

# Developing an Intersectoral National Strategy to Reduce Social Inequalities in Health.

## The Norwegian Case

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# 1. Subject/scope

## 1.1 *The Intersectoral action for health project*

The case study presented in this document is the Norwegian contribution to the *Intersectoral Action Project*, a Canadian “country stream” of work for the WHO Commission on the Social Determinants of Health. The goal of the project run by the Public Health Agency of Canada is to develop a review of experiences in intersectoral action for health.

Intersectoral action for health is defined as:

***“a recognised relationship between part or parts of different sectors to take action on issues to improve health and health equity”***

The review will include a synthesis of available literature, the case studies from participating countries, analyses and recommendations for tools and resources to support future country work. The experiences, analysis and findings will shape the contents of a report on intersectoral action to the WHO Commission on Social Determinants of Health (CSDH).

The individual case studies from a variety of country contexts are intended to advance the following general questions:

1. What are some of the specific mechanisms used in working on policies and programs to advance intersectoral action to benefit health and health equity?
2. What role or roles does the health system/sector frequently take in these various models?
3. What are the common architectural arrangements of different models adopted?
4. What are the main strengths, weaknesses, threats (barriers to implement and sustain the action) and opportunities (facilitating factors) of the different models?

## 1.2 *The Norwegian case*

Norway has experienced enormous improvements in public health the last century. However, the last decade or so, there has been an increasing awareness that average measures of public health conceal systematic inequalities that are socially produced, unfair and modifiable. The 9<sup>th</sup> of February 2007 the government launched the white paper Report No. 20 (2006-2007) to the Storting *National Strategy to reduce Social Inequalities in Health*. The 6<sup>th</sup> of June 2007 the white paper was adopted by the parliament (Storting). This case study presents the process of developing the strategy. In only a few years the policy environment went from ignorance to developing a comprehensive, intersectoral policy to reduce social inequalities in health. This case study will present the case with respect to four areas of study:

1. **Context** - meaning the broad environment where the policy development took place, including a short description of the stages up to the agenda setting for the national strategy
2. **Approach** and content of the policy and intersectoral arrangements in the process of developing the policy.
3. **Impact** - make some reflections on implementation and possible results of this new policy
4. **Reflections** of key actors, factors and events that may have enabled the Norwegian strategy to become a comprehensive intersectoral policy.

## 2. Methodology

This case study is written in the perspective of the resource unit on inequalities in health in the Norwegian Directorate of Health and Social Affairs. Through the process of developing the national strategy, two of the authors were part of the MOH secretariat for development of the white paper. This is a narrative about how the issue of social inequalities in health reached the political agenda, how the issue was framed and policy developed in interplay with a changing context.

The purpose of the case study is to identify key factors that facilitated rapid change from neglect of social inequalities in health to the development of a comprehensive intersectoral policy to reduce social inequalities in health. The case should be viewed as a narrative told by “insiders” of the policy process with the potential biases that might give. An insider may for example perceive the experiences more successful than other actors may judge them to be. On the other hand the inside perspective may give details that would have been difficult to disclose from outside analysts.

Information is drawn from discussions with health sector policy makers and review of policy documents. There has been no aim of being exhaustive/complete in the analysis. This case study is rather an attempt to draw attention to some key learnings that might also benefit other health sector policy makers that are engaged in intersectoral action for health.

## 3. Context

### 3.1 Facts about Norway<sup>1</sup>

Norway is located in northern Europe, bordering the North Sea and the North Atlantic Ocean, sharing physical borders with Sweden, Finland and Russia. The Country is a monarchy with a parliamentary form of government.

Norway is a highly developed welfare state with comprehensive welfare arrangements. The Welfare State Model is characterised by broad universal schemes to ensure social, health and educational benefits to the whole population. Norway has a high degree of gender equality within education, the labour market and political life.

In 2001, the proportion of the population with a university education, among the 30 to 39-year-olds, was 29% for men and 36% for women. 57% of the population over the age of 16 had completed secondary education. The enrolment level in secondary and tertiary education thereby amounts to more than two-thirds of Norwegians over 16 years, which makes Norway one of the most highly educated countries in the world.

Health is a priority on the governmental and societal agenda. 10,3 % of GDP was spent on health care in 2003. Equal access to health services has been a long standing core value for the provision of health services. The Norwegian population reached 4.6 million in 2005. Life expectancy in Norway is among the highest in the world. Diseases of the circulatory system are the primary cause of mortality. Cancer is the second largest cause of death.

There are three independent government levels – the national government, the county councils and the municipalities. In 2003, there were 19 counties and 431 municipalities. Population density varies widely throughout Norway, ranging from 218 to 500 000 inhabitants

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<sup>1</sup> The content of this chapter is mainly drawn from Johnsen JR. (2006) Health Systems in Transition: Norway. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies

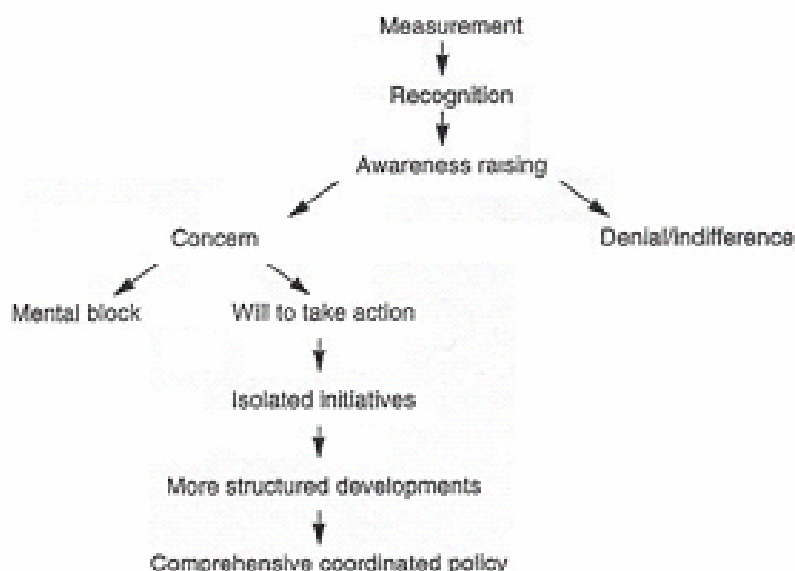
per municipality. The municipalities are responsible for health promotion, primary health care, care of the elderly, care of people with disabilities, including mental disabilities, kindergarten and primary school education, social work (child protection and social protection), water, local culture, local planning and infrastructure. The counties are responsible for dental care, secondary education, energy delivery and communication. Secondary health care is a responsibility for the state level, delegated to four regional health enterprises.

Politically, the country has been stable, with a Labour Party holding office between 1945 and 1965. From 1965 to the time of writing, Norway has had a Labour government, alternating with periods of non-socialist coalition governments. From 2001 to 2005, the country was ruled by a threeparty coalition government (Christian Democratic Party, Liberal Party and Conservative Party). A new government coalition came to power following the 2005 election with the Labour Party for the first time ever in a government coalition, with the Socialist Left Party of Norway and the Centre Party (Johnsen 2006).

### 3.2 Agenda setting - Origins of the policy program

#### 3.2.1 From neglect to a growing recognition

Social inequalities in health had been recognised as a problem by leading scientists in Norway for quite a long time. In 1987 a white paper described the challenge in a policy document for the first time in Norway (St. meld. nr. 41, 1987—88). But it took a long time before political action. In 2002 a leading Norwegian scientist in this field, Espen Dahl, proposed the following question: Why is a social democratic, highly egalitarian country like Norway so ignorant or indifferent about social inequalities in health? (Dahl 2002) Applying Whitehead's framework "Action Spectrum on inequalities in health" (Whitehead 1998) he concluded that Norway, despite the evidence of inequalities, was located at the upper end of Whitehead's action spectrum – somewhere in the area around "measurement", "awareness raising", and "indifference".



**Figure 1.** Action spectrum on inequalities in health (Whitehead, 1998).

In 2003 the three-party coalition government (Christian Democratic Party, Liberal Party and Conservative Party) launched a White Paper “Prescriptions for a Healthier Norway” (St. meld. nr. 16, 2002-2003). This policy document set reduction of social inequalities in health as one of the objectives of the public health policy. This moved Norway down the spectrum, but the white paper did not outline any new intersectoral policies on the issue. It referred to another white paper on action to reduce poverty (St. meld. nr. 6, 2002-2003). The key initiative on social inequalities in health in Prescriptions for a Healthier Norway was to establish a resource centre on inequalities in health in the Norwegian Directorate of Health and Social Affairs. Furthermore the Directorate was assigned to build knowledge and develop an action plan to reduce social inequalities in health.

The directorate is a subordinate body to the Ministry of Health and Care Services and the Ministry of Labour and Social Inclusion that holds three roles that may be summed up in the following points:

- **Advisory role** - advising national authorities on health and welfare policy issues, and the formulation of national guidelines to enhance health and welfare services. Providing technical support and guidance to regional and local authorities, services and the general public.
- **Regulatory role** – financial administration and execution of authority on of health and welfare legislation
- **Implementation role** – implementing national health and welfare policy

### 3.2.2 Intersectoral challenges requires intersectoral solutions

In 2004 the work of preparing an action plan on social inequalities of health started in the directorate. Based on available research the directorate concluded that status for social inequalities in health in Norway may be summed up in the following points:

- they concern all age-groups and both sexes
- they are significant whether socioeconomic status is measured as education, occupation or income
- likewise, they are significant for most common health indicators
- and they form a *gradient* throughout the socioeconomic groups: it is not only that people below a certain threshold of poverty are less healthy than the rest of us. The richest are healthier than the second richest, who are in turn healthier than the third richest and so on.

The factors that generate and perpetuate social inequalities in health extend far beyond the control of the health sector. It was evident that reducing social inequalities in health is not a challenge for the health sector to handle alone. It would be impossible for the directorate – a body subordinate the Ministry of Health and Care Services - to make a plan of concrete action without political commitment in all sectors. In order to come to grips with the causes of social inequalities in health in Norway, there must be agreement on comprehensive packages of measures on top national level. It was therefore decided that the action plan made by the Directorate should provide the foundation for the Directorate’s own work on social inequalities in health. This would then be a first phase of the governments long term work to reduce social inequalities in health. “Action plan” therefore became a slightly misplaced term for this plan that was redesigned to be a preparatory plan for a more comprehensive national policy. The action plan was named “**The challenge of the gradient**” (The Norwegian Directorate for Health and Social Affairs 2005) and had two main objectives:

1. Increase knowledge of social inequalities in health and
2. Develop measures to reduce social inequalities in health.

In order to support the Directorate in its work, an interdisciplinary **expert group** of 9 researchers (sociologists, medical doctors, health economist) was established in January

2005. The discussions in the expert group and their advice became an important resource for the directorate in the further process of building knowledge for a national strategy to reduce social inequalities in health. One of the first challenges the Directorate gave the expert group was to develop “action principles” for reducing social inequalities in health. A comprehensive European review of strategies in different countries had identified entry points for policies to reduce social inequalities in health (Mackenbach and Bakker 2002). The WHO publication *The Solid facts* (Wilkinson and Marmot 2003) identified key social determinants of health (Wilkinson and Marmot 2003). Inspired by these publications and the document “The concepts and principles for equity and health” by Margareth Whitehead (Whitehead 1992), the directorate wanted the expert group to develop action principles for a Norwegian strategy to reduce social inequalities in health. The expert group identified 6 principles for action that they meant a Norwegian strategy should be based on. Among their key messages was that policies in this field should be comprehensive, coordinated and based on the fact that social inequalities of health is a challenge of a gradient.

### 3.2.3 Framing the gradient challenge – an intervention map for comprehensive policies to reduce social inequalities in health

The Directorate’s action plan stressed the fact that social inequalities in health is a gradient challenge. This is a key point to note and one which has important consequences for framing policy response. The gradient in itself has two implications for policy design:

1. There is a need for population strategies (not only high-risk groups)
2. Measures should be directed towards the whole causal chain, including the social determinants or structures

*First*, since the gradient runs right through all groups, selective measures directed at high-risk groups are not enough. There is a need for measures directed at the entire population. Social inequalities in health concern the whole population, and measures therefore have to be universal. Certainly it is the most vulnerable groups that need most levelling-up of their health. But targeting, for example on the basis of means testing, may have stigmatising effects and actually undermine the purpose. General welfare schemes may be more beneficial to the poor, they are less stigmatising and serve to prevent people ending up in high-risk situations. This does not mean that policies should not selectively target those who are worst off, but they cannot do only that. Policies must build on broad universal welfare schemes and at the same time implement special measures to help the most vulnerable.



**Figure 2.** A stream of causes behind social inequalities in health

*Second*, the fact that the social health gradient systematically keeps emerging across diseases and risk factors should point policies in the direction of structural measures and underlying causes. When lifestyle follows socio-economic patterns, there must be some social determinants of that behaviour - the causes of the causes. Preventive efforts should therefore focus on the whole causal chain of inequalities. The causes of inequalities in health are ranging from basic determinants such as personal economy, education and work, to more immediate causes such as health behaviour and use of the health services. Although these areas are interrelated and overlapping, they may be viewed like a stream of causes: upstream, midstream and downstream (figure 2).

We need to think widely in our efforts to reduce social inequalities in health. Complex problems require comprehensive solutions. From a combination of the two arguments above, the Directorate for Health and Social Affairs developed the ***Intervention Map*** for comprehensive policies to tackle social inequalities in health. The map gives strategic entry points for policies in the whole stream of causes combining universal and selective approaches. The point is to pay attention to all the 6 cells on the map as entry points for policy, and not only the bottom right corner where we all too often tend to end up. In figure 3 policy areas are exemplified in each cell.

	Social reform Upstream	Risk reduction Midstream	Effect reduction Downstream
Universal measures	public system for education, taxes, labour market policies etc	Working and living environment, broad lifestyle measures etc	Health systems
Selective measures	means-tested social benefits etc	targeted lifestyle measures etc	targeted health services

**Figure 3.** The Norwegian Directorate for Health and Social Affairs (Torgersen, Giæver) 2005 ***The Intervention Map for comprehensive policies to reduce social inequalities in health***

## 4. Approaches

### 4.1 Objectives and approach of the national strategy

In 2005 a government coalition of the Labour Party, Socialist Left Party of Norway and the Centre Party came to power. The 9<sup>th</sup> of February 2007 this government launched the white paper Report No. 20 (2006-2007) to the Storting *National Strategy to reduce Social Inequalities in Health*. The primary objective of the strategy is to: **reduce social inequalities in health by levelling up**

The strategy states that the challenge now is to bring the rest of the population up to the same level of health as the people who has the best health, and argues for a comprehensive policy approach and identifies the following **4 priority areas**:

- 1) Reduce social inequalities that contribute to inequalities in health, This includes the following areas: Income, childhood conditions including education, employment and working conditions.
- 2) Reduce social inequalities in health-related behaviour and use of the health services,
- 3) Targeted initiatives to promote social inclusion, and
- 4) Develop knowledge and cross-sectoral tools

A closer look at the white paper shows that this structure of the policy mirrors the intervention map developed in the resource centre in the Directorate for Health and Social Affairs (see figure 4). Priority area 1 – 3 identifies explicit priorities and measures within each of the cells of the map.

	Social reform Upstream	Risk reduction Midstream	Effect reduction Downstream
Universal measures	public system for education, taxes, labour market policies etc <b>1</b>	Working and living environment, broad lifestyle measures etc <b>2</b>	Health systems
Selective measures	means-tested social benefits etc	targeted lifestyle measures etc <b>3</b>	targeted health services

**Figure 4.** Policy priorities in accordance with the Intervention Map

Within each of the priority areas objectives are identified. The targets are measurable, but not quantified in numbers or dated in time.

The strategy defines the framework and sets out direction for the Government and Ministries' efforts to reduce social inequalities in health over the next ten years. It commits the Ministries' work on:

- Annual budgets
- Management dialogues with subordinate agencies, regional health enterprises, etc.
- Legislation, regulations and other guidelines
- Interministerial collaboration, organisational measures and other available policy instruments

Measures to reduce social inequalities in health are largely linked to the follow-up of other white papers and action plans in specific areas. An important element of the future efforts to reduce social inequalities in health will be ensuring that this perspective is also integrated into subsequent initiatives.

## **4.2 A closer look at the priority areas of the National Strategy to reduce social inequalities in health**

The four priority areas in the National strategy to reduce social inequalities in health may be summarised in the following points:

### *4.2.1 Reduce social inequalities that contribute to inequalities in health*

- **Income** directly affects individuals' ability to take advantage of opportunities to improve their health – better living conditions, healthier food, health-promoting leisure activities, etc. However, the health returns diminishes gradually as income increases. This means that income redistribution contributes to reduced inequalities in health. The Government is going to continue its work to ensure that the tax system promotes fairer income distribution in society
- **Childhood conditions** - The foundation for social inequalities in health is laid early on in life, and childhood is a critical period. Early action is therefore necessary to prevent social inequalities in health from developing. The Government wants to create safe childhood conditions through kindergartens, schools and high-quality services for children and young people across social divides.
- **Work and working environment** - With a view to reducing social inequalities in health linked to work, the Government will continue its investments to promote a more inclusive labour market and will take steps to ensure a healthier working environment in occupations with significant occupational stress.

### *4.2.2 Reduce social inequalities in health behaviour and use of the health services*

- **Health behaviour** - People's diet, physical activity, smoking and other health-related behaviour varies with social background and has a major impact on people's health. This means that we need to focus attention on the underlying and structural causes of these behaviours and then introduce measures that will promote healthier choices. The Government will give greater priority to policy instruments that influence price and availability in its efforts to prevent lifestyle diseases.
- **Health services** – Some evidence suggests inequality of health care services in Norway. Since there is limited knowledge about the correlation between social background and treatment in the health service, it is necessary to investigate whether the Norwegian health service is helping to level out social inequalities in health or if it is actually reinforcing them. The Government wants to improve knowledge about social inequalities in access to health services and further develop schemes to ensure equitable services.

### *4.2.3 Targeted initiatives to promote social inclusion*

- **Social inclusion of vulnerable groups** – It is important to prevent social exclusion of groups that drop out of education and employment because of poor health or for other reasons. Many disadvantaged people need more targeted services. Universal schemes must therefore be supplemented with specially adapted services and measures tailored to the individual. User oriented and specially adapted public services are necessary to ensure that everyone, regardless of their background and circumstances, has access to equitable services. The Government will take steps to promote inclusion in the workplace, inclusion at school and adapted health and social services.

### *4.2.4 Develop knowledge and cross-sectoral tools*

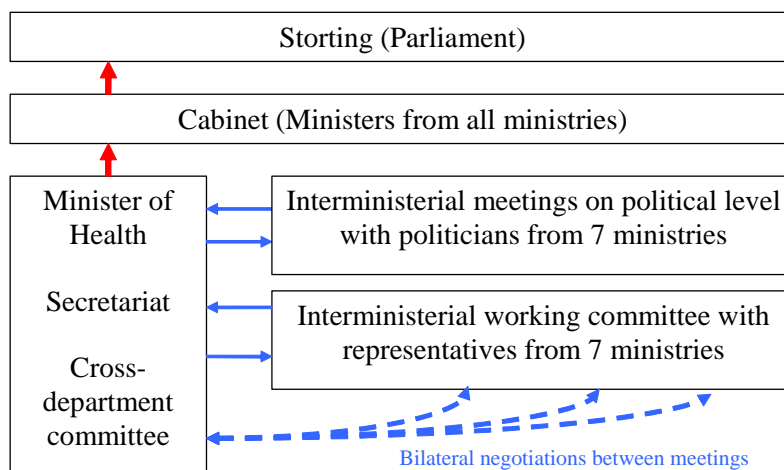
- **Annual policy reviews** - The government will establish a review and reporting system for monitoring progress in the work on reducing social inequalities in health. (see 4.4.1)
- **Cross sectoral tools** – it is a need to raise awareness among decision-makers in all sectors and on all administrative levels about the social distributional effects of social processes, strategies and measures. Cross-sectoral tools such as health impact assessments and social and landuse planning are important policy instruments, along

with stronger partnerships for public health (see 4.4.2) and building up local competencies about social inequalities in health.

- **Advancing knowledge** – There is sufficient knowledge to implement measures where causal connections are obvious and proven, but there is still a need for more knowledge about causes and effective policy instruments. The Ministry of Health and Care Services will strengthen research on social inequalities in health. A monitoring system is also proposed to track developments in social inequalities in health.

### 4.3 Intersectoral process of developing the policy (Architectural arrangements)

#### 4.3.1 Inter ministerial arrangements



**Figure 6.** Decision line (red) and communication lines (blue) in the process of developing the white paper

The white paper was developed through a 14 month process from January 2006 to February 2007. The Minister of health established a secretariat of four persons in the Department of Public Health in the Ministry of Health and Care services (MOH) to co-ordinate the process. The strategy was anchored on top political level from the start. A cabinet decision to develop the strategy in January 2006 was the formal starting point of the process.

It was decided that state secretaries (politicians) from each of the 7 ministries that were most closely involved in the process, should have meetings and discuss milestones and progress regularly throughout the process. The ministries represented in this group were the Ministry of Finance; Education and research; Labour and social inclusion; children and equality; Justice and the police; Local government and regional development: Health and care services.

An inter-ministerial working group with bureaucrats from the same Ministries operationalised the directions from the political level and discussed concrete contributions from each of the ministries. The representatives in this group had responsibilities for co-ordinating the formal input to the policy from their respective ministries.

Within the MOH a working group with representatives from each of the departments in the ministry supported the work of the co-ordinating team.

#### *4.3.2 Level of integration across Ministries*

The development of the national strategy to reduce social inequalities in health coincided with initiatives for equity policies in other sectors. *First* - in the educational sector there was an initiative to develop policies to reduce social inequalities in learning. The government therefore launched the white paper *Early intervention for lifelong learning* (St. meld. nr. 16, 2006-2007). In this white paper the Government presents a policy to make better use of education as a tool for reduction of social inequalities. *Second* – in the Ministry of Labour and Social Inclusion there was a process of developing a white paper on social inclusion and welfare policies (Report no. 9 to the Storting, 2006–2007).

A close collaboration across these processes was very important. The co-ordination team in the MOH therefore also had responsibility to ensure that health equity aspects were included in the other sector policies. Together the three white papers represent the Government's comprehensive policy for reduction of social inequalities, inclusion and combating poverty. The strategy to reduce social inequalities in health comprises the health aspect of this policy.

#### *4.3.3 Civil society - Meetings with NGOs*

Through 9 workshops in an early phase of the process more than 80 different actors from NGOs, labour organisations, research institutions, regional and local authorities gave valuable input to the policy process. Workshops were arranged on the following issues:

- Research and knowledge development
- Work and working environment
- Children and adolescents
- Sami issues (meeting with the Sami Parliament)
- Social inclusion and exclusion
- Behaviour/lifestyle
- Health services
- Intersectoral tools
- Regional and local actors

A general impression worth noting was the advocacy for a broad determinants perspective from organisations one might expect would promote a narrower single interests perspective. The input from the workshops gave inspiration, better understanding of the challenges and clear demand for action.

## **4.4 Mechanisms and tools to support intersectoral implementation**

#### *4.4.1 Horizontal mechanism - Annual policy reviews*

In order to monitor progress in action according to the four priority areas in the national strategy the government has decided to establish an intersectoral review and reporting system, providing a systematic, regularly updated overview of developments in the work on reducing social inequalities in health. This policy review system will be based on the objectives and goals in the white paper strategy. One or more performance indicators will be developed for each of the defined objectives and goals enabling monitoring of developments over time. The Directorate for Health and Social Affairs is responsible for coordinating the design and development of indicators and reporting system that will be developed in close collaboration between relevant ministries, directorates and professional environments in the various sectors involved.

Based on the review and reporting system annual policy reviews will be published. The annual reports will contain a presentation of the main initiatives and strategies on the national level, in conjunction with the goals for reducing social inequalities in health, as well as comments on the trend of each indicator. This will be used as a basis for annual reporting in the national budget through joint reports in the Ministry of Health and Care Services' budget proposition.

Parallel to the policy review system, a comprehensive monitoring system on social inequalities in health outcomes (mortality and morbidity) will be developed by the Norwegian Institute of Public Health.

#### *4.4.2 Vertical mechanisms - Public health partnerships in regions and municipalities*

In order to support counties and local municipalities on action to reduce social inequalities in health the government awards grants to counties and municipalities that organise their public health work in regional partnerships for public health. In each county there are public health advisers to support the partnerships. The purpose of the scheme is to make local public health work more systematic and comprehensive by ensuring a stronger administrative and political grounding and by improving coordination between authorities and the labour market, schools, voluntary organisations and others. Each of the partnership is developing intersectoral plans of action and there are local co-ordinators in each of the participating municipalities. The Directorate of Health and Social Affairs provides advice and professional support on health determinants, monitoring, health impact assessment, tools for health in all planning etc.

## **5. Impact**

The White paper that was launched by the government in February was adopted by parliament (the Storting) the 6<sup>th</sup> of June 2007. This implies that most of the impact of the policy is yet to materialise. However since the policy is so integrated with equity policies in other areas, several measures to reduce social inequalities have been introduced. Some of these are the following, listed according to the priority areas of the National strategy:

**Income:** The redistribution of income through income taxes has been strengthened through the National Budgets of 2006 and 2007. Income taxes for persons with low income have decreased, whereas taxes on high incomes from savings and investments have increased. The net level of tax revenues has been kept stable in order to support the social welfare system.

**Childhood conditions:** Full kindergarten coverage (i.e. places for all applicants) by the end of 2007 is a national target. The maximum limit on parents' fees in kindergartens was reduced by some 18 percent in 2006 (and most municipalities have progressive, means-tested fee systems). Pilot projects offering free kindergarten time to 5 and 4 year old (preschool) children in multi-ethnic or disadvantaged areas are established. Special importance is attached to preschool children with a low mastery of the Norwegian language.

All public education in Norway is free up to and including the upper secondary level, but pupils at the secondary level have had to provide means of instruction (paper, books etc.) themselves. From 2007 these means will gradually be provided for free. There are various efforts to reduce secondary school drop out rates and to provide homework help.

In addition, several special projects targeting children from disadvantaged backgrounds have been introduced.

**Work and working environment:** Labour market initiatives were considerably strengthened in the national budget for 2007, with particular emphasis on people with a loose or no ties to the labour market. Other groups targeted in this budget were immigrants and people with mental sufferings.

A new working environment act with a stronger emphasis on requirements regarding systematic health, environment and safety work took effect in 2006. Extended requirements regarding employer's follow-up of employees on sick leave were effected from March 2007. A cooperation considering revisions of the mandatory Norwegian employee's health service scheme is under way.

**Health behaviour:** The Norwegian Ministry of Health and Care Services has issued separate action plans in the areas of physical activity, nutrition, tobacco control and substance abuse. The action plan on nutrition ("Recipe for a healthier diet"), in particular, was developed in cooperation with the strategy against health inequalities and has the reduction of social inequalities in nutrition as one of two main targets. One of the direct impacts of the strategy against inequalities in health is a gradual expansion of a free fruit and vegetables programme in schools. As of August 2007 all children between 8<sup>th</sup> and 10<sup>th</sup> grade receive free fruit daily, and in some deprived areas all children up to and including 10<sup>th</sup> grade are included in the free fruit programme.

Norway has a long tradition for a restrictive alcohol policy, limiting consumption through availability and price. The renewed focus on health inequalities has provided arguments for the maintenance of this policy in the face of International pressure to liberalise alcohol policies.

**Health services:** The strategy against social health inequalities has generated a stronger focus on potential inequalities in the health services. The Ministry of health and care services is now – for the first time – making inquiries into the social distribution of health services in Norway. In addition, mental health services, school health services and out-of-pocket payments have received renewed attention.

**Social inclusion of vulnerable groups:** The National Action Plan to Combat Poverty was further strengthened in the National Budget for 2007, as was initiatives directed towards the inclusion of immigrants, and the rehabilitation of convicts.

**Annual policy reviews:** The main, built-in instrument to promote an impact of the inequalities strategy, is a review and reporting system that will analyse developments and results in all relevant sectors on a yearly basis. The policy review system will be developed in a cross-sectoral process towards the first publication in spring 2009, and annual reports will be issued until 2017.

## **6. Reflections – actors, factors and events**

### ***6.1 Building demand for action – creating arenas for scientists***

In an early stage of the policy process it was a challenge to obtain policy advice from the Norwegian research institutions on policy action and policy approach. Norwegian researchers in the field of health inequalities are geographically and institutionally scattered throughout the country. When researchers in 2002 were invited to a meeting to give advice to the government on action to tackle the health inequalities, they were somehow reluctant to give clear advice. They called for more research and evidence. When the interdisciplinary expert group was set up in 2003 the Directorate for Health and Social Affairs experienced a rapid change in the dialogue with researchers. Giving the researchers this arena for

communication made them a strong voice into the policy process. Furthermore the group has been a driving force for national conferences and thereby increased attention and research within the field. The Norwegian version of action principles for a Norwegian policy to reduce social inequalities in health constituted important premises for a comprehensive national strategy (see chap 3.2.2). Furthermore, translating the WHO-principles into a Norwegian context was important to create broader ownership to the policy process.

## **6.2 Framing the issue – The Intervention Map**

Translating evidence into policy is a challenging task, especially within a complex field of interrelated and overlapping causal chains that are analysed across various scientific disciplines. Evidence on action to tackle social inequalities in health directs us towards intersectoral comprehensive strategies (Dahlgren and Whitehead 2007). To grasp such an issue, framing and conceptualising is of paramount importance. The intervention map developed in Norway (chap 3.2.3) guided the policy process and content in a strategic direction.

Models in the area of inequalities in health are often focused on explaining causal relations. The intervention map tries in a simple way to combine the causal relations with two main approaches to policy (population/universal approach and high risk/selective approach) in order to map out *entry point* for policies. The experience is that this made it easier to keep the rationale for comprehensive policies in situations where some actors tended to focus too narrowly on the issue.

## **6.3 From prescriptions to negotiations in intersectoral policies**

In a historic perspective it may be useful to make some critical reflections on the traditional role of the health sector in policy processes. For obvious reasons the health sector is influenced by traditional biomedical thinking in the sense of making diagnoses and prescribing the right cure. To some degree the health sector also may have applied this approach in intersectoral processes.

This may be exemplified by the relation to the educational sector. The health sector may for example develop guidelines for health promoting schools before approaching the educational sector with a demand for implementation. If the educational sector shows hesitation, the health sector may judge the educational sector to be reluctant to the importance of pupils' health. Such approaches need reconsideration. Policy formulation is a process of negotiation, where different objectives have to be acknowledged. Successful intersectoral implementation requires common ownership of both problems and solutions. In the example of the health sector, equal access to education is one of the most fundamental determinants of health inequality that the health sector control. If the Ministry of Education manages to ensure equity of education, they are giving a major contribution to equity of health. The powerlessness and exclusion that some children may experience in early years may be determinants of e.g. unhealthy lifestyles and mental health problems. Effort to ensure an inclusive school and to reduce social inequalities in learning is therefore investment in reducing social inequalities in health later in life. This link has to be clearly established. And when a good cooperation climate is established, there might be agreement on other common objectives paving the way for nutrition, physical activity and other health promotion activities within the school.

The health sector may in some cases have to improve its role as team player with the other sectors in policymaking. If there are initiatives for equity in other sectors, the health sector should first and foremost support these initiatives. The health sector should rather integrate

health objectives in equity policies in other sectors through health diplomacy, than enforce own health targets on other sectors.

#### **6.4 The role of the health sector in intersectoral action to reduce social inequalities in health.**

The role of the health sector may be described in the 5 following points:

- Describe social inequalities in health and make the link to their determinants
- Make visible the impact of other sector policies on health
- Support intersectoral collaboration and advocate for action in other sectors
- Strengthen preventive health service
- Ensure equity of health systems

The Norwegian experience is that to what extent the health sector itself can take the leading policy role depends on the issue at hand. *First* there are issues where the health sector both have the knowledge about effective measures *and* control those means, like preventive services and measures to make health systems more equitable. Here the health sector has a natural leading role. *Second*, there are issues where the health sector have knowledge about effective measures but do not control the arena or means for implementing the measures. Examples may be health promoting schools with physical activity, healthy school meals, mental health programmes, smoking prevention programmes etc. In the development of policy in this field the health sector may take a lead role in promoting solutions but have to ensure close cooperation and ownership of the problem and solutions by the other sector. *Third*, there are the determinants of health where the health sector have knowledge about the adverse health impacts of other sector policies, but where the health sector itself neither control the means for implementation nor has exact knowledge about how measures should be framed. Examples are inclusion to the labour market, reducing social inequalities in learning in schools etc. In the process of developing policies within these very up-stream policy areas the health sector may only play the role of a policy partner that on equal terms may inform the policy process with the health inequalities perspectives.

#### **6.5 Structures for sustainability of intersectoral initiatives**

The development and implementation of intersectoral policies needs sustainable intersectoral organisational arrangements. Although not intended, the sectors all too often operate in what may be characterised as vertical silos. Committees with representatives from the various sectors involved are therefore often key elements of organisational arrangements for intersectoral work. The challenge, however, is to ensure that such committees are continuously anchored in the sectors represented. Otherwise there is a danger that the committees end up as silos like the ones they are meant to cut across.

This dilemma runs out of the very nature of intersectoral challenges and has no easy solution. There is a need to strike the balance between on the one hand build on existing decision and- organisational structures and on the other hand efficient arrangements for the intersectoral issue at hand. When the ambition is to change existing structures there may be limited potential to accomplish this though extraordinary structures. In the Norwegian process of developing the national strategy to reduce social inequalities in health it was a deliberate choice to base the policy process on existing structures as much as possible. Since it was recognised that reducing social inequalities in health requires an up-stream determinants perspective, the challenge was to redirect policies on fundamental parts of social policies (income distribution, inequalities in education and work etc). The integrated strategy is therefore intended to be implemented through reorientation of existing initiatives and budget allocations through the national budget rather than through a separate action plan with separate budget allocations. An exact funding pool for action to reduce social inequalities in

health could have undermined the understanding of a need for reorientation of existing policies. In order to support the implementation process the expert group, the Norwegian Directorate for Health and Social affairs and the Department of Public Health within the MOH play the role as driving forces for policy implementation.

What organisational and procedural arrangements that may enable sustained intersectoral action to reduce social inequalities in health will certainly vary across different country contexts, settings and levels of society. It is yet to be learnt whether the arrangements for the Norwegian national strategy will bring success. The yearly policy reviews starting from 2009 will give answers to this.

## **6.6 The non-linearity of policy processes – socially responsible opportunism**

In a rational view of policy making it may be believed that issues reach the policy agenda by recognition of problems. From a normative perspective governments should, in the public interest, search for problems and rationally assess problems, solutions, actors, timing, context and implications (Hogwood and Gunn 1984). Nevertheless, experience from actual processes shows non-linearity of processes, sometimes processes that protract and other times rapid change. The Kingdon model of policy making (Kingdon 1995) contrasts with the perception that policy processes more or less proceed from identification of a problem through the seeking of alternative solutions. According to Kingdon “Streams” of problems, policies (solutions) and politics (political support) exist side by side. And when they come together “windows of opportunities” opens for new policies to be developed. This model may be a valid analytical lens for how social inequalities in health reached the agenda and became the issue of a broad intersectoral policy in Norway.

The *problem* of social inequalities in health had been recognised by scientists for quite a long time without automatically triggering any comprehensive policy response. Earlier when white papers for parliament on public health policies have been developed they have been preceded by professional inquiries or reports similar to e.g. the UK Acheson report in UK (Acheson 1998). This time the government decided to go straight on the process of developing the white paper. Why did this rapid change occur? The *politics* stream was evident. The current government got into power on promises of fighting poverty, fairness of income distribution, fair systems of education and health services. The agenda of reducing social inequalities in health in the ministry of health coincided with the agenda to reduce social inequalities in learning in the Ministry of Education and Research and the agenda of developing policies for an inclusive labour market in the Ministry of Labour and Social Inclusion. The evidence social determinants of health and conceptualisation of the issue through the intervention map for action (*policies*) gave the health rationale for social justice in other sectors. The streams converged. Health inequities were not an publicly expressed priority for the government when it came into power, but the welfare profile of the government constituted a window of opportunity for addressing these inequities. Some of the interventions in other sectors than the health sector would have been implemented without reference to health inequality. Yet it is important to tie these interventions to the health inequality policy because this implies explicit liability to health and thereby commitment to evaluate and correct action according to health targets.

It is in the tension between the norm of rationality and the reality of complex contexts policy makers have to navigate carefully. Streams of problems, policies, and politics must be identified and policy makers may in the right circumstances influence whether the streams meet or not. Achieving success in the development of intersectoral action for health might therefore be an issue of “*socially responsible opportunism*”.

## **6.7 Influence of international processes**

Global initiatives influence the national policy agenda. The leadership of the World Health Organisation has constituted important support for developing a national policy to reduce social inequalities in health in Norway. Technical support, work through partnerships and exchange of evidence-based policy options has given legitimacy to the national processes and intersectoral action. Developing the Norwegian policy has taken place alongside the work of the Commission on Social Determinants of Health. The importance of the attention brought to health inequalities by the commissions work has probably been a more important vehicle for change in Norway than we are able to comprehend. More generally, the WHO's continued focus on health inequalities and social determinants over several years has been a necessary foundation for the development of a Norwegian intersectoral strategy to reduce social inequalities in health.

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