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Norwegian policies to reduce social inequalities in health: Developments from 1987 to 2021

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Abstract

Reducing social inequalities in health has been an important aim in the development of the Nordic welfare states. This Commentary presents the development of Norwegian policies in this area from 1987 to 2021. Social inequalities entered the political agenda in Norway in the 1980s, but were mostly defined as a problem for selected marginalised groups. The World Health Organization project led by Michael Marmot was an inspiration for Norwegian policy-makers and the concept of the social gradient was introduced. From 2005, levelling the social gradient in health became a central strategy in Norwegian policy-making and culminated in the Public Health Act 2012. This Act focuses on the structural determinants of health and the municipalities have a central role in its implementation. However, the municipalities are mostly responsible for services providing downstream measures and have little control over social determinants such as tax or labour market policies. The Public Health Act is important because it institutionalises social inequalities as a policy field within public health. Not only the municipalities, but all administrative levels have to contribute to meet the aim of reducing the social gradient.

Keywords: *Norwegian public health policy, social inequalities, social determinants of health, national policy, local policy*

The reduction of social inequalities is embedded in the Nordic social democratic welfare model [1]. In Norway, the labour movement was a vital force in developing public health policies and improving the health of the population in the 1930s. What we today refer to as the social determinants of health was on the agenda and living conditions – including a fair income, healthy housing and social welfare benefits – were increasingly understood as prerequisites for good public health. The development of the Norwegian welfare state started after the Second World War and reducing social inequalities was an important political aim, formulated and implemented by the social democratic governments in office. However, in the 1960s, the focus shifted to health care measures and more individual measures, aiming to change individual lifestyles. The issue of increasing global social inequalities was reintroduced in the 1980s by global movements such as the World Health Organization (WHO) (including

Health for All 2000 and the Ottawa Charter for Health Promotion).

This Commentary addresses Norwegian policies within public health, with a focus on the social inequalities in health from 1987 to 2021. In particular, we focus on whether health inequalities have been on the agenda, how these inequalities have been described and what policies have been developed and implemented.

The concepts developed by Dahlgren and Whitehead [2] of upstream and downstream policy measures are useful in characterising the different approaches to policies that can reduce social inequalities in health. Downstream factors are the behavioural, social and psychological risk factors that are most proximal to the individual, whereas upstream factors are the broader risks to population health at both international and national levels – for example, global neoliberal trade policies, national economic growth strategies that neglect poverty reduction,

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income inequalities, poverty, work-related health hazards and a lack of social cohesion. In terms of political measures, upstream measures include structural measures addressing the social determinants of health, whereas downstream measures are more targeted at individuals or groups at some sort of risk. Although both upstream and downstream policies are important in reducing social inequalities in health [3], an awareness of the structural determinants of health is important.

In Norway, reducing inequalities in health was established as a goal with the adoption of the WHO strategy Health for All 2000. In 1987, a Government White Paper was published as a follow up to these strategies [3]. Reducing social inequalities in health was a central aim in the White Paper (author's translation; p. 22):

With the adoption of the WHO targets for Health for All in 2000, Norway has made a commitment to reduce social inequalities by improving health conditions for the most vulnerable.

The suggested lines of action related to public health were to increase the focus on health in policy-making in all government sectors. A second action was to increase activities within disease prevention and health promotion. A third was to stimulate the reorganisation of health services in a direction that would give special attention to inequalities in terms of social background and geographical factors and to promote equality in the distribution of health services. The political strategies were highlighted in this White Paper. However, no specific targets or goals were set.

In the first White Paper on health promotion from 1993 [4], the Ottawa Charter [5] was the explicit basis for the Norwegian vision of how health promotion policy should be expressed. Even though the White Paper had a general focus on the broader determinants of health, issues of equity and social inequalities in health were not included. This policy document was followed by a number of action plans in several areas. Even though the rhetoric of the White Paper was inspired by a broad understanding of health, the policies to follow it up were narrower in focus and mostly concentrated on downstream measures in fields such as accidents and injuries [6].

A new White Paper on public health was published in 2003 [7]. It was entitled 'Prescriptions for a healthier Norway' and outlined Norway's public health policy for the next decade. It was the first time since 1987 that inequalities were raised as an issue in a White Paper. However, it was mainly conceptualised as a problem for a small minority of the population. There was a strong

focus on lifestyle factors that may cause disease and the situation for vulnerable and marginalised groups was the focus of attention. The development of increasing social inequalities was considered a problem, but was again formulated as a problem for only some population groups (author's translation; p. 8):

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.

In line with the emphasis on marginalised and vulnerable social groups, mostly downstream measures were suggested – for example, interventions to influence lifestyles would be assessed in terms of their consequences for social inequalities in health. At the time, there was not much research on social inequalities in health in Norway. Many social themes were analysed using gender or geographical differences as variables, but social inequalities were not included in the analysis [8,9].

However, in some respects, the policy paper did point towards more upstream measures. First, social inequalities in health should be introduced as an element in health impact assessment. Second, competence would be built up in the field of health inequalities and, third, a plan of action (the Challenge of the Gradient) would be developed to combat social inequalities in health [10]. These three areas of action pointed towards a policy shift. The development of the plan of action was delegated by the Ministry of Health and Care Services to the Directorate for Health and Social Affairs. The action plan should provide a foundation for the Directorate for Health and Social Affairs in their work on social inequalities in health. The action plan indicated a shift of focus compared with former policy documents. In the plan, it is argued against a perspective where the focus is only on the poorest groups (author's translation; p. 9):

Working to reduce social inequalities in health means making efforts to ensure that all social groups can achieve the same life expectancy and be equally healthy. Differences in health not only affect specific occupational groups or the poorest people or those with least education. On the contrary, research indicates that we will not address the relation between socioeconomic position and health if we base our activities on strategies that focus on 'the poor' as an isolated target group.

In 2005, a left-wing, red–green coalition took over office in Norway. One of their main aims was to

reduce poverty and social inequalities. The action plan was perfect for their purpose and the national policies were developed further based on the Challenge of the Gradient [11].

The Directorate for Health and Social Affairs was also assigned the task of establishing a centre of competence on social inequalities in health. As a follow up to Challenge of the Gradient, a national expert group was established. The mandate of the expert group was to contribute to the further development of national strategies to reduce social inequalities in health. The group members were all highly qualified researchers from the field, representing different backgrounds and approaches to studying social inequalities. In 2005 the national expert group developed a set of action principles to tackle social inequalities in health and six general action principles that should be followed in the efforts to reduce social inequalities in health.

The action principles were in accordance with the ideology outlined in the action plan. Upstream strategies were prioritised and these strategies were developed further as the government issued the White Paper National Strategy to Reduce Social Inequalities in Health in February 2007 [12]. This had a ten-year perspective for developing policies and strategies to reduce health inequalities.

The main point of the White Paper was that 'equity is good public health policy'. This implies a view on public health policies that aims for a more equal distribution of positive factors that influence health. The emphasis on upstream factors is strong in the paper (author's translation; p. 5):

The Norwegian population enjoys good health. However, averages conceal major, systematic inequalities. Health is unevenly distributed among social groups in the population. We have to acknowledge that we live in a stratified society, where the most privileged people, in economic terms, have the best health. These inequalities in health are socially determined, unfair and modifiable. The government has therefore decided to initiate a broad, long-term strategy to reduce social inequalities in health.

A perspective underlining universal welfare state policies was further emphasised (author's translation; p. 5):

A fair distribution of resources is good public health policy. The primary goal of future public health work is not to further improve the health of the people that already enjoy good health. The challenge now is to bring the rest of the population up to the same level as the people who have the best health – levelling up. Public

health work entails initiatives to ensure a more even social distribution of the factors that affect health.

The Norwegian Public Health Act was adopted in 2012 and may be considered as a follow up to the White Paper on equity. The act was based on five basic principles for public health: reducing social inequalities, health in all policies, sustainable development, promoting awareness and participation [13]. The Public Health Act may thus be understood as a revitalisation of the social democratic policy that was the cornerstone of the Nordic welfare state project through its focus on the social determinants of health [16].

In Norway, public health activities are mainly carried out at the local government level. The Public Health Act established a new foundation for strengthening systematic public health work in the development of policies and planning. This was achieved both horizontally in terms of better coordination of public health work across sectors and actors and vertically between authorities at the local, regional and national levels [14,15]. Local governments are mandated to produce health overviews, including monitoring the health status of their population as well as positive and negative factors influencing public health. The act communicates with the Planning and Building Act, which is the most important act for local governments. The act states that the overview is to be the basis of the Planning and Building Act mandated planning strategy made every four years. The local master plan is a central instrument for Norwegian municipalities and forms the basis for action plans, policies and concrete measures. The Directorate for Health has a central role in supporting the municipalities in the implementation of the Public Health Act.

Municipalities have given increased attention to public health and health inequalities since the Public Health Act was adopted [16,17]. For example, high-quality daycare institutions can reduce the risk of school dropout and may consequently contribute to levelling the social gradient [18].

Norwegian municipalities and also the Norwegian Association of Local and Regional Authorities are encouraged to apply the UN Millennium Development Goals, which include goals to reduce poverty and social inequalities, in their policy-making and planning. This has contributed to an increased awareness of health equity. There has also been a development from individual-oriented policies addressing mainly lifestyle issues to a policy addressing the social determinants of health and the social gradient in health. In the terminology of

Dahlgren and Whitehead [2], there has been a development from downstream to upstream policies. The Public Health Act is of particular significance because it mandates all administrative levels to address social inequalities.

Differences between governments may also be observed. Although right-wing governments have had their main focus on downstream measures, the policies of left-wing governments have addressed upstream factors [19]. However, the municipalities still have a high degree of freedom in making priorities and there are few sanctions for those who do not follow up all the intentions of the Public Health Act. However, we observe an increasing interest and commitment among municipalities regarding issues of health inequalities. Even though Norwegian policy is based on an understanding of the social determinants of health and outlines policies in all sectors of society, it does not mean that determinants such as tax policy, work–life policy or housing policy are addressed in concrete policies and measures.

Reducing health inequalities is acknowledged as a so-called wicked problem [20,21]. Wicked problems are embedded in political conflict and this makes it difficult to find sustainable policy solutions. The definitions of the problem may cause disagreement regarding both the causes and the solutions to the problem. Policies to reduce social inequalities in health tend to drift downstream, which means towards policies addressing individual lifestyle factors and not the wider social determinants of health. In other words, the wicked problem is being redefined into a tame one, meaning that the problem is being redefined into a simpler, less contested problem and thus presenting solutions that are manageable, often by the health services [22]. The consequence is that even if problems related to health inequalities are conceptualised in terms of the social determinants of health in national policy papers, the actual policy measures are seldom in line with these concepts. In short, they are not comprehensive and do not include whole-of-society measures.

Even if local awareness represents a positive development, the local level alone cannot reduce social inequalities. Many policy areas demand national policies and measures that include addressing the social determinants and the ‘causes of the causes’ as formulated by Michael Marmot. The fact that Norway has a public health act is still important. In the act, health inequalities have been institutionalised as an important policy field. By adopting the act, the issue of health inequalities is not so easy to move down the agenda, particularly if it also gains a footing at the local level.

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