Public health strategies reflect governments' wish to make people's lives longer and healthier. This can either be achieved by influencing the frames of people's lives and activities or the way they behave, i.e., to try to 'conduct their conduct'. In this paper the motivations for and methods of four national public health strategies are analysed. They are the English, the Norwegian, the Danish and the Swedish. Four questions are addressed: i) how is the governing activities aimed at improving the health of the population justified; ii) which issues are defined as problems; iii) which causes of the problems are identified; and iv) which governing techniques are suggested to solve the problems. The English and Danish programmes focus on mortality while the others give high priority to non-lethal diseases and conditions. The Danish programme mainly aims at making people conduct themselves in a more healthy way, i.e. change their behaviour, often guided by health professionals. The Norwegian paper has empowerment as its central strategy. The strategy is based on the assumption that if people get more power over their own lives they will become more healthy and behave in a more healthy way. The Swedish emphasis is on changing people's living conditions and much less is said about the role of the individual. The English programme launches a national contract where individuals and authorities should work both to change people's behaviour and their living conditions. All strategies deal with the increasing social inequality in health, the English and Swedish strategies more than the others. There does not seem to be a specific Nordic model in this field of welfare state politics.

Keywords: governmentality, policy, public health, social inequality, England, Denmark, Norway, Sweden
and to develop methods to solve the problems, and they are also used as a means to legitimize decisions and to tinge them with neutrality.

To change people’s behaviour, to make them govern themselves in specific ways, is one way to improve their health. With a Foucauldian concept, the way these efforts are carried out may be labelled governmentality. It contains the duality of governing others and of making people govern themselves in specific ways, a ‘conduct of conduct’. Hence, according to Nikolas Rose, freedom of the governed is presupposed, ‘to govern humans is not to crush their capacity to act, but to acknowledge it and utilize it for one’s own objectives’. When one studies governmentality the purpose is to identify the techniques by which authorities, or others, try to make people behave differently. ‘Empowerment’, one of the governing techniques often proposed in public health policies, is about giving people more control over their own lives. Behind this technique lies the assumption that if people are empowered they will act as the government wishes them to act and will adopt more healthy lifestyles.

METHODS AND MATERIALS

The article is based on analyses of the content of selected public health strategies published in 1998–2000. They are ‘Our healthier nation’ in Norway, ‘The Danish Government Programme on Public Health and Health Promotion’ in Denmark and ‘How can Sweden improve her health?’ in Sweden. The purpose of the comparison is to make the characteristics of the strategies more visible. By analysing all three Scandinavian countries it is also possible to see if there is a ‘Nordic model’ in this area of welfare state policies. All four countries have tax-financed health care systems and, except for Norway, have had social democratic governments during the period that the strategies were prepared. The Danish and English programmes were published by the governments as their policies, the Norwegian paper was written by a committee set up by the government, but does not necessarily represent the ideas of the government. The Swedish papers and the programme proposal were prepared by a committee with representatives from all political parties in parliament. The Danish and English programmes are the most easily read. They are short, printed with big letters, few references, many figures and, in the English case, also photos. The Swedish and the Norwegian papers are more reflective and explicitly research-based in their presentation. Both are published in shorter versions. Politicians, civil servants and other actors in the field constitute the main audience for all papers with the general public apparently being of secondary importance.

This article deals with what is proposed in the name of public health, and follows the definitions of what belongs to public health presented in each paper. Their definitions of public health are significant to their understanding of it and thus form part of the object of this study. Any effort to delimit it might therefore violate the study object. One country may have a very comprehensive public health concept and policy while another may make similar interventions under social policy or another heading. The article neither deals with what is actually implemented nor with possible effects of the strategies.

The analysis is centred on the discourses around the above mentioned questions of justification, problem identification, explanations and means of governing. The purpose is to identify the different ways of thinking and talking about health and about how to govern, i.e. it also contains an analysis of the rhetoric used in the papers. This paper focuses more on differences than similarities and on themes related to the exercise of power.

WHAT ARE THE REASONS FOR GOVERNMENTS TO IMPROVE THE HEALTH OF THEIR POPULATIONS?

In a democracy, the exercise of power in a certain field must be accepted and the reasons for it considered legitimate and supported by a majority of the population. How do governments argue for initiatives to govern the way people live and behave in order to improve public health?

In the Danish programme hardly any statement is given as to why the government considers the health of the nation, especially the mean life expectancy, is a problem to act upon. It is seems to be considered self-evident. When something is said about this issue it is formulated as a combination of a state reason, i.e. in the interest of the public sector or society, and care for the citizen: ‘There is much to be gained from an economic and a health point of view by smoking cessation — both for the individual and society ...’ The Danish government also argues in a pastoral way, it wishes to ‘give the Danes a longer and better life’.

Similar arguments can be seen in the Norwegian paper, where it is stated that politicians promote health because they have a ‘responsibility for the welfare of the people and the economy of society’. On the other hand they maintain that possible economic benefits for society are irrelevant, because it is considered a goal in its own right to maintain good lives as long as possible. What is seen here is a conflict between an economic and an ethical or idealistic discourse, or between the state reason and the aim of creating good lives for the individuals.

The Swedish reports also present what they call ethical views and thus get into the same unsolvable dilemma of different goals. On the one hand they state that ‘(f)reedom from disease and bad health is a fundamental precondition for the possibility of people to shape their own lives, not an investment in economic development of society ...’. On the other hand metaphors from the economic sphere are often utilized to motivate the initiatives in the Swedish paper. They say that they are investing in health, that the gains of a public health policy are dual, individuals gain longer lives and society more prosperity. The Swedish texts are characterized by a combination of scientific rationality and welfare state
ethos, 'it is a task for the public sector to promote the welfare of people'. The texts lean very much upon research and by the continuous discussion of interpretation and arguing about pros and cons, they use the language of research papers. The suggestions thereby seem less directed by values. At the same time they establish in an authoritarian way, as if outside the scope of discussion, an assumed agreement on some fundamental questions such as the equal value of every human being, taking for granted that the reader is part of a common understanding by stating that their claims are natural or self-evident. This may be called an encompassing rhetoric.

The English programme wants to create 'A modern and successful country [which] needs more people in better health'. While the previous politics was 'old' and 'tired', this government creates something new, initiatives are taken for 'the first time ever' and the politics is 'dynamic'. The English programme presents three cases for improving health. i) The personal case, creating good lives for the citizens 'Good health is the foundation of a good life'. ii) The social case, 'a modern society, united by core values of fairness and compassion', a nation with less inequality. iii) The economic case which is about saving money in the public and private sectors and increase prosperity: 'A healthier work force improves productivity and performance'. The English programme also talks about investing in health though not as frequently as the Swedish reports. The reasons for increasing the efforts are a combination of a wish to create a country with a strong economy and to act as the good shepherd towards individuals who deserve more 'fulfilled lives'. The government does not seem to consider possible conflicts between the three cases.

The Swedish and the English papers argue most explicitly about the reasons for a public health policy. All papers stress the combination of care for the individual and the nation or the society as reasons, that is they perceive better health both as a goal and as a means to achieve other goals, such as a more affluent society. To the extent that reasons are given for the public health policies the four countries are fairly similar.

IDENTIFICATION OF HEALTH PROBLEMS OF THE POPULATION

To define and identify health problems is a prerequisite for action. It is also a way to exercise power, to set the agenda and decide which problems it is relevant to deal with and which are not. Efforts are made to quantify the health problems in order to identify them, to justify the political choices of intervention areas and to be able to evaluate the effect of the interventions. Here experts and researchers play a central role as they produce the knowledge utilised, and thus contribute to defining the problems.

The Danish programme is launched with a background of poor progress in longevity compared to other Western European countries (Table 1). The poor progress is most pronounced among middle-aged women. Danish women aged 35–64 have a 50% excess mortality as compared to Swedish and Norwegian women. The programme gives priority to and is targeted towards problems that especially influence the unsatisfactory development in average life expectancy in Denmark. Here one can speak of the 'power of a single figure', where one figure is setting the main agenda. The most important health problem identified is thus the comparatively high mortality. Based on mortality, cardiovascular diseases, cancers, accidents and respiratory diseases are considered the greatest problems. Another health problem it addresses is social inequality in health, where it focuses on the health of marginalized groups. Mortality is seen as the top of the iceberg indicating a large disease burden. Non-lethal health conditions are seldom mentioned.

The English programme has chosen to focus on four major 'killers': cancer, coronary heart disease and stroke, accidents and suicide. The reason why mortality is chosen is not that it is considered the only important health problem but that 'mortality data currently offer the most robust basis on which to set a numerical target'. It also helps to make 'The strategy ... focused and disciplined' and 'give a spur to action'. The government obviously considers numbers to be powerful. The English papers describe thoroughly and much more extensively than the others, social, ethnic and geographical inequalities in health and they place emphasis on deaths before the age of 65 or 70 years of age. Like the Danes the English make many comparisons with other EU countries, but England's level compared to others does not seem to direct their choices.

The Swedish reports reflect some complacency: 'The Swedish society has been exceptionally successful in creating and maintaining good preconditions for prosperity and a good health development'. They state that the general health of the nation is good and improving, but with some social groups lagging behind; thus the inequality in health is increasing which is 'one of the most

Table 1 Mean life expectancy (years) at birth in the four countries in 1970 and 1996

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th></th>
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<th>Women</th>
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<tbody>
<tr>
<td>Denmark</td>
<td>70.8</td>
<td>72.8</td>
<td>2.0</td>
<td>75.9</td>
<td>78.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Great Britain</td>
<td>68.6</td>
<td>74.4</td>
<td>5.8</td>
<td>75.2</td>
<td>79.3</td>
<td>4.1</td>
</tr>
<tr>
<td>Norway</td>
<td>71.0</td>
<td>75.4</td>
<td>4.4</td>
<td>77.5</td>
<td>81.1</td>
<td>3.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>72.2</td>
<td>76.5</td>
<td>4.3</td>
<td>77.1</td>
<td>81.5</td>
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Source: Sundhedsmistenet
serious health problems'. They identify what they call the disease burden they calculate consequences of lethal and non-lethal diseases, people's self-rated health and the costs of disease. Psychiatric disorders are given a high priority.

The Norwegians have a very broad definition of health. Health is not just absence of disease but also quality of life, which includes having a purpose, a meaning, challenges and content in life, and ability to cope. The main action areas are strain injuries (muscle skeleton diseases), accidents and injuries, psycho-social problems and asthma and allergy. In the Norwegian paper mortality plays a minor role, but it is mentioned. Norwegians, who have high mean life expectancy in the European context (table 1), are less self-confident than the Swedes. The committee chooses, somewhat masochistically, to compare Norway with Japan and concludes than many lives may be saved and that the 'relatively bad development in mean life expectancy causes concern'.

The countries differ with respect to the degree of complacency with their health situation. They also differ in their definitions of health problems: the Danes and the English mainly look at mortality and lethal diseases, the Swedes and Norwegians include non-lethal diseases and self-rated health, and Norwegians also include quality of life in a very broad sense.

Why do these governments address such different health problems? There are of course many causes. One reason is that the disease and mortality patterns differ. The relatively slow development in Danish mean life expectancy might be a reason behind the focus on mortality. The English do, however, focus on mortality too in spite of a very large increase in life expectancy. Only the English mention teenage pregnancies as a problem. They are four times as common there as in Denmark and Sweden. On the other hand the English do put much less emphasis on obesity than the others in spite of the fact that the proportion of obese (BMI >30) is about twice as high as in Denmark and Sweden. In the Norwegian report it is said that social inequalities are increasing more than in other countries. Of the four they make least out of that problem. The morbidity and morbidity of a country play a role in the identification of health problems, but obviously cannot explain the priorities alone.

**CAUSES OF ILL HEALTH**

The way ill health is explained is closely related to the way it is dealt with, i.e. to what extent governments try to make people behave differently or attempt to change their living conditions. Whether the means or the causes are identified first and the other as a consequence of the first probably differ. To identify the causes of health problems is an important part of the governing process. The causes of ill health identified by politicians partly depend on the problems they consider relevant. When, as in Denmark, the focus is mainly on mortality, factors which are associated with non-lethal diseases are of little or no interest.

In the Danish programme people's behaviour is considered the main cause of the relatively bad health. 'Our life-styles are to blame [for the relatively low mean life expectancy SV] – tobacco, alcohol, accidents, too much fat food and too little exercise.' The programme mentions other areas of society which have influence on health briefly and refers to policies in these areas, but the overall focus is on these five individual risk factors.

The English programme states 'that the causes of ill health are many: a complex interaction between personal, social, economic and environmental factors.' OHN [Our Healthier Nation] recognizes that there are wider influences on health (health determinants). While individual lifestyle decisions (such as diet, exercise and sexual behaviour) will have an important effect there are many other factors that lie outside of the individual's control but that can still directly influence their health'. Poverty and social exclusion are often mentioned as causes of bad health and of increasing social and ethnic inequalities in health.

The Swedish reports also present a complex view of causes both of mortality and morbidity, they talk about 'multi factorial etiology' and 'network of causes'. In the Swedish papers it is repeatedly emphasized that most health problems have a combination of causes associated with structural factors in society and factors related to individual behaviour. 'People with short education and bad economy are exposed to a higher extent both to life style risks and risk of more structural nature.' In the Swedish report it is suggested that the degree of social integration, the confidence among people and towards institutions is as important as the economical wealth for public health and they assume that Sweden has lot of this 'social capital' since health development is so good. The Norwegian, the Swedish and the English papers all refer to R.G. Wilkinson's research on the relations between income inequality and social cohesion and disease burden. research results which are compatible with the wish to strengthen the role of the welfare state. As mentioned, the Norwegian committee uses a broad definition of health and accordingly of the causes of good and bad health. It does not present the same multifactorial etiology in identifying the causes of diseases as the Swedish and English papers, but defines groups of disease according to three separate types of causes and talks about i) infectious disease, ii) 'life style diseases' such as cancers, heart diseases and diabetes and iii) new diseases caused by deficiencies in society, community and solidarity such as psycho-social problems, lighter mental disorders, and strain disease or muscle-skeleton diseases. In the Norwegian text 'life style diseases' are almost consistently put in quotation marks. 'It is important to realise that genetic predisposition, and factors we do not know enough about today, influence the fact that some fall ill and others do not, even though their habits are fairly similar. ... (and) makes it totally erroneous to blame the individual who is affected by illness to be guilty of being ill.' They want to avoid the trap of victim blaming attached to the responsibility.
The countries differ substantially as to where the main causes of ill health are to be found, in individual behaviour or in social relations and living conditions.

**HOW TO IMPROVE HEALTH: CHANGED BEHAVIOUR OR CHANGED LIVING CONDITIONS?**

Two methods to improve public health are characterized in the Swedish report as either 'persuade or 'force' people to stay healthy ... or create preconditions and options for people to live a healthy life.'11 When identifying means one also places responsibilities. When responsibility is located it lies close to placing guilt, or, as said in a Swedish newspaper heading: 'Responsibility is neighbour to guilt'.16

In the Swedish papers, early public health initiatives are characterized as trying: 'to influence the attitudes and values of individuals so that they chose by themselves to live a more healthy and less risky life';11 that is making people govern themselves. According to the Swedish committee this method does not sufficiently take into account the total living conditions habits or economical interests, as for example the tobacco industry. The Swedes therefore advocate a combination of strategies orientated towards structures as well as individuals. When changes of lifestyles and restrictions are discussed they are argued to be means to help those who would be harmed by unhealthy behaviour, that is an act of solidarity. In the Swedish reports some effort is made to point out areas where the individual has no or little influence. The Swedes seem reluctant to impose any responsibility on people. The main interventions are aimed at changing the living conditions in a way which may be characterized as solicits but also patronizing. Many of the risk, disease, age and arena focused targets are criticized in the Swedish papers for being too one sided often leaving the structural causes of disease aside, e.g. using the housing area as an arena for public health activities focusing on lifestyles or social networks does not affect the poor standard of housing or segregation, which could also be important causes of ill health in the area.

The Danish programme is focused on health behaviour in four areas: tobacco, alcohol, diet and exercise. These areas each have their own targets and are also central in the activities towards target groups and arenas. The authorities, it is claimed, have an obligation to inform the population about risky and healthy behaviour,9 as well as deliver messages and provide solutions.9 Motivating people to change behaviour is crucial, that is to change their minds, as it is said, people cannot change their lifestyles because they do not want to.9 In the Danish programme hardly any attention is given to living conditions, and when it does it is mainly as 'frames for our choices' of lifestyle.9 The role of the health services and the social sector is much more prominent in the Danish programme than in the others. It is considered to 'play a central role in the public health programme’.9 The professionals job is to act as role models and perform a 'health dialogue’10 with their clients and patients. They are expected to discover people with problems and intervene. This type of intervention is the most important method mentioned to reduce social inequality. The activities to reduce social inequality focus almost exclusively on marginalized groups such as pregnant women with substance abuse or other problems, young people who are marginalized from the workforce and isolated old people. Among the professionals 'the GP is a key person, when it comes to strengthening efforts to reduce social inequality in health.'9 Many interventions are adapted to methods of curative activities such as smoke cessation programmes, treatment of 'excessive consumers' of alcohol, elaborations of clinical guidelines for preventive measures etc.9 People's health behaviour is considered the responsibility of both the individual and the authorities. The health care professionals should help people govern themselves in the directions suggested by the professionals. This could be characterized as a fairly paternalistic approach. In the Danish programme many statements are given in authoritarian language. It repeatedly claims that 'studies show' without giving references. Hardly any dilemmas or possible conflicts are mentioned.

The Norwegian paper, with its very broad definition of health, tends to make the health policy all-embracing. The committee advocate 'a unifying strategy to develop inclusive and secure local communities'. A very central means is 'empowerment'. 'There can be few doubts that strengthening values which give the individual or groups of individuals possibilities for responsibility, participation, solidarity, coping and control also will reduce the prevalence of lifestyle-related diseases.'8 The committee also expects social inequalities in living conditions, quality of life and living standards causing bad health to be reduced by the method of empowerment. In the Norwegian report powerlessness is seen both as a part of bad health and as a cause of bad health, and consequently empowerment is considered to be both a part of good health and a means of obtaining it.8 The committee seems convinced that people will act as the committee finds appropriate in relation to health if they get more control over their lives. This in spite of the fact that it also mentions that people value factors which are not compatible with health even higher than health such as fat food, alcohol etc. The strategy of empowerment can be characterized as encircling, to use a military term.

In the Norwegian paper it is said that: 'To work for a good public health is a responsibility for both the public sector and the individual. The task of the public sector is to arrange for the individuals to take responsibility for their own health.'8 It is parallel to the Danish strategy and to the poor law politics of the nineteenth century in which the poor should be helped to help themselves. This function of the state could, with Nikolas Rose, be characterized as ‘the facilitating, the enabling state’,5 which helps individuals take responsibility. The tone in the Norwegian paper is very committed, sometimes almost missionary, especially in making the reader accept and support their broad definition of health and what
follows from it, above all the concept of empowerment:
‘To arouse political Norway to a comprehensive and coherent public health combat requires schooling to obtain changed attitudes and behaviour’. The Norwegian word ‘vekke’ (arouse) has religious connotations, ‘With a joint effort and drive we can make what seems impossible possible.’

In accordance with the way the English papers explain diseases, both changes in peoples living conditions and in their behaviour are promoted. Many of the factors influencing health, like housing, unemployment, etc., are part of other of the government’s initiatives, and the papers describe carefully how the public health programme works together with other public programmes. They launch a ‘national contract’ which they want people, local communities and national authorities to enter into in order to achieve the goal of better health. The English papers, especially ‘Saving lives’, are characterized by the will to demonstrate drive and fighting spirit and power to create a new, modern and healthy England, a pep talk. Another characteristic of the English papers is the use of military metaphors: the government will undertake ‘a crusade for health’, ‘combat’, ‘armed with knowledge’, it is ‘tackling head on’, makes a ‘fundamental attack’ etc. Among the activities suggested by the public health programme, most focus on changed individual behaviour. As a means to make people change their behaviour the government wants to establish Healthy Living Centres where people can get help to stop smoking, get dietary advice, employment training, etc. Responsibility is a central theme in the English papers. They wish to find ‘a third way between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other’.

While the Danish government wants to tell people what to do, give them solutions, the English expects that to be counterproductive. It claims to consider individuals as autonomous partners to enter into a contract not as subjects who are to be directed. ‘As long as people are aware of the risk they are taking, it is their decision whether to put themselves at risk’. However, empowerment as a means to make people do what government wants them to do is also mentioned in the English programme and the government cannot totally hide its ambitions to govern: ‘The government recognises the importance of individuals making their own decisions about their own and their families’ health. But we also believe that there are steps we can take to help support the decisions people make’. One can assume the government only wants to support decisions they approve of. It is also stated that ‘individuals have a responsibility to do all they can to live a healthy life’. The message is contradictory: people can decide for themselves, but they have a responsibility to make healthy decisions. The political debate in England is obviously characterized by a political discourse where the liberal and individualistic features are strong and the somewhat paternalistic policy suggested should be defended towards these ideals.

CONCLUSION
The public health strategies analysed in this article may be viewed from very different angles. This author has chosen to study them as a means to exercise power, and, as mentioned, has focused on the differences between the countries. There are of course also many similarities and had the four countries been compared with USA or Russia the similarities might have overshadowed the differences. It is worth mentioning again that the study is of programmes and papers, thus saying something about the ideas and intentions of the politicians but nothing about what is actually done. When analysing papers and programmes one can, furthermore, only say something about what the governing bodies want to present about their aims and motives; they may have aims and motives which they do not find it appropriate to write about.

The reasons for trying to improve the health of the population are, if they are expressed at all, a combination of state reasons, strengthening the state, the nation, the economy, and of acting as the good shepherd, creating good lives for citizens, not least for the lower classes in order to achieve fairness but also social cohesion. Possible conflicts between these goals are hardly considered.

The countries differ both in which health problems they define (from mainly looking at mortality and lethal diseases to a focus on non-lethal diseases) and in the emphasis given to social inequality. The English write a lot about social inequality and have a longer tradition both of registering it and performing research into its causes than the Scandinavian countries. The causes identified to some extent depend on the problems identified. Both the Danish and the English programmes focus mostly on mortality, but the English identify many more different causes to deal with than the Danes, who almost exclusively focus on individual behaviour. The Swedish and Norwegian papers have more focus on non-lethal diseases. Here the Swedes look more for the structural causes while the Norwegians focus on powerlessness. Research and quantification plays a central role in all papers. The Norwegian and Swedish papers are more research orientated, even the most recent Swedish paper which is formulated as a programme, while numbers play a more prominent role in identifying and describing problems and causes in the English and Danish programmes.

Finally the countries differ in the way and the extent to which they want to govern people in order to make them govern themselves. This may reflect general differences in the political culture of the four countries, and may be more pronounced in this area than in others. The Danes give very high priority to changing lifestyles and do so in a fairly paternalistic way by giving the health professionals an important role in efforts to change peoples’ behaviour. The Norwegians rely on empowerment, to make people choose for themselves to act in a more healthy way. They see a mission in mobilizing people locally, which might be associated both with the regionalism of Norwegian policy and with the revivalist movement which has been and is fairly strong in Norway. The English policy rests on
a combination of changing living conditions and changing lifestyles. There is a contradiction between the reverence for liberal ideals of autonomous individuals and the wish to change peoples behaviours. Using the metaphor ‘contract’ about the public health policy can be seen as significant in the mother country of economic liberalism. Here the concept of enabling state, where much responsibility is given to the individuals, is relevant. They also wish to change peoples lifestyles, but are fairly reluctant to demand something from the individuals and rather ask for structural changes, placing the responsibility on a caring state. The state is considered responsible for creating good lives.

Finally one can ask if it is meaningful to speak of a ‘Nordic model’ in this area of welfare state politic. In several respects one can say that England combines traits of the three Nordic countries’ politics, they propose structural changes as the Swedish papers, combined with lifestyle advice as the Danish programme and empowerment as the Norwegian. The Nordic countries have, however, in spite of their differences, in common a more positive attitude to the role of the state, which could be characterized as a more social democratic less liberal view. It might also be significant that public health in the Nordic countries is called people’s (folk) health, the distinction between the concepts state, society and people are not very clear and not antagonistic in their rhetoric.

Niels Arnfred, Lene Koch and Allan Krasnik have given useful comments to the paper.

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16 From a literature review in Dagens Nyheter 11th of February 2000.


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