NORWEGIAN POLICIES TO REDUCE SOCIAL INEQUITIES IN HEALTH: DEVELOPMENTS AND CHALLENGES. A QUALITATIVE CASE STUDY

MARIE JOSEFINE GRIMM

Department of Health Promotion and Development
Faculty of Psychology
University of Bergen

Master's thesis submitted in partial fulfilment of the requirements for the degree Master of Philosophy in Health Promotion, University of Bergen

Spring 2012

DECLARATION OF ORIGINALITY

I hereby declare on oath that this thesis is my own work and that, to the best of my knowledge, it contains no material previously published, or substantially overlapping with material submitted for the award of any other degree at any institution, except where due acknowledgement is made in the text.

Marie Josefine Grimm

Bergen, May 8, 2012

"Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together […] to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all […]."

Rio Political Declaration on Social Determinants of Health,

Rio de Janeiro, Brazil, 21 October 2011

ACKNOWLEDGEMENTS

The development of the present thesis was solely possible through the ambitious help and support of several people, whom I would like to thank profoundly.

First and foremost, I would like to express my deepest gratitude to my supervisor Prof. Dr. Elisabeth Fosse, whose professional advice and guidance helped me to develop a deeper understanding of the subject, and whose practical support during the preparation of interviews enabled me to conduct and finish this thesis.

The same applies to Mali Strand, who agreed on being a gatekeeper for the interviews, and who was such a great help in organising the interview sessions. It is a pity I could not thank her personally. The more I would like to express my appreciation here.

Moreover, I want to thank my family and friends, who did a marvellous job motivating and supporting me throughout the time of study, the more so as some of them had to cope with me being far away. My warmest thanks go to Daniel for sticking by me in every situation. I am such a lucky person to know him.

Finally, as this thesis was developed during the master's programme, I would like to thank all lecturers and my fellow-students, who provided critical feedback on the methodologies applied in this study. Let me representatively thank Maurice B. Mittelmark, Marguerite Daniel, J. Hope Corbin, Torill Bull, Annegret Wubs, Amy L. Blaisdell, Ausra Fehlker, Tamila Tsirekidze, Manana Beruchashvili, Milton B. Rugaaza, Nana Peikrishvili and Peter S. Gmatieyindu. The latter students were members of a working group exchanging critical feedback, which I hope strengthened us all.

ABBREVIATIONS

CEHAPE	Children's Environment and Health Action Plan for Europe
CSDH	Commission on Social Determinants of Health
GRADIENT	Tackling the Gradient: Applying Public Health Policies to Effectively Reduce Health Inequalities amongst Families and Children
HIA	Health impact assessment
HiAP	Health in All Policies
SDH	Social determinants of health
SIH	Social inequities in health
WHO	World Health Organisation

TABLE OF CONTENTS

ABSTRACT

Background Although health inequities have increasingly been acknowledged as an urgent public health challenge in all European countries, the health gap still widens, while there remains a lack of knowledge about how to effectively tackle social inequities in health (SIH). Responding to this knowledge gap, the present thesis investigates Norwegian policies to reduce SIH, after that the Norwegian government has put the reduction of SIH on the political agenda in 2005. Through the examination of the Norwegian case and recent vital political developments, such as the adoption of the new *Public health act*, this thesis hopes to contribute to the identification of effective political strategies to reduce SIH.

Objectives This study seeks to a) map Norwegian national upstream and downstream policies to reduce SIH; b) explore how different types of policies work together to protect individuals from falling into poverty and ill-health; and c) to determine expected impacts of the type of policy on the reduction of the social gradient. The objectives are pursued by addressing seven research questions: 1) What policies are in place at the national level to reduce the social gradient? 2) How are upstream and downstream policies combined? 3) How coordinated are these national policies? 4) What are the political values national policies are based on? 5) Which mechanisms of stakeholder involvement and inter-sectoral cooperation can be identified in the process of policy development? 6) What are the strategies of policy implementation at all relevant political levels? 7) The new *Public health act*: what are the perceived potentials, improvements, and challenges for future health promotion in Norway?

Theoretical framework Whitehead's action spectrum forms the basic theoretical framework for this study, helping to identify the degree of political commitment to reduce SIH in Norway. Furthermore, Esping-Andersen's typology of welfare state regimes was used as an overall tool of political analysis.

Methods The research questions were answered by adopting a case study design, combining document content analysis and qualitative one-to-one interviews. Documents were official policy documents, while the interview respondents were staff members of the Norwegian Directorate of Health.

Results and discussion The reduction of SIH has been made an explicit part of the Norwegian political agenda. This task is considered an inter-sectoral and cross-level one, while general, population-based measures are viewed as particularly effective. Comprehensive welfare provisions are understood as the fundament of all health promotion policies aiming at combating SIH. The new *Public health act* is to clarify political responsibilities and to anchor the consideration of SIH at all political levels. Since this study indicates a fragmentary implementation of national priorities in some municipalities, the new *Public health act* forms an important political step towards the consideration of SIH at both local, regional, and national levels.

Conclusions Norwegian national policies are coordinated and comprehensive, and clearly in line with the characteristics of social-democratic welfare regime types. However, further research should investigate as to how this judgement holds true for implementation, coordination and evaluation processes in municipalities and counties, examining the constraints faced at these levels.

1. Introduction and study objective

1.1 Problem statement

During the last years, health inequities have increasingly been acknowledged as an urgent public health challenge in all European countries. Already in 1986, the World Health Organisation (WHO) called for greater equity in health "for all" (First International Conference on Health Promotion, 1986, p. 1). 19 years later, the Bangkok Charter endorsed this endeavour, pointing to the need of improving health equity at both national and global level (Sixth Global Conference on Health Promotion, 2005).

In contrast to these intentions, various studies have shown growing health inequities within and between European countries, revealing socio-economic circumstances as a main cause (Crombie, Irvine, Elliott, & Wallace, 2005; Graham, 2009; Mackenbach, 2006; Whitehead & Dahlgren, 2006b). Each step down the social class ladder is thereby correlated with an increased risk of ill-health, which is known as the 'social gradient' (Graham, 2009; Whitehead & Dahlgren, 2006).

In its recently published Public Health Report, the Norwegian Public Health Institute acknowledges the existence of SIH in Norway, stating that

> *"During the last years, all groups in Norway have become healthier. However, this improvement was much greater for persons with long education and high income […]. It is particularly those with the lowest social status who are behind, while the differences can be observed throughout the entire socio-economic hierarchy. These health inequities apply to children, adolescents, adults, and elder people, and refer to both physical and mental health." (Public Health*

Institute Norway, 2010, p. 59)

With reference to the WHO and Whitehead and Dahlgren, this study considers such *social* inequities in health (SIH) unjust, unfair, socially produced, and therefore modifiable (cf. section 2.1.3).

Although European national governments became aware of SIH during the past years, the health gap still widens, while there remains a lack of knowledge about how to effectively tackle SIH. Responding to this knowledge gap, the research project *Tackling the Gradient: Applying Public Health Policies to Effectively Reduce Health Inequalities amongst Families and Children* (GRADIENT, 2009-2012[1]) was initiated to define effective policy actions to tackle SIH amongst families and children. Work package five[2] of the project compares policies of England, Slovenia, Sweden, and the Netherlands, and aims to identify the impact of different welfare state regimes on political approaches to reduce SIH (GRADIENT, 2011b).

The Norwegian case is not considered in the research project. However, the Norwegian government has put the reduction of SIH on the political agenda since 2005, resulting in national action plans and reports on the socio-economic causes of health inequities (Directorate of Health and Social Affairs Norway, 2005a, 2005b; Directorate of Health Norway, 2005; Fosse & Strand, 2010). The study of Norwegian policies can thus be of major interest for the definition of effective

[1] The GRADIENT project (www.health-gradient.eu) was coordinated by EuroHealthNet, and has received funding from the European Community (FP7 2007-2013) under grant agreement no. 223252

[2] Other work packages are: WP 1 „Coordination of the Research Consortium and Project Management“; WP 2 „Development of an EU Gradient Evaluation Framework to assess policy effectiveness“; WP 3 „Differential impact of public health policies among children and families from various socio-economic groups“; WP 4 „Identification of protective factors for the health of children and families, and the role of social capital“; WP 6 „Policy recommendations and dissemination of the findings at European, national, regional and local level“ (GRADIENT, 2011a)

policies to reduce SIH, the more so as Norway is classified as a social democratic welfare state regime with a strong emphasis on social equality (Esping-Andersen, 1990). Lundberg and colleagues emphasise the world-wide relevance of Nordic experiences, arguing that

> *"It is the social achievements of the Nordic model that have tended to interest politicians and scientists. The Nordic countries are often found among the world's leading nations in terms of economic and social performance […]. While economic performance, social development and fair play are important aspects of a good society in their own right, they are also important components of macro-level social determinants of health." (Lundberg, Yngwe, Stjärne, Björk, & Fritzell, 2008, p. 7)*

Strand et al. agree that "the basis for including health inequity in the political agenda is in place" in Norway (Strand, Brown, Torgersen, & Giæver, 2009, p. 12). Nevertheless, they acknowledge the existence of systematic inequities, and claim further political strategies (ibid. p. iv).

With reference to Lundberg et al., this study aims to explore Norwegian policies tackling SIH. It thus seeks to contribute to the investigation of effective political measures to reduce the social gradient in European countries.

1.2 Study purpose

Responding to the knowledge gap outlined above, this qualitative case study aims to contribute to the investigation and identification of effective political measures to reduce SIH in European countries. It focuses on Norwegian policies, taking into

account recent political developments, such as the adoption of the new *Public health act* in 2011. It further seeks to shed light on policy implementation processes and related challenges identified by national experts in the field.

This approach is followed by combining document content analysis and qualitative one-to-one interviews with administrative staff members representing Norwegian policies. The interview data are thus presented in the context of existing Norwegian policy documents dealing with the topic.

As reflected in the following section, the study will thereby take different types of policies and political values into account.

1.3 Objectives and research questions

The objectives of the present study are threefold and, to a large extent, based on the GRADIENT project outlined above. This study similarly seeks to a) map Norwegian national upstream and downstream policies (cf. section 2.1.7) to reduce SIH; b) to explore how different types of policies work together to protect individuals from falling into poverty and ill-health; and c) to determine expected impacts of the type of policy on the reduction of the social gradient .

The objectives are pursued by addressing seven research questions:

1) What policies are in place at the national level to reduce the social gradient?
2) How are upstream and downstream policies combined?
3) How coordinated are these national policies?
4) What are the political values national policies are based on?
5) Which mechanisms of stakeholder involvement and inter-sectoral cooperation can be identified in the process of policy development?

6) What are the strategies of policy implementation at all relevant political levels?
7) The new *Public health act*: what are the perceived potentials, improvements, and challenges for future health promotion in Norway?

As outlined above, the research questions will be answered by combining document content analysis and one-to-one interviews.

1.4 Significance and contribution of the study

During the past years, several studies have been carried out on SIH in the European region. Chapter two introduces vital literature in the field of study, which invariably suggests political action to reduce SIH through influencing the social determinants of health (Commission on Social Determinants of Health, 2008; Dahlgren & Whitehead, 1991a; Hurrelmann, 2003; Regional Office for Europe of the World Health Organisation, 2003). Nevertheless, it is shown that there still remains a lack of knowledge of *which* political actions are effective to tackle the social gradient (GRADIENT, 2009; Graham, 2009).

This thesis follows up on previous studies investigating Norwegian policies, while it particularly considers recent political developments, such as governmental White papers, the adoption of the new *Public health act*, and latest reports on health promoting policies in Norway. Beyond the identification of these policies, it sheds light on improvements and challenges of health promoting policies in Norway, taking into account the necessity of implementation processes and cooperation at different administrative levels.

By adopting these approaches, the study contributes to the identification of

effective political measures in the European region. Further, it can provide helpful information about political implementation processes and values influencing the nature of adopted policies. While this information may benefit both national politicians and citizens in the European region, the identified challenges of policy implementation processes may be of particular interest for Norwegian politicians.

2. Scientific background of the study

2.1 Literature review

This chapter sheds light on scientific literature about the key concepts and objectives of this study. After highlighting research on the concepts of social determinants of health, Health in All policies, and the social gradient, the section continues with investigating literature about Norwegian policies to reduce SIH. Finally, the role of politics, the welfare state and political strategies to reduce SIH are discussed.

2.1.1 Social determinants of health (SDH) and Health in All Policies (HiAP)

The study of national policies to reduce SIH requires a concept of which policies and policy sectors are relevant in this context. The model of main determinants of health, introduced by Dahlgren and Whitehead in 1991 (fig. 1), indicates that health is influenced by a variety of factors and life circumstances. They outline different types of health determinants, distinguishing biological factors, individual lifestyle factors, social and community related factors, living and working conditions, and general socio-economic, cultural, and environmental factors. While biological factors refer to the individual age, sex, and hereditary factors, personal behaviour and lifestyles include knowledge, individual skills, beliefs, and coping abilities. Social and community networks influence health through the degree of support and integration, whereas living and working conditions include aspects of the work environment, agriculture and food production, education, unemployment, housing conditions, and access to facilities and services. Finally, general socio-economic, cultural, and environmental factors refer to standards of living, cultural and

ecological aspects, and the labour market.

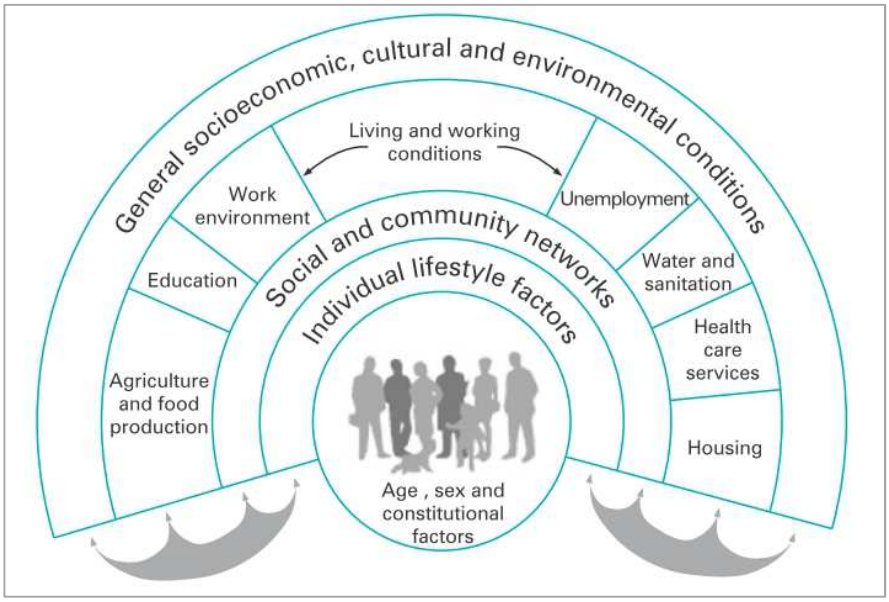

Fig. 1: The main determinants of health (Dahlgren & Whitehead, 1991b, p. 11)

There is common agreement that socio-economic determinants have a major influence on health, while other determinants can either hardly be influenced, such as specific biological determinants, or have less impact on health than others, such as health care-related determinants (Commission on Social Determinants of Health, 2008; Mielck, 2008; Regional Office for Europe of the World Health Organisation, 2003; Whitehead & Dahlgren, 2006; World Health Organisation, 2010). Due to the relevance of social factors for health, the Commission of Social Determinants of Health (CSDH), established by the World Health Organisation (WHO) in 2005, calls such determinants “the causes of the causes” (Commission on Social Determinants of Health, 2008, p. 42).

As a consequence of this holistic view on health, all policy sectors representing these social determinants are responsible for the promotion of health, which is called the Health in All Policies approach (HiAP). The Finnish Ministry of Social Affairs and Health describes the approach as follows:

> *"Health in All Policies addresses the effects on health across all policies such as agriculture, education, the environment, fiscal policies, housing, and transport [...]. Thus HiAP is not confined to the health sector and to the public health community, but is a complementary strategy with a high potential towards improving a population's health, with health determinants as the bridge between policies and health outcomes." (Ministry of Social Affairs and Health Finland, 2006, p. xviii)*

Dahlgren's and Whitehead's model and the resulting concept of HiAP have been widely used in both studies and reports, and are represented in the work of the WHO (Regional Office for Europe of the World Health Organisation, 2003; Whitehead & Dahlgren, 2006). The researchers Graham, Fosse and Strand (Fosse & Strand, 2010; Fosse, 2011; Graham, 2004) include a variety of policy sectors in their analyses of health promoting policies. Vital international reports building on the same concepts are

- *Health in all policies. Prospects and potentials* by the European Observatory on Health Systems and Policies (Ministry of Social Affairs and Health Finland, 2006),
- *Concepts and principles for tackling social inequities in health: Levelling up part 1* and *European strategies for tackling social inequities in health: Levelling up part 2* (Whitehead & Dahlgren, 2006b, 2006),
- *Health inequalities: Europe in profile* (Mackenbach, 2006),
- *Strategies to reduce socio-economic inequalities in health in Europe: lessons from the Eurothine project* (Mackenbach, Judge, Navarro, & Kunst, 2007), and

- the final report of the CSDH *Closing the gap in a generation. Health equity through action on the social determinants of health* (Commission on Social Determinants of Health, 2008).

At the national level, the Norwegian Government has shown awareness of both social determinants of health and the importance of HiAP, which is reflected in national action plans and reports such as *Principles of action to tackle social inequality in health* (Directorate of Health Norway, 2005), *The challenge of the gradient. The Norwegian Directorate for Health and Social Affairs' plan of action to reduce social inequalities in health* (Directorate of Health and Social Affairs Norway, 2005b), and *Social inequalities in health. A review* (Directorate of Health and Social Affairs Norway, 2005a).

Due to the holistic approach of HiAP, this study will consider all political sectors beyond the health-care sector to investigate Norwegian policies to reduce SIH. Beyond this, it will investigate to which extent different sectors have collaborated to develop multi-sectional strategies, and if and how these efforts have been coordinated.

2.1.2 Distinction between health inequalities and health inequities

Generally, a distinction is drawn between the terms "health inequality" and "health inequity". While "health inequality" refers to any kind of differences and variation in the health outcome of individuals or groups, "health inequity" refers to those inequalities in health that are unacceptable, unfair, systematically produced, and unjust (EuroHealthNet & Federal Centre for Health Education Germany, 2006; Whitehead, 1991; Whitehead & Dahlgren, 2006). Nevertheless, the terms are often used inconsistently, since some languages merely provide a single

word for both meanings (Whitehead & Dahlgren, 2006). With reference to the definitions given above, the present master thesis makes use of the term “health inequities”, while divergent terms are respected in direct quotations.

2.1.3 The origin of social inequities in health

Whitehead and Dahlgren outline the difference between health inequalities and *social* inequities in health, explaining that

> *“Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are systematic, socially produced (and therefore modifiable) and unfair.” (Whitehead & Dahlgren, 2006, p. 2).*

Mielck sheds further light on the systematic and social aspect of health inequities, differentiating influencing factors on the individual health behaviour and health status. These include social and material resources, differences in health threat, the environment, and differences in benefits from the health sector. While these factors shape the health status, it important to acknowledge the mutual influence of social status and health inequity (fig. 2).

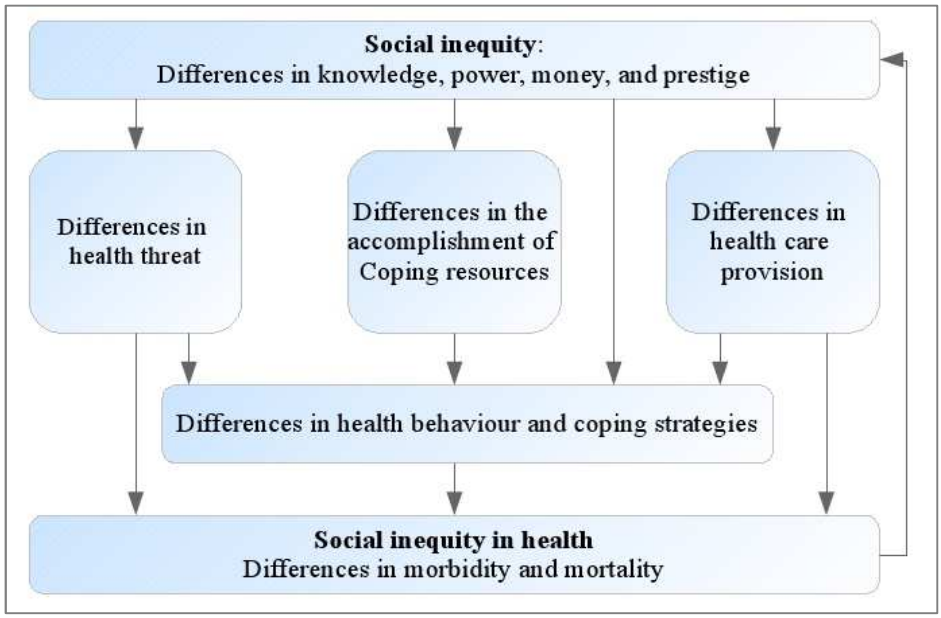

Fig. 2: Explanatory- and intervention model on social inequities in health. (based on Mielck, 2000, p. 173)

In its Public Health Report 2010, the Norwegian Institute for Public Health defines similar factors contributing to SIH, stressing the interdependency of the factors presented in figure 2 (Public Health Institute Norway, 2010).

Building on the prior discussion of health determinants, Mielck's model particularly outlines factors involved in the origin of *social* inequities in health. In doing so, it provides a basis for the analysis of Norwegian policies to reduce SIH, moving the focus to policies on education, labour, social affairs, and regional development.

2.1.4 The social gradient

Social inequities in health form a social gradient throughout European societies (Graham, 2004, 2009; Marmot, 2007). The WHO summarises:

"Poor social and economic circumstances affect health throughout life. People further down the social ladder usually run at least twice the risk of serious illness

> *and premature death as those near the top. Nor are the effects confined to the poor: the social gradient in health runs right across society, so that even among middle-class office workers, lower ranking staff suffer much more disease and early death than higher ranking staff" (World Health Organisation Regional Office for Europe, 2003, p. 10)*

Several researchers have argued for and applied the gradient perspective in their studies. In its final report, the CSDH recommends several actions to reduce the social gradient in health (Commission on Social Determinants of Health, 2008). On behalf of the same commission, Marmot outlines the existence of a social gradient from a global perspective (Marmot, 2007). Lundberg and colleagues demonstrate the gradient for Scandinavian countries (Lundberg et al., 2008). While Dahl (Dahl, 2002), Fosse, and Strand (Fosse & Strand, 2010) consider the social gradient in their analysis of Norwegian policies to reduce SIH, Graham (Graham, 2009) focuses on British developments during the last decades.

Similar to the concepts of SDH and HiAP, the perspective of the social gradient is widely accepted and adopted in both national and international studies and reports. At the Norwegian national level, this is reflected by action plans such as *The challenge of the gradient. The Norwegian Directorate for Health and Social Affairs' plan of action to reduce social inequalities in health* (Directorate of Health and Social Affairs Norway, 2005b).

However, the mere knowledge of the social gradient does not necessarily indicate a political awareness of the problem, the political will to reduce that gradient, or a deeper knowledge about which policies are effective to reduce it. With regard to the first two aspects, this study seeks to identify Norwegian values and strategies to tackle the problem. A comparison of this study with those investigating

other countries can answer the latter question.

2.1.5 Social inequities in health in Norway and Norwegian policies to reduce these

As for all European countries (Graham, 2004, 2009; Marmot, 2007), social inequities in health are documented in Norway for the past forty years. Recent studies revealed significant differences in mortality among socio-economic classes, concluding that it was groups with higher education and income who benefitted most from the recent decrease of the mortality rate (Public Health Institute Norway, 2007; Strand et al., 2010). In their study on educational inequalities in mortality in Norway, Strand and colleagues explain:

> *"All educational groups showed a decline in mortality. Nevertheless, and despite the fact that the Norwegian welfare model is based on an egalitarian ideology, educational inequalities in mortality among middle aged people in Norway are substantial and increased during 1960-2000." (Strand et al., 2010, p. 1)*

Besides educational differences, the Norwegian Ministry of Health points out to the correlation between social inequities and place of residence. According to the ministry, in Oslo there are "differences in average life expectancy between different urban districts [...] up to 12 years or more among men" (Ministry of Health and Care Services Norway, 2006, p. 8).

For this reason, Norwegian public health policies have been in the focus of Scandinavian researchers during the last decade. While Dahl analyses the consideration of SIH in Norwegian public health policies in 2002 (Dahl, 2002), Fosse and Strand investigate the development of Norwegian policies tackling the problem in 2010 (Fosse & Strand, 2010). Additionally, Fosse puts this topic into the

context of welfare state regimes and political traditions (Fosse, 2009). As part of the WHO's studies on social and economic determinants of population health, Strand, Brown, Torgerson and Giæver analyse political approaches to reduce health inequity in Norway (Strand et al., 2009). Finally, Lundberg, Yngwe, Stjärne, Björk and Fritzell compare the Nordic welfare states with regard to their political characteristics and their impact on population health (Lundberg et al., 2008).

The mentioned studies are considered most relevant, as they reveal the development of Norwegian policies to reduce SIH over time. However, as shown above, health data indicate that SIH are still increasing. Further research is needed to investigate political strategies more in-depth, and to reveal the challenges and constraints faced during policy development and implementation processes at all administrative levels. Before this background, the present thesis follows up on earlier studies by investigating recent political developments and exploring improvements and challenges perceived by the different interview participants. Thereby, this study considers the importance of political values influencing policies, which is discussed in the following paragraph.

2.1.6 Politics behind policies and the role of the welfare state

In 2001, Navarro and Shi studied the political context of social inequities in health (Navarro & Shi, 2001), revealing a link between political traditions and the level of health inequalities in 29 OECD countries between 1945 and 1980. They conclude that politics clearly influence national policies, and that, in contrast to Christian democratic and liberal parties, countries with a tradition for social democratic and redistributive policies do better in reducing social inequities in health.

The clustering of countries into types of welfare state regimes, as done by

Navarro and Shi, is a widely used approach in social sciences to study the link between politics, policies and health outcomes. Bambra provides an overview over different clusters applied until 2005 (Bambra, 2007). A particularly influential comparative study is Esping-Andersen's *Three worlds of welfare capitalism* (Esping-Andersen, 1990), in which he analyses 18 OECD countries in terms of their social policy systems and contributions to social solidarity. He concludes by identifying three main regime types, which are the liberal, conservative, and social democratic regime. Norway thereby represents the latter type, which is assumed to have the strongest emphasis on social solidarity. Section 2.2.1 discusses Esping-Andersen's theory more thoroughly and outlines the extent to which his typology forms the theoretical framework of this study.

2.1.7 Comprehensive polices: upstream and downstream measures

Previous research has shown that there are different types of political approaches to tackle SIH. Whitehead and Dahlgren summarise three approaches, distinguishing the focus on people in poverty ("downstream" or targeted policies), narrowing the health divide, and the reduction of SIH among the whole population ("upstream" or universal policies) (Whitehead & Dahlgren, 2006). Thus, upstream policies typically target at wider parts of a population, while downstream policies aim at smaller parts of a population, such as specific vulnerable and marginalised groups. Whitehead and Dahlgren notice that these approaches are interdependent to one another. Hence, these types of policies should build on one another and consider the social gradient as a phenomenon throughout the entire population (ibid.). Marmot supports the latter argument, pointing out that "we are all in need - all of us beneath the very best-off" (Marmot et al., 2010, p. 16). He further introduces the principle of proportionate

universalism, arguing that

> *"To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem." (Marmot et al., 2010, p. 16)*

Mackenbach and colleagues agree in that all of these policy types are required (Mackenbach et al., 2007). Thereby, the types of adopted policies are highly influenced by the type of welfare state regime and, thus, by political values and orientations (Esping-Andersen, 1990; Fosse, 2009). While social democratic welfare state regimes are characterised by an emphasis on upstream measures, liberal regimes tend to focus on market forces and individual responsibility for individual social conditions.

Before the political discussion of different strategies, however, it has to be considered that political values affect *if* and *how* problems will be put on the political agenda. Hence, this study will identify types of political measures in the context of political values.

2.2 Theoretical framework

2.2.1 Esping-Andersen's welfare state regime typology

As outlined above, the development of welfare state typologies is a widely used tool in social and political science. A particular ground-breaking typology was Esping-Andersen's *Three worlds of welfare capitalism* in 1990. According to Esping-

Andersen (Esping-Andersen, 1990), welfare state regimes can be clustered into three main regime types, which are the liberal, conservative, and social democratic regimes.

Liberal regimes are thereby characterised by the general intention to stimulate market forces through a reduction of welfare state interventions and regulations. Hence, welfare is seen as a commodity (Bull, 2011, p. 49). Due to an emphasis on individual responsibility for social integration and health, state provisions of welfare are means-tested and often follow strict entitlement criteria. Moreover, social insurance regulations are rather modest. Countries representing this type of welfare state regime are Australia, Canada, Ireland, New Zealand, the United Kingdom, and the United States of America (Bambra, 2007; Esping-Andersen, 1990; Fosse, 2011).

Conservative (also: corporatist or traditional) welfare state regimes are distinguished by their value of traditional family structures including single providers, which are traditionally male bread-winners. As a consequence, social security is not commodified, but rather regarded as the responsibility of families. While social security systems are considered as vital, welfare benefits are earnings-related and thus “status differentiating” (Bambra, 2007, p. 1098). In general, the redistributive impact can be regarded as minor. Countries representing conservative welfare state regimes are Austria, Finland, France, Germany, Italy, and Switzerland (Bambra, 2007; Esping-Andersen, 1990; Fosse, 2011).

Finally, social democratic welfare regimes are built on the concepts of solidarity and universalism, with the aim to promote full employment and income protection for both men and women. A high productivity, which is to be ensured through the involvement of both sexes in the labour market, thereby forms a

prerequisite for this rather extensive welfare system. Welfare policies are mainly understood as universal benefits and the promotion of equality through redistributive policies. As a consequence, state interventions and regulations are more common than in other welfare state regime types. Examples for such policies are progressive tax systems, the state's responsibility for childcare, and the encouragement of all women to participate in the labour market. Bull concludes with that “the social-democratic regime goes further than any other class of regime in liberating welfare delivery from the market (de-commodification) and the family (de-familialization)” (Bull, 2011, p. 50). Social democratic welfare states are first and foremost the Nordic countries (Bambra, 2007; Esping-Andersen, 1990; Fosse, 2011).

Despite the influence of Esping-Andersen's study in 1990, it has been criticised for several reasons. While some authors added welfare regime types, such as the Confucian, Southern (Bambra, 2007), Ex-fascist (Navarro & Shi, 2001), and Wage earner (Chung & Muntaner, 2007) welfare state regimes, other authors debated whether such typologies may capture all characteristics of states included in one “idealised” category (Bambra, 2007).

For the present study, however, it should be noted that there is common agreement among all authors that Norway represents the social democratic welfare state regime with a strong emphasis on equality and universal, redistributive policies. Furthermore, this thesis seeks to use Esping-Andersen’s classification as a rather overall tool of analysis and primarily focuses on empirical results rather than detailed pre-defined characteristics. Hence, this study aims at revealing political characteristics, strategies, and values both corresponding and contradicting Esping-Andersen's typology.

Finally, it must be stressed that Esping-Andersen’s work was already

published in 1990. Due to previous developments in the Norwegian Government and public policy during the last decades, this study seeks to compare present public health policies with the characteristics defined above.

2.2.2 Whitehead's action spectrum

In 1998, Whitehead introduced an "action spectrum", which reflects different degrees of political efforts and commitments to reduce social inequities in health (Whitehead, 1998, cf. fig. 3). While one end of the spectrum represents countries that merely measure health inequities among their populations, the other end represents countries with coordinated national strategies to tackle the problem. As indicators for the official commitment to policy development, Whitehead suggests national action plans, research programmes, information- and monitoring systems, government reports, and parliamentary statements.

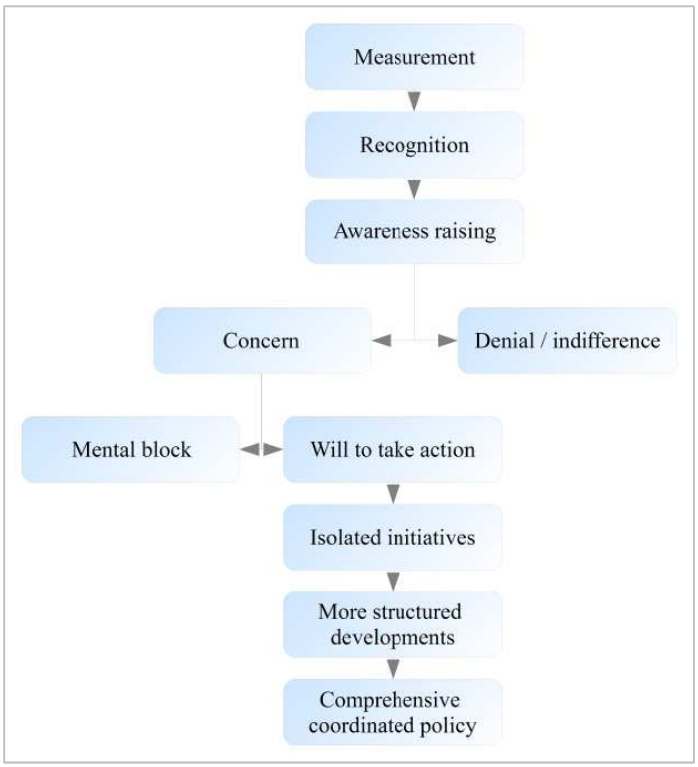

Fig. 3 The action spectrum (Whitehead, 1998, p. 471)

Using the action spectrum for an analysis of Norwegian policies, Dahl classified these as “somewhere in the area around “measurement”, “awareness raising”, and “indifference”” in 2002 (Dahl, 2002, p. 72).

Eight years later, however, Fosse concluded that

> *“There are some similarities between England and Norway, in both countries there is a focus on the broader determinants of health and the overall aim is to reduce social inequalities in health. There also seems to be a strong political commitment in both countries, in the sense that policy documents are followed by action plans with concrete targets, deadlines and responsibilities. In both countries, there is recognition that health promotion demands inter-sector collaboration between national governmental bodies, between different administrative levels of government and with actors outside government.” (Fosse, 2011, pp. 266-267)*

Fosse’s assessment is interesting in that it reflects the increased political will to put the reduction of SIH on the political agenda after 2005.

While the present thesis aims at validating Fosse’s assessment before the background of latest political developments, it additionally investigates the extent, recent improvements, and challenges of policy development and implementation processes. This approach is based on the awareness that the recognition of the demand of inter-sector collaboration and cross-level implementation might be an endeavour met by constrains and challenges, which need to be identified to allow for further improvement.

3. Research methodology

3.1 Study design and research methods

The research questions were answered by adopting a case study design, which combines document content analysis and qualitative one-to-one interviews. Documents were official policy documents, while the interview respondents were staff members of the Norwegian Directorate of Health.

3.2 Sampling procedure and methods of data collection

The document analysis included national policy documents, particularly Government White Papers, reports, and national action plans. These documents were treated as a data source in their own right, since they can be considered as authoritative, credible, and representative for governmental policies and political perspectives on certain phenomena (Denscombe, 2007, p. 232). Since the reduction of SIH requires the contribution of several political sectors beyond the health-care sector (Commission on Social Determinants of Health, 2008; Dahlgren & Whitehead, 1991a; Whitehead & Dahlgren, 2006b, 2006), the investigated documents represent policies of the labour market, cash benefits, childcare, education, cultural participation, sports and recreation, access to decent housing and safe neighbourhoods, health care, and social services. All documents were found via the Internet, using the database HP-Source.net and websites of national institutions, ministries, and the Norwegian government. Since the author speaks Norwegian, documents in English were not necessary, but considered when available.

Inclusion criteria for documents were therefore:

- national policy documents explicitly and implicitly aiming at the

reduction of SIH

- online publication of documents until October 2011
- Norwegian and/or English language.

Key words for data collection included social equity/inequities/inequalities in health, health equity/inequity/inequality, social/health gradient, well-being, social exclusion/disadvantage, social inclusion/protection/integration, and poverty. Documents without these key words were excluded.

The document analysis was complemented by semi-structured one-to-one interviews with purposefully selected administrative staff members representing national policies to reduce SIH in Norway. Hence, the interviews were conducted with six staff members of the Norwegian Directorate of Health.

The Norwegian Directorate of Health is a national institution subordinated to the National Ministry of Health and Care Services. It forms a professional body contributing to policy development and the implementation of national health policies. Furthermore, it functions as an advisory body to authorities and organisations at all political levels (Strand et al., 2009). For this reason, all interview participants were regarded as experts in the field of study, being able to provide relevant knowledge on Norwegian policies to reduce SIH, horizontal (inter-sectoral) and vertical (cross-level) cooperation, and the processes of planning, implementation and evaluation of policies. To promote a trustful, open and comfortable atmosphere for the respondents, interviews were conducted individually rather than in focus groups.

Earlier studies on Norwegian policies (Fosse, 2009; Fosse & Strand, 2010;

Strand & Fosse, 2011) facilitated the identification of relevant respondents. Through the help of a gatekeeper, potential interviewees received both basic information about the study and the informed consent form.

The participants were interviewed after the document analysis and the individual agreement of respondents. All interviews were held in Norwegian to be recorded, transcribed, analysed, and translated into English. Additionally, notes were taken during the interviews, which allowed for the consideration of observations and impressions that could not be audio-recorded. The interview guide was developed before and during the document analysis[3].

3.3 Data management

The analysis of both documents and interview transcripts was done manually by using office software. Notes that were taken during the interviews were considered separately. To ensure confidentiality of interview respondents, though, interview records will be destroyed latest one year after the analysis.

3.4 Data analysis and interpretation

The analysis and interpretation of policy documents and interview transcripts was done by following Creswell's model of data analysis in qualitative research, including the reading of all data, coding, identifying themes and their interrelations, and finally interpreting the meaning of these themes (fig. 4). The interpretation was thus be done through coding and categorising these, covering opinions, particular expressions and explanations, types of action, and implied meanings (Denscombe, 2007, p. 294).

[3] An English version of the interview guide can be found attached to this thesis.

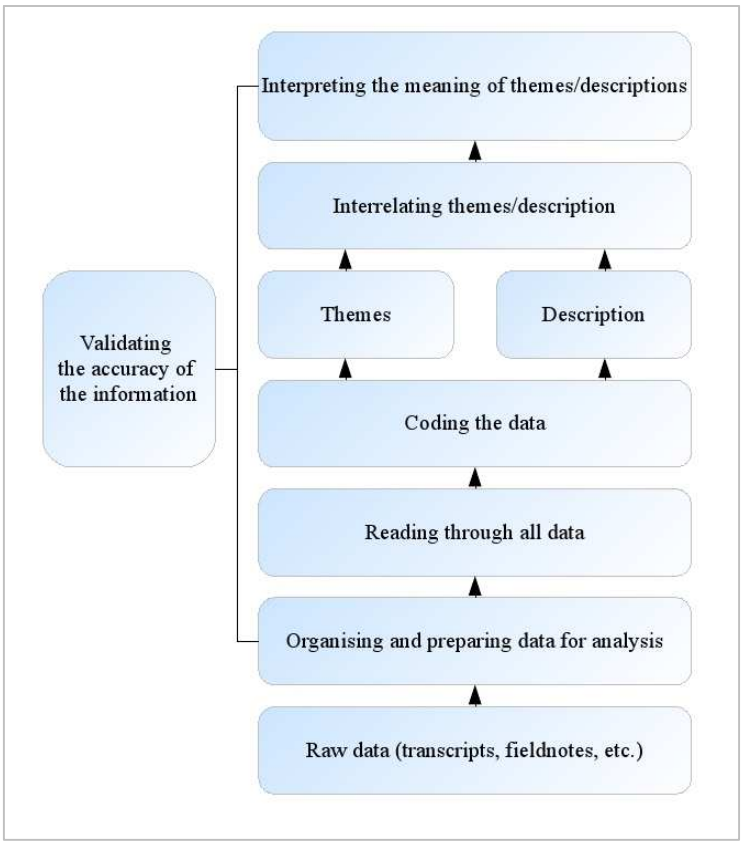

Fig. 4: Data analysis in qualitative research (Creswell, 2009, p. 185)

Both data types were analysed with regard to the research questions established above. The analysis was thus conducted by thematic content analysis, revealing

- types of policies (upstream/downstream),
- political and social priorities portrayed through the text,
- awareness of the social gradient,
- inter-sectoral collaboration,
- cross-level cooperation,
- perceived responsible actors,
- political and social values conveyed in the text,
- identified challenges, and
- relations between portrayed ideas (based on Denscombe, 2007, p. 238).

To some extent, findings of the analyses could be tested through triangulation of data. In addition, it was hoped that respondents could provide further information about processes of, particularly, cross-level communication, the implementation of national strategies at different political levels, and the new *Public health act* to be introduced in January 2012 (Norwegian Government, 2011).

The impact of the welfare state regime and its shared values was interpreted by identifying relationships between corresponding codes. As an example, the expressed emphasis on equality, which is one characteristic of social democratic welfare state regimes, was compared to the actual awareness of the social gradient and expressed political priorities.

3.5 Role of the researcher

As outlined by several researchers, all qualitative analysis is, to some extent, influenced by the researcher. This section critically reflects on the issues of subjectivity and objectivity of this study by identifying possible bias, values, and influencing effects caused by the chosen research approach.

3.5.1 The 'interview effect' and the role of power-imbalances

A potential challenge of qualitative studies may arise from the fact that analysed data were produced for a different purpose than the conducted research. In this study, though, the political documents were purposely produced for the public and their thorough investigation. In terms of interview data, all respondents were political experts of the research topic, being informed in advance about the field of study. On the one hand, these initial points may have strengthened validity, since data were

produced for the same purpose as the study. On the other hand, the interview situation might have influenced respondent's accounts. In this study, the participation in the interview was part of the respondent's occupational duties and tasks, which may have caused the participants' behaviour to represent their workplace in the best way, to be afraid of giving 'wrong' answers, or to feel obligated to participate without any personal interested in the study.

A second aspect possibly influencing interview accounts is a power-imbalance between the researcher and interview respondents, which may arise in situations interviewing people that are relatively more powerful than the researcher, among others. These situations are referred to as “elite interviewing” (Green & Thorogood, 2009, p. 108). In the course of the present study, however, it can be stated that no such power-imbalances were experienced and that interviews were a source of important in-depth data. It is possible that this research might have benefitted from the respondent's earlier contacts with the University of Bergen.

3.5.2 Objectivity and subjectivity of the present study

These reflections, following a critical approach to research (Green & Thorogood, 2009, p. 18), show that research is understood as a social process itself. This includes both interview situations and the process of document investigation, since both data are produced in certain social contexts. The importance, credibility, and transferability of this study, though, arise from the analysis of Norwegian policies in their social context, by using a structured approach of inquiry, by critically reflecting on contradictory data and explanations, and through regular team supervision with the supervisor.

3.6 Ethical considerations

Since this case study was conducted in Norway, it sought to follow the ethical guidelines of the Norwegian National Committee for Research Ethics in the Social Sciences and the Humanities (National Committee for Research Ethics in the Social Sciences and the Humanities Norway, 2006). The implementation of this study required the prior ethical approval by the Norwegian Social Science Data Services. Beyond these prerequisites, the study required voluntary consent from all interview respondents and their represented workplaces.

With regard to research quality, the following sections highlight how the validity, reliability, and transparency of this study were promoted. Adding to these, this section briefly describes the efforts made in meeting further ethical requirements.

As one of the most important ethical principles, all interview respondents participated voluntarily, and were protected from potential harm by remaining anonymous to the public. Details directly allowing an identification of participants, such as names or sex, were and will be deleted in any publication of the study. Too obvious position details of respondents were replaced by wider occupational descriptions, such as the name of directorate. While these changes allow for respondents' anonymity to the public, it is likely that close colleagues may still be able to identify certain participants. This possibility results from the limited number of professionals working in the area of health promoting policies in the Directorate of Health.

All interview records were stored in a locked private place and exclusively accessed by the researcher. The original records and all existing copies will be

destroyed latest one year after interview conduction. This time span allows additional checks of correct transcriptions and interpretations, and the publication of an article after the writing up of this study.

Second, all participants were fully informed about the purpose, methods, and use of the study before conduction of interviews. They had the explicit right to refuse interview answers or withdraw from the data collection process at any time.

Third, the correct understanding of interview accounts was ensured through response checking during interviews. To guarantee a correct representation of interview statements, further, the participants received the result chapter before publication to check if statements are presented as intended.

All efforts of participant protection outlined above were summarised in an informed consent form, which was sent to all respondents in advance. The prior sending of the form was to ensure that it was read thoroughly and without external interference. For ethical clarity, participants were asked to read and sign the form at the beginning of interview meetings.

Further practical information included in the informed consent form concerned the planned length of the interview and contact persons at the University of Bergen.

3.7 Validity

As outlined by several authors, qualitative validity refers to the accuracy of findings and “truth” of interpretations (Creswell, 2009; Denscombe, 2007; Green & Thorogood, 2009). According to Denscombe, qualitative validity of documents can be measured by four basic criteria, being authenticity, credibility, representativeness, and meaning (Denscombe, 2007, p. 232). Since this study used national policy documents downloaded from official websites and databases, it can be assumed that

all documents are genuine and what they purport to be, namely expressions of government policies and values. Therefore, the authenticity and credibility of the documents is high. In addition, the chosen documents were typical data of its kind in Norway, and are thus representative (Denscombe, 2007, p. 232). Finally, “meaning” refers to the interpretation of hidden meanings (ibid.). Although the present document analysis particularly concentrated on contents, it was done with particular consideration of this aspect. The use of the internet as a main searching tool for documents was not expected to be a limitation to the validity of the study, since Norwegian political documents are typically available online.

The validity of interviews is strongly connected to the credibility of respondents’ accounts (ibid., p. 200). This study ensured credibility through interviewing participants being political experts in the field of study. Further, member checking of interpretations and response validation (reformulation of statements to check the interviewee's agreement) ensured appropriate interpretations. Additionally, the credibility of respondents’ accounts could be, to some extent, checked through a comparison with other interviewee's accounts and with findings of the document analysis (triangulation of data). Yet, differing interviewee's responses do not necessarily indicate “false” accounts, but require a thorough reflection of the individual experience, meaning, and context. The validity of interview data was strengthened through thick descriptions, the identification of discrepant findings, and the clarification of possible bias and the role of the researcher.

However, the study had to deal with specific threats of validity. As several authors highlight (Creswell, 2009; Denscombe, 2007), the issue of language is of basic importance for the interpretation of data. In this study, documents were read in both

Norwegian and English, while interviews were held in Norwegian. For the researcher, this required good foreign language skills[4]. Although the researcher has been living in Norway and communicating in both languages for several years, she was aware of this possible threat to the validity of the study.

Moreover, the use of political documents is limited, as they state "what a government intends to do, and can be accused of presenting wishes and vague plans rather than solid results" (Fosse, 2011, p. 262). Nevertheless, it has to be emphasised that they form a credible data source for this study, revealing political values, conceptions of social inequities in health, and intentions to tackle these.

3.8 Reliability

Reliability relates to the repeatability of interpretation (Creswell, 2009; Green & Thorogood, 2009). This criterion was ensured by a clear documentation of selection criteria for documents and respondents, such as key words, appropriate document sources, and inclusion criteria of interviewees. Further, all data were documented, including field notes and interview transcriptions. To ensure confidentiality of interview respondents, though, interview records will be destroyed on year after the analysis. A second approach to promote the reliability of the study was the discussion of codes with colleagues, and to use these in a consistent manner. Within the capabilities of the present thesis, interpretations were explained and supported by thick descriptions. Translations from Norwegian to English were marked as such, and were done with special awareness of cultural and contextual meanings.

[4] The author is German.

3.9 Transferability

Since this case study is an in-depth analysis of Norwegian policies, the study findings are not necessarily valid for other political and cultural contexts. Yet, the study is transferable, as its findings contribute to the development of public policy recommendations. Building on earlier policy research in this area (Fosse, 2009; Fosse & Strand, 2010; Strand & Fosse, 2011), this study can provide helpful data in terms of effective measures and the implications of the social democratic welfare state regime to reduce SIH. The value of the present study thus lies in the political contextualisation of SIH and its implications for further practice and research. In terms of conceptual transferability, the active consideration of cross-level implementation challenges and their solutions may be adopted in further studies in and beyond the European region.

3.10 Methodological limitations of the study

As this study is a master thesis, it is subject to several methodological limitations. A first limitation refers to the number and professional background of interview respondents. The inclusion of a greater number of interviewees from a variety of political sectors might have promoted a richer set of data. However, six participants, who are regarded as experts in the field, were expected to provide vital information about the research topic. Despite the initial intention of interviewing staff members from several national ministries, it was not possible to realise the interviews within the given time frame.

Secondly, the study does not include respondents from other administrative levels, such as the municipal and county level. Due to this limitation, the master

thesis concentrates on national views on policies and their implementation.

Finally, it has to be emphasised that political documents are representative for political attitudes rather than established policies, their outcomes, or prior decision making processes. Nevertheless, they formed a credible data source for this study, being a mirror of political values, conceptions of SIH, and intentions to tackle these.

4. Political structure of Norway

Norway is a constitutional monarchy with a parliamentary democratic governance system. While the Norwegian King is the official representative of Norway, political power and responsibilities are divided between different governing authorities and geographical levels. Focusing on health promoting policies, this chapter provides a brief overview of these levels, which are the national, county, and municipal level.

4.1 National level

At the national level, Norwegian state power is divided between the national assembly called “Storting”, the Government, and courts. As the highest political body in Norway, the Storting is elected every fourth year. Its formal responsibilities range from the approval of bills and national budgets to monitoring of the efforts of the Government and discussing general political orientations and priorities (Hanssen, Helgesen, & Vabo, 2005a; Royal Norwegian Embassy in Washington, 2011a).

Further, based on democratic principles, the government is derived from the Storting. Main tasks of the government are to submit bills and budget proposal to the Storting, and to implement political decisions through the ministries (Royal Norwegian Embassy in Washington, 2011b). Areas of responsibility thereby refer to the national insurance system, hospitals, higher education, the labour market, refugees and immigrants, national transport, environment, and agriculture, foreign policy, and specialised social services, among others (Ministry of Local Government and Regional Development Norway, 2008).

As outlined by Strand and colleagues, the Norwegian Ministry of Health

bears the overall responsibility for health and care services. Subordinated to this ministry, the Directorate of Health is a professional body contributing to the implementation of national health policies. Further, it forms an advisory body to central authorities, municipalities, regional health authorities, and voluntary organisations (Strand et al., 2009).

4.2 County level

Norway is currently divided into 19 counties, each with its own government (Hanssen, Helgesen, & Vabo, 2005b). Despite of their self-administration, both county authorities and municipalities are subject to the authority and supervision of the central government (Ministry of Local Government and Regional Development Norway, 2008). The main representative of central government supervising county and municipal authorities is the county governor ("Fylkesmann"). The county governor has the formal responsibility to coordinate the activities of other central government bodies at the county level, and to review the legality of decisions made at regional level (Ministry of Local Government and Regional Development Norway, 2008). Notwithstanding, Hanssen et al. point out that, resulting from the democratic system, the respective political priorities of county governments might influence municipal service offers (Hanssen et al., 2005b).

Main responsibilities of county authorities refer to upper secondary schools, regional planning and development, regional and public transport, business development, and cultural institutions (Ministry of Local Government and Regional Development Norway, 2008). Resulting from these responsibilities, Hanssen and colleagues emphasise the importance of counties for public health and health promotion (Hanssen et al., 2005b), which is supported by the Norwegian

government in 2002:

> *"Through their position as regional planning authorities and driving force, counties play a central role in public health."(Ministry of Health Norway, 2002, p. 74)*

Importantly, within the constraints of national frameworks and goals, counties may have the possibility to distribute funds flexibly to their own strategies. While national earmarked funds are provided for prior defined purposes, the use of general funds may be influenced by counties' individual priorities (Hanssen, Helgesen, & Vabo, 2005c; Ministry of Local Government and Regional Development Norway, 2011a).

4.3 Municipal level

The Norwegian counties are further divided into currently 430 municipalities. Within the boundaries of national frameworks and guidelines, municipalities' responsibilities include primary and lower secondary schools, kindergartens, primary health care, elder care, social and physical rehabilitation, sanitation, social services, local planning and transport, environmental issues, and culture and business development (Hanssen, Helgesen, & Vabo, 2005d; Ministry of Local Government and Regional Development Norway, 2008).

As Hanssen et al. outline, municipalities are of basic importance for the implementation of health and health promoting structures, as their responsibility includes crucial educational, social, and medical services. It would thus be the municipalities that provide the main part of welfare services in Norway (Hanssen et al., 2005b).

Since municipal decisions have to be consistent with regional conditions, cooperation between municipalities and the county authorities and regional partners is an important criterion for success. Beside the prerequisite of legal consistency, financial support of municipalities through their counties requires consistent communication between these levels (Ministry of Local Government and Regional Development Norway, 2011b).

4.4 Importance of the Norwegian political structure for health and health promoting policies

This chapter outlined three interdependent political levels in Norway, which are the state, county, and municipal level. Resulting from their different responsibilities, reach, and financial dependencies, there is a need for collaboration and the involvement of all levels to effectively implement health promoting strategies and policies. Thus, besides horizontal (inter-sectoral) communication discussed in previous sections, there is a strong need for vertical (cross-level) collaboration.

Although this study concentrates on national strategies and values, it considers the importance of political collaboration to effectively establish national strategies at all relevant levels. Hence, aspects of vertical collaboration are addressed by two of the research questions presented above:

- How coordinated are these national policies?
- What are the strategies of policy implementation at all relevant political levels?

These research questions will be answered through both documents and expert interviews.

5. Background: Norwegian policy documents on SIH

Since SIH form an urgent challenge for the Norwegian society and policy, the Norwegian government put the topic on the political agenda in 2005, which resulted in the development of several reports, action plans, and laws to reduce the health gradient. This chapter presents an overview of the most relevant political documents, taking into account the impact of several determinants and political sectors on the health of the population.

5.1 Prescriptions for a healthier Norway (White paper no. 16, Ministry of Health Norway, 2002)

With its White paper *Prescriptions for a healthier Norway*, the Norwegian government seeks to improve the health of people living in Norway. This goal is to be reached through comprehensive policies following four main strategies, which are a) policies to promote individual health behaviour, b) cross-level partnerships and collaboration, c) preventive measures, and d) the creation of evidence base and promotion of knowledge. These action areas are complemented by an explicit focus on women at the end of the document, concentrating on gender-related aspects such as natal health, mental health, and the prevention of violence, among others.

The so-called "White paper on public health" contains an entire chapter on SIH and recurrently emphasises the correlation between socio-economic circumstances and health. Social inequities in health are further referred to as unfair and unjust, the more so as health is understood as “a prerequisite for social activity and participation in a wider sense.” (p. 47). Based on these assumptions, SIH is suggested as an integral element of HIA.

Nevertheless, no explicit reference to a population-wide health gradient can be identified. Rather, the White paper concentrates on vulnerable groups and harmful life-style factors to a large extent:

> *"Risk factors are often particularly concentrated in vulnerable parts of the population. There is a need to shed more light on the special health problems of the immigrant population. In general, there is a need for improved adjustment of interventions to the needs of groups at risk for developing health problems." (Ministry of Health Norway, 2002, p. 8)*

Finally, the government clearly calls for inter-sectoral action at all political levels, stressing the importance of the HiAP approach (p. 74).

5.2 The challenge of the gradient (Directorate of Health and Social Affairs Norway, 2005b)

Pursuing the previous White paper, the action plan *The challenge of the gradient* was developed two years later by the Directorate of Health and Social Affairs. The action plan traces out the Directorate's future professional foundations and activities. In accordance with the preceding White paper and proposition, the Directorate defines two main goals for its work. These are a) to increase knowledge about SIH, and b) to develop measures to reduce SIH through developing impact assessments and preparing a professional basis for a national strategy that will involve all sectors.

The first goal is thereby to be achieved through a new competence centre on SIH, which is expected to provide professional advice, to build a network of professionals and institutions in the area of SIH, to arrange research groups, and to disseminate knowledge through professional seminars, reports, and conferences (pp.

9; 24-26).

The second goal is to be reached through the implementation of HIA, the consideration of SIH in all its existing tasks, and advocating for inter-sectoral national policies to reduce SIH. The action plan is clearly focusing on the importance of social fairness and equity, referring to SIH as “unfair, avoidable and unnecessary” (p. 4).

As indicated by the title of the present action plan, it forms a shift of focus from vulnerable and marginalised groups, as identified in *Prescriptions for a healthier Norway*, towards social inequities among the entire population. It is thus clearly outlined that

> *"When illustrated graphically, social inequalities in health form a gradient throughout the population. Not only do the poorest people have the poorest health. The richest people are slightly healthier than the second richest people, who are in turn slightly healthier than the third richest, etc. Social inequalities in health are therefore a matter of concern for all of us." (Directorate of Health and Social Affairs Norway, 2005b, preface)*

To follow up the action plan, a national expert group was assigned to further recommend and develop national strategies on SIH in 2005. The expert group published its action principles in the same year (Directorate of Health Norway, 2005), calling for explicit and measurable approaches, the use and promotion of evidence-based measures, a focus on universally oriented strategies, and the implementation of coordinated, comprehensive cross-level and inter-sectoral policies (pp. 4-6).

5.3 Early action for life-long learning (White paper no. 16, Ministry of Education and Research Norway, 2006)

In this White paper, the Norwegian government presents its past, current, and future policies to reduce social inequities in the Norwegian society. The document is based on a life-course perspective, demonstrating the link between early living conditions and later opportunities and resources for well-being and social inclusion. It further stresses the correlation between the family background, economic conditions, health, and democratic participation (p. 7). Based on this perspective, the government places a strong focus on the importance of education, seeking to reduce class differences and poverty through the life-long promotion of skills and knowledge.

> *"The Norwegian government seeks to establish an active policy for reducing inequities in society. Our aim is to reduce class differences and economic inequities, and to combat poverty and other forms of marginalisation." (Ministry of Education and Research Norway, 2006, p. 7)*

Central measures thereby include the promotion of language skills, full kindergarten coverage, extensions of school services, quality in day care, a close follow-up of all pupils, the reduction of drop-out, and the allowance for further education in all age groups, among other things.

However, it is emphasised that White paper no. 16 forms one part of a greater comprehensive political approach to reduce poverty and marginalisation (p. 9). As indicated by the publishing ministry, the reduction of SIH and the prevention of social exclusion seem to form an inter-sectoral aim of the Norwegian government.

5.4 National strategy to reduce social inequalities in health (White paper no. 20, Ministry of Health and Care Services Norway, 2006)

Together with two other White papers on *Employment, welfare and inclusion* (Ministry of Labour and Inclusion Norway, 2006) and ...*Early action for life-long learning* (Ministry of Education and Research Norway, 2006), the present White paper is part of the Norwegian government's policy against SIH, poverty, and social exclusion. The document presents a ten year perspective for developing policies and strategies to reduce health inequities. It thus guides the ministries' annual budgets, legislation, regulations, collaborations, and measures. The overall strategy is based on four priority areas, which are a) the reduction of social inequalities that contribute to inequalities in health, b) the reduction of social inequalities in health behaviour and use of the health services, c) targeted initiatives to promote social inclusion, and d) the development of knowledge and cross-sectoral tools.

Hence, the White paper establishes health equity as a central political goal, which is to be reached through an equal distribution of factors promoting health. Relevant policies and strategies refer to people's income, childhood conditions, employment, working environment, health behaviour, health services, and social inclusion (p. 6). It is, however, stressed that measures recommended in the present strategy are largely linked to those discussed in other action plans and reports to the Storting. Besides the reports outlined above, other relevant plans are the *Action plan against poverty (2008)*, the *Diet action plan 2007–2011*, and the *National health plan 2007-2010* (p. 6).

Strongly arguing for the importance of welfare state policies, White paper no. 20 places emphasis on population-based measures and the responsibility of the

public sector for contributing to a fair distribution of health resources.

> *"As long as systematic inequalities in health are due to inequalities in the way society distributes resources, then it is the community's responsibility to take steps to make the distribution fairer." (Ministry of Health and Care Services Norway, 2006, p. 5)*

Moreover, the necessity of inter-sectoral communication in promoting health is clearly stressed. Regular reports, which are to be developed with the contribution of more than ten national ministries and directorates, are expected to monitor efforts and developments in each of the four priority areas. Hence, the government hopes to gain a systematic overview of the work towards reducing SIH (p. 84).

Further tools recommended to mainstream social inequity concerns are HIA, health considerations in municipal and regional planning processes, and inter-sectoral and cross-level partnerships.

5.5 National health plan 2007-2010 (Ministry of Health and Care Services Norway, Ministry for Labour and Social Inclusion Norway, 2006)

The *National health plan* presents the status quo of the Norwegian health-care system and suggests political measures to improve current health services. Chapter six particularly discusses the importance of a fair distribution of good health, which requires the contribution of all political sectors beyond the health care sector. In this context, HIA across political sectors is seen as a main opportunity to identify health consequences at all political levels in Norway. This implies the incorporation of health considerations in municipal, regional, and national planning processes. To allow for inter-sectoral communication, the authors recommend a variety of tools,

including annual professional meetings of relevant actors (p. 247), the adoption of cross-sectional strategies and action plans, cross-sectional partnerships, HIA, and HiAP based on the *Planning and building act* (p. 250). For a discussion of further details, the plan refers to the Report to the White paper no. 16 *Prescriptions for a healthier Norway*.

5.6 Children's future. National strategy for health and a healthy environment for children and adolescents 2007-2016 (Ministries of Norway, 2007)

The *Norwegian strategy for health and a healthy environment for children and adolescents* was initiated at the WHO's Fourth Ministerial Conference on Environment and Health in Budapest, 2004. At the Conference, which was held under the theme "The future for our children", the participating ministers made a commitment to implement the Children's Environment and Health Action Plan for Europe (CEHAPE) in their respective countries. The present document thus presents the Norwegian strategy to protect and promote the health of children (Ministries of Norway, 2007, p. 4). The strategy aims to give an overview of the challenges in the area of health and environmental policy aimed at children and adolescents. Further, it defines three goals, which are a) to uncover challenges in the areas of the environment and health, b) to meet these challenges through inter-sectoral action, and c) to contribute to an optimal environment and health for children and adolescents from zero to twenty years old. To reach these goals, key action areas refer to environmental conditions, housing conditions, child care and education, prevention, and social participation (p. 5).

5.7 Action plan against poverty (Ministry of Labour and Social Inclusion, 2008)

The *Action plan against poverty* is to complement existing White papers, particularly report no. 9 (2006-2007) *Labour, welfare and inclusion*, no. 16 (2006-2007) *Early intervention for lifelong learning*, no. 20 (2006-2007) *National strategy to reduce social inequalities in health, Action plan on the integration and inclusion of migrants*, and the *Action plan against drug addiction* (p. 5).

The present action plan pursues three main goals, which are a) to ensure employment among all people, b) to promote the development of and participation among all children and adolescents, and c) to ensure better living conditions for the most disadvantaged people (p. 5). It thus defines social justice, a fair distribution of resources, and equal opportunities as a central goal, touching on policies in the areas of childcare, education, the labour market, housing, and welfare.

In terms of early poverty prevention, the authors argue for the responsibility of the public sector, suggesting the maintenance and development of upstream measures, such as welfare state policies and an affordable and accessible education sector. The latter is particularly understood as a main means to warrant the individual's inclusion into the labour market and a secure income (p. 3).

> *"We need good welfare provisions that include everyone, and we need more targeted measures. The Norwegian welfare system is characterised by comparably strong redistributions through taxes, universal welfare regulations, a solid public education system, an active labour policy, and flexibility in the labour market." (Ministry of Labour and Social Inclusion, 2008, p. 3)*

Cross-sectional work is thereby understood as a prerequisite for success (p. 19): while the *Action plan against poverty* is the responsibility of the entire government, its measures are to be implemented by six different ministries.

Finally, the annual reporting system established in White paper no. 20 includes areas of the present action plan, and therefore allows for a first evaluation of policies aiming at poverty reduction.

5.8 Governmental strategy on prevention. Solidarity, safety, social balance (Ministries of Norway, 2009)

The *Soria Moria Declaration*, which the current government's work is based on, calls for better health and quality of life, less exclusion from the labour market, and reduced crime levels among the Norwegian population within the following years. The present strategy draws on the Declaration, illuminating how the government seeks to pursue these aims through prevention (p. 7). The term "prevention" thereby implies aspects beyond the medical perspective, as it is seen as an approach shaping the economic, social, and health related conditions of the Norwegian population (p. 32). In this context, the authors argue for public, universal, and welfare state policies:

> *"Policies aimed at the broader population are the foundation of all preventive efforts and are based on general welfare policies linked to quality of life, security, and equal living conditions. [...] An active labour policy, a universal welfare system, full kindergarten coverage, and a good education system for all are important prerequisites for shaping security, preventing social inequities, and promoting social inclusion." (Ministries of Norway, 2009, p. 32)*

In general, the document points out different approaches to public prevention efforts, which are a) the promotion of a close community, b) the promotion of active participation in the labour market, c) the reduction of economic and social inequities, and d) the promotion of a safe community free of individual worries about employment, income, quality of life, safety, or health (pp. 9-11). Different action areas to be considered are thus safe environments for children, poverty and social problems, health and social inequities in health, inclusive working life and safe occupational environments, accidents and injuries, crime prevention, and local safety (pp. 17-31).

Finally, the strategy illuminates the government's effort to strengthen cross-level and inter-sectoral work, and provides several examples of preventive programmes and policies in different social and political areas.

5.9 Health promotion – achieving good health for all (Directorate of Health Norway, 2010a)

The report *Health promotion – achieving good health for all* is part of an annual report series by the Norwegian Directorate of Health. The latest report from 2010 is devoted to public health and challenges faced in this area. Besides the illumination of present challenges, the Directorate of Health discusses strategies to promote the development of public health in Norway. The report is divided into three parts, discussing a) data, challenges and strategic choices, b) the implementation of health promotion at different administrative levels, and c) outlooks and suggestions for the improvement of public health and health promotion in Norway.

According to the report, municipal authorities bear particular responsibility for health promotion through their work in a variety of political sectors, including

social services, policies on health and prevention, and local development (p. 7; 76; 87). Notwithstanding, the report identifies several points of criticism concerning municipal public health and health promotion endeavours. While some municipalities are reported to have implemented public health tools in policy processes to a great extent, others are apparently characterised by inadequately keeping track of local challenges, a lack of political targets, poor coordination of work, and a demanding resource situation (p. 79). Furthermore, it is criticised that, in contrast to national ambitions, health promotion issues are often assigned to the medical sector only, and not prioritised enough in municipalities (p. 81).

Responding to the identified challenges, counties are called upon to support the work of municipalities through their policies on upper secondary education, culture, dental health services, and transport. Furthermore, counties are prompted to support municipalities through the provision of health data (p. 81).

Based on several evaluations and reports, the Directorate concludes with eight central strategies for the improvement of local and regional health promotion. These include

- boosting efforts to identify local challenges,
- continuing the programme “Health in Planning”,
- clarifying the foci of partnership initiatives and municipal opportunities,
- strengthening municipalities through earmarked grants,
- increasing the support from regional and national levels,
- strengthening interactions with universities, and
- promoting the role of voluntary organisations in health promotion (p. 94).

Values such as equity and a fair distribution of resources play a central role in the

present report, whereas the origin of SIH is attributed to several social and economic arenas beyond the health care sector (p. 53). In addition to the goal of shaping a fair and health promoting environment for the population, the maintenance of a sustainable welfare state is seen as an urgent goal. The recommended strategies in *Health promotion – achieving good health for all* are based on the HiAP principle. As an inter-sectoral tool established at all administrative levels, HIA is intended to help review the health impact of a variety of policies (7).

5.10 Annual report on the reduction of social inequities in health (Directorate of Health Norway, 2010b)

The *Annual report on the reduction of social inequities in health* 2010 is the second of its kind published by the Norwegian Directorate of Health. The document is based on White paper no. 20. Following the pre-defined priority areas of income, childhood and adolescence, work life, health behaviour, health services, and social inclusion, the report presents data, sub-targets, and measures conducted by a variety ministries (p. 11).

The annual report generally acknowledges the existence of the social gradient in health among the Norwegian population (p. 3). With regard to the presented policies, it is striking that elements of the public welfare system are considered as key measures in the combat of SIH and the maintenance of equity (p. 5). In contrast, the report contains no statements on the individual responsibilities and duties of the private sector. Education and employment are seen as essential factors in reducing social exclusion, marginalisation, and poverty (pp. 3-4).

5.11 The new Public health act (Norwegian Government, 2011)

As indicated by the previously presented documents, municipalities play a key role in reducing SIH, as they directly influence the living conditions of their inhabitants. Up to the present day, however, several details of these duties have not been legally anchored, which has led to distinctions in the scope of municipal actions on SIH. With its *new Public health act* to be introduced in January 2012, the National Ministry of Health and Care Services seeks to clarify national, regional, and municipal obligations for public health. Moreover, the act is to strengthen the importance of local and regional planning processes, and to allow for systematic coordination between several sectors and levels (p. 12). The new law is to be considered in the context of a planned law dealing with municipal health- and care services (p. 12). In brief summary, the following new regulations can be identified:

- Responsibilities for public health will be delegated to *all* political sectors of communities
- With the support of counties and national institutions, municipalities are obligated to create local health profiles to allow for evidence-based public health work
- Communities are to define public health aims and strategies, which are to be taken into consideration for all measures that are subject to the *Planning and building act*. Local health challenges are to be tackled through municipal and regional planning. (p. 12)

The discussion of cross-level coordination forms the core theme of the new law, since it is seen as a prerequisite for systematic public health measures (p. 11). Due to

their responsibilities and scope, municipalities are regarded as the most important actors in the field of health promotion and public health. As a result, the new law seeks to explicitly anchor communities' duties to "promote public health, well-being, and good social and environmental conditions" (Ministry of Health and Care Services Norway, 2010, p. 227), and to reduce SIH (ibid.). This is to be done through the contribution of several political sectors, the creation of municipal health profiles, municipal master planning (pp. 12, 227, 228), and the implementation of HIA.

Counties are likewise called upon to create regional health profiles and to incorporate health considerations into regional planning systems (p. 230). They are understood as the driving forces for cross-level partnerships and "developmental forces [...] being responsible for planning and the promotion of public health in a regional context" (Ministry of Health and Care Services Norway, 2010, p. 33) .

At the national level, duties of the Directorate for Health include the support of authorities and other actors at all levels through information and advice on health determinants and effective strategies, and the development of national norms and standards (p. 230). Moreover, county governors are to contribute to the implementation of national public health policy at municipal and county levels (ibid.). The National Public Health Institute, finally, is responsible for health research, the gathering of health- and environmental data, counselling, and the provision of these data for communities (pp. 230-231).

Besides cross-level coordination, the importance of inter-sectoral communication is acknowledged recurrently. Hence, the new law is clearly based on a HiAP perspective, which is realised through assigning local health efforts to the entire municipalities, taking into consideration the health impacts of a variety of

political sectors (p. 32.).

Finally, the new *Public health act* considers health as a value in its own right. The promotion of health is made both a political and ethical task aiming at a fair society with equally distributed welfare goods (pp. 11, 191). Moreover, the existence of a social gradient is mentioned and criticised as constituting "an urgent societal problem" (p. 47). Hence, a focus is placed on employment and social inclusion as central factors in promoting health.

6. Interview analysis

Political documents are a source providing valid information about political aims, strategies, and values. Other data sources, however, additionally allow for the investigation of processes behind these statements. Such processes include planning, implementation and evaluation processes as well as ways of inter-sectoral and cross-level communication and cooperation. For this reason, the present study includes six semi-structured one-to-one interviews with purposefully selected staff members of the Norwegian Directorate of Health. This institution was chosen, as it is essentially involved in the development of national action plans and reports. Moreover, its responsibilities include the distribution of related knowledge among a variety of actors, and the provision of professional advice to both political and non-governmental institutions. The involved interviewees are thus considered as experts in the area of national health promoting policies in Norway.

This chapter presents the interview results with regard to the following topic areas:

- Policies and strategies to reduce SIH
- Strategies considered most important: upstream policies, downstream policies or a combination of both
- Mechanisms for and challenges of a coordinated implementation of national policies at all political levels
- Stakeholder involvement and inter-sectoral participation in policy development
- The new *Public health act*: potentials, improvements, and challenges for health promotion in Norway.

6.1 Policies and strategies to reduce SIH

With the aim of validating the findings of the prior document analysis, all interview respondents were asked about the most important policies and corresponding political documents to reduce SIH. This question was answered similarly by all respondents. In terms of documents, the White papers no. 16 *Early intervention for lifelong learning* and no. 20 *National strategy to reduce social inequalities in health* were considered most vital. While White paper no. 16 was thereby described as focusing on the reduction of social inequities through education and the promotion of skills, White paper no. 20 was referred to as considering various life areas throughout the life-course. As indicated by both documents, the consideration of the life-course, and, hence, the early prevention of SIH already during childhood and adolescence is considered vital.

> *"With regard to SIH, White paper no. 20 […] is very relevant. […] It deals with different action areas… […] political areas related to growing up… It is this part of the document that, in terms of SIH, is the most important and most basic one at the national level concerning children and growing up." (R.1)*

> *"At the same time, another White paper, no. 16, was developed [..]. This is also a very important document in this context, since it deals with the reduction of social inequity in education. So it might be discussed if it is this or the other one that is most important. This means that this one [White paper no. 20] has a more superior character, as it deals with different areas. The other one concentrates on social inequity in education." (R.1)*

"You have probably had a look at White paper no. 20. So you have seen the chapter focusing on children and growing up. There […] was a clear focus on kindergarten coverage, the completion of primary school education and early identification of children at risk, which is related to child protection. And children's and school health services." (R.3)

During the discussion of political strategies, it was emphasised repeatedly that these documents could not be seen as isolated political initiatives. Rather, there has been a year-long development of health policies and laws, gradually re-defining health aims and responsibilities for health. Thus, the understanding of health has been shifting from a health care-related topic towards the consideration of health as a responsibility of all political sectors. The revision of the *Planning and building act* in 2009 and the recent adoption of the new *Public health act*, which establishes an explicit HiAP-perspective based on the latter act, should be seen in the same light.

"It has been a sort of process of public health documents. White paper no. 16, for instance, may not have such a strong focus on health inequities, which is more dealt with in White paper no. 20. However, the foundations were already laid in White paper no. 16, among other things with regard to the idea of embedding [policies in planning systems]. [...] And this has been focused on even more in White paper no. 20 [...]." (R.2)

"I am not surprised of how it [the new Public health act] looks like, and there has been readiness for it for a long time. [...] First, there was the reform on the health sector, which had an almost explicit focus on health care, individuals, and services. After its adoption, there were many communities, counties, county

governors and representatives of the Storting who were of the opinion that the reform was missing a public health perspective. So such solutions had been developed over time and finally caused a political request. An additional, important factor was the adoption of a public health law for counties [Law on counties' public health responsibilities, 2008/2009 ...]. There, it was no longer a health care-related law, but a law that defined public health as a responsibility of counties as such. [...] So this meant a shift of thinking from public health as health care-related plans towards an incorporation of health in the Planning and building act" (R.3)

In addition, all respondents emphasised the fundamental importance of the welfare system for an effective reduction of SIH. While political values and strategies may vary among governments, and while certain initiatives and programmes may focus on merely single aspects of health and disease, the welfare system is regarded as most important in terms of the promotion of health and the prevention of risk groups. Core aspects of a health promoting welfare system are thus income security through financial redistribution and the allowance for affordable insurances.

"Policies addressing children and adolescents can be found in almost all political areas – with regard to family policy, with regard to school, with regard to kindergarten. [...] The universal welfare system, which allows for income security among families, and similar policies. So there are very many areas that address children and youth. In addition, there are welfare services such as child benefits and these kinds of services." (R.6)

"If you, for instance, think of children and the life-course perspective, this would

include all regulations from... pregnancy leave, child benefits, the fact that child benefits are linked to women as well, rather than men only – several countries do not have such policies [...] – sick benefits, income support, that is... It is very easy to [...] forget about the very basic, important welfare policies that have been the broad fundament for a long time. I think that this redistribution – our tax and insurance system during the life-course – supports you when having children, so you work for a while, so you will be supported as an elderly. It is these kinds of policies that are vital." (R.3)

6.2 Upstream and downstream policies

As indicated by the previous section, universal, population-based measures are considered important by all interview participants. Corresponding measures include redistributive policies such as welfare services, child care regulations, and the tax and insurance system. In addition to this, two participants explicitly outlined the significance of combining upstream and downstream measures:

"Universal regulations minimise risk groups. In addition, you need policies aimed at risk groups. For this reason, we have youth welfare services and similar measures. We in Norway have also solid, active policies targeted at risk groups, but due to universal policies we have smaller risk groups than others." (R.3)

"There is this perspective directed at the entire population, the population-based gradient that is to be tackled. [...] In addition, there are vulnerable groups that many actors easily refer to, which are to be concentrated on as well. However, there is a stronger focus on the gradient." (R.5)

6.3 Mechanisms for and challenges of a coordinated implementation of national policies at all political levels

During the interviews, several mechanisms were outlined to support a successful implementation of national policies and guidelines at regional and municipal levels. Depending on the type of measure, political sector and involved actors, discussed strategies reached from legal regulations to earmarked funding and the distribution of information. Respondent two made particularly clear the distinction between these three forms of government:

> *"The state, the government, the Storting – they have [...] three main instruments [...]. The first is the adoption of laws; the second are economic efforts, the financing and support of measures, that is; and the third is, in my opinion, important as well but often less communicated, and it deals with the ways in which national policies might be implemented. A new law and plenty of money do not warrant effective political action. Implementation requires a method, the knowledge about trials, about the use of prior experiences [...]. So I think the latter strategy is important as well." (R.2)*

The following sections will follow this typology of instruments.

6.3.1 Legal regulation

With regard to legal instruments, most respondents referred to both the revised *Planning and building act* and the new *Public health act*. Both laws are regarded as significant, as they clearly define public health responsibilities among different political levels, legally anchor an HiAP perspective, and establish a common focus on SIH.

"I can see that laws have been changed in the past [...], for instance the revised Planning and building act [...], and this law includes a separate paragraph specifying that planning, including municipal planning, is to contribute to the promotion of people's health and to reduce SIH. There are several respective elements in the law." (R.2)

"For me, it [the new Public health act] is very important and helpful as a tool for [reducing] inequity.[...] It will form the basis for which measures have to be implemented, how they are to be anchored in planning systems at both municipal and regional level, and how measures are to be evaluated [...]. [...] Planning systems are absolutely vital for communities, and as soon as public health has been put on the agenda, the reduction of SIH is an integral part of it, I think." (R.4)

"Now [...] we have adopted a new Public health act that is directed at municipalities and counties, and that establishes SIH as one of the overall principles. So now we have a law that obligates municipalities and counties to consider SIH." (R.1)

6.3.2 Financial support of communities and counties

Besides legal obligations, the use of earmarked funds is understood as a further instrument of stimulation. In the area of health promotion, national earmarked funds have been used to promote the implementation of a variety of policies, including greater kindergarten coverage in communities, regional partnerships, and different action plans developed by national authorities. Respondents three and four explain:

"[...] It is usual in Norway that [..] efforts initialised at national level are followed by earmarked funds [for communities and counties]. Earmarked funds are often intended for the initial implementation period. And as soon as a certain level of implementation is reached, national funds may be granted within a rather broader frame of requirements, which enables communities to prioritise their use depending on own purposes. [...] And communities often find themselves in situations where certain things have to be prioritised in favour of others." (R.3)

"The Directorate of Health does not govern counties. Counties are independent bodies that are not directly governed. We have provided earmarked grants, which are administered by counties, whereas there has been a clear focus on life-style, physical activity, tobacco, nutrition and collaborations with voluntary organisations. In addition, they received grants for partnerships. Fortunately, I experience that despite of these [national] foci, counties have a broader perspective on public health and health promotion than life-style." (R.4)

Despite of the general awareness of the relevance of financial support, it was outlined that the form of support would depend on the type of policy to be promoted. For example, the promotion of a broader conception of health and its consideration in all political sectors would be an effort requiring a rather communicative approach.

"It is obvious that many processes require financial stimulation. Nevertheless, there have not been distributed greater amounts of money in the context of the White paper [no. 20]. It is rather a matter of implementing a certain perspective. Which means that it is not necessarily a question of economics, but of adjusting measures, or of increasingly evaluating their effects in terms of SIH, or of putting

things on the political agenda that one wishes to promote. It is not necessarily required to implement many new measures, but rather to use the available resources more effectively." (R.6)

6.3.3 Distribution of information

In general, all respondents agreed in that the distribution of information and knowledge promotes the development of competencies and a broader understanding of health among different political levels. However, there were slightly varying notions of the potentials, ways, and appropriateness of information distribution, depending on the type of policies to be promoted and the recipient of information. Similar to the outlined debate of financial means, the interview respondents recommended the prior investigation of the type of political endeavour. Moreover, two participants referred to the limitations of the Directorate's advice, since effective policies to reduce SIH would depend on the individual conditions and problems of the respective municipality or county. Due to this, the Directorate concentrates on mediating the HiAP approach.

"If you have an action plan on […] physical activity, it requires motivation, the promotion of the topic, it demands a lot of communication, while other important welfare policies in the communities are regulated through legal guidelines and financial support." (R.3)

"So it was surely right to have a focus on the production of knowledge and the promotion of competencies to… well, to know what has to be done. […] However, I also think that gradually, knowledge has been developed, and it rather becomes a challenge of implementation, meaning putting knowledge into practice." (R.5)

"We endeavour to go out and inform about White papers, to give presentations and contribute to active information. However, […] it is an unfortunate situation; there is not a single solution for the problem. It is rather required to implement a certain perspective into ordinary work. A single measure will not solve the problem. It is rather a method or a perspective, a policy. To mediate this... to anchor this at municipal levels is not an easy process." (R.6)

Different forms of information discussed by the interview participants were presentations at regional conventions, the publication of annual newsletters, the formulation of detailed recommendations, and the support of individual counties through professional advice.

"After its publication [White paper no. 20], we travelled a lot and presented the document particularly at regional public health conventions." (R.1)

"One of the activities of the Directorate of Health – I have to say that the Directorate has no direct governing or controlling function towards communities – but we publish an annual newsletter, which can be found on our website, and which addresses both communities, counties, the county governors, and regional health services. It is supposed to mediate important aims and priorities in the area of health for the following year. The reason for this newsletter is to allow these four recipients for seeing what we communicate to all of them. And that also we become aware of the different roles and responsibilities of the respective actors." (R.4)

> *"We are currently working on explaining and writing down how these aims can be fulfilled, how communities may move from paragraph five, which is to have an overview of the health status, towards paragraph six, which describes the definition of aims and planning. So […] we try to give recommendations with regard to tools and to contribute to the right thinking" (R.4)*

One participant outlined the function of county governors in this regard, referring to their obligation to fulfil national assignments and represent national interests at the regional level. According to respondent six, direct informative efforts of the Directorate of Health form a rather subsidiary effort supporting county governors.

> *"There is a formal hierarchy or line of commission from the state to county governors, which allows the state to charge county governors to further communicate these aspects. Additionally, there might be the demand to go out and inform actively among municipal public health counsellors or county governors. Still, this is a rather subsidiary task, I think." (R.6)*

With regard to the promotion of competence among different political levels, the responsibility of the national level was generally described as "supportive", meaning the distribution of helpful information and the provision of relevant data and advice to municipal and regional actors. Thereby, a clear distinction was drawn between the rather equal, communicative character of support, as aimed by the Directorate of Health, and legal guidance.

6.4 Stakeholder involvement and inter-sectoral participation in policy development

6.4.1 Involvement of responsible actors

While most of the analysed documents do not give any indication on prior strategy development processes and influencing parties, some interview participants provided essential information on these aspects. Participant three emphasised the collaboration and communication between different political levels, which gave particularly the new *Public health act* a "very bottom up character" (R.3):

> *"There is a systematic collaboration between us, county governors, counties, where we wish to create an ownership of the entire process through the involvement of different parties [...], which means a strong dialogue from local up to the national level [...]" (R.3)*

Respondent one primarily referred to White paper no. 20, outlining the prior involvement of parties representing different political levels and areas. Thereby, systematic teamwork meetings were organised to help defining and specifying action areas in accordance with the views and experiences of the involved actors. The actors included administrative, political and non-governmental organisations.

> *"There, we had a so-called "idea teamwork" on the various topic areas of the White paper. Correspondingly, we had such teamwork on the chapter about children and growing up. [...] The different parties participating were more or less public organisations working on children's environments and education in a variety of ways. One of the present organisations was the Central Association of*

Communities[5]*, which is the Norwegian union of [...] communities and counties. So these were able to participate in the development process through this interest organisation. This was the main mechanism of involvement." (R.1)*

Another respondent pointed out extensive hearings that were organised in preparation of the new *Public health act*.

"I am not sure about the extent of established involvement mechanisms for the Public health act. However, there were comprehensive hearings. [...] These hearings allowed for a huge participation from different parts of the country – it all can be found online. [...] So there was a long list of participants who maybe could not finally decide, but the hearings were open for everybody." (R.5)

6.4.2 Involvement of several political sectors

To some extent, the mechanisms described above, such as the "idea teamwork" meetings and hearings, allowed for a cross-sectoral approach through the involvement of a variety of actors. In addition, the work on White paper no. 20 was guided by a cross-sectoral secretarial committee [6] representing several national ministries.

"The work on White paper no. 20 was guided by a secretary committee of state secretaries from all involved ministries, which were about eight ministries. In addition, there was a respective committee at an administrative level, meaning bureaucratic representatives from the same ministries." (R.1)

[5] „Kommunesentralforbund"

[6] „Sekretærutvalg"

As outlined above, both the *Planning and building act* and the new *Public health act* determine health as an aspect to be considered in municipal planning systems and, thus, by several political sectors. Contributing to the applicability of such a broad *Planning and building act*, respondent two described the work on its required revision:

> *"There [... was] a committee working on the applicability of the Planning and building act for all sectors beyond the master planning sector [...], so we included much of this work in White paper no. 16, and, with an even stronger focus, in White paper no. 20 [...]." (R. 2)*

However, the actual implementation and evaluation of policies seems to be based on a traditional sector-related structure. Discussing policies related to education, for example, it was made clear that the Directorate of Health's responsibilities are limited to the stimulation of the integration of health-related considerations into other sectors. Thus, the Directorate has neither control of nor detailed information about respective implementation and evaluation processes (R.3).

6.5 The new Public health act: potentials, improvements, and challenges of health promotion in Norway

At the time of interviewing, the new *Public health act* was recently adopted. Before this background, it was particularly interesting to discuss the potentials of the new law and to reflect on the prior and future development of health promotion in Norway.

It is striking that all respondents appreciate the new *Public health act* as a helpful

tool for systematic, inter-sectoral health promotion in Norway. The law's overall perspective on equity is considered vital in terms of improving an awareness of SIH among all political levels. Furthermore, the detailed definition of responsibilities and the establishment of a HiAP perspective through the incorporation of health considerations into the *Planning and building act* are judged positively.

> *"Not all aspects of the new Public health act are new; much of it was already defined as a municipal responsibility. However, these responsibilities are made very clear now, and the processes around the new law and its implementation have created a greater awareness locally and regionally. [.. They have also] promoted a clear responsibility among national authorities to develop supportive measures for public health in communities and counties, such as better data or overviews of the health status. So I would be surprised if the law would not create a greater focus on social inequity, among others, at municipal levels." (R.1)*

> *"For me, it [the new Public health act] is very important and helpful as a tool for [reducing] inequity. [...] It will form the basis for which measures have to be implemented, how they are to be anchored in planning systems at both municipal and regional level, and how measures are to be evaluated [...]. [...] Planning systems are absolutely vital for communities, and as soon as public health has been put on the agenda, the reduction of SIH is an integral part of it, I think." (R.4)*

> *"Several elements of the new law indicate a positive development. The law emphasises the perspective on social inequity, it emphasises health in all policies [...], it emphasises responsibilities to have an overview of health challenges."*

(R.6)

Nevertheless, there were identified a variety of challenges and constraints to health promotion in Norway, which are highlighted in the following section.

6.5.1 Challenges of health promotion policies

The challenges outlined by the interview respondents cover different areas. These include a demanded shift of perspective towards a holistic understanding of health, the promotion of competencies at all political levels, the gap between knowledge and action, the definition of effective measures, the availability of resources, and unpredictable developments and global movements.

Establishing a holistic perspective on health

The adoption of both the revised *Planning and building act* and the new *Public health act* provided a legal basis for embedding health promoting policies in municipal and regional planning systems, allowing for the consideration of health aspects by all political sectors (HiAP). However, several interview respondents outlined a remaining need for communicating and implementing a HiAP approach at municipal and regional levels. In addition, several respondents reported on communities and counties considering health as being assigned to the health care sector. Finally, it was doubted that all communities were aware of SIH, which may result from a lack of significant statistics.

"I have waited for a... shift of paradigm, from illness to rather positive elements. This is still a job remaining, since many still have not heard about the new law. Last week we were on a seminar, where one municipality distinguished between

specialised health care services, prevention, and public health projects. This is not the way we understand health promotion and public health. We wished to hear about health promotion, local development and how different political sectors were motivated to participate... and this is quite typical, I think. I cannot even remember if they mentioned social inequities in health." (R.5)

"I think that a shift of paradigm is an important challenge – you have to make people think about distributive effects in different political areas. [...] It all comes down to Health in All Policies. In some areas, it will be other political sectors that have main influence on health, which is not necessarily seen that way by all actors. So I think that this perspective is important, while there are still other challenges. We cannot dictate perfect solutions." (R. 6)

"It is difficult to establish the understanding that health problems are not solely the responsibility of the health care sector, but that they are consequences of action of a variety of sectors. Concerning SIH, it is a challenge that social inequities have a tendency to be invisible at municipal level, as we do not have sufficient statistics – data are too limited, they sort of disappear in the statistics. What is most visible in communities are selected groups that are most disadvantaged, while the broader, rather structural inequities in health, the gradient, disappears. So it remains a challenge to clearly show the gradient and corresponding demands at local levels." (R.1)

Explaining these sceptical findings, it has to be stressed that the participants were explicitly asked to reflect on current and future challenges. Yet, their accounts were

not limited to negative descriptions, as they had observed a clear development of knowledge, awareness, and competence in communities and counties. Being asked about a general assessment of health promotion in Norway, one participant outlined that

> *"I strongly believe that [health promotion in Norway is on a good way], particularly after recently visiting a public health convention [...], where I experienced a significantly greater knowledge about prevention and the health promotion perspective compared to some years ago. This was very impressing. So I do have a good feeling about health promotion in Norway." (R.1)*

> *"We have provided earmarked grants, which are administered by counties, whereas there has been a clear focus on life-style, physical activity, tobacco, nutrition and collaborations with voluntary organisations. [...] Fortunately, I experience that despite of these [national] foci, counties have a broader perspective on public health and health promotion than life-style." (R.4)*

From knowledge to action

The gap between knowledge about and the actual implementation of health promoting policies was mentioned as a further challenge. The effective use of resources, the incorporation of a health promotion perspective into all political sectors, and the assessment of effects of policies and interventions served as examples for areas in need of improvement. Hence, it was outlined:

> *"However, I also think that gradually, knowledge has been developed, and it rather becomes a challenge of implementation, meaning putting knowledge into*

practice. I think this still forms a main challenge." (R.5)

"It might be a challenge to understand how to work in public health, to grasp what it is, how one can work with it. Fortunately, these tasks are strongly linked to [...] local development, so municipalities work on the topic all along, so the fundament is a solid community. This means that the two things are not contrary at all." (R.4)

"I think that [...] it is a major challenge to build the bridge between being aware of the problem [...] and implementing sufficient measures. It is very difficult to shape political measures that do not influence the effects of social disadvantage. [...] So I rather see it as a continuous work to hold the topic on the agenda and... maybe, within the capacities we have, control that things do not move into overly negative directions." (R.6)

The definition of effective measures

A known challenge in health promotion is the definition of effective measures and the transferability of good practice examples. The effects of certain interventions might be complex, difficult to measure, be influenced by other policies, may vary among certain population groups and, not least, may appear first a long time after the initial implementation. With respect to recommended policies, these aspects were experienced as challenging by several interview respondents. However, the Directorate of Health is said to work on the definition of success criteria.

"Together with the Norwegian Knowledge Centre for the Health Services, we are currently working on the definition of effective measures through using national

and international databases. It is difficult that Randomised Controlled Trials are not very useful for our field, since we can hardly establish control groups. So we have to find other ways to define solid criteria for effective measures. [...] The Norwegian Healthy Cities are collecting... you cannot call it effective measures, but good practice examples, which we hope can be distributed on our website. Still, communities may doubt the transferability, but this is something we work on." (R.4)

"There are many challenges connected to this topic. How do you shape political measures, what does it imply, which policies can be recommended [...] – we do not always have the answers to these questions. We can say something about the required perspective [...], but there may be better experts on landscape planning, for example. We cannot dictate any solutions... this has to be done by the sectors that can provide helpful measures. [...] It is easy to distribute a simple message, while it is challenging to mediate a certain perspective." (R.6)

Resources available at municipal and regional level

The implementation, coordination, improvement, and evaluation of political measures require a variety of resources at local and regional levels, including competencies and personal and financial resources. The availability of such resources for health promotion differs between communities, depending on their size, structure, and priorities. This aspect was considered by several respondents. However, mentioned forms of needed resources varied: while respondent four primarily discussed personal resources, respondent three acknowledged the need for competencies to work inter-sectorally.

"Of course, resources are vital: a municipality's resources. There are always two sides of a coin, and [...] it is an advantage of the new law that communities are to use all of their sectors [...]. However, at the same time you need somebody promoting this process, explaining the importance of the educational sector thinking health promoting, and the resources for such activities are, as we know, limited in communities. There are some public health coordinators, many communities have these, but they may hold positions down to 30 percent and may be nurses primarily. And so they are to work on health promotion besides, promoting it a bit in the political and administrative sectors – that is challenging." (R.4)

"There are surely challenges concerning all aspects of implementation. Competencies, capacities, and resources are some of the categories. Many communities would maybe say that resources are the greatest challenge. However, personally, I think that capacities are the main challenge. The capacity to systematically work inter-sectorally. Some communities have accomplished that. [...] One municipality, which has achieved a lot in this area and works systematically and with a broad perspective, responded that the new law would rather be a detailed version of the previous law, and would thus not have any new economic consequences. The law obligates us to the same tasks as the latter. Many other communities think that the new law establishes many new requirements, but... it is precise, but it is actually not that new." (R.3)

In terms of competencies, the Directorate of Health currently collaborates with several universities to incorporate required knowledge into provided study

programmes. This work is strongly linked to competencies demanded by the new *Public health act*:

> *"[... The Directorate of Health] currently works on a document defining competencies required to work with the new Public health act. We built up a network with [...] the HEMIL Centre and similar educational institutions and universities. So we developed a first draft of a document [...], which was distributed to all of the ten, twelve institutions, which was exciting, since it will form the basis of future adjustments in study plans [...]." (R.2)*

Interestingly, only one respondent referred to the *national* economic situation to promote public health and health promotion in communities and counties.

> *"We had a challenge there, as the new Public health act is part of the reform of the health sector, and most money is provided for health services. We have the respective laws, but still require more economic resources to communicate the advantages of prevention and health promotion. That is just the way it is: money is provided for issues paid most attention to, and these are hospitals, health services and similar." (R.2)*

Unpredictable international developments

Being asked about the general development of health promotion in Norway, one respondent pointed towards international and global developments, whose effects and consequences may not be fully predicted and controlled by Norwegian politics. The European financial crisis and the development of wages due to the globalisation were exemplified to outline this point.

"There are several aspects that, in my opinion, point into a positive direction. However, you can see that there may be forces that lead to other directions, which may not be controlled… if you think of the […] economic crisis in Europe, which of course will affect Norway. There, hiring several public health counsellors might not solve the problem. Rather, you have greater market trends […]. So […] it is difficult to predict if we are «on the right way»." (R.6)

7. Discussion

This chapter seeks to summarise and critically discuss the findings of the document and interview analysis. The first part compares the interview findings to results of the document analysis, allowing for a validation of findings. It thereby follows the thematic areas covered by the research questions. The second part of this chapter discusses the study results in the light of Esping-Andersen's *Three worlds of welfare capitalism*. Finally, the third part concludes with an assessment of the political commitment to reduce SIH in Norway by adopting Whitehead's action spectrum.

7.1 Comparison of document and interview findings

7.1.1 Policies and strategies to reduce SIH

With regard to political approaches to promoting the health of the Norwegian population, there are clear similarities between the respondents' accounts and the reviewed documents.

First, both data reveal the consideration of a variety of political sectors and general policies. While the precision of described policies in the analysed documents varies due to different core themes, the authors agree in that general policies on education, labour, social affairs, the environment, health care, and transport are vital contributors to the reduction of SIH. In terms of child care, kindergarten places are expected to ensure a safe and healthy development and the promotion of language- and other basic skills as prerequisites for further education.

These findings are in line with the interview accounts, where the contribution of different policy sectors to health is emphasised recurrently. Health in All Policy, which is legally anchored in the revised *Planning and building act* and the new

Public health act, is to allow for the consideration of health aspects in all political sectors. Hence, inter-sectoral collaboration and the common consideration of health are consistently understood as a main aim by both policy documents and interview respondents.

The WHO supports this conception of effective health promoting policies, as the Ottawa Charter argues for a healthy public policy combining different political measures.

> *"Health promotion goes beyond health care. [...] Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity."(First International Conference on Health Promotion, 1986, p. 2)*

Furthermore, beyond the awareness of specified political action plans and strategies, there is common agreement on the fundamental importance of the welfare system. Both data sources understand welfare policies as vital for the reduction of SIH, and refer to the national insurance system and income security through redistributive policies, such as child and other benefits.

Supporting this view, several interview participants described the welfare system as a stable fundament for health promotion, being less susceptible to different political parties and priorities. The combination of a stable welfare system and subsidiary political strategies is viewed as most effective in terms of reducing SIH in Norway, which is also reflected in the analysed documents.

The positive estimation of the welfare system is in line with several studies and reports emphasising its importance for an effective reduction of SIH (Esping-

Andersen, 1990; Fosse, 2009; Fosse, 2011; Lundberg, 2009; Lundberg et al., 2008; Marmot et al., 2010). For instance, in their recent report *Fair society, healthy lives. The Marmot review*, Marmot and colleagues point out that

> *"Strategies that rely only on intervention in one part of the system will be insufficient to make the necessary difference to patterns of inequality. A whole-system approach is needed [... and] concerned with:*
>
> - *The imperative of greater social justice and sustainability and the implications for policies to redistribute power and resources, and improve financial systems*
> - *Policies to maintain and improve universal health and welfare systems*
> - *Strategy and policy to enable public services to create and promote the conditions within which individuals, communities and the public take control of their own lives and have a voice." (Marmot et al., 2010, p. 151)*

The found similarities between policy documents and interview accounts are allegeable, as several interview respondents were involved in the development of critical national documents, providing advice to the National Ministry of Health and Care Services and contributing to the revised *Planning and building act*. In addition, it has to be mentioned that several respondents brought along the respective documents to refer to and cite from. Nevertheless, the detailed knowledge of these documents among experts is considered an interesting finding, the more so as White paper no. 16 was developed by the Ministry of Education and Research. This fact indicates a certain degree of inter-sectoral communication.

Finally, several respondents endorsed the continuous development of political

strategies over a long period of time. Thus, the new *Public health act* should be seen as being based on former health laws, going back to the 1980s. Accordingly, White paper no. 20 is rooted in White paper no. 16, which in turn was developed based on the report *The challenge of the gradient* in 2005. Such a development can indeed be identified in the policy documents, as they repeatedly refer to one another and reflect an increasing knowledge base concerning SIH and policies to tackle these.

This policy development is insofar interesting, as it is strongly influenced by the government's will to put SIH on the political agenda. Two assumptions can be drawn from this finding: first, there seems to be an integral political interest in promoting social equity in health. As different authors have argued (Fosse, 2009; Fosse, 2011; Lundberg et al., 2008; Navarro & Shi, 2001), left wing governments tend to focus on upstream measures and the promotion of social equity, and thus do better in reducing SIH. As was outlined in chapter one, the Norwegian government has been putting the reduction of SIH on the political agenda since 2005, resulting in several national action plans and reports (Directorate of Health and Social Affairs Norway, 2005a, 2005b; Directorate of Health Norway, 2005; Fosse & Strand, 2010). It should be noted that it was a left wing government that replaced a conservative government in 2005 in Norway[7].

Second, due to the year-long development of policies, it can be assumed that experts' advice and knowledge development, such as provided by the Directorate of Health in Norway, plays a certain role in advocating for social equity and retaining the topic on the political agenda. Several interview accounts indicated this aspect (e.g. "So I rather see it as a continuous work to hold the topic on the agenda", R.6).

[7] Government 2001-2005: Coalition of the Conservative Party, Christian Democratic Party, and Liberal Party; Government 2005 – time of writing: Coalition of the Labour Party, Socialist Left Party, Centre Party (Norwegian Government, 2012)

The steady development of knowledge about SIH is represented in the reviewed political documents, as there can be identified a growing awareness of the social gradient and the importance of HiAP and HIA, and an increasingly detailed identification and monitoring of health promoting policies.

7.1.2 Upstream and downstream policies

A striking similarity among all documents and interview accounts is the unequivocal support of both upstream- and downstream measures. There is common agreement in that a combination of population-based policies and those targeted at risk groups is most effective. General, population-based policies are thereby consistently referred to as re-distributive welfare policies, childcare– and education policies, tax policies, and policies on labour, social affairs, the environment, and transport. While most documents suggest the implementation of HIA to ensure the consideration of health at all administrative levels and across political sectors, the interview participants particularly highlighted the preventive effects of a comprehensive welfare system with regard to risk and vulnerable groups.

Aside these universal approaches, however, most documents clearly define vulnerable groups to target at. These include long-term unemployed individuals receiving social assistance, people living in poverty, prisoners, people with lower education and income, individuals with drug addiction or mental illnesses, and children of these groups. In addition, there could be identified a strong focus on immigration and related challenges. The latter are consistently defined as inadequate basic- and Norwegian language skills, reduced social participation, and resulting unemployment. Hence, integration efforts seem to form a substantial part of the political agenda.

The described combination of upstream and downstream measures, as introduced as "proportionate universalism" by Marmot, is supported by a number of authors, such as Lundberg and colleagues, Fosse, and Marmot (Fosse, 2009; Lundberg et al., 2008; Marmot et al., 2010), who agree in that

> *"To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. [...] Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem." (Marmot et al., 2010, p. 16)*

Nevertheless, several interview respondents acknowledged the demand for further significant statistics to clearly show the social gradient in health. Municipal and county health profiles are particularly expected to create an evidence base for effective policies.

7.1.3 Mechanisms of a coordinated implementation of national policies at all political levels

While some information given during the interviews is similar to what can be found in political documents, the interviews respondents could cast further light on cross-level communication and implementation. According to both documents and interview respondents, legal regulation, such as the adoption of the *Planning and building act* and the new *Public health act*, is a useful means to obligate stakeholders at all political levels to promote the health of the population. The policy documents describe such legal obligations in greater detail, referring to municipal

and county health profiles, the support of municipalities through data provision, and the implementation of HIA at all levels. According to the documents, municipal authorities own a significant responsibility for health promotion through their work in a variety of relevant political sectors. The report *Health promotion – achieving good health for all* points out that this responsibility would be clearly expressed in a number of laws, including those on municipal health services, prevention, the sale of alcoholic beverages, education, child welfare, and social services. The importance of municipalities in particular for health promotion is further clarified and legally anchored in the new *Public health act*.

A second mechanism concerns national financial support in the form of earmarked grants, which is commonly considered an effective measure, as certain types of interventions require the provision of further financial resources within the restrictions of the state. Such interventions reach from the development of health services to the establishment of voluntary cross-level partnerships and cooperations.

Third, the distribution of information and, thus, the promotion of competence at all levels are viewed as a means of equal importance. This includes the development of national reports, the provision of research results, the development of national goals, and advice for organisations at all political levels. In this context, both documents and interview accounts refer to the Directorate of Health as a central institution. The role of the state is consistently described as “supportive”, referring to the provision of information, data, and professional advice rather than guiding counties or dictating defined solutions. In terms of communication between national and regional levels, county governors are considered vital in mediating national priorities and obligations.

Discussing these approaches with the interview respondents, however, it was

outlined that each of these means should be assessed with regard to their stimulating effects for specific political measures. Particularly national grants and the distribution of information were debated with regard to their applicability for certain interventions.

Adding to these common findings, some interview respondents outlined specific mechanisms for the involvement of different political levels in the development of national policies and strategies. In addition to hearings, one respondent described so-called “idea teamwork meetings” for each of the topic areas covered in White paper no. 20. These meetings allowed for the participation of both a variety of actors working on children and the Norwegian union of municipalities and counties.

As far as the cross-level implementation of national policies is concerned, it has to be emphasised that further research is needed to cast light on detailed processes and challenges at regional and, particularly, municipal levels. This study cannot provide details as to how the implementation of policies initiated by other political sectors than the health sector is managed. Second, there is no systematic, direct communication between municipalities and the Directorate of Health, which made it impossible to consider the views of local actors in this study.

Finally, it can be debated to which extent and under which circumstances the provision of national grants helps to achieve precise national goals and priorities. As outlined above, Norway has a tradition of providing earmarked grants to municipalities and counties to stimulate the implementation of a variety of policies. After reaching a certain level of implementation, however, earmarked grants can be

replaced by rather general economic provisions, waiving detailed requirements of the state. On the one hand, this approach enables communities and counties to consider individual needs. On the other hand, the use of general grants becomes strongly influenced by unequal political and financial priorities in municipalities and counties. These concerns seem to be known to at least some of the interview respondents, since it was stated that “communities often find themselves in situations where certain things have to be prioritised in favour of others” (R.6) in this context.

This study does not assess to which extent broadly framed grants are actually used by municipalities and counties to further achieve national goals. Still, this aspect may be worth further investigation, as it allows for conclusions on the effectivity of the described funding system. In the context of health promotion and the reduction of SIH, it should be studied if and how the new *Public health act* promotes the use of national grants for respective measures through legal obligations.

7.1.4 Stakeholder involvement and inter-sectoral participation in policy development

Both documents and interview accounts reflect a general appreciation of HiAP approaches and a seamless presence of public policies. Yet, among the analysed documents, recommended tools to implement this approach vary, and almost no standardised way of involving different stakeholders and political sectors in policy development processes can be identified. The only exceptions in this regard are hearings of draft bills: through the discussion of their drafts in hearings, the *National health plan* and the *Suggestion for a new public health act* were developed with

contribution of a variety of actors, representing different political levels and sectors. The number of participating parties thereby varied from more than 200 (*Suggestion for a new public health act*) to more than 600 (*National health plan*). These included both political actors from different levels and non-governmental stakeholders from a variety of working fields, such as universities and organisations working in medical, social, and psychological areas.

As a second example of stakeholder involvement, the strategy *Children's future* is based on prior questionnaires and meetings with youth organisations. It can, however, not be assessed to which extent different focus groups were represented in these investigations, such as specific vulnerable or disadvantaged children and adolescents.

Moreover, the *Annual report on the reduction of social inequalities in health* illuminates a variety of contributing ministries, departments, authorities, and organisations.

Here, the interviews provide additional information. While it was confirmed that hearings would form a main mechanism of involvement during legal development processes, one respondent was able to present further details about the development of White paper no. 20. Hence, "idea teamwork meetings" were held for each of the topic areas covered in the White paper. These meetings formed an arena for sharing expert views and developing aims and priorities for different topic areas. Moreover, a cross-sectoral secretarial committee participated in the development of White paper no. 20, representing about eight national ministries. Besides these political actors, a respective committee of administrative representatives was involved.

These interview accounts are not necessarily transferable to other policy development processes, such as action plans initiated by other ministries. Nevertheless, the presented information allows for an insight into inter-sectoral cooperation and the inclusion of vital stakeholders in the area of health promotion. The *Annual report on the reduction of social inequities in health*, for example, is developed with the contribution of ten different national ministries and directorates, which indicates a shared responsibility of and perspective on SIH.

With reference to Lundberg and colleagues, such an inter-sectoral approach is to be appreciated. As the authors put it:

> *"While the effect on public health of each specific policy might be small, the combined effect of all policies and institutions is likely to be substantial. This is especially true from a life-course perspective, where a life with access to resources provided by the welfare state, in addition to the resources of the market and the family, is likely to be longer. (Lundberg et al., 2008 pp. III-IV)*

As outlined above, however, this study cannot conclude on main tools to implement this approach in Norway, since descriptions and recommendations in the analysed documents vary to a great extent.

7.1.5 The new Public health act: potentials, improvements, and challenges of health promotion in Norway

Due to the foci of the presented policy documents, a general reflection on the current development of health promotion in Norway could not be included in the document analysis. Still, before the background of the new *Public health act*, it was interesting to discuss this topic with the interview participants.

Generally, the adoption of the new *Public health act* is considered as a positive and helpful development by all interview respondents, since it forms an instrument to legally anchor a holistic understanding of health, a HiAP approach, and a general focus on SIH at all political levels. Moreover, it precisely defines responsibilities for health promotion among different actors, which is appreciated by all respondents.

Besides these improvements, one respondent particularly outlined that certain obligations had already been legally established before, including the development of health profiles and the inter-sectoral responsibility for health in communities and counties. Despite these existing obligations, the Norwegian Directorate of Health concluded in 2010 that

> *"It is a general characteristic that the municipality does not consider health promotion to concern the entire range of the municipality's activities, and that tasks in the field of public health are handled by professionals, primarily the municipal medical officer, nurses and physiotherapists. It is also the impression of the Norwegian Directorate of Health that the municipalities do not perceive health promotion to be mandatory [...]." (Directorate of Health Norway, 2010a, p. 81)*

Beyond this background, it will be interesting to investigate future changes and, possibly, improvements in municipal and regional action on SIH after the implementation of the new *Public health act*. In further studies, aspects of interest thus include the contribution of several political sectors to health promotion, the extent of prioritisation of health aspects in these sectors, the extent of implemented health impact assessments, and, with reference to section 7.1.3, the actual use of

national grants.

However, the great variety of challenges outlined in the previous chapter indicates the complexity of required implementation processes at different levels. Of course, the presented accounts cannot be regarded as a satisfying investigation of implementation processes at the national level. Due to the limitations of this master thesis outlined in chapter three, it was not possible to include the views and opinions of different political sectors and actors working in municipalities and counties. However, the presented challenges indicate that a more thorough analysis of municipal and regional implementation processes should take the unequal conditions among communities and counties into account. Factors to be considered are thus differing governments, sizes, available resources, main health challenges, and political priorities of municipalities and counties, among other things.

7.2 Norwegian welfare policies and political values: Esping-Andersen's typology of welfare regime types

Several studies have sought to cluster countries with regard to their welfare policies, allowing for conclusions about the effect of national policies on specific aspects, such as health and health inequality. As introduced earlier, Esping-Andersen provided a particularly influential study, identifying three main regime types, which are the liberal, conservative, and social democratic regime (Esping-Andersen, 1990). According to the author, Norway represents the latter type, as it represents the following characteristics:

- policies are built on the concepts of solidarity and universalism
- the welfare system can be described as extensive and strongly redistributive

- the welfare system is based on full employment and a high productivity
- promotion of full employment and income protection for both men and women
- state interventions and regulations are common and accepted means, and are reflected in progressive tax systems, the state's responsibility for childcare, and the encouragement of all women to participate in the labour market, among other things.

Although Esping-Andersen's typology has been the subject of debate concerning its accuracy of idealised clusters, it is striking that both policy documents and interview accounts presented in this study confirm Esping-Andersen's description of social democratic welfare state regimes.

The presented findings are utterly consistent in their political values and priorities. All investigated data emphasise the importance of solidarity and universalism, and judge existing correlations between socio-economic circumstances and health as unfair, unethical, and unacceptable. Values such as equity, fairness, equal chances and opportunities, and social security are focused on in both data sources.

The same conclusion can be drawn with regard to the relevance of the welfare system. A main finding of the present study is the fundamental importance of a comprehensive welfare system, which is expected to reduce risk groups and to form the stable basis for further political approaches to tackle the gradient. Described welfare policies thereby reach from an affordable insurance system to extensive child care and education, income security through unemployment benefits, child and maternity benefits, pensions, and sick leave, among other things. In the

same vein, education and the life-long promotion of skills are understood as some of the most important measures, as these are prerequisites for later employment and income security.

Finally, it is striking that the responsibility for health and social inclusion is primarily assigned to the public sector and the society as such, as individual choices are expected to be influenced and limited by public offers and regulations. Based on this assumption, the reduction of SIH is viewed as an essential and, not least, moral endeavour of the public sector.

These findings are interesting in that they confirm the link between social democratic welfare regimes and a political focus on equity, solidarity and fairness, which are essential values for health promoting policies. The importance of these values is confirmed by different studies and reports, such as the Marmot review *Fair society, healthy lives* (Marmot et al., 2010), Fosse's analysis of policies in three different European countries (Fosse, 2011), and *The Nordic experience. Welfare states and public health* (Lundberg et al., 2008).

Based on these findings, it can be assumed that social democratic welfare regime types do better in putting topics related to fairness and social equity on the political agenda, and thus, in reducing SIH. The *extent* to which Norwegian politicians actually seek to reduce the problem shall further be identified by using Whitehead's action spectrum.

7.3 The Norwegian level of political commitment to reduce SIH: Whitehead's action spectrum

Since 1998, Whitehead's action spectrum, which defines different levels of political commitment to reduce SIH (cf. fig. 3), has been used several times to investigate Norwegian policies on SIH. While Dahl classifies the latter as “somewhere in the area around “measurement”, “awareness raising”, and “indifference”” in 2002 (Dahl, 2002, p. 72), further political developments let Fosse come to a different result in 2010. According to Fosse, Norway has a “strong political commitment [...], in the sense that policy documents are followed by action plans with concrete targets, deadlines and responsibilities.” (Fosse, 2011, pp. 266-267).

Following up on these studies, the findings of the present thesis support Fosse's assessment. First, there are various political statements, action plans, and laws developed at the national level that explicitly seek to reduce the social gradient. The most relevant documents are presented in chapter six.

Second, there can be identified a clear development of policies between 2002 and 2011, as the different documents built on and refer to one another. This finding is endorsed by several interview participants.

Third, the Norwegian government established an annual reporting system, which is developed with the contribution of ten ministries and directorates, and which is to provide an overview of recent developments in different political areas. The annual reports do not only show a certain level of inter-sectoral communication, but, in the long term, may allow for the identification of successful and effective measures on the reduction of SIH.

Critically examining Norwegian policies on SIH, it should be noticed that the Norwegian Directorate of Health established an expert group in 2005 to develop action principles for effective strategies to reduce SIH[8]. The action principles are

- explicit and measurable approaches: quantification of targets and time limits for milestones
- use and promotion of evidence-based measures through monitoring, evaluation and HIA
- focus on universally oriented population (upstream) strategies, which are complemented by target-oriented measures aimed at disadvantaged groups (downstream measures)
- combination of individual and structural measures
- implementation of coordinated, comprehensive cross-level and inter-sectoral policies, and
- reduction of unfortunate social consequences of disease and ill health. (Directorate of Health Norway, 2005 pp. 4-6)

Some of these action principles are clearly reflected in current Norwegian policies, such as the principle of proportionate universalism, the general focus on inter-sectoral cooperation, and the reduction of consequences of disease and ill-health through welfare services and medical interventions. For specific policies, time limits have been defined, whereas it should be noted that the reduction of the social gradient itself has not been formulated as a quantitative target. Rather, it forms a general goal that is sought to be reached through the long-term contribution of a variety of sectors.

[8] From 2012, the expert group has been institutionalised as a national expert advisory board

> *"It will take time before we can measure the results of the policy in the form of reduced inequalities in health in all these areas. For this reason, time limits have not been set for achievement of the goals; rather they require continuous input over the next ten years." (Ministry of Health and Care Services Norway, 2006, p. 6)*

Within the capabilities of this study, however, there were identified areas with remaining potential for both further documentation, evaluation and improvement. These areas particularly refer to the coordinated cross-level implementation of national policies and the implementation of HiAP and HIA at municipal and regional levels. Several interview respondents outlined a health care-related view on health promotion and a lack of a Health in All Policies approach. These views are supported by the report *Health Promotion - Achieving good health for all* (Directorate of Health Norway, 2010a, p. 81).

Based on these findings, Norwegian national policies can indeed be described as comprehensive and coordinated, and it will be worthwhile to investigate the effects of both early and recent policies, such as the new *Public health act*.

A minor restriction, however, refers to the fragmentary documentation of inter-sectoral collaboration. While the interview accounts indicated a coordinated inter-sectoral communication for certain strategies at national level, the analysed documents did not allow for a valid judgement in this regard.

Nevertheless, this generally positive judgement applies to the national level only, since data in the present study indicate an incomplete implementation of national

perspectives in - at least some - communities and counties, including a HiAP perspective and a holistic view on health taking the life-course approach into account. This study thus argues for the need of successfully implemented national policies at municipal and regional levels, since there is agreement in that municipalities are most important in terms of health promoting policies. It can further be argued that the values and political strategies identified by Esping-Andersen are the more significant the more they are represented and appreciated at *all* political levels of a country. Still, it should be noted that this study primarily focuses on national policies, and that further studies are required to investigate municipal and regional conditions in-depth.

8. Conclusion

Approaches to effectively reduce social inequities in health continue to be of major interest to the scientific and political arena. The present study provides further insight into Norwegian policies to do so, shedding light on political values, priorities, policy implementation processes and related challenges.

It has been shown that the reduction of SIH has been made an explicit part of the Norwegian political agenda, and there are detailed endeavours to promote social inclusion and minimise the social gradient among the Norwegian population. This task is considered an inter-sectoral and cross-level one, as the promotion of health and well-being is conceded to a variety of political sectors. Thereby, population-based measures are viewed as most important and to be complemented by measures targeted at specific risk and vulnerable groups. For the same reason, general welfare provisions are viewed as the fundament of all health promotion policies aiming at combating SIH. Based on these findings, Norwegian national policies are clearly in line with the characteristics of social-democratic welfare regime type, which includes a strong focus on equity, social inclusion and a public responsibility for health. Furthermore, political measures can be described as coordinated and comprehensive.

From a health promotion perspective, these findings form a good practice example for European policies to promote social equity, as they illustrate the fundamental influence of comprehensive welfare regulations on the reduction of SIH and the prevention of vulnerable groups. Income security, redistributive policies and public

childcare are thereby key elements of the Norwegian strategy to promote social inclusion.

Building on these general welfare state regulations, it is made clear that the political consideration of the social gradient forms an important component of successful health promoting policies. It can be assumed that the active contribution of the Directorate of Health and the establishment of a national expert advisory board on the reduction of SIH promote the political awareness of the topic. The explicit aim to reduce health inequities has, over time, led to comprehensive policies based on a steadily increased knowledge-base and clear responsibilities across all political levels and sectors. The Norwegian case exemplifies how this development can culminate in a detailed, inter-sectoral law on the promotion of health and reduction of SIH.

A final recommendation concerns the regular follow up of specific policies to reduce SIH. Here, too, the Norwegian case forms an example of good practice, since its *Annual report on the reduction of social inequalities in health* allows for inter-sectoral work on the topic and further helps to conclude on both successful and less effective political interventions. Although it is known that certain health promoting measures have rather long-time effects, an annual monitoring over time can form a feasible solution for this challenge.

Aside from these conclusions, further research is needed with regard to communication, implementation and evaluation processes particularly at Norwegian municipal and county levels. As far as the cross-level implementation of national

strategies is concerned, this study reveals a variety of challenges and constraints faced by municipalities, including financial, personal and competence based aspects. While it provides a first overview of possible challenges, they need to be investigated more in-depth to allow for practical solutions and to ensure a successful implementation of national strategies at all political levels. Thereby, future studies should take the unequal conditions among municipalities and counties into account, such as differing governments, sizes, available resources, and differing health challenges. The recent adoption of the new *Public health law*, which clearly defines municipal and county responsibilities, forms a new legal demand of respective research attempts.

In this context, the use and limitations of general national grants should be further investigated with regard to their effectivity in stimulating implementation processes at municipal and county levels. While this study does not question the benefits of earmarked grants, there are indications that grants without specified national requirements may be used for other purposes than originally intended. This study, however, cannot provide enough evidence base to come to a final judgement in this regard.

Finally, it is recommended to pursue the initiated national monitoring to allow for a learning process concerning successful interventions. Based on the autonomy of municipalities and counties, it should be investigated if such a monitoring can be beneficial at municipal and county level as well. The advantages can be threefold: first, respective endeavours can make explicit the political priority to reduce SIH at local and regional levels. Second, this study reveals a lack of inter-sectoral work for

health equity in some municipalities. An inter-sectoral monitoring may, however, strengthen the needed Health in All Policies perspective at these levels. Finally, an inter-municipal knowledge exchange based on annual monitoring and experiences can promote important insights on effective measures to reduce SIH.

REFERENCES

Bambra, C. (2007). Going beyond the three worlds of welfare capitalism: Regime theory and public health research. *Journal of Epidemiology and Community Health*, *61*(12), 1098 –1102. doi: 10.1136/jech.2007.064295

Bartley, M., Blane, D., & Montgomery, S. (1997). Socioeconomic determinants of health: Health and the life course: why safety nets matter. *British Medical Journal*, *314*(7088), 1194–1196. doi: 10.1136/bmj.314.7088

Bull, T. (2011). *Combining employment and child care: the subjective well-being of single women in Scandinavia and in Southern Europe* [Doctoral dissertation]. University of Bergen, Bergen, Norway.

Chung, H., & Muntaner, C. (2007). Welfare state matters: A typological multilevel analysis of wealthy countries. *Health Policy*, *80*(2), 328–339. doi: 10.1016/j.healthpol.2006.03.004

Creswell, J. W. (2009). *Research design: qualitative, quantitative, and mixed methods approaches. 3. ed.* London: Sage Publications.

Crombie, I., Irvine, L., Elliott, L., & Wallace, H. (2005). Closing the health inequalities gap: an international perspective. Copenhagen.

Dahl, E. (2002). Health inequalities and health policy: the Norwegian case. *Norsk Epidemiologi*, *12*(1), 69–75.

Dahlgren, G., & Whitehead, M. (1991a). Policies and strategies to promote social equity in health. *Institute of Futures Studies 2007*:14

Dahlgren, G., & Whitehead, M. (1991b). The main determinants of health. In: Policies and Strategies to Promote social equity in health. *Institute of Futures Studies 2007*:14

Denscombe, M. (2007). *The good research guide: for small-scale social research projects. 3. ed.* Maidenhead: McGraw-Hill International.

Directorate of Health and Social Affairs Norway. (2005a). *Sosiale ulikheter i helse. En kunnskapsoversikt* [Social inequalities in health. A review]. Oslo.

Directorate of Health and Social Affairs Norway. (2005b). *The challenge of the gradient. The Norwegian Directorate for Health and Social Affairs' plan of action to reduce social inequalities in health*. Oslo.

Directorate of Health Norway. (2005). *Handlingsprinsipper for å takle sosial ulikhet i helse* [Principles of action to tackle social inequality in health]. Oslo.

Directorate of Health Norway. (2010a). *Health Promotion – achieving good health for all*. Oslo.

Directorate of Health Norway. (2010b). *Helsedirektoratets årlige rapport om arbeidet med å utjevne sosiale helseforskjeller. Folkehelsepolitisk rapport 2010*. Oslo.

Dragano, N., & Siegrist, J. (2009). Die Lebenslaufperspektive gesundheitlicher Ungleichheit: Konzepte und Forschungsergebnisse [The life course perspective on health inequity: concepts and research results]. In: Richter M., Hurrelmann K. *Gesundheitliche Ungleichheit: Grundlagen, Probleme, Perspektiven. 2. ed.* (pp. 181–194). Wiesbaden: VS Verlag.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton: Princeton University press.

EuroHealthNet, & Federal Centre for Health Education Germany. (2006). *Position paper on "Tackling health inequalities"*. Brussels: Cologne.

First International Conference on Health Promotion. (1986). *Ottawa Charter for Health Promotion*. Ottawa.

Fosse, E. (2009). Norwegian public health policy: revitalization of the social democratic welfare state? *International Journal of Health Services, 39*(2), 287–300. doi: 10.2190/HS.39.2.d

Fosse, E. (2011). Different welfare states -different policies? An analysis of the substance of national health promotion policies in three European countries. *International Journal of Health Services, 41*(2): 255-72. doi: 10.2190/HS.41.2.e

Fosse, E. (2011). Policies to reduce health inequalities in families with children. Document analysis in four European countries [published working document]. Retrieved from: http://www.equityevidence.eu/GRADIENT/EN/publications/

Fosse, E, & Strand, M. (2010). Politikk for å redusere sosiale ulikheter i helse i Norge: fornyet politisering av folkehelsespørsmål. *Tidsskrift for velferdsforskning, 13*(1), 14–25.

GRADIENT. (2009). *Gradient: Description of Work* [unpublished report to the Seventh Framework Programme Health, Annex I].

GRADIENT. (2011a). *Tackling the gradient in health*. Retrieved November 21, 2011, from http://www.health-gradient.eu/GRADIENT/EN/home/

GRADIENT. (2011b). *Tackling the gradient: applying public health policies to effectively reduce health inequalities amongst families and children*. Retrieved February 16, 2011, from http://www.health-gradient.eu/GRADIENT/EN/home/

Graham, H. (2004). Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly*, *82*(1), 101–124. doi: 10.1111/j.0887-378X.2004.00303.x

Graham, H. (2009). *Understanding health inequalities. 2. ed.* Buckingham: Open University Press.

Graham, H., & Power, C. (2004). Childhood disadvantage and health inequalities: a framework for policy based on lifecourse research. *Child: Care, Health and Development*, *30*(6), 671–678. doi: 10.1111/j.1365-2214.2004.00457.x

Green, J., & Thorogood, N. (2009). *Qualitative methods for health research. 2. ed.* London: Sage Pubn Inc.

Hanssen, G. S., Helgesen, M. K., & Vabo, S. I. (2005a). Storting og regjering. In: *Politikk og demokrati. En innføring i stats- og kommunalkunnskap* (pp. 96–124). Oslo: Gyldendal.

Hanssen, G. S., Helgesen, M. K., & Vabo, S. I. (2005b). Fylkeskommunen og det regionale nivået. In: *Politikk og demokrati. En innføring i stats- og kommunalkunnskap* (pp. 143–160). Oslo: Gyldendal.

Hanssen, G. S., Helgesen, M. K., & Vabo, S. I. (2005c). Forholdet mellom kommune og stat. In: *Politikk og demokrati. En innføring i stats- og kommunalkunnskap* (pp. 213–239). Oslo: Gyldendal.

Hanssen, G. S., Helgesen, M. K., & Vabo, S. I. (2005d). Politisk organisering i kommunen. In: *Politikk og demokrati. En innføring i stats- og kommunalkunnskap* (pp. 161–189). Oslo: Gyldendal.

Helgesen, M. K. (2011). *Governance and health in planning*. Master lecture at the University of Bergen, Bergen.

Hurrelmann, R. (2003). Determinanten von Gesundheit. In: Federal Centre for Health Education. (2003). *Leitbegriffe der Gesundheitsförderung. Glossar zu Konzepten, Strategien und Methoden in der Gesundheitsförderung. 4. ed.* (pp. 26–28). Cologne: Peter Sabo.

Lundberg, O. (2009). How do welfare policies contribute to the reduction of health inequalities? *Eurohealth*, *15*(3), 24–27.

Lundberg, O., Yngwe, M. Å., Stjärne, M. K., Björk, L., & Fritzell, J. (2008). *The Nordic experience: welfare states and public health (NEWS)*. Health Equity Studies No 12. Stockholm: Centre for Health Equity Studies (CHESS) Stockholm University/Karolinska Institute.

Mackenbach, J. (2006). *Health inequalities: Europe in profile*. Expert report commissioned by the UK Presidency of the EU. Rotterdam.

Mackenbach, J., Judge, K., Navarro, V., & Kunst, A. (2007). Strategies to reduce socio-economic inequalities in health in Europe: lessons from the Eurothine

project. In: *Tackling inequalities in Europe. Final report from the Eurothine project*. Rotterdam: Department of Public Health, University Medical Centre.

Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. *The Lancet, 370*(9593), 1153–1163. doi: 10.1016 / S0140-6736(07)61385-3

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair society, healthy lives. The Marmot review. Strategic review of health inequalities in England*. London. Retrieved from: http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

Mielck, A. (2000). *Soziale Ungleichheit und Gesundheit: empirische Ergebnisse, Erklärungsansätze, Interventionsmöglichkeiten*. Bern: H. Huber.

Mielck, A. (2008). Soziale Ungleichheit und Gesundheit in Deutschland. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz, 51*(3), 345–352. doi: 10.1007/s00103-008-0465-1

Ministries of Norway. (2007). *Barnas framtid. Nasjonal strategi for barn og unges miljø og helse 2007-2016* [Children's future. National strategy for health and a healthy environment for children and adolescents 2007-2016]. Oslo.

Ministries of Norway. (2009). *Regjeringens strategi for forebygging. Fellesskap, trygghet, utjevning* [Governmental strategy on prevention. Solidarity, safety, social balance]. Oslo.

Ministry of Education and Research Norway. (2006). *... og ingen sto igjen. Tidlig innsats for livslang læring* [Early intervention for lifelong learning]. Oslo.

Ministry of Health and Care Services Norway. (2006). *National strategy to reduce social inequalities in health*, Based on report to the Storting nr. 20 2006-2007. Oslo.

Ministry of Health and Care Services Norway. (2010). *Forslag til ny folkehelselov. Høringsnotat* [Suggestion for a new law on public health. Hearing note]. Oslo.

Ministry of Health and Care Services Norway, Ministry for Labour and Social Inclusion Norway. (2006). *Nasjonal helseplan 2007-2010* [National health plan 2007-2010]. Based on St.prp.nr.1, 2006-2007. Oslo.

Ministry of Health Norway. (2002). *Resept for et sunnere Norge* [Prescriptions for a healthier Norway], based on report to the Storting nr. 16 (2002-2003). Oslo.

Ministry of Labour and Inclusion Norway. (2006). *Arbeid, velferd og inkludering* [Employment, welfare and inclusion] Report to the Storting no. 9 2006-2007. Oslo.

Ministry of Labour and Social Inclusion. (2008). *Handlingsplan mot fattigdom* [Action plan against poverty], based on St.prp.nr.1 (2008-2009). Oslo.

Ministry of Local Government and Regional Development Norway. (2008). *Local government in Norway* [brochure]. Oslo.

Ministry of Local Government and Regional Development Norway. (2011a). *The county authorities as regional developers*. Retrieved May 26, 2011, from http://www.regjeringen.no/en/dep/krd/Subjects/rural-and-regional-policy/organisering-roller-og-ansvar/the-county-authorities-as-regional-

devel.html?id=528754

Ministry of Local Government and Regional Development Norway. (2011b). *The municipality's role in community development*. Retrieved May 26, 2011, from http://www.regjeringen.no/en/dep/krd/Subjects/rural-and-regional-policy/organisering-roller-og-ansvar/the-municipalitys-role-in-community-deve.html?id=528198

Ministry of Social Affairs and Health Finland. (2006). *Health in all policies. Prospects and potentials*. Helsinki.

National Committee for Research Ethics in the Social Sciences and the Humanities Norway. (2006). *Guidelines for research ethics in the social sciences, law and the humanities*. Oslo.

Navarro, V., & Shi, L. (2001). The political context of social inequalities and health. *Social Science & Medicine*, *52*(3), 481–491. doi: 10.1016/S0277-9536(00)00197-0

Norwegian Government. (2011). *Lov om folkehelsearbeid* [Public Health Law]. Stortinget [Norwegian Parliament]. Retrieved September 16, 2011, from http://www.stortinget.no/no/Saker-og-publikasjoner/Saker/Sak/?p=49358

Norwegian Government. (2012). *Norway's Governments since 1945*. Regjeringen.no. Retrieved February 7, 2012, from http://www.regjeringen.no/en/the-government/previous-governments/the-structure-of-the-registry/governments/modern-times/governments-since-1945.html?id=438715

Public Health Institute Norway. (2007). *Sosial ulikhet i helse. En faktarapport [Social inequities in healh. A review]* (No. 2007:1). Nydalen. Retrieved from http://www.fhi.no/eway/default.aspx?pid=233&trg=MainLeft_5565&MainArea_5661=5565:0:15,3261:1:0:0:::0:0&MainLeft_5565=5544:61282::1:5567:17:::0:0

Public Health Institute Norway. (2010). *Folkehelserapport. Helsetilstanden in Norge* [Public health report. The health state in Norway] 2010 (Vol. 2). Oslo.

Regional Office for Europe of the World Health Organisation. (2003). *Social determinants of health: The solid facts*. Copenhagen.

Royal Norwegian Embassy in Washington. (2011a). *The Storting*. Norway. The official site in the United States. Retrieved June 6, 2011, from http://www.norway.org/aboutnorway/society/political/storting/

Royal Norwegian Embassy in Washington. (2011b). *The Government*. Norway. The official site in the United States. Retrieved June 6, 2011, from http://www.norway.org/aboutnorway/society/political/government/

Sixth Global Conference on Health Promotion. (2005). *The Bangkok Charter for Health Promotion in a Globalized World*. Bangkok.

Strand, Groholt, E.-K., Steingrimsdottir, O. A., Blakely, T., Graff-Iversen, S., & Naess, O. (2010). Educational inequalities in mortality over four decades in Norway: Prospective study of middle aged men and women followed for cause specific mortality, 1960-2000. *British Medical Journal, 340*(c654), c654–c654. doi: 10.1136/bmj.c654

Strand, M, Brown, C., Torgersen, T., & Giæver, Ø. (2009). *Setting the political agenda to tackle health inequity in Norway*. Studies on social and economic determinants of population health, Nr. 4. Copenhagen.

Strand, M., & Fosse, E. (2011). Tackling health inequalities in Norway: applying linear and non-linear models in the policy-making process. *Critical Public Health*, *21*(3), 373–381. doi: 10.1080/09581596.2010.492210

Whitehead, M. (1991). The concepts and principles of equity and health. *Health Promotion International*, *6*(3), 217 –228. doi: 10.1093/heapro/6.3.217

Whitehead, M. (1998). Diffusion of ideas on social inequalities in health: A European perspective. *The Milbank Quarterly*, *76*(3), 469–492. doi: 10.1111/1468-0009.00099

Whitehead, M., & Dahlgren, G. (2006). *Concepts and principles for tackling social inequities in health: Levelling up part 1*. Copenhagen.

Whitehead, M., & Dahlgren, G. (2006b). *European strategies for tackling social inequities in health: Levelling up part 2*. Copenhagen.

World Health Organisation. (2005). *European strategy for child and adolescence health and development*. Copenhagen.

World Health Organisation. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva: Commission on Social Determinants of Health.

World Health Organisation. (2010). *The determinants of health*. Retrieved

November 19, 2010, from http://www.who.int/hia/evidence/doh/en/

World Health Organisation Regional Office for Europe. (2003). *The solid facts*. EURO Nonserial Publication (2nd ed.). Copenhagen.

LIST OF FIGURES

All interviews conducted for this study were held in Norwegian. This section presents an English version of the interview guide, and leaves aside formal aspects that are originally included in the Norwegian version, such as the introduction, presentation of the study, informed consent, and similar information.

INTERVIEW GUIDE

National strategies to reduce social inequities in health: aims and development

- What are the most important national policies/strategies to reduce SIH in Norway?
    - What are the most important measures recommended in these policies/strategies?
    - Which actors are responsible for the implementation of these measures? (Are these local, regional, or national actors?)
    - Does the policy/strategy focus on the entire population, specific groups, or both?

- Could the responsible actors (local, regional, national level) participate in the development of these policies?
    - If yes: in which ways? If no: who developed the strategies?
    - Were there inter-sectoral working groups (or similar) to allow for

an inter-sectoral perspective?

- How was the policy development process coordinated?

Implementation: political levels, responsible actors, challenges, success factors

- Which political level is most important with regard to the reduction of SIH (local, regional, national)?
  - Why?

- Do you think that local and regional actors are motivated to implement a national policy/strategy? (You may think of those you mentioned in the beginning)
  - If yes: How and why?
  - If no: In your view, how could the actors at these political levels be motivated to implement a national strategy?

- How do the different political levels cooperate to successfully implement a national policy/strategy at all levels?

- In your view, what are the main challenges of implementing national policies/strategies at <u>local</u> levels? (You may think of those you mentioned in the beginning)
  - Which factors are most important for a successful implementation at local levels (how can obstacles be overcome)?

- In your view, what are the main challenges of implementing national

policies/strategies at regional levels? (You may think of those you mentioned in the beginning)

- Which factors are most important for a successful implementation at regional levels (how can obstacles be overcome)?

The new Public health act: perspectives and developments

- Who initiated the development of the new Public health act?
  - Did local and regional actors contribute to the development of the law (how)?
  - Were there inter-sectoral working groups (or similar) to allow for an inter-sectoral perspective?
  - How was the policy development process coordinated?

- What are the most important strategies to successfully implement the new Public health act at local and regional levels?
  - Which role does financial support play, e.g. earmarked grants?

- In your view, what are the main challenges of implementing the new Public health act at all political levels?

- Do you think that the new Public health act will help to establish a higher priority of health promotion in Norway (how, why not)?

Is there something else you wish to ask or say?

APPENDIX II: ETHICAL APPROVAL BY THE NORWEGIAN SOCIAL SCIENCE DATA SERVICES (NSD)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Elisabeth Fosse
HEMIL-senteret
Universitetet i Bergen
Christiesgt. 13
5015 BERGEN

Vår dato: 16.06.2011 Vår ref: 27331 / 3 / MAB Deres dato: Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 01.06.2011. Meldingen gjelder prosjektet:

27331	*Norwegian Policies to reduce Social Inequities in Health among Families and Children: A qualitative Case Study*
Behandlingsansvarlig	*Universitetet i Bergen, ved institusjonens øverste leder*
Daglig ansvarlig	*Elisabeth Fosse*
Student	*Marie Josefine Grimm*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 01.07.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Bjørn Henrichsen Marte Bertelsen

Kontaktperson: Marte Bertelsen tlf: 55 58 33 48
Vedlegg: Prosjektvurdering
Kopi: Marie Josefine Grimm, Fosswinckels gate 51 A, 5008 BERGEN

Avdelingskontorer / *District Offices:*
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. HSL, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. martin-arne.andersen@uit.no

APPENDIX III: INFORMED CONSENT FORM

Informasjon til deltakerne om studien: "Norwegian policies to reduce social inequities in health among families and children"

Denne studien er en masteroppgave som behandler norske politiske strategier til å redusere sosiale ulikheter i helse blant familier og barn. Studien inkluderer både analyser av politiske dokumenter og intervjuer med medarbeidere av forskjellige departementer.

Vi tror at din erfaring kan bidra til å gi oss viktig informasjon i denne sammenhengen.

Dersom du bestemmer deg å delta i intervjuet, vil du forbli anonymt. Kjennemerker som gjør mulig å identifisere deg (navn, kjønn, for tydelige personlige- og posisjonshenvisninger) vil slettes i skriftlig rapport. Navnet vil erstattes med tall ("Respondent 1"). Ingenting som blir sagt eller gjort under intervjuet vil kommuniseres til andre personer eller orgniasasjoner, med unntak av anonymiserte opplysninger i publikasjonen. Inspillingene vil beskyttes med sikkert passord på datamaskin og ødelegges senest ett år etter intervjuet.

For å garantere at dine opplysninger er forstått og publisert som aktet, har du mulighet å sjekke resultatkapittelen før publikasjon.

Hvis du deltar i denne studien, har du rett til å nekte svar eller avslutte din deltakelse når som helst mens intervjuet pågår. I så fall vil alle opplysninger slettes med det samme.

Dersom du vil delta, vær så snill å lese og signere følgende ark.

Takk for samarbeidet,

Marie Josefine Grimm

Master student av programmet "International Master in Health Promotion" ved Universitet i Bergen (UiB)

Veileder: Prof. Dr. Elisbabeth Fosse, Førsteamanuensis ved UiB

E-post: Marie.Grimm05@gmail.com

Skriftlig samtykke

Målet og metodene som brukes i studien ble forklart på en forståelig måte. Det ble opplyst at dersom jeg deltar i intervjuet, vil mitt navn, kjønn, stilling og andre kjennetegn bli slettet i den skriftlige rapporten. Ingenting som blir sagt under intervjuet vil kommuniseres til andre personer eller organisasjoner uten fullstendig anonymisering. Innspillingene skal ødelegges senest ett år etter intervjuet.

Jeg har rett til å nekte svar eller avslutte min deltakelse når som helst mens intervjuet pågår. I så fall vil alle opplysninger slettes med det samme.

Navn: _____

Signatur: _____

Dato: _____