ranking of state performance (Mahon & McBride 2008; Jacobsson 2006). The primary function of coordinative activities is to execute surveillance, which is done by monitoring and evaluating the programmes and by building databases (Jakobi 2009). The WHO has used quantitative target-setting and linked it to the building up of common system of indicators, called the *Health for All* database, since the 1980s. *Health for All* database has provided an easy way to compare countries in terms of their health status and health systems. The quotation below from 1992 describes exactly the same themes that have more recently been debated in the literature of transnational governance and put under the rubric of coordinative activities. In his retrospective analysis of the *Health for All* Strategy Tom Rathwell (1992) wrote: "It will be recalled that the Regional Health for All Strategy was to be more than a statement of intent, as Member States agreed to undergo and to undertake regular monitoring and evaluation of their progress towards Health for All. Member States agreed to be monitored on the basis of agreed set of indicators. The regional office must submit a report bi-annually (subsequently changed to tri-annually) to the Regional Committee and the World Health Assembly. In addition every member state undertook to make 6 yearly evaluations of their individual Health for All policies."

The EU (Eurostat) has also been compiling an extensive statistical indicator bank since the 1980s. With the launch of the *Open Method of Coordination* and its public

health variant called *Structured Cooperation Method* (2007) the strategic use of comparisons as a part of EU policy making has increased. (See Jacobsson 2004a; Mörth 2006, 128–133; Niemelä & Salminen 2009.) Thus besides relying on disciplinary force of discourse to establish ideas and prescribe the behaviour, an essential part of the soft governance exercised by international governmental organizations has been based on the execution of surveillance by binding the Member States to the production and delivery of statistical information to databanks and to use the labels, categorizations and subject positions produced in the comparative practices. This observation is shared by Jacobsson and Sahlin-Andersson (2006), who argue that monitoring activities are often coupled with rule-setting and serve to ensure compliance.

6.3 A question of compliance: time and degree

Amitai Etzioni (1967) differentiates between three different types of compliance: coercive, utilitarian and normative. All three types are understood to enjoy equal status and no assumption is made that economic factors would ultimately determine the distribution and dynamic of the others. (Etzioni 1967, 14–17.) The idea of equal status of compliance types presented above, however, has not guided most of the subsequent empirical research made in the sphere of international organizations and the emphasis has been on the hierarchical relation between the regulator and the regulatee, and the use of coercive law and money. (Cf. Kettunen 2008.) In the preceding decade it has been reaffirmed and also taken as an explicit concern in this research area that compliance can rest on socialization, acculturation or normative pressures (Djelic & Sahlin-Andersson 2006, 6). Compliance is often understood to require some sort of authority. In soft governance the authority is gained via the modes of regulation presented in Chapter 6.2. When these modes are used together the chances of compliance may grow. (Jacobsson & Sahlin-Andersson 2006.)

Jacobsson and Sahlin-Andersson (2006, 258–262) have identified three other means by which the authority of soft rules is attained. The first is *to organize*. By voluntarily joining an organization (e.g. WHO, EU) the Member States commit themselves to following the rules issued by that organization. The second is *to claim expertise*. Those regulated should follow rules, not because they must do so as members, but because these are the best rules and models available as proven by science or expertise (e.g. evidence-

based policy-making in the health sector). In Article IV the claiming of expertise was discussed in the case of the EU but also in the case of rating agencies. Rating agencies are private firms, but have managed to to create a powerful image of themselves as neutral expert institutions.

The third way is *to team up with other authorized rule-makers* and make linkages to other rules. This approach is achieved as regulatory constellations are formed. In the area of public health there are several examples of what can be called new regulatory constellations. The WHO and the EU have claimed cooperation in various initiatives, *Health in All Policies* being one example, the cooperation in terms of the building of databases the second. In evidence-based health promotion the power constellations are even wider. The *Health Evidence Network*, established in 2010 and coordinated by WHO European Regional Center, works with more than 30 international agencies and institutions (WHO 2012).

The main challenge in the literature dealing with compliance is to offer explanations for why Member States comply with the rules which are not legally binding. Prominent answers can be found in the literature analysing policy making from a discursive approach. According to Maarten Hajer (1995), to be taken seriously actors are supposed to respond in the same discursive frame, using the right vocabularies and denying or accepting the positions offered. In the sphere of international governmental organizations, failing to use the shared discourses and right vocabulary is taken as a sign of non-compliance. The sanctions that may follow from non-compliance include loss of reputation and social exclusion (Marcussen 2004, 105; Jacobsson 2004).

Ahrne and Brunsson discuss how meta-organizations have exploited the effects of rules. They depart from the notion that rules do not merely have an important role when someone tries to control someone else's behaviour. Rules moreover influence norms, facilitate coordination and create differentiation and status orders. When rules are internalized they become norms. Norms are either perceived as being an element of our own will, or experienced as external but taken-for-granted and accepted as a condition of life. Ahrne and Brunsson conclude that when rules turn into norms the chances for compliance increase substantially. *Open Method of Coordination*, or its more recent variant called *Structural Cooperation Mechanisms*, is a remarkable example of how meta-organizations try to turn their standards into norms. (Ahrne & Brunsson 2004, 188; Jacobsson 2004b.)

The question of compliance has been discussed in the governance litarature as soft rules are voluntary and include large elements of self-regulation and co-regulation (e.g. Jacobsson & Sahlin-Andersson 2006, 253). While self-regulation signifies that there is plenty of space for those who are being regulated to interpret and edit the rules, the term co-regulation emphasizes the dialogue between the regulator and the regulatee. Jacobsson and Sahlin-Andersson (2006) argue how common norms and understandings develop in such dialogues and form opportunities for voluntary compliance. Regulations also evolve incrementally in this dialogue. As a consequence it is not clear who is regulating whom. This ambiguity is increased by the fact that many new regulations come in packages and are connected to existing regulations. According to Jacobsson and Sahlin-Andersson (ibid. 254) this is why it is difficult to measure the compliance, or the impact of individual rules.

According to Jacobsson and Sahlin-Andersson (2006) the current mechanism of compliance in monitoring and agenda-setting activities is to include participating actors in a group and persuade them that it is of great importance to preserve their good name within the group. The Finnish example in relation to taking up the assigned position of pilot country and upgrading it to pioneer country certainly fits this thinking. Although there are signs of this in the Portuguese government documents as well, the continuous pattern of assigning the negative position in relation to reference group does not fit this line of thinking.

Ahrne and Brunsson (2004) emphasize that standard-setting should not be underestimated in terms of its efficiency as a regulatory instrument. Soft regulation is often efficacious, but instead of immediate compliance the influence takes place over a longer time period (Ahrne & Brunsson 2004, 187; Marcussen 2004, 187; Armingeon & Beyeler 2004). Empirically the analysis of compliance is challenging. Research questions and time frames must be planned taking these issues into account. The four decades analysed made it possible to trace gradual changes occurring over many years.

It is difficult to define what can be considered successful compliance. Klaus Armingeon and Michelle Beyler (2004), who have evaluated the influence of OECD's recommendations on the policies of 14 European states in the period 1970–2000, conclude that the OECD's influence is rather *indirect* than direct and rather *time taking* than immediate. What is emphasized as important are the education and training given to civil servants and politicians as well as the conferences and country meetings, the

reports, publications and statistics produced. Armingeon and Beyler conclude how all these have contributed to the birth of an epistemic community, which speaks the same language and applies similar modes of thinking and analysis. (Armingeon & Beyler 2004.)

It can be concluded that it is almost impossible to measure the degree of compliance. It is a question of quality (i.e. rationality, modes of thinking) rather than quantity. However the labelling of different kinds of "success stories" in the sphere of international governmental organizations suggests that there are at least implicit indicators which can be interpreted to lead to full compliance.

7 Discussion II: Interplay of international ideas and national policies – the cases of Finland and Portugal

This study traced how the story of health promotion is told in the international policy agendas, and how it has been interpreted nationally. The term interpretation is used here to emphasize that the ideas, programmes and policies recommended by international governmental organizations are always interpreted (and not only literally translated) and adapted (and not only adopted) into the local context. Pertti Alasuutari calls the process where worldwide policy models are tamed into the local context *domestication* (Alasuutari 2009; 2011). Kerstin Sahlin-Andersson (2006) refers to this process as *editing*.

Conceptualizing health promotion policy as programmatic policy consisting of declarative and programmatic dimensions has made it possible to analyse the declarations and statements, but also the programmes along with the associated coordinative practices (e.g. cross-country comparisons, comparative databases) and methods of surveillance (e.g. country evaluations). In tracing the spread of ideas and diffusion of policies different theoretical and methodological frameworks have been used. This concluding chapter discusses the interplay of international ideas and national policies, and summarizes the main findings of the original articles in terms of idea diffusion and policy change.

7.1 International ideas – national policies

The term health promotion appeared on the international health policy agenda in the end of the 1970s. Initially the WHO provided an organizational forum for these debates. In 1978 an appeal was made that "a main social target of *governments*, *international organizations* and the *whole world community* in the coming decades should be the

attainment by all the peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (WHO and Unicef 1978, Italics added). This appeal became known as *Health for All* and a subsequent policy framework was soon created. It evolved over the years and health promotion was given a fundamental role in it. This appeal also opened the door for the WHO as a major advice giving institution in the area of public health.

Later on other major institutions entered the field. The Roman Catholic Church was one of the first to follow. Pastoral da Saúde as an organized form of the Catholic Church's activity on health matters was initiated at the beginning of the 1980s, formally at the level of the Vatican at 1985. The following year the Pastoral da Saúde was organized in Portugal. (Feytor Pinto 1999.) In its programmatic documents the Catholic Church repeatedly refers to the WHO and its *Health for All* programme. It has been an evident inspiration for the Pastoral da Saúde. Thus both the WHO and the Roman Catholic Church have been active on public health issues since the beginning of the period called new public health.

Although health protection issues had been on the EU agenda ever since its early days, it was only in the 1990s through the Treaties of Maastricht (1992) and Amsterdam (1997) that the scope was broadened from workers to the whole population and from the protection of health towards wider public health. The first EU public health programme was published in 1993; later on the building of a wider health specific indicator bank was iniatiated and in 2007 the *Structured Cooperation Mechanism* in issues of public health was launched. Based on the analysis of strategic programmes or formal competencies, EU seems to have entered the field of public health policy relatively late.

This research has identified these three meta-organizations to have played a significant role in contemporary European public health policy and thinking. Their role was traced by analysing the core texts and by making visible the patterned ways of language use (i.e. discourses) as well as the modes of governance that have been used.

This study approached the governance practised by international governmental organizations from the constructivist point of view. Constructivism made possible to analyse the constitutive effects of governance methods in questions of health and welfare. Empirically this was done by analysing how *discourses*, *comparisons* and *categorizations* shape and form national policy-making and identity formation. At the same time as particular terms, vocabularies and entire discourses are integrated into

national agendas, subject positions are taken which locate the Member States in relation to these meta-organizations and in relation the community these organizations bind together.

The chosen approach also showed that international governmental organizations have not so much advised governments in terms of the content of the policies, but first and foremost guided how policies should be made. Governments have been advised to write national health programmes, to take health into account in all policies, to set the policy objectives in terms of goals and targets, to monitor how these objectives have been achieved and to measure the attainment of the targets and other programme outcomes. International governmental organizations have coordinated and scrutinized the outcomes of these policies using different comparative and evaluative practices. On the other hand governments have been encouraged to learn from the experiences of others and to share their own good experiences with wider audiences. The use of comparisons and comparative discourses has played an important role in predisposing countries to future policy initiatives.

The focus on *policy discourse*, rather than on policy actors and interest groups, and on *governance* rather than on politics and power relations, has redirected the focus of policy analysis into new spheres. The expansion of the analytical scope from governments to non-governmental organizations, in this case to majority churches, indicated how the health promotion discourse has been actively taken up by majority churches in Portugal and in England. In temporal terms it is worth noting that while the first national health strategy was being prepared in Finland, Pastoral da Saúde as an organized form of church activity was being formed in Portugal. Secondly, by focusing on international comparisons authored by the WHO and the EU and their use in national policy-making, this study (especially Articles III and IV) has pointed out how EU has also had an influence on national policy-making long before it actually gained any formal competencies to do so.

7.2 The spreading of ideas and policies

This study approached transnational governance by identifying core policy discourses and by analysing their spreading from one space to another. The term policy transfer has been used to refer to the spread of policy ideas from one political setting to another (e.g.

Dolowitz & Marsh 2000). According to Diane Stone (2004) the policy transfer literature draws attention to the ways in which seemingly closed national policy routines can be disrupted by the policy prescriptions of international organizations. Particular policy transfer frameworks have been criticized for portraying policy transfer as a rational form of policy-making (James & Lodge 2003). The alternative concepts of spreading, travel or diffusion provide a more consensual way to describe the same phenomena.

Independently of the term used to describe the spread of ideas and policies, all the individual articles are based on the assumption that the diffusion of ideas is not a unidirectional but multi-directional process, not solely formal in the limits of acknowledged international governmental organizations, but also taking place in a considerable and growing manner via transnational actors and networks. Transnational actors can be long established organizations such as the Roman Catholic Church or more fluid and informal networks of like-minded individuals who are brought together by a common concern on a political issue, civil servants sharing the same administrative concern, or scholars sharing the same research interest.

The idea of health promotion has travelled across geographical borders, but also across a number of other boarders: between states, civil society and media, between communities of science, policy-making and religion. Analysed from an historical point of view (i.e. tracing the appearance of *Health for All* components chronologically in national policy-making) Article I suggests that what was transferred from the *Health for All* framework to national policy-making were the health promotion projects based in local settings. This happened in Portugal. Article II indicates that the way churches came to define problems and identify issues of concern is linked to international debates in the spheres of policy-making and science. This refers to idea diffusion via problem definition. Articles III and IV conclude that those issues are perceived as problems nationally where the nation-state seems to lag behind the international comparative reference level. The national policy goals are also set in relation to international comparisons. On a more general level this study has made explicit how ideas are spread via international comparisons.

7.3 Understanding change and continuity of national agendas

The core findings of the individual publications are presented in Table 2, on page 81. Although I have not systematically aimed at studying policy change in all the individual publications, the time frame of four decades and the interest in the interplay between national and international have kept the question of change alive throughout the research process. I will now discuss the significance of the findings listed in Table 2 in terms of change and continuity.

Article I concluded that the launch of the *Health for All* policy did not change the nationally chosen path of public health policy, and that the changes that were made to national policies were incremental and in line with the earlier policy choices. What was not taken into account in the analysis is that although the *Health for All* policy did not result any significant new legislation or system reforms, it may nevertheless have offered a reason to keep the issue on the national agenda. Furthermore, as Hajer (1995) has noted, in order to continue, policies must be constantly reproduced either in debates or in documents.

A key finding in Article II was that a change from the treatment of sickness towards the promotion of health had taken place in the programmatic documents of the majority churches. Besides relying on their own doctrines (e.g. solidarity) the churches actively used the discourses of other actors. The *Health for All* discourse was recontextualized into the church framework in the case of the Catholic Church in Portugal. The Anglican Church of England on the other hand shared the discourse of (British) radical health research. The Evagelical Lutheran Church of Finland did not actively participate in the health promotion debate and thus the work continued along the old lines emphasizing social work without taking account of health concerns and on the other hand by participating in the spiritual care of the sick in the curative sector. Even though the emphasis changed from death to life and from sickness to health in the Portuguese and English cases, all the churches continued in the old traditions of (1) targeting the population most in need of attention and (2) emphasizing the community responsibility in health and welfare issues. While community participation is at the core of health promotion policy, the focus on risk groups is at odds with the principle of universality present in the *Health for All* policy.

Article III analysed the positions offered to Finland and Portugal in the comparative discourses of the EU and the WHO and how these positions had been taken nationally.

During the period analysed, the pejorative positions (e.g. laggards, peripheral position) were reproduced. Thus, what characterizes the positioning is rather permanence than change. However, questioning these positions is also explicit. In Portugal a change which explicitly questions the internationally assigned laggard position has been taking place. In these accounts Portugal is pictured as a model country and a pioneer in relation of certain areas of social and health policy. The Finnish case offers an interesting example of how the internationally assigned position of pilot country was used in policy-making. Instead of accepting the assigned position of pilot country, Finland presented itself as a pioneer or a model country in health promotion policies. The image of a forerunner was carefully reproduced throughout the period analysed; only the international institutional context changed from WHO (Health for All) to EU (Health in All Policies). In Portugal the laggard position was reproduced throughout the time period analysed, only the content assigned to it varied. Overall, in both countries, there was a change from good to best practices as a comparative reference.

Article IV studied how certain taken-for-granted positions diffuse from one societal arena to another. The individual terms (*rudimentary, laggard, peripheral, crisis country, PIG*) to describe Southern Europe and Southern European countries changed, but it is possible to conclude that the overall discourse has remained the same throughout the four decades analysed. This reproduction of the core terms of this discourse has contributed to making the position of laggard a self-evident way to describe these countries.

When the analysis of policy diffusion is combined with the the question of policy change, the debates come close to policy convergence (i.e. the tendency of societies to become more similar over time). I did not explicitly aim to ascertain if the policies in Finland and Portugal converged over time in terms of their content. Instead, what the findings of the individual publications indicate is that there has indeed been convergence in the policy-making process. Convergence of this kind has been identified by Stephen Harrison, Michael Moran and Bruce Wood (2002) in health care policy. They call it *ideational convergence*. According to these authors, it is convergence in relation to framing the policy problems and the intellectual underpinnings of policy solutions. The findings of the individual articles indicate that ideational convergence has taken place in the area of public health policy, too.

The transnationally diffused health promotion discourse and international comparative practices have been important in setting the national agendas and defining the problems. Comparisons have been used throughout the time period analysed in defining national problems and in setting objectives. However, there has been a change in terms of the comparative reference. While the problems used to be defined in relation to European averages, now the comparative reference level is set according to the best performers. In the time period analysed reliance on science and expertise steadily increased. Currently the terms of evidence-based policy-making and knowledge informed policy-making are the fashionable and recommended ways to make public health policies.

Imitating other countries' experiences has long been part of policy-making. As such there is nothing new into it. But what is new is the environment in which this imitation takes place. The overall internationalization of the policy-making has changed the rules of the game. It is possible to observe a change from occasional or ad hoc policy diffusion to an environment which more systematically provides opportunities to borrow ideas from others and encourages learning from their experiences (e.g. open method of coordination and structured cooperation mechanism). When countries earlier learnt voluntarily from the good practices of other countries, mostly from their neighbours, now the European and international trend to learn from the best practices encourages countries to imitate the demonstrably best performers however remote in geographical, economical or in cultural terms.

Secondly, it is possible to argue that the focus of international policy diffusion has shifted from normative policies and strategic programmes towards operational programmes and measurable practices. Achieving the exact targets and fitting the timetables and to being able to deliver the required outcomes keep policy actors busy, and the bigger framework including ideological orientation may go unquestioned and unanswered. This presents a challenge for the research community. Instead of producing neat information for the needs of these seemingly technical programmes, or alternatively for the purposes of evidence-based decision making, researchers should work harder to expose the rationalities and ideological underpinnings of these projects.

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Transfer of Health for All policy – What, how and in which direction? A two-case study

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Abstract

Background: This article explores the transfer of World Health Organization's (WHO) policy initiative *Health for All by the Year 2000* (HFA2000) into national contexts by using the changes in the public health policies of Finland and Portugal from the 1970's onward and the relationship of these changes to WHO policy development as test cases. Finland and Portugal were chosen to be compared as they represent different welfare state types and as the paradigmatic transition from the old to new public health is assumed to be related to the wider welfare state development.

Methods: The policy transfer approach is used as a conceptual tool to analyze the possible policy changes related to the adaptation of HFA into the national context. To be able to analyze not only the content but also the contextual conditions of policy transfer Kingdon's analytical framework of policy analysis is applied.

Conclusions: Our analysis suggests that no significant change of health promotion policy resulted from the launch of HFA program neither in Finland nor in Portugal. Instead the changes that occurred in both countries were of incremental nature, in accordance with the earlier policy choices, and the adaptation of HFA program was mainly applied to the areas where there were national traditions.

Introduction

The World Health Organization (WHO) launched a policy framework called Health for All by the Year 2000 (HFA2000), in 1978, and has since then been advocating this framework for health policy making to all its member states [1,2]. This paper explores the transfer of HFA policy into national contexts by using the changes in public health policy of Finland and Portugal from the 1970's onward and their relationship to WHO policy development as test cases. Finland and Portugal were chosen to be the cases observed as they represent different welfare state types and as the paradigmatic shift from the old to new public health is assumed to be related to the wider welfare state development. The development of the welfare state constitutes the frame of reference for the analysis of transfer of HFA policy.

Policy transfer is a theoretical perspective that has been used to describe the spread of policy ideas from one political setting to another [3]. Most studies have concentrated on studying the transfer between countries, here the transfer is assumed to be mediated through an international organization (WHO) to its member states. Our aim is to locate the transfer of HFA policy in a broader conceptual framework. This entails clarifying the theoretical and political assumptions inherent in HFA policy as well as

studying the transfer process in the historical context of broader welfare state development.

In order to analyze the transfer of HFA policy it is necessary to recognize that HFA policy is not a totally coherent health strategy that can be defined in one compact and consensual manner. The ambiguous nature of HFA policy stems from fact that it is constructed in various policy documents drawn up in temporally and contextually different situations. We refer to the following four central documents and the ideal model of public health policy they construct when we speak of HFA policy: the Declaration of Alma-Ata (1978) [1], Targets in support of the European regional HFA strategy (1985) [4], the Ottawa Charter (1986) [5], Health21 for Europe (1999) [6]. There are points of convergence in the picture of the ideal policy model these documents transfer, but also differences linked to the evolution of temporal macro-political cycles (collapse of colonialism, new international economic order, expansion of the welfare state, collapse of communist regimes in Eastern Europe, globalization and the crisis of the welfare state) or to the regional characteristics (European vs. global). Thus when we speak of HFA we refer to the HFA policy constructed in the aforementioned documents. To be able to analyze the adaptation of HFA in national contexts we have concentrated on examining three aspects of it: primary health care, community approach and healthy public policies. Based on the analysis of these aspects the study aims to explore how since the 1970's a number of essential aspects of health promotion policy have changed in Finland and in Portugal in relation to the ideas of HFA.

While a few studies have addressed the spreading of the HFA policy to the member states [7-11], this is quite seldom based on any theory of policy change or policy transfer. Also, while most of these studies have either been descriptive in nature or focused on evaluating national policies in the program level by verifying program's outcomes or situational validity of its objectives, we aim to analyse the policies in a broader societal context by taking into account the societal-level vindication as well as the political context of health policies [12].

In the policy transfer literature past policies, present policy complexity and the question of policy feasibility are seen as possible policy constraints. Likewise factors such as identical past policies or similar ideology can be seen to facilitate the transfer [3]. Locating the transfer of HFA policy in the context of existing public health policies and the wider political and social contexts of the countries in question offers one means to identify essential capacities, constraints and conditions for the adaptation of this particular policy innovation.

To be able to analyze not only the content (*What was transferred?*) but also the contextual conditions (*How/why did this happen?*) of policy transfer we use Kingdon's (1986) analytical framework of policy analysis [13]. According to Kingdon, a policy change process is conditioned by three analytically distinct streams: problem, policy and politics stream. Problem stream brings issues to the political agenda, while policy stream, which consists of experts, produces solutions and alternatives to policy problems. From these alternatives the politics stream then determines what, if any, are politically feasible alternatives to be adapted. A window of opportunity is open for a major policy change only if these three different streams of policy making process coexist simultaneously.

Policy transfer may occur at different stages of the policy making process. In this paper we will focus mainly on the agenda-setting and policy formulation phases. These phases can be regarded as a valuable starting point for the further development and implementation of HFA at the national level. The policy transfer approach is used as a conceptual tool to analyze the possible policy changes that the adaptation of HFA into the national context may have caused.

Method and materials (see figure 1)

We aim to identify concrete examples of transfer related changes in the content of formal government documents such as laws, reports, strategies and government programs. The detailed analysis of these documents provides some evidence of policy transfer. Non-formal government documents, evaluative reports, studies and relevant discussion are also used as material. The analysis of the policy documents was supported by expert interviews conducted in both of the countries in 2003–2004 for the purposes of this study. Historical reading of the documents can provide evidence about the time frame of policy change. In Portugal the first health strategy was published in 1999 [14], and thus the primary material for the analysis of governmental health policy before 1999 is government programs [15]. Finnish health promotion policy and its relevant documents [16-18] have been evaluated twice by an international review group [19,20] and several times by Finnish public health experts and national committees [20] and thus the analysis of the Finnish case is rather based on these evaluations and reviews than on the programs.

Results

HFA as a rethinking of public health policy

WHO advocated "Health for All" as a rethinking of and challenge for reform in the national public health policies of the member states. HFA was frequently understood as a policy for developing countries focusing on advocacy for linking public health aims with broad social and

Figure 1
The Analytical Framework of the Study

environmental development policy at the local level, instead of investing in hospital medicine for the elites of the country. The core idea of the Alma-Ata Declaration (1978) was to advocate such a policy under the concept of *primary health care*.

In most OECD countries there already was some organizational form of primary *medical* care. Many health policy makers thought that HFA does not apply to OECD countries. Others argued that the idea of a comprehensive social and intersectoral health policy under the banner of primary health care also challenged the OECD countries. According to this understanding, Europe, too, was to develop its own HFA policy [21].

Seven years after Alma-Ata, in 1985, the WHO Regional Committee for Europe adopted its own HFA policy. It advocated a comprehensive, intersectoral and participatory health policy aiming at health gain and equity in health [4]. The conceptual differences between the Global and the European HFA are significant. The European HFA located primary health care as one aspect of "appropriate care" and to the basic level in the organization of health services. Both the Global and the European HFA argued for a comprehensive and intersectoral health policy. However, the meaning of these concepts is dependent on the context in which they are used. It may be argued that in the European HFA, the context is a welfare state – at that time either state capitalistic or state socialistic – with its numerous institutions and administrative sectors. The context in the Global HFA was a general and broad social and economic development of so-called developing countries.

The concept of HFA was accompanied by the introduction of two other challenging concepts: health promotion [5] and new public health [22]. All three were rhetorically contrasted to something that was called old or dominant way of thinking and making health policy that was characterized as focusing on hospital and cure, following a biomedical model and applying a narrow understanding of health and determinants of health.

Each of these three concepts had their own history and points of reference. For example, health promotion was mainly developed from a critical assessment of the health education of the 1970's [23]. New public health was advocated as a response to the change in the disease panorama, which meant that instead of hygiene, physical environment and vaccinations the new focus of interventions was to be on the social, cultural and political determinants of lifestyles and health [24]. HFA advocated an outcome-oriented health policy implemented by a wide range of social and economic institutions instead of focusing on the supply of medical care inputs.

The Ottawa Charter on Health Promotion mentions peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity as basic prerequisites for health [5]. In addition to advocating reorientation in health services and the development of personal health skills, the Charter also includes in health promotion foci a wide range of public policies, communities and daily social and physical environments. The WHO Vienna Dialogue (1986) even concluded that the best health promotion policy is a good social policy [25]. Taking into consideration that OECD had declared,

in 1979 [26], the "Crisis of the Welfare State", we may locate the conceptual innovation of health promotion in OECD countries as advocacy for certain aspect of welfare state reform, as one remedy for the "crisis".

The European version of HFA may also be read from a welfare state reform advocacy perspective. The European HFA strongly advocates a broad health policy managed by objectives [21]. The strong management by objectives advocacy in the European HFA [4,6] links it with the managerialistic reform agenda of the welfare state [e.g. [27,28]]. Managerialism seems to be less prominent in the Ottawa Charter. Rather, it is possible to claim that the Charter has been influenced by ideas to develop welfare states leaning on social and community movements [29].

For the purposes of this study, we may conclude that there are three related concepts, health for all, health promotion and new public health that have a lot in common in their critique of the hospital focused and biomedically oriented health policy paradigms. They all advocate a broader socio-political orientation for health policy. However, they do not have a common idea of what this broader orientation is. We find it helpful to distinguish at least three different orientations. The first is the broad social and economic development context where the Alma-Ata Declaration located the radical local development program under the concept of primary health care. The second is the managerialistic welfare state reform context where the European HFA located the proposed health policy guided by HFA targets. A third orientation has been developed under the banner of the Ottawa Charter. This third variant may also be located in a welfare state reform context, but in a different idea of reform emphasizing community development.

Finland and the HFA challenge

Finland experienced an extremely rapid urbanization phase in the 1960's and the 1970's. A large part of the population moved from the rural areas to industrial and service workplaces in the urban centers. The proportion of working people earning their main income from agriculture decreased from 26% to 10% in 1950–1980 [30]. A significant part – about 7 % of the population – even moved outside the country, to Sweden. Part of the rapid and profound socio-economic change experienced was the development of a Scandinavian type welfare state in Finland. In about 25 years the country developed universal old age, sickness, disability and unemployment benefit systems and started the expansion of a public day care system for children and long term care for the elderly. The existing public education and culture systems were rapidly expanded and a universal health care system was set up. By 1985, it was possible to include Finland in the group of small, prosperous and egalitarian Nordic countries, still somewhat poorer and less generous than the older sisters Sweden and Denmark [31].

Primary care

In the late 1960's and the early 1970's, the challenge of the Finnish health policy was often articulated by asking: "Why does a country with Europe's healthiest children have the sickest middle-aged male population?" International comparative statistics had indicated that the country was at the European top in terms of low child mortality, but the adult population, particularly males, was dying younger than most other West European adult populations. The positive health status of children was understood as an outcome of a universal, strong and preventive maternal, child and school health system. The health system for the adult population was criticized for being too hospital centered [32,33]. The context of rapid socio-economic change, left-center-coalition government and a perspective of rapid overall development of the welfare state was a fertile growing ground for extending the example of universal, public and preventive child and maternal care to the adult population as well.

The Primary Health Care Act of 1971 started the building of multi-professional and multi-functional local health centers to carry forward the idea of "people's health work" at the local level [34]. It took about 25 years to build health centers throughout the whole country. Thus, in Finland the idea was not restricted to demonstration projects or particular regions as in some other countries, from which the idea of health center was learned [35]. The North Carelia Project, which received widespread international recognition as an example of broad community action for public health initiated by the local health centers [36], was developed as a demonstration project specifically to reduce the high mortality rate from cardiovascular diseases, in the rural and less prosperous part of Finland.

Given this background, the WHO concept of Primary Health Care as expressed in the Alma-Ata Declaration (1978) was not foreign to Finnish health policy experts. Rather, many of them felt that Finns were pioneers significantly contributing to the development of the WHO policy and demonstrating its applicability also in the Northern hemisphere [21,37].

However, transforming into practice the radical idea of the local health center carrying out "people's health work" was not a simple task. Since the initial expansion phase, the developmental activities and reforms of the health centers have mostly focused on improving the medical cure and care functions [19]. According to some evaluators, health promotion, community-based prevention and public health have largely been pushed to the mar-

gins. The emphasis of main reforms addressing the health centers have focused on the management of diseases, division of labour between health centers and hospitals and the development of the GP function in medical care [35]. Thus, the radical concept of Alma-Ata was, in practice, transformed into a normalized concept of primary medical care.

The community approach

The North Carelia project was and continues to be the best known Finnish example of community action for public health. However, the evaluators of Finnish health promotion policy have repeatedly expressed critical assessment of the leadership and implementation of community action at the local level [19,20]. It has not been mentioned as the strong or innovative part of the Finnish health promotion policy.

Finland also used to be a dissident in resisting the managerialistic idea advocated by the WHO Regional Office for Europe to manage health promotion policy by setting the policy aims in the form of numerical health improvement targets [38].

At the beginning of the 2000s, reference to the role and responsibility of local actors and local community is an essential part of health policy rhetoric [39]. The latest national health promotion programme "Health 2015" [18] is also built around numerical health improvement targets. Thus, we may conclude that both the managerialistic approach and the community approach to the redesign of health policy in the welfare state have been introduced to national health promotion policy rhetoric. However, at the same time as they are present, the evaluators have indicated that these approaches are not effectively implemented.

Healthy public policy

One aspect of the rapid expansion of the Finnish welfare state in the early 1970s was the idea of improving people's health through a comprehensive planning system of all public sectors. Health indicators were to be used to provide feedback on the health impact of developments in the various public sectors and policies in these sectors should be adjusted accordingly [40]. Alcohol taxation and restrictions on its availability had already been used in Finland, mainly to reduce alcohol related criminality and social problems, but now the same policies were motivated primarily by public health concerns [41]. A comprehensive nutrition policy to change the traditional Finnish diet rich in fatty dairy products and poor in vegetables and fruit was developed. In addition to health education, policies such as shifting the priorities in the subsidies of agricultural products and negotiating changes in the dietary practices of the catering services in the schools and workplaces were used to reduce the consumption of high fat dairy products [42,43]. Tobacco control policies were developed as a flagship of the new health promotion policy applying high excise taxation, restrictions in the availability of tobacco and a ban on advertising. This policy was continuously tightened from the Tobacco Law of 1977 to the late 1990's [44]. Environmental health was also a rapidly developing sector, both as a part of occupational health and as a part of the development of overall environmental legislation and administration, particularly in the 1980s.

The Finnish record on developing policies outside the health sector to promote health has been referred to in placing the country among the forerunners of the Health for All policy in Europe [19,20]. In any case, Finland may be taken as an example of combining ambitious and rapid welfare state building with the ambition of promoting health through the development of the health impact of other policy sectors. It is less obvious that Finland could be taken as an example of how to do this in more mature welfare states. We may, rather, argue that the maturing of the Finnish welfare state from the late 1980's on has been paralleled by growing problems in the development of healthy public policies. The most dramatic example is the dismantling of the traditional Nordic alcohol control policies in the process of redesigning the welfare state under the pressures of European single market legislation and globalization [45]. The existence and at least partly increasing inequity in health between different socio-economic population groups has also been taken as an indication of the less successful development of healthy public policies [46]. Paradoxically, the strengthening of the capacity of the sector to promote health has also separated it from the mainstream health promotion policy. Development of environmental policy and policy administration has contributed to the growing distance in policy discourse and policy communities of environmental and public health. The latest international evaluation of the Finnish national health promotion policy [20] gave a critical assessment of the capacity of health policy makers to assess and influence the policies of other sectors.

Portugal and the HFA challenge

The Carnation Revolution in 1974 ended a long period of authoritarian rule in Portugal and opened the door to the democratization of the country. As in the other Southern European countries, the democratic Constitution was of a progressive nature while conferring wide economic, social and cultural rights and duties on the citizens [47]. The Constitution that came into force in 1976 aimed at the creation of a welfare state as a political form of transition to a socialist state and society [48]. Although the goal of a socialist, classless society was removed from the Constitution in its reform in 1982, the state's responsibilities to

guarantee the economic, social and cultural rights of its citizens were left untouched [49]. Welfare state remained the ultimate goal, but the socialist model was changed to the model of social protection the European Economic Community (EEC) advocated [50,15].

The Southern European welfare state is a relatively recent addition to the conceptual map of European welfare state models. Many southern countries' present day characteristics are related to the legacy of authoritarianism, as well as to the historically strong presence of the Catholic Church [51]. Leibfried sees the weak institutionalization of constitutional promises of social rights as a characteristic feature of Southern European welfare states [47]. The term semi-institutionalized welfare state can be used to describe the whole of the Southern European welfare state that has been built up in principle, yet not implemented in practice. On the other hand it is recognized that southern welfare states have during recent decades been catching up the more developed European welfare systems [47,51]. But in spite of the catching-up effect and the overall pressure towards convergence of social policies in the European Union, Southern European countries seem to maintain a relatively distinct type of welfare state [52,53]. Portuguese welfare state development seems to follow the southern pattern, and Portugal is here analyzed from the viewpoint of the Southern European welfare state type.

The notions of *semi-institutionalization* and *catching up-effect* conceptualize the Southern European welfare state on the one hand as a developing (vs. mature) welfare state and on the other hand as following a different path than the more northern European welfare states [See [47,52]]. The attempts to institutionalize welfare state in Southern Europe occurred simultaneously with the era of welfare state crisis. Consequently, the crisis rhetoric was assumed in Portugal in the initial phases of welfare state development. Thus the welfare state was declared to be in a state of crisis before it actually even existed [53]. Due to the dynamics of *crisis before maturation*, welfare state has remained to some extent a semi- institutionalized promise until the present day.

The development of Portuguese health policy can be broadly divided into two historical phases that are linked to the general welfare state development. The first period from the beginning of the 18th century until 1971 was dominated by preventive public health policies. Through general preventive measures, such as sanitary education, environmental sanitation, hygiene, mental hygiene and sickness prevention "sanitary police" (*polícia sanitária*) aimed at governing the health of the nation. Preventive policies were directed towards the collectivity and they benefited the individual citizen only indirectly. Publicly provided health care services were tied to the clientele of social assistance and were only available to poor people until 1971, when the right to health care was legally defined to be the right of every citizen [54]. The reform bill of Health and Assistance (*Reforma de Saúde e Assistência*) established in 1971 marked the beginning of the second phase of health policies [55]. The consolidation of the universal right to health care in the Constitution and in the National Health Service (NHS) (*Sistema Nacional de Saúde*) law in 1979 [56] signified the strengthening of the social citizenship rights and changed not only the nature of health policies, but also the general nature of the Portuguese welfare state. The qualitative change in the welfare policies from the distributive to productive policies happened precisely in the area of health [53].

Primary care

Maternal and child health were already part of health policy during the authoritarian era, and women's and children's health was also included into the primary health care concept established with the Reform of Health and Assistance [57]. However these programs were limited to the health education and medical monitoring of women's and children's health during and after pregnancy as family planning was prohibited for political and religious reasons until 1974. A right to family planning was legally defined in the Constitution of 1976 [58]. The integration of family planning into primary health care has widened the scope of maternal and infant health policies in Portugal. Since 1979 Portugal has been collaborating actively with WHO/UNFPA in improving services in family planning [21,59]. In Portuguese health strategy reproductive issues are included in various priority areas. The importance of social policies directed to women, children and family is recognized in the strategy as well as in the government programs. The policies concerned with maternal and child health have developed during the last three decades into policies of reproductive health. The indicators of maternal and child mortality have improved significantly and are on the level of other EU countries [60].

The reform of Health and Assistance aimed at creating a nationwide network of local level health centers that were supposed to provide primary health care services for the entire population [61]. Although the full implementation of this reform was hindered due to political and organizational obstacles, it is seen to mark the beginning of a new era of expansion in Portuguese public health policy [62,63]. This reform included most of the principles of primary health care recognized in the Alma-Ata Declaration seven years later [63,64]. The building of a primary health care network was further consolidated in the Constitution and in NHS law. The process of building up a primary health care network was on the Government's health policy agenda from the beginning of the 1970's until 1985 (15). Analysis of scientific texts and reports on the devel-

opment of Portuguese public health policy as well as the expert interviews conducted for this study in 2003 indicate that although the Declaration of Alma-Ata was used to legitimise the development of the primary health care system – at least on the level of policy stream – the adaptation of the primary health care-concept presented in Alma-Ata did not change the national policy line.

A right to health care has been an essential part of the democratization process, strengthening social citizenship. Nevertheless the democratization of health care has not been linear; health was politicized following the creation of the public NHS. The critical welfare state philosophy of the liberal political cycle (1985–1995) affected the content of health policies by favoring privatizations of health care during the term of office of the Social Democrats (centre-right party) [63,64]. Due to continuing political and financial problems in the implementation of NHS, difficulties in access to health care services have persisted as a health policy problem. This situation has in its turn kept the development of the health care system and medical care approach in the center of the problem stream feeding the political agenda. According to some of the public health experts interviewed the clinical, curative approach of health care gained more control in the health sector's internal power sharing during the liberal cycle and at the same time the position of public health declined. The analysis of the government programs proves that at the same time the development of primary health care disappeared from governments' agenda. The crisis period of public health policy lasted a decade (1985–1995) [61]. However as the institutionalization of health care has signified the permanent centrality of services on the health policy agenda, not even the crisis period of public health did signified a great break in terms of health promotion in policy documents. Indeed some health education campaigns were launched during the crisis period [15].

The Portuguese Journal of Public Health (*Revista Portuguesa de Saúde Pública*) published a special issue dedicated to HFA in 1988. In the Editorial of the journal it is suggested that HFA2000 should in Portugal have as an objective rather "adequate health care for all" than "health for all" [65]. The general health service orientation of health promotion and disease prevention is also present on the level of government programs. The clinical, treatment-centered ethos typical of the expansion period of the health care system is dominant in the government programs 1976–2002. Health promotion and disease prevention are conceptualized as activities of primary health care and they are seen to be implemented by the medical and nursing professions [15]. Concentration on the primary health care element of the HFA-program is not only a Portuguese specialty; other Southern European countries, such as Spain and Greece, have also put weight on the development of primary health care [59]. The first health strategy is likewise disease-oriented (14 out of 27 of the priority areas are diseases), and since the health service sector is seen as the main actor of health promotion policy, the means are mainly biomedical or educative. Emphasizing rather the individual level than the structural level seems to be a more general Southern European feature in public health policies [66].

The community approach

The Ottawa Charter calls the countries to strengthen community action. However, it does not explicitly define what is meant by the concept of community. In the social policy literature the term community is often understood to refer either to the network of family members, friends and neighborhoods, or to civil society, understood as a complex of social associations and non-governmental organizations. The archetype of Southern European welfare state carries the connotation of the strong and traditional role of community in welfare provision. [67] However, most comparative studies fail to mention that during the authoritarian era the civil society element of community was repressed, as free associations were prohibited by law. In Portugal only a few religious associations connected to the Catholic Church were approved by the state. Since 1974 the number of associations acting in the field of social and health issues has expanded. [68] Often the call to strengthen community action is seen from the perspective of the welfare state crisis debates. However, in Portugal the growth of the civil society element of community was not an answer to the welfare state crisis as such, but its growth should be located in the context of the recent liberation from state repression. Yet Sousa Santos [69] argues that the state restricts true citizen participation and the functioning of those associations created after 1974 as it continues to support conservative religious organizations.

In the Portuguese health strategy (1999) private institutions of social solidarity (Instituições Particulares da Solidariedade Social) and non-governmental organizations (Organizações Não-governamentais) are recognized as the main representative categories of community. Strengthening partnerships with these organizations is seen as indispensable for achieving the goals set. Although these organizations are also identified as doing health promotion work, they are mainly actors in curing and caring. The second community level actor identified as relevant for health promotion activity is the local level of public administration. Direct citizen participation (e.g. user/consumer/patients' associations) and the need to cooperate with syndicates and health professionals are also mentioned in the strategy. However, they are not given any significant role in the program implementation. All these community categories identifiable in the health strategy seem to match the current categorizations of com-

munity actors and their partners in the social sector [See [68]].

The fourth category of community action for health promotion manifest in the form of setting-based projects of Healthy Cities (WHO), the Health Promoting Schools-network (WHO & EU) and Healthy Workplaces (EU). The first Healthy City was established in 1995 and now there are 9 cities belonging to the national network of Healthy Cities [70]. The Health Promoting Schools- network was initiated in 1994 and reaches currently one third of pupils in the public education system [71]. These projects represent the model of community action that is unique for the domain of health promotion. This kind of community based action model targets the whole population of a certain community, while the traditional actors in social and health sectors concentrate on caring for and curing those who are in need of care. Targeted solidarity of traditional community action is challenged by universal equality dominant in these health promotion projects. The model of community action adapted with these projects introduced new ideology and forms of organization into the sphere of public health. When analyzing the adaptation of HFA in a timeframe it seems that the community level adapted HFA philosophy before the national level.

Healthy Public Policies

The Ottawa Charter emphasizes the role of policy as a factor promoting healthy choices. In other words, this means that health should be taken into consideration in all public policies. When analyzing the Portuguese development in relation to intersectoral policies, there is action in conventional intersectoral issues, such as tobacco, alcohol and nutrition, but it does not seem that any major development has happened in these policy domains. The project of Healthy Schools and the overall health education campaigns are based on interministerial cooperation and pacts between the Ministry of Health and the Ministry of Education. Intersectoral work is also carried out in the field of drug addiction [14,15]. In this section we focus on one case of public policies, that of sanitation, and observe its development in the welfare state development context.

Portuguese public health indicators have shown remarkable improvements during the last three decades. The fact that public health indicators have been improving side by side with general socio- economic indicators has led researchers to conclude that although the creation of NHS and the improved access to health care have influenced the positive evolution of the health status of the Portuguese population, these improvements are greatly connected to general improvements in economic and social conditions, such as education, income and living standard, housing, sanitation, hygiene, and transport infrastructures [72,73,54]. These improvements occurred in the context of the expansion of the welfare state. In this process some of the core issues of the ancient sanitary police, such as matters of basic sanitation, have conceptualized more clearly under respective sectoral policies, out of the national health policy agenda. This reflects the administrative differentiation of state functions and sectoral differentiation of respective policies that typifies the expansion of the welfare state.

Basic sanitation (*saneamento basico*) has been a priority in Portuguese post- authoritarian development policy, however in the government programs (1976–2002) basic sanitation is not recognized as a priority of health policy. Although in some programs environmental conditions and habitation are seen to influence public health and the welfare of the population, basic sanitation is not explicitly considered either as a health policy problem, or as a goal or means. Basic sanitation is not conceptualized as an issue of health policy, it is not explicitly on the government's health policy agenda, neither is health used as an argument to improve it in other sectors. Only in the XIII Government Program (1995–1999) are water quality and the intersectoral action needed to reach it mentioned in the section dealing with health policy. Apart from this, the issue of basic sanitation has become conceptualized as an issue of renovation of infrastructure, and this discourse has constituted it as a policy of infrastructure and renovation. In the Regional Development Plan (2nd Community Support Framework 1994–1999) basic sanitation is conceptualized as an issue of environment and no reference is made to health [74]. In the national health strategy, healthy environments refer to social environments and basic sanitation is not conceptualized as a policy action area. The differentiation of sanitation from the domain of health policy implies that although a change clearly came about in the content of "healthy public policies", it did not happen towards new public health as the improvement of sanitation was not justified by health reasons. Some of the recent documents [75] imply that in recent years the development has begun to turn in a different direction as issues of basic sanitation are again included in the domain of health policies.

Discussion and conclusions

"Health for All" was developed as an international synthesis of emerging health policy ideas of the 1970's, sometimes conceptualized as "the new public health". Reflecting both the many roots of the concept and the many different contexts to which it was to be adapted, different interpretations of HFA have coexisted. The Alma-Ata Declaration was adapted to combining new public health with local socio-economic development in the developing countries. The HFA targets of the WHO European Region and the Ottawa Charter combine the new public health with the reform demands of state capitalistic

and state socialistic welfare states. The target approach is closer to the managerial reform agenda while the Ottawa approach seems to lean more on the community empowerment agenda.

HFA was launched to contribute to the development of national health policies. Thus it may be used as a standard for evaluating national health policies and health promotion policies, as has been done in some studies inspired by the WHO [7-10]. However, understanding HFA as a synthesis of many policy tendencies and allowing different contents for different policy contexts makes such direct comparisons between national policies and WHO documents problematic. In the policy transfer perspective the role of the WHO (or, for that matter, of the EU) may not be that of an international policy leadership but, rather, that of an international policy mediator.

We have tried to trace the impact of HFA on the development of the Finnish and Portuguese health policies. The Finnish development of "people's health work" and local health centers was clearly inspired by the same ideas as the primary health care concept of the Alma-Ata Declaration. The Portuguese health policy ideology expressed in the reforms of 1970's also comprehended the ideas of Alma-Ata Declaration. However, neither of these can be seen as a transfer from WHO to the member states. Rather, the Finns claim that the direction of the transfer was from Finland to WHO. The Portuguese primary care concept also had its own national roots, e.g. in the pre-revolution development of maternal and child health.

The subsequent development of primary health care in both countries indicates that the Alma-Ata idea of broad primary care tends to contradict the welfare state reforms inspired by the ideas of the New Public Management. This context tends to reduce primary health care to primary *medical* care. The impact of this change in the welfare state context may be identified both in Finland and Portugal from the 1980's on as well as in comparing the primary care concepts of the Alma-Ata HFA and the HFA targets of the WHO Europe. At the same time, the aim of the Ottawa Charter of reorienting health services towards health promotion does not seem to have guided primary care development in either country.

Thus the development of primary care in both countries has been in dialogue with the HFA. However, what primary care means in the framework of HFA has changed over time and the dialogue cannot be simplified into the unidirectional transfer of HFA policy from WHO to member states.

Dialogue or interaction are also appropriate concepts to describe the relationship between WHO and the two countries with regard to developing a community approach in health promotion policy. First of all, the different variants of HFA locate "community" in different contexts. In Alma-Ata, community is the totality of local actors without making distinctions between economic, social and health actors or private and public actors. The European HFA target documents [4,6] see community as a partner or a cluster of partners to the health sector and public authorities. The Ottawa Charter seems to be build around the idea of community empowerment and increasingly participative health policy making. The Finnish community approach as expressed in the North Carelia project, in the cooperation of the public health sector with the traditional public health associations and in the emphasis on local public sector action, seems to be quite close to the approach of the European HFA targets. Both the broad community concept of Alma-Ata and the community empowerment approach of Ottawa seem more alien to Finnish health policy strategies.

A number of welfare state characterizations [e.g. [47,67]] create expectations that we should find, in Portugal, a strong role of traditional communities strongly linked to the Catholic Church in health promotion policy. Such an expectation may fail to recognize the historical legacy of the authoritarian Salazar regime, which, while keeping close linkage to the Catholic Church, was quite a state centered regime that did not allow strong independent community action. Our analysis indicates that the role of community action in health promotion is not particularly eminent in Portugal, either in governmental health policy documents [14,15] or according to the opinion of public health experts [61,76]. The activity of the Catholic Church and religiously inspired organizations in health promotion is, however, visible [77,78]. But so is also the attempt of the government to conceptualize community action through projects such as Healthy Cities and Health Promoting Schools, where community action is led or arranged by the public authorities.

Thus, whatever is meant by the community approach in health promotion policy, Finland and Portugal do not seem to be strong examples of policy development following the initiative of HFA. We could not identify policy transfer other than in participation in the Healthy Cities and other "health settings" projects.

Healthy Public Policy was our third focus in health promotion policy. The concept was raised in the European HFA document in 1985. In Alma-Ata the integration of health and other policies is extended much further and no specific concept resembling health public policy is needed.

The Finnish health promotion strategy has included a number of public policies outside the health sector, particularly with regard to alcohol, tobacco, nutrition and physical exercise. We could not identify any specific impact of the different HFAs of the WHO on these policies. Rather, there seems to be growing pressure to restrict the use of the impact of other sectors in alcohol control. At the same time, the distance between the mainstream health promotion policy and environmental policy seems to be growing, although the public health impact of environmental policies is obvious. Thus, with the exception of tobacco policy, the idea of healthy public policy may even experience increasing problems, although this is not so far reflected in the development of the health status of the population.

The rapid positive development of the health status of the Portuguese population during the last 30 years reflects the rapid improvement of the sanitary conditions as well as of the social determinants of health [72,73,54]. Sanitary policy, including both preventive services such as vaccinations and health education, as well as improvement of environmental and housing conditions, has been the most significant aspect of Portuguese healthy public policy. However, the analysis of health policy documents indicates that Portugal has also experienced a distancing of environmental policies and health policies, that is: a trend antagonistic to the ideas of the different version of HFA. Other public policies, including tobacco and alcohol control and nutrition policies are weakly developed in Portugal. Thus, we cannot identify any significant transfer mediated by the WHO in Portugal either.

At the beginning of 1970's public health indicators showed that Finland and Portugal were lagging behind the majority of Western European countries in terms of public health indicators. Both defined this distance from the Western European level as the core health policy problem [15]. This way of defining the policy problem has clearly contributed to the fact that both countries have looked to international organizations and international comparison for their policy development.

The Finnish health policy expert community has often referred to WHO and Finland has been an active member of the European region of this organization. In the 1980's, it even took the responsibility for acting as a pilot country for the national development of HFA in Europe [37]. Thus there has been much interaction between WHO and Finland in health policy development. Our analysis indicates that this interaction cannot be understood as policy transfer and that it has influenced Finnish health policy development much less than is often assumed.

For the Portuguese government documents, the EU and the idea of a "European welfare state" has been the reference much more often that the WHO [15]. However, Portugal has also been in dialogue with the WHO in health policy development, although not to the same extent as Finland.

We have also asked what conditions the adoption of HFA policy in the two countries. Our analysis indicates that the phase of welfare state development matters a lot. The ambitious welfare state development period in the late 1960's and the 1970's in Finland was a good basis for adopting the ambitious idea of "people's health work" and setting far-reaching aims for the development of the health impact of all public policies. Much of the Finnish health promotion policy development until the 1990's is rooted in the initiatives of this period. HFA, as expressed in the Alma-Ata Declaration and in the later versions of HFA were taken in Finland as international evidence in support of the policy choices already made in the country. Portugal also had courageous ambitions of developing a European welfare state, after the Carnation Revolution and the call of Alma-Ata was heard in this context. While Finland was fairly successful in building a universalistic institutional welfare state of the Scandinavian type, Portugal seems to have so far ended up in what Leibfried (1992) calls a semi-institutional welfare state. This may be a good explanation for the continuity of health promotion policy in Finland, in contrast to the discontinuity in Portugal which also is reflected in the concept "semi-institutional".

Both HFA and the two countries examined have also been influenced by the end of the "Golden Age of the Welfare State" [79]. The differences between the Alma-Ata approach and those of the Ottawa Charter and European HFA expressed in policy targets is not only the difference between global and Europe or OECD. It is also a difference between the ambitions of the Golden Age and the post-expansion period [80] of the Welfare State. Now the political agenda is dominated by the idea of reforming the (existing) welfare state. We have linked the Ottawa approach to a reform agenda emphasizing community empowerment and the European HFA targets approach to the more managerialistic reform agenda. While we can identify the impact of the managerialistic agenda in both countries to the reduction of "primary health care" to "primary medical care", we are more hesitant regarding the impact of the community empowerment agenda on the health policy development in the two countries.

The development of health promotion policy in the two countries has also been related to changes in politics, particularly to changes in the political composition and orientation of the national governments. In this regard, the Portuguese development has been stormier with a radical

regime shift in the Carnation Revolution, starting a new regime inspired by socialist visions, followed by a turn to liberal conservative governments ten years later. The Socialist Party's victory in the elections of 1995 after ten years in opposition signified a change in social policy orientation once again [50,81]. However, there does not seem to be any significant changes in the health promotion policy even if the government has published health strategy. The Finnish political development has been much less stormy. The tradition of coalition governments which normally include both the Social Democratic Party and some parties of the bourgeois side has strengthened continuity rather than radical turns in Finnish health policy. However, within this continuity, an incremental movement from welfare state expansion to post-expansive welfare state reform policy may be identified [82-84].

Our analysis does not give a clear picture of the significance of politics in the adoption of HFA in the two countries. We may assume that the continuity in the Finnish politics has contributed to the continuity in the Finland-WHO dialogue and interaction as expressed, e.g., in the reviews of WHO-teams of Finnish health policy development [19,20]. The more stormy political development in Portugal may also have caused more discontinuity in the WHO relationship. However, the level of interaction was not a direct indicator of significant policy transfer. Rather, our analysis shows that the political context and its changes in countries probably impacts on which version of HFA is adopted. Thus, during the dominance of politics in support of more radical or expansionist welfare state development, Alma-Ata seems to have been the preferred version of HFA, while the European HFA target approach may be more feasible in the post-expansive welfare state politics.

In Kingdonian (1995) terms, we may sum up that the health policy problem of both Finland and Portugal, being European laggards in the 1970's, caused them to be open to transfer of policies from abroad. Thus, the "problem stream" was ready for policy transfer. The "policy stream" seems also to have been ready for a certain kind of transfer, but only for those versions or elements of HFA that could be fitted into the specific policy contexts of the countries. HFA as such was not a dynamo of policy change in either country. The "politics stream" changed in both countries so that the window for radical policy changes was closed fairly soon. After that, if any political window was open, it was only for incremental changes in line with the post-expansive welfare state reform agenda.

Competing interests

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JL acted as a scientist in WHO Centre for Health Policy, Brussels, in 1999.

Authors' contributions

JL is responsible for the analysis of Finnish policy while LTG has done the analysis on Portugal and drafted the other parts of the article.

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ARTIKKELI

LEENA TERVONEN-GONÇALVES

Kirkollista terveyden edistämisen diskurssia etsimässä

Kansanterveystyön pitkän kehityshistorian tuorein käänne on paikallistettu 1970-1980-lukujen taitteeseen, jolloin termi terveyden edistäminen *(health promotion)* otettiin käyttöön kansainvälisillä terveyspolitiikan keskustelufoorumeilla (Lalonde Report 1974). Terveyden edistämisen on nähty olevan keskeinen osa nk. uuden kansanterveyden liikettä (new public health) (Martin & McQueen 1989.). Sen keskeisimpänä välittäjänä on ollut Maailman terveysjärjestö *(World Health Organization, WHO)* ja erityisesti Terveyttä kaikille-ohjelmat[1]. WHO (1986) on määritellyt terveyden edistämisen toiminnaksi, joka lisää ihmisten mahdollisuuksia niin terveytensä hallintaan kuin sen parantamiseenkin. Terveyskasvatuksen, informaation ja preventiivisten terveydenhoidon toimien ohella ihmisten mahdollisuuksia hallita ja parantaa terveyttään pyritään edistämään intersektoraalisen politiikan ja yhteisöllisen toiminnan keinoin.

Terveyden edistämisen intersektoraalisuudesta ja yhteisöllisyydestä voi olettaa lähtökohtaisesti seuraavan laajan toimijajoukon, mutta terveyden edistämispolitiikkaa on analysoitu usein keskittyen sellaisten korkean tason hallinto-organisaatioiden kuten sosiaali- ja terveysministeriön toimintaan. (Stevenson & Burke 1991, 281.) Valtiokeskeisen näkökulman hallitsevuudesta on seurannut se, että potentiaalisesti tärkeitä terveyden edistämispolitiikan yhteisöllisiä toimijoita on tutkimuksellisesti sivuutettu. Tutkimuksen valtiokeskeisyys on yllättävää ottaen huomioon, että niin terveyden edistämistä linjanneissa poliittisissa asiakirjoissa (WHO 1986; 1997) kuin tieteenalan teoreettisessa kirjallisuudessakin (Rawson 1992, 215.) on yhteisöt nähty keskeiseksi toimijaksi ja resurssiksi.

Toisaalta niissä harvoissa tutkimuksissa, joissa yhteisöjen roolia terveyspolitiikassa on tarkasteltu, on niiden roolin väitetty jääneen tyhjäksi ja terveyden edistämisen yhteisökeskeisyyttä on kritisoitu idealistiseksi. (Kelly & Charlton

1995, 81.) On kuitenkin tärkeää huomata, että näissä tutkimuksissa yhteisöjä ja niiden roolia onkin melkein poikkeuksetta tarkasteltu hallitusten tai WHO:n asiakirjoista, sijoittamatta niitä laajempaan yhteiskunnalliseen kontekstiin, erittelemättä yhteisötoimijoita niiden yhteisöksi kutsumista jäsentyneemmin tai ylipäänsä analysoimatta yhteisöjä niiden omista lähtökohdista. Eräs terveyden edistämispolitiikan tutkimuksessa laiminlyöty yhteisöllinen toimija on kirkko. Vaikka kirkot ja erilaiset uskonnolliset toimijat ovat mainittuina useiden länsimaiden kansanterveysstrategioissa, ei niitä ole tutkimuksissa noteerattu juuri niiden tunnistamista pidemmälle[2].

Terveyden edistämistutkimuksen lähitieteisiin luettavassa sosiaalipolitiikassa (Esim. Bunton 1992.) kirkot ja uskonnolliset toimijat huomioivaa tutkimusta on sen sijaan tehty. Vertailevan hyvinvointivaltiotutkimuksen kentällä kirkolla ja uskonnosta inspiraationsa saavilla tunnustuksellisilla puolueilla on esitetty olevan vahva asema erityisesti Euroopan katolisissa maissa (Esping-Andersen 1990, Anttonen & Sipilä 1994, van Kersbergen 1995.). Tutkimuksissa on kiinnitetty huomiota kirkkojen ja uskonnollisesti inspiroituneiden organisaatioiden rooliin politiikkojen toimeenpanossa, erityisesti sosiaali- ja terveyspalvelujen tuottamisessa. Vähemmän on tutkittu kirkkojen roolia hyvinvointipolitiikkojen ja poliittisten diskurssien muotoilussa ja asioiden esille nostamisessa.

Tähän tutkimukseen on valittu analysoitaviksi kolmen länsieurooppalaisen maan – Suomen, Englannin ja Portugalin – enemmistökirkkojen[3] alaisten erityisaluekohtaisten komiteoiden ja työryhmien tuottamia ohjelmallisia asiakirjoja hyvinvoinnin ja terveyden edistämiseen tähtäävästä toiminnasta. Tutkimuksessa pyrin identifioimaan ja nimeämään kirkollisia tapoja puhua terveydestä ja sen edistämisestä. Koska intressinäni on tavoittaa kirkollisen terveyden edistämisdiskurssin yhteinen ydin, vertailen tutkimusmaita pääasiassa asiakirjasta toiseen esiintyvän diskurssien toiston, en niinkään niiden variaation suhteen.

Tutkimusasetelma

Artikkelissa tutkitaan Portugalin, Englannin ja Suomen enemmistökirkkoja terveyden edistämispolitiikan toimijoina. Kirkkojen toimijuutta tarkastellaan tekstuaalisella tasolla, analysoimalla kirkkojen ohjelmallisissa asiakirjoissa esittämiä tapoja puhua terveydestä ja sen edistämisen politiikasta diskurssianalyytti-

sen tekstin- ja yhteiskuntatutkimuksen näkökulmasta (Vuori 2002, Fairclough 1992, 2001, Linell 1998.).

Tässä tutkimuksessa diskurssi käsitetään toiston kautta kiteytyneeksi kielellisten ilmaisujen kokonaisuudeksi, joka on teksteistä analyysin avulla tunnistettavissa (Vuori 2002, 81–84.). Tämä kokonaisuus rakentuu Fairclough'n (1992) kolmiulotteisen diskurssin mallin mukaan tekstistä sekä diskursiivisesta ja sosiokulttuurisesta käytännöstä. Diskursiivisen käytännön kontekstia, joka kuvaa tekstin tuottamisen ja jakelun käytäntöjä, läpikäyn tekstien esittelyn yhteydessä, sosiokulttuurista kontekstia erittelen läpi artikkelin.

Aineistoa lähdetään analysoimaan seuraavista kysymyksistä: millaisia merkityksiä kirkot ovat terveydestä, sen edistämisen keinoista, kohteista, ja taustalla vaikuttavista ongelmista sekä omasta asemastaan terveyden edistämispolitiikan kentällä tuottaneet ja miten niitä tuotettu. Näiden kysymysten ohjaamana olen lähtenyt etsimään valitsemistani teksteistä dominoivia tapoja jäsentää terveyden edistämistä ja nostanut aineistopätkin analyysissä esiin kunkin maan teksteissä toistuvat ja sille leimalliset kokonaisuudet. Eriteltyäni tekstejä kansallisissa konteksteissa, siirryn analysoimaan kirkko-instituutiota toimijana laajemmassa terveyspoliittisen toimijakentän mittakaavassa etsien vastausta kysymykseen: mistä rakentuu kirkollinen terveyden edistämisen diskurssi.

Se, mitkä terveyteen liittyvät kysymykset nähdään ongelmiksi ja kirkon toimintaa vaativiksi, perustuvat yhtäältä kirkon perinteeseen ja oppiin. Toisaalta kirkkokaan ei toimi ja tuota tekstejään eristyksissä muusta maailmasta, vaan vuorovaikutuksessa ympäröivään yhteiskuntaan. Tämä ilmenee tekstien tasolla intertekstuaalisuutena eli tekstien välisyytenä. Esittäessään **kuvauksia** itsestään terveyspoliittisena toimijana kirkko tulkitsee ja soveltaa muiden toimijoiden sanomisia omaan kontekstiinsa. Tätä tekstien ja diskurssien adaptaatioprosessia kutsutaan rekontekstualisaatioksi. (Linell 1998, 145.) Koska tekstit syntyvät aina osaksi tekstien jatkumoa, ja siten intertekstuaalisuudenkin voi ymmärtää kaikkialla läsnä olevaksi, en ole tutkimuksessani kiinnostunut mistä tahansa satunnaisesta intertekstuaalisuudesta, vaan samanlaisena tai samantapaisena tekstistä toiseen ulottuvasta intertekstuaalisuudesta. Ymmärrän diskurssit Vuoren tavoin ja sanoin ”toistossa kiteytyneeksi intertekstuaalisuudeksi”. (Vuori 2001, 90–93.)

Aineisto

Aineistona ovat sellaiset kirkkojen ohjelmalliset tekstit, joissa otetaan kantaa ihmisten terveyteen ja hyvinvointiin terveyden edistämisen näkökulmasta. Asiakirjojen valintakriteerinä ei ole ollut niiden mahdollinen ”virallisuus” kirkon äänenkantajana[4], vaan olen valinnut aineistoksi nimenomaan nk. ohjelmallisia asiakirjoja, joissa kirkot linjaavat omaa toimintaansa suhteessa laajempaan toimijakenttään. Ohjelmalliset asiakirjat toimivat referenssinä pitemmän tähtäimen toiminnalle ja ne tavoittavat oletettavasti laajemman yleisön kuin yhteen asiaan keskittyvät valtionhallinnon kirkkojen keskushallinnoilta pyytämät kannanotot. Lisäksi ohjelmallisten asiakirjojen laatimista voi pitää merkkinä siitä, että kirkoilla on intressiä profiloitua kyseisellä alueella. Asiakirjat ovat julkaistut 1980-luvulla tai sen jälkeen ja sijoittuvat siten kaikki nk. uuden kansanterveyden aikakaudelle.

Portugalissa Terveyden Pastoraalin Kansallinen Komitea *(Comissão Nacional da Pastoral da Saúde, CNPS)* järjestää vuosittain terveysalan ammattilaisille ja vapaaehtoisille, sairaalakappeleiden henkilökunnalle, seurakunnan toimijoille, sekä muille kristillisesti inspiroituneiden sosiaalisella alalla toimivien yhteisöjen vastuuhenkilöille kansallisen tapaamisen, jossa keskustellaan ajankohtaisista terveyteen ja terveyspolitiikkaan liittyvistä teemoista ja ongelmista. Olen valinnut vuodesta 1986 järjestetyistä tapaamisista analysoitavaksi kahden tapaamisen asiakirjat niiden yleisaiheiden perusteella. Vuonna 1998 CNPS:n tapaamisen teemaksi oli valittu ”*Informoitu Nainen – Terveellinen Äitiys. Haasteita ja ehdotuksia”* ja vuonna 1999 tapaamisen aiheena oli ”*Kirkon vastuu terveyspolitiikassa”.* Asiakirjat koostuvat kutsutuista esitelmistä ja puheenvuoroista. Kyseisinä vuosina tapaamisissa pidetyistä puheista toimitettiin ja julkaistiin kirjat, ja tätä kautta tekstit ovat laajasti yleisön saatavilla. Vaikka puheenvuorot henkilöityvät viime kädessä yksittäisiin ihmisiin, voidaan kyseisiä asiakirjoja pitää CNPS:n kannanottoina. Tämän vuoksi en tarkemman analyysin kohteeksi valitsemissani otteissa ole viitannut yksittäisiin kirjoittajiin, vaan CNPS:iin organisaationa. Näiden lisäksi aineistona on ollut CNPS:n internet-sivuilla julkaistu teksti ”*Terveyden Pastoraalin tavoitteet”* (CNPS 2005.).

Englannista olen analysoinut Anglikaanisen kirkon poliittisesti kantaaottavan asiakirjan, vuonna 1985 ilmestyneen “Faith in the City” raportin *(Faith in the City, FITC)*. Raportti syntyi deprivoituneita kaupunkialueita (Ns. urbaaneja priori-

teettialueita *Urban Priority Areas, UPAs.)* tutkimaan nimetyn Canterbury'n arkkipiispan erityiskomitean toimesta. Asiakirja on nimetty raportiksi ja siinä selvitetäänkin laajasti yhteiskunnallista tilannetta UPA-alueilla, mutta määritellään myös kirkon suositukset eri politiikka-alueille. Koska tässä tutkimuksessa kiinnostus on kirkon terveyspolitiikkaa koskevien lausumien ohjelmallisuudessa, olen valinnut tarkemman analyysin kohteeksi siitä vain eksplisiittisesti terveyttä ja terveyspolitiikkaa koskevat, suosituksia antavat osiot. Alun perin aikomuksenani oli analysoida myös vuosina 1990 ja 1995 julkaistut FITC-seurantaraportit. Jätin ne tarkastelun ulkopuolelle, koska niissä ei tuotettu uutta ohjelmallista puhetta, vaan keskityttiin tarkastelemaan vuonna 1985 asetettujen tavoitteiden saavuttamista.

Suomessa Kirkon diakonia ja yhteiskuntatyön toimiala (KDY) on Kirkkohallituksen toiminnallinen osasto, jonka tehtävänä on kehittää kirkon piirissä tehtävää diakonia- ja yhteiskuntatyötä sekä hoitaa siihen liittyviä erityistehtäviä. KDY pyrkii vaikuttamaan yhteiskuntaan herättämällä sosiaalieettistä keskustelua erilaisten kannanottojen ja aloitteiden kautta (KDY 2005.). KDY:n tekee terveyspolitiikan kannalta relevantiksi toimielimeksi se, että diakoniatyöntekijöinä toimii paitsi sosiaali- myös terveydenhuoltoalan koulutuksen saaneita henkilöitä. (Pyykkö 2004, 111.) Juuri KDY:n voidaan nähdä olevan Kirkkohallituksen toimielimistä se taho, joka määrittää terveyttä ja terveyspolitiikkaa koskevat kannanotot.[5] Olen valinnut Suomesta analysoitavaksi kaksi KDY:n asiakirjaa: "Vastuun ja osallisuuden yhteisö. Diakonia- ja yhteiskuntatyön linja 2010" (2003) sekä "Osallisuuden ja jakamisen yhteisö. Suuntaviivoja diakonia- ja yhteiskuntatyön kehittämiseen" (1995).

Portugalin Terveyden pastoraali – Kuoleman kulttuuri kirkollisen terveyden edistämisen haasteena

Analysoiduista teksteistä CNPS:n asiakirjat ovat ainoita, jotka käsittelevät yksinomaan terveyttä ja terveyspolitiikkaa. Kirkon aktivoituminen terveyspolitiikassa ei ole kuitenkaan ainoastaan portugalilainen kansallinen erikoisuus, vaan laajemmin katolisen kirkon organisoitua pastoraalista toimintaa jäsentävä ilmiö.[6] Vaikka katolisella kirkolla on pitkät perinteet sairaiden hoidossa sekä hoivassa, ja terveyden pastoraalikin on nähtävä tämän perinteen eräänlaisena historial-

lisena jatkumona, rakennetaan asiakirjoissa eroa menneeseen, aikaan, jolloin kirkon läsnäolo sairaan vierellä rajoittui lausuman *"…tilanne on hyvin vakava, pappi on jo mennyt hänen luokseen"* (CNPS 1999, 125.) kuvaamaan tilanteeseen.

Sairaiden pastoraali, joka keskittyi sairaan henkilön kuolemaan valmisteluun pyhän sakramentin ja sielunhoidon keinoin, korvattiin terveyden pastoraalilla 1980-luvun alussa. Tätä muutosta ja siihen johtaneita syitä kuvataan seuraavassa otteessa: *"...kävi ilmeiseksi, että sairaiden pastoraali oli riittämätön ja että se antoi kirkolle jopa negatiivisen ulottuvuuden. Kirkko on elämän palveluksessa, elämän laadun ja ilon palvelija kaikissa elämän vaiheissa. Ei riittänyt, että kirkko kääntyi ihmisten puoleen vasta kuoleman porteilla. Johannes Paavali II:n sairauden myötä, salamurhaajan iskettyä 13. toukokuuta 1981, itse Pyhä Isä päätyi pohtimaan muutosta. Kiertokirjeessään Salvifici Doloris Paavi kehottaa lähestymään kärsimystä ylösnousemuksen näkökulmasta sekä pitämään sairaiden auttamista kitsastelemattomana lähimmäisenrakkautena. Omasta aloitteestaan laatimassaan kirjeessä Dolentium Hominum Paavi perusti Paavillisen terveysalan toimikunnan, josta syntyi myöhemmin Paavillinen terveyden pastoraalin neuvosto. Kirkko alkoi työstää maailmanlaajuisesti terveysnäkökulmaansa: lisää ja parempaa terveyttä kaikille ihmisille. Näin terveyden pastoraali tuli institutionalisoiduksi."* (CNPS 1999, 126.)

Otteessa kirkon organisoidun toiminnan muutosta rakennetaan arvottamalla sairauden pastoraali negatiivisesti ja liittämällä kirkon mennyt rooli ainoastaan kuoleman valmisteluun. Vastakohtana kuolemaan keskittymiselle uutta vaihetta kuvaa terveyden edistämisen liittäminen iloon, elämän laatuun ja elämään. Otteessa kirkon maailmanlaajuiseksi tehtäväksi hahmotetaan WHO:n Terveyttä kaikille- sloganin sanoin "antaa lisää terveyttä ja parempaa terveyttä kaikille ihmisille". Terveyden edistäminen Terveyttä kaikille- ohjelman hengessä esitetään osana terveyden pastoraalin tekstuaalisia käytäntöjä. Puhe terveyden pastoraalin institutionalisoitumisesta korostaa myös tämän uuden ajattelun aiheuttamaa rakenteellista muutosta. Viittaamalla paavillisiin kiertokirjeisiin, tuotetaan ideaa siitä, että kyse on katolisen kirkkohierarkian korkeimmalla mahdollisella tasolla tapahtunut ajattelutavan ja virallisten käytäntöjen muutos. Toisaalta hierarkkista etäisyyttä puretaan liittämällä terveyden pastoraalin synty Paavin omiin kokemuksiin sairaudesta.

CNPS:n kokouksessa 1999 terveys määriteltiin seuraavasti *"...täydentäen WHO:n määritelmää...terveys muodostuu fyysisen, psyykkisen, sosiaalisen ja*

spirituaalisen hyvinvoinnin harmonisesta jännitteestä, eikä pelkästään sairauden puutteesta. Tämä antaa ihmisille puitteet toteuttaa Jumalan hänelle määräämä tehtävä kulloisenkin elämänvaiheen mukaisesti.” (s. 15) Intertekstuaalisuuden kannalta huomion arvoista tässä otteessa on viittaus WHO:n terveyden ja terveyden edistämisen määritelmiin. Viittaamalla WHO:hon CNPS:n voi nähdä yhtäältä tunnustavan tämän organisaation asiantuntijuuden terveyden edistämisessä ja tulevan tätä kautta myös itse varteenotettavaksi julkiseksi keskustelijaksi terveys-kysymyksissä. Toisaalta otteessa toteutuu CNPS:n ja WHO:n välisen intertekstuaalisen suhteen kannalta tyypillinen suunnan tarkastus. Vaikka WHO:hon viitataan, niin sen sanoman sisältöä täydennetään ja tarkennetaan: bio-, psyko-, sosiaalinen terveyden määritelmä laajennetaan kattamaan myös spirituaalinen ulottuvuus. Määriteltäessä terveys ”harmoniseksi jännitteeksi kokonaisvaltaisen hyvinvoinnin suuntaan”, nähdään terveys suhteellisena, ei absoluuttisena, hyvinvoinnin tilana. Terveys voimavarana- näkökulma rekontekstualisoidaan tässä otteessa kristilliseen perspektiiviin, kun terveys nähdään resurssina Jumalan antamien tehtävien loppuun viemiseksi. Holistinen terveyden määritelmä tuotetaan pikemminkin toiminnan lähtökohdaksi kuin tavoitteeksi.

Terveyden pastoraalin nähdään toteuttavan Jumalan pelastavaa tehtävää *”...antaen lisää terveyttä jokaiselle ihmiselle niissä konkreettisissa olosuhteissa, joissa tämä elää”* (CNPS 2005.). Tässäkin otteessa toistuu Terveyttä kaikilleohjelman tavoite, ilmaisun ”jokaiselle ihmiselle” viitatessa universalistiseen jakoon, ei kohdistettuun tai jollain tavalla rajattuun kohdejoukkoon. Mutta linjatessaan, että pastoraali pyrkii antamaan lisää terveyttä ihmisille niissä konkreettisissa olosuhteissa, joissa nämä elävät, irtoaa määrittely WHO:n terveyden edistämisen ideasta ja Terveyttä kaikille- ideologiasta eli pyrkimyksestä vaikuttaa ihmisten terveyteen parantamalla terveyteen vaikuttavia olosuhteita.[7] Kun CNPS:n tavoitteeksi lisäksi määritellään *”solidaarisuus kaikkia, mutta ennen kaikkea kaikkein köyhimpiä ja kärsivämpiä kohtaan”* (CNPS 1999, 132; 2005.) on tuloksena omintakeinen sekoitus universalistista Terveyttä kaikille- diskurssia ja katolista partikularististisen solidarismin- diskurssia.

Vaikka CNPS:n teksteissä tehdäänkin eroa menneeseen aikaan, käytetään kirkon toiminnan kohdetta ja toiminnan eetosta määriteltäessä kirkko-instituution pitkää historiaa köyhien ja sairaiden hoidossa toiminnan legitimoimiseen. Vuoden 1999 asiakirjassa kirkon todetaan *”…yhä nykypäivänä, kuten jo vuosisatojen ajankin, vastaavan oman luonteensa ja missionsa mukaisesti köyhim-*

mistä köyhimpien sosiaalisiin ongelmiin, näiden joukossa myös terveysongelmiin" (s.122.). Tässä kirkon toiminnan luonnolliseksi ja historiallisesti ajattomaksi kohteeksi määritellään "köyhimmistä köyhimmät" lukuisine sosiaalisine ongelmineen, joista terveyteen liittyvät ongelmat ovat vain yksi, mutta terveyden pastoraalin kannalta keskeinen esimerkki. Tämä metaforinen ilmaisu "köyhimmistä köyhimmät" jätetään CNPS:n teksteissä usein konkretisoimatta. Seuraavassa harvinaislaatuisessa otteessa tämä toiminnan kohdetta jäsentävä ilmaisu konkretisoidaan: *"Mutta kenen puolesta kirkko lopulta toimii? Köyhimmistä köyhimpien, joita tänä päivänä ovat alkoholistit, kodittomat, huumeriippuvaiset, aidsin runtelemat, vammaiset, vanhukset, kroonikot sekä parantumattomasti sairaat ja saattohoidossa olevat."* (Emt., 122.) Köyhyys näyttäytyy kirkon tavassa puhua yhtäläisenä kaikenlaisen resurssien vajavuuden, myös terveyden puutteen, kanssa.

Seuraavassa katkelmassa kirkon terveyttä edistävä toiminta määrittyy syrjäytymisen ehkäisemiseksi. *"Kirkko pyrkii ulottamaan yhteiskunnalliset ja kulttuuriset tuntosarvensa terveysasioihin tunnistaakseen lukemattomat poikkeavat käyttäytymismuodot, jotka voivat johtaa kahteen vakavaan syrjäytymiskierteeseen. Ensimmäinen niistä on itseaiheutettu syrjäytyminen, joka johtuu kulttuurisesti poikkeavista käyttäytymismalleista, kuten alkoholismista, asunnottomuudesta, AIDSista sekä huumeriippuvuudesta. Näiden elämäntapojen seurauksena on yleensä kuoleman kulttuuri. Toisen syrjäytymiskierteen syynä on tietty sosioekonominen malli, joka luo syrjäytymistä mm. vuode- tai kroonikkopotilaiden, vammaisten, vanhuksien, parantumattomasti sairaiden tai saattohoidossa olevien tapauksissa; heidät on tuomittu kuoleman kulttuuriin, joka on luonut uusia syrjinnän muotoja."* (Emt.,122.)

Syrjäytyneet jaotellaan tässä kahteen ryhmään: itse-syrjäytyneisiin ja syrjäytyneisiin. Otteessa näiden ryhmien terveysongelmien yhteiseksi nimittäjäksi nähdään paitsi syrjäytyminen, niin myös "kuoleman kulttuuri". Kuoleman kulttuuri on merkityksellistetty kuvaamaan yhtä lailla sosioekonomiseen mallin seurauksia kuin tiettyihin alakulttuurin muotoihin liittyvän käyttäytymisen seurauksia. Vallitsevan sosioekonomisen mallin kutsuminen kuoleman kulttuuriksi on tulkittavissa valtakulttuurin kritiikiksi.

Köyhimmistä köyhimpien lisäksi asiakirjoista määrittyy toisena toiminnan kohdetta kuvaavana kategoriana hedelmällisyysiässä olevat naiset. Määrittely

on kuitenkin epäsuoraa ja tätä kohderyhmää ei nimetä eksplisiittisesti, vaan se tuotetaan määriteltäessä terveyden pastoraalin tärkeimmäksi päämääräksi *"elämän puolustaminen ja edistäminen"* (CNPS 2005.). Tähän päämäärään tähtäävään toimintaan sisältyvät kysymykset hedelmällisyydestä, abortista ja eutanasiasta. Hedelmällisyyskysymyksen kautta seksuaalivalistus ja -kasvatus ja niiden moraalinen perustelu nousevat keskeisiksi terveyttä edistäviksi keinoiksi. *"Koska ennaltaehkäisy on olennaista, on tärkeää kasvattaa terveelliseen elämäntapaan, jossa myös seksuaalisuus elettäisiin vastuullisella tavalla"* (CNPS 1998, 24.)

Terveyden suhteen ongelmaksi määritellään sekularisaatio, individualisaatio ja niihin liittyvä kuoleman kulttuuri. Seuraavaa otetta edeltää tekstissä kohta, jossa käsitellään voimakkaan tuomitsevasti valtiollisen tason syntyvyyden säännöstelyn kampanjoita, tapahtuivatpa ne sitten ehkäisyvälineiden, sterilisaatioiden tai abortin keinoin. ”*Kehotamme paneutumaan mainittujen tosiasioiden syntyjuuriin, jotka löydämme Kuoleman kulttuurista, jonka juuret puolestaan ovat sekularismissa. Paavi Johannes Paavali II puhuu edellä mainitussa kiertokirjeessään maallista elämää hallitsevasta vihasta, ahneudesta, vastuuttomuudesta, valheesta ja materialismista."* (Emt.,13.) Aborttia tai hedelmällisyyden kontrollointia ylipäätään ei nähdä lisääntymisterveyden kysymyksenä, vaan moraalisena kysymyksenä elämästä ja kuolemasta. Naiseen yksilönä kohdistuva terveydellinen aspekti on abortti-keskusteluissa mukana ainoastaan spirituaalisena, kun abortti konstruoidaan uhaksi naisen henkiselle terveydelle tai hänen sielulleen. Abortti on tuomittavaa paitsi yksilön psyykkisen ja hengellisen terveyden näkökulmasta, myös yhteisön hyvinvoinnin kannalta haitallista.

Tuomitseminen tapahtuu niin em. otteessa kuin CNPS:n teksteissä yleisemminkin rakentamalla antiteesi kirkon toiminnalle. Metaforinen ilmaus "kuoleman kulttuuri" saa vastinparikseen ”elämän kulttuurin" käsitteen. Seuraavassa otteessa ilmenee näiden kahden poolin vastakkain asettelu ja rajanveto. ”*…Näin elämää eletään, se on vahvoja varten, mikä siis tarkoittaa heikkojen tuhoamista niin yksilöinä kuin yhteisöinäkin. Näin luodaan Kuoleman kulttuuria. Tällainen suorituskulttuuri johtaa äärimmäiseen individualismiin."* (Emt., 17.). Terveyden edistämisessäkin on lopulta kyse elämän edistämisestä.

Vuoden 1998 kokouksen nimi "Informoitu nainen- Terveellinen äitiys. Haasteita ja ehdotuksia" määrittää terveellisen äitiyden informoidun naiseuden kysymykseksi. Nimi on alaotsikkoa lukuun ottamatta WHO:n vuoden 1998 maailman

terveyspäivän teema. Terveyskasvatus ja -neuvonta sekä tiedon jakaminen yleisemminkin nähdään teksteissä kirkon tehtäviksi ja terveyttä edistävän toiminnan keinoiksi, mutta niiden ei nähdä yksinään olevan riittäviä. *”On selvä, että informaatio ei yksinään riitä. On pikemminkin myönnyttävä vastuuttamiselle... Informaatio, joka on sinänsä riittämätöntä, vaatii täydennyksekseen arvot, joiden kautta voi suodattaa itselleen oikean tavan hyödyntää saamaansa tietoa.”* (Emt., 30.) Tämä seksuaalikasvatusta käsittelevä teksti heijastaa yleisemminkin kirkon kantaa tietoon ja sen riittämättömyyteen päätöksenteon perusteena. *”..Tämä tarkoittaa, että katolisen kirkon (seksuaalikasvatusta antavien) keskusten tulee rohkeasti kasvattaa arvojensa mukaisesti eikä yrittää sekoittaa etiikkaa tieteeseen.”* (Emt., 99.). Tässä otteessa eettinen ymmärrys ja tiede erotetaan toisistaan, ja kirkon katsotaan edustavan eettistä ymmärrystä ja arvoja. Puhumalla seksuaalikasvatuksesta rohkeutta vaativana tehtävänä, luodaan kuva rationaalisen tiedon hallitsemasta ympäristöstä katolisten arvojen vastaisena ja suorastaan vaarallisena.

Faith in the City-raportin radikaali terveyden edistämisen agenda

Verrattaessa FITC-raporttia kansainvälisiin auktoriteetteihin viittaviin CNPS:n asiakirjoihin, voi tämän Anglikaanisen kirkon raportin todeta tukeutuvan pääasiassa kansallisiin aineistoihin *(Esim. General Household Survey Data.*), yhteiskuntatieteellisesti painottuneisiin terveystutkimuksiin *(Esim. “The Black Report”, 1980.)* sekä hallituksen terveyspoliittisiin selvityksiin *(Esim. Report of the House of Commons Social Services Committee, 1984.).* (FITC 1985, 265–271.) Näitä lähdemateriaaleja yhdistää brittiläisen alkuperän lisäksi myös niissä dokumentoitu terveyden ja yleisen hyvinvoinnin sosioekonominen epätasa-arvo. Epätasa-arvon moraalinen hyväksymättömyys on kirjoitettu kirkon ehdottaman radikaalin UPA-politiikan agendalle ja sitä on perusteltu tieteellisillä tutkimuksilla ja poliittishallinnollisilla selvityksillä.

FITC-raportti on osoitettu paitsi hallitukselle, myös koko Englannin kansalle. Raportin johdannossa todetaan, että vaikka kirkolla ei ole erityistä kompetenssia sosiaalisten reformien ehdottamiseen *”on sillä vastuu tuoda UPA-alueiden tarpeet kansan tietoisuuteen”.* Raportin näkökulman todetaan perustuvan *”kris-*

tillisiin, oikeudenmukaisuuden ja laupeuden periaatteisiin”. Näiden periaatteiden uskotaan olevan *”myös Englannin kansan suuren enemmistön arvoja”.* Konstruoidessaan omat toimintaperiaatteensa yhteneväisiksi kansan arvojen kanssa, kirkko pyrkii legitimoimaan sanomaansa vetoamalla yhteisesti jaettuihin eettisiin arvoihin ja yhteisöistä suurimpaan eli kansaan.

Terveyden, kuten laajemmankin hyvinvoinnin suhteen, ongelmaksi määritellään sosiaalinen eriarvoisuus ja siitä seuraavat väestöryhmien väliset terveyserot. *”UPA-alueita kuormittavan eriarvoisuuden luonnetta voidaan tarkentaa monella eri tavalla. UPA-alueilla asuu suhteettoman paljon haavoittuvia ihmisiä – työttömiä, ammattitaidottomia, kouluttamattomia, sairaita, vanhoja, vähäosaisia etnisiä vähemmistöjä. Nämä alueet kärsivät silmiinpistävästi tulotason alhaisuudesta, riippuvuudesta valtion viranomaisiin ja sosiaaliturvaan, sairauksista, rikollisuudesta, perheiden hajoamisesta ja asunnottomuudesta. Lueteltuja olosuhteita koskevien synkkien tilastojen avulla on mahdollista piirtää eriarvoisuudesta yksityiskohtainen kartta. Mortaliteetti- (kuolleisuusluvut) ja morbiditeettitilastot (sairastavuusluvut) ovat, melko kirjaimellisesti, elämän mahdollisuuksien indikaattoreita.* (FITC 1985, 13.).

Tässä katkelmassa toiminnan kohteeksi määrittyvät ensisijaisesti UPA-alueilla asuvat ”haavoittuvat ihmiset”. Listaamalla koko joukon UPA-alueiden väestön ongelmia ja toteamalla näiden olevan tilastollisia tosiasioita, vedotaan tieteelliseen näyttöön ja numeeriseen faktaan. Tieteelliseen asiantuntijuuteen vedotaan käyttämällä lisäksi latinalaisperäisiä kansanterveystieteen asiantuntijakieleen kuuluvia termejä “morbiditeetti- ja mortaliteettitilastot”. Myös siirtymä uuteen aikakauteen jäsennetään em. tilastojen avulla:

”Kuolleisuusluvut ovat käytetyin yhteisön sairaalloisuuden mittari, mikä heijastaa terveys-palveluiden voimakasta hoitosuuntautuneisuutta. Koska kuitenkin elämän laatua korostetaan jatkuvasti enemmän kuin sen pituutta, sairastavuustilastoja on alettu käyttää yhä laajemmin. Yhä enemmän painotetaan sairauksien ehkäisyä ja hyvän terveyden edistämistä (WHO on määritellyt terveyden ”ei ainoastaan sairauden puuttumiseksi, vaan myös täydellisen fyysisen, psyykkisen ja sosiaalisen hyvinvoinnin tilaksi”).” (Emt., 266.)

Tekstissä sairauksien hoitoon keskittyvä palvelujärjestelmä ja kuolleisuuslukujen mittaamiseen suuntautunut kansanterveystiede tuotetaan vanhanaikaisina ja riittämättöminä. Uusi, vasta vaihtumassa oleva, sairauksien ehkäisyn ja terveyden edistämisen aikakausi liitetään WHO:n terveyden määritelmään. Seu-

raavassa katkelmassa esitetään kirkon ehdotus uuteen aikakauteen siirtymiseksi.

”... sairauksiin ja huonovointisuuteen voidaan reagoida tehokkaasti vain, jos käydään käsiksi niiden perimmäisiin syihin.
Esitämme, että tähän tulee sisällyttää:
a) sitkeä ja hyvin organisoitu hyökkäys köyhyyttä, työttömyyttä, huonoja asumisoloja ja ympäristöongelmia vastaan; tämä muodostaa perustan UPA-alueiden terveysolojen parantamiselle
b) uudet ohjelmat, joilla saadaan yhteys ryhmiin, joita ei kovin menestyksekkäästi ole tavoitettu perinteisin terveyskasvatuksen menetelmin. On harkitusti omaksuttava ”terveyden edistäminen”, jonka puitteissa kaikkien ministeriöiden on tarkasteltava politiikkansa terveysvaikutuksia, sekä verotuksen avulla ja muin keinoin on tuettava terveellisiä ruokailutottumuksia ja vähennettävä epäterveellisten tapojen (kuten tupakka- ja alkoholiriippuvuuden) houkuttelevuutta.
c) naapurustoprojektit, joiden kautta eri ihmisryhmät voivat hyötyä kunkin tarpeita varten suunnitelluista tukiryhmistä. Vammaiset ihmiset, yksinäiset vanhukset, yksinhuoltajat, pienten lasten äidit, entiset mielenterveyspotilaat ja vapautuneet vangit kuuluvat ryhmiin, joiden kyky elää ihmisarvoista ja toiveikasta elämää UPA-alueilla parantuisi ja kehittyisi tällaisten verkostojen tuella.” (Emt., 270–271.)

Katkelman alussa määritetään ehdotusten yhteiseksi nimittäjäksi iskemistä huonon terveyden perimmäisiin syihin. Tavoitteen saavuttamiseksi ehdotetaan kolmea keinoa. Ehdotuksista ensimmäinen on yleisen tason lausuma, joka linjaa terveyttä edistävän toiminnan suunnan sosiaali- ja ympäristöpolitiikaksi. On huomionarvoista, että terveyspalveluita ja terveydenhuoltopolitiikkaa ei mainita lainkaan.

Toinen ehdotus koostuu itse asiassa useammasta ehdotuksesta. Ne ovat kohdistetut hallitukselle ja sen kaikille ministeriöille. Ehdottaessaan harkittua siirtymää terveyden edistämiseen, mennyt kansanterveyspolitiikka esitetään muutosta kaipaavana. Erityisesti perinteisten terveyskasvatuksen menetelmien käyttäminen kuvataan uudistusta vaativana. Ratkaisuksi tarjottu terveyden edistäminen esitetään tekstissä lainausmerkeissä. Raportin ilmestymisen aikoihin Englannissa oli vallalla konservatiivihallituksen yksilövastuuta korostava ja terveyskasvatukseen suuntautunut kansanterveysstrategia *“Prevention and Health: Everybody´s Business”.* Sosio-ekonomisiin rakenteellisiin tekijöihin keskittyvä

terveyden edistäminen oli vuonna 1985 poliittisella agendalla vielä toistaiseksi tuntematon termi. (Parish 1995, 14–15.)

Viimeinen ehdotus naapuruusprojektien kehittämisestä ei ole kohdistettu hallitukselle, eikä selkeästi muullekaan toimijalle. Subjektittomuuden voi tulkita sisältävän ajatuksen haavoittuvien ryhmien itseavusta ja vertaistuesta. Tässä yhteydessä kirkko myös nimeää ihmisryhmät, jotka ovat UPA-alueilla erityisen heikossa asemassa. Subjektittomaan yhteisölliseen toimintamuotoon vetoaminen juuri kaikista heikoimpien ryhmien auttamiseksi on toisaalta silta kirkon oman tehtävän määrittämiseksi terveyden kentällä, sillä kirkon katsotaan osallistuvan juuri näiden ryhmien auttamiseen. *”Kirkon tulee edistää terveyden merkityksen laajempaa ymmärtämistä. Tässä on otettava huomioon enemmän kuin pelkkä sairauden puuttuminen. On otettava huomioon Raamatussa mainittu “shalomin” ja kokonaisuuden käsite: on huolehdittava niin ihmisten elämän laadusta kuin sen pituudestakin. Tämä on erityisen merkittävää haavoittuville ryhmille. Avustamalla ja tukemalla naapurustoprojekteja, jotka edistävät mainittujen ihmisryhmien terveyttä, kirkot voisivat siirtää tällaisten teologisten pohdintojen tuloksia välittömään käytännön työhön.”* (FITC 1985, 271.)

Kirkon rooliksi nähdään holistisen terveyskäsityksen edistäminen ja osallistuminen naapurustoprojekteihin. Terveyden laajan merkityksen määrittelemiseksi sulautetaan yhteen osa WHO:n terveyden määritelmästä ja raamatullinen holistinen käsitys terveydestä. Puhe kirkon osallistumisesta avunannon ja rohkaisun keinoin konstruoi kirkon yhdeksi osallistujaksi yhteisöllisissä naapuruusprojekteissa, ei täysivaltaisen vetovastuun kantajaksi.

Sisällöllisesti raportti esittää kansanterveyspolitiikan suunnaksi radikaalia muutosta ja siirtymistä terveyden edistämiseen. Näissä otteissa ongelmaksi määrittyy hoitoon keskittyvä terveyspalvelujärjestelmä ja terveyskasvatuksellisen painotuksen tehottomuus UPA-alueilla.

Diakonia- ja yhteiskuntatyön keskuksen asiakirjat – vaikeneminen terveyskysymyksissä

Jo tutkimusmateriaalien hankintavaihe ja alustava aineiston analyysi osoittivat, että verrattuna Portugalin katoliseen kirkkoon ja erityisesti CNPS:een, on Englannin ja Suomen kirkoilla suoranaisesti terveyden edistämiseen liittyviä kan-

nanottoja vähän, ja kansanterveydellisesti merkittävät kysymykset nousevat esille laajempaa hyvinvointia käsittelevien kannanottojen kautta. Mutta vaikka anglikaaninen kirkko näyttää ainakin FITC-raportissa tulevan terveyden kentälle ikään kuin kiertoteitse yleisen sosiaalisen hyvinvoinnin kysymysten kautta, argumentoidaan sosioekonomisten erojen vähentämistä eksplisiittisesti myös terveyssyin. Vastaavanlaista hyvinvoinnin jäsentämistä terveydellisen ulottuvuuden kautta ei KDY:n asiakirjoissa, tai esimerkiksi Piispojen puheenvuorossa hyvinvointiyhteiskunnan tulevaisuudesta (1999) ole havaittavissa. Vaikka myös Suomen kirkon toiminnan kohteena ovat syrjäytyneet, ei tätä toimintaa perustella terveyssyin. Vuonna 2003 KDY linjasi erääksi kehittymistavoitteekseen: *"Tuetaan henkisissä, sosiaalisissa, taloudellisissa vaikeuksissa olevien ihmisten mahdollisuuksia saada apua vaikeuksiinsa…"* Terveydellisiä tai fyysisiä vaikeuksia ei tavoitteeseen ole kirjattu. Otteessa ilmenevä terveydellisen ulottuvuuden puuttuminen on tyypillistä tässä analysoiduille KDY:n asiakirjoille.

Vaikka hyvinvointia ei KDY:n asiakirjoissa juuri jäsennetäkään terveyden näkökulmasta, ja analysoidut tekstit eroavat tässä suhteessa Portugalin ja Englannin kirkkojen asiakirjoista, on tiettyjä yhtymäkohtiakin havaittavissa. Kuten Portugalin, niin myös Suomen asiakirjassa vedotaan kirkon ajattomaan tehtävään vähempiosaisten auttamisessa. *"Kristillinen usko on alusta saakka saanut ilmauksensa diakoniana, rakkaudenpalveluna, joka on kohdistunut yhteiskunnan vähäosaisiin ja syrjäytyneisiin: köyhiin, sairaisiin, vammaisiin, yksinäisiin ja sosiaalisesti eristettyihin."* (KDYK 1995, 7.). Kirkon toiminnan erääksi strategiseksi tehtäväksi määritellään *"taistelee heikkojen ja syrjäytyneiden puolesta"* (KDY 2003). Tehtävän määrittelyn kautta määrittyvät myös toiminnan kohteet. "Heikot ja syrjäytyneet" on ilmaisu, joka kaksinkertaisella vähempiosaisuuden ilmaisulla tekee näistä ihmisistä absoluuttisemmin syrjäytyneitä. Äärimmäistä huono-osaisuutta tuotetaan seuraavassa diakonisen avun kohteen kuvauksessa kvantifioimalla avun tarpeen määrä. *"Koska diakonian on autettava näitä, joiden avun tarve on suurin ja jotka eivät saa muualta apua, seurakunnan on jatkuvasti etsittävä näitä ryhmiä ja yksilöitä, seistävä heidän rinnallaan…"* (KDY 1995, 44.).

Seuraavassa otteessa toistuu Portugalin ja Englannin kirkkojen asiakirjoista tuttu käsitys kokonaisvaltaisesta terveydestä. *"Yhteisenä tavoitteena kirkon diakonia- ja yhteiskuntatyöllä on kristillisen uskon motivoima yksilön, yhteiskunnan ja luonnon integriteetin vahvistaminen. Tämä merkitsee: yksilöelämäs-*

sä ihmistä eheyttävää, kokonaisvaltaiseen terveyteen, itsensä ja muiden tasapainoisen arvostamiseen, ja lähimmäisvastuun kasvamiseen tähtäävää toimintaa" (Emt., 40.). Kokonaisvaltaisen terveyden käsitettä ei eritellä tarkemmin, mutta se nähdään osaksi laajempaa toimintaa yksilön elämän eheyttämiseksi. Kokonaisvaltaisesti terve ja ehyt ihminen tuotetaan tässä tekstissä yhteisön vastuulliseksi jäseneksi.

Vaikka kokonaisvaltaista terveyttä edistävä toiminta on nostettu yhdeksi diakonia- ja yhteiskuntatyön yleistavoitteeksi vuoden 1995 ohjelmassa, ja siten sen voi katsoa olevan erillisten toimintalinjojenkin tavoitteena, ei terveys-syillä argumentoida yhtään spesifiä toimintaehdotusta. Sana terveys ei esiinny asiakirjassa tämän yleistavoitteessa tehdyn maininnan jälkeen lainkaan, sen sijaan sen johdannaisia: terveyskeskus, sosiaali- ja terveystyö, sosiaali- ja terveysviranomaiset, terveydenhuolto, mielenterveysongelmaiset ja mielenterveystoimisto, käytetään muutaman kerran. Yleisemmin nämä terveys-sanan johdannaiset esiintyvät seuraavankaltaisissa lauseyhteyksissä kuvattaessa kirkon yhteistyötä eri viranomaisten kanssa: *"Yhdessä kunnallisten viranomaisten kanssa huolehditaan siitä, että mielenterveysongelmaiset ja heidän omaisensa saavat riittävästi tukea."* (KDYK 1995, 46.). Tämänkaltainen kapeahko, pääasiassa viranomaisyhteistyön kautta avautuva, näkökulma terveyteen ja sen edistämiseen välittyy myös Vastuun ja osallisuuden yhteisö- asiakirjasta. Siinä terveyttä ei enää mainita strategisena tavoitteena, mutta todetaan diakonialaitosten, -säätiöiden ja -järjestöjen tuottavan yhteiskunnan hyväksymiä palveluja *"ihmisten terveyden ja sosiaalisen hyvinvoinnin edistämiseksi" (*2003, 18.).

Osallisuuden ja jakamisen yhteisö- asiakirjan työaloittaisissa kehittämisehdotuksissa kohderyhmänä ovat: vanhukset, sairaat, vammaiset, maahanmuuttajat ja pakolaiset, asunnottomat, päihteiden käyttäjät, vangit ja vapautuneet, rikoksen kohteeksi joutuneet, suuronnettomuuksien uhrit ja heidän omaisensa, köyhät ja velkaantuneet, työttömät. (KDYK 1995, 46–52.) Kirkon toimintaa näiden ryhmien hyvinvoinnin edistämiseksi ei argumentoida terveydellä. Englannin ja Portugalin kirkkojen asiakirjoissa sairautta ja terveyttä koskevat alueet ovat jäsennetyt terveys-termin alle. Vastaavanlaista jäsentämistä ei ole Suomen teksteissä tapahtunut. "Sairaat" otsikon alle kootussa erityisaluekohtaisessa kehittämissuunnitelmassa keskeisiä keinoja määritellään seuraavasti. *"Sairaalasielunhoidon lisäksi tarvitaan diakonian suuntaamista vanhainkodeissa, terveyskeskuksissa ja avoterveydenhuollon piirissä olevien sairaiden sielunhoitoon*

ja käytännön auttamiseen sekä terveydenhuollon henkilöstön tukemiseen heidän tehtävässään" (Emt., 46.) Tässä otteessa kirkon ja diakoniatyön tehtäväksi ja hyvinvointia lisääväksi keinoksi nähdään sairaiden sielunhoito. Myös vanhustyön kohdalla se on nostettu esiin: *"Vanhusten osalta sielunhoito on seurakunnan tärkein tehtävä."* (Emt., 46.) Sielunhoidon korostamisen voi tulkita kirkon painottavan omassa työssään nimenomaan hyvinvoinnin ja terveyden spirituaalista ulottuvuutta.

Teksteissä kirkon avun konstruoidaan kuuluvan "vaikeuksissa oleville ihmisille". Toiminnan voi olettaa olevan tällöin pääasiassa korjaavaa tai hoitavaa, ellei toisin argumentoida. Vuoden 1995 asiakirjassa ennaltaehkäisevän työn merkitys on käsitellyistä erityisryhmistä tunnistettu päihderiippuvien osalta. *"Seurakunnat kiinnittävät päihde- ja opetustyössään ja muussa toiminnassaan huomiota päihdeongelmien ehkäisemiseen."* (KDYK 1995, 48.) Uudessa ohjelmassa päihdeongelman ehkäisy on vaihtunut päihde- ja huumeongelmaisten hengelliseen kuntoutukseen. *"Tuetaan henkisissä, sosiaalisissa, taloudellisissa vaikeuksissa olevien ihmisten mahdollisuuksia saada apua vaikeuksiinsa …kehittämällä päihde- ja huumeongelmaisten tueksi hengelliseen kuntoutukseen perustuvia hoitotapoja ja paikkoja"* (KDY 2003, 30.).

Seuraavassa katkelmassa rakennetaan kirkon tehtävää nyky-yhteiskunnan ongelmista käsin. *"Individualismin ja kilpailutalouden hallitsemassa yhteiskunnassa, jossa ihmisten on kamppailtava omasta paikastaan ja menestyksestään, kirkon haastava tehtävä on pitää esillä välittämisen, huolenpidon ja solidaarisuuden arvoja."* (Emt., 27.) CNPS:n tapaan ongelmaksi nähdään yhteiskunta, jota individualismi ja kilpailutalous hallitsevat. Kuvaamalla kirkon tehtävää välittämisen ja solidaarisuuden arvojen esillä pitämisestä haasteeksi, piirretään kuvaa vallitsevasta yhteiskunnallisesta järjestyksestä näiden arvojen vastaisena. Kuten FITC-asiakirjassa, kirkon tehtäväksi, jollei suorastaan kollektiiviseksi vastuuksi, nähdään tässä tilanteessa yhteiskuntamoraalin rakentaminen osallistumalla yhteiskunnalliseen keskusteluun. *"Kirkon on tuotava esiin vaikeuksissa olevien ihmisten hätä ja vedottava ihmisten omiin tuntoihin. Omista arvoistaan käsin sen tulee osallistua yhteiskunnan arvopäämääristä käytävään keskusteluun"* (Emt., 27.). Puhumalla kirkon omista arvoista tehdään eroa muihin vallitseviin arvoihin, kuten poliittisiin tai taloudellisiin arvoihin.

Toisaalta pohjoismaisen hyvinvointipolitiikan perusarvot hyväksytään, kun asetutaan tukemaan vallitsevaa yhteiskuntajärjestelmää. Vastuun ja osallisuu-

den yhteisö- asiakirjassa erääksi kehittämistavoitteeksi on asetettu: *"Tuetaan suomalaisen yhteiskunnan kehittämistä pohjoismaisen mallin mukaisena hyvinvointiyhteiskuntana, jossa valtio ja kunnat kantavat vastuun kansalaisten perusturvasta ja takaavat kattavan sosiaaliturvan maassa asuville"* (Emt., 31.) Seuraavassa otteessa kirkon tehtäväksi määrittyy hyvinvointiyhteiskunnan tukeminen luovalla persoonallisella huolenpidolla: *"Luterilaisen näkemyksen mukaisesti yhteiskunnan (valtion, kuntien) tulee ensisijaisesti vastata kansalaisten hyvinvoinnin edellytyksistä ja sosiaaliturvasta, mutta kirkon on tuettava sitä yhteyttä luovalla persoonallisella huolenpidolla"* (Emt., 27.).

Luova persoonallinen huolenpito on ymmärrettävissä yhteydessä tavoitteeseen *"osallisuuden vahvistamisesta"* (KDYK 1995, KDY 2003.). Osallisuuden vahvistamisella viitataan yhteisöllisyyden tukemiseen ja kehittämiseen. Yhteisö määritellään tässä yhteydessä laajasti ja erilaisten yhteisöjen yksilölle tarjoama huolenpito mielletään luonnolliseksi. *"Kirkon tulee olla mukana ehkäisemässä syrjäytymistä vahvistamalla lähiyhteisöjä ja niiden luontevaa huolenpitoa jäsenistään. Kokemus yhteisöön kuulumisesta tukee yksilön sisäistä eheyttä ja antaa hänelle merkityksen. Perhe, suku, naapurusto, kyläyhteisö, kaupunginosayhteisö, työyhteisö ja erilaiset harrasteyhteisöt ovat parhaimmillaan yksilöä tukevia ja yhteiskuntaa eheyttäviä yhteisöjä ja antavat mahdollisuuden omaehtoiseen osallistumiseen."* (KDY 2003,28.)

Kirkollisen terveyden edistämisdiskurssin ydin

Hahmottaessani kirkkojen tapaa puhua terveyden edistämisestä lähdin liikkeelle sen kysymisestä, miten kirkot ylipäätään puhuvat terveydestä ja mitä merkityksiä ne sille antavat. Terveys ymmärrettiin teksteissä hyvin kokonaisvaltaisesti. Portugalin ja Englannin kirkkojen teksteissä lähdetään liikkeelle holistisesta terveyskäsityksestä toiminnan lähtökohtana, kun taas Suomen kirkon asiakirjassa kokonaisvaltainen terveys on kirjattu tavoitteeksi. Holistinen terveyskäsitys kirkon kontekstiin sovellettuna on ymmärrettävissä haasteeksi sairauskeskeiselle terveyskäsitykselle. Se tarjoaa mahdollisuutta terveyteen sairaille ja kärsiville, sillä lääketieteen sairaaksi määrittelemä henkilö voi olla spirituaalisesti terve. Kirkon omaksuman holistisen terveyskäsityksen voikin nähdä rakentuvan biolääketieteellisen dualistisen ja reduktionistisen terveyskäsityksen kritiikille.

Kirkollinen terveyden edistämisen diskurssi rakentuu näiden asiakirjojen pohjalta tehdyn analyysin perusteella kahdesta osadiskurssista. Diskursseissa konstruoituvat kirkon toiminnan kohteet, keinot ja se, miten kirkko määrittää näillä alueilla omaa asemaansa ja kumppanuuttansa valtioon. Olen nimennyt diskurssit seuraavasti: yhteisöllinen solidaarisuus terveyden voimavarana ja spirituaalisuus terveyden voimavarana. Ensiksi mainittu diskurssi on vahvasti konstruoitu kaikkien maiden asiakirjoissa, spirituaalisen diskurssin rajoittuessa Suomen ja Portugalin asiakirjoihin.

Yhteisöllinen solidaarisuus terveyden voimavarana- diskurssissa toiminnan kohteeksi määrittyvät yhteiskunnan vähempiosaiset. Sellaiset ilmaisut, kuten "köyhimmistä köyhimmät" (CNPS 1999), "kaikista eniten tarpeessa olevat väestöryhmät" (CNPS 1999), "haavoittuvat ryhmät" (FITC 1995), "heikot ja syrjäytyneet" (KDY 2003), "…ne, joiden avun tarve on suurin ja jotka eivät saa muualta apua" (KDY 1995) konstruoivat toiminnan kohdetta kirkkojen asiakirjoissa. Nämä ilmaisut konkretisoidaan köyhiin, kodittomiin, syrjäytyneisiin, päihderiippuvaisiin, vammaisiin ja vakavasti sairaisiin, Aids-potilaisiin ja HIV-tartunnan saaneisiin, perheväkivallan uhreihin, yksinhuoltajaäiteihin, pahoin velkaantuneisiin, vankeihin, suuronnettomuuksien- tai rikoksen uhreihin ja ikäryhmistä lapsiin, nuoriin ja vanhuksiin. Näiden ryhmien nostamista toiminnan kohteeksi perustellaan kaikissa asiakirjoissa solidaarisuuden näkökulmasta. Toisaalta toimintaa perustellaan sillä, että nämä ihmiset eivät saa apua muualta. Näin tuotetaan ajatus kirkon avun viimesijaisuudesta paitsi avunsaajan, myös avunantojärjestelmän näkökulmasta. Tässä diskurssissa kirkkojen asemaa suhteessa julkiseen valtaan määrittää viimesijaisuus, ja sen oman toiminnan keinona on yhteisöllisen solidaarisuuden edistäminen.

Yhteisöllisen solidaarisuuden diskurssissa ongelmana ovat yhteiskunnissamme laajalle levinneet individualismi ja materialismi, sekä niiden hengessä ihmisten elämää ohjaava voittamisen tavoittelu ja kova kilpailutalous. Näiden arvojen ja tavoitteiden vallitessa nähdään heikkojen yksilöiden jäävän vahvojen jalkoihin. Yksilön nähdään tulevan terveeksi ja eheäksi, kun toimintaa ohjaa keskinäinen solidaarisuus. Solidaarinen yhteisö on puolestaan hyvinvoiva yhteisö. Yhteisöllisen solidaarisuuden diskurssi rakentaa näin yhteiskuntamoraalia. Tässä diskurssissa vedotaan menneisyyteen ja kirkon ajattomaan tehtävään näiden kaikista heikoimpien ihmisten auttamisessa.

Spirituaalisuus terveyden voimavarana- diskurssissa kirkon toiminnan koh-

teena ovat päihderiippuvaiset ja hedelmällisessä iässä olevat naiset. Ongelmaksi hahmottuvat sekularisaatio ja individualismi, ja terveyttä edistäviksi keinoksi nähdään spirituaalinen tukeminen ja moraalinen kasvatus. Seksuaalikasvatuksen ja päihdetyön alueilla kirkko ei tuota itseään viimesijaisena avuntuottajana, vaan nämä alueet konstruoidaan terveyden edistämisen kannalta kirkon aktiivista toimintaa vaativiksi. Näillä kumppanuuden alueilla kirkko myös puhuu osittain erilaisella kielellä kuin valtiotoimija. Tämä kieli, nämä puhetavat, ovat ymmärrettävissä diskursiivisen kamppailun kontekstissa haasteeksi dominantille tavalle puhua kyseessä olevista kansanterveyden erityiskysymyksistä. Kirkko ei haasta alan ns. teknistä asiantuntijuutta, vaan eettisen pohjan. Kärjistetyimmillään tämä ilmenee Portugalin aineistossa, todettaessa, ettei seksuaalikasvatuksessa tule sotkea etiikkaa ja tiedettä.

Tässä diskurssissa spirituaalisuus ja kristillisestä maailmankatsomuksesta nouseva moraalisuus nähdään terveyden voimavarana. CNPS:n asiakirjoissa spirituaalisuus, ja niin yksilöllisen kuin kollektiivisenkin päätöksenteon moraalinen perustelu, nähdään terveyden resursseiksi erityisesti hedelmällisyyden kontrollointia koskevissa kysymyksissä sekä päihderiippuvaisten hoidossa ja kuntoutuksessa. Suomen asiakirjassa spirituaalisuus terveyden voimavarana diskurssi konkretisoituu päihderiippuvien kuntoutuksessa. Myös sielunhoidon ja hengellisen tuen korostaminen sairaiden, vanhusten ja vammaisten kohdalla ilmentää spirituaalisuuden korostamista hyvinvoinnin voimavarana.

Vaikka kirkon asema ja tehtävät antavat sille mahdollisuuden nostaa ihmisten terveyden ja hyvinvoinnin edistämisen käsittelyyn yhtä lailla yksilön, väestön kuin yhteisöjenkin tasolla, ovat toiminnan kohteet määritelty molemmissa ydindiskursseissa tavalla, joka edustaa yksilötasoista terveyden edistämistä. Kirkot pyrkivät edistämään tasa-arvoa keskittämällä toimintansa huono-osaisiin, ja koko väestöön kohdistuva terveyden edistäminen jää toiminnassa taustalle. Yhteisöt ja yhteisöllisyys ovat nähty pikemminkin toiminnan keinona tai resurssina kuin kohteena.

Globaali terveyden edistämisen metadiskurssi

Terveyteen liittyvien arvojen on esitetty viimeisten vuosikymmenten aikana nousseen yhä keskeisemmiksi länsimaisen ihmisen elämässä. Lääketieteen on

nähty korvanneen uskonnon vallitsevana moraalisena ideologiana ja sosiaalisen kontrollin instituutiona läntisissä yhteiskunnissa (Conrad 1992, 213–214.). Sekularisaation, individualisaation ja medikalisaation prosessien lisäksi myös globalisaatio on muovannut terveys- ja hyvinvointipoliittista toimintakenttää. Vaikka tutkin tekstejä ensisijaisesti kansallisessa sosiokulttuurisessa kontekstissa ja ymmärrän kansallisen toimintaympäristön ehdollistavan kirkkojen tekstuaalisia käytäntöjä, niin osoitti aineiston analyysi myös sen, että kirkkojen terveyden edistämisen diskursseja rajoittaa ja ehdollistaa samanaikaisesti WHO:n välittämä terveyden edistämisen diskurssi. Kutsun tätä kansanterveyspolitiikan uutta aikakautta jäsentävää lähestymistapaa *globaaliksi terveyden edistämisen metadiskurssiksi*[8]. CNPS:n tekstit ovat hybridejä, joissa kirkkoinstituution kansalliseen perinteeseen sekoittuvat Vatikaanin ja WHO:n tekstit. Tekstit ovat esimerkki globaalin terveyden edistämisen metadiskurssin leviämisestä myös kirkko-instituution piiriin. Myös Englannin kirkon raportista on luettavissa tämän globaalin metadiskurssin yhden osan, kriittisen yhteiskunnallisen terveystutkimuksen, adaptaatio.

CNPS:n asiakirjoissa ja FITC-raportissa viitataan WHO:hon erityisesti konstruoitaessa siirtymää kirkon ja valtion terveyden edistämiseen liittyvässä toiminnassa. Käyttäessään WHO:n välittämää ja läntisen Euroopan maiden kansanterveyspolitiikassa vallitsevaksi noussutta terveyden edistämisen diskurssia, lähenee kirkko toimijana valtiota. Tutkimuksellisesti kirkkojen aktivoituminen terveyden edistämispolitiikassa saattaa olla kirjaamaton havainto, mutta lähihistorian perspektiivistä katsoen kyseessä ei ole uusi ilmiö.

Terveyden pastoraalin komitean perustaminen laajensi katolisen kirkon toiminnan painopistettä sairauden hoidosta ja kuoleman kohtaamisesta terveyteen ja terveyden edistämiseen 1980-luvulla (Feytor Pinto 1999.). Tarkasteltaessa Portugalin katolisen kirkon aktivoitumista terveyden edistämisessä maan terveyspolitiikan historiallisessa kehityksessä on huomattava, että ensimmäinen kansallinen terveysstrategia julkaistiin vasta vuonna 1999 (Ministério da Saúde). Lisäksi kansallista strategiaa voi pitää ennemminkin sairauksiin kuin niiden ehkäisyyn keskittyvänä, pääpainon ollessa hoitojärjestelmän kehittämisessä (Tervonen-Gonçalves & Lehto 2004.). Ohjelmallisten asiakirjojen tasolla tarkasteltuna kirkko näyttää Portugalissa omaksuneen teksteihinsä globaalin terveyden edistämisen metadiskurssin ajallisesti ennen kuin valtio.

Myös Englannissa kirkko ehti ehdottaa siirtymistä terveyttä edistävän yhteiskuntapolitiikan suuntaan ennen kuin hallitus kirjasi sen tavoitteekseen. FITC-raportissa on omaksuttu asiantuntijateksteissä dominantti terveyden edistämisen diskurssi melko täydellisesti sellaisenaan, eikä sitä ole pyritty juurikaan muokkaamaan kirkon kontekstiin. Kirkko ottaa poliittisen opposition roolin kritisoidessaan istuvan hallituksen politiikkaa ja ehdottaessaan radikaalia muutosta terveyspolitiikkaan.

Samoihin aikoihin kun Vatikaanissa valmisteltiin Paavillisen terveysammattilaisten komitean perustamista, luonnosteltiin Suomessa ensimmäistä kansallista Terveyttä kaikille- ohjelmaa. (Maailman terveysjärjestö 1991, 11–12.) Globaalin terveyden edistämisen metadiskurssin voidaan katsoa suodattuneen terveyssektorin kielenkäyttöön 1980-luvulla. KDY:n teksteissä ei kansanterveystyön muutosta sitä vastoin ole kuvattu, eikä terveyden edistämisen metadiskurssi näytä suodattuneen sen kielenkäyttöön ylipäätäänkään. KDY:n asiakirjojen vaikeneminen terveyskysymyksissä korostuu erityisesti verrattaessa asiakirjoja tässä analysoituihin Portugalin ja Englannin kirkon teksteihin.

CNPS:n teksteissä ja FITC-raportissa ei vedota ainoastaan eettisiin yleisesti hyväksyttäviin periaatteisiin, vaan asiakirjoissa viitataan tavan takaa myös byrokraattis-hallinnollisiin asiakirjoihin sekä tieteelliseen asiantuntijuuteen. Tämä voidaan tulkita kirkon tarjouksena ja sillanrakentamisena valtion ja asiantuntijayhteisön suuntaan. Vaikka kirkot näyttävät yhtäältä hyväksyvän valtiollisen terveyden edistämisen diskurssin tekniset perustelut, eivätkä kyseenalaista asiantuntijavetoista, evidenssipohjaista politiikantekoa (riskiryhmät, prioriteettisairaudet jne.) niin haastavat kirkot julkisen sektorin moraaliin ja etiikkaan liittyvissä kysymyksissä. Haasteelle näyttäisi olevan kansanterveyspolitiikan kentällä tilaakin, sillä politiikan normatiivisuuden on nähty jääneen biolääketieteellisen tutkimuksen ja epidemiologisen evidenssin jalkoihin. (Beaglehole & al. 2004.) Myös suomalaisen kansanterveystyön strategiaksi on esitetty muodostuneen ns. kantaaottamattomuuden etiikka (Sulkunen & al. 2003, 101–102.). Vaikka kirkot eivät osallistuisi nykyistä enempää kansallisen terveyden edistämispolitiikan muotoiluvaiheeseen tai kansanterveyttä koskeviin sosiaalieettisiin keskusteluihin, niin ainakin kirkon avun kohteena olevien syrjäytyneiden ihmisten terveyden ja yleisen hyvinvoinnin edistämisen kannalta olisi tärkeää, että terveydellinen näkökulma tulisi huomioiduksi kirkon hyvinvoinnin edistämiseen tähtäävissä linjauksissa ja niiden käytännön toimeenpanossa.

Havainto kirkon marginaalisesta roolista niin kansallisissa politiikka-asiakirjoissa kuin ns. policy- relevantin tutkimuksenkin saralla herätti minut pohtimaan, kuulevatko politiikan tekijät ja tutkijat kirkon tai ylipäänsä yhteisön ääntä laisinkaan. Tarkastelemalla tutkimusmaiden enemmistökirkkojen asiakirjoja, pyrin laajentamaan terveyden edistämispolitiikan tutkimuksellista areenaa yhteisötoimijoiden suuntaan. Kirkot voidaan nähdä merkittäväksi terveyden edistämisen resurssiksi, joka on jäänyt ainakin pohjoismaisessa terveyden edistämispolitiikan tutkimusperinteessä syrjään. Vaikka kirkot menettivät monopolistinen aseman kuratiivisten terveydenhuoltopalveluiden tarjoajana modernisaation prosessien myötä, näyttää uuden kansanterveyden aikakausi ja yhteisöllisyyden vaatimus kuitenkin avanneen kirkoillekin eräänlaisen “mahdollisuuksien ikkunan” palata terveyspolitiikan kentälle terveyttä edistävänä toimijana. Jotta terveyden edistämisen yhteisöllisyyden vaatimus voitaisiin ottaa tosissaan, on alan tutkimuksenkin kyettävä ottamaan vastaan haaste käsitellä vaihtoehtoisia terveysdiskursseja ja herättävä tutkimaan yhteisötoimijoita niiden omista lähtökohdista.

Lyhtenteet

CNPS	Comissão Nacional da Pastoral da Saúde
FITC	Faith in the City
KDY	Diakonia- ja yhteiskuntatyön keskus
UPA	Urban Priority Area
WHO	World Health Organization

Kiitokset

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VIITTEET

1) Terveyttä kaikille vuoteen 2000 on WHO:n v. 1981 julkaisema terveysstrategia, joka tähtäsi kaikkien maailman ihmisten terveyden nostamiseen sellaiselle tasolle vuoteen 2000 mennessä, että se mahdollistaisi sosiaalisesti ja taloudellisesti tuottoisan elämän. Ohjelma uudistettiin 1998.
2) Tämän tutkimuksen kohteena olevien maiden; Suomen (STM 1993), Englannin (Secretary of the State for Health 1999) ja Portugalin (Ministério da Saúde 2004), hallitustason terveysstrategioiden ohella myös Ruotsin strategiassa (Ministry of Health and Social Affairs 2000) kirkot ja uskonto mainitaan terveyttä edistävänä toimijana ja resurssina.
3) Evankelis-luterilainen kirkko Suomessa ja anglikaaninen kirkko Englannissa ovat protestanttisia kirkkoja, kun taas Portugalissa roomalaiskatolinen kirkko on enemmistökirkon asemassa.
4) Kirkon kannanottojen viralliseksi luokittelun problematiikkaa on käsitelty laajasti Hytösen (2003) tutkimuksessa s. 13-20, 40-50.
5) Kirkkohallituksen Sairaalasielunhoidon toiminnallinen osasto (KS) keskittyy niin potilaiden, heidän omaistensa kuin terveydenhuoltohenkilöstönkin sielunhoidolliseen palveluun. Koska KS ei konstruoi toimintaansa terveyden edistämisen kautta, vaan rajoittuu sairaiden hoitoon sielunhoidollisesta näkökulmasta, olen rajannut sen tämän tarkastelun ulkopuolelle.
6) Vatikaanin asiakirjojen tasolla muutos sairaiden pastoraalista terveyden pastoraaliin on paikallistettu kahteen dokumenttiin: Salvifici Doloris ("Kärsimyksen pelastusmerkityksestä") (1984), Dolentium Hominum ("Inhimillinen kärsimys") (1985). Vatikaanin aktivoitumisen seurauksena useissa maissa kirkolliskokoukset loivat pastoraalisia osastoja, jotka laajensivat toimintaa, joka oli siihen saakka rajoittunut sairaalakappelien ja seurakunnan sairaiden palveluiden piiriin. Portugalissa terveyden pastoraalin toiminnalle luotiin perusteet v. 1982 nimitettäessä sairaiden pastoraalin ongelmia tutkimaan kansallinen koordinaattori. Vuonna 1985 vain 2 kuukautta sen jälkeen kun Vatikaanin oli perustettu Paavillinen terveysammattilaisten komissio, nykyinen Paavillinen terveyden pastoraalin neuvosto, perustettiin Portugaliin Terveyden pastoraalin kansallinen komitea. (Feytor Pinto 1999) Vatikaanin Terveyden pastoraalin www-sivut: http://www.healthpastoral.org/ [28.9.2005]
7) Tavoite terveyden edistämiseksi olemassa olevien elinolosuhteiden mahdollistamissa puitteissa on linjassa laajemman katolisen yhteiskunnallisen ajattelun kanssa. Solidaarisuus on katolisessa kontekstissa ymmärrettävissä paitsi arvona, myös yhteiskunnallisena tekona, tai sosiaali- ja terveyspalvelujärjestelmää jäsentävänä rakenteena. Portugalissa "yksityiset sosiaalisen solidaarisuuden instituutiot" (instituiçoes particulares de solidariedade social, IPSS) tuottavat valtaosan hyvinvointipalveluista, mutta pääosin valtion rahoituksella. (Santos Luis 1997, 241-243) IPSS- organisaatiot ovat yksityisestä aloitteesta syntyneitä voittoa tavoittelemattomia instituutioita, joiden tarkoituksena on antaa organisoitu ilmaus ihmisten "moraaliselle velvollisuuden tunteelle solidaarisuuteen" sekä edistää oikeudenmukaisuutta. (Fátima Barroco 1997, 59-61.) Institutionalisoimalla solidaarisuus näihin organisaatioihin, joista merkittävimmät ovat yhä yhteydessä katoliseen kirkkoon, tuotetaan rajaa julkisen ja yksityisen vastuun välille, mitä tulee vähempiosaisten auttamiseen. Tämänkaltaisella toiminnalla on juurensa katoliseen yhteiskuntadoktriinin perusperiaatteessa, subsidiariteettiperiaatteessa.
8) Olen omaksunut metadiskurssin-käsitteen Jaana Vuoren tutkimuksesta. Vuoren mukaan alun perin Foucault 'n käyttöönottama termi diskursiivinen muodos-

tuma on eräänlainen yleisemmän tason diskurssi, metadiskurssi, joka ylittää yksittäisten teemojen, kohteiden, ilmaisujen, instituutioiden, ammattien, teorioiden ja tieteenalojen rajat. Metadiskurssin käsitteellä pyritään hahmottamaan kokonaisille aikakausille ominaisia diskursiivisia prosesseja. (Vuori 2001, 83–84) . Käytän metadiskurssin käsitettä kuvaamaan terveyden edistämis- teeman hallitsemaa aikakautta kansainvälisessä kansanterveyspolitiikassa.

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From Averages to Best Performers
Use of Comparisons in Identity-formation

Abstract

This article examines the use and interpretation of international comparisons in national policy-making in Finland and Portugal. By analyzing policy programs from a discourse-theoretically informed perspective the article addresses the question of how comparative discourses of international govermental organizations frame and shape the identity-formation of their member states in the domain of public health policy. In the analyzed data the comparative information is mostly used to position the country at a disadvantage compared to others. Future objectives are set in order to overcome the disadvantage. However the negative use of comparisons and assigned pejorative positions are also explicitly doubted. These doubts have opened the way for different self-identifications celebrating national originality. In temporal terms the detailed reading of policy documents covering four decades indicates that there has been a substantial change in the use of comparisons from averages towards best performers in the turn of the century.

Key words: international comparisons, identity formation, IGOs, nation states, policy discourse analysis

Introduction

Comparisons are used in everyday life, in science, and in politics to make sense of complex reality. We understand different and unknown practices and phenomena by comparing them with familiar ones. We also make comparisons in order to understand who 'we' are in relation to 'others'. Learning from others happens essentially by comparing. It is in these processes of *comparative understanding* that identities are formed and transformed.

Most socio-political studies on identity have approached the issue from individual actors' perspectives. Some analysts have shifted the focus from individuals' stories to a consideration of public policies as collective stories narrated by polities in the process of policy-making. (Yanow 2000, Schram 1993, Sevón 1996, Marcussen 2004, Kettunen 2006.) In this paper the focus is on welfare-related state identities told in the government programs and strategies. The process of identity formation is approached empirically

by analyzing the use(s) of international comparisons in national policy-making. Instead of trying to sketch the formation of generic nation state identities, I concentrate on the identity formation of the states in the specific domain of public health policy.

Public health policy can be understood in contrast to health care policy. It is characterized by a population level (vs. individual level) concern over a wide variety (vs. narrow focus on biological or behavioral factors) of issues determining health (vs. ill-health). In a historical perspective the public health policy paradigm is perceived to have shifted during the 1970s and 1980s (Petersen & Lupton 1996, Harjula 2007, Baum 2008). The contemporary public health paradigm is known as the "New public health". While the former public health policy was focused on curing sicknesses by means of medicine, the new public health aims at promoting health by taking into account the societal level in creating healthy environments. New public health has been considered to be a health policy of a welfare state (de Leeuw 1989, Kaprio 1991). As the majority of health determinants are beyond the immediate scope of health care policies, it is suggested that public health policy should be studied in the wider policy context of the welfare state, thus taking into account social and health policies (e.g. Navarro & Shi 2001, Navarro 2002, Blank & Burau 2004, Burau & Blank 2006, Lundberg et al. 2008). This challenge is answered here by analyzing national policy agendas.

National agendas are set in an increasingly global context. (Lechner & Boli 2005.) In line with the sociological neo-institutionalism that asserts the influence of this broader environment in shaping and constituting social actors by defining their goals and identities, comparative practices of international governmental organizations (IGOs) are here taken to be the context in which national identity stories are told (Schofer et al. 2009, Alasuutari 2011.) Here the focus is on two IGOs: the European Union (EU) and the European Regional Office of the World Health Organization (WHO). While the WHO is an IGO dedicated solely to health issues, the EU also has a wide variety of other concerns. Although they share a common policy concern on public health issues, neither of them has mandatory power over the public health policies of their member states. They mainly[i] coordinate nation states' behavior by making recommendations, promoting programs and guidelines, by collecting and diffusing comparative information, by monitoring nation states performance and by engaging nation states to use certain discourses. (Jacobsson 2004, COM 2007.) Such coordination has been described as soft governance (Jacobsson & Vifell 2005, Mörth 2006). Accordingly actors at the national level do things not because they must, but because they want to. (Alasuutari & Rasimus 2009, p. 91.) Comparisons authored by IGOs in their formalized and authoritative systems of categorization play a significant role in this mode of governance. It has been suggested that not only nationally perceived problems are defined in relation to

international comparisons (Sahlin-Andersson 1996), but that future desires are also socially constructed by comparing them to those of other nation-states (Sevón 1996).

In this article policies are taken to be manifest in the form of government programs. (Shore & Wright 1997.) These programs have a basic narrative structure which consists of situational descriptions and statements of objectives and desired outcomes. Comparisons can be made in relation to differences or to similarities, and used either in the description of the situation or in the definition of the desires. Guje Sevón (1996) uses the term matching to explain the judgment of similarity. According to her matching is used in self-identification, but it is the matching of desires that leads to identity transformation. This transformation is based on imitation. In cases of imitation nation states may label themselves with reference to and in comparison with, for example, some highly ranked nation in a certain indicator or a nation with a good reputation in a given policy domain. One reason for this is that the thought collective or epistemic community to which nation-states belong has a shared language for labeling and comparison. (Sevón 1996, Marcussen 2004, Alasuutari & Rasimus 2009.) This shared language frames the legitimate vocabulary. In order to be taken seriously, actors must speak with the right vocabulary. Even if they disagree with the content of the narrative or the subject position given to them in it, they must use the right vocabulary to set aside or to distinguish themselves from it. (Hajer 1995, p. 57.) In the sphere of IGOs failing to use the shared discourses and right vocabulary is taken as a sign of non-compliance. The sanctions that may follow from non-compliance include loss of reputation and social exclusion (Marcussen 2004, p. 105, Jacobsson 2004).

This study departs from the notion that international comparisons authored by IGOs shape national identity-formation in a continuous manner. Despite the growing academic interest in national identities from the perspective of Europeanized policy-making[ii] and several references to it in world polity literature[iii], little empirical research has been done in this particular area. By studying the issue in the wider historical and comparative perspective this paper aims to contribute to this debate. Following Alasuutari (2005, p. 121) identity is here understood rather as a verb than a noun. This non-essentialist conception of identity emphasizes the *process of identity formation* which takes place in interaction with wider social environment (Sevón 1996, p. 53). By discussing the constitutive effects of international comparisons on national policy-making and identity formation, this paper seeks to contribute to comparative social and health policy debates that have been largely dominated by a positivist approach. (See Paul 2009.) The following questions are addressed: How has comparative information been used in the national policy-making in Finland and Portugal during the last three decades? How is comparative information used in the process of identity formation, particularly in the description of the situation and in setting the objectives?

The case countries, Finland and Portugal, have traditionally been categorized to represent different welfare state models (i.e. the Mediterranean and Nordic models) (e.g. Ferrera 1996, Alestalo & Flora 1994). Although the focus is not the welfare state but the public health policy and its changes in the context of comparative practices of the relevant IGOs, the classification of countries provided by welfare state studies served as the selection criteria for country cases, particularly as the public health policy is determined by broad social policies and since its contemporary variant is referred to be understandable in the context of welfare state. (See Blank and Burau 2004, p. 16.) The countries compared are also different in the analytical context of this study: Finland volunteered and was nominated by WHO as a "Health for All model country", while Portugal was not. Regarding the relationship between public health policy and welfare state model, Finland and Portugal offer interesting cases for analyzing the policy agendas and changes in them. They serve as extreme cases of European welfare state types. Such a research design based on comparing the most different cases, typically aims at tracing similar processes of change. (Keränen 2001.)

Despite the differences Portugal and Finland have important similarities which make the cases comparable. First, they belong to the same Western European context and second, they are both Member States of the WHO and the EU. More particularly as small countries on the geographical borders of the Europe, they offer interesting cases for the purposes of this study as both smallness and the geographically peripheral[iv] position are attributes that can be seen to dispose countries to international comparisons. (Kettunen 2006, p. 37.) Studying two countries similar in disposition to international comparisons, but different in terms of institutionalized context of welfare production, can shed light on the converging influence of transnational comparative practices. The comparative interest here is not in cataloguing and explaining cross-national differences in terms of causalities but in interpreting country-specific experiences (Oinonen 2004, p. 41) and offering a contextual explanation of these experiences by analyzing them in the frame of the transnational comparative practices. (Paul 2009, p. 243, Keränen 2001.) In the wider context of comparative policy analysis, the interpretative comparative approach employed here is better known as process tracing approach (Gerring 2007, pp. 172–185).

The article is organized as follows: First, I describe the data and introduce the theoretically oriented analytical approach. Second, I present the dominant discourses that IGOs use in terms of comparisons. Third, I present the ways in which international comparisons and the positions assigned to nation-states are used and interpreted in national policy programs. The concluding chapter will summarize the findings, discuss temporal changes and ponder the constitutive effects of comparisons on national policy-making.

The data, methods and theories

Empirical data

Empirical research focuses on texts, more specifically on government programs. According to Freeman (2006, p. 52) government in general is a "text-based medium" and thus works essentially by producing and communicating its ideas, suggestions, proposals, and plans in the form of texts. In contemporary public health policies in particular, the production of a core text has been the case across countries. (Freeman 2006.) The EU also relies on texts in its governance and EU policies are characterized to be rather programmatic than system-based in nature. (Palola 2006.)

The time frame of the document analysis is 1976–2009. This period of contemporary public health policy, which is often recognized to form a distinct era (the so-called New Public Health) in the history of public health, forms a logical period to analyze in terms of international comparisons, as it is also the era of the internationalization of public health policies. (Koivusalo & Ollila 1997.) While internationalization, in general terms can, be used to refer to increasing interconnectedness of the world and growing cooperation of countries in different IGOs, the literature on soft governance has developed valuable new approaches to the empirical analysis of IGOs' influence (e.g. Mörth 2004, Jacobsson 2004). International comparisons are here treated as instruments of soft governance. Marcussen (2004, p. 125) notes that compared to hard law governance the effects of soft governance are long-term and typically less visible, less direct and less causally related to soft governance. This requires a long-term research perspective. The analytical scope of three decades covers the process of internationalization and it is a long enough time to track down the possible historical changes on the discursive level.

The empirical data from the case countries consists of policy documents: public health strategies, their evaluations as well as government platforms. The documents analyzed from Portugal include the Public Health Strategies (Ministério da Saúde 1999, 2004) and the following parts of the Government programs (I–XVII) since 1976 and their annual and medium-term updates called Grandes Opções do Plano (GOP): the introductions, the chapters on social and health policy and the chapters covering European issues. Finnish data consists of Public Health Strategies (1986, 1993, 2001, 2008) and chapters covering health and social policy as well as European issues of the Government programs since 1976. As evaluations commissioned from the WHO (1991, 2002) have been widely diffused and referred to in national programs, they have been used as supplementary data. All the documents analyzed are public, produced with the specific purpose of being widely read. As such, they not only communicate information, knowledge and ideas, but also coordinate behavior. (Freeman 2006, p. 53.) Although the

documents are public, they are written primarily for national and local level policymakers and field practioners. But the fact that all the Finnish public health programs and their evaluations are published in English reveals that international audiences are also taken into account.[v]

Theoretical and methodological framework

The methodological approach of this study can be characterized as policy discourse analysis. (Paul 2009, p. 243, Paul 2007, Hajer 1995, Hajer & Wageneer 2003, Fischer 2003.) Following Howarth (2000, p. 9) discourse is understood here as a "historically specific system of meaning which forms the identities of subjects and objects". This productive nature of discourse in forming identities and assigning subject positions to actors forms a central concern in this paper. In order to analyze the productive nature of discourse in the context of IGOs I have combined this approach with insights from the soft governance literature. Martin Marcussen (2004) has identified soft governance to have legal, normative and cognitive dimensions. According to Marcussen (ibid., p. 107) cognitive governance concerns the *regular production of discourse* about the world and about the roles that IGOs and the member states play in it. It is a question of producing stories about the past, present and future challenges, visions, values and feelings. This way IGOs provide the Member States and their civil servants with a *vocabulary with which to describe themselves*, thereby socially constructing imagined communities (See also Anderson 1991). Normative governance on the other hand concerns the development and diffusion of shared knowledge structures – ideas - through different peer review processes (e.g. country evaluations) and in a multitude of committees. Ideas can be formulated in the form of theoretical statements or as guidelines for appropriate behavior. Through repetitive interaction, research and dialogue *rules of appropriate behavior* are created, which national civil servants and other political actors tend to follow. (Ibid., p. 106.) Comparisons play a central role in both these modes of governance. For the purposes of this study, I first identified the aforementioned IGOs to be relevant in the production of comparative knowledge in the domain of European public health policy. Then I identified the corresponding discourses (i.e. the dominant ways these IGOs use to compare countries) and named them *the EU social policy discourse* and *the Health for All discourse*. (Section 3.)

Much of the literature analyzing the role of IGOs is built on the hierarchic and quasi-deterministic assumption that policy models promoted by IGOs diffuse to individual countries in a top-down manner. Post-positivist scholars have emphasized that international models are always interpreted (Yanow 2000), translated (Czarniawska & Sevón 1996), re-edited (Sahlin-Andersson 1996) or domesticated (Alasuutari 2011) into

the local context. My argument is that comparisons play an essential role in diffusing the international models to national contexts by offering indicator- and performance-based subject positions to Member States. On the discourse analytical tradition Maarten Hajer's social-interactive discourse theory (1995) offers some answers to the dilemma of (national) subject vs. (inter/transnational) structure. While seeing subjects as active in relation to taking up and denying subject positions, it assumes that not all action is active, but instead there is considerable power in the structured ways of seeing. According to Hajer (ibid., p. 57), "the disciplinary force of discourse and its categories is based on the often implicit assumption that the subsequent speakers will answer with the same discursive frame… Even if actors do try to challenge the dominant narratives, they are expected to position their contribution in terms of the known categories."

Although the main empirical interest here is in discourses, I share with Hajer (2009) his understanding that "discourse should always be conceived of in interrelation with the practices in which they are produced, reproduced and transformed". It is in the context of the dominant discourses and the related practices of comparative knowledge production that policy documents from Portugal and Finland have then been analyzed. These practices of comparative knowledge production (e.g. the collection and maintenance of statistical databases, the making of cross-country and case-oriented evaluations of policies and programs, and the collection and diffusion of best practices) are coordinated by IGOs, but they are produced in cooperation with the national epistemic communities. Besides taking into account the practice of transnational knowledge production, the term practice here also refers to the routine production of national level programs. In Portugal the practice of producing key texts has traditionally taken the form of wide and comprehensive government programs, in Finland government programs became this wide only at the end of the 1990s. In the domain of public health policy the tradition in Finland has been to write extensive and detailed sectoral strategies, while in Portugal this form of program writing took place at the end of 1990s. These differences in form are not important for analytical purposes. The documents in and between the countries are comparable as they are all government level texts in which the present situation and future goals are publicly declared. More importantly, from the point of view of analyzing soft methods of governance, they form a practice where international comparisons are used deliberately.

What I have looked at in the national policy documents are the repeatedly used discursive elements – ideas, concepts, and categorizations – where international comparisons are used and interpreted to position the country in the European context and in relation to other countries. After critical reading of the documents several times I was able to identify different categories in their uses. Following the basic narrative structure inherent in the documents, I classified the uses of comparisons into situational

descriptions (Who are we? What situation is this?) and definitions of future goals (What we would like to be? What is appropriate for us in this situation?). This division also presents the key processes of identity-formation in terms of comparisons. Comparisons are used in the process of self-identification as well as in the construction of future desires. (Sevón 1996.)

This article is based on the premises that 1) programmatic government documents form a practice where nation states explicitly answer the mentioned questions, and 2) the comparative discourses of IGOs frame how to do so. The next section presents the dominant discourses in terms of the core concepts, principal production practices and communication channels, as well as the overall timing of these comparative projects. The purpose of the third section is not to offer detailed analysis of the history of comparative practices of the IGOs, but to describe the broader context where nation states make their policies.

Dominant discourses

The Health for All discourse

In Europe, the Regional Office of the WHO has been the core international actor in developing and making public health comparisons from the beginning of 1970s. Since the 1980s it has been promoting the Health for All program6 (HFA) as an ideal model of public health policy (WHO 1982, 1985, 1993, 1999). In order to be able to evaluate the public health situation and its development across the region, a common knowledge base, called the HFA-database, was created in the mid-1980s. (WHO 2009.) Still today the HFA-database is an integral part of WHO's governance, which according to the organizations self-description is essentially based on the providing "data and evidence for Member States" (WHO 2012).

Besides coordinating the collection of statistical information on the HFA -database covering more than 200 indicators and thereby enabling the cross-country comparisons, there is also a series of communications which evaluate the member states' public health policies from the HFA perspective (e.g. WHO 1991, 2002, Ritsatakis et al. 2000). The evaluation is mostly done on the basis of case studies and thus the countries are studied as individual units. However, comparative positions and categorizations are produced in these communications, which are published with the explicit aim of diffusing knowledge and the experiences of HFA development between countries (ibid.). One such position was created in 1981 when the WHO asked Finland and the Netherlands to act as '*pilot countries*' for the European HFA program (WHO 1991, p. 3–6; WHO 2002). In the case

of Finland this position was reproduced in two evaluative country reports (1991, 2002) coordinated by the WHO and conducted by high-level expert groups. These reports are archetypical examples of normative governance. However, these evaluative reports also contribute to cognitive governance by assigning subject positions to countries and by setting the future goals.

In this discourse the norm for a good public health policy is condensed in the morally binding idea of 'Health for All', which is then exemplified by measuring it by using certain calculable factors (HFA-database) and by evaluating it in different review practices. The communication is channeled via scientific communication practices (conferences, courses, journals and other publications) and the networks of the member states' political-administrative machinery (meetings, common projects, and the production of the HFA-database).

The EU social policy discourse

While comparative studies on social and health policies have mainly emphasized the institutional differences between European regions (Arts & Gelissen 2002, Burau & Blank 2006) the political concept of the *European Social Model* that appeared in the sphere of the EU in the 1980s has stressed the unity of the European countries. This interpretation is especially striking in the global context as the European social model is presented in contrast to the US/American or the Japanese/Asian models. (Büchs 2007, p. 43.) Reviewing the term more carefully in the European context, it can be argued that although the European Social Model refers to one European model, the policy instruments used by the EU are based on making the differences visible in the form of comparisons and country rankings.

The accelerated spreading of the Open Method of Coordination OMC[vii] after the Lisbon Summit of 2000 has brought comparisons in the form of benchmarking and best practices to the fore, but the history of comparisons as an instrument of governance in the sphere of the social and health policies of the EU is much older. One of the main terms used to promote the European social dimension has been convergence. A key comparative tool for promoting convergence has been the *European average – "EUR12, EUR15, EUR27"*. Another key concept has been *social cohesion*. The principles of both cohesion and convergence are based on an understanding of the differences inside the region and on a wish to reduce them. This understanding is derived largely from measuring the social and economic differences. The term cohesion acquired a regional bias in the 1980s after Greece (1981), Spain (1986) and Portugal (1986) joined the European Communities. As recipients of financial benefits from the Structural Funds (e.g. the Cohesion Fund), these countries and Ireland were soon after their accession

grouped together under the label of '*cohesion countries*'. (Wallace 2000, p. 31.) In the new millennium the comparative measurement results are increasingly presented in the form of country rankings or clusters grouping best and worst performers together (e.g. European Commission 2003, 2004). Eurostat coordinates this action in cooperation with the national statistical offices (European Commission 2011) as well as with other international actors such WHO (European Commission 2012a).

The health of the citizens is declared to be one of main priorities of the EU and its ensuring this is understood to require cross-sectorial efforts (European Commission 2007). This is proclaimed in the EU Treaty 2002. It is also explicitly stated in the current health strategy (European Commission 2007, p. 3). To further this aim a common approach called Health in All Policies (HiAP) was initiated in 2006 (Ståhl et al. 2006). The practices through which this discourse is produced and reproduced are the joint European tasks, different committees and working groups, expert groups, round tables, the official EU forums for practicing OMC, Eurostat and EU statistics (Hämäläinen 2008, European Commission 2012b). In this discourse countries are compared, categorized and labeled by means of statistics, ranking lists and by pointing out best practices.

Identity stories

A detailed reading of the national policy programs shows that there are number of uses of comparisons. As the analytical interest has been to study the policy texts as one place where nation states tell their identity stories, this section is divided into subsections that correspond to the narratively constructed process of identity formation. (Sevón 1996, p. 65.) The first subsection consists of situational descriptions where the nation states identify themselves in relation to their reference groups. The examples of the second subsection consist of declared objectives and future desires, which are mostly set in causal relation to the stated situational descriptions. But the causal reasoning in plotting the story is not totally intact. This is illustrated in the third subsection by giving examples which explicitly doubt the assigned pejorative positions and instead celebrate national originality.

Lagging behind the others

In both countries the use of cross-national statistical comparisons in the area of public health policy and the related positioning is a constant feature of situational description throughout the time period analyzed. The source of (statistical) information varies between the EU (Eurostat) and the WHO (and its HFA database).[viii] In the documents

analyzed indicators are typically used to show *the poor comparative position* of the country. In the following utterances, the position that the public health indicators give to Portugal in comparison to the reference group is described in extremely negative terms. The reference group varies from the majority of European or EU countries, to the European average or the average of the EU, to the center of Europe or the center of the EU.

> *"When it comes to health indicators … the country is situated in an extremely unfavorable position in comparison with the other European countries…* (GOP 1977, p. 195.)

> *"The principal health indicators reveal the inferior positioning of Portugal in the European context, particularly in regard to the child mortality rate (8.7‰ in Portugal, 6.5‰ in EUR 15) … and the life expectancy at birth (70.6 for men and 77.8 for women in Portugal, respectively 73 and 79.4 in EUR15).* (GOP 1996, p. 16.)

> *"… Even if some health indicators improved, the position of Portugal in the framework of the EU is still unsatisfactory."* (GOP 2000, p. 21.)

Throughout the decades analyzed, the unsatisfactory position in relation to Europe is expressed textually and also reproduced in the charts. The last text represents a typical framing of the issue from the 1990s onward: despite some improvements, the situation is still not satisfactory. The disadvantaged position is described in relation to general public health indicators (e.g. life expectancy at birth or infant mortality), specific diseases (e.g. morbidity and mortality from tuberculosis or AIDS), wider health determinants (e.g. housing conditions or the quality of nutrition), or at the system level (e.g. the volume of resources allocated to the sector). In other words, the gloomy picture painted by the use of indicators is somewhat holistic.

Compared to this broad use of qualitatively different indicators to position Portugal in the European context, positioning Finland in comparative terms is characteristically done on the basis of two *mortality indicators*: those of children and adult men. Contrary to the overall trend of negative positioning, infants low mortality rate shown by international statistics has been reproduced in the documents analyzed:

> *"Infant mortality has long been well below the EU average."* (STM 2001b, p. 10.)

Another comparison used throughout the years has been the poor health of Finnish men in the European perspective. Although there has been a positive development in this regard, Finland is still described as having high mortality rates compared with its reference group. What counts as the reference group has changed over the years. In the first national health program, the Finnish situation was mostly compared with

neighboring Sweden (STM 1987, p. 57) and to a slightly lesser degree with the other Nordic countries. However, European and worldwide comparisons were also used to put the high male mortality into international perspective.

> *"… mortality among adult men is still high from an international perspective and poses a continuing challenge to health policy. It is particularly important to note that male mortality from cardiovascular diseases is still among the highest in the world and that suicide rates are unacceptably high…"* (STM 1987, p. 36.)

Since Finland joined the EU in 1995, European comparisons have been replaced by western European comparisons and the EU countries are taken to form the comparative reference group. (e.g. STM 2001b, 10.)

As presented above, the use of the different indicators as a basis for positioning the countries in a wider comparative perspective consists of evaluative arguments that use simple binary oppositions such as the best/worst, high/low and satisfactory/unsatisfactory. According to the data, the use and interpretation of public health indicators in the above manner is the most common form of comparative positioning. Another typical way of positioning the country in comparison to others is to use the term '*lag*' or '*delay*'.

> *"Finland lags behind Sweden in the prevention of occupational safety and health hazards, particularly accidents at work."* (STM 1987, p. 110.)

In the most recent Finnish document (2008), which is designated to the reduction of health inequalities, and especially in its semi-formal appendix, the laggard position is reproduced. Now, however, the narrow focus on comparisons of mortality is broadened towards evaluating *policies* in a comparative perspective or taking into consideration the wider *social determinants of health*, such as levels of poverty (STM 2008a, p. 151).

> *"Finnish tobacco policy lags behind that of several European countries."* (STM 2008a, p. 110.)

In the Portuguese data, the lag is typically described as being of a *structural* kind and it is presented in the context of "*different phases or levels of development*". Compared with the positioning conducted on the basis of specific indicators from a certain year, these utterances widen the perspective beyond the scope of a certain year, indicator or policy. Portugal is generally positioned as belonging to a different phase of development in relation to the European (Union) countries (e.g. GOP 1977, p. 195), but in the quotation below a dichotomy between the developed and developing countries is articulated.

> "... *If we consider three diseases whose incidence correlates with the level of development (cardiovascular diseases, cancer and tuberculosis) it can be concluded that the state of health of the Portuguese is characterized by a mixed incidence of diseases that are typical of developed countries and of developing countries...*" (GOP 1989–1992, p. 477–478.)

Towards the end of the period analyzed, the reference turns from the "*European average*" into the "*most developed European countries*" and ultimately to the "*best countries*". Parallel to these changes, the term "*European ranking*" appears in the Portuguese documents in 2002 (GOP 2002, p. 79). In terms of comparisons these changes mean that the "European average" is no longer the only reference. Instead, it puts emphasis on the single best and worst performing countries of each quality ranked.

> "... *Regarding maternal mortality, it equally presents a great fall, going down from 10.3‰ in 1990 to 5.2‰ in 1999. In this indicator, we are also above the European average (1997) ahead of such countries such as France, Germany and the United Kingdom.*" (GOP 2002, p. 79.)

In this extract, the positive development of maternal mortality is first explained in the national context by the rapidly decreasing mortality ratio. This national description of the situation is then put into a European perspective by comparing it with the average of the European countries. However, the comparative dimension gains new rhetorical strength at the end of the extract when Portugal is positioned ahead of France, Germany or the United Kingdom. This is of special importance in the case of maternal mortality as it is a classic indicator used to measure the overall public health or the development of the welfare state[ix]. It is possible to observe that along with the discursive shift towards best practices, the positive positioning of Portugal has increased. Nevertheless it is equally important to recognize that the performance of Portugal has in fact improved in recent decades and that its relative position inside EUR27 is also better than it used to be in EUR15.

The shift towards comparing the national situation with the best countries instead of averages is also present in the Finnish documents. In contrast to Portugal, this has not given reason for a more optimistic positioning of the country in comparative terms. Although in the following extract the Finnish situation is described as having improved, an understanding remains that despite these improvements Finland continues to lag behind the new reference levels.

> "*Mortality among 65-year-olds has also considerably declined although we are still 1–2 years behind the longest lived Western Europeans in the case of men.*" (STM 2001b, p. 10.)

Underlying the arguments belonging to the category of 'lag', there is an inherent modernist assumption that other countries are on a more advantageous developmental

level and further in progress while the particular country in question is lagging behind this general pattern of development. Alasuutari and Rasimus (2009) and Alasuutari (2011) have pointed how in policy documents the nationally perceived lag functions as a legitimate reason for reforms.

From averages towards best performers

In the typical argument, the 'unfavorable position' or 'lag' is a description of the actual situation and the objective is to overcome this (lag) in the future. Such argumentation follows causal reasoning: what is before causes what is after. (Sevón 1996, p. 61.) This logic of causality presents the future choices as natural endings for the perceived situation. A strong idea of a more advanced Europe occurs in the Portuguese data. As in the extracts below 'Europe' is constructed as *progressive, democratic, free, pluralistic, developed* and *open* in the documents analyzed.

> *"… making the change from a society that is still in many domains – the mental, social and economic – governed by the "closed model" to another type of an open model, similar to our partners in the Community"* (GOP 1989–1992, p. 474.)

The objectives set in the Portuguese documents tell a story where the 'collective us' has to develop and modernize the country in order to be able to approach and achieve the *levels, patterns, models, requirements, values and the normative framework* typical of "Europe".

> *"… The situation of a relative lag in the community context demands that in the following decades approaching the European standards of living constitutes one of the fundamental objectives for our country ... It is not only the well-being of the Portuguese population calculable in quantitative terms that is in question; the convergence between the different regions of Europe in the standards of living is also an essential condition for strengthening the economic and social cohesion of the Community…"* (GOP 1988, p. 289.)

In the sample above, the generalized quantitatively oriented comparative culture is obvious in the arguments presented for achieving the European level. This objective was already deemed important in 1988 for the sake of *improving the quantifiable well-being of the population*. On the other hand, the national objective of approaching the European level is argued to be important for the sake of the convergence of the European regions. Throughout the time period analyzed 'the European average' or 'developed Europe' or the 'European level' is experienced as a norm or a reference. From the end of the 1980s, convergence is also presented as a goal and reference of development. In the latest Health

Strategy (2004) the national indicators are compared with *the best countries of the EU* and the national objectives are also derived from comparisons with the best countries.

> *"Comparing Portugal's indicators with the best countries of the EU, it is considered that it is possible to reduce the premature mortality rate by 38% in the case of men and by 10% in the case of women…"* (Ministério da Saúde 2004, p. 4.)

Although comparisons have been used in the Finnish documents in the description of situations, the objectives are mostly set in the context of national trends of development, without an explicit comparative reference. However, there are two exceptions: Sweden and the Nordic countries. Back in the 1980s Finns were seen to lag behind the Swedes in levels of health and thus the objective was to achieve the Swedish level.

> *"It seems that Finland could achieve the Swedish level for women by about 1990 (average life expectancy 81 years) and for men by the year 2000 (average life expectancy about 74 years)."* (STM 1986, p. 53.)

If the desire to reach Sweden was only manifest in the 1980s, identification with other Nordic countries has been a constant theme in the data analyzed. The term *Nordic cooperation* is used as an intended course of action throughout the time period analyzed. Identification with the Nordic countries in public health issues has also been on the agenda in the context of European integration. In this process, the health aspects of a wide variety of policies such as alcohol policies (STM 1993b, p. 36) or the principles of equality and universality have been emphasized as being specifically Nordic.

> *"In international cooperation and EU policy it is also important to bring out the traditional values and goals of the Nordic welfare policy which strongly endorse equality considerations."* (STM 2008b, p. 29.)

In these texts, the Nordic welfare model is presented as a solid basis for successful public health policies. Furthermore, the Nordic welfare model is constructed as an export product for the public health policy of the EU.

Due to the causal reasoning illustrated by examples in above sections, it is possible to conclude that the choice of reference group does not only define the self-identification, but largely also influences the setting of future objectives. In both of these processes the comparative reference has turned from averages towards best performers.

Pioneers and model countries

As described above, the causal reasoning binds together the uses of comparisons in self-identifications and in setting the future desires. But there is a comparative language use which does not depart from the notion of lagging behind and subsequently follow the logic of causal reasoning. In this subsection I present examples of *self identifications* which celebrate national originality and superiority. In the case of Portugal the negative use of comparisons and pejorative positions taken nationally are explicitly doubted. The Finnish data offers an example of how the internationally assigned subject position has been systematically upgraded in the national policy programs. Instead of imitating other nation states, these texts promote national models for other countries.

Although the Finns did not position their country especially high in terms of the standard of public health in the 1980s, this did not prevent the Finns from building a very positive image of their country in terms of public health policy. As stated earlier, Finland was nominated as a *HFA pilot country* in 1981 for the European Region of the WHO. However, the term pilot country was never used in Finnish policy documents but was replaced by the term '*pioneer country*'. The pioneer position was keenly adopted in the national policy-making circles in the 1980s and still at the beginning of the 1990s, but the term was a source for yet another interpretation. In the Finnish health policy documents, the concept of pioneer country was somewhat systematically translated as '*model country*'.

It has required a careful reading of both the Finnish and English versions of the health programs and reviews[x] to gain an understanding of the systematic upgrading of the country's position in national policymaking and to be able to demonstrate by text extracts how this was done. While the Finnish version of the first public health strategy refers to Finland as a model country (STM 1986, p. 147), in the English version of the strategy the term used is 'pioneer country' (STM 1987, p. 189). In the *Finnish version* of the first WHO evaluation (WHO1991b), Finland was presented as a '*model country*' in health care (p. 216), health policy analysis (p. 63) and developing the HFA program (p. 68, 73). In the original *English version* of the review (WHO 1991a) Finland was presented as a 'test case' for policy analysis (p. 55) and as a '*pilot country*' for HFA strategy (p. 60) and policy (p. 64) development. This terminological discrepancy between the model and pioneer country exists between the Finnish and English versions of the key documents. It is partly a question of translation but as such an important one. As the term is used repeatedly in the different documents it was hardly 'a mistake' in translation, but instead the term has been deliberately adopted and reproduced.

By using the term pioneer country (internationally) and model country (nationally) these documents constructed an understanding that in public health policy or, at

least in public health policy development, Finland was an exemplary case. Later, the pioneer position taken in relation to the Health for All discourse was successfully recontextualized into a new institutional (EU) environment.

> *"During its EU presidency in 2006, Finland made the Health in All Policies approach the main focus of its health policy. The concept of horizontal, comprehensive health policy has grown in strength in the EU and the Health in All Policies principle is incorporated into the Union's health strategy."* (STM 2008b, p. 29.)

By changing only one word in the slogan, the change from Health for All policies to Health in All policies has been smooth. As the declared principles of the policy (e.g. comprehensiveness and intersectorality) remained the same, it has been easy for Finland to continue on the same course and reproduce its pioneer position in the international scene.

Although the laggard position is prevalent in the data from Portugal, in the following texts, the positions assigned to Portugal in the dominant discourses are doubted and explicitly questioned.

> *"…Similarly, a country like Portugal will tend to represent a periphery less and less. We have to use those crossways which will consider us a reference point. An already existing polycentrism obliges us to contradict with determination what must not be seen as an inevitable fate – our geographic situation, distanced from the traditionally significant centers."* (GOP 1989–1991, p. 471.)

Instead of accepting the peripheral position concluded on the basis of indicators or political categorizations as a *fact*, peripherality is here understood as a representation. The peripheral position in these texts is actively rejected by encouraging the 'collective us' to contradict these stagnant habits of thought with determination.

> *"We continue to converge with Europe from the economic point of view and, more importantly, from the social point of view and the well-being of people and families. We recognize our structural deficiencies. However, these must not leave us to fall into unrealistic positions, nor to paralyze our determination. It is possible to continue to improve in all fronts in our situation … in social solidarity – launching the basis for a new welfare state via generating new social policies and by being pioneers in the experiences of socio-professional integration or in looking for a new model of social cohesion, sustainable and compatible with our level of wealth."* (XIV 1999–2002, p. 10–11.)

These texts do not only reject the positions assigned to the country in the dominant discourses but also position Portugal on the map of Europe in a new way (*e.g. reference point, a pioneer, the new welfare state*). On the other hand, by emphasizing the novelty of

these models and policies and defining the conditional factors on the use of term welfare state, it is conceptualized into national policymaking. By questioning the prevailing interpretations these texts open the door to different self identifications.

Conclusions and discussion

In this article I analyzed nation states' identity-formation in the domain of public health policy in the context of international comparative practices. By studying Portugal and Finland I limited the research to Europe and identified two IGOs to be relevant to the topic on this continent. As stated in the Introduction, I have not aimed at cataloguing differences between countries but rather paid attention to similarities between countries and compared those similarities in time in the wider discursive context. Before discussing the similarities and possible convergence, I first present some brief conclusions on how the discourses authored by IGOs have shaped identity formation in each country.

The long-standing pattern of constructing Finland as having an advanced level of public health policy began by deliberately constructing the image of Finland as an HFA model country and later on as an exemplary case in EU circles. The authority of the WHO has been used in the (re)production of this image, first by volunteering to act as a pioneer country and gaining international visibility in this respect, then inviting the national public health policy to be reviewed by a panel of international experts and finally by widely referring to this position and these reports in national policymaking. This can be thought of as a matter of external recognition if looking only at the authorship of the reviews or thinking generally in terms of strict institutional limits between the national and international actors. I prefer to see it essentially as a matter of self-identification. Even though the reviews were authored by the WHO, they are the result of a broad scale consulting of Finnish policymakers and other relevant actors, as well as of the analysis of key national documents. As pointed out earlier, the translation of the key terms of these reports is a case in point. Although historically the position of the HFA model country was short-lived in terms of its active production, it has left quite a long-standing legacy. For example, although the high male mortality has been constantly used in the description of the situation, the broader use of indicators and the lag or unsatisfactory position in relation to them was reported only in 2008, and only in the strategy's semi-formal appendix. The national desire to meet the expectations linked to the position of a model country may until recently have closed the eyes of policy-makers to learn from other countries in terms of policy solutions. Furthermore, as in the other domains of the welfare policies, the Nordic model has been branded as a model of the good society to be

copied by other countries, also in the area of public health. (See Kuisma 2007, p. 17.) This highlights the two-way traffic of idea(l)s regarding policymaking in the sphere of IGOs.

Portugal entered almost directly from a half a century of dictatorship to the EC as a candidate country in 1978. Although there has been a tremendous amount of development, it has proven difficult to shed the institutionalized image of a peripheral country. The primary subject position offered to Portugal has until very recently been that of a laggard and this position has been reproduced in the documents analyzed until the turn of the millennium. Besides being durable, the position of a laggard has also been a holistic one. What has persisted throughout the time period analyzed is '*lag*' and only the content (economic, political or social) given to the term has varied. 'Lag' does not necessarily refer to a permanent condition, but as it is actively reproduced over and over again, it acquires a ritual character and starts to work as a metaphor. Other terms commonly used to position Portugal in relation to Europe are unfavorable, deficient or peripheral. The comparative disadvantage can be used in domestic politics to put public health issues on the agenda. Still, for whatever motives these positional statements are uttered, there is clearly a marked awareness of separateness in relation to 'Europe' in public health policy matters. At the beginning of the fourth section I described the way certain positions are routinely reproduced and at the end of the section how their discursive questioning has taken place. These moments of doubt have opened the way for alternative identities, but it remains to be seen if they are to be reproduced in time. In light of the current labeling of Portugal as a "crisis country", these alternative identities may not be taken in the near future.

Göran Therborn (1995) describes how recognition by others influences how 'the self' is defined and to whom, how and in relation to what we socialize to the others. The pioneer position assigned to Finland can be understood as a positive external recognition. However, according to Therborn, it is specifically the *discriminatory recognition* that may provide an impetus for identity formation (Therborn 1995, pp. 229–231). This seems a valid point given the persistence of the laggard position taken in Portuguese policy documents.

Although I have not aimed to present a detailed chronology of the period analyzed, I have in any case tried to offer an historical account of what happened in the last three decades in terms of comparative practices. Based on my analysis, it is possible to distinguish two chronological eras in terms of comparative cultures: the era of European averages (1976–2000) and the era of best performers (2000–). These are not mutually exclusive but parallel: as elements of the new era arise, parts of the old era persist. This shift towards best performers has taken place in the description of the situation as well as in setting of future objectives both in Finland and in Portugal. This convergence in terms of changing comparative reference in setting the agendas is interesting as the

comparison has been carried out between the most different cases as regards the welfare state context.

What are the effects of the new era on national policies? The analysis indicates that although policy objectives have long been defined in causal relation to situational descriptions, the era of best performers has brought with it a closer fusion of situational descriptions and policy objectives. In other words, the level of the best performing country tends to automatically and linearly define the policy goals and levels of criteria (e.g. p. 23). This raises a question: will the national policy agendas with a certain holistic grip based on the local or regional socio-historical characteristics disappear because of the pressure to follow a series of indicators each measuring a certain narrow quality? This might imply that national developmental trends turn out to be less important. What is the importance of a declining national trend if the ranked position of the country is considered acceptable? It is equally important to ponder if the way paved by the best performers leads to a success spiral, where positive national development is not enough, but the goal is to endlessly improve the performance and attain globally competitive results. This competitive twist may partly explain the reproduction of a laggard position through the period analyzed in both countries. The analysis also indicates that along with the discursive shift towards best practices, it has become more commonplace to challenge the normative and to a certain degree stereotypic assumptions about the poorly performing south and forerunning Nordic models.

Although international comparisons have long been used in public health policy, there are surprisingly few studies looking at this process from the perspective of international governance. Being an IGO specialized in health issues, the WHO is traditionally recognized as a dominant actor in setting the European public health agenda. The EU on the other hand is described to have entered the field of public health only in the 1990s with competence defined in the Treaties of Maastricht (1992) and Amsterdam (1997). (E.g. Taylor 2000.) Approaching the issue from the perspective of comparisons and soft governance has resulted in an understanding that the EU has profoundly shaped the public health policies of its member states long before gaining any formal powers to do so. Likewise WHO has shaped the policies of its Member States through comparative practices, and not solely through strategic programs or issue specific action lines. Paying closer attention to the constitutive nature of comparative policymaking practices can be recommended for the future research. Identities of nation states do not precede policies, but are shaped in the processes of policymaking.

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Endnotes

[i] In the area of public health, EU has legislation on blood, tissues, cells, organs, water and air quality. (COM 2007, p. 2.)

[ii] Several researchers have touched upon the issue of identity linked to the recent European policy-making. Noël (2006) writes how open method of coordination (OMC) contributes to construction of national identities and positions. According to Palola (2007, 13), the function of the persuasive story told about the European social model is to shape the identity of the member states so that they are favorably disposed to the desired political targets.

[iii] Schofer et al. (2005) in their paper discuss how the constitutive influence of social context on defining actors' identities is treated in this literature.

[iv] Alestalo, Flora and Uusitalo (1985) and Alestalo and Flora (1994) have contributed to our understanding on how to study small and peripheral states from a comparative perspective.

[v] While there are official English translations available of the Finnish documents, the Portuguese documents are only available in Portuguese. The author has for the purposes of this research translated the Portuguese documents into English.

[vi] In 1977, the World Health Assembly decided that the main social target of governments and the WHO in the coming decades should be "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to live socially and economically productive lives". This goal is commonly known as the "Health for All by the Year 2000". The HFA policy framework was amended in 1999.

[vii] Comparisons play a pivotal role in OMC as its central idea is to encourage learning between nations on the basis of comparisons and the sharing of the so called 'best practices'. (Jacobsson 2004, p. 363) Although OMC has not yet been strongly implemented in public health matters, it has influenced the general atmosphere and the overall discourse in social and health policy. Furthermore, the actual Health Strategy is aimed to be implemented by using the '*structured cooperation mechanism*' which can be seen as an adjusted replica of OMC. (COM 2007.)

[viii] OECD statistics are used in relation to health care system performance. As the focus here is on public health policy, these comparisons related only to curative side of health policy are not included in the analysis.

[ix] For example, Navarro and Shi (2000) have used maternal mortality rates as one of the key indicators to measure the public health performance of the different welfare states.

[x] Although the WHO reviews are not written by Finns and cannot directly be counted as a part of the formation of national identities, the reviews are based on interviews with Finnish public health experts, policymakers and other relevant stakeholders. (WHO 1991b, p. 1–11, 2002, p. 15–22.) In addition, the translations of the reviews into the Finnish language have been made by Finns and reviewed and approved by Finnish policymakers. Thus it is important to study the positioning and terms used in also these documents.

ARTIKKELIT

Vertailun valta

LEENA TERVONEN-GONÇALVES & ERIIKKA OINONEN

Johdanto

Euroopan unionin (EU) maiden valtiontalouksien velkakriisi on viimeksi kuluneen vuoden ajan ollut niin eurooppalaisen kuin kotimaisenkin politiikan ja julkisen keskustelun keskiössä. Keskustelu on ollut runsasta ja värikästä, mutta valitettavan usein stereotypisoivaa ja osoittelevaa. ”Mustien lampaiden katras on nyt koossa ja aitauksessa”, kirjoitti Helsingin Sanomat pääkirjoituksessaan 18.4.2011. Tämä tekstinpätkä kuvaa hyvin euromaiden velkakriisistä käydyn keskustelun luonnetta. Velkojensa kanssa kamppailevat Kreikka, Portugali ja Irlanti ovat nyt eurolauman mustia lampaita. Samaan eläinaiheisten vertauskuvien joukkoon sopii myös taloustieteistä alkunsa saanut ja sittemmin mediaan ja politiikkaan levinnyt Portugalin, Italian, Kreikan ja Espanjan kutsuminen englanninkielisellä lyhenteellä *PIGS* eli siat.

Kategorisoinnit ovat tehokas keino yksinkertaistaa ja tehdä ymmärrettävämmäksi monimutkaista todellisuutta. Tällä hetkellä vallalla olevat, usein karkeasti yksinkertaistavat ja jopa halventavat eteläeurooppalaisten maiden kategorisoinnit eivät ole tulosta vain viimeaikaisesta velkakriisistä ja sen käsittelystä, vaan ne ovat rakentuneet nykyisenkaltaisiksi pidemmän ajan kuluessa. Dikotomista jakoa ”etelään” ja ”pohjoiseen”, ”periferiaan” ja ”keskukseen” on tehty useilla foorumeilla, myös tutkimuksen saralla. Vaikka on vaikeaa ja hyödytöntäkin pyrkiä osoittamaan, mistä jokin kategorisointi alun perin juontaa juurensa, tutkimuksellisesti on kiinnostavaa ja poliittisesti tärkeää pyrkiä ymmärtämään, millä tavoin jostain kategorisoinnista tulee vallitseva ja itsestään selvänä pidetty.

Kategoriaa voidaan pitää itsestään selvänä, kun sen käyttöä ei tarvitse erikseen perustella. Menestynyt kategorisointi on helposti ymmärrettävää. Helppo ymmärrettävyys edesauttaa sen leviämistä ihmiseltä toiselle, raportista strategiaan ja lehtijuttuun, tutkimuksesta politiikkaan, maasta toiseen jne. Menestyneet kategorisoinnit ovat useimmiten dikotomioita, joskus trikotomioita, mutta harvoin tätä moniulotteisempia (ks. Noêl 2006). Kun poliittiset päätöksentekijät ottavat käyttöön jonkin kategorian, voidaan sen ajatella luovan mahdollisuuksia kategorian laaja-alaiselle leviämiselle. Tämä tapahtuu usein yhteistyössä median kanssa (Czarniawska & Joerges 1996, 31). Vaikka populismi ja pinnalliset kategorisoinnit ovat saaneet uudelleen sijaa eurooppalaisessa politiikassa, vallalla ovat yhä viime vuosikymmenen aikana kasvaneet vaatimukset tehdä näyttöön perustuvaa politiikkaa. Kaivattu näyttö on luonteeltaan tieteellistä, ja tutkijoita ja tieteen tuomaa auktoriteettia kaivataan poliittisen päätöksenteon tueksi. (Fischer 2009.) Mutta minkälaiselle tiedolle on kysyntää?

Vaikuttaa siltä, että tutkimukset, jotka tuottavat näyttöä kategorisointien muodossa, ovat erityisen kysyttyjä. Vertailevaa tietoa ja malleja tuottava hyvinvointivaltiotutkimus on vastannut tähän haasteeseen Euroopassa (esim. Esping-Andersen & al. 2002). Vaikutusvaltaisena ja arvovaltaisena poliittis-hallinnollisena instituutiona EU virallistaa tutkimuksen tuottamia kategorisointeja. Asiantuntijuuden ja politiikan yhteenkietoutuminen tai tiedolla hallitseminen ei ole uusi asia (esim. & Miller & Rose 2010; Fischer 2009). EU:ssa vertailevalle sosiaalitutkimukselle on ollut erityistä tarvetta ryhdyttäessä rakentamaan sosiaalista ulottuvuutta ja jalostamaan siitä edelleen Euroopan sosiaalista mallia (Savio 2001). Elina

Tätä tutkimusta ovat taloudellisesti tukeneet Emil Aaltosen säätiö ja Pirkanmaan sairaanhoitopiirin kilpailutettava tutkimusrahoitus. Arvokkaista kommenteista kiitämme Matti Alestaloa ja Juhani Lehtoa.

Palolan (2007, 32, 36) mukaan vertaileva hyvinvointivaltiotutkimus nousi jo 1990-luvulla vastaukseksi EU:n tarpeeseen saada tietoa eri maiden järjestelmistä ja niiden kehityksestä, mutta Lissabonin kokouksen (2000) jälkeen tiedon ja tutkimuksen laaja-alainen käyttö eurooppalaisessa sosiaalipolitiikassa on noussut kokonaan uudelle tasolle. (Ks. Esping-Andersen & al. 2002.)

Kielellä ja puhetavoilla on keskeinen rooli eurooppalaisessa politiikassa, mutta keskustelu nimeämisestä ja kategorisoinnista ja niihin liittyvästä vertailun vallasta on ollut lähes olematonta (ks. Keränen 2001). Tämä artikkeli pyrkii avaamaan keskustelua kategorisointien todellisuutta rakentavasta luonteesta. Kategorisoinnit eivät vain heijasta monimuotoista eurooppalaista todellisuutta, vaan rakentavat sitä nykyistä ja tulevaa Eurooppaa, jossa elämme ja tulemme elämään. Tässä artikkelissa pyrimme valottamaan kategorisointien konstitutiivista luonnetta erilaisten tekstiaineistojen avulla. Empiirisesti tarkastelemme sitä, miten Etelä-Euroopasta ja erityisesti Portugalista on puhuttu tutkimuksen, politiikan ja median piirissä.

Käytämme aineistojen analyysiin genealogista lukutapaa. Genealogia lähtee liikkeelle kielen konstituoivasta luonteesta. Käsitteenä se merkitsee jonkin asian historiallista muodostumista. Genealogia on menetelmä, joka tutkii, kuinka itsestään selvinä pidetyt totuudet, kuten tieteelliset totuudet, ovat historiallisia konstruktioita, joilla on juurensa tietyissä poliittisissa ja sosiaalisissa tilanteissa ja tietyillä agendoilla. Genealogiaa voidaan käyttää analysoimaan diskurssien ja ideoiden historiallista muodostumista. Kun perinteinen alkuperän historia legitimoi nykyhetken löytämällä sen juuret menneisyydestä, genealogia päinvastoin tutkii historiaa haastaakseen nykyhetken. Pyrkiessään vastaamaan tähän haasteeseen genealoginen tutkimus on monesti kriittistä. (Saukko 2003.)

Vertailu ja nimeäminen

Vertaileminen on luontaista meille kaikille. Vertailujen avulla teemme maailmaa ymmärrettäväksi ja suhteutamme omaa itseämme, asemaamme ja tekemisiämme ympäristöömme ja muihin ihmisiin. Vertailujen tekeminen on luontaista myös yhteiskunta- ja sosiaalitieteille, sillä mitään yhteiskunnallista tai sosiaalista ilmiötä ei voida tarkastella irrallaan muista yhteiskunnallisista tai sosiaalisista ilmiöistä (Durkheim 1982 [1895]).

Vertaileva tutkimus on myös yksi yhteiskunta- ja sosiaalitutkimuksen alalaji. Vertailevan tutkimuksen määritelmästä ei vallitse täyttä yksimielisyyttä. Useimmiten vertaileva tutkimus määritellään tutkimukseksi, jossa vertaillaan systemaattisesti jotakin sosiaalista ilmiötä vähintään kahdessa maassa, yhteiskunnassa tai kulttuurissa. (Oinonen & Alestalo 2006, 209.)

Vertaileva tutkimus voidaan jakaa kahteen metodologiseen lähestymistapaan: muuttujaorientoituneeseen tutkimukseen ja tapausorientoituneeseen tutkimukseen. Muuttujaorientoitunut tutkimus tutkii yhtä muuttujaa tai pientä määrää muuttujia suuressa määrässä tapauksia. Tapausorientoitunut tutkimus puolestaan tutkii useita muuttujia pienessä määrässä tapauksia. Tapausorientoitunut vertaileva tutkimus voidaan edelleen jakaa kahteen eri tyyppiin: muutamaa tapausta vertailevaan tutkimukseen, jossa vertailtavia tapauksia (maita, kulttuureja) pidetään uniikkeina, ainutlaatuisina, ja pientä määrää tapauksia vertailevaan tutkimukseen, jossa korostetaan tutkittavien tapausten samankaltaisuuksia. (Ragin 1987; Oinonen & Alestalo 2006.) Pientä määrää tapauksia tutkivat vertailevat tutkimukset pitävät tyypittelyä keskeisenä keinona ymmärtää ja selittää eroja. Perinteinen vertaileva hyvinvointivaltiotutkimus hyvinvointivaltiotyyppeineen on esimerkki pientä määrää tapauksia (esim. kehittyneet länsimaat) tutkivasta vertailevasta tutkimuksesta.

Vertaileva hyvinvointivaltiotutkimus on ensisijaisesti luottanut tilastollisiin aineistoihin ja instituutioita koskeviin tietoihin. Se on tuottanut vakuuttavia jaotteluja erilaisista hyvinvoinnin tuottamisen ja rahoittamisen tavoista eri puolilla läntistä maailmaa. (Esim. Flora 1986; Palme 1990; Kangas 1991.) Tilastojen käyttöä on tuettu yhteiskuntahistorian analyysillä. Tunnetuin näistä jaotteluista on Gøsta Esping-Andersenin (1990) esittämä hyvinvointivaltioregiimien typologia. Myöhemmät tutkimukset ovat rakentaneet Esping-Andersenin jaottelun pohjalle sitä kritisoiden tai kiittäen. Kritiikkiä on esitetty naisnäkökulman laiminlyönnistä (esim. Orloff 1993), keskittymisestä tulonsiirtoetuuksiin (esim. Anttonen & Sipilä 1994), keskittymisestä taloudellisten asioiden käsitteellistämiseen ja kulttuuristen merkitysten huomiotta jättämiseen (Clarke 2004) ja eri maiden tai alueiden sijoittumises-

ta tai sijoittumattomuudesta typologian malleihin (esim. Leibfried 1992; Castles 1993; Ferrera 1996). Kritiikkiä esittäneet tutkijat ovat täydentäneet mallia oman tutkimustyönsä hedelmillä. Näin on syntynyt kukoistava tutkimusala, jonka tuottamat mallit ja niitä toteuttaneet tutkijat ovat löytäneet tiensä myös poliittisen vaikuttamisen sfääreihin. Eurooppalaisessa mitassa alan huippututkijoiden tie on vienyt aina poliittisen vaikuttamisen ytimeen saakka EU:n neuvonantajiksi (Jepsen & Serrano Pascual 2005; Palola 2007; European Communities – Commission 1994).

Hyvinvointivaltioiden vertailu perustuu pitkälti hyvinvointivaltiollisuuden mittaamiseen. Jotta hyvinvointivaltiollisuutta voidaan mitata, valitaan ensin jokin julkisen politiikan alue, jota halutaan tarkastella. Tämän jälkeen politiikka redusoidaan numeroiksi ja numeroita analysoidaan. Kun numeerisen vertailun tulokset puetaan esitettävään muotoon, niistä tehdään jälleen politiikkoja ja edelleen hyvinvointivaltiomalleja. Keskusteluissa ei ole juuri problematisoitu, kadotetaanko tässä politiikan numeroiksi kääntämisessä ja sen jälkeisessä politiikaksi laajentamisessa jotain (ks. Yanow 2000). Vaikka mittaamisen menetelmiä kehitellään jatkuvasti, on yllättävää, kuinka vähän huomiota on kiinnitetty siihen vertailevan tutkimuksen tärkeään osaan, jota voimme kutsua kategorisoinniksi ja nimeämiseksi.

Sosiologian piirissä nimeämistä (*labeling*) ovat tutkineet Barbara Czarniawska ja Bernward Joerges. Heidän mukaansa sanoista tehdään nimiä (*label*) toistamalla niitä paitsi usein niin myös kyseenalaistamattomalla tyylillä samankaltaisessa kontekstissa. Toisaalta menestyksekkäät nimet leviävät kontekstista toiseen, ja lopulta niistä tulee itsessään institutionaalisia kategorioita (Czarniawska & Joerges 1996, 32). Tässä keskitymme erityisesti kansainvälisen vertailun käytännöissä ja kategorisoinneissa käytettyyn nimeämiseen ja erittelemme myös nimeämisen keinoja. Aineistossamme nimeämistä on harjoitettu ja edistetty toiston, selviöiden ja dikotomisoinnin keinoin sekä käyttämällä luokitteluja ja numeerisia mittareita. Lisäksi on vedottu tieteen auktoriteettiin ja näyttöön perustuvaan politiikkaan sekä vaikutusvaltaisiin toimijoihin.

Vertaileva tutkimus tuottaa usein suuriin tilasto- ja kyselyaineistoihin perustuvia eroja tai yhtäläisyyksiä korostavia luokitteluja, kategorioita ja tyypittelyjä. Nimeäminen on olennainen osa vertailua. Nimeäminen voidaan ymmärtää välineeksi vertailun tulosten, löydettyjen erojen ja yhtäläisyyksien kommunikoimiseksi ja kuvaamiseksi. Paitsi että kategorisointi ja nimeäminen auttavat hahmottamaan monimutkaista todellisuutta, ne myös luovat identiteettejä (Schram 1993; Tilly 2008). Otetaan esimerkiksi Suomi. Suomi ei kuulu Esping-Andersenin hyvinvointivaltiotypologiassa skandinaaviseen hyvinvointivaltiomalliin, mutta monet tutkimukset ovat asettaneet Suomen Norjan, Ruotsin ja Tanskan rinnalle yhdeksi maailman johtavista hyvinvointivaltioista. Esimerkiksi Matti Alestalo sanoo saaneensa Suomen skandinaaviseen ryhmään kuuluvaksi käyttämällä korosta ja lakaise -menetelmää: samalla kun korostetaan yhteneväisyyksiä, eroavaisuudet lakaistaan maton alle (Alestalo 2010, 301). Kun maita kategorisoidaan ja nimetään sosiaalidemokraattisiksi, liberaaleiksi tai konservatiivis-korporatistisiksi (Esping-Andersen 1990) tai heikoiksi ja vahvoiksi (HS 21.4.2011), nimeäminen korostaa eroja luotujen kategorioiden välillä, mutta häivyttää niitä kategorioiden sisällä.

Tutkimusaineisto

Seuraavissa luvuissa analysoimme, kuinka Etelä-Eurooppaa ja erityisesti Portugalia on kutsuttu tutkimuksen kentällä, EU-politiikan piirissä ja suomalaisessa mediassa ja miten tähän nimeämiseen on suhtauduttu Portugalissa. Koska intressinämme on tutkia, kuinka kuva alkeellisesta etelästä on kategorisen nimeämisen kautta muodostunut vallitsevaksi, olemme keskittyneet eri aineistoissa samankaltaisina esiintyneiden puhetapojen esiin nostamiseen.

Aineistoina olemme käyttäneet kolmen viimeksi kuluneen vuosikymmenen aikana julkaistuja kansainvälisiä hyvinvointivaltiotutkimuksia, EU:n koheesiopolitiikkaa koskevia julkaisuja ja raportteja, Portugalin hallitusohjelmia sekä vuoden 2011 aikana Helsingin Sanomissa (HS) julkaistuja kirjoituksia. Sovellamme aineiston lukuun genealogista lukutapaa ja kysymme, kuinka tietyistä ajattelutavoista tulee vallitsevia ja itsestään selvänä pidettyjä tiettyinä ajanjaksoina. Tarkoituksenamme ei ole tutkia yksityiskohtaisesti kutakin diskurssia ja debattia, vaan pikemminkin osoittaa, kuinka useat debatit ja toimintapolitiikkaa ohjaavat diskurssit ovat kehittyneet samansuuntaisiksi kolmen viimeksi kuluneen vuo-

sikymmenen aikana ja osaltaan uusintaneet dikotomista etelä–pohjoinen-ajattelua.

Tutkimuksiksi luokitellut ainestot koostuvat kirjoista, kirjanluvuista ja tieteellisissä aikakauslehdissä julkaistuista artikkeleista. Tieteellisen julkaisemisen perinteen mukaisesti kirjoittajat esiintyvät omilla nimillään. Kirjoitukset on pääasiassa julkaistu englanniksi. Olemme valinneet analysoitaviksi sellaiset alan keskeiset kirjoitukset, jotka kuvaavat Etelä-Eurooppaa. Koska "Etelä-Eurooppaa" on kuvattu suhteessa "Pohjois-Eurooppaan", on aineistona myös eksplisiittisesti Pohjois-Eurooppaa ja implisiittisesti Etelä-Eurooppaa käsitteleviä kirjoituksia. Tutkimuksellinen aineisto sijoittuu vuosien 1990 ja 2010 väliin.

EU:sta olemme valinneet analysoitaviksi alueeli koheesiopolitiikkaa käsitteleviä julkaisuja, joissa Etelä-Eurooppa on mukana. Analysoituja komission julkaisuja ovat Koheesionpolitiikan toinen arviointiraportti (2001), Koheesiopolitiikan historiikki "EU Cohesion Policy 1988–2008" (2008) sekä aluepolitiikkaa esittelevillä www-sivuilla julkaistu "History of the Policy" ja parhaillaan käynnissä olevan aluepoliittisen rahoituskauden (2007–2013) esittely. Edellä mainittujen komission tuottamien ja julkaisemien aineistojen lisäksi olemme analysoineet myös eräitä komission tilaamia tai komission tiedonhankinnan prosesseissa tuotettuja tekstejä, joissa kirjoittajana on yksityinen henkilö (Sapir 2004; Tsipouri 2002). Tämä heijastaa sitä yleisempää trendiä, jossa eri alojen asiantuntijat kutsutaan EU:n tai EU:ta koskevien raporttien ja taustapapereiden tuottajiksi. Vaikka analysoidut tekstit on julkaistu vuoden 2000 jälkeen, ne kokoavat yhteen koheesiopolitiikan kaudella käytetyt kategorisoinnit vuodesta 1988 lähtien.

Portugalin asiakirjat koostuvat hallitusohjelmista sekä hallitusohjelmien pohjalta vuosittain laadituista asiakirjoista (Grandes Opções do Plano, GOP). Hallitusohjelmat ja parlamentin julkaisemat GOPit ovat satoja sivuja pitkiä, yksityiskohtaisesti tulevaa politiikkaa linjaavia asiakirjoja. Tulevaisuutta linjataan paitsi asettamalla tavoitteita myös kuvaamalla laajasti nykyistä tilannetta ja ratkaisua vaativia ongelmia. Näistä asiakirjoista olemme analysoineet tarkemmin sosiaali- ja terveyspolitiikkaa ja EU-politiikkaa koskevat osiot sekä johdannot[1]. Asiakirjat on julkaistu portugaliksi, ja niitä voidaan pitää ennen kaikkea portugalilaiselle yleisölle suunnattuina. Ajallisesti aineistot kattavat koko vallankumouksen jälkeisen ajanjakson (1976–2009). Tämä aikakausi kattaa myös koko EU:hun integroitumisen prosessin.

Suomen suurin sanomalehti Helsingin Sanomat on valittu edustamaan suomalaista mediaa. Muista edellä esitellyistä aineistoista poiketen olemme tarkasteleet Helsingin Sanomia vain vuoden 2011 ajalta ja analysoineet kirjoituksia, jotka käsittelevät Portugalia kriisimaa-puheen kontekstissa. Emme kiinnitä huomiota yksittäisten Helsingin Sanomien toimittajien henkilöllisyyteen, mutta mielipideosastolla julkaistuista kirjoituksista olemme maininneet kirjoittajan.

Vertaileva hyvinvointivaltiotutkimus: perässätulijoita ja edelläkävijöitä

Vaikka hyvinvointivaltioiden vertailut pohjautuvat numeeriseen mittaamiseen, tutkimuksen tulokset kommunikoidaan sanoin. Tutkijat ovat käyttäneet kuvatakseen eteläeurooppalaista hyvinvointivaltion mallia seuraavia ilmauksia: *alkeellinen* (Leibfried 1992; Gough & al. 1997), *semi-institutionalisoitunut lupaus* (Leibfried 1992), *perifeerinen* (Kosonen 1995), *post-autoritaarinen* (Lessenich 1994), *erillinen perässätulijoiden ryhmä* (Katrougalos 1996), *ex-fasistinen* (Navarro & Shi 2001), *kypsymätön* (Muffels & Fouarge 2004). Tämä kaiken kattava "kypsymättömyys" on nähty osittain kehitykselliseksi, ohimeneväksi piirteeksi (*catch up countries*) (Leibfried 1992), mutta myös suhteellisen pysyväksi, rakenteelliseksi tai institutionaaliseksi piirteeksi. Termin *catch-up countries* takana on modernistinen olettamus, jonka mukaan perässä laahaavat Etelä-Euroopan maat seuraavat kehityksessään edistyneempiä hyvinvointivaltioita. Pääasiassa eteläeurooppalaiset tutkijat ovat Maurizio Ferreran (1996) viitoittamana tunnistaneet näistä maista oman, erillisen hyvinvointivaltiotyypin ja nimenneet sen puhtaasti maantieteellisin termein "eteläeurooppalaiseksi" tai "välimerellisek-

1 Asiakirjoja on analysoitu yksityiskohtaisemmin ja erilaisesta näkökulmasta toisessa tutkimusartikkelissa (ks. Tervonen-Gonçalves 2012).

si" (Ferrera 1996; Rhodes 1997; Moreno 2000; Guillen & Matsaganis 2000).

Toinen ääripää eurooppalaisten hyvinvointivaltioiden vertailussa on sijoitettu Pohjois-Eurooppaan, erityisesti Pohjoismaihin. Peter Baldwinin (1990, 43) mukaan pohjoismaista mallia on yleisesti pidetty "hyvinvointivaltion kehityksen korkeimman asteen ilmentymänä". Tutkijat ovat yleensä käyttäneet joko maantieteellisiä termejä (*skandinaavinen, pohjoismainen*) kuvatakseen mallia tai kutsuneet sitä *sosiaalidemokraattiseksi* (Esping-Andersen 1990). Sosiaalidemokratia on puolestaan yhdistetty positiivisesti latautuneisiin universalismin, tasa-arvon ja solidaarisuuden arvoihin (Kuisma 2007). Margitta Mätzke ja Ilona Ostner (2010) kutsuvat Skandinavian maita *edelläkävijöiksi* suhteessa postindustrialistisen yhteiskunnan ongelmiin.

Arkikielessä esitettyjä kategorisointeja muista maista tai kansallisuuksista pidetään helposti stereotyyppisinä ja kapeina, omasta kansallisesta paremmuudesta kiinni pitävinä. Tieteessä tuotettujen kategorisointien voisi olettaa olevan sofistikoituneempia, mutta näin ei kuitenkaan näytä olevan. Jari Aron mukaan (1999, 17–18) ylistämistä ja halventamista käytetään usein tieteessä keinona muodostaa hierarkioita eri näkemysten välille.

On myös esitetty, että pohjoismaisilla tutkijoilla on ollut taipumus analysoida kaikkia hyvinvointivaltioita valitsemalla sellaiset muuttujat, jotka ovat keskeisiä Pohjoismaissa, mutta eivät välttämättä muissa yhteiskunnissa (Hellsten 1995, 432). Tutkimuksen valtavirta on painottunut analysoimaan kaikkia hyvinvointivaltioita perustuen instituutioihin, arvoihin ja poliittiskulttuurisiin valintoihin, joiden on tunnistettu olevan keskeisiä Pohjoismaissa (Baldwin 1996). Matti Alestalo, Sven E. O. Hort ja Stein Kuhnle (2009, 45) ovat kuvanneet tätä painotusta "skandosentrismiksi". Ana M. Guillen ja Manos Matsaganis (2000) ovatkin osoittaneet, kuinka Etelä-Euroopan maiden nimeäminen alkeellisiksi hyvinvointivaltioiksi on ollut harhaanjohtavaa ja perustunut empiirisen datan väärinlukemiseen. Heidän mukaansa Etelä-Euroopan hyvinvointijärjestelyjen ongelmana ei ole se, että ne olisivat "perässä" järjestelminä, vaan se, että ne kärsivät järjestelmän osien epätasapainosta, joka johtaa kasvavaan epätasa-arvoon ja tehottomuuteen.

Yhteiskuntatieteilijöillä on tapana olla samaa mieltä siitä, että pohjimmiltaan kaikki tieteenalalla luodut typologiat ovat "vain abstrakteja malleja". Ne nähdään eräänlaisina käsitteellisinä välineinä, jotka auttavat ymmärtämään kompleksista todellisuutta. Kuitenkin, samaan aikaan, nämä käsitteelliset mallit myös rajoittavat ajatteluamme ja toimintaamme tutkijoina, kansalaisina, politiikantekijöinä ja virkamiehinä. Tämä ei tarkoita, että kaikki kategorisoinnit houkuttelisivat yhtä paljon. Sen sijaan huomio riippuu siitä, missä määrin nämä kategorisoinnit ovat kykeneviä kontribuoimaan paradigman institutionalisoitumiseen, mikä puolestaan riippuu siitä, mitä tieteellisiä ja poliittisia paradigmoja pidetään sillä hetkellä ajankohtaisina (Bothfield 2008). Esping-Andersenin regiimijaottelu ja sen jälkikasvu saavuttivat hallitsevan aseman kansainvälisen sosiaalitutkimuksen kentällä 1990-luvulla. Peter Abrahamsson (1999, 394) nimesi tämän kukoistavan käytännön "hyvinvointivaltiomallien *businekseksi*" kymmenen vuotta sitten. Lisäksi hän osasi ennustaa sen jatkavan tärkeänä hyvinvointi- ja sosiaalipolitiikkatutkimuksen osana reilusti tämänkin vuosituhannen puolelle. Business-ajattelua on tukenut muun muassa EU rahoittamalla vertailevia tutkimusprojekteja (Keränen 2001).

Politiikka: portugali ja euroopan unioni

Poliittinen vallankumous vuonna 1974 päätti lähes puoli vuosisataa kestäneen diktatuurin Portugalissa. Demokratiaan siirtymisen jälkeen (1976) maan perusinfrastruktuuria kehitettiin, yleinen elintaso nousi ja väestön terveys parani (Medina Carreira 1996; Santana 2000). EU laajeni 1980-luvulla Etelä-Euroopan suuntaan. Portugali ja Espanja liittyivät jäseniksi 1986, Kreikka 1981[2]. Laajenemista edelsi noin vuosikymmenen kestänyt valmistelu- ja neuvotteluvaihe. On hyvä palauttaa mieliin, että EU[3] oli tuolloin ennen kaikkea taloudellinen liitto. Vaikka laajeneminen etelään merkitsi talousalueen laajenemis-

2 Italia oli yksi EU:n perustajajäsenistä.

3 Portugali haki Euroopan yhteisön (EY) jäsenyyttä miltei heti vallankumouksen jälkeen, ja sen jäsenyyshakemus hyväksyttiin vuonna 1977. Täysjäsenyys EY:hyn tuli voimaan 1986. EY hyväksyi vuonna 1991 Maastrichtissa pidetyssä EY:n jäsenmaiden hallitusten välisessä kokouksessa sopimuksen Euroopan unionista (EU). Tässä artikkelissa puhumme yhtenäisyyden vuoksi EU:sta kautta tarkasteltavan ajanjakson. (Http://europa.eu/about-eu/eu-history/index_fi.htm.)

ta, se oli ennen kaikkea poliittinen kädenojennus näille pitkien oikeistodiktatuurien köyhdyttämille maille. Integraatiokehityksen historiassa tämä laajeneminen merkitsi taloudellisen yhteisön laajenemista poliittisten ja sosiaalisten kysymysten suuntaan.

Vaikka paljon kehitystä oli tapahtunut vuoteen 1986 mennessä, ero yhteisön muihin jäsenvaltioihin oli vielä suuri. Tätä eroa on eurooppalaisessa politiikassa pyritty kaventamaan ”koheesiopolitiikan” keinoin. Käytännössä tämä on merkinnyt koheesiopoliittisten tavoitteiden määrittelyä ja niiden perusteella jaettavia taloudellisia tukia. Koheesiopolitiikkaa on toteutettu rakennerahastojen ja vuonna 1993 luodun koheesiorahaston kautta. Kaudella 1988–1992 koheesiopolitiikan keskeiseksi periaatteeksi määriteltiin keskittyminen ”köyhimmille ja kehittymättömimmille alueille” (European Commission 2011a). Kausina 1989–1993, 1994–1999 ja 2000–2006 rakennerahastojen maksamien tukien ensisijainen tavoite oli ”tukea kehitystä ja rakenteellista sopeutumista niillä alueilla, joiden kehitys laahaa perässä” (European Commission 2008). Kaudelle 2007–2013 ensimmäinen tavoite on ”tukea kehitystä vähemmän vauraille alueilla” (European Commission 2011b).

Koheesiorahastolla on alusta asti ollut ennemminkin kansallinen kuin alueellinen painotus, ja sen rahoituskohteena ovat olleet ”ne jäsenmaat, joiden henkeä kohden laskettu bruttokansantuote on alle 90 % EU:n keskiarvosta ja jotka seuraavat ekonomisen konvergenssin ohjelmaa” (European Commission 2001; Sapir 2004). Käytännössä tämä on tarkoittanut Kreikkaa, Espanjaa, Irlantia ja Portugalia (esim. Tsipouri 2002, 3). Nyt käynnissä olevalla kaudella 2007–2013 koheesiomaiksi luetaan Kreikan ja Portugalin lisäksi myös koko joukko uusia jäsenmaita (European Commission 2011a). Kaunis ajatus koheesiopolitiikan takana on lisätä maiden ja alueiden välistä yhteenkuuluvuutta, mutta Espanjaa, Portugalia, Irlantia ja Kreikkaa kutsutaan koheesiomaiksi lähinnä niiden saamien tukien vuoksi (esim. Wallace 2000, 31).

Jos akateeminen kielenkäyttö on osaltaan konstituoinut EU:ssa rakennettua poliittista todellisuutta, niin viesti on mennyt perille Portugaliin saakka. Hallinnan hengessä puhe ”perifeerisestä ja perässä tulevasta” maasta on otettu aktiiviseen käyttöön kansallisessa poliittisessa kielenkäytössä (Tervonen-Gonçalves 2012). Seuraavissa hallitusohjelmista poimituista tekstinäytteissä kiteytyy kansanterveysindikaattoreista johdettu perässätulijan positio. Perässätulijuus määritellään suhteessa viiteryhmään, joka vaihtelee ”muista eurooppalaisista maista” ”enemmistöön eurooppalaisia maita” tai ”eurooppalaisesta keskiarvosta” ”EU-maiden keskiarvoon” ja ”parhaisiin suoriutujiin”.

> “Mitä tulee terveyden indikaattoreihin… maa on sijoittunut erittäin epäedulliseen asemaan verrattuna muihin Euroopan maihin…” (GOP 1977, 195)

> ”Pääasialliset terveyden indikaattorit paljastavat Portugalin ala-arvoisen aseman eurooppalaisessa kontekstissa erityisesti koskien lapsikuolleisuuslukuja (8.7 ‰ Portugali, 6.5 ‰ EUR 15)… ja elinajanodotetta... (GOP 1996, 16)

> “…Vaikka eräät terveyden indikaattorit ovat parantuneet, Portugalin asema EU:n puitteissa on yhä epätyydyttävä.” (GOP 2000, 21)

Vaikka perässätulijuus kuvasi todellisuutta ja itseymmärrystä suhteessa Eurooppaan erityisen hyvin 1970- ja 1980-luvulla, Portugalissa tapahtuneen kehityksen voisi kuvitella muuttaneen tilannetta. Kuitenkin perifeeriseksi nimeäminen on kuluneina vuosikymmeninä siinä määrin vakiintunut, että siitä on ollut vaikea päästä eroon. Siitä itsestään on tullut institutionalisoitunut kategoria, joka jäsentää myös kansallista itseymmärrystä suhteessa Eurooppaan. Jos maan suhteellinen tilanne onkin jollain indikaattorilla mitaten päässyt parantumaan, on pian huomattu jälkeenjääneisyyttä jollain toisella alueella. Perässätulijan positio on pysynyt, vain sille annetut merkitykset ovat muuttuneet. (Tervonen-Gonçalves 2012.)

Toisaalta millä muilla tavoin portugalilaiset voisivat sijoittaa itsensä suhteessa Eurooppaan? On esitetty, että tullakseen vakavasti otetuksi keskustelijaksi on käytettävä samoja diskursseja kuin muutkin yhteiskunnallisesti merkittävät tahot käyttävät (Hajer 1995: Fischer 2003). Maarten Hajeria mukaillen tätä voisi kutsua diskursiiviseksi disipliiniksi. Kansallisvaltiot voivat joko hyväksyä tai hylätä niille yhteisillä foorumeilla annetut subjektipositiot, sellaiset kuten mallioppilas tai perässätulija, mutta ne eivät voi sivuuttaa niitä. Tätä vahvistaa lisäksi se seikka, että osallistuminen vertailevan tiedon keräämiseen ja käyttöön on nähty soveliaaksi tavaksi toimia kansainvälisesti. EU:ssa avoimen koordinaation menetelmä on vahvistanut tätä toimintatapaa entisestään (ks. Saari 2006).

Vaikka perässätulijan positio on vallitseva Portugalin hallitusohjelmien terveys-, sosiaali- ja EU-politiikkaa käsittelevissä osioissa, nostamme seuraavaksi esiin aineistopätkiä, jotka kuvaavat Portugalille osoitettujen perässätulijan positioiden avointa kyseenalaistamista. Tämänkaltaista kyseenalaistamista voi pitää merkkinä niiden vallitsevuudesta.

”…Portugalin kaltainen maa edustaa periferiaa aina vähemmän ja vähemmän. Meidän tulee käyttää niitä tienhaaroja, jotka pitävät meitä referenssinä. Jo olemassa oleva polysentrismi velvoittaa meidät kiistämään päättäväisesti sen, mitä ei tule nähdä väistämättömänä kohtalona – maantieteellistä sijaintiamme, joka on etäällä perinteisesti merkittävistä keskuksista.” (GOP 1989–1991, 471.)

Sen sijaan, että eri indikaattorien vertailuista johdettu tai poliittisena kategoriana esitetty perifeerinen positio hyväksyttäisiin faktana, perifeerisyys ymmärretään tässä tekstissä yhtenä, joskin vallitsevana tulkintana. Yhtäältä tätä vallitsevuutta puretaan redusoimalla perifeerisyys maantieteelliseksi seikaksi. Toisaalta puhutaan *nykyisestä* polysentrismistä ja *perinteisistä* keskuksista. Väistämättömäksi kohtaloksi koettua perifeeristä positiota hyljeksitään rohkaisemalla ”kollektiivista me-toimijaa” aktiivisesti kiistämään näitä pysähtyneitä ajattelumalleja.

”Me jatkamme konvergoitumista Eurooppaan paitsi taloudellisesti myös sosiaalisesti kuin myös ihmisten ja perheiden hyvinvoinnin näkökulmasta ... Me tunnistamme rakenteelliset puutteemme. Niiden ei kuitenkaan tule pudottaa meitä epärealistisiin asemiin eikä halvaannuttaa päättäväisyyttämme. Tilanteessamme on mahdollista jatkaa kehitystä kaikilla rintamilla … sosiaalisessa solidaarisuudessa – lanseeraten pohjan uudelle hyvinvointivaltiolle, kehittäen uusia sosiaalipolitiikkoja ja olemalla pioneereja sosio-professionaalisen integraation saralla tai etsien uutta sosiaalisen koheesion mallia, kestävää ja yhteensopivaa meidän vaurautemme tason kanssa.” (Programa do XIV Governo Constitucional 1999–2002, 10–11).

Nämä tekstit eivät ainoastaan hylkää Portugalille osoitettuja positioita, vaan ne myös asemoivat Portugalin Eurooppaan uudella tavalla (esim. referenssipiste, edelläkävijä, uusi hyvinvointivaltio). Korostamalla näiden mallien ja politiikkojen uutuutta ne kontekstualisoidaan kansalliseen politiikkaan. Kyseenalaistamalla vallitsevat tulkinnat nämä tekstit avaavat tietä erilaiselle itseymmärrykselle (Tervonen-Gonçalves 2012).

Media

Tuorein kategorisointi Etelä-Euroopan maille on *kriisimaa*. Sillä on poliittisessa kielenkäytössä ja mediassa viitattu rahoitukselliseen kriisiin, joka on kohdannut Kreikkaa, Portugalia ja Irlantia sekä uhannut Espanjaa ja Italiaakin. Kriisimaa-käsite on sujahtanut kotoiseen kielenkäyttöömme jokseenkin sulavasti. Suomen eduskuntavaalien alle kevättalvella 2011 osunut ”Portugalin kriisi” on otettu käyttöön niin kansan kuin poliittisen eliitinkin keskuudessa. Mediassa on esitetty arvauksia siitä, ratkaisiko ”Portugalin kriisi” Suomen eduskuntavaalien tuloksen ja mursi poliittisen kulttuurimme vanhat mallit. ”Persu-kansan” syvien rivien mediassa esittämiä kannanottoja seuraamalla tämän voisi nähdä hyvinkin olleen yksi keskeinen seikka. Myös hallituksen muodostamiseen ”Portugalin kriisi” toi oman lisänsä.

Vaikka kriisimaiksi nimettyjä maita on muitakin, keskitymme tässä artikkelissa erityisesti Portugalin kategorisointiin kriisimaaksi suomalaisessa mediassa. Valitsimme empiirisen analyysin kohteeksi Suomen suurimman sanomalehden Helsingin Sanomat (HS). Syötimme HS:n sähköiseen arkistoon hakusanoiksi ”Portugali kriisimaa”. Tulokseksi saimme 88 osumaa vuoden 2011 seitsemän ensimmäisen kuukauden ajalta. Vuonna 2010 kriisimaa-termiä oli käytetty tässä yhteydessä 27 kertaa. Vuonna 2009 julkaistuista jutuista löytyi vain yksi osuma haulle ”Portugali kriisimaa”. Analyysi perustuu vuotta 2011 koskevaan aineistoon. Käsite on vuonna 2011 levinnyt HS:n taloussivujen ja pääkirjoitusten palstoilta laajalti myös kotimaan sivuille. Kuva ”kriisimaa Portugalista” tiivistyy 8.4.2011 julkaistussa pääkirjoituksessa, jossa se kuvataan taloutensa sotkeneena, poliittisesti vastuuttomana, kilpailukyvyttömänä, rakenteeltaan jäykkänä ja talousrakenteeltaan ongelmallisena. Lisäksi samaisessa kirjoituksessa Portugalin kerrotaan olevan hätäavun varassa, ulkona lainamarkkinoilta, umpikujassa, muiden autettavana, velkakriisin tartuttajana, vakausrahaston uutena asiakkaana ja karsinaan aidattuna mustana lampaana.

Miksi kriisimaa-termi on ollut niin tavattoman helppo ottaa käyttöön (esimerkiksi) juuri Portugalin kohdalla? Saman velkakriisin uhatessa Belgiaa ja viimeksi USA:ta, on vedottu kriisien poliittiseen luonteeseen ja kielletty niiden vertaaminen ”oikeisiin kriisimaihin” (HS 28.7.2011). Mikä selittää kriisimaa-termin kyseenalaistama-

tonta suosiota? Tätä voi yrittää ymmärtää pohtimalla nimeämisen politiikassa käytettyjä keinoja.

Retorisesti on ollut äärimmäisen tehokasta puhua kriisimaaksi luokittelusta. Luokittelu antaa kuvan täsmällisestä ja objektiivisesta metodista ja etäännyttää lukijan nimeämisen poliittisesta luonteesta. Luokituslaitokset tai luokittajat kuulostavat kunnioitettavilta ja puolueettomilta instituutioilta. Oikealta nimeltään ne ovat kuitenkin luottoluokitusyhtiöitä. Vasta hiljattain on Euroopan politiikassa ja mediassa ryhdytty keskustelemaan kriittiseen sävyyn näistä yhtiöistä. Euroopassa on herätty siihen, että kaikki EU-maiden lainoja luokittavat yhtiöt ovat amerikkalaisia. Pekka Pihlanto huomauttaa HS:ssa 14.7.2011 julkaistussa mielipidekirjoituksessaan, ettei liialliseen hyväuskoisuuteen luokittajien toiminnan suhteen ole varaa. Pihlannon mukaan huomiota ei herätä ainoastaan luokittajien yhtenäinen kansallisuus, vaan myös se seikka, että luokittajien toiminta on suosinut rahoituslaitoksia, joilla on saatavia kriisimailta. Heikki Patomäki ja Marissa Varmavuori (Suomen Attack) esittivät HS:n mielipidesivuilla 12.5.2011 julkaistussa kirjoituksessaan kysymyksen siitä, ilmentääkö kriisimaiden auttamiseen tarkoitetut EU:n ja IMF:n yhdessä toteuttamat tukipaketit eurooppalaista solidaarisuutta vai globaalien rahoitusmarkkinoiden yleistä periaatetta ”yksityiset voitot, sosialisoidut riskit”.

Jokseenkin ironista on, että myös OECD, jonka on nähty edistäneen neoliberaalia reformia pitkälti juuri analyysiensä ja suositustensa avulla (Marcussen 2004; Alasuutari & Rasimus 2009), on kritisoinut luottoluokitusyhtiöitä siitä, etteivät ne ainoastaan välitä informaatiota, vaan myös ”esittävät arvioita ja näin nopeuttavat erilaisia kehityskulkuja”. On helppo yhtyä OECD:n pääekonomistin huomioon siitä, kuinka luottoluokitusyhtiöt ovat tuottaneet ”itseään toteuttavia ennusteita”. (HS 8.7.2011.) Itseään toteuttavista ennusteista puhuessaan Robert K. Merton (1968, 475) viittaa niin kutsuttuun Thomasin teoreemaan: ”Jos määrittelemme tilanteet todellisiksi, ne ovat todellisia seurauksiltaan.” Merton havainnollistaa tätä muun muassa 1930-luvun amerikkalaisella pankkikriisillä, jossa menestyvät ja vakavaraiset pankit kaatuivat, kun huhuna alkaneet tilanteen määrittelyt pankkien maksuvalmiudesta vaikuttivat tallettajien käyttäytymiseen tehden huhuista todellisia. Itseään toteuttavat ennusteet ovat aluksi tilanteen erheellisiä määritelmiä aiheuttaen uudenlaista käyttäytymistä, joka tekee alun perin paikkaansapitämättömästä ajatuksesta toden. Iberian maiden politiikkaa tutkinut Robert M. Fishman (2011) toteaa kirjoituksessaan, että ennen luokituslaitosten suositusten pohjalta tehtyä korkojen nostoa Portugalin talous näytti olevan hyvässä kunnossa, eikä maa ollut erityisen pahasti velkaantunut. Nyt tilanteen (kriisin) ratkaisemisessa auttavat EU, IMF ja Maailmanpankki ja edellyttävät julkisen sektorin laajaa yksityistämistä. Tässä pakkoraossa Portugalin valtionomaisuutta myydään. Kaupan ovat muun muassa kansallinen lentoyhtiö, öljy-yhtiö, energiayhtiöitä, postilaitos ja pääkaupungin metro. Tiukat taloudelliset faktat ovat oikeuttaneet madonlukujen lukemiseen eteläiselle tuhlarille.

Vaikutusvaltaisiin toimijoihin tai numeroihin ja mittareihin vetoamisen lisäksi on muitakin keinoja nimeämisen politiikalle. Yhtenä keinona on dikotomisointi. Siinä, että maailma tai tässä tapauksessa Eurooppa jäsennetään dikotomioiden kautta, ei ole mitään uutta. Useat dikotomisoinnit ovat toimivia ja jopa menestyksellisiä. Ongelmallista ja epäilyksiä herättävää on kuitenkin se, että (kahtia)jaosta seuraa usein yhden osan suosiminen toisen osan kustannuksella (Czarniawska & Joerges 1996, 45). Vuonna 2011 HS:ssa julkaistuista ”kriisimaa Portugali” -haun tuloksena löydetyistä kirjoituksista erotimme seuraavat dikotomiat, jotka uusintavat pohjoinen etelä-jaottelua talouskriisipuheessa:

Heikot ja vahvat (euro)maat
Häviäjät ja voittajat
Ottavat ja antavat
Nettomaksajat ja nettosaajat
Kriisimaat ja apua antavat maat
Parhaat euromaat ja vaikeuksiin joutuneet maat
Velkaantuneet ja tiukan talouspolitiikan maat
Oikeat kriisimaat (Kreikka, Portugali, Irlanti) ja kriisimaat (USA)
Oikeat kriisimaat (Kreikka, Portugali, Irlanti) ja velkaantuneet maat (Iso-Britannia, Belgia, Italia, Espanja)

Johtopäätökset ja keskustelua

Portugalin tapaus osoittaa, että kategorisoinneista tulee vallitsevia ja itsestään selviä erityisesti toiston kautta. Kun tutkimus, poliittiset päättäjät ja media ovat tarpeeksi kauan ylläpitäneet kategorioita ja nimenneet Portugalin talouden, kulttuurin ja yhteiskunnan tavalla tai toisella negatiivisin termein, samanlainen kielenkäyttö on

omaksuttu myös portugalilaisten keskuudessa.

Viimeaikainen Etelä-Euroopan maiden kutsuminen taloustieteestä alkunsa saaneella lyhenteellä ja sittemmin laajaan käyttöön levinneellä PIGS-termillä[4] on kuitenkin räikeydellään aikaansaanut vastarintaa. Ensimmäisenä asiaan reagoi Portugalin valtiovarainministeri vuonna 2008, ja Portugalin ja Espanjan lehdistö julisti sen halventavaksi. Sittemmin merkittävä investointipankki *Barclays Capital* on kieltänyt PIGS-termin käytön ja *Financial Times* on rajoittanut sen käyttöä (Wikipedia 2.8.2011). Myös tätä kirjoittaessa tuoreen EU-puheenjohtajamaan Puolan pääministeri Tusk "inhoaa" kriisimaiden nimittelyä sioiksi ja pitää nimittelyä "brutaalina" (HS 2.7.2011). Entä me tutkijat?

Haluamme herätellä keskustelua nimeämisen politiikasta vertailevan yhteiskuntatieteellisen tutkimuksen ja erityisesti hyvinvointivaltiotutkimuksen saralla. Kun yhä suurempi osa politiikasta on tietoon tai evidenssiin perustuvaa ja kun tutkijoita kaivellaan kammioistaan legitimoimaan politiikkaa ja sen argumentteja asiantuntijuudellaan (esim. Fischer 2009), on mielestämme syytä miettiä aiempaa huolellisemmin, kuinka nimetä erilaisia tapoja elää ja ratkaista yhteiskunnallisia kysymyksiä. Ensinnäkin, vaikka tieteessä voidaan esittää reunahuomautuksia ja ehdollisia tekijöitä, niillä on tapana kadota ja kategorisoinnit ja nimet jatkavat omaa elämäänsä politiikan ja julkisen keskustelun sfääreissä. Toisekseen on mahdollista, että lopulta politiikan kohteet alkavat käyttäytyä, kuten niiden oletetaan käyttäytyvän (ks. Miller & Rose 2010). Kun esimerkiksi Portugalia on vuosikymmenien ajan kutsuttu jälkeenjääneeksi, on mahdollista, että se pitää itseään jälkeenjääneenä. Kun se positioidaan Euroopan kartalle yhä uudestaan epäkypsänä ja alkeellisena perässätulijana, on mahdollista, että se vaikuttaa kansalliseen omakuvaan ja poliittiseen toimintaan lamaannuttavasti ja negatiivisesti. Epäilemättä perässätulijan positiot ovat tuoneet mahdollisuuksia rakennerahastojen tukien kautta, mutta ovatko ne myös rajoittaneet niitä ja sulkeneet uusia avauksia? Tätäkin olisi syytä pohtia.

Kategorisointi ja nimeäminen eivät ole konstitutiivisuuden näkökulmasta erityisen ongelmallista maille, jotka on kategorisoitu ja nimetty "pohjoismaisiksi hyvinvointivaltioiksi". Asia on koko lailla käänteinen Etelä-Euroopan kohdalla. Negatiivinen nimeäminen ja yleiskuvaus Etelä-Euroopasta niputtaa maat yhteen ja peittää alleen jossakin maassa tai joissakin maissa esiintyviä positiivisia hyvinvoinnin tuottamisen tai organisoinnin piirteitä, instituutioita ja kulttuuria. Portugalin kohdalla on peittynyt näkyvistä naisten eurooppalaisittain korkea työhön osallistumisen aste. Kun hyvinvointivaltioita on kategorisoitu suhteessa naisten palkkatyöhön osallistumisen asteeseen, korkea osallistumisaste on esitetty osana pohjoismaista mallia (ks. Hearn & Pringle 2006). Tämä on ollut varmasti yksi syy Pohjoismaiden määrittelyssä sukupuolineutraaleiksi ja tasa-arvoisiksi. Portugali on tässä yhteydessä vain "mielenkiintoinen" tai kiusallinen poikkeus. Tämänkin mittarin suhteen on uusinnettu dikotomista ajattelua, jossa Pohjoismaat ovat tasa-arvon mallimaita ja Etelä-Euroopan maat taas miesvaltaisen kulttuurin viimeisiä linnakkeita. Naisten työhön osallistumisen aste on eittämättä ollut myötävaikuttamassa kuvaan miesvaltaisesta eteläeurooppalaisesta kulttuurista. Näin negatiivinen kuvaus työmarkkinarakenteista on laajennettu koskemaan myös kulttuuria.

Olemme väittäneet, että luodessaan tyyppejä ja kategorioita vertaileva tutkimus korostaa samaan kategoriaan luokiteltujen maiden välisiä yhtäläisyyksiä. Näin tehdessään tutkimus tulee häivyttäneeksi kategorioiden sisällä vallitsevia maiden välisiä eroja. Vaikka Etelä-Euroopan maita kuin myös Pohjoismaita yhdistää moni muukin tekijä kuin maantieteellinen sijainti, ne ovat keskenään hyvin erilaisia. Otetaan esimerkiksi juuri naisten työssäkäynti. Yhtenä eteläeurooppalaisia yhteiskuntia kuvaavana tekijänä on pidetty naisten vähäistä palkkatyössä käyntiä verrattuna muuhun Eurooppaan. Vuonna 2010 naisten keskimääräinen työllisyysaste EU:ssa oli 58 %. Vastaava aste Italiassa oli 46 %, Kreikassa 48 %, Espanjassa 52 % ja Portugalissa 61 % (Eurostat 2011). Portugalissa naisten työssäkäynti on yleisempää kuin muissa Etelä-Euroopan maissa ja EU:ssa keskimäärin ja on näin pohjoiseurooppalaista tasoa. Samalla tavoin Pohjoismaita katsotaan yhdistävän naisten palkkatyössä käynnin yleisyys. Naisten työllisyysaste onkin EU:n keskiarvoa suurempi liikkuen Suomen noin 67 prosentista Nor-

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4 PIGS-termin yleisyydestä kertoo osaltaan se, että termi on määritelty ja sen käytön historiaa kuvataan laajalti lähteisiin viitaten myös Wikipediassa (http://en.wikipedia.org/wiki/PIGS_%28economics%29).

jan 73 prosenttiin. Kun katsomme osa-aikatöitä tekevien naisten osuutta kaikista työssä käyvistä naisista, kuva yhteneväisestä Pohjolasta muuttuu. Noin 40 % ruotsalaisista, tanskalaisista ja norjalaisista työssä käyvistä naisista tekee osa-aikatöitä, mikä on huomattavasti enemmän kuin EU:ssa keskimäärin (32 %). Suomalaisista naisista sen sijaan osa-aikatöitä tekee vain noin 20 % ja – vertailun vuoksi – portugalilaisista naisista vain noin 16 %. (Eurostat 2011.)

Etelä-Eurooppaa luonnehditaan myös traditionaaliseksi ja uskonnollisia arvoja ylläpitäväksi. Kuitenkin niistä seitsemästä Euroopan maasta[5], jotka sallivat samaa sukupuolta olevien avioliitot, kaksi on eteläeurooppalaisia. Espanjasta tuli vuonna 2005 Hollannin (2001) ja Belgian (2004) jälkeen mailman kolmas maa, joka sallii maanlaajuisesti samaa sukupuolta olevien avioliitot. Portugalissa vastaava laki tuli voimaan 2010. (Oinonen 2008; ILGA Europe 2011.)

Emme kiellä tyypittelyjen ja kategorisointien käyttökelpoisuutta yhtenä tutkimuksen ja yleensä maailman hahmottamisen elementtinä. Sen sijaan peräänkuulutamme sellaista vertailevaa otetta, joka tähtää ymmärtämiseen eikä yleistämiseen (Adcock 2006; Alapuro 2004). Vertailevan tutkimuksen ei tulisi keskittyä ainoastaan samankaltaisuuksien etsimiseen luotujen kategorioiden sisällä ja niistä johdettuihin yleistyksiin. Tutkimuksen ja tutkijoiden tulisi olla erityisen kiinnostuneita erojen havainnoinnista, niiden tulkinnasta ja tutkittavien tapausten erityislaadusta (ks. Moses & Knutsen 2007). Vertailevalla tutkimuksella on paljon tarjottavaa yrittäessämme ymmärtää maiden historiaa ja nykypäivää. Vertailua tulisi käyttää pikemminkin jonkin tapahtuman tulkintaan eikä niinkään suurten yleistysten tekoon. Yleistysten pinnan alle menevä vertaileva tutkimus johdattaa esittämään uusia kysymyksiä *miksi* ja *miten*, jotka puolestaan johdattavat syvempään ymmärrykseen.

Jotta pääsisimme kategorioiden pinnan alle, meidän tutkijoiden tulee edellä esitettyjen esimerkkien valossa olla kiinnostuneita siitä, miksi portugalilaiset naiset käyvät eteläisiä kanssasisariaan enemmän töissä ja miksi suomalaiset naiset eivät tee pohjoisten kanssasisartensa lailla enempää osa-aikatöitä. Tai miksi portugalilaiset ja espanjalaiset ovat olleet valmiit myöntämään yhtäläiset avioliitto-oikeudet kaikille seksuaalista suuntautumista katsomatta katolisen kirkon vahvasta vastustuksesta huolimatta? Näihin kysymyksiin vastaaminen vaatii monenlaisten aineistojen ja menetelmien käyttöä, se vaatii kontekstin kokonaisvaltaista tuntemista (Anttonen 2005) ja tiheää kuvausta (*thick discription*) (Geertz 1973). Vertailevan tutkimuksen tulisi myös terävöittää ymmärrystämme kontekstista, sillä konteksti tarjoaa konstitutiivisen merkityksen tarkasteltavalle tapahtumalle (Moses & Knutsen 2007, 241).

Mertonia (1968) ja Thomasin teoreemaa lainaten voi itseään toteuttavien ennusteiden kehästä päästä eroon vain hylkäämällä alkuperäisen tilanteen määrittelyn. Kun alkuperäinen oletus on kyseenalaistettu ja uusi tilanteen määrittely esitetty, lakkaa usko isännöimästä todellisuutta. Itsestään selvänä pidettyjen ja syvälle juurtuneiden määrittelyjen kyseenalaistaminen vaatii "hyvää tahtoa" eli rohkeutta kurkistaa niin arki- kuin tieteellistäkin ajattelua jäsentävien ennakko-oletusten taakse.

5 Hollanti (2001), Belgia (2004), Espanja (2005), Norja (2009), Ruotsi (2009), Portugali (2010), Islanti (2010) (ILGA Europe 2011).

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ENGLISH SUMMARY

Leena Tervonen-Gonçalves & Eriikka Oinonen: The power of comparison (Vertailun valta)

Comparative social research often produces categorizations and classifications that highlight differences or similarities based on the analysis of statistical data. An important part of comparison is labeling, which can be understood as a tool to communicate and describe the outcomes of comparisons. Although comparisons are central to both research and European policy-making, has the debate on labeling and categorization and the associated power of comparisons been scarce. This article aims at stimulating discussion about the role and nature of comparisons and categorizations in constituting reality. Categorizations do not only reflect the diversity of European reality but constitute the current and future Europe in which we live. The empirical focus of our article is on how Southern Europe and Portugal, in particular, has been described and labeled in the social scientific research literature, in the realm of the EU policy and in Finnish media and how these labels have been taken in Portugal.

Our data consists of comparative welfare state research published over the past three decades, reports and publications on the EU cohesion policy, Portugal’s government programmes and articles published in the biggest Finnish newspaper Helsingin Sanomat in 2011. We apply a genealogical reading to the data and ask how certain ways of thinking become predominant and taken for granted during the given time period. Our analysis that focus particularly on the identification of repeated discourses throughout the data reveals that Southern Europe appears as primitive, poor, immature and backward and Portugal is pictured as a deeply indebted and weak crisis country depending on the benevolence of other countries. In our data labelling has been carried out and promoted by means of repetition and dichotomizations and by using classifications and numerical indicators. Furthermore the texts have appealed to the authority of science and evidence-based politics and to influential opinion leaders.

We would like to encourage the researchers to break from the current trend of Scandocentrism (Alestalo et al. 2009) and to question deeply rooted presumptions related to this regional bias in European comparative research. As politics relies more and more heavily on knowledge or evidence, and researchers are called upon to lend their expertise and legitimize politics and its arguments, we feel it is necessary to give more careful thought to the question of how to describe and label different ways of living and resolving social issues. Firstly, even though it is possible in research to make comments and specify conditional factors, they tend to disappear and categorizations and labels continue on their own life in the spheres of politics and public debate. Secondly, it is possible that in the end, the objects of politics begin to behave as they are expected to behave.

Keywords: categorization, labelling, comparative research