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Addressing the social determinants of health at the local level: Opportunities and challenges.

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Introduction and background

The gradient in health inequalities reflects a relationship between health and social circumstance with evidence demonstrating that health worsens as you move down the socio-economic scale [1].The gradient approach to policy action comprises broad universal measures combined with targeted (proportionate) strategies for disadvantaged groups); this is termed 'proportionate universalism'[2]. Approaches targeting only the most disadvantaged are unlikely to be effective in levelling-up the gradient and may even contribute to an increase in Health inequalities. Furthermore, a gradient approach to policy also necessitates a focus on the upstream determinants of health inequities (such as income, education, living, and working conditions).

Reducing HI has been high on the political agenda in various Europe countries for many years, yet few European governments have specifically attempted to address the gradient; instead focusing on 'the gap' [3,4]

For more than a decade, the Norwegian National government has developed policies to reduce social inequalities in health by levelling the social gradient. The most significant National policy documents were the action plan from 2005, titled "The challenge of the gradient" [5]. The action plan indicated a shift of attention, compared to former policy documents, where the focus mostly were targeted measures aimed at disadvantaged groups [6]. One sign of this change is that social inequalities in health now were defined in terms of the social gradient. A Government White paper on social inequalities in health entitled National Strategy to Reduce Social Inequalities in Health was released in 2007 [7]. It had a ten-year perspective for developing policies and strategies to reduce health inequities. One main point of the White Paper was that "Equity is good public health policy." This implies a view on public health policies that aims at a more equal distribution of positive factors that influence health. With the release of this Government White Paper, reducing social inequalities in health became an overall aim in the Norwegian public health policy. The policy includes all policy sectors at National, regional and local level.

A further movement towards a comprehensive policy was the adoption of the Public Health Act in 2012 [8]. The main aim of the act is to reduce social health inequalities by adopting a Health in all Policies approach. The Health in all policies approach emphasizes relationship building through inter-sectoral collaboration, rather than sporadic coordination via single projects, for acting on the social determinants of health. Intersectoral action is regarded as key to reduce health inequalities. One of the main features of the Health in all polices

approach is that it places responsibility for public health work as a whole-of-government responsibility rather than a responsibility for the health sector alone. In the proposition underlying the Act it is stated that: Only by integrating health and its social determinants as an aspect of all social and welfare development through intersectoral action, can good and equitable public health be achieved [9].

In Norway, being one of the most decentralised countries in the western world, the municipalities play an important role [10]. The municipalities have the overall responsibility for welfare provision, including services such as pre-schools, schools, child care, and care for the elderly, social support and services, primary health care, culture, agriculture and the development of local areas. Municipalities are thus regarded as key in the implementation of the act. [11].

On one hand, the municipalities are agents for the welfare state through their responsibility for implementing national policy goals. On the other hand, they form independent local democratic areas able to decide how to use national funding in accordance with local priorities [12, 13]. The Public health act allows the municipalities to adjust the policies to their own context, and the relative freedom of the independent municipalities may result in differences in implementation at the local level.

The project "Addressing the social determinants of health. Multilevel governance of policies aimed at families with children" (SODEMIFA) ran from 2012 through 2016. The main aim of the project was to study the development of the "new" public health work, with a particular emphasis on implementation in the municipalities. The main research questions in the project were:

How can municipalities:

- Contribute to reduce social inequalities and level the social gradient?
- Contribute to develop intersectoral responsibility and achieve a Health in all policies approach to public health?

In this paper, we will provide some answers to the research questions. The paper is based on the results from the project, as presented in publications.

Methods

In the SODEMIFA project, a mixed methods approach was applied, and the data sources consisted of surveys as well as qualitative interviews. The following table provides an overview of the studies that were a part of the project, including some of the publications based on those studies.

Table 1. STUDIES AND PUBLICATIONS IN THE SODEMIFA PROJECT

STUDIES	PUBLICATIONS*
Interview study Directorate of Health 2011, Interview with 6 policy-makers	Tallarek, Helgesen & Fosse, 2013 [11]
Survey to municipalities 2011 sent to 430 municipalities and 15 Oslo districts. Response: 360 municipalities and districts (87% response rate)	Tallarek, Helgesen & Fosse, 2013 [11] Hagen, Helgesen, Torp & Fosse, 2015 [19] Fosse and Helgesen, 2015
Qualitative interviews in six municipalities: 6-8 interview in each municipality. Political and administrative leaders and leaders of different sectors or units were interviewed along with public health coordinators	Fosse & Helgesen 2015 [20]
Survey to municipalities 2014 . Response: 304 municipalities and districts (73% response rate)	Hagen, Torp, Helgesen & Fosse 2016 [16] Helgesen, Fosse & Hagen 2017 [23]

*Some of the articles used data from several of the studies

The informants in the interview study at the National level were policy-makers in the Directorate of Health and the Ministry of Health and Care Services who were responsible for supporting the implementation in the municipalities [14].

In the surveys, the main focus was on how the municipalities organised their policies to address health inequalities and Health in all policies. The survey was sent to the chief executive officers in municipalities and urban districts who either answered the survey themselves or passed it on to a relevant employee to answer.

Individual interviews were additionally conducted with policy makers from six municipalities. The municipalities were sampled strategically, and the main inclusion criteria were that municipalities had already started the process of implementing the act . Political and administrative leaders and leaders of different sectors or units were interviewed along with public health coordinators.

In this debate article, the published findings will be the basis for answering the research questions. In the published results, the methodological issues are presented and discussed more extensively. The project received ethical approval from the Norwegian Centre for Research Data. In the following we will present some of the findings from the studies in light of the overall research questions.

Findings

The project followed the municipalities over a period of three years, and in general we found that there was a development over this period. The awareness and knowledge of the content of the Public health act was more known and adapted at the later stage of the project than at the outset.

Reducing social inequalities and levelling the social gradient

In 20111, the National level policy-makers expressed that it was difficult to address social inequalities at the local level; the focus on these issues was a new approach in Norwegian policy. Furthermore, the policy-makers found it challenging to promote the Health in all policies approach, since public health traditionally had been a responsibility for the health sector.

Based on findings in the first survey, it was concluded that most municipalities had a rather narrow understanding of public health [14]. In a paper examining Norwegian National and municipal approaches to reducing social inequalities in health, a divide between national and local priorities were found [11]. The national government had a strong focus on the social determinants of health and the involvement of various political sectors. However, the majority of Norwegian municipalities adhered to individual life-style and health-care related measures.

The Public health act is based on an understanding that the social determinants of health influence the health of the population. Addressing living conditions will thus be important. The 2011 study found that only six per cent of the municipalities had living conditions as a main priority [15] and in 2014, this number had increased to 48 per cent. Nevertheless, still more than half of municipalities did not prioritize such conditions.

An interesting finding from the 2014 survey was that larger municipalities were more likely to define living conditions as a main challenge compared to smaller municipalities [16]. One might assume that ensuring good living conditions is more demanding in larger and more urbanized municipalities than in smaller municipalities. The larger and more urbanized municipalities are more heterogenic and complex , and urbanized locations both attract subgroups of people with lack of resources and are characterized by an internal gap of social inequalities in health.

In the 2014 survey, we also asked if the municipalities believed that health inequalities can be reduced by actions at the local level. A large majority, 82 per cent reported that they believe they are capable of reducing inequalities in health. The qualitative findings indicated that there is raised awareness of the significance of social determinants among an increased number of municipalities and that they are in the process of developing policies specifically to level the social gradient in health.

The interviews further indicated that the municipalities had grasped the message that reducing social inequalities is an important priority in public health. However, very few had an understanding of social inequalities that could be described as a gradient approach. Most respondents agreed that reducing health inequalities was important, but it was mostly described as developing policies and measures aimed at disadvantaged groups [17].

Still, most wanted a combination of universal and targeted measures. The Norwegian welfare state is to a wide extent built on universal measures, and this approach seems to have support in the municipalities. Universal measures, in combination with extra support to vulnerable individuals and groups, seem to be the preferred strategy.

Developing a Health in all policies approach

Collaboration has been stated as the "new imperative" for improving health and well-being and inter-sectoral collaboration is a key tool in Norwegian public health policy [18]. Based on our results, it seems reasonable to believe that municipalities establishing inter-sectoral collaboration will be more able to improve the vital social determinants of health, and hereby improve their citizens' health, in line with the intentions of the Public health act. The surveys showed that the municipalities to a small extent had adopted the principles of the act. Many municipalities still focused mainly on life-style and health-care related measures.

Employing a local public health coordinator has been regarded as an important tool in achieving an increased understanding of the new public health policy. [19]. The Public health coordinators has been identified as an 'inter-sectorial facilitator' whose role is to be a collaborative link between different municipal sectors. However, we found that only 22 per cent of the health coordinators were employed full time. When 78 per cent are employed in part time positions there is reason to believe that a gap exists between intentions and practice. When the public health coordinators are employed in low part-time positions, it may be hard to fulfil the intention of inter-sectorial facilitation in complex municipal organisations.

By employing the coordinator with the chief executive leaders' (CEO) staff or in the staff of the planning agency, the opportunities to actually have a coordinating role increases, and would give the coordinator some authority in the municipal administrative organization [20]. This study indicated that few municipalities had employed public health coordinators in positions where they have an optimal overview of the planning process and decision making, since only 28 per cent were located within the staff of the chief executive officer.

One of the central requirements of the Public health act was that municipalities should develop local health overviews to identify local challenges following from, for instance, health behaviour, environmental or demographic circumstances or living conditions. The overviews and identification of local challenges is regarded as a starting point for systematic

public health work. These overviews should be evidence based and the Norwegian National Institute of Public health has provided so-called health profiles for all municipalities, to be used in the local development of the health overviews (www.fhi.no/hn/helse/). In 2011, 13 per cent had developed an overview of health challenges in their municipality and in 2014 the number was 25 per cent. In 2014 we asked if the overview was used to make priorities between policies. 12 per cent had used it to prioritize in their Action Program and four per cent in their Master Plan. In the Master Plan, local governments outline their long term economic priorities. In other words, there had been an increase in the development of overviews from 2011 to 2014. However, the overviews were only to a small extend used to guide the further steps in the policy process [20].

Establishing intersectoral working groups is vital in developing inter sectoral collaboration. In 2011, 95 per cent of 316 municipalities had established such groups. In 2014 this was reduced to 62 per cent. In spite of this reduction, there was an increase in the reported number of municipal service providing agencies involved in these groups as well as CEO staff and the planning departments [20]. This may be interpreted as step in the direction of achieving intersectoral collaboration and reflects a process where public health is being increasingly integrated into plans and policies.

Municipalities which had started the implementation of the act were included in the qualitative interview studies. Even these studies showed differences between the municipalities. Some municipalities still prioritised individual life style measures, while others were in the process of integrating the policies across sectors [20].

Municipal income is provided through economic transfers, consisting of general grants from the national government, carried out as a formula budget system. No earmarked funds have been allocated to the municipalities for the implementation of the PHA. The municipalities reported that some funding is available to target particular priorities but these are mostly for time limited projects and programs [21].

Discussion

The national government has the main responsibility to oversee that the PHA is being implemented in the municipalities. The main tool to do so is audits of the municipalities' Master plan. Still, the municipalities have a high degree of freedom in how they will implement the policy. [14]. Our findings indicate that the municipalities meet the challenges of the new act differently. Particularly how the expectations that they should contribute to

level the social gradient in health are met seems to vary, and then especially how this problem is being conceptualized.

One point of departure for the project was based on the finding that to be implemented at the local level, the public health policy needs to be anchored at the executive political and administrative level in the municipalities. In the early phase, we observed that few politicians and administrative leaders took part in the process of developing the public health policy. The main actors were the health services, and services they naturally work with, like the social services. After the PHA was adopted, administrative leaders and even planning departments were increasingly involved. This is a natural consequence of the act, since the municipalities are mandated to include public health in their Master plan.

Our findings also indicate that the municipalities had a rather vague understanding of the concept of health inequalities, and even more so, the concept of the social gradient in health. The most common understanding was that policy to reduce social inequalities concerned disadvantaged groups. Accordingly, policies and measures would be directed at these groups, rather than addressing the social gradient

Conclusions: possibilities and limitations

The Norwegian public health policy has attracted attention, since it is one of few countries which have adopted a public health act where the act explicitly addresses the social determinants of health and the social gradient. The act provides opportunities but also limitations for increasing equity in health in the Norwegian context.

It should also be noted, that the social determinants of health include structural measures and addresses tax policies, labour market policies, housing policies etc. These are not strictly local policies and would demand National prioritizations, beyond the jurisdiction of the municipalities. These themes are seldom addressed, neither by the National nor the local level.

To increase the priority of health in all policies approach, there needs to be explicit support – and even political pressure - from the national government [20, 22). Our findings indicate that funding is important to incentivize municipalities to take on the new challenges in public health work. Funding is always a strong incentive to prioritize health, and so far, the funding to the municipalities following the Public Health Act has been scarce. Coordinated action at the national level, also expressed in coordinated funding, may be an important tool to initiate a process in which the municipalities give higher priority to developing a health in all

policies approach to health promotion. In addition, there is also a strong need for capacity building at the local level [23].

An important challenge is of course the question: Will having an act increase priority of the government to reduce social inequalities in health? The answer is yes; so far the act has contributed to a strong focus on social equity [24]. In 2005 there was an open policy window of opportunity for this policy in Norway [25]. However, these policy windows may shut, if political constellations shifts or other issues enter the political agenda [26].

This could also be the final message of the SODEMIFA project: There has been a movement towards an understanding and adoption of the new, comprehensive understanding of public health. To continue this process, both local and National levels must stay committed to the principles of the act.

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