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ORIGINAL ARTICLE

Determinants of effective health promotion actions in local contexts: a study of the perceptions of municipal politicians

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Abstract

Objective To compare municipal politicians' perceptions of health promotion policy and its impact, and whether these perceptions varied according to political variables.

Methods A mail survey to all municipal politicians ($N = 195$) in four municipalities in Finland. Response rate was 52%. Data were analysed by descriptive statistics and multivariate regression analyses.

Results The politicians gave 'passable grades' when evaluating health promotion activities and their effectiveness in the municipalities. Three factors in a multivariate model explained 49% of the variance in this evaluation: emphasis on the promotion of health and quality of life of older people, capacity of primary health care and capacity of care for older people. There did not appear to be a consistent view on the local health promotion policies among the politicians. 'Terms in office' was more significant than political party affiliation to explain differences in the policy makers' perceptions.

Conclusions Paying attention to the possible impeding effects of structures, as well as enhancing institutional capacity, could open ways for a stronger focus on health promotion, including community participation, in local councils.

Keywords Community participation · Health promotion · Local health policy · Municipal politicians

This article is part of the section "Knowledge synthesis, translation and exchange".

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Introduction

As a key strategy in health promotion, the World Health Organization launched building healthy public policy (WHO 1986). The importance of healthy public policy—at all levels of government—has been stressed (Sihto et al. 2006; Catford 2006): it is seen to establish the environment that makes the other strategies possible (WHO 1988; Jackson et al. 2006). Healthy public policy is concerned with the role of government and the public sector in creating conditions that support health and requires that health is high on the agenda of policy makers (WHO 1988). However, the development of healthy public policy has remained a challenge. A literature overview suggests that the barriers reside in political and administrative structures (Fosse 2003). Although much research has been done on the determinants of health and causes of disease, and how to influence those factors, we know considerably less about the impact of politics on health policy and outcomes (Ritsatakis et al. 2000; Navarro 2008). Moreover, because of politicians' key role, there has been an urge to focus public health policy research on their views (Ashley et al. 2001; Cohen et al. 2001). This study considers health promotion policy and its impact at the local level from the viewpoint of political decision makers. It does so with

special reference to political party and experience as councillor, as one approach to examine the structures of the local government.

Research setting, theoretical framework and objectives

In Finland, the current national health policy focuses on health promotion (MSAH 2001). Although the national administration defines general health policy guidelines, the national steering is quite weak: local, i.e. municipal governments are self-governing and responsible for local conditions: not only the provision of local public goods, but also health care, social welfare, and most education and cultural services (Loikkanen and Nivalainen 2011). Accordingly, the key role of municipalities in health promotion (Jackson et al. 2006) is evident in Finland; however, it is still not well established (WHO 2002; Uusitalo et al. 2007). As sufficient knowledge about how to stimulate health promotion in municipalities is lacking (Guldbrandsson 2005), more research at this level of government is needed.

Health promotion policies within local government have earlier been studied mainly by content analysis of local governmental documents as well as interviews, and by surveys directed, for example, to municipal managers and chairs of municipal bodies (e.g. Perttilä 1999; Andersson et al. 2003; Guldbrandsson 2005; Poikajärvi and Perttilä 2006; Uusitalo et al. 2007). However, we have little knowledge about the perceptions of municipal councillors on local health promotion policy and its effectiveness, i.e. how they perceive that health promotion is emphasized and what the impact of health promotion policy has been; furthermore, whether there are differences based on political variables in these perceptions. The relevance of left–right ideology in today's welfare democracies has been challenged; however, this dimension seems to have an effect on policy output at both the national and local levels (Fredriksson and Winblad 2008; Fosse 2009). Moreover, studies have found differences in views on health promotion depending on political party affiliation (Ashley et al. 2001; Cohen et al. 2001). Then again, the more experienced municipal councillors appear to perceive first-term councillors' ideas as 'utopian' and as hindering factors in decision-making (Laamanen et al. 1994). Based on an actor-structural approach (e.g. Guldbrandsson 2005) this could imply 'socialization' to the current state of affairs. Thus, there might be differing views on local health promotion policy according to political party and/or terms in office. Since political learning—seen as making changes in public policy possible—is proposed to take place between at least two groups with different beliefs and perceptions (Sabatier 1998; Gagnon et al. 2007), this information could have consequences for how health promotion issues are best discussed in local councils.

More specifically, studies on health policy making (Rütten et al. 2003a, b), based on von Wright's general model (Von Wright 1976), suggest that 'goals', 'resources' and 'public opportunities' predict the outcome of policy. As regards health promotion as defined by WHO (1986), the focus is on the broad determinants of health and on the empowerment of individuals and communities. At local levels especially, the role of communities and civil society in initiating and shaping, as well as undertaking, health promotion is considered essential (Gillies 1998; Scriven and Speller 2007). Informed by these frameworks, we wanted to explore to what extent local political decision makers' evaluations of health promotion activities and their effectiveness in the municipalities (i.e. health policy impact) was influenced by: (1) *goals* for health promotion in the municipal budget and operational plans; (2) *opportunities* given for community participation in the municipality; and (3) *resources*, in this study social and healthcare services and local voluntary associations (LVAs).

Thus, the objectives of this study were to compare local political decision makers' perceptions of health promotion policy and its impact, and whether these perceptions varied according to the decision makers' terms in office and political party affiliation.

The study is part of a larger evaluation of primary healthcare (PHC) performance in four municipalities: the Southern (SM), Eastern (EM), South-Western (SWM), and Western (WM) Municipalities. SM was included as a special case: in 1998, politicians decided to contract out all PHC services and care for older people to a non-profit organization. The non-profit organization emphasized health promotion as a central value in its operations. Moreover, the frame agreement stated that the municipality and the service provider would cooperate to develop the municipality into a 'health promoting region'. The other municipalities produced their PHC services mainly publicly. The municipalities were all situated close to larger cities and similar in size (about 7,000–13,000 inhabitants), and in industrial and population structures.

Methods

Data collection

A questionnaire and two reminders were sent by postal mail in 2004 to all members and deputy members of the municipal councils, executive boards, and boards of social and health services in the four municipalities ($N = 195$). Altogether, 101 politicians (52%) returned the questionnaire. Of these questionnaires, 94 were accepted in the study (seven questionnaires were answered only partly).

Table 1 Summary of item content for health policy impact and proposed determinants

Health policy impact (Cronbach's alpha 0.89)	Evaluation of health promotion in the municipalities using Finnish school marks: a scale from four (failed) to ten (excellent): a) health promotion activities; b) the effectiveness of health promotion activities
Determinants of health policy impact	
(a) Goals	Emphasis in the budget and operational plans on….(response range 1–5; 'not at all'—'very much')
Promotion of healthy and safe environments (alpha 0.87)	(a) Promotion of healthy environments, (b) safe environments, (c) physical activities, (d) work against illicit drug use
Promotion of mental and social health (alpha 0.73)	(a) Mental health work, (b) paying attention to and supporting social networks, (c) sexual health counselling
Promotion of healthy lifestyles (alpha 0.86)	(a) Promoting healthy diet habits, (b) promoting non-smoking, (c) preventing alcohol abuse
Promoting health and well-being of different population groups	Six separate questions; see Table 2
(b) Opportunities given for community participation	Emphasis in the budget and operational plans on cooperation between LVAs and municipal sectors responsible for ….(range 1–5; 'not at all'—'very much')
Cooperation between 'primary care authorities' and LVAs (alpha 0.81)	(a) Health-care services, (b) social services, (c) education
Cooperation between 'leisure authorities' and LVAs (alpha 0.87)	(a) Sports, (b) youth, (c) culture
LVAs' influence on the municipality (alpha 0.56)	'LVAs have influence on decision-making in health matters in the municipality', 'The municipality appreciates the work done by LVAs'; (range 1–5; 'totally disagree'—'totally agree')
(c) Resources	
Capacity of primary health care (alpha 0.79)	Assessment of: comprehensiveness, effectiveness, quality, accessibility, efficiency (range 4–10)
Capacity of care for older people (alpha 0.91)	Assessment of: comprehensiveness, effectiveness, quality, accessibility, efficiency (range 4–10)
LVAs' activity in health issues (alpha 0.64)	'LVAs actively follow discussions about residents' health and well-being', 'LVAs want to influence decision-making concerning health issues in the municipality', 'LVAs have a positive influence on residents' health and well-being'; (range 1–5; 'totally disagree'—'totally agree')
LVAs' significance in promotion of residents' health	One question with five response alternatives ranging from 'no significance' to 'very considerable significance'

The respondents' background factors (sex, age, political party, position in political organs, terms in council) did not differ between the municipalities, except for terms in council and age, as described below. The survey was conducted in the last year of the 4-year term for which councillors were elected, and for 49% of respondents this was at least their second term in the council (hereafter called senior politicians). The remaining 51% (48 persons) are here called first-term politicians (19 of these, however, reported that they had been on a board for more than one term). EM (69%) and SWM (73%) had more first-term politicians than SM (36%) and WM (42%; $p < 0.05$). The average age of the respondents was 55.4 years (SD 10.2), being highest in EM (60.9, SD 7.2) and lowest in SWM (49.8, SD 9.2; $p < 0.05$). Over half (59%) of the respondents were men, 18% were chairs or vice chairs, 46% were from centre/right-wing political parties, 44% from left wing and 10% from other political parties: the Green party and independents.

Measures

We asked the politicians to evaluate health policy impact, and posed questions about the emphasis on health promotion (goals), opportunities for community participation and resources in the municipalities, with items as shown in Table 1. The three dimensions of health promotion goals and two dimensions of cooperation opportunities are based on the results of principal component analyses (PCA).

We constructed the health policy impact and determinant scales by averaging the responses on the items defining the respective scale. The question measuring LVAs' significance in health promotion was dichotomized into those reporting that LVAs' significance was quite or very considerable, and the rest (no or little significance or could not say).

Political party affiliation and terms in office were reported as described in "Data collection". Four items concerning knowledge about residents' health and living

conditions (including the socioeconomic situation of the population, health problems and morbidity; alpha 0.82) served as a proxy measure for interest in health issues, included as a control variable; the scale was dichotomized (at the median, at 3.5) into low and high knowledge/interest in health issues.

Statistical analyses

Data were analysed by cross-tabulations (Chi-square tests, Fisher's exact tests), one-way-analysis of variance and Bonferroni multiple comparison tests; as some variables did not meet normal distribution assumptions when divided into groups (e.g. by political party), nonparametric tests (Mann–Whitney U and Kruskal–Wallis tests) were also employed. Multivariate binary logistic regression analyses were used to examine the associations of political party and terms in office with the perception of emphasis on the three dimensions of health promotion. For these analyses, the dimensions were dichotomized at the median. Univariate and stepwise multivariate linear regression analyses, with all proposed determinants included, were used to study factors associated with evaluation of health policy impact. The analyses were performed with SPSS 15.0 for Windows.

Results

Table 2 presents the results of descriptive statistics according to terms in office and political party, and compares SM with the other municipalities. There were no differences between SM and the other municipalities with regard to the politicians' evaluations of health policy impact (i.e. health promotion activities and their effectiveness) in their respective municipality. Of the respondents, 15% gave very low grades (under 6; range 4–10): the majority of these were from left-wing parties. Overall, politicians from centre/right-wing parties gave higher grades than politicians from left wing and other parties; however, the difference was not statistically significant when controlling for municipality. Concerning the proposed determinants of health policy impact, the only difference between SM and the other municipalities was that politicians in SM perceived LVAs to be significantly more active in health issues compared to politicians in EM (4.0/3.3; $p < 0.05$).

First-term politicians, compared with senior politicians, perceived that there was significantly less emphasis on the three health promotion dimensions, as well as on the promotion of health and well-being of people with illnesses and the unemployed (Table 2). The difference was statistically significant also when controlling for municipality regarding the promotion of mental and social health and healthy lifestyles (Table 3). On the other hand, members of left wing and other political parties, when compared with members of right-wing parties, perceived significantly less emphasis given to healthy and safe environments, also when controlling for municipality (Table 3). There were no statistically significant differences concerning the councillors' perception about opportunities given for community participation. Nonetheless, senior politicians reported significantly more often that LVAs' significance in promoting residents' health was considerable; the difference was no longer statistically significant, however, when controlling for municipality.

The councillors perceived their knowledge about residents' health and living conditions to be on an average level (mean 3.4, median 3.5, SD 0.7); 45% belonged to the computed 'high knowledge/interest' group, with no difference by municipality or terms in office. Compared to 40% of centre/right- and left-wing politicians, a majority from other political parties had a high interest in health issues ($p < 0.05$). In general, politicians with a high interest reported that there was less emphasis on health promotion and less opportunity given for community participation; however, the only statistically significant difference concerned perceived emphasis on cooperation between LVAs and 'leisure authorities' (3.0/3.5; $p < 0.05$).

In the linear regression analyses, before adjustments, all health promotion goals, except emphasis on the health and well-being of children and the unemployed, were significantly positively associated with health policy impact. The same was true for all variables measuring opportunities for community participation. With regard to resources, the capacity of PHC and care for older people as well as LVAs' significance in health promotion were significantly positively associated; however, LVAs' activity in health issues was not. Of the background factors, political party alone was associated with health policy impact; members of centre/right-wing parties gave significantly higher assessments.

The result of a stepwise linear multivariate regression analysis is presented in Table 4. The capacity of PHC and care for older people, and emphasis on promoting the health and quality of life of older people explained 49% of the variance in health policy impact. The same picture persisted when adjusting for municipality and interest in health issues.

When repeating the analysis above separately for first-term and senior politicians (excluding emphasis on different population groups to restrict the number of variables), and adjusting for municipality and interest in health issues, respectively, in the last step, there were some differences. A perceived strong emphasis on promoting healthy and safe environments, and a good capacity of care for older people influenced the first-term politicians' assessment, whereas a good capacity of care for older people and a perceived strong emphasis on healthy lifestyles influenced

Table 2 Health promotion policy and impact as perceived by local politicians, by terms in office, political party and municipality

	Terms in office		*p*	Political party			*p*	Municipalities
	First term	Senior		Centre/ right wing	Left wing	Other		SM/EM,SWM, WM Total
Health policy impact i.e. health promotion action and effectiveness (4–10)	6.6 (1.1)	6.9 (1.0)		7.1 (0.8)	6.6 (1.1)	6.2 (0.9)	*	6.8 (1.0)
Health promotion goals (range 1–5)								
Promotion of healthy and safe environments	2.8 (0.9)	3.2 (0.7)	*	3.3 (0.7)	2.9 (0.8)	2.5 (0.7)	**	3.0 (0.8)
Promotion of mental and social health	2.5 (0.7)	2.8 (0.7)	**	2.8 (0.7)	2.5 (0.8)	2.5 (0.5)		2.6 (0.7)
Promotion of healthy lifestyles	2.3 (0.7)	2.7 (0.8)	**	2.7 (0.7)	2.4 (0.9)	2.3 (0.7)		2.5 (0.8)
Promotion of health and well-being of								
Older people	3.3 (1.0)	3.4 (0.9)		3.4 (0.8)	3.2 (1.0)	3.2 (0.9)		3.3 (1.0)
Children	3.1 (0.8)	3.3 (1.0)		3.3 (0.9)	3.2 (0.8)	3.0 (0.7)		3.2 (0.9)
Youth	3.0 (1.0)	3.2 (1.0)		3.3 (1.2)	3.1 (1.0)	2.7 (0.7)		3.1 (1.0)
Adults of working age	2.6 (0.9)	3.0 (0.8)		2.9 (0.8)	2.7 (0.9)	2.7 (0.7)		2.8 (0.8)
People with illness	2.6 (0.9)	3.0 (0.9)	*	3.0 (0.8)	2.7 (1.0)	2.7 (0.7)		2.8 (0.9)
Unemployed	2.3 (0.9)	2.8 (0.8)	***	2.7 (0.9)	2.5 (0.9)	2.1 (0.6)		2.6 (0.9)
Opportunities for community participation (1–5)								
Emphasis on cooperation between LVAs and								
'Primary care authorities'	2.5 (0.6)	2.8 (0.8)		2.8 (0.6)	2.5 (0.8)	2.3 (0.6)		2.6 (0.7)
'Leisure authorities'	3.2 (0.9)	3.3 (0.8)		3.4 (0.8)	3.3 (0.8)	2.6 (1.0)		3.3 (0.9)
LVAs' influence	3.1 (1.0)	3.5 (0.8)		3.3 (0.9)	3.3 (0.9)	2.9 (0.9)		3.3 (0.9)
Resources								
Capacity of health services (4–10)								
Primary health care	7.2 (0.7)	7.2 (7.2)		7.4 (0.7)	7.0 (0.9)	7.1 (0.5)		7.2 (0.8)
Care for older people	7.1 (0.8)	7.4 (1.0)		7.4 (0.7)	7.1 (1.0)	7.1 (0.8)		7.2 (0.9)
LVAs as resources in health promotion								
Their activity (1–5)	3.7 (0.6)	3.8 (0.7)		3.9 (0.6)	3.7 (0.7)	3.7 (0.8)		3.8 (0.7)*
Their significance: considerable	39%	61%	*	53%	53%	30%		50%

Finland, 2004

Statistical significance between groups: one-way analysis of variance/Kruskal–Wallis test/Mann–Whitney U/Chi-square

Statistical significance: difference between SM and the other municipalities

Means, standard deviations, and percentage

SM Southern Municipality, *EM* Eastern Municipality, *SWM* South-Western Municipality, *WM* Western Municipality, *LVAs* local voluntary associations

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

the senior politicians. In addition, first-term women councillors gave lower assessments.

Discussion

We studied the perceptions of local politicians regarding their municipality's health promotion policy and the impact of the policy in four municipalities with different forms of PHC provision. According to our findings, it seems that municipal policy- makers in general have given health promotion rather low priority on their agenda or, alternatively, that this theme has not been realized in the local budget and operational plans. The most significant elements of health promotion policy in terms of impact, as perceived by politicians, were the *goal* of promoting the health and quality of life of older people and the *resources* in the form of capacity of health services. There did not seem to be consensus on the local health promotion policy in all regards; terms in office was more significant than political party affiliation to explain differences in the policy makers' perceptions.

The perceived importance of promoting health and quality of life of older people is understandable, since the ageing population was one of the main concerns of the local politicians (unpublished data). Financial concerns were

Table 3 Associations of terms in office and political party with municipal politicians' perceptions about emphasis on three dimensions of health promotion

	Healthy and safe environments OR (95% CI)	Mental and social health OR (95% CI)	Healthy lifestyles OR (95% CI)
Terms in council			
First-term politician	1.00	1.00	1.00
'Senior' politician	2.13 (0.7–6.7)	5.26 (1.6–18.2)**	3.42 (1.1–10.2)*
Political party			
Centre–right wing	1.00	1.00	1.00
Left wing	0.24 (0.07–0.8)*	0.49 (0.2–1.5)	0.42 (0.1–1.3)
Other	0.06 (0.01–0.6)*	0.27 (0.03–1.9)	0.40 (0.07–2.4)

Finland, 2004

Odds ratios (OR) from multivariate logistic regression analyses (adjusted for municipality and age)

* $p < 0.05$; ** $p < 0.01$

Table 4 Multivariate linear regression analysis of factors explaining the variance in municipal politicians' evaluation of health policy impact

	Beta	*t* value	*p* value
Health promotion goals			
Emphasis on promoting health and quality of life of older people	0.34	3.37	0.001
Resources			
Capacity of primary health care	0.24	2.24	0.029
Capacity of care for older people	0.33	2.78	0.007
$R^2 = 0.49$, adjusted $R^2 = 0.46$, $F = 19.55$, $p = 0.000$			

Finland, 2004

Health policy impact = health promotion activities and their effectiveness

another major issue. Together, these concerns might have raised specifically health promotion in relation to the elderly on the local policy agenda: that is, as a way to curb healthcare expenditure. Savings and better living conditions for residents have been justifications for decisions on health promotion by local governments (Uusitalo et al. 2007). The significance of a good capacity of services for older people further highlights the perceived importance of health of the elderly on local levels. Home nursing and care were also prioritized when Finnish municipal politicians ranked health-care services in the 1990s (Lammintakainen and Kinnunen 2004). Changes strengthening health promotion in the municipalities might have been of incremental character, in accordance with choices made earlier (Ter-vonen-Gonçalves and Lehto 2004) and understood by theories explaining stability, such as path dependency (Vrangbæk and Christiansen 2005). However, the elderly are in focus more than before in national health policy in Finland (MSAH 2001), and the ageing population and its impact on welfare spending are deemed challenging for all Nordic countries (Nygård 2006).

The most important aspect of health promotion, as perceived by the councillors, appeared to be healthy and safe environments—including the promotion of physical activity and work against illicit drug use. This finding is consistent with the focus of health promotion policies in Finnish municipalities as found in municipal policy documents; physical activity and substance abuse are especially prioritized (Uusitalo et al. 2007). While Canadian studies found a high emphasis on traditional risk factors (Anderson et al. 2008); the present study did not find any particular stress on the promotion of 'healthy lifestyles', which concerned tobacco, alcohol and nutrition-related activities. Local governments may consider the measures taken at the national policy level to be sufficient. Furthermore, new risks in the form of illicit drug use might have been higher on the agenda and hence prioritized; in fact, among the current problems brought up by politicians concerning citizens' health (unpublished data) was, in addition to alcohol abuse, illicit drug use. Illicit drug use may well have been interpreted as a problem of safety; as based on the analysis, it was included in the healthy and safe environments dimension.

Politicians' views on the crucial role of health services in health promotion is in line with earlier findings (WHO 2002; Uusitalo et al. 2007). Nevertheless, health promotion does not appear to be a central issue when local governments choose service producers (Laamanen et al. 2005). This confirms a need for more systematic health promotion strategies. However, health services alone cannot be responsible for health promotion. Other parts of the public sector are important as well, as are the activities of local communities (MSAH 2001; Scriven and Speller 2007); these include the voluntary sector, which we focused on in this study. Although local politicians believe that the

promotion of population health requires cooperation between municipality authorities and LVAs (unpublished data), emphasis on cooperation seemed to be quite low in the policy plans, especially regarding 'primary care authorities'. This discrepancy might reflect barriers that previous studies have pointed out, such as lack of concrete measures for enhanced citizen participation and the power of the local bureaucracy (Kettunen 2003). Furthermore, when resources are scarce, politicians might be reluctant to direct money to cooperation activities in light of the challenges concerning evidence of effectiveness (Ansari et al. 2001). Overall, the broad concept of community empowerment has been considered rather unfamiliar to Finnish health policy strategies (Tervonen-Gonçalves and Lehto 2004).

Terms in office explained more of the differences in the councillors' perceptions of health promotion policy than political parties. Furthermore, there were only few differences according to the other background factors, including knowledge. On the national level in the Nordic countries, support for the welfare state is fairly stable among all political parties (Green-Pedersen 1999; Nygård 2006). Yet, market-type solutions have become more salient, especially among right-wing parties, and thus political affiliation still matters (Nygård 2006). This seems to be true at the local level as well (Laamanen et al. 2008). However, politicians are least likely to outsource preventive services. It has been argued that inequality issues have placed health promotion on the political agenda. The same applies to issues regarding the responsibility borne by the individual as opposed to society (Pettersson 2007). The latter topic might partly explain the finding that representatives of left-wing parties perceived less emphasis given to healthy and safe environments than politicians from centre/right-wing parties. The politicians, however, did not comment on inequality in health as a problem at the local level.

First-term councillors, compared with senior councillors, perceived that there was significantly less emphasis on health promotion; the biggest disagreement was related to promotion of social and mental health. One interpretation based on an actor-structural approach (see Guldbrandsson 2005) is that politicians who have been members of the municipal council for a longer time have been 'socialized' to see things in a similar way. This finding may also refer to path dependencies and institutional inertia (Vrangbæk and Christiansen 2005). First-term politicians might conceive problems and needs in the municipality, as well as solutions needed, differently. Furthermore, first-term councillors' evaluations of health policy impact were influenced by goals related to healthy and safe environments, whereas senior councillors' evaluations were influenced by goals related to promoting healthy lifestyles. This might suggest differences in views on health promotion. If political learning takes place between coalitions with different views and values (Sabatier 1998; Gagnon et al. 2007), these 'coalitions' may not primarily follow political party affiliation in local health promotion policy. Thus, new approaches to health promotion policy could be promoted by discussions in local councils without demanding party political consensus. In addition, health promoters might influence the political debate better in local councils than in the forum of political parties. Differing views on the current policy, however, could indicate a need to strengthen the institutional capacity of local government for health promotion.

The politicians in SM, where PHC (including care for older people) was outsourced to a non-profit organization, reported that the LVAs were active in health issues; activation of LVAs in health promotion was one of the goals of the organization. Otherwise, we found no significant differences between SM and the other municipalities. Then again, the emphasis on health promotion was not the main issue for politicians when choosing the non-profit organization, but instead employment and other financial factors, as well as the comprehensiveness of services (Laamanen et al. 2005). Similar health promotion policies in the four municipalities could be understood in a framework of possible tensions between local governments (importance of local circumstances) and the central government (the principle of universal services) (Vrangbæk and Christiansen 2005; Loikkanen and Nivalainen 2011). Studies suggest that not only organizational 'will', or policy making, but also profound developments in infrastructure and leadership are needed to support health promotion action (Dressendorfer et al. 2005; Anderson et al. 2008).

Methodological considerations

The study was carried out by a postal survey in four middle-sized municipalities. The average response rate of 52% (varying from 67% in SM to 34% in EM) is consistent with several previous Finnish and international studies. However, the low response rate in EM, where also a significant difference between respondents and non-respondents appeared in terms of overrepresentation of left-wing politicians among the respondents, suggests lower reliability of the findings for EM compared to the rest. In the other municipalities, the respondents did not differ from the target population or from the non-respondents with regard to political affiliation. However, the findings were quite similar in all municipalities. As the questionnaires mainly comprised questions concerning outsourcing of health-care services, councillors specifically interested in health-care issues might have been more prone to answer. A more detailed description of the analysis of possible bias has already been published (Laamanen

et al. 2008). It should be noted that the findings regarding politicians' perceptions might differ from the actual health promotion policies.

Our study of health promotion policy and impact was guided by the model of Rütten et al. (2003a, b). They explicitly focused on the policy-making process; however, the general model has been considered applicable to different levels of action. We studied the content of health promotion and population groups targeted; we did not consider approaches to health promotion or structural factors such as education or socioeconomic issues, which could yield another picture. Our focus concerning resources was on PHC, care for older people and voluntary associations, although there are other important resources for health promotion in the municipalities. Most of the variables in the study consisted of items that we combined to form scales. To form the health promotion goal and cooperation scales, we used PCA though the sample was quite small; however, the Kaiser–Meyer–Olkin measure of sampling adequacy was at an acceptable level (0.89/0.69) and the Bartlett's Test of Sphericity was significant ($p < 0.000$). The PCA of the items measuring goals on health promotion had three factors set to increase the proportion of variance explained. The concept 'LVAs' influence' had a Cronbach's alpha of 0.56, which is rather low, whereas the other scales had alphas ranging from 0.64 to 0.91, reflecting sufficient to good internal consistency. The final model explained 49% of the variance in perceived health policy impact. Investigating perceptions of 'obligations' and 'organizational opportunities', which have been suggested to predict policy output (Rütten et al. 2003a), could give further insight into local health policy making.

Conclusions

In the view of local councillors, the policy goal of promoting the health and quality of life of older people and resources in the form of a good capacity of PHC, with special emphasis on care for the elderly, constituted a major focus in local health promotion policy. When choosing service providers, however, rather low emphasis on health promotion suggests a need for a theme of more health-promoting services. Limited political disagreement regarding health promotion policy in general could have contributed to a path-dependent development, with a focus on health-care services. A stronger impact of policy goals might require, besides resources, more specific and concrete goals as well as community engagement, i.e. public opportunities (Rütten et al. 2003a). In terms of organizational opportunities, enhancing the institutional capacity of local governments within the framework of the Ottawa Charter (WHO 1986), and emphasizing the view that issues can be discussed without demanding party political consensus, could open ways for a stronger focus on health promotion.

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