How do Icelandic National Authorities Implement Public Health Policies?

Master Thesis in Health Promotion and Health Psychology

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Foreword

I would like to thank Elisabeth Fosse for lighting a spark of interest during her first lecture in this master program about health politics. Since I can remember politics and its influence on society has been a big interest of mine. Later as an adult, lifestyle and its impact on mental health became an interest of mine through my bachelor studies in psychology. Elisabeth managed to combine my two main interests -politics and health- and it has been on my mind ever since. Her lectures went through the history of health politics in Norway over the last decades and in my free time I read about the development of health politics and policies in Iceland. I quickly noticed a difference which I wanted to explore, and the results are presented in this thesis.

I would like to thank my supervisor Torill Larsen for her patience, understanding and support throughout this demanding process. I would also like to think Sigrún Guðlaugsdóttir Henriksen for support, tips, and feedback for the past year and a half. My dear friend Elín, thank you for taking my phone calls in all kinds of moods and for always cheering me on. Last but not least my biggest thanks go to my fiancé Elvar, my biggest support. Thank you for being a shoulder to cry on when this process got extra tough, thank you for your fantastic jokes which always cheer me up, thank you for your limitless patience and belief in me and thank you for taking care of our baby daughter while I wrote this thesis.

To my dearest daughter Margrét Alda, mommy did this for you.

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Abstract

Iceland is one of the Nordic welfare states, which are known for their generous welfare services, income redistribution and solidarity. Like many other Western societies, Iceland faces public health challenges which are unequally distributed amongst the population, despite the Nordic emphasis on equalities. The aim of this study is to add knowledge to the literature about Icelandic authorities' public health policy implementation. It also aims to find out to what extent Icelandic national authorities address social inequalities in health and apply "Health in All Policies" in their actions. This is a qualitative study where data were collected through six interviews with informants from both national and local levels. Semi-structured interviews were conducted with a phenomenological approach and thematic analysis was used for the data analysis. The findings suggest a lack of political commitment to reducing health inequalities and that the "Health in All Policies" approach does not seem to be applied despite the government's expressed interest of the approach in previous policy statements. The current legislation puts the legal responsibility of health promotion on the Directorate of Health, which also is a regulatory body for the health sector. The informants had limited resources for policy implementation and called for increased intersectoral collaboration in public health. Recent policies are mainly lifestyle oriented and linked to the health sector.

Key words: Social inequalities in health, Health in All Policies, Iceland, health politics, social determinants of health, health promotion, Lippitt-Knoster Model of Complex Change.

Sammendrag

Island er et av de nordiske velferdstatene som er kjent for sine sjenerøse velferdstjenester, inntektsomfordeling og solidaritet. Som flere vestlige land står Island overfor folkehelseutfordringer som følger den sosiale helsegradienten, tross for det nordiske fokuset på sosial uliket. Formålet med denne studien var å innhente mer kunnskap om hvordan islandske nasjonale myndigheter implementerer folkehelsepolitikk og undersøke i hvilken grad deres politikk er knyttet til sosial ulikhet i helse. I tillegg ble det sett på i hvilken grad islandske myndigheter addresserer sosial ulikheter i helse og anvender «helse i alt vi gjør» tilnærmingen i sine tiltak. Dette er en kvalitativ studie som brukte en fenomenologisk tilnærming til å forstå informantene sine opplevelser av å jobbe med islandsk folkehelsepolitikk. Data ble samlet gjennom seks semistrukturerte intervjuer med informanter fra både nasjonalt og lokalt nivå. Tematisk analyse ble brukt som metode for dataanalysen. Funnene antyder at islandsk folkehelsepolitikk blir i liten grad implementert grunnet mangel på nødvendige ressurser. Informantente beskrev rekke barrierer som hemmet implementering og ønsket større grad av tverrsektorielt samarbeid innen folkehelse. Politisk vilje til å redusere sosiale helseforskjeller er også begrenset og «helse i alt vi gjør» tilnærmingen er i liten grad brukt til tross for regjeringens tidligere erklærte vilje om å anvende metoden i tidligere stortingsmeldinger. Gjeldene lovgivning legger ansvaret for folkehelsearbeid og helsefremming på Helsedirektoratet, som også er en tilsynmyndighet for helsesektoren. Nylig folkhelsepolitikk fokuserer i stor grad på å endre helseatferd og er ofte koblet mot helsesektoren.

Nøkkelord: Sosial ulikhet i helse, helse i alt vi gjør, Island, folkehelsepolitikk, sosiale helsedeterminantene, sosiale helsegradienten, helsefremmende arbeid, Lippitt-Knoster Model of Complex Change.

„Above all, on humanitarian grounds national health policies designed for an entire population cannot claim to be concerned about the health of all the people, if the heavier burden of ill-health carried by the most vulnerable sections of society is not addressed“ (Whitehead, 1991, p. 218).

1. Introduction

The Nordic welfare states are known for their sizeable public sector, where policies and structures are based on principles of universalism and equality (Pedersen & Kuhnle, 2017). The Nordic welfare model places a strong emphasis on income redistribution through taxation and social benefits which targets not only those in the greatest need but the entire population (Fosse, 2011). A characteristic of the Nordic countries is their social security systems which provide the whole population benefits in form of unemployment benefits, paid sick leave, disability benefits and retirement payments (Pedersen & Kuhnle, 2017). Individual assessed subsides are accessible for groups who are at risk of poverty (Eklund Karlsson et al., 2022) which is done to promote equality between different groups so that people's background, gender, or race does not hinder people's chances in life (Kvist, 2001). The public sector is a leading supplier of health and social services (Fosse, 2011), which are tax-funded and provide universal coverage for residents (Christiansen et al., 2018). The responsibility for welfare services is divided between the state, regional and local authorities (Eklund Karlsson et al., 2022; Kvist, 2001). Local and regional authorities are financed with local taxes as well as national budgets and they're responsible for prioritizing services based on their budgets (Eklund Karlsson et al., 2022). Countries with a generous, universal, social protection system have less poverty and smaller income inequalities compared to countries which aim their support only to the poor, resulting in better population health (Marmot et al., 2008).

Fosse and Helgesen (2019) conducted a public health policy review on how the Nordic countries address the social determinants of health. The social determinants of health can be described as the prerequisites for health. All countries provide services which are vital for reducing social inequalities in health (the lower the socioeconomic level, the poorer the health) such as day care, schools etc (Fosse & Helgesen, 2019). These services are regulated by local governments in all countries with minor differences (Fosse & Helgesen, 2019). Their analysis found that Norway and Finland have a public health act where local municipalities are obligated to address the social determinants of health (Fosse & Helgesen, 2019). These acts were the only commitments at the national level which mandate Nordic authorities to address social health inequalities (Fosse & Helgesen, 2019). The Swedish government as a whole is accountable for all policymaking, spanning ministries, but in the rest of the Nordic countries, ministries of health are responsible for national public health initiatives (Fosse & Helgesen, 2019). Denmark focuses on individual behaviour in their policies and health inequalities are mainly seen as a problem which should be addressed by health professionals

and not as a political commitment (Fosse & Helgesen, 2019). Fosse and Helgesen (2019) concluded that Norway and Sweden have public health policies where reducing social inequality in health is one of the main goals.

Despite this emphasise on equality in the Nordic countries, social inequalities in health are still present in all countries. In Norway for example, a 40-year-old man in the richest 1% is expected to live 14 years longer than a man at the same age in the poorest 1% (Helsedirektoratet, 2021). The health inequalities are sometimes even greater in the Nordic countries than in countries which have higher levels of inequality (Ólafsdóttir, 2021) and there are no signs of them decreasing; in fact numbers suggest that they are increasing (Fosse & Helgesen, 2019).

1.1 Iceland as a Welfare State

Iceland is a Nordic welfare state, meaning that it has an active social state with a wide public responsibility for the well-being of its residents (Pedersen & Kuhnle, 2017). Iceland's administrational system is divided into state level and municipal level (Karlsson & Eythórsson, 2019). Iceland has 64 municipalities (Samband íslenskra sveitarfélaga, n.d.) registered and they have legal obligations to provide a wide range social and welfare services which are important to reduce social inequalities in health (Eklund Karlsson et al., 2022). These services are for example child protective services, financial and social support, services for people with disabilities, housing services, primary schools, music schools, recreational centres, and sport facilities (Innviðaráðuneytið, 2022). In addition, Icelandic municipalities are free to provide services that are not governed by law if they wish to or have the financial means to do so (Innviðaráðuneytið, 2022). An example of a service which is not bound to law but almost every municipality has, are childcare services such as kindergartens.

1.2 Public Health Legislation in Iceland

The Ministry of Health has a responsibility for public health measures as well as health care services, retirement homes, medicinal matters, and health insurances (Stjórnartíðindi, 2022). The Directorate of Health is an institution under the Ministry of Health. The legal framework around public health work in Iceland is mainly found under the laws which describe the legal role of the Directorate of Health in Iceland (Lög um landlækni og lýðheilsu nr. 41, 2007). The legislation defines public health work as "sustaining and improving the health, well-being and the environment of the nation and its societal groups with health promotion, preventative measures and health services" (Lög um landlækni og lýðheilsu nr. 41, 2007). According to the

law, the Directorate of Health has four defined roles when it comes to health promotion; (1) take care of preventative measures and health promotion projects, (2) to promote public health work in co-operation to others who work within the field as well as to support education within the field of public health, (3) collect and analyse data about the population's health and health services and (4) evaluate regularly the progress of public health measures and compare it to existing goals (Lög um landlækni og lýðheilsu nr. 41, 2007). In addition, The Directorate of Health is responsible for advising the Minister of Health and other governmental institutions on matters related to health, health promotion and disease prevention[1] (World Health Organization, 2023a). The Directorate of Health also publishes regular reports about results and analysis form their public health data, such as a report by Elínardóttir (2021) where they analyse data to measure health inequalities in Iceland and suggest relevant interventions and policies to address health inequalities. The report is based on the World Health Organization's report (2019) which suggests describes causes of health inequalities and policies and interventions to reduce them.

In addition to these obligations, the Directorate of Health is also responsible for regulating health services and health professionals, keeping various health registers such as birth registers, disease registers and a register for prescription drugs. The institution also gives out licenses to health professionals and receives complaints from users of the Icelandic health care system (Lög um landlækni og lýðheilsu nr. 41, 2007).

In 2011 the Public Health Institute of Iceland was moved to the Directorate of Health where there is now a department of public health (World Health Organization, 2023a).

1.3 Current Governmental Policies in Public Health

The Icelandic government puts forward a public health plan which is updated every five years. The Directorate of Health publishes public health indicators every year where they measure the status of public health in different districts (Embætti landlæknis, 2023a). This year they also published indicators for the nine biggest municipalities in Iceland for the first time (Embætti landlæknis, 2023a). In addition to their indicators, they also maintain an online dashboard where they measure certain key variables in public health, such as self-rated physical and mental health, vegetable consumption, financial security, sleep etc. (Embætti landlæknis, 2023a). They also conduct a big study every five years called the Health and

[1] The 2021 policy says: health promotion and prevention, which is interpreted in this thesis as disease prevention.

Well-Being survey which monitors Icelander's well-being and welfare (Embætti landlæknis, n.d.).

1.3.1 The First Public Health Policy 2016

The Ministry of Welfare put forward the first public health plan/policy in 2016 (World Health Organization, 2023a). The policy is a result from a ministerial committee on public health where the Prime Minister, Health Minister, Social- and Housing Minister and the Minister of Education and Cultural Affairs worked together to create the policy (Velferðarráðuneytið, 2016). The Minister of Health steered an additional advisory committee where representatives from various institutions and organizations contributed to the policy development. A project management group was also established where three persons were involved to coordinate the process (Velferðarráðuneytið, 2016). The government at the time which created the policy included the Independence party which is a right-wing party and the Progressive party which is a central party.

In the introduction, lifestyle factors are mentioned such as exercise and nutrition as well as some social and environmental factors. The policy shortly discusses the work of Michael Marmot and the effect one's socioeconomic status has on health. It also discusses the right of every child to have access to healthy food and the ability to take part in leisure activities independent of their parents' income (Velferðarráðuneytið, 2016). They further add that the school systems, workplaces, and institutions should be health promoting.

In contrast, the policy mentions multiple times that Icelanders are responsible for their own health and the future vision the policy specifically mentions is that "Icelandic citizens are conscious about their responsibility for their own health" (Velferðarráðuneytið, 2016, p. 9). In the conclusion they further emphasise personal responsibility by writing "We are not only responsible for our own health and welfare but also for our children's because we are their role models, with clear goals, courage and foresight as guiding principles, and not to mention, the right priorities, then no one should have choose to their disadvantage." (Velferðarráðuneytið, 2016, p. 20).

The policy's main goal is that Icelanders will be amongst the healthiest in the world by 2030.

The subgoals to achieve this goal is to: (Velferðarráðuneytið, 2016)

1. Make all municipalities participants in the project "Health Promoting Community". Including all educational levels and workplaces.

2. To take goal-orientated preventative measures when it comes to upbringing and education, nutrition, exercise, mental health, dental hygiene, violence, accidents, alcohol, tobacco, and use of other illicit drugs.
3. Decrease the prevalence of chronic diseases.
4. Develop social- and health measurements which provide information about Icelanders' social and health status amongst different groups.
5. When developing policies, authorities should think about how their actions impact the health and well-being of individuals. The "Health in All Policies" approach should be applied to governmental decisions.

Along with the policy, the Ministry of Welfare published an action plan. The action plan contains six steps to achieve this: (Velferðarráðuneytið, 2016)

1. Every municipality should become health promoting by participating in the Directorate of Health's Health Promoting projects.
2. To promote good upbringing for parents of children six years and below, this will be achieved through offering a course about upbringing in health care centres.
3. That professionals who work with children and parents get access to educational content/information about rest, physical activity, outdoor activities, nutrition, and mental health. A special emphasise will be put on physical activity, mental health, and nutrition in schools and at home.
4. All students in pre- and elementary schools will be physically active daily during school hours.
5. All children in pre- and elementary schools will learn about relaxing the mind as a way to improve concentration, mindfulness and to support relaxation.
6. "Health in All Policies", national policies should go through a health impact assessment. The Prime Minister's Office and The Directorate of Health should develop a framework which should be implemented by 2019.

1.3.2 Health Policy 2021 and Action Plan 2023

The Minister of Health put forward a new public health policy in 2021. It was put forward by a health minister from a left-wing party which was in government with the Independence

Party (a right wing party) and the Progressive party (a central party) (Stjórnarráð Íslands, 2022). The policy was accepted by the parliament which concluded that the guiding principle in the public health policy should be health promotion and disease prevention, which should be a part of all service provided by the health care system (Þingskjal 1108, 2020-2021). Their future vision for public health is:

1. Public health work should be goal-oriented, high-quality and co-operation between sectors is important, especially between health care centres and other sectors such as municipalities, with an emphasise on health promotion and preventative measures.
2. Public health work should be evaluated by measuring its quality, safety, accessibility, success, cost, and cost-effectiveness.

The plan from 2021 had seven main factors which were supposed to support public health work in Iceland. They are (1) Successful leadership, (2) Right services in the right place, (3) People first, (4) Active users, (5) Efficient service purchases, (6) Quality as a priority and (7) Future thinking (Þingskjal 1108, 2020-2021). The policy further states that public health work should be guided by equity and equality. Each factor had three to seven sub-goals.
To summarize some of the sub-goals (Þingskjal 1108, 2020-2021):

- Re-evaluate the legal framework around public health which defines the role of health care institutions, municipalities and others who do public health work.
- Define the financial responsibility and role of national authorities which do public health work.
- Public health should be a leading factor in all of the government's policy and plan-making.
- Public health research should be improved.
- Health promotion and prevention should be a part of all health care services.
- Authorities support increased health promotion for everyone by creating preferred circumstances in all aspects of people's lives throughout the whole lifespan and for people with different needs…Structural factors which prevent people from living healthy lives should be eliminated, such as poverty, unemployment, inequality, lack of education, lack of social support and marginalisation.
- The Directorate of Health will continue to have a leading role in public health work.

- Collaboration should be increased between institutions and ministries when it comes to public health.
- A multidisciplinary health promoting reception in health care.

In March 2023 a draft for a new action plan in public health was published for feedback from public by the Ministry of Health. The action plan is from the same government as in 2021 but now from a health minister from the Progressive party (Stjórnarráð Íslands, 2022). This is supposed to follow-up the governments public health plan from 2021. The action plan was created by a working group which was appointed in 2022 and one of their assigned goals was to create a plan which encourages Icelanders to care for their own health. Their results were first published at a public health conference hosted by the Ministry of Health in November 2022. A special emphasis was on health literacy. Goals for the next five years were to (Heilbrigðisráðuneytið, 2023):

1. To identify if there was a need for a new law framework around public health where the roles of the state and municipalities is made clear.
2. A health impact assessment should be made a part of the government's sustainability impact assessment when a new policy or legislation is being created.
3. A public health agreement will be made between multiple sectors in Iceland where a special attention will be given to (1) equality and equity, (2) exercise, training, nutrition, sleep, and mental health and (3) education and new solutions. In addition, collaboration between national authorities will be increased to activate different sectors which work with public health in Iceland.
4. Keep supporting health promoting projects led by the Directorate of Health, sustain the success Iceland has achieved with decreased alcohol and tobacco youth consumption as well as prevent the use of nicotine products in the same age group. Increase everyone's ability to be physically active no matter age. Support health promotion amongst seniors. Increase education within sport organizations about injuries and overtraining.
5. Raise awareness and increase health literacy within the public in collaboration with various sectors by educating about prevention and health promotion and the individual's responsibility for their health.
6. Improve electronical access to information about health promotion and preventative measures through official internet services as well as improve the health promoting

reception within the health care centres where people and groups can get advice about healthy living.

7. The role of the public health fund should be re-evaluated, and the fund should be better financed. It should be better defined who gets support from it and it should possibly be linked to other official plans.

1.4 Health Promoting Communities Project

As mentioned above, one of the policy's sub-goals was to make every municipality in Iceland a "Health Promoting Community". The project supports local communities to promote Icelanders' health and well-being by creating supportive environments (World Health Organization, 2023a). The project approaches public health work systematically and enables multilevel governance and community empowerment with its infrastructure (World Health Organization, 2023a). They use the UN's Sustainable Development Goals as a guiding framework in the project and have linked the goals to their version of Dahlgren and Whitehead's (2007) model which is a major tool for the municipalities as well as seven checklists which the Directorate of Health has developed (World Health Organization, 2023a). Every municipality has a coordinator who is responsible for the project implementation, and an intersectoral steering group. Municipalities have access to public health indicators which measure local challenges (World Health Organization, 2023a).
As of today, 41 out of 64 municipalities in Iceland participate in the project which means that 96% of the population live in a municipality which is Health Promoting (Embætti landlæknis, 2023b).

The Directorate of Health also has projects called Health Promoting Workplaces and Health Promoting Schools for all levels of education, namely preschools, elementary schools, and upper secondary schools (World Health Organization, 2023a). They apply the same systematic approach as with their community project. In their school projects they aim to engage parents, students, teachers and leisure organizations to create health promoting school settings (World Health Organization, 2023a). The schools gain access to information, an online working area, conferences, workshops, teaching materials, signs, posters and flags from the Directorate of Health (World Health Organization, 2023a).

1.5 Parliamentary Resolution on Implementing a Health Impact Assessment

In February 2023, a parliamentary resolution was put forward in the Icelandic parliament which suggested that a health impact assessment should be implemented into Icelandic

legislation (Þingskjal 428, 2023-2024). It did not receive parliamentary treatment but was put forward again in October 2023. 11 members of parliament support the resolution which suggests that a public health assessment should be a legally binding process which evaluates governmental proposals' impact on the population's health. The majority of the parliament members who support the resolution are from the Progressive party, a centrist party which is a part of the Icelandic government (Stjórnarráð Íslands, 2022). The resolution suggests that a group of specialists should be appointed by the Minister of Health where members of relevant ministries, academia, municipalities, and the Directorate of Health should suggest relevant methods to evaluate governmental proposals' impact on population health. The group should hand in their proposals by May 1st, 2024 (Þingskjal 428, 2023-2024). As this is written, the resolution is under parliamentary treatment.

A document which is attached to the resolution provides good argumentation for the benefits of a health impact assessment on Icelandic governmental proposals. It talks about an aging population which means that need for health care services will increase in the coming decades (Þingskjal 428, 2023-2024). It also shortly describes the social determinants of health, and that public health needs to be addressed across sectors. It further argues that there is a body of evidence which shows that legislations has proven to be very beneficial for population health and that this resolution matches current public health policies (Þingskjal 428, 2023-2024).

1.6 Iceland and the Well-Being Economy

Iceland is a part of the Well-Being Economy which emphasises on putting people and the planet first and that the economy should be designed to serve that purpose, not the opposite (Wellbeing Economy Alliance, 2022). This economic system prioritizes natural, economic, human, and social capital (OECD, n.d.). Iceland, along with Wales, Scotland and Finland have committed to shift the focus from only measuring typical economic factors such as gross domestic product to instead looking at factors such as well-being, sense of belonging, social cohesion, and equity (World Health Organization, 2023b). Iceland has also committed to implementing the United Nation's Sustainable Development Goals (SDG). The work of the SDG's and the Well-Being Economy is carried out by the Prime Minister's office and Statistics Iceland has developed indicators which measure important variables related to the SDG and the Well-Being Economy (World Health Organization, 2023a). The variables are measured in three categories: Society, Environment and Economy. Variables in the categories include trust in others, work-life balance, ratio of renewable energy, unemployment, quality

of housing etc (World Health Organization, 2023a). Iceland's top six priorities are (1) Mental health, (2) Secure housing, (3) Better work-life balance, (4) Zero carbon emissions, (5) Increasing scale and intensity of innovation and (6) Better communication with the public (World Health Organization, 2023a).

The World Health Organization did a status report about the implementation of the Well-Being Economy approach (World Health Organization, 2023a). They addressed several challenges in Iceland for the implementation of the approach. Some of these challenges include the need to address fragmented division of labour between ministries and governmental bodies (World Health Organization, 2023a); improving and implementing the new indicators and measures so that it can be agreed on across government sectors; a need for a comprehensive well-being policy which legally binds the commitment to work on Icelander's well-being across sectors (World Health Organization, 2023a); and balance between short-term and long-term thinking for politicians since it might take some years for policies to show positive effects and increase public awareness of the new approach (World Health Organization, 2023a). The report also stated that despite the Prime Minister's Office political commitment, it was visible that the health sector (Directorate of Health) was a driver, co-creator and a beneficiary of the Well-Being Economy policy approach (World Health Organization, 2023a).

1.7 Public Health Challenges in Iceland

Iceland faces several public health challenges like many other Western countries. Many of them are lifestyle related but the distribution of ill health is unequal in Iceland, where those in higher social positions are more likely to have better health (Elínardóttir et al., 2021).

In 2018, three out of four Icelanders report having good health while one third of Icelanders (32%) report having a chronic disease (OECD/European Observatory on Health Systems and Policies, 2021). Health risk behaviour accounts for 38% of deaths in Iceland. The combined impact of tobacco use, and poor nutrition contributes to 32% of this total. Other health-risk behaviours which cause death are alcohol consumption and lack of physical activity (OECD/European Observatory on Health Systems and Policies, 2021). Smoking rates amongst adults and adolescents is lower than in any European Union country: 8% of adults report smoking daily and only 6% of 10th graders report having smoked a cigarette during the last month prior being asked (OECD/European Observatory on Health Systems and Policies, 2021).

Alcohol consumption was noticeably lower than in the EU, in 2018 only 7% of 15-year-olds had been drunk more than once in their life compared to 22% in the European Union. Icelandic adults consumed 25% less alcohol than the European average in 2018. Despite low rates of alcohol consumption in Iceland, it is estimated that 24% of the Icelandic adult population have a harmful drinking pattern (Embætti landlæknis, 2023a). Low rates of alcohol and tobacco consumption amongst Icelandic youth can be traced back to a tight multi-sectoral collaboration in the late 90's where various groups in society collaborated to reduce the consumption of alcohol and tobacco amongst Icelandic youth (OECD/European Observatory on Health Systems and Policies, 2021).

Obesity rates in Iceland are amongst the highest in Europe, with the percentage of obese adults increasing from 20% in 2007 to 27% in 2017. Every fourth Icelandic adult engages in less than one hour of physical activity per week (Embætti landlæknis, 2023a), and 40% of Icelandic adults do not consume a serving of either fruits or vegetables daily (OECD/European Observatory on Health Systems and Policies, 2021). Only 10.4% of Icelanders meet the guidelines of eating at least five portions of fruits or vegetables every day (Embætti landlæknis, 2022).

In 2018, 21% of 15-year-olds were either overweight or obese, which is the fifth highest percentage in Europe (OECD/European Observatory on Health Systems and Policies, 2021). Approximately one fifth of adolescents in the same age group met official physical activity guidelines in 2022 (Embætti landlæknis, 2023a) and two thirds of 15-year-olds do not consume at least one portion of fruits or vegetables on a daily basis (OECD/European Observatory on Health Systems and Policies, 2021).

When it comes to mental health, 54.7% of Icelanders consider themselves as being very happy (at least eight or higher on the scale 1-10) (Embætti landlæknis, 2023a). Icelanders who report their mental health being poor or decent in 2022 was 32.6% (Embætti landlæknis, 2023a) and 24.8% report feeing stressed often or very often in daily life (Embætti landlæknis, 2021). The daily intake of anti-depressants was 157.3 per 1000 inhabitants in 2022, this has been a steady increase since 2010 where daily dose of anti-depressants was 101.3 per 1000 inhabitants (OECD, 2023). This is also the highest number of daily defined doses (DDD) measured amongst the OECD countries (OECD, 2023).

2. Theoretical Framework

This chapter will go through the foundation of health promotion and the Ottawa Charter of Health Promotion (World Health Organization, 1986). Social inequalities in health and its consequences will be described as well as some strategies to reduce social health inequalities. It will then explain the social determinants of health and the "Health in All Policies" (HiAP) approach which is used to improve population health and reduce health inequalities (Stål et al., 2006) The Lippitt-Knoster Model of Complex Change (1993) will be presented which includes important factors for successful policy implementation. Finally, the importance of politics and welfare regimes in the context of health promotion will be described as well as local authorities' roles in the Nordic welfare states.

2.1 Health Promotion and the Ottawa Charter

Health promotion evolved as a research field when the need to address environmental and behavioural determinants of health grew. A growing need to address factors such as the physical environment and socioeconomic environment has led to a focus on creating conditions where health flourishes rather than viewing health problems as biomedical issues or results of unfavourable health behaviours (Green et al., 2019).

The Ottawa Charter for Health Promotion (1986) was developed at the first health promotion conference in Ottawa, Canada. The document has had a shaping influence on health promotion around the world ever since (Kemm, 2015). The Ottawa Charter (1986) defines health promotion as "the process of enabling people to increase control over, and to improve, their health". This process includes making sure that everyone has access to "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity" or what the Ottawa Charter defines as the prerequisites for health (World Health Organization, 1986). The charter defines health as a "resource for everyday life, not the objective of living". Further, the charter described three focus areas to promote health (World Health Organization, 1986):

1. *Advocate* for favourable conditions for health, these conditions include political, social, cultural, economic, and biological factors to name a few.
2. *Enable*: health promotion strives for equity in health, meaning that everyone should be able to achieve their fullest health potential. To ensure this it is important to secure supportive environments that promotes health and enables people to take control over factors which impact their health.

3. *Mediate*: the health sector alone cannot bear the burden of ensuring prerequisites for health, it requires coordinated actions by all sectors. Health promotion should mediate between different interests with the aim to promote health.

Further the charter defines five action areas: (1) *Build healthy public policy* by using policy and legislations to create an environment which increases equity and makes the healthier choice the easy choice. (2) *Create supportive environments* by considering health consequences in the way we organize our society. This means considering how leisure, work, energy production and urbanization impact health. (3) *Strengthen community action* by empowering communities and public participation. (4) *Develop personal skills* by promoting it in schools, work, home etc. (5) *Reorient health services* by creating a health care system that contributes to promote health (World Health Organization, 1986).

2.2 Social Inequalities in Health

Health inequalities is the systematic difference of health status between various groups in a society: the better the social status, the better one's health (Marmot et al., 2010). This pattern is consistent, where those who are in the most disadvantaged groups have worse health and higher mortality rates (Dahlgren & Whitehead, 2006). The term social gradient refers to this systematic relationship between socioeconomic status and health (Helsedirektoratet, 2018). This pattern is identifiable across the whole income range, but it is based on averages in each group, so many exceptions exist (Helsedirektoratet, 2018). Political decisions such as insufficient social policies and unfair distribution of wealth contributes to health inequalities (Marmot et al., 2008). It is therefore important to address economic inequalities to reduce social health inequalities, since they are often the root cause (Green et al., 2019).

It is documented that lifestyle varies between social classes and it is well known that individual health-related behaviour influences health (Sosial- og helsedirektoratet, 2005). However, if social, economic, and other similar factors did not influence people's choice behaviour, then smokers should be evenly distributed across all layers of society, which is not the case (Sosial- og helsedirektoratet, 2005). When a health behaviour, such as smoking, is so closely linked to socioeconomic position, it is only reasonable to examine social factors which impact health behaviour, either favourably or adversely (Sosial- og helsedirektoratet, 2005). Health inequalities can therefore not be reduced by fixing one "bad" health behaviour or increasing access for those with ill health to health care services (Marmot et al., 2010).

A great body of evidence can be found which supports the importance of reducing social health inequalities. For example, a Norwegian study by Kinge et.al. (2021) found that

children who had low-income parents were three to four times more likely to have a mental disorder (except for eating disorders) than children with high-income parents. The main difference was the high prevalence of ADHD amongst boys and depression and anxiety amongst girls in low-income families. These differences could not be explained by genetics, parents' mental disorders or other socio-demographic factors (Kinge et al., 2021). This is why health promotion strives for equity in health where everyone can reach their full health potential. It does so by advocating for favourable health conditions where the prerequisites for health can be accessible for all (World Health Organization, 1986).

Health inequalities can be measured in various ways. They are commonly measured by evaluating whether there are regular discrepancies in health status when people are grouped by social variables such as income or education (Christiansen et al., 2018). The differences are most apparent when analysed by profession, education or income (Dahlgren & Whitehead, 2006). These inequalities are measurable in all European countries, but vary between and within countries (World Health Organization, 2019).

The World Health Organization identifies five main factors which contribute to these health inequalities between social groups. These factors are (1) *Health Services*, (2) *Income Security and Social Protection*, (3) *Living Conditions*, (4) *Social and Human Capital* and (5) *Employment and Working Conditions* (World Health Organization, 2019). Difference in Living Conditions, Income Security and Social Protection explain more than two thirds of inequalities in health between groups (World Health Organization, 2019).

To reduce the social gradient in health, policies and services must be universal, but proportionally targeted at people depending on where they are placed in the social gradient (Marmot et al., 2010). This method to public service provision is called universal proportionalism (Marmot et al., 2010). Universal proportionalism is considered to be the most effective way to reduce health inequalities (Marmot et al., 2010). It has shown that focusing only on the most disadvantaged in society does not reduce health inequalities properly. Countries with universal social protection have better population health, less poverty and less inequalities than countries which only aim their support at the poor (Marmot et al., 2008).

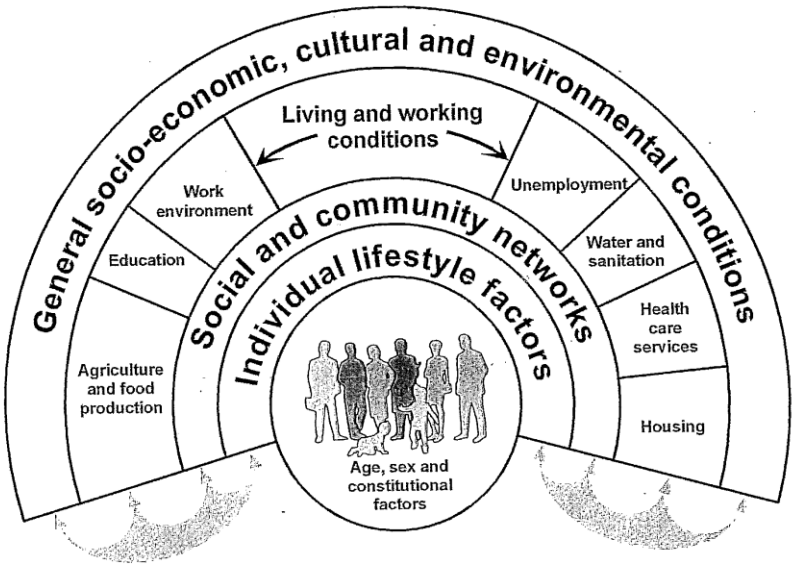
2.3 The Determinants of Health

Health promotion is concerned with a full range of factors which impact health, not only individual health behaviour but also factors which are out of individual control (Nutbeam & Kickbush, 1998). The social determinants of health are non-medical factors that have an impact on people's health outcomes, such as early child development, employment and

working conditions, social status, education, income and social protection, food security and access to health care (World Health Organization, 2023c). The term "determinants of health" includes these social factors as well as people's characteristics such as genetics or gender (World Health Organization, 2017). From now on, the term social determinants of health will be used in the thesis. The social determinants of health can also be described as our living conditions, which inevitably influence one's health throughout the whole life-span (Nutbeam & Kickbush, 1998). Health inequalities are caused by discrepancies in accessible resources required for health, there is, unequal access to the social determinants leads to health inequalities. This unequal distribution is the result of public policy (Marmot et al., 2008). Dahlgren and Whitehead (2007) created a model (see Figure 1) that illustrates different layers of the health determinants. The model aims to conceptualise how one's health behaviour is influenced by social norms, living, and working conditions which are all influenced by the cultural and socioeconomic environment (Dahlgren & Whitehead, 2006). The determinants, policies and population's health should be viewed as a chain of causality which needs to be addressed in order to improve a population's health (Stål et al., 2006). It has been shown to be more beneficial to tackle ill health through policies which tackle the social determinants of health rather than addressing health behaviour through the health sector (World Health Organization, 2023c).

Figure 1

The Determinants of Health



Note. From "Policies and Strategies to Promote Social Equity in Health," by G. Dahlgren and M. Whitehead, 2007, *Institute for Future Studies*, p.11. *https://www.iffs.se/publikationer/arbetsrapporter/policies-and-strategies-to-promote-social-equity-in-health/.* In the public domain.

Innermost in the centre of the model are individual characteristics and constitutional factors such as age, gender, race etc. (Dahlgren & Whitehead, 2006). The first layer around individual factors includes behavioural factors such as physical activity or eating habits. The second layer, social and community networks represents social interactions and people's local communities which individuals are inevitably influenced by (Dahlgren & Whitehead, 2006). An example which belongs to this layer is family and friends' support category (Dahlgren & Whitehead, 2007). The third layer is work and living conditions, food accessibility and access to necessary services such as healthcare and welfare services (Dahlgren & Whitehead, 2006). Living and working conditions influences one's ability to maintain good health. If someone's neighbourhood has frequent levels of high air pollution or if one must do heavy lifts in their job, then it will inevitably impact their health. The last layer is general socioeconomic, cultural and environmental conditions which serve as a mediator to public health (Dahlgren & Whitehead, 2006).

Dahlgren and Whitehead (2007) categorize the determinants that can be impacted by individual, political and commercial decisions into positive health factors, protective factors and risk factors (Dahlgren & Whitehead, 2006). Positive health factors assist with health maintenance and are for example, financial security, decent housing, and food security. Protective health factors reduce the risk for ill health (Dahlgren & Whitehead, 2006). An example of protective health factors can be seen in a study by Cherewick et al. (2023) where they looked at protective mental health factors amongst orphanage teenagers. Their results revealed that community relationships, self-esteem and autonomy were protective factors for depression, anxiety, and externalized behaviour (Cherewick et al., 2023). The third and last category is risk factors, which are factors that cause health issues that are preventable. They can be environmental, lifestyle-related, socioeconomical or cultural (Dahlgren & Whitehead, 2006). In Cherewick et al. (2023) they identified emotional neglect, emotional abuse, and physical neglect as risk factors for mental health issues in their study. Traditionally the focus has been on risk factors, but it is equally important to look at protective and positive health factors to find out how people stay healthy (Dahlgren & Whitehead, 2006).

2.4 Health in All Policies

Addressing health through policy has been a part of health promotion ever since the Alma Ata Declaration (1978) raised the importance of healthy public policy. The emphasise on healthy public policy continued in the Ottawa Charter (1986) and in 2006, Finland used their presidency in the European Union to promote a policy approach called "Health in All

Policies" (Stål et al., 2006). "Health in All Policies" is an approach which emphasises the importance of tackling public health through policies in all disciplines and sectors, shifting the policy focus away from the health sector (Stål et al., 2006). The purpose of this systematic cross-sectional public health strategy is to promote population health and minimise health inequalities (Stål et al., 2006). Health consequences should, according to the approach, be addressed in all policy decisions, including transport policies, education policies, tax policies, and housing policies (Stål et al., 2006).

The three layers in the Determinants of Health Model (2007) between the innermost and outermost determinants, are factors which can be influenced by policy (Dahlgren & Whitehead, 2006). Individual lifestyle factors such as drinking habits can for example be influenced by pricing policies (Dahlgren & Whitehead, 2006). Social and community network can be influenced by urban planning policies which support human interaction (Wahlbeck et al., 2017) and living and working conditions can be improved with policies which for example increase employers' control at work, which has been linked to better self-related health (Bambra et al., 2010). An example of policy for the top layer is Lundberg's et al (2008) findings of a negative association between family policy and infant mortality where more government spending on social policy decreased infant mortality rates.

There is a great body of evidence that supports their policy approach because economic and social policies have shown to be successful at reducing health inequalities (Fritzell, 2008). Wahlbeck et al. (2017) conducted a systematic review where they looked at evidence for interventions which reduced mental health effects of poverty and mental health inequalities. Their findings revealed that urban planning policies which provided everyone with access to either green or blue (ocean) places was associated with improved mental health (Wahlbeck et al., 2017). Their review also found evidence that employment policies which assist people into the labour market had a positive influence on their mental health. People who had experienced difficulties joining the labour market after high school as well as those who had dropped out benefited from programmes that assisted them to re-enter the labour market (Wahlbeck et al., 2017). In the same review, they found evidence which showed that suicide rates increased when unemployment rates rose suddenly and concluded that policies which encouraged employment during economic downturns enhanced mental health (Wahlbeck et al., 2017).

2.5 Implementing Policies

In order for authorities to implement changes through policy for the benefit of public health, some factors need to be present for a successful implementation. The Lippitt-Knoster Model (1993)(see Figure 2) contains six elements which need to be present for a complex change to succeed (Ferrán et al., 2023). This model was originally presented at a conference by Knoster (1991), but Dr. Mary Lippitt, the founder of Enterprise Group, Ltd. developed the model (Ferrán et al., 2023). The model has mainly been used in educational studies for school settings, but it has also been applied to other change processes. It varies whether the model contains five or six elements, but the model with six elements is used in this thesis. The sixth element which sometimes is left out is *consensus*, which is an essential factor for healthy public policy (Ferrán et al., 2023).

According to the model, *vision, consensus, skills, incentives, resources,* and *action plan* are important factors for what he calls an inclusive change where everyone is willing to participate in the change process (Knoster, 1993). One can argue that that healthy public policy indeed is a complex change process which demands certain elements to succeed.

Vision is the first element in the model. A common vision for implementing change is necessary because it answers the question why the change is necessary (Knoster, 1993). In the context of health policy, a new healthy public policy which addresses a health determinant can serve as a common vision which leads to change. One might also use the "Health in All Policies" approach as a common vision and break it down to smaller units to specify the vision. If a vision is missing, it leads to confusion amongst stakeholders because no one is heading in the same direction, this confusion leads to inaction in policy implementation according to the model (Travers, 2021).

The second element in the model is *consensus.* One cannot force change, for a healthy public policy to succeed there has to be a public support for it (Ferrán et al., 2023). A public consensus can be achieved when politicians and supportive interest groups create a strategic alliance to impact the public opinion (Zalmanovitch & Cohen, 2015). Politicians therefore need to be on board with a policy since they have access to policy tools which can promote health (Zalmanovitch & Cohen, 2015). Consensus is also important amongst the policy makers and other stakeholders. An agreement needs to be established which everyone is willing to collaborate on throughout the policy implementation process. Consensus fosters collaboration and a lack of consensus can lead to sabotage of the policy process because anxiety and mistrust emerges when a consensus is missing (Ferrán et al., 2023).

The third model's third element is *skills*. Those involved need to perceive that they are able to implement change (Knoster, 1993). Skilled staff with background in health promotion can be considered as skills for policy implementation. Access to research on successful policies which address the social determinants of health and the ability to apply research in a local context can also be a part of skills needed in health policy implementation. If skills is a missing element in policy implementation, it leads to anxiety because those involved do not know what they are doing or where they can access relevant tools (Travers, 2021).

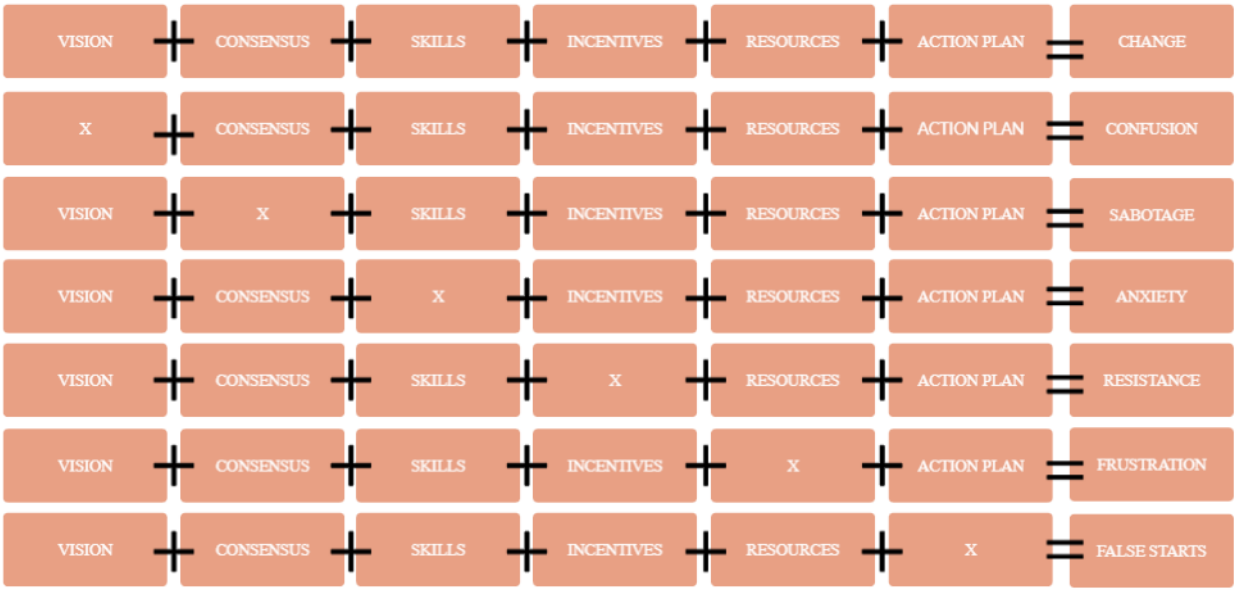
The fourth element of the model is *incentives*. Those involved need to feel that they somehow benefit from participating in the policy implementation (Knoster, 1993). The motivation can be driven by the opportunity to influence policy making, the possibility of self-development or attain new skills through the policy process. If incentives are missing from the process it can lead to resistance from participants because they do not see how they benefit by contributing to the policy process (Knoster, 1993).

Resources is the fifth element in the model. Resources for policy implementation can be sufficient funding, which provides the ability to hire skilled staff, enough time to develop a new policy or implement it and access to relevant data. Support from other institutions which provide guidance or tools can also serve as a resource. A lack of resources leads to a frustration where people do not know how to begin the process or how to proceed if they meet challenges in the implementation process (Knoster, 1993).

The sixth and final factor in the model is *action plan.* It is necessary to articulate the policy implementation by listing how the skills, resources, and vision are put into action (Knoster, 1993). As described above, the Icelandic government puts forward an action plan which often is created by a working group assigned by a minister. In addition to having an action plan which leads the policy implementation process, it is important that the goals listed in an action plan are realistic and clear. The action plan also has to fit with the common vision. According to Knoster (1993), no action plan leads to false starts where no policy change will occur.

Figure 2

The Lippitt-Knoster Model of Complex Change (1993)



Note. Figure is adapted by Knoster's presentation at the TASH conference in 1991, Washington, DC and based on a model presented in *Inclusive education: research and practice* (p. 26) by O. R. Ferrán, B. Hofman and B. Schraepen, 2023, Wanceulen Editorial. Copyright by Wanceulen Editorial.

2.6 Politics to Promote Health

It has now been described how policy effects population health and some examples have been provided to support the argument. However, the policy making process and its implementation has not gained as much attention from health promoters as the ideal content of policies has (Zalmanovitch & Cohen, 2015). But policies which support and distribute the social determinants of health equally, are dependent on political action (Bambra et al., 2005). Hence health like the majority of other aspects of people's life, is politics (Bambra et al., 2005). Political decision can therefore either create or maintain social inequalities, or reduce them (Sosial- og helsedirektoratet, 2005). Healthy public policy is seldom discussed in political terms (Bambra et al., 2005) even though it is strongly related to power and politics (Fosse, 2011).

2.6.1 Welfare Regime and Public Health

Esping-Andersen (1990) compared three types of welfare regimes in his book *The Three Worlds of Welfare Capitalism.* He compared a *liberal welfare regime*, *corporatist/traditional welfare regime* and *social democratic regime* (Esping-Andersen, 1990). Fosse (2011) summarized the three welfare regimes and compared them to existing public health policies in

each welfare regime. Her summarization will be used to describe the different welfare regimes. *Liberal welfare regime* has a dominant market which the state encourages to flourish with either state deregulation or by actively supporting the market by funding private welfare schemes (Fosse, 2011). The state means-test public transfers and only minimal social insurance and universal benefits are available. Countries which can be described as having liberal welfare regimes are the United Kingdom, Canada, United States and Australia (Fosse, 2011).

Corporatist/traditional welfare regime does not have a dominant market and social security networks have high levels of trust. The regime is considered conservative because the social security system supports the idea of traditional family values where the male is the breadwinner and the women do not participate in the labour market (Fosse, 2011). Countries which can be categorized as corporatist are Italy, Germany and France and the Netherlands (Fosse, 2011).

The social democratic regime emphasis on solidarity, universal measures and transfers resources through a progressive tax system and social assistance to disadvantaged groups. The tax system is also used to redistribute to children and to finance child-care services (Fosse, 2011). This results in a labour market where women are active participants, which the labour market is dependent on. The Nordic countries can be categorized as having a social democratic regime and are often called welfare states (Fosse, 2011).

When these regimes are put in the context of health promotion, the social determinants of health and universal proportionalism, the social democratic regime would be considered the most fitting approach to address the social gradient (Fosse, 2011). Esping-Andersen‘s (1990) book has received criticism but there is substantial amount of empirical evidence that supports the fundamental theory that population health is best in social regimes where there are generous redistributions and welfare services (Fosse, 2011).

Fosse (2011) analysed policies in the Netherlands (corporatist/conservative regime) , England (liberal welfare regime) and Norway (social democratic regime) where she looked at how these countries addressed health promotion in relation to health inequities and compared her analysis with Esping-Andersen‘s (1990) welfare state analysis to see if it matched. She concluded that her analysis fitted Esping-Andersen‘s (1990) hypothesis. Norway and England both recognized the social determinants of health and that they needed to be addressed systematically across sectors. Their approach to tackle the social gradient varied: England aimed their interventions mainly at the poor while Norway addressed the social gradient and

used structural measured inspired by universal proportionalism to address health inequalities (Fosse, 2011). The Netherlands did not address the social determinants of health and were more focused on the individual lifestyle behaviour and considered it to be a personal responsibility to change risky health behaviour (Fosse, 2011). Suggested interventions in the Netherlands were also mainly aimed at the poor (Fosse, 2011).

Another argument to support the relation between welfare state regime and health comes from Olafsdottir‘s (2007) comparison of the effect of stratification in Iceland (social democratic regime) and the United States (liberal welfare regime) on self-assessed health. She also measured if the welfare regime had an impact on the relationship between health and socioeconomic status (Olafsdottir, 2007). The effect of stratification on health was the same but the relationship between wealth and health was weaker in Iceland than in the United States. A vulnerable family situation did not affect health as negatively in Iceland as it did in the United States and being a parent, independent of marital status was associated with better health in Iceland (Olafsdottir, 2007). She concluded that the Icelandic welfare state worked as a buffer to protect the negative health outcomes of those who are vulnerable in the society (Olafsdottir, 2007). ´

Esping-Anderson‘s (1990) theory, Fosse‘s (2011) analysis and Olafsdottir’s (2007) research puts different welfare regimes into a health promotion context and highlights the importance of considering political contexts when it comes to health promotion. Welfare state regimes influences which resources are available to inhabitants, and therefore health (Fritzell, 2008). This especially concerns the quantity of resources which are available to middle and lower classes in society (Fritzell, 2008).

2.6.2 Local Authorities in Welfare States

As previously described, the Nordic Countries are categorized as welfare states which provide universal measures as well as welfare assistance to disadvantaged groups (Esping-Andersen, 1990). The responsibility for the specific measures aimed at the most vulnerable in society is in the hands of the local governments (Eklund Karlsson et al., 2022). In Iceland’s case it is, for example, social services, daycare, elementary education, and sports facilities (Innviðaráðuneytið, 2022).

This arrangement has some benefits. For instance, local governments are better equipped to provide services based on local needs (Sellers & Lidström, 2007). They are also in a stronger position than national authorities to reduce social and geographical inequalities that characterise a capitalistic society and minimize the social gradient (Sellers & Lidström,

2007). And finally, they have more influence on national policy makers because they carry a strong political mandate from their local residents, especially if the leading party in government is also the leading party at the local level (Sellers & Lidström, 2007).

On the downside, local authorities are also responsible for following national policies and guidelines but they struggle to do so due to limited budgets (Eklund Karlsson et al., 2022). This hinders their abilities to assist people living in poverty and to address living conditions, especially in areas where the proportion of people in disadvantage is high (Eklund Karlsson et al., 2022). Another downside of this arrangement is that the municipalities are provided with freedom to adjust national policies to their local communities which can result in variation of policy implementation (Sellers & Lidström, 2007). Due to the great power local authorities have, national governments mostly rely on advice and information as governing tools for national policy implementation (Sellers & Lidström, 2007). This means that even though national authorities have created legislations or policies to tackle social inequalities, they have little power to control how their policies are implemented in municipalities (Sellers & Lidström, 2007). Thus, despite the positive aspects of strong local governments, policy implementation and available services differs between municipalities (Eklund Karlsson et al., 2022).

3. Literature Review

This chapter will cover literature about social health inequalities in Iceland and other welfare challenges such as poverty and inequalities in education. It will also present Norwegian literature about the Norwegian Public Health Act which aims at reducing health inequalities with an intersectoral approach (Folkehelseloven, 2011, § 1). First the search strategies will be described and then the findings will be presented.

3.1 Search Strategies

There is not a great amount of literature on the topic of governmental action in Iceland to tackle social inequalities in health, so the inclusion criteria were quite broad. To supplement the lack of Icelandic data, Norwegian data were included, especially because Norwegian national authorities implemented legislation to tackle social inequality in health in 2012 (Folkehelseloven, 2011, § 1) and because Norway is a welfare state like Iceland (Pedersen & Kuhnle, 2017). The criteria were that (1) the literature could not be older than from the year 2000, (2) it had to describe "Health in All Policies" and or social inequality in health in Iceland or in Norway, and or governmental actions to tackle social inequality in health or (3) describe or be a part of the Icelandic government's public health actions, both those directly aimed at social inequality in health, but also public health actions generally. Other reports which described poverty, or the educational system were also included. The systematic search was conducted in December 2022 and January 2023. New official reports were looked for regularly throughout the writing process.

Most of the relevant literature was found by looking at official documents, reports, and websites from Icelandic ministries or from the Directorate of Health. Websites which were frequently used were stjornarradid.is (Icelandic ministries), landlaeknir.is (Directorate of Health) althingi.is (the parliaments' official web page) and the website for the Scandinavian Journal of Public Health. Literature which was referred to in official documents was looked up and included if relevant. A report on social inequality in health in Iceland from 2021 from the Directorate of Health referenced to multiple Icelandic studies and articles on the topic, and most of them were included in the literature review. The Icelandic Medical Journal was also used with search terms such as "education", "residence" and "income"; each search term gave one relevant result. When conducting the systematic search on bigger data bases, the search term "education*" was originally included since there were several articles in Icelandic which showed a relationship between level of education and health outcomes. Including this search term did not provide relevant articles, so it was removed from the search terms.

To find Norwegian documents Elisabeth Fosse's articles were looked up, as well as references in her articles. A systematic search on the Web of Science was conducted for the Norwegian context. This involved search terms such as "Public health act" Norway which gave 21 results and "Public health act*" Norway which gave 64 results. In April 2023 an additional search with the search term "Public health act" Norway was conducted through the University of Bergen's library search engine Oria. It gave 50 results, thereof 4 relevant articles. A few systematic searches for the terms "social inequality in health" and "Health in All Policies" were conducted as shown in Table 1.

Table 1

Data Base	Search Terms	Results/ Relevant Articles
Web of Science	("social inequality" OR "social determinant*") OR (inequality NEAR/2 health OR income*) AND (Iceland*)	216/11
Proquest Social Sciences	abstract(("social inequality" OR "social determinant*") OR (inequality NEAR/2 health OR income*)) AND abstract(Iceland*)	209/0* *Mostly duplicates which appeared in the Web of Science search
Ebsco Chinal	(("social inequality" OR "social determinant*") OR (inequality NEAR/2 health OR income*)) AND abstract(Iceland*)	113/0* *Again, mostly duplicates which appeared in the Web of Science search
Scandinavian Journal of Public Health	"Social inequality" Iceland	18/0
Scandinavian Journal of Public Health	Polic* Iceland	164/4
Web of Science	"Health in All Policies"	427/9
Scandinavian Journal of Public Health	"Health in All Policies"	42/ 6
Web of Science	"public health polic*" NEAR/2 Iceland	1/0

Note. Overview of databases, search terms and relevant articles in the systematic search.

3.2 Health Inequalities in Iceland

Life expectancy in Iceland is relatively high compared to rest of Europe or 83,1 years (OECD/European Observatory on Health Systems and Policies, 2021). According to numbers from 2019, men born and raised in Iceland are expected to live for 81 years and women for 84 years (Heilbrigðisráðuneytið, 2021). Healthy lived years for men are approximately 70 years and for women 64 years (Heilbrigðisráðuneytið, 2021).

The social gradient in health is present in Iceland where the main difference stems from different educational levels and income (World Health Organization, 2019). Life expectancy for people with tertiary education has increased more than for people who have finished lower levels of education, this accounts for both lower secondary school and upper secondary school (Hagstofa Íslands, 2020). Women who have finished tertiary education are expected to live for 3,3 years longer than women who finished lower secondary school. This gap is greater when it comes to men, or about five years (Hagstofa Íslands, 2020).

Three out of four Icelanders report having good health, but there is a pattern of inequalities present in these numbers. 66% of people in the lowest income group report having good health compared to 86% of those with the highest income (OECD/European Observatory on Health Systems and Policies, 2021). Men with lower secondary education are 2,7 times more likely to report their physical health as decent or poor, compared to men who have tertiary education (Elínardóttir et al., 2021). Men who experience difficulties making ends meet are 2,77 times more likely to evaluate their physical health as being decent or poor compared to men who do not experience financial difficulties (Elínardóttir et al., 2021).

This pattern is also present for women. Women with lower secondary education are 2,38 times more likely to report decent or poor physical health compared to women who have finished tertiary education. Women who experience difficulties in making ends meet in Iceland, are 2,2 times more likely to report decent or poor physical health than women who do not experience financial difficulties (Elínardóttir et al., 2021). The gap between men when it comes to education and financial difficulties has increased between 2012 and 2017. With women, the gap between lower secondary school vs. tertiary education has decreased between 2012 and 2017 and it has not changed in the same time span when it comes to financial security (Elínardóttir et al., 2021). A similar pattern can be seen in people's reports on their mental health with small variations (Elínardóttir et al., 2021). New numbers from 2022 show that those who experience difficulties in making ends meet are less likely to report their mental health as being good (Guðmundsdóttir et al., 2023). In 2022, 44% of those who

experienced difficulties in making ends meet evaluated their mental health as being good, compared to 76% of those who did not experience difficulties in making ends meet (Guðmundsdóttir et al., 2023). The same pattern is present concerning self-evaluated happiness, 35% of those who experienced difficulties in making ends meet considered themselves as being very happy compared to 63% of those who did not experience difficulties in making ends meet (Guðmundsdóttir et al., 2023).

It should be mentioned that the report from the Directorate of Health about social inequality in health from 2021 is based on already existing data from 2017 and only covers Icelandic speaking residents in Iceland (Elínardóttir et al., 2021), so the gradient could be wider or narrower.

3.2.1 Icelandic Research on Health Inequalities

Some research on social inequality in health has been conducted in Iceland. Most of this research shows that social inequality in health is present in Iceland. The majority of the research looks at the relationship between the place of residence and health or education and health. The definition "social inequality in health" is seldom used even though the results indeed indicate the presence of social health inequalities in Iceland.

Eidsdóttir et al. (2013) showed that children who had parents with lower secondary education were more likely to be obese, such that the odds of offspring obesity decreased when the parental educational status improved. They measured the pattern for 18 years which showed that the difference between educational groups and the odds of offspring obesity grew over time (Eidsdóttir et al., 2013).

Steingrímsdóttir et al. (2010) looked at the relationship between education, smoking, and location of residence in Iceland. The results revealed that women living in the districts were 66% more likely to be categorized as obese compared to those living in the capital region, when education, smoking, age, and alcohol use had been controlled for. The study also showed that Icelandic women with lower secondary and upper secondary education were more likely to be obese than women with tertiary education (Steingrímsdóttir et al., 2010).

Another study which looked at the relationship between place of residence and education showed conflicting results: women in the age category 46 and above, living in the districts were 39% more likely to be overweight or obese, but these results did not apply for women younger than 46 years old or for men (Guðjónsdóttir et al., 2015). The same study also showed that residents in the capital region of Iceland were more likely to follow the national dietary guidelines, especially when it comes to the consumption of unsaturated fats

and fibre intake (Guðjónsdóttir et al., 2015). Further research on diet in Iceland shows that those who had difficulties in making ends meet ate less vegetables, fruits, and whole-grain bread and drank more sugary soda drinks than those who did not experience difficulties in making ends meet (Steingrímsdóttir et al., 2014).

A new longitudinal study by Andersen et al. (2022) showed that the risk factors for atherosclerosis which are daily smoking, lack of physical activity, taking blood-pressure medication, and diabetes type 2, were more common amongst those who had lower levels of education. People who had completed upper secondary education or vocational education were more likely to a have higher body mass index and experiencing a metabolic disorder than those who had completed lower secondary education or tertiary education (Andersen et al., 2022). Their study also revealed that level of education is related to the amount of atherosclerosis in carotid arteries. Those who had vocational education, or a comparable education had 50% increased chances of having severe atherosclerosis in their carotid arteries compared to those with tertiary education (Andersen et al., 2022). Those who had finished lower secondary education were 84% more likely to have severe atherosclerosis in their carotid arteries compared to those with tertiary education when risk factors for atherosclerosis had been controlled for (Andersen et al., 2022).

Last but not least, a study from 2022 by the Icelandic Cancer Society examined the underlying causes of higher cancer death rates in the Reykjanes peninsula. Their results revealed that higher cancer rates were caused by unhealthy lifestyle. Before the study was conducted it was suspected that the chemical Trichloroethene was the major cause of higher cancer death rates in the area. The chemical was suspected to be found in the area's drinking water after the American army had used it to wash their airplanes while they had an army base in the region (Þórisdóttir, 2022). Their results could possibly be explained by the fact that there are fewer people with higher education who reside in the area compared to the national average or 26.4% vs. 43.4% (Embætti landlæknis, 2023a). The ratio of people living in low-income in the area was also the highest in Iceland in 2020 or 14.6% (although the second highest percentage was 14.1%) (Guðmundsson et al., 2023) and those who experience difficulties making ends meet are 21.2% compared to 15.5% nation-wide (Embætti landlæknis, 2023a). Further, the proportion of immigrants who reside in the area is 12% higher than the national average or 28% compared to 16.3% as national average[2] (Hagstofa

[2] Statistics Iceland defines immigrants as those who are born abroad and have parents and grandparents who were also born outside of Iceland (Hagstofa Íslands, 2022a).

Íslands, 2022a). Measurements of self-rated health also support the findings of the study, 47.5% of adults in the area evaluate their physical health as being decent or poor compared to 41% nation-wide. This pattern is also visible for self-rated mental health where 38.5% report their mental health as being decent or poor compared to 32.6% nation-wide (Embætti landlæknis, 2023a).

3.3 Poverty in Iceland

Even though Iceland is a Nordic Welfare State there are some challenges present in Iceland today. According to the European Union's definition of poverty, people living in households with disposable incomes below 60% of the median equivalised disposable income in the population are considered to be living in poverty (Povlsen et al., 2018). Nordic national documents use this definition to define relative poverty (Povlsen et al., 2018).

The numbers of residents in Iceland who experience difficulties in making ends meet is on national average 15.5% according to numbers from the Directorate of Health (Embætti landlæknis, 2023a) while numbers from Statistics Iceland from 2021 showed that 24.1% of households experienced difficulties to make ends meet (Hagstofa Íslands, 2022b). Those who are most likely to live below the low-income threshold for more than four years are single parents and immigrants[3]. The same groups are also both frequently measured right above the low-income threshold (Guðmundsson et al., 2023).

It is estimated that societal cost due to poverty in Iceland is between 1-2.8% of Iceland's gross domestic product or 31-92 billion Icelandic kroners. This estimate can be broken down into 0-21 billion to health care, 1.5-3 billion to criminal activity, 29.3-64.8 billion due to loss of productivity and 0.9-3.2 billion due to child poverty (Guðmundsson et al., 2023).

Growing up in poverty has various long-term effects on people (Eklund Karlsson et al., 2022; Marmot, 2015). Numbers from Iceland show that adults who grew up in poverty are less likely to finish upper secondary and tertiary education, they are more likely to still be under the low-income threshold as an adult, be a single parent, have passed away early or received official financial support (Guðmundsson et al., 2023).

The ratio of Icelandic children living in relative poverty varies with the parents' educational status (Félagsmálaráðuneytið, 2021), but it is estimated that around 9000 (14%)

[3] An immigrant is defined by Guðmundsson et.al. (2023) as having one parent who has immigrated to Iceland, being born in Iceland and both parents are immigrants, or being born abroad but both parents are Icelandic.

Icelandic children live in poverty (Guðmundsson et al., 2023). Numbers from 2020 show that 14.1% of children under the age of five live in relative poverty (Guðmundsson et al., 2023). Children in this age group with parents with lower secondary education are three times more likely to live in relative poverty compared to children who have parents who have finished tertiary education (Félagsmálaráðuneytið, 2021). For the age group 6–11-year-olds, 10.7% of children lived in relative poverty in 2020 (Guðmundsson et al., 2023). However, the prevalence varies greatly with education: 22.7% who had parents with lower secondary education lived in relative poverty compared to 4.7% who had parents with tertiary education (Félagsmálaráðuneytið, 2021). The gap is not as big for children from age 12-17 years or 7.9% vs. 4%[4] (Félagsmálaráðuneytið, 2021) but the overall percent of children in this age group is 10.2% (Guðmundsson et al., 2023).

There is a big gap between children living in poverty depending on their parents' nationality. Of children who have parents who are foreign citizens, 16.4% live in relative poverty, compared to 9.4% of children who have parents who are Icelandic citizens (Félagsmálaráðuneytið, 2021). As previously mentioned, immigrants are frequently measured right above the low-income threshold or are most likely to live in relative poverty for four or more years.

The overall number of children living in relative poverty in Iceland decreased from 15% in 2000 to 12% in 2020 and the number of children living in relative poverty in each age group has also decreased in the same time span (Guðmundsson et al., 2023).

3.4 Education and Inequalities

The Programme for International Student Assessment (PISA) is a program by OECD which examines student's skills in reading, mathematics, and science at age 15 (OECD, 2019). When it comes to Iceland, students are below the OECD average in reading comprehension and science and above average in mathematics (Menntamálastofnun, 2018). In 2009, Icelandic adolescents had similar performance as the rest of the Nordic countries and was around or above the average of the OECD countries. Since then, there has been a steady decline in Icelandic adolescent's performance, except in mathematics where the performance improved between 2015 and 2018 (Menntamálastofnun, 2018). Literacy skills are to be concerned about, in 2018, 26% of students did not have basic literacy skills, including 34% of

[4] These estimates are both lower than a separate estimate of total poverty in this age group where differences across levels of parental education were not assessed.

boys. This means that one in three boys at the age of 15 in Iceland does not have proper reading comprehension. Since the correlation between health and education is so strong (Eide & Showalter, 2011) there is a reason to look at this as a public health problem.

The number of young adults who do not finish upper secondary education have also been relatively high in Iceland for a long period of time even though there has been a steady decline in dropout numbers since 2011 (Hagstofa Íslands, 2022c). Dropout is defined by Statistics Iceland as those who start upper secondary school and do not graduate at follow-up four (which used to be the usual length of upper secondary school in Iceland), six or seven years later (Hagstofa Íslands, 2022c). The number of dropouts was the highest in 2003 were 29.6% of enrolled students did not finish upper secondary school, the newest update is for students who were enrolled in school in 2016, where 19.9% did not graduate from upper secondary school (Hagstofa Íslands, 2022c).

In 2009, the Icelandic government created the independent organization known as the Welfare Watch. Its duties included advising Icelandic officials and assessing the effects of the 2008 financial crisis on Icelandic households (Stjórnarráð Íslands, 2023). According to a report written for the Welfare Watch in 2022, the likelihood of a student dropping out of upper secondary school in Iceland was significantly influenced by their socioeconomical status (Stefánsson & Eyjólfsson, 2022). The greatest influence on drop-out risk came from parental education, those who had parents with tertiary education had the lowest chance of leaving school, and if they had left and returned, they also had the lowest risk of dropping-out again. Parental income and dropout also had a strong correlation but when other factors are considered, the relationship becomes significantly weaker (Stefánsson & Eyjólfsson, 2022). This is largely because the link between income and dropout partially accounts for the impact of other background factors, particularly parental education and living with a single parent which impacts educational outcomes (Stefánsson & Eyjólfsson, 2022).

Children who immigrated to Iceland are less likely to seek education in kindergarten, secondary education, and university than those born in Iceland (Hagstofa Íslands, 2019). The difference is highest in upper secondary schools, where numbers from 2017 show that almost all children born in Iceland start upper secondary school at age 16 while only eight out of ten immigrants start upper secondary school. At age 19, seven out of ten of those born in Iceland were enrolled in upper secondary school compared to two out of ten immigrants (Hagstofa Íslands, 2019). This is a repeated pattern which has been noticeable since 2008. These numbers suggest that dropout from secondary school is more common amongst immigrants

than those born in Iceland. Most immigrants who seek secondary education have lived in Iceland for nine years or longer (Hagstofa Íslands, 2019).

3.5 Norwegian Legislation to Reduce Health Inequalities and Promote Intersectoral Collaboration

Norway has a public health act (PHA) which aims to reduce social inequalities in health. The act mandates authorities at municipality, county municipality and national level to reduce social health inequalities with intersectoral collaboration (Folkehelseloven, 2011, § 1).

Research has revealed some positive changes as well as some challenges since the PHA was implemented in 2012. Initially, in 2011, before the PHA was implemented, policy makers at the national level experienced difficulties in addressing health inequalities at the local level because the social determinants of health and the "Health in All Policies" (HiAP) approach was new to the municipalities (Fosse et al., 2018). Until the PHA, municipalities had mainly focused on lifestyle related interventions through the health care sector (Fosse et al., 2018).

Intersectoral collaboration increased following the PHA (Fosse et al., 2018). Following the legislation, municipalities had to establish a multisectoral working group to work on public health; in 2017, 72% of the municipalities had established one (Fosse et al., 2019). Statistics show improving involvement in these working groups over time. For instance, there was a substantial increase in the plan/environmental sector's participation in the intersectoral work groups, where participation increased from 17% in 2011 to 65% in 2014. Participation from the CEO staff also increased following the act from 56% in 2011 to 69% in 2014 as well as from the school agencies or 69% in 2011 vs. 75% in 2014 (Fosse & Helgesen, 2015). In 2017 representation from kindergartens in the intersectoral working groups had increased from 50% in 2014 to 60%. The results from 2017 showed that 85% of municipalities had created an overview of health and health inequalities compared to 39% in 2014. Numbers from 2017 also showed that 70% of the municipalities used these overviews to prioritise local planning and 68% to prioritise services (Fosse et al., 2019). It is worth noting that these changes are not solely in participation but are also relevant to outcomes: Hagen (2018) found that those who developed health overviews after the PHA's implementation were two and a half times more likely to prioritize fair distribution in political decisions compared to those had not. In addition, those who were focused on improving their health promotion competence and creating networks to collaborate with external actors were almost three times more likely to consider fair distribution compared to those who did not (Hagen et al., 2018). Hagen et al. (2017) found that municipalities which used tools like an intersectoral working

group and inter-municipal collaboration were two to three times more likely to prioritize living conditions as their main priority in public health work.

In 2014, 85% of municipalities had a public health coordinator, relative to 74% of municipalities which had hired a public health coordinator before the act was implemented (Fosse & Helgesen, 2015). Karlsen et al. (2022) found that the three factors which enabled a public health coordinator to influence intersectoral agency were position size (i.e., being a full-time or almost a full-time employee), being positioned under the CEO's and having a formal job description which specified tasks and responsibilities. Those who identified themselves as intersectoral agents were more likely to be able to effect budgets and local politics. This is somewhat interesting because Fosse et al. (2018) found that in 2014, only 22% of the public health coordinators were full-time employees and only 28% of them were located amongst the CEO staff. In 2011, the ratio of public health coordinators placed in the municipalities' health sector was 46%, which goes against the purpose of the PHA (Tallarek née Grimm et al., 2013). Hagen et al. (2018) also found that municipalities which had hired a public health coordinator after the PHA enforced were almost four times less likely to prioritize fair distribution in their health promotion inititavies, indicating that hiring a public health coordinator does not necceseraly result in increased focus on fair distribution.

Political participation also increased following the PHA since it was mandatory to include public health in the municipalities' master plans (Fosse et al., 2018). In Hagen's (2017) study, investigating which HiAP methods Norwegian municipalities used to promote local health they found the municipalities' political profile did not have an impact on the results. That is, having a left wing, centrist or right wing mayor did not play a role in how municipalities addressed local health challenges (Hagen et al., 2017). Fosse et al. (2019) found that the national governments' emphasis impacted local public health work, in 2017 the government focused on individual mental health measures which 58% of municipalities reported as a top priority.

The Office of Auditor General in Norway looked at Norwegian public health work at all administrational levels following the PHA implementation (Riksrevisjonen, 2014-2015). The findings suggest that the municipalities and county municipalities were in general satisfied with the support they received from the Norwegian Directorate of Health but that they lacked advice and recommendations about evidence-based public health interventions, especially to reduce social inequalities in health (Riksrevisjonen, 2014-2015). There were also some

shortcomings in available data for municipalities and the Institute of Public Health experienced legal issues in linking available data together (Riksrevisjonen, 2014-2015).

Hofstad's (2016) findings also report issues linked to data. She revealed that a knowledge-based approach on a local level was challenging because the access to local statistics is limited in many municipalities and their ability to do their own surveys is also limited. Regional and local governments therefore also struggled to evaluate the effectiveness and cost-effectiveness of possible measures and therefore end up following national guidelines or base the measures on personal experience (Hofstad, 2016). She also identified difficulties in engaging and coordinating different competence across sectors in municipalities, especially when it comes to creating a health overview (Hofstad, 2016).

When it comes to differences in municipal size, Hagen et al. (2017) found that larger municipalities more often look at living conditions as the main contributing factors to social inequalities in health and considered themselves to have greater capacity to address health inequalities than smaller municipalities. Larger municipalities were also more than 1.5 times more likely than smaller municipalities to prioritise living conditions, and those who prioritised living conditions were also more likely to have established an intersectoral working group for public health (Hagen et al., 2017). Fosse et.al. (2019) conducted a survey in 2017 amongst Norwegian municipalities, in which a lack of the social gradient approach was apparent, especially in smaller municipalities. In 2011, many of the smaller municipalities looked at the social inequalities in health mainly as a problem for the marginalized groups and focused on lifestyle related interventions which the authors found still to be an existing pattern in 2017 (Fosse et al., 2019).

Research on the PHA has also revealed some issues with funding where many municipalities were unsatisfied with the funding arrangement for the PHA. Multiple municipalities had received funding through the county council in 2004 which most of them used to hire a public health coordinator, but no funding was ear-marked in the new legislation (Fosse & Helgesen, 2015). The majority of their funding came from external actors and funds where for which municipality had to apply for them. They mostly applied for funds for specific actions which were supposed to target vulnerable groups and wondered if this form of funding was sustainable. Universal measures were mostly funded by the municipalities, but specific measures had external funding (Fosse & Helgesen, 2015).

The PHA is currently under revision, and the Norwegian government wants to specify the role of the national institutions and health services in reducing health inequalities (Meld.

St. 15, (2022-2023), p. 117). Authorities also want to explore the option of coordinating the act with other acts such as the act for social services, and to investigate how they can improve collaboration between the departments of urban planning and public health (Meld. St. 15, (2022-2023), p. 117). Quality of life and loneliness will possibly be added to the legislation and the possibility to apply social medicine and social psychology methods will be considered to promote health in municipalities (Meld. St. 15, (2022-2023), p. 117).

3.6 Summary of the Literature Review

The literature review shows that social inequalities and therefore health inequalities are present in Iceland. The academic literature seldom addresses health inequalities as a reason for their findings or discusses why they are present. This is also apparent in governmental health policies. The national policies have, in the last few years, begun to address the relationship between socioeconomic status and health, but seem to lack concrete descriptions on how health inequalities should be addressed. There is also little information about whether already existing national policies have been implemented and/or reevaluated following implementation. Recent policies addressed a need for intersectoral collaboration in public health but there is limited literature on how intersectoral collaboration has been implemented. This study aims at addressing the knowledge gap about policy implementation in Iceland. It will also look at to the extent which national authorities address social inequalities in health and apply the "Health in All Policies" method in their public health actions.

As described, Norway and its PHA is an example of a national strategy to address health inequalities at all administrational levels. It has led to several positive changes on all administrational levels, but there have also been some barriers to a successful implementation. The literature from Norway will be used as a comparison with the findings of this study since both countries are categorized as social democratic regimes and have similar administrative systems.

4. Study Aim and Research Questions

4.1 Study Aim

The literature review reveals a gap between academic literature which addresses the cause of health inequalities and literature about national strategies to reduce health inequalities. The aim of this study is to collect data on how national authorities have implemented public health policies. It also aims to determine to what extent national authorities address social inequalities in health and apply the “Health in All Policies” approach in their actions.

4.2 Research Question

This thesis aims to add knowledge to the literature about Icelandic public health policies specially focusing on how Icelandic authorities implement public health policies. The focus is mainly on national actions and the data collection will be centred around these questions:

1. How do Icelandic national authorities implement public health policies?
2. To what extent to national authorities address social inequalities in health and apply the “Health in All Policies” approach in their actions?

5. Method

This chapter will outline for the study ‘s scientific paradigm, research design and data collection. Further it will describe how participants were recruited, the data analysis and how reliability, validity and generalisability were ensured during the research process. Finally, the researcher’s role will be explained as well as some ethical considerations in the study.

5.1 Scientific Paradigm

Every research approach in social sciences is founded on philosophical assumptions which argues for the most suitable way to do research (Neuman, 2011). A paradigm can be described as an interpretive framework (Creswell & Poth, 2018) which is a collection of philosophical assumptions for a specific research approach. A paradigm represents a set of philosophical believes about ontology, epistemology, and methodology (Punch, 2014). Ontology describes the researcher ‘s view of reality (Creswell & Poth, 2018). Epistemology describes how the researcher knows reality (Creswell & Poth, 2018) and methodology is the process of research (Creswell & Poth, 2018) where the most suitable method to conduct research is based on the answers to the first two terms (Punch, 2014).

Positivism used to be the dominant paradigm within social sciences where the research methods were quantitative (Neuman, 2011) but after years of debates about the most logical way to conduct social research, qualitative research has now become a mainstream research approach within the field (Punch, 2014). Qualitative research methods mainly use textual data (Creswell & Poth, 2018) and rest on a paradigm called constructivism (Punch, 2014). Constructivists believe that there are multiple realities out there and that they are socially constructed (ontology) (Creswell & Poth, 2018). The paradigm argues that reality is not directly experienced (Neuman, 2011) but that it is shaped by our life experiences and interactions with others (Creswell & Poth, 2018).

According to the paradigm’s epistemological assumptions, the researcher and the subjects construct reality together and that reality will unavoidably be affected by individual experiences (Creswell & Poth, 2018). A constructivist’s main purpose in research is to gain an understanding of the world in which people live and work, seen from the view of those who have experienced the phenomena being studied (Creswell & Poth, 2018). The methodological assumptions of the paradigm "are concerned with process, context, interpretation, meaning or understanding through inductive reasoning" (Yilmaz, 2013, p. 313).The aim is to gather a wholistic description of a phenomena rather than making generalisations and to understand how people put meaning to their lived experiences (Yilmaz,

2013). When this holistic explanation is sought, the contexts in which the findings take place must be considered (Neuman, 2011).

The purpose of this study is to find out how Icelandic national authorities implement public health policies from the standpoint of those who both participate in the policy work and are responsible for implementing it. A qualitative research methodology based on the constructivist paradigm is therefore a suitable approach to conduct this study.

5.2 Research Design

This study is conducted with a phenomenological approach where the aim is to describe the participants common experiences of a phenomenon (Creswell & Poth, 2018), which is in this case the common experience of those who work with public health in Iceland at national and local level. My role as the researcher is to gather data from people who share the experience of the phenomenon and describe the essence of their common experiences (Creswell & Poth, 2018).

5.3 Data Collection

Interviews, observations and text analysis are the main methods to collect qualitative data within constructivism (Creswell & Poth, 2018). The participants in this study work at different institutions and administrational levels with public health. To gain insight in their experiences in the field, interviews were considered a suitable method. Interviews give the opportunity to capture and communicate participants' experiences in their own words (Yilmaz, 2013, p. 313). There are different types of interviews one can choose from, based on the purpose of the study (Punch, 2014). This thesis uses a semi-structured interview, the format provides good balance of structure with some pre-determined questions and the flexibility to ask unprepared follow-up questions (Punch, 2014). The flexibility also gave participants a chance to express their thoughts and experiences on the topic independent of the pre-determent questions they were asked.

5.3.1 Preparation for the Interviews

Scripting an interview is according to Brinkmann and Kvale (2015) the preparation stage for the interviews. The interviews for this thesis required good preparation since the interviewees were only interviewed once. During the scripting stage for a semi-structured interview, I reflected on which topics should be covered, which questions should be asked and how they should be asked (Brinkmann & Kvale, 2015). I then created the interview guide (see Appendix B) with these points in mind and was conscious about creating open-ended

questions in order to gain an understanding of interviewees' knowledge and views on the topic (Yilmaz, 2013). The questions were both general and related to the main theoretical terms of the study such as "social inequalities in health" and "Health in All Policies". The questions were also based on data that I read for the literature review, such as previous governmental action plans and the implementation of those. I sought feedback from a scholar and took her reflections into consideration. Since the method was a semi-structured interview, I was aware that it was dependent on how the interviews would flow, how much the interview guide would be used (Brinkmann & Kvale, 2015).

I conducted a pilot interview before the interviews were conducted to practice and get comfortable with the interview guide. A friend of mine who knew the topic of the study acted as an interviewee. The purpose of doing a pilot interview was to get a sense of the questions, how it was best to formulate them, and to get an insight into what could be improved or missing in the interview guide. After having conducted a few interviews for the study, I added an additional question about data accessibility to the standard questions since it was a reoccurring topic in the interviews.

I borrowed a voice recorder from a friend but bought a separate SD card for the interviews. I tested the voice recorder in the test interview and put in a good effort to get familiar with the voice recorders' functions to prevent any complications while the interviews were conducted. I used a notebook to take notes during the interviews.

5.4 Language Barrier

Early in the process it was apparent that I would need assistance for the thesis from someone who speaks Icelandic since the interviews were taken in Icelandic. My supervisor suggested an Icelandic woman who works with Health Promotion in Bergen, Norway and is familiar with the public health field in Iceland. She agreed to assist me with the thesis process. She suggested relevant informants, shared information about the development within the public health field in Iceland for the past years, read over interviews once they had been transcribed, and assisted me during the data analysis. She also read over some chapters in the thesis and gave feedback and comments throughout the whole process.

5.5 Recruiting Participants

Early in the process I contacted the Directorate of Health in Iceland to discuss if they had any projects to evaluate or if they knew about a possible topic for the thesis. After having consulted with a scholar, the theme of this current study was chosen. I then had an online

meeting with an employee at the Directorate of Health and two from the Ministry of Health to discuss the thesis and possible participants. My Icelandic speaking assistant also came with suggestions for participants. This recruitment method is similar to the snowball method where selected subjects suggest individuals who have knowledge and can provide relevant information which fulfil the study criteria (Goodman, 1961; Heckathorn, 1997).

A typical sample size for a phenomenological study is somewhere between three to ten (Creswell, 2014). In phenomenological research it is important that all participants have an experience of the phenomenon being studied and therefore criterion sampling was chosen (Creswell & Poth, 2018). I carefully chose the informants with the purpose of gaining the best understanding of the research topic and with the research question in mind (Creswell, 2014). The participants worked both at national and local level, at governmental and regional institutions and municipalities. Some of them worked closely with public health daily, others had it as a part of their job but had other responsibilities as well. Some of them had higher education related to public health and others did not. Those who had higher education within the field had also been working within the field, on and off for a while. This variety in work experience, education, and different administrative location within the field provides multiple perspectives, over a wide spectrum which is one of the key criteria for good qualitative research (Creswell & Poth, 2018). Before I interviewed two of the informants, I had already had some discussions with them about public health generally in Iceland.

Most of the informants were contacted via email where I introduced myself shortly and provided a short description of the study and its purpose. To get in touch with one informant I called the institution to find out who it would be most appropriate to interview, once that was resolved, the correct person was contacted via email.

The date and time to be interviewed was open but after few answers from the participants the interviews were all scheduled in the same week. One participant did not want to participate. During the first five interviews, some interesting information came up, so I decided to contact two other relevant people and asked if they wanted to participate. One of them participated and the other one did not respond to the invite. I decided not to resend the invite, mostly due to time pressure. The final sample size of this study was therefore six participants.

5.6 Conducting and Transcribing Interviews

Six interviews were conducted, five in person and one over Teams. Before the interview started the participants read the informed consent and signed it. The participant who was

interviewed on Teams got the informed consent sent via email and send it back signed the same way. Before the standard questions were asked, the purpose of the study was explained to the participants and the main terms “social inequalities in health” and “Health in All Policies” were also explained to those who wished. The informants were informed that notes would being taken, but I ended up not taking many notes, as I felt that it distracted me from actively listening to the participants.

The participants chose where the interview to took place. All of the participants had good facilities at their workplace and invited me to meet them there during work hours. This arrangement is considered fitting for qualitative research where gaining knowledge should occur in the participants natural settings (Yilmaz, 2013). A minimum criterion was that there would be privacy to conduct the interviews, especially since the interviews were sound recorded. The pre-given time for the interviews was about 30-45 minutes, most of the interviews ended up being around an hour in length expect for two participants who had a tight schedule.

Between interviews I evaluated my performance and tried to be aware of the balance between withholding my own reflections on the topic and adding something to the conversation. I felt when I was more accessible to the participants they relaxed more and were more open to share their thoughts. I soon got a sense that some of them had concerns about being identified through their interviews because public health is a small field in Iceland. This is a concern I was very aware of myself. I also think that I was too afraid of asking leading questions, which sometimes hindered med to ask follow-up questions where it would have been appropriate. In hindsight, I felt that some questions in the interview guide were irrelevant depending on who I was interviewing and the person’s background. For example, questions which had been pre-determined about implementation at a national level, were not appropriately formed for those who were interviewed at the local level. Therefore, some questions were adapted to the interviewee and with their background in mind.

Before the interviews were transcribed, I listened to all of the interviews to get a sense of our conversation. The interviews were then all transcribed in Microsoft Word, on a laptop which was locked with a password. During the transcription, my voice was marked as Ég (I in Icelandic) and the interviewee was marked as V (first letter for Viðmælandi which is the Icelandic word for interviewee). The file names were Interview 1, Interview 2 etc. When names, workplaces or personal information came up they were replaced with XXX in the text. The files were then move to the Nvivo Pro 12 software for the data analysis. All of the files in

Nvivo Pro 12 got code names which were a few letters. Words in the middle of a quotation which were irrelevant were taken out or marked as … in the results. Quotations for the results chapter were chosen based on the ability to keep anonymity.

I relistened to the interviews once they had been transcribed, to make sure that the transcriptions were correct. The transcription process was the step which took the longest during the thesis writing, and it was done continuously over the course of several weeks.

5.7 Data Analysis

The next step was to analyse the data. There are multiple methods one can chose to analyse data, depending on the purpose of the study (Punch, 2014). The majority of qualitative analysis methods include extracting data into themes by coding the text, condensing the codes and presenting the results from the data analysis (Creswell & Poth, 2018). Coding is the process of putting names or labels on small or large chunks of text, code is therefore the given label or name to a piece of text (Punch, 2014). Codes are created to organise the data which is fundamental for the rest of the analysis (Punch, 2014). A theme is a pattern of responses (codes) or meaning in the data collection which captures essential information related to the research question (Braun & Clarke, 2006).

This study used thematic analysis by Braun and Clarke (2006) which is a method used to identify, analyse and report patterns in textual data (Braun & Clarke, 2006). The method provides flexibility because it is not based on methodological traditions or philosophies (Malterud, 2017). The method has in later years been named reflexive thematic analysis (Braun & Clarke, 2022), but since the steps and methods from the original article were used, thematic analysis will be used to describe the method in the text. Thematic analysis has two ways of categorizing themes or patterns, inductive and deductive (Braun & Clarke, 2006). The inductive approach is when the data are specifically collected for the study and are analysed without trying to fit the coding into a preexisting coding frame; this approach can also be called bottom-up or data driven thematic analysis (Braun & Clarke, 2006). The deductive approach is when thematic analysis is conducted based on the researcher's theoretical and analytical interest and is sometimes called top-down approach or analyst-drive thematic analysis (Braun & Clarke, 2006). This study used an inductive approach to analyse the data in order to gain rich descriptions of the data whereas the deductive approach tends to provide a less rich description of the data and is better suited to analyse specific parts of the data (Braun & Clarke, 2006).

Thematic analysis contains six steps. Once the transcription was finished, I read over the text while I listened to the interviews. I then read over the transcriptions a few additional times to get to know the data. Already then, I added some comments to some text bits (step 1). I then transferred the text to the Nvivo Pro 12 software to continue the analysis. Once the material had become familiar to me, the entire text was coded in Nvivo Pro 12 (step 2). After the coding process was finished, I gathered the codes into themes and sub themes which began to be apparent during the initial coding (step 3). Once the themes and subthemes were decided I re-evaluated whether the subthemes were placed beneath the right theme, for example if the theme *data* should be its own theme or be placed under the theme *resources* (step 4). After the fourth step, I re-read all the codes and themes and evaluated whether some of the codes or themes should be redefined or replaced, or if there should be any additional subthemes (step 5) and finally the last step was to present the data by creating a table with the themes and sub themes (step 6) (Braun & Clarke, 2006).

The data analysis was an ongoing process involving constant evaluation, getting feedback, and rethinking and I went back and forth between steps. Many sentences included topics which concerned more than one theme or subtheme and one of the main challenges was to code and categorize the data appropriately. The process was nonetheless based on the six steps of Braun and Clarke's (2006) thematic analysis and the analysis went through all six steps.

5.8 Data Quality

Qualitative research methods use different strategies to measure quality in research than quantitative research due to the difference in ontological, epistemological and theoretical beliefs behind the research methods (Yilmaz, 2013). Reliability and validity are terms which can both be used to evaluate research quality for qualitative and quantitative methods. However, how one ensures validity and reliability varies between research methods (Yilmaz, 2013). Other qualitative researchers have chosen to create their own research evaluation procedures such as Lincoln and Guba (1989) where they use the terms credibility (validity) and dependability (reliability) to evaluate quality in qualitative research methods. Here, the term reliability, validity and generalisability will be used to describe how the study's quality was ensured throughout the research process.

5.8.1 Reliability

Reliability describes the consistency and trustworthiness of the results and is concerned with the reproducibility of the data, that is, would the participants answer in the same way to another interviewer (Brinkmann & Kvale, 2015), and would another researcher come to the same conclusion using the same data? (Green & Thorogood, 2018).

To ensure reliability in the study, the interview transcripts were read a few times to ensure that everything was written correctly based on the voice record. The codes and themes were also read and evaluated several times, and my supervisor as well as a third person were gave feedback during the coding process. The results chapter also provides a good amount of raw data to support the interpretation of the interviews. These steps all increase the study‘s reliability according to Green and Thorogood (2018).

5.8.2 Validity

Validity asks if the results capture or measure the reality, this can be challenging since constructivists argue that reality is socially constructed (Green & Thorogood, 2018). Validity in qualitative research is therefore evaluated by the methodological decisions that were made during the research process. Such decisions are for example, which method was used for data collection, data analysis, participant recruitment or if a second opinion was sought (Yilmaz, 2013).

To ensure validity in this study, several steps were taken. As previously described, when preparing for the interviews, an interview guide was created with questions which aligned with the research question (Yilmaz, 2013). A pilot interview was also conducted to test out the questions. During the interviews the informants were asked if they wanted an explanation of the terms “social inequalities in health” and “Health in All Policies” and the goal of the study. Follow-up questions were asked in the interviews when an uncertainty came up about what the participant meant to make sure that the information they were giving were correctly understood. Validity was also ensured by reflecting on personal biases during the research process and describing them in the thesis (Yilmaz, 2013). In addition, the sample of participants were from various institutions and administrational levels which provided a variety in perspectives (Yilmaz, 2013). I provide good argumentation in the discussion chapter to support the interpretations. The transcriptions were read by the Icelandic speaking assistant and the results were presented to her and the thesis’s supervisor to get feedback (Yilmaz, 2013). A third party who works as an associate professor in psychology read over

the thesis as well and gave comments. All of these procedures aim to increase the validity of the results (Yilmaz, 2013).

5.8.3 Generalisability

Generalisability is when the results of the study can be applied to other similar cases or to the wider population (Green & Thorogood, 2018). In quantitative studies this is usually done by recruiting participants who are statistically representative of a larger group or society. This does not however apply to qualitative studies since the sample is seldom selected to represent a larger population (Green & Thorogood, 2018). Generalisability is achieved by providing a detailed description of the whole research process which this chapter aims to do (Guba & Lincoln, 1989). Generalisability in this thesis is also ensured by having descried the whole research process thoroughly and by arguing for the study's epistemological standpoint (Yilmaz, 2013). It is also ensured by referring to other similar studies which have previously been made which either support or contradict the results of this study (Green & Thorogood, 2018).

5.9 The Researcher's Role

Philosophical assumptions within constructivism deny the possibility that a researcher is able to be unbiased in their research (Malterud, 2017). Every researcher has a preconception based on previous experiences and knowledge (Malterud, 2017). This preconception is important because it often motivates the researcher to choose a topic of interest to study (Malterud, 2017). The motivation can both nurture and strengthen the research process, but it can also hinder the researcher to see beyond their preexisting thoughts and ideas about their research topic (Malterud, 2017). Reflexivity is important in this context for qualitative researchers. Reflexivity both involves reflecting and being critical on the research process itself and oneself as a researcher (Green & Thorogood, 2018). A part of reflexivity is to be aware of and consider how one's socio-economic status, gender and background might affect the study process or the participants perception of one as a researcher (Green & Thorogood, 2018). The researcher‘s professional interests, motives and personal experiences also impact the decision making for methods, research question, which results answer the research question and how the results are interpreted, presented and discussed (Malterud, 2017).

Qualitative findings are dependent on context (Yilmaz, 2013) and I as a researcher am a part of the context. My personal position should therefore be described as well as any personal or professional information that might have an impact on the data collection,

analysing process and interpretation of data (Yilmaz, 2013). The question is therefore not if but how the researcher impacts the research process (Malterud, 2017).

During the research process I was very much aware of my preconceptions on the topic and political opinions. I constantly reflected about how it might have impacted the process and my decision making. The interest for this study came during the first year of the master studies after having read official governmental documents about public health strategies for the past 15 years in Iceland while attending classes about health politics in Norway. There is a difference in these two countries' approaches on public health as described in the introduction and literature review. This approach difference has been on my mind ever since and became therefore the subject of this thesis.

This motive was a driving force to gain knowledge throughout the whole study, while at the same time it resulted in constant second thoughts and reflections about my working methods and how they could be improved to reduce the effect of personal thoughts on the results.

The knowledge I acquired during the first year of the master studies has indeed impacted how I look at public health work in Iceland and my political opinions. I never initiated any conversations about politics in the interviews, other than asking those who worked closely with politics if they felt that they were being heard or if their work received any political interest. It however came up in some of the interviews, sometimes someone hinted a political party and sometimes it was a general discussion about the fact that public health generally involves many political questions.

My educational background might have impacted the participants in different ways. It might have been a comfort to some of them and enabled them to relax and trust me with their thoughts and experiences. For others it might have been intimidating to talk to someone who had studied this subject. In both cases I did my best to make the informants feel comfortable and was curious about their thoughts and experiences no matter what their background was. I adapted the questions to their context to get my questions better across to the informants when the public health terms confused them. The study‘s topic was familiar to those who had an education or had worked with public health directly. Others were not as familiar with the topic, but it was connected to their jobs indirectly. Some informants made comments such as "I am not an expert in this, and I might be wrong about this". This might have impacted how secure they felt to share their knowledge in the interview.

Those who I had talked to before the interviews to get assistance with recruiting participants were more aware of my personal preconceptions which might have impacted their answers and how they felt during the interviews. At the time of these conversations, it had not been decided that they would participate in the study, and I was therefore not as aware of that it might have an impact later.

The informants decided where they wanted the interviews to be taken. The fact that they were all taken in a place of comfort for them hopefully resulted in them feeling better during the interviews rather than if they would have been taken at a place unfamiliar to them.

When I translated the policies, I had to pick and choose what to write in the thesis. I was careful to translate a variety of points and statements and tried to avoid picking statements which supported my thoughts and opinions.

6. Ethical Considerations

Qualitative data describes people's thoughts and experiences (Malterud, 2017) therefore it is important that ethical considerations are considered throughout the whole research process to ensure the participants privacy (Brinkmann & Kvale, 2015).

6.1 NSD

Approval for gathering personal data was applied for at the Norwegian Centre for Research Data. Along with the project plan, documents with the interview guide and informed consent (see Appendix A & B) were sent as an attachment with the application. The application was accepted (see Appendix C)

6.2 Informed Consent

Informed consent is important so that participants do not feel forced or convinced to participate in research against their own will. Participation should be voluntary, and participants need to understand the implications of participating in the study (Green & Thorogood, 2018). Therefore, it was important that they sign an informed consent form (see Appendix A) before the interviews were conducted. The informed consent sheet provided participants with information about the study, and possible risks of participating were described as well as how the data would be stored and made anonymous. The sheet also explained their right to retract their consent and participation at any time and their rights to access their personal data. Information was provided about where they could make complaints about how their personal data was used as well as including my own contact information if they had any questions. Before the interviews started, I asked the informants to read the informed consent first and sign it.

6.3 Confidentiality

Keeping the participants' confidentiality was the most important and challenging ethical concern in this study. It was a challenge to provide good quality descriptive data and at the same time ensure anonymity because the public health field in Iceland is rather small.
The majority of the informants had at some point met each other through their work. It could be a challenge, especially when interesting information had come forward in an interview and I wanted to ask about someone else's experience of the that same topic. When that occurred, I was very careful with how I formulated the question to ensure confidentiality.

It was also a challenge to write out the results so that the informants would not be recognized based on their professional status, opinion, or previous experience. Several informants were concerned that the information they shared could be traced back to them. Due to these concerns, the results are written with generalisations to avoid recognition.
Since two informants had suggested relevant informants for the study, it cannot be excluded that some informants will be recognized. It was also written on the informed consent that the possibility that people would be recognized could not be excluded.

6.4 Data

The data were stored on a locked laptop where a password was needed for login. Once the interviews had been transcribed, the sound files were deleted. The sound files, interview transcriptions and the thesis' writing document were saved on a personal OneDrive through the University of Bergen. This was done to ensure backup if anything would happen to the laptop which was used to analyse the data and write the thesis. As previously described, personal information was marked as XXX during transcription and the transcription files had names such as Interview 1 etc. In Nvivo Pro 12 the files had codenames which were a few letters. To avoid recognition, citations which were used in the thesis were adjusted so that informants would not be identified in the text. All of the data was deleted after the thesis had been evaluated and graded.

7. Results

The goal of this study was to contribute to the literature about how Icelandic national public health policies are implemented as well as to find out to what extent national authorities address social inequalities in health and apply the "Health in All Policies" approach in their actions. This chapter will present the themes and the subthemes that came up in the data analysis.

7.1 Study Results

This study had two research questions, "How do Icelandic national authorities implement public health policies?" and "To what extent do national authorities address social inequalities in health and apply "Health in All Policies" in their actions?". There were four themes identified in the analysis and three out of four themes had subthemes. Many of themes and subthemes overlap each other and some of them might describe similar phenomena but with different terms and descriptions.

Table 2

Politics	**Policy**
Resources	**Capacity** - Workload - Financial Resources **Knowledge** - Understanding of SIH - Data **Support**
Collaboration	
Structure	**Directorate of Health** **Health Promoting Communities** **Municipalities** **Mandate**

Note. Overview of themes and subthemes from the data analysis.

7.2 Politics

Politics as a theme emerged in the interviews as the informants described how politics influences public health. The theme politics presents the informants' perspectives on politicians' view on public health, the need for a public health assessment to be a standard governmental procedure and descriptions about recent increases in intersectoral political collaboration. The subtheme *policy* came up in relation to politics when the informants' described the national policymaking process and how national policies could be improved.

The informants explained that politicians tend to overlook public health interests when financial interests weigh heavier. The informants also described that politicians tend to view the Directorate of Health as some sort of stakeholder when they advise national authorities.

> *"There are so many interests that weigh heavier than public health interests. And if we just talk about politics, it is really hard to advise national authorities, there are many people who look at the Directorate of Health as some sort of stakeholder for some other forces… I mean really, there are people who want to put alcohol in every grocery store and just look at the Directorate of Health as some sort of propagandist."* - *Informant 6*

The issue of the alcohol discussion also came up in another interview where an informant described a mismatch between ministers in the same government concerning alcohol policy. The informant further described the importance of measurable success to convince politicians and thought that national authorities should do a health impact assessment on planned actions.

> *„Because if you are going to sell something to politicians, especially, or if you want something to be funded you need to be able to demonstrate specific results and something like that...and it is related to being able to measure, and also that a public health assessment is actually made on the actions... a public health assessment on all the actions that authorities specifically engage in, and of course, an example that has been mentioned in this is that maybe you know the Minister of Health talks a lot about public health, but then the Minister of Alcohol Affairs comes...and wants to put alcohol in stores...it doesn't quite go together in some way, sound and image do not match."* -*Informant 5*

Another informant agreed on the need for doing a health impact assessment and that it should be standard governmental procedure along with their environmental impact assessments.

> *"There should be almost an intertwined environmental and public health assessment for some actions, whether it is a power plant or a new neighbourhood etc. so that it is not only just bound to some architects or some environmentalists. "*
>
> *-Informant 3*

The informants further explained that politicians, both at the local level and national level, often lacked an understanding of what public health work is about and what works as preventative measures.

> *"But that party just thinks that health education equals preventative measures, it is just the same thing in their eyes."*
>
> *-Informant 6*

The same informant said that politicians are not always aware of what causes inequalities and that some politicians think it is a personal responsibility that someone ended up in a vulnerable situation or is poor.

> *„I think once again that people define it in different ways, and always when we talk about inequalities, it is just default to think about money...and nothing else. But there are so many other factors which impact inequalities and not to mention social inequalities. But I would say that specialists, people who work with people who are vulnerable or marginalized are very aware...However, I am not neccesserily so sure that everyone who is working in politics is, and politics play a big part in how it should be tackled...I mean what are possible ways and solutions and some just think it is just a part of reality, I mean it is just a bit your problem if you have gotten yourself there and it is not ours to resolve it for you."*
>
> *-Informant 6*

Some informants explained that cooperation between ministers was increasing and that they found that promising in relation to public health.

"At least today there is a ministerial committee on coordinating affairs, and they are trying you know within the structures. There is a project manager for coordinating affairs and a leader for sustainability in the Prime Minister's Office."

– Informant 1

Another informant explained how the process of establishing a ministerial committee occurs. The informant also described a recent legislation which demands collaboration between ministries which the informant found to be a good example that it is possible to work across ministries.

"It is just called for depending on which ministers should be involved in the issue when it is requested that some case should be coordinated, in the ministerial committee on coordination of affairs. Then the minister talks to, you know, the prime minister calls for a committee or those involved in the case, so it is possible to somehow address the issue better. It is also somewhat interesting to see what has been put into legislation that applies to many ministries, like the Child Welfare Act. It is also like intersectoral, so it's interesting to see that we can do this and that there are precedents for it."

-Informant 4

7.2.1 Policy

Policies are created by politician's requests, *policy* emerged therefore as a subtheme under *politics* when the informants described the national policies as being too extensive, with too many goals, and that their objective should be better prioritised. The informants also described a frustration about not being consulted in the policymaking.

One informant explained that national public health policies were reactive and did not address future challenges.

"We need be better at prioritising and to look a bit further ahead, because from my point of view, I think Iceland is more reactive than proactive, we are just like hey! Now this is wrong, we need to do something, and then everyone just does that and fix it and even with some sort of a campaign."

- Informant 3

Another informant found the policy objectives too unclear which made them unrealistic to implement.

"There have to be really specific goals, not just something like promote Icelanders' public health."

-Informant 5

One informant described that the state assigns responsibilities for policy goals to municipalities without consulting them.

"The state creates a policy and assigns things to do and those who they make responsible for it are maybe municipalities, but a conversation does not take place about that action, not to mention funding or resources, and therefore it ends up being nothing."

-Informant 3

The same informant found it frustrating that policies were created without consulting those the policy concerns or are meant for. The informant further described that different sectors are not necessarily up to date themselves on national policies or are willing to invest according to the policy's goals.

"Do not forget to consult others, and not manage someone else's time that you do not have authority over, without asking their permission. That is just a basic thing, to not expect that the groups being discussed in some report will necessarily read it word for word, let alone that a municipality, institution, company will invest money in it just because it says so in the government's policy."

-Informant 3

Several informants said that in order for a policy to be implemented, it should be accepted by the parliament. They explained that a policy which was accepted by the parliament was more likely to outlive governments.

"Well, it is very different how policies are made and who makes them. Whether it is the, this minister, this policy under a ministry, that there is some group that also proposes a policy. Often when a policy formulation is started, a working group proposes a policy... so it has actually been the most successful to go through parliament with it, then you have like, a parliamentary process."

-Informant 4

7.3 Resources

Resources came up as a theme when the informants discussed which resources were available or were missing in their jobs. This theme was the biggest one in the analysis and had four subthemes, (1) *Capacity* related to workload and financial resources**,** (2) *Knowledge* including access to information and understanding of social inequality in health and (3) *Support.*
As the description of the theme describes, the informants talked about various obstacles regarding resources. The informants all described that access to resources was the prerequisite for a successful policy implementation.

> *"This is just something that someone gets on the corner of their desk, and it can just end up as filling out some checklists about whether or not there are fruits available in the school cafeteria you know, this is just like with everything else, you will not succeed if you do not put any resources into it."*
>
> *-Informant 5*

7.3.1 Capacity

Capacity came up in the analysis when the informant described their abilities to address their obligations at work. The informants mainly talked about heavy workload and financial resources when they described their capacity at work.
The informants said they did not have enough time to do everything they wanted to and sensed that others did not have time to collaborate with them.

> *"We all deal with having more to do than we have time for, and sometimes people feel that adding this task on top of what they already have is unnecessary, what it really comes down to is stress…and then you as an outsider are a little bit like an unnecessary addition in their mind…but of course there are also others that are really interested and want to be involved."*
>
> *-Informant 3*

Other informants described that people working in Icelandic administration often had many roles due to how small the population is. According to them, this resulted in difficulties managing working hours and they explained that they were not expected to work overtime.

"Oh no, we are just like everywhere else, I think, in the administration nationwide, and we know that in municipalities, they are just a bit of understaffed. It is a bit of a mix of traditional work, you cannot do this in overtime, so you also just take it upon yourself as a volunteer."

-Informant 1

Other comments about workload was the wish for more time to work on important projects.

"But to be able to do what you want and what you see is necessary, then it would maybe be best to have more than 24 hours."

-Informant 6

Capacity was also frequently linked to funding: the informants mentioned that funding policies and funding in general were a barrier.

One informant said that there was a common frustration within the system because they put a lot of work into policies and action plans but said that it often ends up not being funded.

"I think there is a frustration, generally within the system that there are created multisectoral groups about this and that and they hand in some report and then it does not get funded, I think there is a lot of precious information which lies spread around in the system."

-Informant 1

The same informant explained that the funding tended to be spread out to different institutions and projects which all had the same goal.

"The budgets are thinned out to all kinds of something that is worked with here, here. Instead of we could just combine the budgets, because really, the end goal is the same."

-Informant 1

Another point that was raised by an informant was that public health is not mandatory for municipalities to work on, so it is not a priority. When their budgets get tight, the funding to public health work is the first thing that gets cut out.

"And then there is this, when the budget gets tight in municipalities, then this is not a mandatory role for the municipalities, and these are the first people that they let go."

-Informant 3

The informants also said that policies which go through the parliament were more likely to be funded and explained that the policies in general tend to be unfunded.

"Of course, there are many things in policies which do not need to be funded, then of course it is easy to do that. Policies have often been made but it has not been thought through how the content of it is supposed to be funded."

-Informant 4

Some informants talked about the public health fund which the Ministry of Health has, which they said could be used to prioritise public health actions in municipalities. The informant further described that municipalities need to engage more in public health issues than they currently do.

"Yeah and make sure that it is sufficiently funded, and another thing that I think maybe needs to be done is to figure out some emphasis on priorities you know….not just something like, if for example the fund has limited budgets then of course we also need to analyse where it is most useful…you know and gain the municipalities attention because you know, these are assignments that they have to put their money into and try to figure out."

-Informant 5

7.3.2 Knowledge

Knowledge as a subtheme emerged when the informants shared their and others knowledge about public health. Most of them said that public health needed to get to a higher level in Iceland and that the general knowledge about what public health is, was limited.
The subthemes understanding of *social inequalities in health* and *data* came up in the analysis when a difference in understanding about the causes of social health inequalities appeared. The majority of the informants also experienced some barriers concerning data access in their work.

The informants who had specialized education or had worked for a while in the field described a knowledge gap between them and some of their colleagues.

> *"And you also see it, with full respect for these good people working here, public health is often discussed and health promotion, but people perhaps do not always fully understand what they are talking about, or there is at least not the same understanding."*
>
> *-Informant 6*

The informants said that generally in Iceland, public health needs to get to a higher level, and one informant explained said they were still stuck in the thought that knowledge changes behaviour and health education would lead to improved public health.

> *"And maybe just the biggest challenges, is that people are still a little bit into just putting up posters, you know and into educating and so on, so there is still an old-fashioned way of thinking in many things."*
>
> *-Informant 6*

Another informant also mentioned the lack of knowledge and a limited understanding of what preventative measures were.

> *"Then of course, the question arises, what is alcohol prevention? Is it talking endlessly about alcohol or is it getting children to come and exercise so they are less likely to follow the path of alcohol?"*
>
> *-Informant 3*

The same informant hypothesized that this limited understanding might be traced back to the assignments that the Institute of Public Health used to have.

> *„And then there is also just the understanding of the concept of public health. Here in Iceland, I think it has evolved a lot from what was initially under the Public Health Institution. Alcohol and tobacco control, mental health, and physical activity. But public health… is much broader, it concerns urban development... and there's something somewhat new for us here, right? Wait, what? Public health... This is a huge public health issue, how we plan new neighbourhoods, so we need to get more into these matters, much much more."*

-Informant 3

The informants also shared that they found public health too often linked to sports and that the complexity of it was confusing to some people. Another informant further described that Icelanders tend to exaggerate when they do something, it is all or nothing, also concerning sports.

> *„This is more complicated, and then they just think you are all over the place and ask why we do not just have the sports week?“*
>
> *-Informant 1*

> *“But you also feel… that people are somehow confusing public health with sports... and Icelanders are a bit like, if they are going to do something then they are going to compete in something, they do not compete in going for a walk, they do a triathlon or something like that, and if you are not willing to do the triathlon, then you are not really promoting health. Just if you go for a walk once a day... there is somehow a missing connection between focusing on your health through exercise and nutrition and sleep and all of that. It is not quite the same as competing in a competition and definitely not the same as being an athlete who competes in sports.”*
>
> *-Informant 5*

Another example that the informants used to describe the gap in knowledge between them and people around them was that public health was frequently linked to the health care sector.

> *“It does not matter whether it is the government, or the labour market, or the individual itself…try somehow to take this you know, the Directorate of Health is there…this needs to get out of the box of the health care system. “*
>
> *-Informant 5*

Understanding of social inequality in health was also a subject related to competence as difference of understanding of the topic came up during the analysis. Those who had education within public health or had worked with it for a while had a full understanding of the concept, while informants who indirectly worked with public health had a limited understanding of the causes of health inequalities.

"Well, I mean it naturally says itself and it is obvious that any inequality is negative in regard to well-being, it is one of the factors that predict unhappiness in society if there is a high level of inequalities."

-Informant 6

All of the informants all raised concerns about immigrants in Iceland. They were all concerned that they were not well enough included in society.

„Just like in child projects, we have children with a foreign background, we are not always able to reach out to them to involve them in social activities, so there are multiple challenges in ensuring social equality. "

-Informant 3

One informant further said that immigrants, as well as other groups often work low-wage jobs which are too low for them to make ends meet in an expensive society like Iceland.

"Who are working in these low-wage jobs, you know, often women, people with foreign backgrounds, and they are poorly paid. It is an expensive society here, just meeting the basic needs like housing and buying groceries, these basic needs, and various services you know, that for people with the lowest wages to make ends meet and fulfil their basic needs has been confirmed that it is impossible for a certain group. And that group is often, as I mentioned, more likely to be women in low-wage jobs, people with foreign backgrounds, and people who receive disability payments."

-Informant 1

Another informant said that the school system in Iceland was a factor which decreased health inequalities in Iceland because all children go to the same public schools and kindergartens.

"You know this access to just good elementary schools maybe and the kindergarten system is an equity tool, especially kindergarten in Iceland, are very, very cheap. You know if you would be paying for a child and would be paying for eight hours full fee which costs, which is allowed to charge for, you know it is about 2-300 thousand that they would have to pay for… but instead you are maybe paying 30-50 thousand or something, so you know this is an equity tool also, which the municipalities are doing a great amount to provide."

-Informant 5

Some informants linked social inequality in health to sports, and one informant was especially concerned with immigrants' participation in leisure activities.

> *"My main concerns about inequalities in public health are when it comes to immigrants because we have not been able to ensure equal participation of immigrant children in sports equal to Icelanders. And just in general in leisure activities and leisure activities of course has a significant impact on public health, so I think it is an important key to public health."*
>
> *-Informant 2*

Other informants also gave examples of things that are meant to decrease inequalities in health, but they found they did the opposite. An example that one informant put forward was the leisure-activity card for children in Iceland. The informant said that it was meant as a tool for levelling out inequality, but the application process was a barrier that came down on many children.

> *"As soon as opportunities and services are dependent on the parent's interest, motivation and knowledge, then you are opening up for that children and individuals fall between a rock and a hard place... just as an example, I mean the leisure activity card, that is just a brilliant concept, and nothing but good to say about it...I mean there is obviously inequality there...if you think about it, it is because it is dependent on that the parents are keeping track of these registrations, managing the payments, and applying for the money...of course it would be better if this would be more automated and there would be a better connection between schools and sports clubs and that this money would just go straight to the club and if a kid is interested in football then he just goes and plays football and the money just follows without having to apply for it."*
>
> *-Informant 6*

Another informant described the leisure activity card as a good tool but meant that it would be a better equity tool if it would mainly be aimed at those who were in the greatest need for it.

> *"One response from the municipalities were these sport grants for children. It was supposed to enable everybody to participate regardless of their financial situation. Of course, they are available for everybody, so as an equity tool maybe, it is often*

mentioned that you should aim equity tools where they will have the greatest impact and not to others, but it was just decided that it would be equal for everybody so that is one equity tool to respond to this.“

-Informant 5

Another aspect related to resources and competence was the lack of available information and access to data sources. Some informants said that they knew about available data sources at different institutions, and some said they would have to apply and pay for data that were necessary for them to enable monitoring and act upon needs in the population.

“We do not have information about where the greatest need is, because often it is maybe kept somewhere else than here, so we maybe have you know, a lot of data, but they are somewhere else.”

-Informant 4

Other informants said they had access to some data sources but to get access to an analysed version of these to get a better overview they would have to pay extra.

“So, if the municipalities would want a better analysis on something related to these data, then they would always have to pay for it.”

-Informant 5

Other comments about data from the informants were that it was hard to create well analysed quality data in Iceland due to the size of the population and the size of some municipalities.

“The challenge in a small society like Iceland where we are so few…is to have enough power in the data to be able to analyse it …based on gender, and then education, and financial situation and income and some other factors that we know are important.”

-Informant 1

One informant felt that some of the data were not collected often enough and said that they had received critical feedback on a project because the data they based it on were outdated. The informant said that the project was based on the most recent data they had available.

“This is complicated, and we have often received, because we are constantly trying to do something… there have been stakeholders which have been against our

interventions, then we have often been criticized for basing our decisions, not on new data or a new data set…but on data that are outdated."

-Informant 4

Another point about statistics came up concerning different official districts. One informant explained that the different districts were not defined in the same way in datasets which made it difficult to apply and compare data and that some of the data were sometimes gathered more than once due to this division of districts.

"And it makes all statistics a little bit difficult because all these districts do not speak together, you know health districts, police districts, regional districts, they all collide these districts, and in general, data collection and analysis are not in a great place in Iceland you know."

-Informant 5

7.3.3 Support

Support as a subtheme came up when the Health Promoting Communities project from the Directorate of Health was described. The informants that were familiar with the project described that the participating municipalities needed more support and follow-up.
One informant felt that the project was put forward as a support but did not experience it as a such.

"But you cannot establish a project which is put forward as a support project but then it turns out to not be a support project at all, that is just fake."

-Informant 3

The same informant explained that there are different challenges in different municipalities and that they need to be able to address local challenges and get support to address them.

"So, if mental health issues are a significant problem in a municipality in the northern part of the country while exercise for senior citizens is a big issue in another municipality in the southern part, then we should be able to address those issues...and receive support to do so, and you cannot expect that the municipalities have specialists in all fields and if I need support concerning mental health issues then I must be able to get it from somewhere, otherwise I will not be able to address the issue."

-Informant 3

One informant said there were some municipalities that seemed to get special treatment in the support provided by the Directorate of Health, which other municipalities, especially smaller ones considered unfair.

> *"Some people have mentioned it that some municipalities get preferential treatment, that Reykjavik municipality obviously got, I mean, received quite a lot of support implementing their public health policy from the Directorate, and reflections from smaller municipalities are like do not we get that as well?*
>
> *-Informant 6*

7.4 Collaboration

The theme *collaboration* came up when all informants described that there were many silos both within and between systems both at national and local levels. The informants mainly described a lack of collaboration within the Icelandic administration and wished that collaboration would increase.

> *"It does not matter whether it is between the educational departments and social services, the planning department, all of this needs to communicate together to create a comprehensive approach to public health issues in municipalities….and there are just silos, they are competing for money, time, staff, all of this, there are silos between the national level and the municipalities."*
>
> *-Informant 5*

The informants also described a need for a holistic approach or common ideology between sectors to approach public health.

> *"Of course you do not want to shoot down some initiatives you know with sports clubs or municipalities which come up with great projects or something… if the government and the municipalities, or national authorities and the labour market are really going to address some public health issues, then there has to be some sort of…there has to be some kind of ideology behind what we are doing, not just a really clever project here and there."*
>
> *-Informant 5*

One informant felt that everyone was in their corner doing their own thing. The same informant further described that the Icelandic administration is small and felt therefore that it was even more important to combine resources to work together on shared interests.

> *"If we could just somehow organize our understaffed administration at national and local level, so we could agree that we are working together towards these goals, each having their role in it. The health and well-being of the people and the Earth should be the outcome that we are striving to unite around."*
>
> *-Informant 1*

One informant said that their workplace could be better at initiating collaboration with sectors/institutions and that they should not expect others to seek this out themselves.

> *"We have often been thinking about when we are thinking about this Health in All Policies… we somehow want everybody to look at health but maybe we should be better at being some kind of ambassadors, or you know seek out, that not everyone somehow has to look to us, but we should maybe reach more out."*
>
> *-Informant 4*

7.5 Structure

Structure appeared as a theme when informants described their workplaces assigned legal roles or job descriptions in public health and that they tried to have an impact within their legal responsibility. The theme has four subthemes (1) *Directorate of Health* where the informants talked about their role within public health in Iceland, (2) *Health Promoting Communities Project* where the informants shared their views on the project and what could be improved, (3) *Municipalities* where the informants talked about the municipalities' role in public health and some challenges within municipalities and (4) *Mandate* where the informants talked about a need to define division of labour better between different sectors who work with public health.

All of the informants tried in their way to have an impact within their sphere of influence.

> *"Our way to bring things forward is always to educate, mediate, assist and advise."*
>
> *-Informant 5*

The informants described structural barriers which impacted their ability to fulfil their legal obligations. One informant said that the responsibility for public health rather belonged to a ministerial committee on coordinating affairs due to the complexity of the issue rather than being at the hands of the Ministry of Health.

> *"Yes this is a little bit, because this is an issue that does not fall under the responsibility of a single ministry... so it is a little bit you know, there has been a ministerial committee on coordinating affairs… which is under the prime minister's office… it is maybe something that rather belongs there, to try to coordinate what each entity is doing, but there are always competing forces you know."*
>
> *-Informant 4*

The same informant described the newest public health policy as being healthcare-service centred because the Ministry of Health, which creates the policy mainly has power within the health sector.

> *"It is health care-service cantered because… it was developed within the Ministry of Health, so it is difficult to go beyond the Ministry of Health. So, it is more like taking a part of the pie, just like the health care policy... it left behind preventative measures and health promotion and only included the health care sector."*
>
> *-Informant 4*

7.5.1 Directorate of Health

Directorate of Health as a subtheme under *Structure* became a theme when the informants described their perception of the role of the Directorate of Health. Some informants said that they found it confusing that the Directorate of Health was supposed to help with health promotion. They said that the Directorate of Health was a regulatory body for the health care system and felt that they were more of a supervisor and not a support provider.

> *"It is my experience, my feeling that people perceive the Directorate of Health as more of like an authority rather than a support battery… but they are an advisor, but there is little bit of a disconnect, I mean, I just feel it that people do not perceive that the Directorate is, you know, maybe going to advise us here in the field."*
>
> *-Informant 6*

The same informant said that because the Directorate of Health is an institution at a national level, it limits their resources to act on public health.

> *"When you are working within the Directorate of Health or really just at the national level, then naturally it is more within policy making and advising."*
>
> *- Informant 6*

7.5.2 Health Promoting Communities Project

The project *Health Promoting Communities Project* was frequently discussed by all informants. The informants described the checklists from the Directorate of Health, which they said was the main tool accessible to participating municipalities. They described them as being too long, too time consuming for them to fill out and too subjective.

> *"For example, if we talk about the Health Promoting Communities again, they expect us to fill out checklists which contain over 200-300 questions, and it is a lot of work, and you cannot do this alone because it concerns other departments, and talking about work related stress, it is just difficult to get people to do it with you."*
>
> *-Informant 3*

Another informant described the checklists as being too subjective which made them a less reliable measuring tool over time.

> *"I am convinced that people are going to interpret this in different ways. Depending on position, depending on personal experience and just interpretation of words... and then of course you have lost the integrity in this because you do not have comparability and not really internal validity, I mean then someone else takes on these checklists in five years and looks at it and interprets it completely differently, what happens then?"*
>
> *-Informant 6*

The same informant described the cost benefit of filling out the checklists and that the outcome of the checklists might not be beneficial to some municipalities.

> *"And if nobody has the time or ability to fill out the checklist then really and not everyone puts the same meaning to it then it turns into kind of a jungle and what for?... you have filled out the checklists, I mean we are still a Health Promoting*

Community but how have we benefitted from it? I am possibly just shooting myself in the foot realizing we need to do this and that, because if I do not fill them out, then we just keep on sailing on the river as a Health Promoting Community and nobody complains about it or criticizes us.“

-Informant 6

The same informant further described Directorate of Health’s role and their ability to control what the municipalities are doing. The informant also suspected that many of the municipalities which had signed up for the project had not done any changes after they signed up to participate.

“They are of course a regulatory body for health care services which is not at a municipality level, so you know, it is not theirs to show up and you know take out, are you doing this? Or are you doing that? And then you get to call yourself this. But you know rather with a statement saying that they are going to be a Health Promoting Community and I think that many of these municipalities that brag about being health promoting, are possibly not doing anything different than they were. “

-Informant 6

Another informant explained that many preschools and elementary schools in the municipalities felt that it was more of a burden to participate in the Health Promoting Schools project and said that they could have Health Promoting Schools without having to fill out some checklists.

“And there is health promoting preschools and health promoting elementary schools, there are very few preschools for example in our municipality that have participated in this project, and it is simply because people perceive it as more stress to answer some checklists. We have health promoting preschools, we can well be so without participating in this project. So, people even just perceive it as more of a burden.”

-Informant 3

The same informant explained that one national public health policy aimed at getting most municipalities to participate in the Health Promoting Community Project, but felt that as a goal in itself it had limited meaning because municipalities lacked support to implement it.

“Suddenly everyone should be a Health Promoting Community, and now it is 90% or 95%, but then the municipalities are just on their own with it, not all

municipalities have a public health specialist or someone who is dedicated, yes everyone has a contact person, all municipalities have a contact person.

-Informant 3

Another informant felt that the project lacked leadership from the Directorate of Health which it said was important for a successful outcome.

"I think for example Health Promoting Schools has somewhat given up, because I do not know if its being led with the same strength as before..But of course Health Promoting Schools which then later becaeme Health Promoting Communities, it is of course a very intersectoral project, but I have a feeling that there is not much leadership in it...Whether it is no leadership or just...less emphasis or something...But it is always important to have leadership, vision and leadership."

-Informant 2

Despite criticism on the health promoting projects, some informants said that establishing the projects was a good thing which has led to positive changes. The main criticism according to one informant was the need for more follow-up and support from the Directorate of Health.

"You know it has indeed impacted a lot, and I mean there are now plenty of health promoting schools and preschools that have started to work much more systematically on health promotion and public health issues than they did before, so I would never say that it has not, but I just think that it needs, and that's what the municipalities are perhaps saying, you know, they need more support and follow-up."

-Informant 5

7.5.3 Municipalities

Municipalities as a subtheme came up in the analysis when the informants described different placement within the administration in municipalities and talked about the municipalities ability to work on health promotion.

One informant who was placed on a rather high level in the administration described it as a positive thing. Despite the location the informant described it as a challenge to work between sectors.

"Yes I think it is very positive because then we get to work across the departments, but there are great challenges...because you do not have direct authority over staff

members in other departments... so you cannot, you need to do this collaboratively... and of course in collaboration with the department managers, my boss and the manager of the department that I am going to work with... needs to be willing to participate in this project, so it is a bit of a challenge, that is you know what I am working on with my boss today."

-Informant 3

In contrast, another informant was placed at a rather low level in the administration but felt that it did not matter because the co-workers were easily accessible independent of their administrational location.

"I am not sure that it will bother me specifically, it could just be beneficial in a way... I am just doing this, and I mean the structure here is rather flat, so I have access to everybody, and everyone is willing to listen."

-Informant 6

One informant explained that the size of the municipalities varies greatly which impacts their ability to work on health promotion.

"Well, you of course have to consider that the municipalities vary in size…so this is, I think it is easier for us in many ways based on resources rather than for example Ísafjörður, or municipalities that are spread out and you cannot have a specialist in every case, then you have got people who have different roles."

-Informant 3

The same informant thought that the municipalities were in a good position to address public health issues in general because they knew their local challenges.

"Yes, I believe that us at the municipal level, we are more implementers within municipalities, and we understand the issues within our municipality much better than any government official at a ministry. So, we need to somehow trust that and assist the municipalities in finding what they want to work on, based on data, and they receive assistance with that, and then it is monitored how it goes."

-Informant 3

Another informant described two different perspectives when it comes to municipal size and their ability to provide services.

"Well, this is, of course, a very sensitive issue because, you know, there is of course this one ideology that suggests that as municipalities grow larger, it becomes easier for them to meet the requirements set for them... while the other ideology suggests that when the municipalities are smaller, they are closer to the residents and can serve them better. So, there are just two different schools of thought, very different political stances. "

-Informant 5

The same informant further described that it varies how municipalities implement policies and that the size of them was not necessarily a major factor.

"But with projects in general it just varies greatly, some small municipalities do a great job even though they are small and just receive projects and just fix it, while with other bigger it just gets lost somewhere in the administration and this is just a little bit like, what does the municipality decide to put their resources in you know. "

-Informant 5

Another informant said that it was important that municipalities do not free themselves from responsibility even though they have hired someone to work on public health.

"At the same time, you need to make sure that a having a position like this is not a justification somehow for a municipality to free themselves from the responsibility, I mean we have hired someone here to work with public health and it just takes care of it."

-Informant 6

7.5.4 Mandate

Mandate became a subtheme to *Structure* when the informants described a need to define roles for different sectors in public health. The informants also described some barriers that they experienced due to the lack of mandate they had.

One informant described that the responsibility for public health sometimes ends up being a shared responsibility which often ends up with inaction.

"Part of what, you know, are these Health-Promoting Communities and health-promoting municipalities, you know, there is a process that you have to go through, through the Directorate of Health, and you obviously just know... there has been criticism that there isn't enough follow-up, that municipalities are not allocating

enough funding… If you do not have at least one person who takes responsibility for this in the municipality, then maybe nothing happens, even if everyone is willing to (do) it."

-Informant 5

Another informant described how complex the issue was because it was concerned with so many disciplines but their mandate to address public health was limited.

"This is, of course, in the hands of so many, you know, it involves both employment, housing, social aspects, healthcare, and it can be difficult to work within because we may only have a certain sphere of influence. We are, of course, to a certain extent, entrusted with a role...and we have the most sort of mandate or, um, we can do certain things... but maybe we cannot quite tell ministries what they should do."

-Informant 4

One informant said that a lot had been done to build up structures within the system to collaborate but the mandate for responsibility had to be made clearer.

"Many things have been done to build up structures and processes and I think in many ways we have done a decent job even though it is not in any way perfect. So, you know a type of governance, but we for example, on this mandate, to clarify this mandate for those who have this role, that it should be even clearer that it is the role of the state and the municipalities to define that even clearer."

-Informant 1

Another informant described the silos between the state and the municipalities and so called "grey areas" where neither state nor municipalities want to take responsibility for assignments.

"And there are just silos, they are fighting over money, time, staff, all of it, there are silos between the state and municipalities... and there is often talk about these grey areas... where there is something like, that needs to be done but the state just says not me and municipalities say not me, and there are definitely silos and grey areas there."

-Informant 5

One informant talked about the contact persons in the Health Promoting Communities Projects. The informant said that it would be best that the contact person for the municipalities would be the mayor and thought it was strange to delegate the responsibility for public health to specific employees and not have the person in charge participate themself.

> *"Really it would just be best if the contact person would just be the town or the city mayor…Just the person that has, is sailing the ship, he is just there, this is like people or the CEO signs all of the employees up for some sort of a course, but they do not attend it themselves."*
>
> *-Informant 6*

8. Discussion

The aim of this thesis was to study how Icelandic authorities implement public health policies and find out to what extent national authorities address social inequalities in health and apply the "Health in All Policies" in their public health actions. This chapter will give a brief summary of the findings, then put them into context with existing literature as well as the thesis's theoretical framework. After the main findings have been summarized the study's limitations and the need for further research will be discussed.

8.1 Results Summary

The informants explained that politicians perceive health promotion and preventative measures mainly as consisting of health education and that public health interests tend to weigh less than other interests in politics. The informants complained about too extensive policies where the goals were too many and reactive rather than proactive. A major factor for successful policy implementation was that it received parliamentary process, which made it more likely to outlive governments. The informants were lacking multiple resources. They reported limited budgeting and heavy workload, and those who had higher education within public health science experienced a knowledge gap between them and their colleagues. The informants also reported various issues with data access to inform their practices and lacked support from the Directorate of Health. Intersectoral collaboration was a struggle for most of the informants due to fragmented division of labour. Placement at different administrational levels also hindered some informants from influencing others whose work impacts public health. Some informants were unsatisfied with the tools and support they received from participating in the Health Promoting Communities Project and the Directorate's of Health dual role as a regulatory body for the health care system along with their public health responsibility was a barrier. The municipalities vary in size and resources, but the informants at municipal level agreed that they were best suited to address local public health challenges. The informants expressed a need for a clearer mandate where different sectors' responsibility for public health is addressed and found that a recent legislation which demands intersectoral collaboration was promising.

8.2 Politics and Policies

Policy making to address unequal distribution of the social health determinants is dependent on politics (Bambra et al., 2005). The results indicate that Icelandic politics are not particularly concerned with addressing social inequalities in health through policy. In recent

years the government has identified that there are inequalities in health (Þingskjal 1108, 2020-2021), but they seldom address the social gradient and that health inequalities are a result of unequally distributed resources for health (Dahlgren & Whitehead, 2006). The solutions they suggest addressing public health challenges are mainly lifestyle related and aim at changing health behaviour (Velferðarráðuneytið, 2016; Þingskjal 1108, 2020-2021). This policy emphasis on lifestyle related interventions occurs despite having access to Icelandic research which for example, reveals health inequalities through a relationship between parental education and childhood obesity (Eidsdóttir et al., 2013) and financial difficulties and healthy food consumption (Steingrímsdóttir et al., 2014). The fact that the first analysis of health inequalities was published in 2021 indicates that the government has not been concerned with the problem.

The government's public health policies were too extensive according to the informants. This is visible in all recent policies. Goal number two in the 2016 public health policy was to take goal orientated preventative measures when it comes to *"upbringing, education, nutrition, exercise, mental health, dental hygiene, violence, accidents, alcohol, tobacco and use of illicit drugs"* (Velferðarráðuneytið, 2016, p. 10). The policies they suggest in addressing this goal are offering an optional upbringing course in health care centres, increasing teacher's access to educational material on various health behaviours, teaching mindfulness in schools and enabling children to be physically active during school hours. This policy along with other governmental policies mainly address health risks and health behaviour but to a limited degree protective and positive health factors such as financial security, decent housing, and food security (Dahlgren & Whitehead, 2006).

The public health policy from 2021 also included rather extensive goals, it contained seven subgoals where each subgoal had multiple, rather extensive subgoals. Many of the goals were linked to the health care sector such as *"A multidisciplinary health promoting reception in health care centres should be established. These health care centres should be actively involved in public health work by collaborating with municipalities."* (Þingskjal 1108, 2020-2021). The informants explained that the policy was health care oriented because it was developed by the Ministry of Health which mainly has a mandate within the health care sector. However, the Ottawa Charter has highlighted the importance of mediating between different interests and sectors to move the focus of health promotion away from the health care sector (World Health Organization, 1986). The "Health in All Policies" (HiAP) policy approach also encourages a multisectoral approach to improve population health and reduce

health inequalities. The 2016 public health policy was developed in collaboration with multiple ministries, organizations and institutions which is in line with the HiAP approach. It was however put forward by the Ministry of Welfare (Velferðarráðuneytið, 2016) and did not receive parliamentary treatment; such treatment was identified by the informants as important to outlive governments. The HiAP approach is a method to address the social determinants of health (Dahlgren & Whitehead, 2006). Icelandic public health policies address to a limited degree the determinants "social and community networks" and "living and working conditions". According to the informants and the policies' content, the government's main focus seems to be on the health determinant "individual lifestyle factors". Although addressing public health through the social determinants of health does not seem to be a political commitment, a framework based on Dahlgren and Whitehead's (2007) model is used by the Directorate of Health in their Health Promoting Communities Project to help municipalities understand the complexity of addressing public health (World Health Organization, 2023a).

The fact that Iceland is a welfare state is health promoting in itself (Marmot et al., 2008). It contains a universal school and health care system with state coverage (Christiansen et al., 2018). Women are active participants in the labour market and there is affordable childcare services available which are characteristics of a social democratic welfare regime (Esping-Andersen, 1990). But one could argue that Icelandic public health policies are similar to policies in a corporatist/conservative welfare regime (Esping-Andersen, 1990). In Fosse's (2011) analysis of public health policies between different welfare regimes, she described Netherlands policies as lifestyle oriented, not addressing the social determinants of health and instead aimed at changing health behaviour which authorities implied were a personal responsibility. One informant described an Icelandic party's perspective on public health issues was that preventative measures equalled health education. The party that the informant talked about was one of the two parties which put forward the public health policy in 2016. The same policy had multiple sentences which emphasised that health was a personal responsibility (Velferðarráðuneytið, 2016), so did the 2021 policy (Þingskjal 1108, 2020-2021). Hence there is a strong similarity between Icelandic public health policies and those in a corporatist welfare regime. One could also argue that Iceland's policy approach is somewhat similar to Danish policies which mainly focus on individual health behaviour and heath inequalities are seen as a problem for the health sector to resolve and not as a political commitment (Fosse & Helgesen, 2019).

According to the Lippitt- Knoster Model (1993), if one lacks a vision, which in this case is policy, it creates confusion amongst policy implementers. A policy is indeed present, but it is so extensive that it creates confusion among the informants. Some of the informants complained about not being consulted during the policy process. This lack of consultation leads to a lack of motivation or what the model calls incentives (Knoster, 1993). Some of the informants do not see why they should implement national policies, which might not be relevant to their local context. A lack of incentives can lead to resistance in policy implementation. The two policies presented in the thesis also had an action plan. These action plans were also rather extensive and did not define division of labour or allocate resources. Due to the action plans limitation, it does not appear to provide sufficient guidance to policy implementers. According to the Lippitt-Knoster Model (1993) no action plan can lead to false starts.

8.3 Lack of Resources

As presented in the results, the informants complained about limited resources. The majority of the informants described limited funding as a barrier for policy implementation which led to a common frustration within the Icelandic administration. The informants' experience is similar to Norwegian municipalities' experience with funding following the Norwegian Public Health Act (PHA) implementation (Fosse & Helgesen, 2015). No earmarked funding followed the Norwegian PHA but many municipalities had received funding in 2004 through the county councils which many municipalities used to hire a public health coordinator (Fosse & Helgesen, 2015). Due to a lack of funding, Norwegian municipalities mainly fund their universal measures, but they have to apply for external funding for specific actions which are aimed at vulnerable groups (Fosse & Helgesen, 2015). Put in the context of the universal proportionalism (Marmot et al., 2010), Norwegian municipalities fund their universal measures, but the proportionate actions aimed to lift up the vulnerable groups are dependent on external funding. This funding arrangement raised some questions about the arrangement's sustainability amongst Fosse and Helgesen's (2015) informants.

The informants also mentioned that because public health is not a legal role for the municipalities in Iceland, it is the first thing they cut out when the budget gets tight. A missing legal obligation and tight budgets might explain why most Icelandic municipalities do not prioritize resources to public health work, as some of the informants mentioned. This is in contrast to Norway where the PHA puts a legal responsibility on municipalities to address

health inequalities independent of budget situation (Folkehelseloven, 2011, § 1), resulting in continuous public health work in Norwegian municipalities.

The informants' experience of a knowledge gap is similar to findings from Norwegian research on the Norwegian PHA implementation (Fosse et al., 2018). Fosse et al. (2018) found that policy makers at the national level described municipalities' limited understanding of public health right before the PHA was implemented. Addressing the social health determinants with the HiAP approach was unusual to local authorities in Norway. The majority of the municipalities' public health interventions had been lifestyle and health care oriented before the PHA was implemented (Fosse et al., 2018) which is similar to Iceland's policies today and the informants' experiences. The difference between Norway and Iceland however is that national authorities in Norway put an emphasis through politics to address health inequalities and the social health determinants through intersectoral collaboration (Folkehelseloven, 2011. § 1). In Iceland it is the other way around; those who work with policy making or lower down in the administration are calling for a political shift in health promotion. The Directorate of Health seems to be the pushing for a political change through the Well-Being Economy (World Health Organization, 2023a) and by publishing reports which emphasises on a wholistic approach in addressing public health issues.

Understanding of social inequalities in health also varied amongst the informants. All informants, however, mentioned immigrants and health inequalities; their reflections match with available data about immigrants' position in Iceland, as described in the literature review. Immigrants, amongst single parents, constitute the group that is most likely to live in poverty or right above the low-income threshold in Iceland (Guðmundsson et al., 2023). This means that children of immigrants are more likely to live in poverty (Félgasmálaráðuneytið 2021) as well as being less likely to finish upper secondary school, especially if they had resided in Iceland for less than nine years (Hagstofa Íslands, 2019).

The limited understanding of SIH can also be seen in Icelandic research which indeed reveals the presence of social inequalities in health in Iceland, such that the authors rarely use the term "social inequalities in health". The studies seldom address what underlies the health inequalities they reveal in their research but describe the difference as "health and education" or "health and residence" etc. It is questionable that the research from the Icelandic Cancer Society which was done in the Reykjanes peninsula, an area with high percentage of immigrants and people without tertiary education (Embætti landlæknis, 2023a) did not

address the social gradient and the social determinants of health when they discussed their results (Þórisdóttir, 2022).

Another difference of the understanding of social health inequalities was when leisure activity was discussed. They leisure activity card is available in almost every municipality, and everyone can apply for it. The sum varies between municipalities, and it is meant to make leisure-activities affordable for everyone. One informant thought that equity tools were best used with means-testing, a method which is used in liberal welfare regimes (Esping-Andersen, 1990) while another informant thought that the card increased inequalities, which is the opposite of its purpose. The fact that parents have to apply for the card/refund makes leisure activity participation dependent on the parent and their financial ability to pay for the leisure activity to then get a refund later. This does not fall under the universal proportionalism approach because putting up an application barrier excludes certain groups from benefitting from the support.

Another resource the informants were in some degree missing, was data sources. The informants either lacked data, access to relevant data, had mismatching data from different districts or experienced difficulties with data analysis. Norwegian findings reveal similar challenges, such that public health coordinators in Norwegian municipalities experienced shortcomings in accessible data sources for their local community. At the same time, they also had limited resources to collect local data themselves (Hofstad, 2016). The Norwegian Institute for Public Health also struggled to link together available data for the municipalities due to legal issues (Riksrevisjonen, 2014-2015). The 2021 public health policy addressed some of the data barriers the informants expressed. It mentioned the barrier with different data districts and aimed for regular data collection. The same policy also aimed to address some of the data access issues which the informants talked about by defining access rights to different data sources (Þingskjal 1108, 2020-2021).

Another resource the informants also thought was missing was a lack of support from the Directorate of Health. They said that they needed more support based on local needs and that they did not perceive the Directorate of Health as someone who could provide them with support. Somewhat similar findings have been reported in Norway where the Office of Auditor General of Norway looked at Norwegian public health work at all administrational levels following the PHA implementation (Riksrevisjonen, 2014-2015). The Norwegian municipalities and county municipalities were in general satisfied with the support they received from the Directorate of Health but missed advice and recommendations about

evidence-based public health interventions, especially to reduce social health inequalities (Riksrevisjonen, 2014-2015). The Norwegian Directorate of Health however does not have a dual role as a regulatory body for the health care system as well as having responsibilities concerning public health like in Iceland (Lög um landlækni og lýðheilsu nr. 41, 2007) which bothered some of the informants.

According to the Lippitt-Knoster Model of Managing Complex Change (1993), when resources are missing, it can lead to frustration. As described, there are multiple resources missing in Icelandic policy implementation. There is not enough qualified staff who work with the implementation, funding seems to be limited except when municipalities take the initiative themselves to hire someone to work on public health. Data are to some degree limited, either due to access, legal matters, or financial barriers and those who work with public health report a lack of support from the Directorate of Health. All of these barriers hinder implementation and as the model suggest and the informants have described, it might result in frustration.

The third element which also seems to be limited in Iceland is a shortage of qualified staff. Not having qualified staff leads to a lack of skills. Since only a small minority of municipalities have hired staff to work with public health in full-time positions it appears as the element skills is missing. If unqualified staff work with public health policy implementation they might not know where to look for relevant research or how to apply their findings to a local context. According to the Lippitt-Knoster Model (1993), a lack of skills can result in anxiety where those involved do not perceive that they are able to implement policies.

8.4 Intersectoral Collaboration in Public Health

The informants discussed a lack of collaboration between sectors, departments, administrative levels, and institutions. The fundamental ideology behind HiAP is addressing the social health determinants through intersectoral collaboration. The social determinants of health, policies and population's health should be viewed as a chain of causality which should be addressed in order to improve a population's health and reduce health inequalities (Stål et al., 2006). According to the informants' descriptions, Icelandic authorities do not acknowledge properly this chain of causality between unequal distribution of health resources and policies and therefore do not address it properly in their policies. National policies express a wish to conduct a public health assessment before implementing new policies or legislations and also state that public health should be a leading factor in all of the government's policy and plan-

making (Heilbrigðisráðuneytið, 2023; Þingskjal 1108, 2020-2021). This indeed is a positive sign, but it has now been seven years since these goals were first put forward in the 2016 policy (Velferðarráðuneytið, 2016) and it has not yet been systematically implemented according to the informants. The parliamentary resolution which was put forward this year on implementing a health impact assessment is however a promising development in Icelandic health politics. It indicates that Icelandic politicians are becoming more aware of the importance of structural and wholistic approaches to public health. The resolution is therefore a promising step in Icelandic health politics. Another promising development for intersectoral collaboration which the informants mentioned is the recent Child Welfare Act which demands intersectoral collaboration when it comes to service provision to children. Improved services and support to children who need welfare services might lead to reduced health inequalities.

As previously described, the aim with the intersectoral collaboration in public health is to move the focus away from the health sector, which Icelandic policies frequently link together (Stål et al., 2006). The informants explained that this connection was because the Ministry of Health's sphere of influence is within the health care system. The World Health Organization's report about the implementation of the Well-Being Economy addressed this fragmented division of labour as a challenge in the Icelandic administration and highlighted the importance of consensus within the governmental sectors to measure the society's success in a new way (World Health Organization, 2023a). Consensus in the Lippitt-Knoster Model (1993) is necessary (Ferrán et al., 2023). Not only is public support important for a successful health policy but also the consensus between stakeholders, policymakers, and politicians on the need for a new health policy. Politicians' views on public health and appropriate actions to address the social gradient do not align with key stakeholders' knowledge on how the social health gradient should be addressed. Some key stakeholders however participate in the policy development, so it is fair to assume that their message on a more wholistic approach has been delivered to the government. Those who work at municipal level might be more vulnerable to this lack of consensus. The informants at municipal level expressed that national policies did not always address their local reality and challenges. As the informants at municipal level also described, they are the ones who are best suited to address local public health issues. According to the HiAP approach it demands intersectoral collaboration where public health coordinators must be able to collaborate across departments, and as the informants reported, it can be a challenge. The lack of consensus can according to the Lippitt-Knoster Model (1993) result in sabotage in the change process (Ferrán et al., 2023).

8.5 Structural Factors in Icelandic Public Health Work

The legislation for the Directorate of Health, which has a dual obligation to regulate the health care system as well as legal responsibility for health promotion and preventative measures (Lög um landlækni og lýðheilsu nr. 41, 2007) seems to be confusing to the informants. The double role was perceived as a barrier for those at the local level to seek support for their local projects. This arrangement, having the health sector and health promotion at the same institution goes against the Ottawa Charter's (1986) encouragement to mediate between different stakeholders to move the responsibility from the health sector. This arrangement does also not align with the HiAP approach which highlights the importance of actions outside the health sector where public health should be a shared responsibility between all sectors in society (Stål et al., 2006).

Another part of The Directorate of Health's role is being an advisor to national authorities for policy making (World Health Organization, 2023a), which one informant described as difficult due to some politician's perceptions of the institution. The World Health Organization's report on the implementation of the Well-Being Economy in Iceland stated that the health sector (Directorate of Health) was a driver, co-creator, and a beneficiary of the Well-Being Economy policy approach (World Health Organization, 2023a). This means that the Directorate of Health seems to have a positive impact on policy development despite the fact that the health sector still has the main responsibility for health promotion in Iceland. As mentioned in the introduction, Iceland used to have a Public Health Institute which was independent from the health sector. The governments' decision at the time to close it and make it a department under the Directorate of Health (World Health Organization, 2023a) supports the argument that the government seems to view public health as something the health sector should address. It also implies that the government does not look at public health as a priority which matches with some of the informants' reports where they stated that public health interests tend to weigh less than other interests.

One informant described that the Directorate of Health, or those who work at the national level in general, are more working with policy development and advising other sectors. This is a characteristic of the welfare states due to the great freedom local authorities in the Nordic countries have (Sellers & Lidström, 2007). The municipalities' great freedom to decide how they implement national policies leaves national authorities with implementation tools such as advising and providing information to follow-up national policies and legislations (Sellers & Lidström, 2007) which the Directorate of Health appears to be doing.

A national policy goal has been to make every municipality participate in the Health Promoting Communities project (Velferðarráðuneytið, 2016). Today 41 out of 64 municipalities participate in the project and 96% of Icelanders live in a municipality which participates in the project (Embætti landlæknis, 2023b). The informants questioned what this particular goal meant and whether or not the project led to any changes in local communities. This study indicates that fulfilling the goal itself has a minimum meaning and does not necessarily lead to improved population health or supportive local environments, mainly because the local coordinators lack multiple resources such as skills, time, data, budgets, and support. The tools do not seem to be relevant to local contexts and do not appear to help the coordinators with addressing local challenges, mainly due to their limited resources. Norwegian research on public health coordinators found that a high position percentage, close to full-time, being positioned under the CEO staff and having a job description with specified task and responsibilities were factors which enabled public health coordinators to work across sectors in municipalities. Those who identified themselves as intersectoral agents were more likely to influence budgeting and local politics (Karlsen et al., 2022). As the informants described, most of the coordinators already have a full-time position concerned with something else than public health and therefore have limited time capacity for addressing public health. A job description related to public health is therefore not present and as the informants described neither is sufficient support from the Directorate of Health. The placement varies; few municipalities in Iceland have a public health coordinator so a conclusion about the effect of placement in the administration cannot be drawn from this study. This means that the three Norwegian criterion about being placed high in the administration, well defined job description and a full-time position to influence municipal intersectoral public health work (Karlsen et al., 2022) is absent in almost all Icelandic municipalities. Participating in the health promotion projects which are supposed to assist local health promotion were for some even more of a burden and to some, addressing the issues on their own seems to be easier.

The informants thought that municipalities were in a good position to address local challenges due to their closeness to their inhabitants. Sellers and Lidström (2007) mention this as a positive factor of strong local governments. Their closeness also makes them better equipped to reduce geographical and social inequalities by providing services based on local needs (Sellers & Lidström, 2007). The downside may be the different services, rather than the freedom to decide how to implement policies (Eklund Karlsson et al., 2022). Eklund Karlson

et al. (2022) said that due to tight budgets which many Nordic municipalities struggle with, it limits their ability to provide some services and follow national policies. This means that their ability to assist people living in poverty and improve living conditions is limited, especially in municipalities where the proportion of vulnerable groups is high (Eklund Karlsson et al., 2022). This is similar to a topic the informants discussed, especially in relation to size of the municipality and their ability to address public health issues. One informant described two scholars where some small municipalities which were close to their inhabitants meant they were better equipped to fulfil service needs while others meant that larger municipalities with more financial capacity were better suited to fulfil local need. It said that size was not necessarily a barrier to service provision and policy implementation but rather a question about the resources municipalities allocate to different topics. This is somewhat in contrast to Norwegian research on the PHA where larger municipalities are better equipped to address health inequalities and were more likely to look at living conditions as a main contributing factor to health inequalities. Larger municipalities are also better at facilitating intersectoral collaboration (Hagen et al., 2017).

One informant also mentioned that it was important that the municipalities did not free themselves from the responsibility to address local public health issues because they have hired someone to work with public health. This is an important statement, as results from Norway indicate that this was the case for municipalities which hired a public health coordinator after the PHA was implemented. The municipalities which did not have a public health coordinator before the PHA was implemented were four times less likely to prioritize fair distribution in their health promotion inititavies (Hagen et al., 2018) which indicates their limited commitment to address health inequalities.

Other issues related to structure and clarity of roles was the lack of a clear mandate. The informants described in various ways how a lack of mandate hindered them and lead to inaction. When no one is responsible in the municipalities it ends up with inaction despite willingness to do something. Karlsson's (2022) findings which were described above highlighted the importance of a clear job description with clear responsibilities and tasks as one criterion for success.

It appears to be a challenge that the Health Promoting Communities project is somewhere between the national level and the local level. The Directorate of Health does not have the ability to control or regulate what the municipalities are doing while the municipalities are not obligated to allocate resources to public health work. The legal

framework however puts the responsibility on the Directorate of Health and to some degree the Ministry of Health which have a limited sphere of influence outside their own institutions (Lög um landlækni og lýðheilsu nr. 41, 2007). Recent national policies have addressed the need for a new law framework around public health to clear this mandate and a need to increase intersectoral collaboration in Icelandic public health work (Heilbrigðisráðuneytið, 2023; Þingskjal 1108, 2020-2021). The need for it seems to be great based on the barriers the informants experience. This is also a challenge the World Health Organization identified in their report on Iceland's Well-Being Economy implementation. They addressed a need for a comprehensive well-being policy which legally binds the commitment to work on Icelander's well-being across sectors (World Health Organization, 2023a). The Norwegian PHA does exactly that, it puts a responsibility on all administrational levels and defines each levels and national institution's role (Folkehelseloven, 2011, § 1). Despite the challenges the implementation of the Norwegian PHA has faced, it has increased intersectoral collaboration, especially at municipal level which the informants in this study struggle with (Fosse et al., 2018).

9. Conclusion

This study has aimed at answering how Icelandic national authorities implement public health policies and to what extent national authorities address social inequalities in health and apply the "Health in All Policies" method in their public health actions.

This study revealed that all of the factors in the Lippitt-Knoster Model of Complex Change (1993) are to some degree missing which prevents successful policy implementation. The policy as a vision does not provide its purpose due to its extensive goals, which do not consider local context enough and are according to the informants, reactive rather than proactive. Consensus appears to be missing between politicians, administrational levels and policymakers which hinders intersectoral collaboration. Skills are also to some degree missing, given that municipalities take the initiative to hire a public health coordinator themselves. Those who are coordinators for the municipalities in the Health Promoting Communities Project might not have appropriate skills to apply knowledge or data to local settings or see local challenges from a health promotion perspective. Due to lack of consultation in policymaking, some of the informants lacked motivation to implement national policies and did not see the purpose of it, therefore it can be argued that incentives were also missing. Resources were a major factor in the Lippitt-Knoster Model (1993) which was missing. Multiple resources were missing such as funding, data sources and support. Action plans for the policies were available, but considering their extensive goals like the policies it limits their usefulness. The informants reports along with all of the missing factors from the Lippitt-Knoster Model of Complex Change (1993) indicates that national public health policies are to a very limited degree implemented and funded due to limited resources available and limited political commitment.

The findings also suggest that addressing health inequalities through public health policy lacks political commitment. The government which has been in office for six years, has not published a strategy to address health inequalities. In recent years they have identified that health inequalities exist in Iceland but do not address to a great extent that they are a result of unfairly distributed health resources (Dahlgren & Whitehead, 2006) nor do they express a reason to address the uneven distribution of health resources. This is a concern since it has been proven that addressing the social determinants of health is proven to be more beneficial than improving health through the health sector (World Health Organization, 2023c). That is why politics play a central role in creating supportive environments which impacts people's health behaviour in a positive way (World Health Organization, 1986). The fact that Iceland is

a welfare state is health promoting in itself (Marmot et al., 2008) and does therefore to some degree reduce health inequalities. The government's overly extensive public health policies are however similar to policies in a corporate welfare regime (Esping-Andersen, 1990) where the main focus is on health behaviour and personal responsibility. However, a recent parliamentary resolution about implementing a health impact assessment which was put forward by members of parliament this year is promising. It indicates increased political awareness on the importance of addressing public health holistically.

Intersectoral collaboration appears to be minimal, the legislation puts the main responsibility on the Directorate of Health which has limited authority over other sectors, administrational levels, and institutions. The Directorate's of Health main role as a regulatory body for the health care system works as barrier and supports the already existing idea that health promotion belongs to the health care sector. Health promotion has for decades tried to advocate for favourable health conditions for all, by shifting the focus away from the health sector and encouraging different sectors to engage in health promotion (World Health Organization, 1986). The Directorate of Health appears to be using their sphere of influence to impact policymaking, by publishing reports which encourage a wholistic approach on public health and by creating their health promotion projects. The informants called for increased intersectoral collaboration in health promotion which is necessary to improve Icelander's health and well-being as well as reducing health inequalities (Stål et al., 2006). The Norwegian Public Health Act (2011, § 1) managed to shift the focus from lifestyle-oriented interventions to a more comprehensive approach on public health. Despite some challenges in the implementation process it has managed to increase intersectoral collaboration, especially in Norwegian municipalities (Fosse et al., 2018).

The informants also called for a clearer mandate and that the responsibility for public health be put on other sectors as well, such as the municipalities. This was also identified by the World Health Organization's (2023a) report on the Well-Being Economy where they noted that a comprehensive policy on well-being is missing. Due to the great freedom Nordic municipalities have (Sellers & Lidström, 2007) it is important that their roles are well-defined and financed, to support national policy implementation. A new piece of legislation in Iceland can therefore not solve everything if relevant resources are missing.

9.1 Strength and Limitations

The informants of this study were six in total. Interviewing more people might have provided other perspectives than were presented in this study. Those six informants were however

located at key institutions and covered main stakeholders in public health in Iceland which gives their statements value. The informants were located at different administrative level which also strengthens the results of the study. Interviewing a coordinator in a municipality who does not work full-time with public health could have provided another perspective. Since the majority of municipalities which participate in the Health Promoting Communities Projects do not have a full-time position related to public health, it would be useful to know how they implement the projects to their local settings.

Recently the government has published policies and action plans concerning seniors' health promotion and services as well as mental health policies and action plans which were not taken into consideration in this analysis. Welfare policies which address welfare issues such as the housing market or educational matters can also have negative or positive effects on health inequalities even though the policies' main aims are not to reduce health inequalities. Studying other policies and their implementation might therefore have affected the results of this thesis.

Most of the Icelandic studies on health inequalities were single studies which limits their credibility. However, they all showed in some form the presence of social inequalities in health which cannot be argued, is present in Iceland. The current size of the social gradient is unclear, both due to limited studies but also because the analysis published in 2021 was from data gathered in 2017 and only covered Icelandic speaking residents in Iceland. Many of the Norwegian studies were also single studies, some of them were analysed from the same data material. Given that most of them reported similar findings this supports their credibility when their findings are considered as a whole.

The perspective that was presented in this thesis is also one-sided from the view of the public health sector in Iceland. Other policymakers and people in charge of funding decisions have to take multiple factors and perspectives into account when they develop policies and allocate funding. Interviewing them might also have impacted the results of this study.

9.2 Future Research

There has limited research been done on Icelandic public health politics, especially by Icelanders. This is the first study of its kind in Iceland that I am aware of so the need to do further research on Icelandic public health policies and politics is great. The health promotion projects from the Directorate of Health could be evaluated further to evaluate its cost-effectiveness. Social inequalities in health have also not been studied thoroughly in Iceland and more detailed research and analysis on health inequalities and its societal consequences

should be studied. The implementation of the recent Child Welfare Act which has encouraged intersectoral collaboration could also be studied as an evaluation study to add literature about policy implementation in Iceland. Such study could provide more detailed descriptions about barriers and enabling factors in Icelandic policy implementation.

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Appendix A

Intervju om folkehelsearbeid på Island

Informasjons og samtykkeskriv til deltakere

Formålet med prosjektet og hvorfor du blir spurt om samtykke
Målet med denne oppgaven er å se hva islandske myndigheter gjør aktivt for å redusere sosial ulikhet i helse og til hvilken grad de bruker «helse i alt vi gjør» tilnærmingen. Du blir bedt om å delta i denne masteroppgaven fordi du jobber med saker som gjelder disse temaene og kan derfor bidra med relevant kunnskap.

Hva innebærer deltakelse?
Deltaklese innebærer at du deltar i et intervju hvor vi snakker om din erfaring og hva du jobber med knyttet til forskningspørsmålet. Intervjuet vil vare i 30-45 minutter, og blir tatt på lydopptak. I tillegg blir notater tatt underveis i samtalen. Opplysingene som kommer fram i intervjuet avidentifiseres ved analyseringen av intervjuen og kan ikke spores til bake til svarer.

Mulige fordeler og ulemper
Fordelen ved å bidra er å gi relevant kunnskap som kan være til nytte når fremtidig folkehelsearbeid skal planlegges. Vi er ikke bevisst noen ulemper med deltakelse, ut over tidsbruken som går i å delta i intervjuet.

Frivillig deltakelse og mulighet for å trekke samtykke
Det er frivillig å delta i intervjuet. Dersom du ønsker å delta, undertegnes samtykkeerklæringen på siste side. Deltaker kan når som helst og uten å oppgi noen grunn trekke samtykket. Dersom samtykket trekkes tilbake, vil man ikke benytte deltakeres opplysninger i evalueringen. Du kan kreve innsyn i opplysningene som utleveres innen 30 dager. Deltakere kan også kreve at data slettes. Kravet gjelder ikke dersom dataene er anonymisert eller publisert. Sletting begrenses også av om data er benyttet i utførte analyser. Dersom du senere ønsker å trekke seg eller har spørsmål til prosjektet, kan du kontakte meg (se kontakt informasjon nederst i dokumentet).

Hva skjer med opplysningene vi samler inn?
Opplysningene som registreres om deltakere skal kun brukes til en masteroppgave og funnene blir mulig presentert til relevante institusjoner som jobber med follkehelsearbeid på Island. Du har rett til innsyn i hvilke opplysninger som er registrert og rett til å få korrigert eventuelle feil. Du har også rett til å få slettet innsamlet personopplysninger og å få innsyn i sikkerhetstiltakene ved behandling av opplysningene. Adgangen til å kreve sletting eller utlevering gjelder ikke

dersom opplysningene er anonymisert eller publisert. Du kan klage på behandlingen av dine opplysninger til Datatilsynet i Norge og personvernombudet hos Universitet i Bergen.
Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Hver deltaker tildeles en tilfeldig kodenavn av masterstudenten som blir brukt under analyseringen av intervjuene. Slik vil andre i prosjektgruppen kun se informasjon som er knyttet til dette tilfeldige kodenavnet. Når lydopptaket fra intervjuet er transkribert og dermed anonymisert slettes det, transkripsjonen beholdes frem til oppgave innlevering eller juni 2023. Masteroppgaven blir skrevet slikt at enkeltdeltakere ikke skal kunne gjenkjennes, men vi plikter å informere om at vi ikke kan utelukke at det kan skje.
Alle opplysningene vil bli anonymisert og koblingsnøkkelen mellom person og datamaterialet vil bli lagret på en passordbeskyttet laptop. Ved publikasjon av masteroppgaven og eventuelle presentasjoner av funnene vil du som person ikke kunne gjenkjennes.

Ansvarlig for personvern

Dersom du har spørsmål om personvernet i prosjektet, kan du kontakte personvernombudet ved Universitetet i Bergen: Janecke Helene Veim, Janecke.Veim@uib.no.

Kontaktopplysninger

Dersom du har spørsmål til prosjektet eller ønsker å trekke deg fra deltakelse, kan du kontakte:

- Student: Sigurros Elddis Huldudottir, 92098096, sigurros.huldudottir@student.uib.no
- Prosjektleder: Torill Larsen, 55589826, torill.larsen@uib.no

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om masterprosjektet jeg skal delta i og har fått anledning til å stille spørsmål. Jeg samtykker til å delta i et intervjuet og dele min kunnskap og erfaringer. Jeg samtykker også at mine opplysninger behandles frem til prosjektet er avsluttet.

(Signert av prosjektdeltaker, dato)

Appendix B

Intervjuguide

Før vi begynner så vil jeg bare si at hvis det er noe spørsmål du ikke ønsker å svare så trenger du ikke å svare på de.

Jeg skal ta samtalen vår opp på lydopptak, er det i orden for deg?

Som jeg nevnte i e-posten så skriver jeg en masteroppgave om disse begrepene, ønsker du at jeg oppsumerer de kort?

> -Helsefremmende arbeid legger vekt på at folkehelsearbeid skal foregå utenfor helsesektoren, eksempler på slike tiltak er å sikre barn adgang til fritidsaktiviteter eller sørge for at ungdom fullfører videregående.
>
> - De to begrepene jeg ser på er sosial ulikhet i helse, det vil si at de som har mindre utdanning og sliter økonomisk sliter i større grad med helsekomplikasjoner, fysiskt og psykist, enn de som har tatt høyere utdanning og ikke sliter økonomisk.
>
> - Helsefremming vektlegger også at folkehelsearbeid er tverrsektorielt samarbeid mellom ulike sektorer i samfunnet, denne tilnærmingen kalles «helse i alt vi gjør». Dette har blitt nevnt i nylige folkehelsemeldinger fra islandske myndigheter og jeg ønsker å vite hvordan det jobbes med denne tilnærmingen på Island.

Begynn gjerne med å introdusere deg selv, hva du jobber med og daglige oppgaver?

Kan du fortelle meg litt om din bakgrunn på feltet?

- Hvordan jobber du med folkehelse generelt i din jobb?
- Hvordan tenker du rundt sosial ulikhet i helse på Island?
- Jobber du med sosial ulikhet i din jobb? Og på hvilken måte?
  Hvilke faktorer synes du er viktig til å bidra til å utjevne sosiale helseforskjeller? Er det noe faktorer du mener står i veien for å utjevne sosiale helseforskjeller?

Intro: Verdens helseorganisasjonen og EU legger stor vekt på at helsefremmende arbeid skal være tverrsektorielt samarbeid utenom helsesytemet, hvor de forskjellige sektorene i samfunnet jobber sammen med å bidra til et helsefremmende samfunn, denne tilnærmingen kalles «helse i alt vi gjør».

> I en av myndighetene sine folkehelseplaner fra 2016 nevner de viktigheten av «helse i allt vi gjør» og at statsministers kontor skulle i samarbeid med Helsedirektoratet

utvilke prosedyrer som gjør det å mulig å jobbe etter den tilnærmingen og at det skulle i verk settes i 2019....har dere tatt opp disse prosedyrene?

    - Hvilke faktoerer er det som bidrar til tverrsektorielt arbeid folkehelsearbeid på Island
    - Hvilke faktorer er det som hemmer tverrsektorielt folkehelsearbeid på Island?
- Føler du at din arbeidsplass bidrar til fokehelsearbeid?
- Opplever du at de planene som blir gjort, blir gjennomført?
    - Hvorfor/hvorfor ikke?
- Får du som er ansvarlig for gjennomføring av folkehelseplanene gode nok vertøy/veiledning?
    - Hvorfor /hvorfor ikke?

Noe annet du synes jeg bør få vite/ønsker å diskutere?

Appendix C

Application Acceptance- Norwegian Centre for Research Data

Sikt

Meldeskjema / What do Icelandic national authorities currently do to tackle health ine... / Vurdering

Vurdering av behandling av personopplysninger

Referansenummer	Vurderingstype	Dato
119469	Standard	08.05.2023

Tittel
What do Icelandic national authorities currently do to tackle health inequalities by addressing the social determinants of health?

Behandlingsansvarlig institusjon
Universitetet i Bergen / Det psykologiske fakultet / Hemil-senteret

Prosjektansvarlig
Torill Larsen

Student
Sigurros Elddis Huldudottir

Prosjektperiode
01.12.2022 - 01.12.2023

Kategorier personopplysninger
Alminnelige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 01.12.2023.

Meldeskjema

Kommentar
Personverntjenester har vurdert endringene som er registrert i meldeskjemaet for ditt forskningsprosjekt.

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så lenge den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg. Basert på denne vurderingen kan behandlingen fortsette.

Vi merker oss også at det er gjort en utsettelse av prosjektslutt til 01.12.2023. Vi vil godkjenne denne utsettelsen under forutsetning av at det er gjort de nødvendige avtaler og tiltak for å sikre forsvarlig behandling av personopplysningene.

OPPFØLGING AV PROSJEKTET
Vi vil fortsette å følge opp prosjektet underveis, med planlagte vurderinger hvert annet år og ved den planlagte avslutningen. Dette er for å sikre at behandlingen av personopplysningene fortsatt skjer i samsvar med den behandlingen som er dokumentert.

Vi ønsker deg lykke til videre med prosjektet, og ta gjerne kontakt hvis det skulle oppstå spørsmål eller behov for ytterligere veiledning.

Vennlig hilsen,
Olav Rosness