

# Policies to address the social determinants of health in the Nordic countries

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UNIVERSITY OF BERGEN



Nordic Welfare  
Centre

## **Policies to address the social determinants of health in the Nordic countries**

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# Preface

The project Nordic National Policies to Increase Equity in Health was a sub-project under the larger project Equal Health - Prerequisites at National Level. The project was initiated and funded by the Nordic Arena for Public Health Issues. The arena consists of health experts from the ministries of the Nordic countries and the Faroe Islands, Greenland and Åland. The arena's work centres on themes pertaining to inequalities in physical health, mental health, and the use of alcohol, drugs and tobacco. The Nordic Welfare Centre acts as the secretariat for the Nordic Arena for Public Health Issues and the centre had the administrative responsibility for the project. The project started in the autumn of 2017 and ended December 2018.

We want specially to thank our informants in Denmark, Finland, Norway and Sweden. They are all experts in their field and working in institutions with responsibilities for public health and policies to address the theme of social inequalities in their countries. We know they are busy people, but still they have taken time to be interviewed, have suggested and sent us relevant documents and commented on the draft report. Thanks to you all, without you there would have been no project.

We also want to thank the staff at the Nordic Welfare Centre for professional follow up and support. We have been collaborating with two of the other sub-projects, Cross-sectoral Cooperation at the Ministerial Level - With a Focus on Health Inequalities, led by Associate professor Karin Guldbrandsson, Public Health Agency of Sweden, and Indicators for Health Inequality in the Nordic Countries, led by professor Else Karin Grøholt, Norwegian Institute of Public Health. The collaboration has included a fruitful exchange of knowledge and data.

It has been very exciting to work on this project and find out more about similarities and differences between the Nordic countries. However, the project period has been relatively short, which means that there are many stones left unturned. For us, the project has raised many new questions that we would have liked to follow up, but the time has not allowed us to do so. Hopefully, there will be more Nordic projects that will be able to follow up our project.

Finally, we want to point out that eventual errors and misinformation in the report is our responsibility.

Bergen and Oslo, September 2019

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# Summary

The Nordic countries have long been characterized as countries with a high standard of living and with small social and economic differences. However, despite a long tradition of reducing social inequalities by introducing welfare policies and structural measures, comparative analyses show that social inequalities in health are growing. This has been termed the welfare paradox of the Nordic countries.

The project Nordic National Policies to Increase Equity in Health was part of the larger project Equal Health - Prerequisites at National Level. The aim of the project was to create better conditions for working towards increased equality in health at the national level in the Nordic countries. The project was a follow up of an earlier project, Tackling Health Inequalities Locally - The Scandinavian Experience (ScanHeiap), which was a review of how Denmark, Sweden and Norway have worked with reducing inequalities in health, mainly at the municipal level.

The purpose of the current project was to analyse national policies in the Nordic countries according to the content and principles of the recommendations from the project. While the ScanHeiap project included Denmark, Norway and Sweden, the current project in addition included Finland and Iceland. The aim of the project was to get a clearer understanding of the efforts undertaken at the national policy development level to increase health equity.

In the project, we have operationalized the 11 recommendations from the ScanHeiap project into four themes and we study whether the countries have 1) A comprehensive approach, 2) Whole-of-society approach, 3) Build policymaking skills and vertical collaboration and 4) Long term commitment and legislation.

This project applies a qualitative methodological approach based mainly on document and literature studies and interviews. Interviews with key stakeholders were performed in Denmark, Finland, Norway and Sweden.

## **A comprehensive approach**

In the countries from which we have interview data, stakeholders at the national level seem to agree on the need to apply a comprehensive approach to secure equity in health. This involves policies to change the determinants of health and it involves a balance between universal and targeted measures. However, the actual public health policies vary between the countries. In Denmark, there is agreement to address the social determinants of health. However, the main measures are related to improving healthy lifestyles. In Finland, there is an acknowledgement of the social determinants, but it is to a smaller extent developed into concrete policies and measures. In Norway and Sweden, the determinant focus has gathered momentum over the last years; in Norway it is strongly included in the public health act, and in Sweden it has moved up on the political agenda as part of government policy.

## **A Whole-of-society-approach**

Finland and Norway both have public health acts. Finland's act was adopted in 1972 but has from 2010 been included in the Health and Care Act. Norway's act is from 2012 and explicitly embraces the social determinants' perspective. In all countries, the ministries of health are responsible, even if there is an explicit aim that all sectors of society should be responsible for policy development in this field. However, interviewees in all the countries report that there are no permanent formal structures in place for collaboration and that the collaboration is mostly ad hoc, or project based.

## **Build policymaking skills and vertical collaboration and support**

In all the countries, the local level has the main responsibility for services that are important for reducing social inequalities in health, like schools, day care, leisure time activities. In all countries there are national bodies supporting the municipalities in their public health work, for example by providing statistics and information material. Some of the material include data on social inequalities that the municipalities may use. In principle, all the Nordic countries have high quality statistical data, even for the local level.

In all countries, the independent role of the municipalities is being confirmed and even emphasized. This implies that national



governments have mostly “soft governing tools” at their disposal. The Norwegian public health act also provides the national government with some hierarchical steering instruments, since the municipalities are mandated to include public health in their master plan.

Local government associations exist in both Denmark, Finland, Norway and Sweden, and they may also contribute to promoting health and reducing social inequalities. This role is quite prominent in Denmark and Sweden.

## Long-term commitment and legislation

Even though the Nordic welfare states are built on an ideology of redistribution among social groups, the policies to achieve social equity do not have the same momentum in the countries. In Denmark, there is no strong political focus on the social determinants, in Finland they have been formulated, but do not play an important role in concrete policy making. In Norway and Sweden, reducing social inequalities in health is central in the current public health policies.

An interesting point is whether reducing social inequalities in health is a politicized issue, and whether left-wing governments will give higher priority to this issue. In Norway and Sweden this is the case, with left-wing governments prioritizing structural measures, while right-wing governments tend to downplay the issue and focus more on individual lifestyle issues

In Denmark, it was also confirmed that left-wing governments has this issue higher on the agenda but that the suggested policies and measures would be the same. In other words, individual measures, aimed at influencing lifestyle would be the preferred measures independent of government. This was explained as a cultural phenomenon, in the sense that structural measures like reducing access to for example alcohol and tobacco neither have political nor population support.

Another interesting point is the role of the Norwegian public health act. It seems that reducing social inequalities in health has gained broad support, particularly at the local level. The municipalities increasingly recognize how their services, like day care, schools and leisure time activities can include an equity perspective. In addition

to these universal services, targeted measures can provide extra support to disadvantaged citizens. Another point regarding the act is the institutionalization of public health, including social inequalities. By having the act, the issue of social inequalities may not be so vulnerable to policy shifts following right-wing and left-wing governments.

## **National commissions addressing social inequalities in health**

One sign of national commitment may be the national commissions, inspired by the Marmot commission on the social determinants of health. Similar commissions were appointed in Denmark, Norway and Sweden. In Denmark and Norway, the assignment was commissioned by the health authorities, subordinate to the ministries of health, while in Sweden the government commissioned the assignment. This difference had consequences for the significance the reports have had, in terms of influencing the national policies. In Denmark and Norway, the reports have not had a significant influence on the policy development, while in Sweden, the government has followed up the report with a Government White paper. A national commission to address social inequality in all sectors was also appointed in 2018.

## **Conclusions**

Reducing social inequalities in health is included in general policy recommendations in all the countries. However, regarding concrete policies and measures, it is often the individual approaches, most often related to lifestyle issues that are being preferred. These are mostly initiated by the health sector. At the national level, the health sector has the overall responsibility for developing and implementing policies. In none of the countries there are permanent structures at the national level to secure that the issue of health inequalities gains a "whole of government support".

In all the countries the municipalities play an important role, both as implementers of national policies and as independent political units. In all the countries, the national level also supports the municipalities in several ways, mostly via so-called "soft" governing tools.

Both Finland and Norway have adopted public health acts, and both acts mandate the municipalities to apply a health in all policies

approach and reduce social inequalities in health. However, there are some differences in the implementation procedures of the acts. In Norway, the national government is auditing whether the municipal plan is following the guidelines of the public health act. In Finland, the implementation is mostly left to the municipalities. In both countries, the municipalities still have a high degree of freedom to make priorities, and there are few sanctions for those who don't follow up all the intentions of the act.

# Introduction

There are social inequalities both in the risk of becoming ill and in the consequences of being ill. Whitehead and Dahlgren state that inequity are those inequalities in health that are unacceptable, unfair, systematically produced and unjust (Whitehead and Dahlgren, 2006). This resembles the definitions used by Marmot where “inequities refer to the systematic inequalities in health between social groups that are judged to be avoidable by reasonable means” (Marmot, 2015:48). These definitions point to the design of societal institutions as drivers for social equity or inequity.

The WHO Rio-declaration in 2011 on Social Determinants of Health, states:

“Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health.”

This quotation directs attention to the need for a more equal distribution of resources that are considered crucial for health and for evaluation of the impact of policies and measures that are implemented. The determinants' perspective on health inequalities demands an awareness of the structural conditions creating social inequalities that would lead to social inequalities in health. Important policies that would influence the social determinants are for example tax policies and housing policies. Structural measures would also be necessary regarding policies with a concrete objective of reducing social inequalities in health. These might be price mechanisms, like increasing prices and accessibility to tobacco and alcohol, or increased taxes on sugar and other unhealthy food products and reducing taxes on fruits and vegetables.

The causes of health inequalities are complex and involve a wide range of factors, which relate to the wider social determinants of health, including living conditions, health related behaviours, education, occupation and income, disease prevention and health promotion services, health care systems, and health policy.

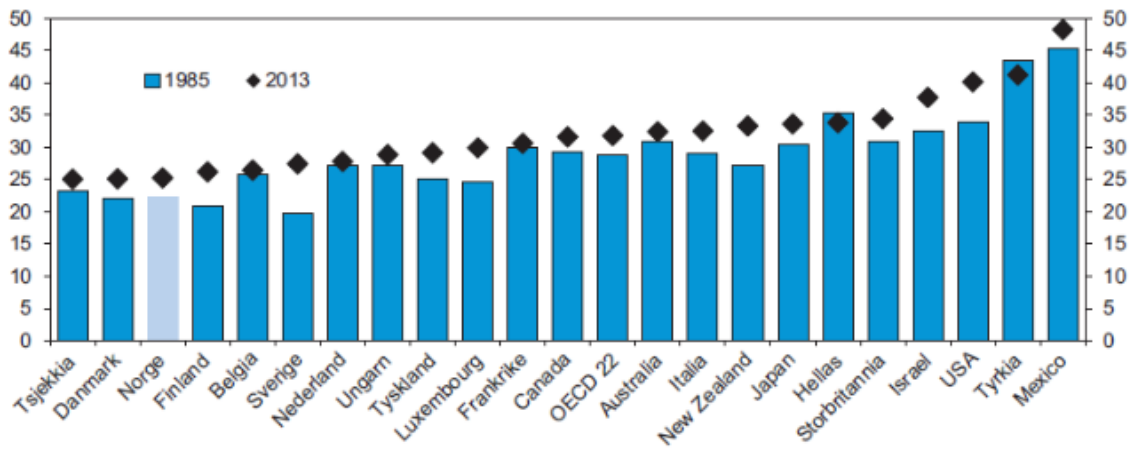
Consequently, action to tackle health inequalities through healthy public policy means addressing those factors, which are deemed inequitable, preventable, and impact unequally on the health of the population. This means that in practice, reducing health inequalities is difficult and has been termed a 'wicked' problem denoting a complex issue with multiple root causes that has no simple solution (Blackman, Marks, Harrington, Elliot, Williams, Greene & McKee, 2010; Fosse, Bull, Burström & Fritzell, 2014).

## The Nordic context

In the 1930's the social democratic parties were a driving force in developing a welfare state. In the area of public health, attention was given to structural conditions for public health – the social determinants of health. Themes were remuneration policies, housing policies and welfare policies, and the suggested measures should improve living conditions and consequently public health (Elstad 2005). Even though the Nordic countries have somewhat different government structures, they can be characterised as social democratic welfare states (Esping-Andersen 1990). These states are characterised by universalism and redistribution among social groups, mainly via a progressive tax system. It is a system of emancipation, both market and the family, and the state acknowledges responsibility for children via direct transfers and childcare. The system is based on high participation in the work force and women are encouraged to work.

The Nordic countries have long been characterized as countries with a high standard of living and with small social and economic differences viewed in an international perspective; they have been regarded as role models with their welfare models. At the same time, a growth in health inequalities is also seen in these countries. Despite a long tradition of reducing social inequalities by introducing welfare policies and structural measures, comparative analyses show that social inequalities have increased over time. This has been termed the welfare paradox of the Nordic countries (Popham et al 2013, Mackenbach 2012). Figure one shows the Gini index for the Nordic countries compared to the OECD-area.

**Figure 1:** *The Nordic countries in context: welfare states and trends in inequalities between 1985 and 2013<sup>1</sup>*



Source: Perspektivmeldingen 2017 (Norwegian government).

As figure one shows, the Gini index for the Nordic countries still is small compared to the OECD-area. Nevertheless, there has been a growth for all the Nordic countries the years between 1985 and 2013. The growth has been largest for Sweden, thereafter for Finland, while for Norway and Denmark the growth has been relatively small, although it seems to have been the smallest for Norway.

<sup>1</sup> There is no information on Iceland in this report.

# Background for the project

The project is funded by the Nordic Council of Ministers and administered by the Nordic Welfare Centre. The project is part of the Nordic Arena for Public Health Issue's work to strengthen Nordic collaboration for equal health.

The comparative report, *Tackling Health Inequalities Locally - The Scandinavian Experience (ScanHeiap)* (Diderichsen et al. 2015), is a review of how Denmark, Sweden and Norway have worked with equal health, mainly at the municipal level. The ScanHeiap report provided the following 11 recommendations for future work:

1. *A comprehensive approach*
2. *Policies build on the premises of each sector*
3. *Support for generic policies*
4. *Knowledge of cost-effectiveness*
5. *Equity indicators linked to each sector*
6. *Build policymaking skills*
7. *Legislation matters*
8. *Whole-of-society approach*
9. *Involve all sectors early on equal terms*
10. *Vertical collaboration and support*
11. *Long-term commitment*

The purpose of the current project is to analyse national policies in the Nordic countries according to the content and principles of the 11 recommendations from the ScanHeiap project (Diderichsen et al. 2015). While the ScanHeiap project included Denmark, Norway and Sweden, this project will in addition include Finland and Iceland. The project will carry out an explorative study to gain knowledge on how the Nordic countries work at the national government level to address health equity. The aim of the project is to get a clearer understanding of the efforts undertaken at the national policy development level to increase health equity.

## Problem statement and research questions

The social determinants influence people's living conditions, which again influence their health. In the project we will build on the determinant perspective, which implies that health inequalities are an outcome of social inequalities in structural determinants like education and income. In this context we will pay attention to if national policies address the "causes of the causes"; the living conditions leading to health inequalities as well as the policies specifically aimed at reducing health inequalities.

In the project, we have operationalized the 11 recommendations from the ScanHeiap project into four themes. These are "A comprehensive approach", a "Whole-of-society approach", "Build policymaking skills and vertical collaboration" and "Long term commitment and legislation".

## A comprehensive approach

There is substantive evidence of a social gradient in health inequalities, demonstrating that health becomes worse as you move down the socioeconomic scale (Davies & Sherriff, 2011; Graham, 2000). Approaches targeting only the most disadvantaged are unlikely to be effective in levelling-up the gradient and may even contribute to an increase in health inequalities. Furthermore, a gradient approach to policy also necessitates a focus on the upstream determinants of health inequities (such as income, education, living, and working conditions).

The 2008 WHO Marmot Commission report concludes that action to reduce social inequalities requires policies to level the social gradient in health, and universal measures are key in this process. In addition to universal measures, targeted measures aimed at disadvantaged groups will also be required (WHO 2008). This combination of approaches has been termed "proportionate universalism" (Marmot 2010). Based on these conclusions, we have formulated the following research questions for this theme:

- How do the Nordic countries apply a comprehensive approach to address social inequalities in health?
- Are both universal and targeted measures applied, and what is the balance between these measures?



## Whole-of-society approach

The Whole-of-society-approach theme builds on the ScanHeiap recommendations “Involve all sectors early on equal terms” and “Policies build on the premises of each sector” and these will here be treated as specifications of this main recommendation. This recommendation builds on the understanding that addressing social inequalities is a responsibility for all sectors of society.

Health in All Policies (HiAP) is an approach that systematically considers the health implications of public policies to improve population health and reduce health inequity. Inter-sectoral action is regarded key to reducing health inequalities (Ståhl et al. 2006; Leppo, et al 2013.) In governance terms, one of the main features of inter-sectoral action is that it places responsibility for public health work as a ‘whole-of-government’ responsibility rather than a responsibility of the health sector alone. Based on this understanding the following research questions were formulated for this theme:

- Are there formal structures in place with responsibility for social inequalities?
- Which institutions at the national level have the main responsibility?
- What horizontal and vertical collaboration structures are in place?
- Are other sectors of society involved (private/voluntary sector)?

## Build policymaking skills and vertical collaboration and support

Decentralization of service provision is an important feature of the Nordic welfare states (Sellers and Lidstrøm, 2007), and municipalities are central in providing services and communicate with citizens. This encompasses their two roles – their frontline responsibility for implementing national policy goals and their role as democratic decision-making bodies (Hagen et al., 2016). The municipalities also play a vital role in the implementation of public health, and in particularly from the perspective of the social determinants. They also have the main responsibility for most

services important to reduce social inequalities among their citizens; like physical and societal planning, day care institutions, primary education and housing. Most national policies allow the municipalities to adjust the content of policies to their own context, and the relative freedom of the independent municipalities may result in differences in implementation at the local level.

Both recommendations address competence and skills building in policymaking at the local level and whether there is national support for such skills building or not. Skills building and vertical collaboration strengthen the local level understanding of the importance of developing a comprehensive understanding and a whole of society approach (Helgesen et al. 2017). Accordingly, the following research questions will be addressed:

- What procedures are in place for supporting the local level in addressing social inequalities in health?
- What monitoring systems are available for municipalities?
- Have programs been developed to support local policymaking?

### **Long-term commitment and legislation matter**

The recommendations Long-term commitment and legislation matters are also connected. All the Nordic countries have policies in place for redistribution among social groups. Finland and Sweden have had policies in place over a long period of time, and in this part of the project, we will explore national commitment to address the social determinants of health. National commitment includes the type of steering instruments applied, as for instance laws and regulations. National commissions with a mandate to suggest policies to reduce social inequalities will also be included.

Still, different governments address this issue differently, and there is a tendency that left-wing governments address the social determinants while right-wing governments focus on individual measures (Fosse 2009, Raphael 2011, Vallgård 2014).

Subsequently, the following research questions will be addressed:

- What is the political and historic background of the current national policies?

- At what level is the policy anchored (administrative/political)?
- Has there been a long-term commitment for the policy (legislation/policy documents)?
- Does the policy's gravity shift dependent on the political majority in government?

## Methodological approach

This project applies a qualitative methodological approach based mainly on document and literature studies and interviews.

Official documents as green and white papers, as well as official government reports considering relevant themes and background information on the state of population health are included. So are documents from other important actors in the field, such as the WHO and the Nordic countries' municipal sector stakeholder organisations. Of special consideration to us is the commissions on inequalities in health in Denmark, Norway and Sweden. Such commissions were not carried out in Finland or Iceland. For Finland, we had to use secondary literature more than for other countries due to language challenges.

We have made searches on academic literature pertaining to all included countries. The literature is on government institutions, regions and municipalities, health systems, socioeconomic situation, public health and health promotion, as well as governance and coordination and whole of government.

Interviews with key stakeholders were performed in Denmark, Finland, Norway and Sweden. In an earlier study, based on political documents, we found that Iceland has no explicit policy to reduce social inequalities in health (Fosse 2017). Statistics on population health status is made but these are not particularly focussed on inequalities in health (Action Plan for the Directorate of Health, 2017–2018). Because of the limited focus on health inequalities, we decided not to interview policymakers in Iceland. The situation in Iceland will be based on policy documents and will have a limited space in the analysis. The Nordic Arena for Public Health Issues provided contact persons in each country. We got some suggestions for persons to interview from them and we have applied the so-called snowball method to find interviewees. We also used the

internet to search country specific institutions and organisations for persons to interview. The institutions have somewhat different roles, and this is also reflected in the sample of informants interviewed. The institutions from which we have interviewed persons are the ministries for health and social affairs, relevant directories (direktorater, myndigheter, styrelser), public health institutes and the stakeholder associations for municipalities.

In the following table, the number and institutional affiliation of the informants are shown:

**Table 2.** Interview respondents, institutional belonging

	Ministries	Directorate/ Public Health authorities	Local government associations	Others*
Denmark	2	2	1	2
Finland	1	1		2
Norway	1	3		
Sweden		2	2	1

\*The category "others" include informants who were researchers, former employees and politicians.

The interviews lasted for about an hour each and are transcribed. For each country interviews are numbered and will be referred to in the text with country and number. To ensure high validity in data both researchers have been working with the interviews in the making as well as the coding and interpretation of transcribed interview data.

In the following, we will present the national bodies responsible for public health and reducing social inequalities, before we move on to present the results from the interviews.

# National administrative bodies

The government structure in Denmark, Finland, Norway and Sweden are quite similar. In February 2019, the government in Denmark is a right-wing government, as is the governments in Finland and Norway. Iceland has a left-wing government and Sweden has a left-green minority government, supported by two liberal parties.

In most countries, there have been changes over the years, both in the institutional settings of public health as well as in the content of the policies. Denmark and Norway have single case ministries focusing on health and health care only, while Finland, Iceland and Sweden have ministries that combine health and social affairs. In Denmark, care for the elderly is included in the portfolio of the Ministry for Health. The Swedish system is a system of inter-ministerial collaboration with collective decision-making at the national government level.

Ministries are the most important national bodies taking part in developing policies on public health and securing equity in health. In **Denmark**, the Ministry of Health is responsible for public health policies including reducing inequalities in health. The ministry launched a 10-year national public health programme in 1999. The programme included 17 targets to cover specific risk factors as well as structural elements and regular monitoring was started covering the risk factors which were life expectancy, social differences in mortality and quality of life, self-assessed health, as well as behavioural factors focussing on smoking, physical activity and obesity. Currently, the policy of the Ministry of Health has its main focus on prevention of diseases, stating that the "Governments' health policy starts far from the hospitals". Behavioural factors are still prioritised, and is regarded one of the key factors in reducing social inequalities in health.

In **Finland**, the Ministry of Social Affairs and Health is responsible for health promotion, which has been a focus for Finnish health care policy for decades. This includes prevention of diseases. Health promotion is carried out both at the national and local levels and

NGOs as well work with health promotion and implement programmes (Vuorenkoski 2008).

In **Iceland**, the Ministry of Welfare is responsible for public health. The Directorate of Health is the responsible expert institution as well carrying out monitoring on a set of individually focussed indicators, among others alcohol, drugs and tobacco as well as vulnerable groups (Sigurgeirsdóttir et al. 2014).

In **Norway** the Ministry of Health and Care Services has the overall responsibility for public health. Other important institutions are the Directorate of Health, and the Norwegian Institute of Public Health, both a research institution and an institution monitoring the health status of the population. Counties conduct monitoring and strategic planning in their geographical areas and are responsible for the administration and provision of public health services within their tasks and responsibilities (Ringard et al. 2013).

The **Swedish** Ministry of Health and Social Affairs is responsible for public health and the reduction of social inequalities in health. County councils and regions are responsible for health care while municipalities are responsible for the bulk of welfare services backing up the determinants for health. The policy is founded on the 11 goals set forth in 2003 and renewed in 2008 adding elements of individual choice and responsibility. The Public Health Agency of Sweden is the national expert institution both following up on the public health goals and developing knowledge on public health (Anell et al. 2012). The 2008 renewed policy focused particularly on children and youth as well as elderly. Emphasis was put on strengthening the parental role, suicide prevention, nutrition, physical activity and smoke cessation (Ibid).

The national administrative bodies both develop and implement policies and there are expert bodies, which work actively with implementation and gather knowledge on the state of health in the population. In addition, municipal sector stakeholder associations are actively working to support the implementation of national public health initiatives in the municipalities.

Directorates (direktorater, styrelser, myndigheter) are institutions to deliver the best knowledge and suggestions on developments of policies in question. They communicate with ministries from whom

they get their assignments as well as with regional state bodies, the county municipalities and municipalities to facilitate implementation and accountability in the public health policies.

Denmark, Finland and Norway have knowledge or research institutions responsible for among others facilitating knowledge on public health for local governments to use when developing and implementing municipal public health policies.

There are regional levels in all countries but Finland. For Denmark, Norway and Sweden these are both state bodies and independent county councils. In Finland, hospitals are managed by sub municipal regions, that is: municipalities cooperate in "kommunförbund" and there are 19 such sub municipal regions, one of which comprises the landscape of Åland. The government suggested a regional reform to establish county municipalities and make these responsible for health care and public health. However, the government did not get political support for the reform, and consequently stepped down in March 2019.

In the countries with regional bodies, these have some responsibilities for public health. All countries have local government stakeholder organisations. For Denmark, Norway and Sweden, these are actively taking part in the municipal implementation of public health policies to reduce inequalities in health. In the findings section, we will describe their role in each country more explicitly.

## Summing up

Table two gives an overview of national administrative bodies important to local implementation of public health policies and policies to increase equity in health.

**Table 2:** Overview over national administrative bodies important in public health policies

	<b>Denmark</b>	<b>Finland</b>	<b>Iceland</b>	<b>Norway</b>	<b>Sweden</b>
<b>Ministry</b>	Ministry of Health	Ministry of Social Affairs and Health	Ministry of Welfare	Ministry of Health and Care	Ministry of Health and Social Affairs
<b>Directorate</b>	Danish Health Authority		Directorate of Health	Directorate of Health	Public Health Agency of Sweden
<b>Knowledge/research institution</b>	National Institute of Public Health	National Institute for Health and Welfare		Norwegian Institute of Public Health	
<b>Regional level</b>	5 regions  Region stakeholder association: Danish regions	19 hospital municipal sub regions, regional reform in the making	8 regions	19 regions  Regional reform in the making	20 regions
<b>Local government stakeholder organisation</b>	Local Government Denmark	Association of Finnish Local and Regional Authorities	Icelandic Association of Local Authorities	The Norwegian Association of Local and Regional Authorities	Swedish Association of Local Authorities and Regions

As we see, there are different organisational structures in the Nordic countries. How these structures constitute the frames for the policies, at national as well as the local level will be elaborated on in the next sections.



# Findings

## A comprehensive approach

All the Nordic countries apply both universal and targeted measures in their public health policies, as this is a part of the Nordic welfare model. However, in this report we will focus on the explicit, formulated aims, policies and measure to reduce social inequalities and whether these policies are comprehensive in the terms of universal or targeted or not.

## Denmark

In Denmark implementing policies to reduce social inequalities in health is a responsibility for the Danish Health Authority, and in a policy document from 2011, it is being described how municipalities can contribute to reduce social inequalities in health, focussing on different stages in life. The document describes two approaches; addressing the social gradient in health and also applying targeted measures, aimed at disadvantaged groups. However, even though structural measures are described, the document speaks of mainly individual, not structural measures.

The Danish programme from 1999, Healthy Throughout Life, strongly focussed on individual health behaviours and not the determinants of health (Olejaz et al. 2012). The political responsibility was downplayed compared to earlier programs, and this program laid the foundations for public health policies as it is carried out today. The Danish government launched their first so-called Health Package in 2009, a national strategy to prevent disease (Olejaz et al. 2012).

In the interviews, it is particularly emphasized that the Danish Health Authority considers that their responsibility is to develop and promote measures within the health field, which is the area they are responsible for:

*"Our responsibility is the health services. We are a professional authority. We develop the guidelines and are responsible for the overall planning." (Denmark 1, 2)*

They also point out that this professional approach means that since they are responsible for the measures within the health services, this

implies that individual prevention is their responsibility within the wider field of social inequalities. This means lifestyle issues like diet, physical activity, smoking and alcohol use:

*"Our approach is an individualistic one. We focus on what families can do to improve their health. We can have a social determinant perspective, but our task is to address issues that is a responsibility for the health services." (Denmark 1, 2)*

## Finland

In Finland, the municipalities have a central role in implementing public health, and the Municipal act (Kommunallagen) and the Health and Welfare act (Hälsa- och välfärdslagen) mandate the municipalities to establish permanent structures to promote health and wellbeing.

It is stated that promoting health and welfare and the reduction of social inequalities should be included in policies in all sectors. The national action program provides the current guidelines, which includes both universal and targeted measures are to be followed (National Institute for Health and Welfare, 2011): address poverty, education, employment and housing, support healthy lifestyles in the population and among particular population groups, improve equal access to health and social services, develop a system for following up observations of health inequalities, including the statistical basis, and gather information about health inequalities and how they may be reduced.

Regarding the actual policies, one of our interviewees pointed to the combination of universal and targeted measures:

*"I think Finland is, as well as the other Nordic countries, are good at developing universal approaches, when you target the whole age group or the whole population you get good results. [Government grant projects] report to us once a month how they are proceeding on projects and many of them make concrete plans on how to target vulnerable groups as well. Their approach varies, but they are developing targeted approaches." (Finland 2)*

One interviewee focused on the balance between universal and targeted approaches:

*"When it comes to social inequalities in health, they [the government] have had many programs, quite extensive programs, quite well thought of programs, for decades. But the problem is the implementation [...] in the municipalities." (Finland 3)*

Pointing to the division of responsibility for health equity between the health sector and other sectors, and how it focusses the determinants of health, one of our interviewees told us that:

*"I always criticize the politicians when they say, this new health reform will help to reduce health inequities, because I am saying that health service, even good health service, can do relatively little. Most of the inequities come from outside services. Of course, the aim I say that the aim, of the reform should be equal access to health services." (Finland 1)*

## Norway

The Norwegian public health act was adopted in 2012, and one of the overall aims is to reduce social inequalities in health by a health in all policies approach. Reducing social inequalities in health was a political priority in public health over the period 2007-2017 and in the report; it is stated (Ministry of Health and Care Services, 2007):

*"The efforts to reduce social health inequalities must combine targeted efforts aimed at disadvantaged groups with general welfare arrangements and population based measures.....it is necessary to strengthen the inter-sectoral approach in public health work and aim for a more equal social distribution of resources, and consequently reduced health inequalities."*

This refers to the balance between universal and targeted measures and is in line with what two of our Norwegian interviewees in 2018 told us about policies to change the determinant for health:

*"In the structure of the Public Health Act, the determinants are clearly included. [...] If you make policies to reach the root causes, it follows that interventions are to be made in other sectors [...] than the health sector, and planning is the tool to coordinate interventions." (Norway 1)*

There is a consciousness about policies to change the determinants of health and these are the universal policies in the non-health

sectors. This is in line with the policies of universalistic and targeted measures:

*"We need both universal and targeted measures. [...] This is in line with § 7 in the Public Health Act that points at possible areas for interventions – we may look at education, other policies for children and youth, and health behavior as well. We include the reduction of social inequalities in policies towards such areas. [...]" (Norway 2)*

The Norwegian determinant perspective in policies as well as the balance between universal and targeted measures were made very clear by a third interviewee who looked at the policies this way:

*"The determinant perspective...is directed at the universal arenas...like work and education [...] while we also need the targeted measures, they are becoming visible now, directed at poor children and children from migrant families as well as those excluded from the work force." (Norway 3)*

## Sweden

In Sweden, there is an explicit focus on social inequalities, which is reflected in the government's home page:

*"The long-time goal of the government's public health policy is to close the health gaps open to be influenced by policy, by a generation."*

The Government White paper based on the report from the Swedish commission on equal health holds a strong focus on the social determinants of health:

*"A basic point of departure is that everybody should have the same opportunity to have a good health and a long life.....Even if the health situation for the whole population shows a positive development, the health gaps have increased over the last decades. The uneven distribution of health in the population is to a large extent due to people's socioeconomic circumstances and social position."*

In line with this understanding, the government suggests both universal as well as targeted measures:

*"[...] we started talking about the determinants – that is what Michael Marmot says, it is where we are born, grow up, get educated, live and grow old – it is under all these circumstances that our health is created."*

*[...] We also develop policies towards health behavior; alcohol, narcotics, drugs and tobacco as well as suicide prevention, sexual and mental health.” (Sweden 2)*

In Sweden as well, the policies are directed at the determinants and there is a balance between universal and targeted measures.

## Summing up

In the four countries from which we have interview data, stakeholders at the national level seem to agree on the need to apply a comprehensive approach to secure equity in health. This involves policies to change the determinants of health and it involves a balance between universal and targeted measures. However, the actual public health policies vary between the countries. In Denmark, the main focus is on individual and citizen-based measures, often related to healthy lifestyles. In Finland, there is an acknowledgement of the social determinants, but it is to a smaller extent developed into concrete policies and measures. In Norway and Sweden, the determinant focus has gathered momentum over the last years; in Norway since it is strongly included in the public health act, and in Sweden it has moved up on the political agenda as part of the government' policy.

## Whole-of-society approach

Health in All Policies (HiAP) is an approach that systematically considers the health implications of public policies to improve population health and reduce health inequity. Inter-sectoral action is regarded key to reducing health inequalities (Ståhl et al. 2006; Leppo, et al 2013).

In all the countries, the health sector, that is the ministry of health or/and social affairs has the overall responsibility for the public health policy, including social inequalities. The subordinate institutions are responsible for the implementation of the policy. However, it varies how the national policies emphasize inter-sectoral collaboration.

## Denmark

There is a general commitment for ministries to collaborate when it is relevant, however; there are no institutional arrangements for working together on crosscutting themes. National initiatives may

cover several sectors, but according to the Ministry of Health, these initiatives are seldom coordinated:

*"I am not aware that there are formalised structures for collaboration across sectors in this field. These are large institutions, and a lot is specific for each area. We are in contact with each other and have conversations, but we don't have formal structures." (Denmark 3)*

The Danish Health Authority has the responsibility for the prevention, and even reducing social inequalities within the health sector.

*"We don't have authority over schools and the social field, but as health authority we may provide arguments for why it is important to address social inequalities." (Denmark 1, 2)*

In Finland, Norway and Sweden there are clearly formulated objectives in the policy documents stating that public health and addressing social determinants demands a whole of government approach and that it requires inter-sectoral collaboration at all levels. Interviewees in all countries tell us that broad ranging inter-sectoral action is necessary as well as decided upon, nevertheless difficult to carry out.

## **Finland**

Finland has a Public Health Act implemented in 1972. This define public health work as the promotion of health and prevention of diseases and accidents directed at the individual, the citizens and the environment, as well as hospital care for individuals. Decisions on the content of the public health work is to be found in the Health and Care Act. The act covers primary care and has over the years, been emptied of its paragraphs on substantial policies. It is now a law deciding that municipalities are to work inter-sectoral to achieve public health policies both horizontally and vertically.

In Finland, one interviewee told us that:

*"We have a very similar type of law [as the Norwegian] it gives detailed instructions on the responsibilities of municipalities in inter-sectorial promotion of health and well-being in the population. [...] The municipalities are also mandated with the responsibility to have an evidence base for their policies and to anchor responsibilities with a leading actor." (Finland 2)*

The interviewee goes on to say that:

*"We have nothing similar at the national level. Nothing is required from the ministries, really. At the national level we must rely on government programs [to ensure inter-sectoral action]." (Finland 2)*

These citations points to that a whole-of-government approach frames the Finnish policies, and that the Public Health Act mandates municipalities to establish intra-municipal collaboration between policy sectors to make policies on public health. However, it is interesting that the interviewee point to the lack of a mandate for inter-sectoral collaboration at the national level.

### Norway

In Norway one of our interviewees share the Finnish perspective on inter-sectoral collaboration at the national level and points out that it most often is necessary to have a project which the different ministries or directorates can work on together to ensure inter-sectoral collaboration at this level (Norway 4). Others talk about the challenges of implementing inter-sectoral collaboration at the national level:

*"It is kind of a challenge ... we ask the municipalities to work intersectorally but are not good at it at the national level." (Norway 3)*

Another interviewee follows this line of thinking by referring to the implementation of the 2007 white paper on social inequalities (Ministry of Health and Care Services, 2007). At the time, an inter-sectoral working group was set up:

*"A ministerial working group was established to follow up on the white paper. The paper had chapters on work and education and how to create equity. A classic determinant perspective focussing policy sectors. [...] It was hard to retain the group [...], that is part of our administrative traditions. [...] We have a strong ministerial responsibility, themes and cases are sorted under different ministries, there are no collective responsibility for the government as a whole." (Norway 1)*

### Sweden

In Sweden, the possibility for collaboration at the national level should be better than the other countries, since it has a collective

government responsibility and no single ministry responsibilities as in the other countries:

*"In Sweden, unanimous government outlines and decides. And I have understood that that is very unique, it is not the public health minister who alone decides upon the public health questions [...] they are all [the government members] collectively a part of the decision."*

(Sweden 2)

The interviewee goes on to say that regarding the white paper on social inequalities made this spring (2018), the minister of finance and the public health minister together was at the receiving end:

*"It was unique that the minister of finance and the minister of public health received this white paper together it showed the enormous symbolic strength. And that it is a highly prioritised field, equity in health."* (Sweden 2)

This may have an important symbolic value, but unfortunately, this does not mean that inter-sectoral work is the most prioritised in public health policies:

*"Between ministries at the government level is coordination not so good."* (Sweden 3)

The Swedish national policy, thus, is fragmented, as it is in the other Nordic countries.

## Summing up

Finland and Norway both have public health acts. Finland's Primary Health Care act was adopted in 1972 but has now been included in the Health Care Act from 2010. Norway's act is from 2012 and explicitly embraces the social determinants' perspective. In all countries, the ministries of health are responsible, even if there is an explicit aim that all sectors of society should be responsible for policy development in this field.

Sweden has a principle of a unanimous government system, where the whole government is responsible for policies in all sectors. This is in contrast to the other countries where each ministry is responsible for policies within their area. In principle, the Swedish system should provide opportunities for inter-sectoral collaboration. However, this does not seem to be the case in most situations. Interviewees in all



the countries report that there are no permanent formal structures in place for collaboration and that the collaboration is mostly ad hoc, or project based.

## Build policymaking skills and vertical collaboration and support

The Nordic governance system may be characterized as decentralized and multi-level (Hanssen and Helgesen 2011). The term multi-level pertains to the changed role of municipalities in the central-local relationship. A shift in governance can be observed towards a more egalitarian relation between actors across sectors and levels of formal authority. This implies that the traditional forms of hierarchical government have been decoupled, and centralized leadership is no longer carried out through a detailed hierarchical system of sanctioned rule following, but increasingly takes place through more indirect regulation, presupposing that actors are self-regulating (Sørensen & Gjelstrup, 2007).

### Denmark

The Danish Health Authority (Sundhedsstyrelsen) is the authority for the professional content of the public health policy and has the role as advisors to the government and other national, regional and local authorities. Within the health authority, there is, however, a unit for prevention, which attends areas within health promotion and disease prevention, including areas like alcohol and tobacco prevention, physical activity, nutrition, health services and social inequalities in health:

*"We are mandated to offer health promotion and prevention to our citizens. It is not clearly defined what we should offer, that is somehow what the municipalities should find out themselves. That is why we don't have any legal means we use towards the municipalities. There are some earmarked grants, and they have to meet some requirements to get these funds."* (Denmark 1, 2)

There is a financial mechanism labelled "satspuljer" that is implemented as concerted action between several ministries. The funds of the "satspuljer" is directed at projects within the social-, health-, and labor market areas. The aim of the "satspuljer" is to improve living conditions for marginalized groups of citizens. While

some of the funds go to time-limited projects, others are funding new policy measures on a permanent basis.

Some of the funding is earmarked for municipalities. The funding allows municipalities to apply for money to carry out projects within specific policy areas singled out by national government. Even though the funds are earmarked, Danish municipalities still have freedom to choose how to implement the measures. This position is emphasized by the Danish Health Authority:

*“These grants (satspuljer) have been used to establish projects and implement them. These have been project aimed at disadvantaged citizens. The Danish Health Authorities have also had some projects on local communities where there also is a focus on health among disadvantaged groups.” (Denmark 1, 2)*

The “satspuljer”, is a “soft” steering instrument because it is voluntary for municipalities to apply for money. Another “soft” instrument used in Denmark is the so-called Prevention packages. These have been developed by the Danish Health Authority and are aimed at the responsibility of the health sector in public health and at reducing social health inequalities. The measures are mostly individual, aimed at promoting healthy lifestyles. The health services play an important role in building up and following so-called prevention streams.

There are 11 packages, covering the following themes: alcohol, physical activity, hygiene, indoor climate in schools, food and meals, mental health, obesity, sexual health, sun protection, drugs and tobacco. The Danish health authority has provided guidelines on how to work across sectors with the prevention packages, for example regarding different target groups; like children and young people and the elderly. Furthermore, there are recommendations on how to work across sectors, and even with the private sector.

National health profiles are also produced. They are called The Health of the Danes. This is a survey going to all Danes every 3-4 years with questions about their health, that is, it measures self-assessed health, and even social situations. The last survey was conducted in 2017 and published in a report from the Danish Health Authority.

The survey is the basis of the monitoring system, an informational steering mechanism. The National Institute of Public Health also produces research and provide data on public health in Denmark.

## Finland

At the national level the Ministry of Social Affairs and Health is responsible for planning and managing public health. The regional level is responsible for overseeing and supporting the local level. Currently the ministry funds projects within the frame "Government Key Projects". Within the area "Health and Well-being", five projects are listed where one specifically addresses the promotion of health and well-being and social inequalities (Finland 2). Besides this, a national action programme for reducing social inequalities has been running since 2008. Priorities are living conditions as well as the traditional lifestyle issues like alcohol, tobacco and physical activity. The municipalities have a central role in public health, to establish permanent structures to promote health and welfare.

Informational steering mechanisms are mainly a responsibility for The National Institute for Health and Welfare (THL). THL is an institution under the ministry and has the main responsibility for public health. The role of THL is to oversee the health of the population, and they are also mandated to do research and are the authority for national statistics on health and social issues. A population survey on self-assessed health is carried out regularly and the results are among others included in a series of books called Welfare in Finland (Finland 3). Besides this THL makes data available for municipalities to use when they analyse the health status of their populations. They are, however not presented in statistical packages as for instance municipal health profiles (Finland 2, 3). Reducing health inequalities is a national objective and should be a responsibility for all sectors.

In Finland, key projects are elaborated and implemented to support municipalities in their public health work:

*"One of our government Key Projects which is specifically focusing on the promotion of health and well-being and social inequalities. That is the smallest of our government Key Projects. [...] Our budget is 7.8 million euros and the focus on health inequalities is practical and pragmatic. [...] The expectation is that we somehow will strengthen*

*the dissemination of best practices on how to promote health, to promote well-being and to reduce health inequalities.” (Finland 2)*

In addition to the Welfare in Finland book series the Institute of Health and Welfare (THL) supports municipalities` in developing the welfare report with data regarding more aspects of the local citizens health status. Some of these data is compiled in a “ready-made” pool of indicators while others are not. Nevertheless, it is an impression that municipalities do not apply them in their public health work:

*“How seriously the municipalities take these reports both in terms of compilation and how they react on [the information given] varies greatly. Roughly, they say that 1/3 puts a lot of effort in it, 1/3 make the reports but do not really care [...], and then there is 1/3 who may or may not make the report as they have other things on their minds.” (Finland 3).*

Besides the financial steering instrument of the projects and the informational instruments of the available data, Finnish municipalities are mandated to document the health status of their citizens in a welfare report and make sure this underpins the planning activities they must undertake:

*“Their monitoring should be done according to population groups so that they could identify inequalities among groups. Unfortunately, in practice the municipalities may monitor the children, the adults, the working age population and the elderly, so they seldom make any detailed analyses looking at social economic differences, regional differences within municipalities or for instance ethnic differences.” (Finland 2)*

Also other internet sites, such as The Welfare Compass, provides data for municipalities. Municipalities must compile these data themselves if they are to use them.

The projects establishing earmarked grants for public health or health promotion in Finland are a responsibility for the different ministries to underpin their policies toward the local level and possible NGOs. The projects and their financing may in other words strengthen the policy fragmentation at the national level.

## Iceland

In Iceland public health is anchored in two acts, the Act on Health Services and the Act on Health and Social services in the municipalities. A national strategy for public health has been developed, it runs to 2020. The strategy has mainly focus on prevention of alcohol and other substances, and the health services is the main actor. The Directorate of Health has the main responsibility for health services, including public health.

The Directorate has a department for Determinants of Health and Wellbeing. This department is responsible for public health issues and for developing statistics within these areas.

## Norway

The Norwegian public health act is based on five basic principles for public health; reducing social inequalities, health in all policies, sustainable development, and participation. The act mandates municipalities to make overviews over the health status of their population. The act communicates with the Planning and Building Act (PBL), stating that the overview is to be the basis of the PBL mandated planning strategy to be made every fourth year (Hofstad, 2011). Interviewees consider the act as important and to have institutionalized policies to change the determinants of health:

*"Reduction of social inequalities in health is part of the definition of public health work in the public health act. It is also included in other strategic documents. For instance, it is included in the government's overall goal for the public health policies."* (Norway 3)

The Directorate of Health is an executive agency and professional authority under the Ministry of Health and Care Services and one of the main goals of the directorate is to ensure contribution to the implementation of national public health policies at the national, regional and local levels. Even though public health policies are institutionalized it is considered important that there is a project at the national level:

*"The policy focus may easily disappear when it is incorporated into the goal formulation of many different policies when it really is a wicked problem at which a continuous focus is needed over time. I think it is important to formulate a kind of strategy to reduce social inequalities in health at the national level."* (Norway 3)

The Norwegian Institute of Public Health (NIPH) is placed directly under the Ministry of Health and Care Services. The NIPH is responsible for knowledge production and systematic reviews for the health sector and provides knowledge about the health status in the population, the influencing factors and how the population's health status can be improved. Further, NIPH provides knowledge for public health and the health and care services as well as support to the institute's activities regarding for example health analysis, research and services. The NIPH publishes regular reports on the health situation of the population, and the 2018 report had a particular focus on health inequalities.

NIPH also monitors the public health status of the population and do research within public health. The institute does not carry out surveys on self-assessed health but provides the municipalities with data compiled into so-called public health profiles. Health profiles are ready-made statistic knowledge municipalities may use for the mandated health overviews. Examples on knowledge included in the profiles are the number of inhabitants having lung cancer and coronary diseases as well as mental health disorders. Self-assessed health is measured for the youth population if municipalities take part in a specialized survey directed at children and youth named "Ungdata". In addition, municipalities are provided with information on the number of dropouts from high school, how many children and young people who live in low-income families, the number of single parent families, and not the least they are given information on all the health behavior variables. A perspective of distribution should also be included, that is how local political priorities affect different socioeconomic groups. Municipalities are mandated by the Public Health Act to make overviews of positive and negative determinants for health, and the health profile may make up the basis for this overview. Thus, the municipalities have the main responsibility for the public health policies, and the local government oversees policies directed at changing the determinants of health.

One of the interviewees is of the opinion that the profiles do not contain enough information on the determinants for health:

*"The way the public health profiles are implemented, if we had more data in them showing the social inequalities at the municipal level, this would be positive. However, it is difficult. It is not a lack of willingness; the data sources are difficult to sort out and apply. Some data exists,*

*and municipalities are very keen on getting this type of knowledge. Such knowledge makes it easy to find argument aimed at the politicians, thus putting the question on the agenda.” (Norway 2)*

As part of the informational steering mechanisms, it is decided that a white paper on public health is to be made every fourth year. The public health bureaucrats appreciate this, and the interviewee continues to say that:

*“That is why it is fantastic this structure of launching a white paper every fourth year, it makes the policies a bit more continuous. If there is a change in government, it will not be able to change the public health policies immediately. This structure creates stability.” (Norway 2)*

### Sweden

The Public Health Agency of Sweden has the main responsibility for public health issues. The informational mechanism of reports on population health status is published on an irregular basis. The information consists of data from surveys measuring self-assessed health as well as other kind of statistics. However, statistical data are published continuously, and they are also developed at the municipal level and even at the different areas of larger cities. The data includes statistics on social inequalities.

One interviewee comments on the policies in the following way:

*“The public health policies have the overall objective of equal health. It is supposed to create equal opportunities for good health. That is the equity aspect of the policies. It is embedded in the 11 goals. [...] The policies focus the inter-sectoral point of departure that is the determinant perspective, and this directs the policies towards the societal challenges like childhood conditions.” (Sweden 1)*

Swedish municipalities have a major responsibility for public health (Ringard 2014). Over the last years, social inequalities in health has moved up the political agenda in Sweden and the Swedish government formulated an aim to reduce actionable social inequalities in a generation.

In Sweden, there is a so-called funding principle when national policies are implemented at the local level. This implies that the national government should not mandate the municipalities to new commitments without securing funding (Sletnes et al 2013). So far,

no concrete policies have been developed, but if the policy adopted by the Parliament results in new tasks for the municipalities, they should also be funded.

## Summing up

In all the countries, the local level has the main responsibility for services that are important to reduce social inequalities in health, like schools, day care, leisure time activities and primary health care. In all countries there are national bodies supporting the municipalities in their public health work, for example by providing statistics and information material. Some of the material include data on social inequalities that the municipalities may use. In principle, all the Nordic countries have high quality statistical data, even for the local level.

In all countries, the independent role of the municipalities is being confirmed and even emphasized. This implies that national governments have mostly “soft governing tools” at their disposal. However, there are some differences between the countries regarding steering instruments. In Denmark the so-called “satspuljer” is an economic steering instruments, which enables municipalities to apply for funding for areas that are prioritized by the national government. In the other countries there are also projects that municipalities may apply for which reflects the national priorities.

The Norwegian Public Health Act also provides the national government with some hierarchical steering instruments, since the municipalities are mandated to include public health in their master plan. The municipal plans are overseen by the national authorities at the regional level, and in principle the plan could be disapproved if it does not include a health overview and suggestions on how to address health challenges, including health inequalities.

## Local government associations

Local government associations exist in both Denmark, Finland, Norway and Sweden, and they may contribute to promote health and reduce social inequalities. Our findings suggest that these associations have different roles in the four countries.

Local Government Denmark (KL) is the association for Danish municipalities. Within KL there is a Centre for prevention in practice.



The main task of the Centre is to support the municipalities and secure quality of the services and that measures and services provided are evidence based. The main activities of the Centre are to visit the municipalities, for example by arranging Thematic days.

KL sees the prevention packages as an opportunity to promote health in the municipalities:

*"All the professionals were happy for the prevention packages. Some places people regarded them as law, other places as recommendations.....But it was a tool, at the minimum in all municipalities. They were very well received."* (Denmark 4)

On the other hand, our informant at KL expressed that it would have been easier to achieve inter-sectoral collaboration if the Prevention packages had been initiated by the government instead of the Health Authority, as the latter is mandated to instigate measures that only is a responsibility for the health sector:

*"How can one expect that municipalities implement inter-sectoral measures, when the Health Authority is not mandated to suggest inter-sectoral measures, only measures for the health services?"* (Denmark 4)

The Norwegian Association of Local and Regional Authorities (KS) has all Norwegian municipalities and counties as members. One of the priorities of KS is public health, and together with the Ministry of Health and Care, they have established a ten-year programme, running from 2017 through 2027. The aim of the programme is to support the municipalities in developing systematic and long-term public health work, and to follow up the public health act. The main focus is to strengthen children and adolescents' mental health and well-being. Reducing social inequalities in health is not formulated as an explicit objective of the programme. Nevertheless, it is acknowledged that social inequalities is part of the reason for the lack of wellbeing among children and youth (Norway 2).

Also, the Association of Finnish Local and Regional Authorities is supporting municipalities in implementing public health policies and programs.

The Swedish Association of Local Authorities and Regions (KL) plays an important role in the Swedish public health policies and especially

regarding the financial mechanisms. An agreement is made between the government and the association that implies that the association distributes public health funding on different policies to municipalities. KL has also been an important driving force for putting social inequalities on the public agenda both nationally and locally, and many municipalities have integrated this theme in their policies and practices. The concepts of “social sustainability” and “social investments” have gained momentum locally, even in the Government White Paper that was issued in 2017 (Swedish government, 2017). This rephrasing is considered by our interviewees to be important:

*"Social sustainability is a broader concept [than social inequalities]. Then I think the officers working locally with policies regarding children, seniors, they are to handle these questions that really is about health, they can be framed within the notion of social sustainability."*  
(Sweden 2)

SKL, together with the Public Health Agency of Sweden, organize The Social Sustainability Forum for discussions of health inequalities and it has had a prominent role in redefining social inequalities in health as social sustainability.

## **Long-term commitment and legislation**

Even though the Nordic countries has had a focus on equity by building a strong and redistributive social democratic welfare state, the countries nevertheless have different historic traditions for the approach to address social inequalities in health.

Regarding Denmark, a paper from 2014 comparing national policy documents on health promotion and equity, found no Danish policy documents that included national goals to reduce social inequalities in health (Povlsen et al. 2014, Ministry of Health and Prevention 2009).

In general, the individual focus on prevention of unhealthy lifestyles has been predominant in Denmark. Health inequalities are mainly described as a problem for health professionals, rather than a political problem. This implies that health inequalities have not been very politicized, which is confirmed by the Danish Health Authority:

*"If you look at the public health programs issued by different governments, they are not so different. They address the same factors and the same measures. Some might emphasise social inequalities more than others, but the tools are still the same." (Denmark 1,2)*

It seems in other words that in Denmark there is a conception of the policies that goes beyond the conservative-social democratic axis. Denmark has a more liberalist tradition than the other Nordic countries and an overall discussion about intervening in the freedom of citizens as well as municipalities. The Ministry of Health elaborates this point:

*"How much should we regulate at the local level; this is a political discussion. From a health perspective, you could document the effects of some measures but in the political considerations this will be weighed against intervening in people's freedom. Even a health minister is part of a government that will relate to these considerations, ideologically and politically." (Denmark 3)*

## **Finland**

In Finland, national policy documents have emphasised implementation of measures such as taxation of tobacco and alcohol, provision of basic social security and unemployment benefits, and prevention of social exclusion (Povlsen et al. 2014). In the paper, it is concluded that the policy documents suggest policies and measures to tackle inequalities in health by addressing the social determinants.

In our interview, the informants stressed the need for upstream measures that include wide and comprehensive targets and goals covering different public health and welfare system sectors. The proposed measures, however, particularly recognised vulnerable and disadvantaged groups as those in need of support. Furthermore, the measures proposed were not articulated in an explicit and concrete way.

This may be changed as one of our interviewees told us that:

*"Everybody in the Parliament has said that social inequality or inequity or let's say the situation of the modest advantaged population groups, should be improved. The prime minister has a slogan that says that growth belongs to everybody. But when you go to the political debates, like in every country, I think that the more left you go the more you*

*hear that the government is not doing enough in this issue and the current government is saying that yes, this is a great concern for us.”*  
(Finland 1)

As shown above, a package of projects, the so-called Key projects are implemented in Finland. These are based on the available knowledge on what is best practice in public health work. The projects were not necessarily evaluated, and results from projects are not part of the evidence base for other municipalities and actors to learn from.

### Norway

In the Norwegian Public Health Act, the main focus is on health determinants. Health is considered a responsibility for all sectors of society and reducing inequities in health is one of the main goals. As described above, the act is particularly committing for the municipalities.

The issue of social inequalities has been politicised, and while social democratic governments has addressed the issue by emphasizing society's responsibility for people's health and wellbeing, conservative governments have emphasized individual responsibility (Fosse 2009, 2012). Accordingly, left wing governments have suggested more structural measures, while conservative governments more often suggest individual, lifestyle-oriented measures.

Research shows that municipalities give increasingly higher attention to public health and health inequalities since the public health act was adopted (Schou et al. 2014, Helgesen et al. 2017). For example, it is documented that high-quality day-care institutions reduce the risk of school drop out later and consequently can contribute to levelling the social gradient (Norway 2). From this perspective, it may be argued that the issue of social inequalities is not very politicized at the local level.

The Public Health Act established a new foundation for strengthening systematic public health work in the development of policies and planning, through better coordination of public health work horizontally across various sectors and actors, and vertically between authorities at the local, regional and national levels (Ringard et al. 2013).

The Directorate of Health has a central role in supporting the municipalities in the implementation of the Public Health Act. A central element of the act is the way it communicates with the Planning and Building Act (PBA). This is an important juridical steering mechanism as told to us by a Norwegian interviewee:

*"The one paragraph, § 3.1 F, in the Planning and Building Act explicitly says something about social inequalities. That is worth its weight in gold. We notice that to communicate the PBA as an important tool vis a vis the Public Health Act is as important as to communicate the Public Health Act vis a vis the PBA [...] You communicate much broader in municipalities when you refer to the PBA. That is what is right, I think, as PBA is the most important law to develop municipalities. The Public Health Act supports this."* (Norway 2)

## Sweden

Sweden was the first of the Nordic countries to formulate policies with the Report Health on Equal Terms (Diderichsen et al, 2015). In 1997 the parliamentary National Public Health Committee was formed. The aim was to develop national objectives to achieve "health for all", including strategies to reach the goal (Backhans and Moberg, 2008). As a follow up to this work, the Public Health Objectives Bill was passed in 2003. The bill focuses on the determinants of health on different levels and domains, presenting 11 objectives. The overarching aim of the Swedish public health policy is to create social conditions that ensure good health on equal terms for the whole population.

When a right-wing government came into office in 2006, there was a shift of focus away from social inequalities towards lifestyle related issues like tobacco, alcohol and drugs, underpinning the need to prioritize among the 11 objectives. It is fair to state that a renewed governmental focus came with the appointment of the commission on social equity. Regarding Sweden, the theme of social inequalities is politicized, as the shift away from a social inequality perspective came with the right-wing government but was revitalized by the red/green government. It is politicized also at the local level as municipalities on their own initiative establish commissions to outline the social inequalities in health.

Whether or not a law would be effective and strengthen public health at the local level in Sweden interviewees cannot give a clear answer to:

*"In Sweden, we have the local self-government and the municipalities decide what to do. So, regarding a law, both the last commission and the one leading to the goals of 2002-2003, [...] they resonated on pros and cons, pros are that a law would support municipalities in for instance their work on early intervention. However, for the wider public health work, would a law be effective for instance for allocating resources?" (Sweden 2)*

The interviewee goes on to make reflections about the policy, stating that equality is an important objective of Swedish public health policies, however that equality as a perspective have not prevailed in the public health policy development or in the implementation:

*"We have had a national public health policy for quite some time, this have been more successful at the local and regional levels than at the national level. Nevertheless, health inequalities have grown." (Sweden 2)*

## Summing up

The policies to achieve social equity do not have the same momentum in the countries. In Denmark, there is no strong political focus on the social determinants, in Finland they have been formulated, but don't play an important role in concrete policy making. In Norway and Sweden, reducing social inequalities in health is central in the current public health policies.

An interesting point is whether reducing social inequalities in health is a politicized issue, and whether left-wing governments will give higher priority to this issue. Research show that in Norway and Sweden this is the case, with left-wing governments prioritizing structural measures, while right-wing governments tend to play down the issue (Fosse 2009, 2012). In Denmark, it was also confirmed that left-wing governments has this issue higher on the agenda but that the suggested policies and measures would be the same. In other words, individual measures, aimed at influencing lifestyle would be the preferred measures independent of government. This was explained as a cultural phenomenon, in the

sense that structural measures like reducing access to for example alcohol and tobacco neither have political nor population support.

Another interesting point is the role of the Norwegian Public Health Act. It seems that reducing social inequalities in health has gained broad support, particularly at the local level. The municipalities increasingly recognize how their services, like day care, schools and leisure time activities can include an equity perspective. In addition to these universal services, targeted measures can provide extra support to vulnerable and disadvantaged citizens. Another point regarding the act is that the institutionalization of public health, includes social inequalities. By having the act, the issue of social inequalities may not be so vulnerable to policy shifts following right-wing and left-wing governments.

## **National commissions addressing social inequalities in health**

One sign of national commitment may be the national commissions, inspired by the Marmot commission on the social determinants of health (WHO 2008). Similar commissions were appointed in Denmark, Norway and Sweden. In the following paragraph we will describe and analyse the three commissions.

Denmark was first and in 2010, the National Health Authority assigned Professor Finn Diderichsen at Copenhagen University to lead the commission. A number of experts contributed, and the report emphasized comprehensive and inter-sectorial action and a focus on the social determinants of health and the social gradient (Diderichsen, Andersen and Manuel 2011). The report suggests increased universal measures to reduce social inequalities in health, with contribution from several sectors. In addition, the report also suggests targeted measures aimed at marginalized social groups.

In Norway, the Directorate of Health appointed a commission that should provide a review of factors influencing social inequalities in health. Professor Espen Dahl at the now Oslo Metropolitan University was appointed leader of the commission. A number of experts, mostly researchers, took part in the review. The report was issued in 2014 and provides recommendations for policy and measures to reduce social inequalities (Dahl, Bergsli and Van der Wel

2014). The report had a focus on the social gradient in health, and universal as well as targeted measures were suggested.

In Sweden, the government appointed the Swedish commission in 2015. The commission was headed by Professor Olle Lundberg at Stockholm University. The Swedish assignment was more comprehensive than in Denmark and Norway. The final report was submitted to the government in 2017. In general, the report had a similar structure to the Danish and Norwegian reports, but in the Swedish report, there is a stronger focus on political governance. The report avoids any political controversial issues related to ongoing policies but provides explicit suggestions for how to organise government to achieve inter-sectorial collaboration and coordination (Regeringen 2017).

The overall aim of the commissions was to present knowledge, mostly research-based evidence, about distribution of social inequalities in the countries. Based on this knowledge, the commissions suggest policies and measures to improve the situation. The role of the commissions has very much been to move the issue to a scientific area and present evidence-based knowledge. By moving the issues to the field of science, the political character of the issue is downplayed. The suggestions of the commissions are mostly based on measures that may be implemented within the existing political structures. This is particularly the case with the Danish and Norwegian reports. The Danish report seems to have a pedagogical aim, to inform policymakers of the scientific evidence in the field. The Norwegian report explicitly states that political decisions should be left to the politicians and as such are outside the mandate of the commission. The Swedish committee is the only one that suggests organisational changes in government in order to meet the recommendations based on how to address the social determinants of health (WHO 2008).

A central question is to what extent the commissions have influenced national policies in each of the countries. In both Norway and Sweden, national policies aiming at reducing social inequalities in health have been developed, and this should give legitimacy to the reports. However, the legitimacy will also depend on which institution gave the assignments. In Denmark and Norway, the assignment was commissioned by the health authorities, subordinate to the ministries of health, while in Sweden the



government commissioned the assignment. This difference had consequences for the significance the reports have had, in terms of influencing the national policies. In Denmark and Norway, the reports have not had a significant influence on the policy development, while in Sweden, the government has followed up the report with a Government White Paper (Regeringen 2018).

A national committee to address economic inequalities in all sectors was also appointed in 2018. The main assignment of the committee was to suggest measures that reduces inequalities on a long-term basis. Among the themes to be addressed are inequalities in living conditions for children, opportunities for high quality education and good working environments. The work of the committee should also contribute to increased equity and strengthen efforts to reduces inequalities in health.

# Discussion

In this project, we have operationalized the 11 recommendations suggested by Diderichsen et al (2015) into four themes suitable for research. We will use these themes also in the discussion of our findings.

## A comprehensive approach

It is important to acknowledge the role of the Nordic welfare model, which includes all the countries. These welfare states are characterized by universal measures, funded mostly by taxation (Esping-Andersen 1990) and high-quality services. This means that there are universal services and transfers to citizens, as well as services and transfers aimed directly at disadvantaged groups. These transfers and services are important to secure citizens a decent life and is a fundament in the Nordic welfare states.

However, there are large social inequalities in health also in the Nordic countries, which has been characterized as the welfare paradox (Mackenbach 2012). In this project, we have focused on the explicit policies to reduce social inequalities in health, and how national policies are developed to meet these challenges.

In line with the Nordic welfare state model, all the countries have overall policy aims to reduce social inequalities. The progressive tax system still holds high legitimacy among citizens and is based on a principle of solidarity. This also implies that large social inequalities are considered unfair.

However, when it comes to substantial objectives and policies that are formulated in policy documents and followed up in plans and measures, there are differences between the countries. In Denmark, the aim of reducing social inequalities in health is formulated as a responsibility for all sectors. However, the areas to be prioritized are mostly those that traditionally are public health issues. These overall aims are to prevent diseases, mostly related to lifestyle issues. The Danish health authority has provided suggestions on how to work across sectors at the local level. However, their formal responsibility is measures based in the health sector, both at the national and local level. In line with this understanding, it makes sense that focus is on individual lifestyle factors, often aimed at disadvantaged groups.

Policies developed at the national level and implemented at the local level have this focus.

In Finland, there is no concrete follow up of the overall aim to reduce social inequalities by applying a HiAP-approach. An action plan was developed but it was not renewed after 2015, when the plan ended. In the interviews, it was said that the plan still was the tool that existed. In practice, policies to reduce social inequalities in health mostly have an individual lifestyle perspective, also in Finland.

In Norway, the Public Health Act is the most important governance tool. It has an explicit aim to reduce social inequalities in health by applying a health in all policies strategy. This is a responsibility for all sectors, at the national, regional and local level. The act is closely integrated with the Planning and Building Act, which is the most important tool for the municipalities in the planning, development and implementation of policies. The act mandates municipalities to make a review of the health situation of their inhabitants and estimate how different social groups will be affected by the policies and measures developed.

In Sweden, the issues of health inequalities have gained momentum over the last years. The role of the SKL has been important for this. SKL has not focused on the health sector but has a comprehensive approach, as has municipalities, regions and others by applying the term social sustainability. This perspective was also taken up by the government, both in the mandate for the commission on social determinants on health and in the Government White Paper issued in 2018. These reports explicitly have a focus on strengthening the welfare state in order to reduce social inequalities.

### **Whole-of-society approach**

Formal structures are in place that have responsibility for reducing social inequalities. The institutions responsible at the national level are, however, the Ministries of Health and their subordinate departments. In other words, the health sector has the overall responsibility at the national level. This implies that reducing social inequalities in health is defined as an issue for the health sector and doubt may be raised on the possibilities for inter-sectoral collaboration at the national level.

In Denmark, it is recognized that reducing inequalities will include other sectors, however emphasized that each sector has responsibility for inequalities within their sector. Accordingly, the education sector is responsible for inequalities in education, the social sector for their sector etc. It is not referred to an inter-sectoral forum where these issues are being coordinated. However, the government fund grants to the municipalities (satspuljer) to stimulate the municipalities to strengthen certain areas and the "satspuljer" is a financial instrument that necessitates some collaboration among Ministries at the national level.

In Finland, it is explicitly expressed in policy documents that a HiAP-approach should be applied. However, at present there seems to be no inter-sectoral responsibility in terms of a project involving more ministries or the establishment of a forum for representatives of more sectors to meet.

In Norway, the Public Health Act places responsibility on all sectors at all levels of government. There is a forum for meetings between the ministries, but this is not active, and it seems that it has a more random function with irregular meetings. Interviewees said that it is important to have a project or possibly a strategy that would demand collaboration at the national level.

In Sweden, the policy is clearly a responsibility for the whole government. This was demonstrated by the fact that the commission on social inequalities delivered its report to the Minister of Finance, not the Minister of Health and Social Affairs. The tradition of unanimous national level government decisions leads us to believe that decisions are made as compromises among all the ministers. As such, the possibilities for collaboration would be better in Sweden than in the other Nordic countries. However, this seems not to be the case. Also, in Sweden, interviewees questioned the existence of a project to unite ministries and ministers on reducing social inequalities. However, such a project was lacking in Sweden as well as in the other countries.

## Build policymaking skills and vertical collaboration and support

The Nordic countries are among the most decentralised in the Western world and the municipalities are also among those having the most autonomy. The municipalities play a vital role in the implementation of public health according to their dual role.

The autonomy of the municipalities is underlined in all the countries. The municipalities are responsible for public health, and they have the main responsibility for most services important to reduce social inequalities among their citizens; like physical and societal planning, day care institutions, primary education and housing. The municipalities have a substantial degree of freedom in implementing national policies.

Local governments have different capacities to implement policies to reduce social inequalities in health. National governments now use informational instruments and so-called "governance by knowledge" is being developed to be a central instrument for steering. This is accentuated in the way the institutions at the directorate level (Danish Health Authority, The Finnish National Institute of Health and Welfare (THL), The Norwegian Directorate of Health and the Swedish Public Health Agency) regard themselves, namely as supporters of the municipal public health work. It is also accentuated because the financial instruments that is the ear marked time limited financing of national government projects must be considered as 'soft' steering instruments.

Building partnerships with the municipalities is an aim most clearly expressed in Denmark, Norway and Sweden. In Denmark, the Centre for prevention in practice has a very clear role. The Danish Ministry of Health initiated and funded the Centre but from 2016 the KL has taken over the responsibility and funding. The role of the Centre is to support municipalities in their public health work, including addressing social inequalities. In Norway, the Directorate of Health has supported the municipalities in many ways in their implementation of the Public Health Act. They have produced written guidelines, among others to support the planning process. They have also supported in other ways, by meetings, conferences etc. and now the Directorate collaborates with the local government stakeholder association on a project to increase the wellbeing of

children and youth in municipalities. In Sweden, the collaboration between SKL and the Swedish Health Authority has resulted in a joint Social Sustainability Forum with the aim to promote social sustainability. The collaboration focus on reducing social inequalities as a part of public health work together with municipalities, regions and other actors within the field

As was discussed above, the local autonomy varied among countries. In Finland, Sweden and Iceland local governments had more autonomy than in Norway and Denmark (Baldersheim, Rose & Sandberg 2017). This difference is mostly based on the number and kind of services local governments had the responsibility to provide for citizens. However, the possibility to tax is also important. In all countries, local governments have the responsibility for the bulk of person-oriented services. Finnish local governments also have the responsibility for hospitals, a service no other Nordic country places with the municipalities. In Sweden, the former regional level, "län", have now had the possibility to develop into regions. The regions have an extended responsibility compared to "län", which in addition to responsibility for health services include responsibility for strategic and developmental issues in their region.

### **Long-term commitment and legislation matter**

Both the inequalities and the means, with which they are reduced, are produced and provided by institutional arrangements. Laws and regulations are part of structural arrangements and as was shown above only Norway has a law that explicitly mention the reduction of social inequalities in health. Nevertheless, all countries have stated objectives to reduce social inequalities in health. However, these objectives are often vague and not always followed up by concrete policies and measures.

Another point is that different governments address this issue differently, and there is a tendency that left-wing governments address the social determinants while right-wing governments focus on individual measures (Fosse 2009, Raphael 2009).

In all the countries, it has been reported that left-wing governments have the issue of social inequalities higher on the political agenda than right wing governments. This is particularly clear in Norway and Sweden where the issue had a boost when left-wing governments came into office. In Norway, this happened in 2005 and the

government had a clear ambition to address social inequalities, not only in the health sector but also in the education and social sectors. In 2007, the ten-year policy of reducing health inequalities was launched (Ministry of Health 2007, Fosse 2009, 2012).

In Sweden, there was a similar development. The Swedish policy from 2003 had a strong focus on social inequalities (Ministry of Social Affairs 2003). When a right-wing government came into office in 2006, the issue of social inequalities was downplayed (Fosse et al 2014). It was revitalized when the social democratic government appointed the commission on social equity.

In Denmark, the situation seems to be slightly different. It was reported that left-wing governments also in Denmark give higher priority to reducing social inequalities than right-wing governments. However, this may not influence the measures that are being applied. From the interviews, it was suggested that structural, top down measures are not holding legitimacy in the Danish tradition. These may be to increase prices on tobacco and alcohol or establish state shops with monopoly to sell alcohol, like the other Scandinavian countries. Even if Denmark belongs to the social democratic welfare state regime, it seems that the strong legitimacy of state driven measures that are so important in Sweden and Norway, are not as legitimate in the political and public opinion. The discourse on this resembles the "nanny state" debate in the UK (Fosse et al 2014). This may also contribute to explain why the individual, lifestyle-oriented measures are dominant, not only in public health in general but also when it comes to addressing social inequalities in health.

# Conclusion

There are many similarities between the Nordic countries in how public health is being organised. Despite the similarities, we expected to find differences in the actual policies to increase equity in health. In accordance with the Nordic welfare state model, all the countries apply both universal and targeted measures for their population. The WHO commission on the social determinants of health pointed to the welfare models of the Nordic countries as exemplars on how to move forward to level the social gradient in health. Even though reducing social inequalities was one of the main aims of the development of the Nordic welfare state, this aim is not always explicitly connected to the current policies. The model has also been challenged by global economic trends and social inequalities are increasing.

There is an awareness of this situation in the Nordic countries and reducing social inequalities in health is included in general policy recommendations in all the countries. However, regarding concrete policies and measures, it is often the individual approaches, most often related to lifestyle issues that are being preferred. These are mostly initiated by the health sector. This may also reflect the organisation of this policy areas in the Nordic countries. At the national level, the health sector has the overall responsibility for developing and implementing policies. Accordingly, the suggested measures are those that is a responsibility for the health sector. In none of the countries there are permanent structures at the national level to secure that the issue of health inequalities gains a “Whole of government support”.

An important common factor is the role of the municipalities. In all the countries they play an important role, both as implementers of national policies and independent political units. The municipalities are responsible for services that is important in reducing social inequalities, like schools, day care institutions, and housing. In all the countries, the national level supports the municipalities in several ways, mostly via so-called “soft” governing tools like time-limited funding, advice and information and even personal support. To a lesser extent, there are means to force the municipalities to follow a certain policy path.



The exception is Norway, which has adopted a public health act with a particular aim to reduce social inequalities in health by applying a health in all policies approach. The national government can also follow up the implementation of the act, by auditing whether the municipal plan is following the guidelines of the Public Health Act. However, the municipalities still have a high degree of freedom in making priorities, and there are few sanctions for those who don't follow up all the intentions of the act.

We believe that the most important point regarding the Norwegian Public Health Act is that health inequalities has been institutionalised as an important policy field. As we have seen, health inequalities is a politicized, so-called "wicked" issue. It has often been moved up and down the political agenda according to political shifts in government. By adopting the act, the issue of health inequalities is not so easy to move down the agenda, particularly if it gains a footing at the local level. Accordingly, it will not be so vulnerable to shifts in national political priorities.

Further research on policies to reduce social inequalities in health in the Nordic countries should have a closer focus on the central- local dimension and the implementation of the policies at the local level. Studying the implementation process could give a deeper insight into how the actual policies and measures reach their targets, and if and how they contribute to reducing social inequalities.

# Policy recommendations

An important question is what types of **inter-sectorial collaboration** should be in place in order to strengthen the whole of government/whole of society involvement in reducing health inequalities. Shared understanding is one keyword. Stakeholders in different sectors should agree on the overall aim to reduce social inequalities in health. A second key word is shared responsibility among the different sectors, like for instance a project as requested by interviewees in all countries. In order to achieve a whole of government approach, each sector needs to participate and commit themselves. There needs to exist ways of collaborating that emphasize shared responsibility, among them sharing resources. Interdepartmental meetings, whether they are permanent or random is not enough, there must be something of substance to elaborate on at meetings.

**Facilitating of structures that promote a whole of government approach and inter-sectorial organisation**, should be carried out. This would include modifying the fragmented structures that exists within government. Changing structures is demanding as it would challenge both organisational and professional boundaries but should be on the agenda in order to meet the demands of a whole of society approach.

When looking into long-term commitment, the concept of **institutionalization is important**. If policies to reduce social inequalities in health are reliant on government constellations, they seem to be vulnerable and may be subject to inconsistency. In Norway, reducing social inequalities has been institutionalized in the Public Health Act and other strategic documents. The act is linked to the Planning and Building Act, which is the basis for all planning and policymaking in the municipalities. While the Public Health Act mandates local government to make an overview of the local population`s health status and the positive and negative determinants in the local environment, the Planning and Building Act mandates municipalities to make this overview the basis for the planning strategy. The document mandates municipalities to build their planning on evidence, for example knowledge from the health

profiles and knowledge gathered from the municipal service providing agencies.

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<https://lovdata.no/dokument/NL/lov/2011-06-24-29>

**Helsedirektoratet (2013).** God oversikt —en forutsetning for god folkehelse. En veileder til arbeidet med oversikt over helsetilstand og påvirkningsfaktorer. Oslo, Helsedirektoratet

**Stortingsmeld. 19 (2014–2015).** Folkehelsemeldingen. Mestring og muligheter. Oslo, Helse—og omsorgsdepartementet

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## Sweden

**Sveriges Kommuner och Landsting (2013).** Gör jämlikt – gör skillnad! Samling för social hållbarhet minskar skillnader i hälsa

**SOU 2016: 55 Det handlar om jämlik hälsa.** Utgångspunkter för Kommissionens vidare arbete. Delbetänkande av Kommissionen för jämlik hälsa. Stockholm

**SOU 2017:4 För en god och jämlik hälsa.** En utveckling av det folkhälsopolitiska ramverket. Delbetänkande av Kommissionen för jämlik hälsa. Stockholm

**SOU 2017:47 Nästa steg på vägen mot en mer jämlik hälsa.** Förslag för ett långsiktigt arbete för en god och jämlik hälsa Slutbetänkande av Kommissionen för jämlik hälsa. Stockholm

**Regeringens proposition 207/18:249.** God och jämlik hälsa – en utvecklad folkhälsopolitik. Stockholm

## Links

### Finland

Finlex – Folkhälsolag

<https://www.finlex.fi/sv/laki/ajantasa/1972/19720066?search%5Btype%5D=pika&search%5Bpika%5D=folkh%C3%A4ls%2A>

Institutet för hälsa och välfärd – Ojämlighet i hälsa och välfärd

<https://www.thl.fi/sv/web/ojamlighet-i-halsa-och-valfard>

Social- och hälsovårdsministeriet – Hälsofrämjande

<http://stm.fi/sv/halsoframjande>

### Denmark

Danskernes Sundhed

<http://www.danskernessundhed.dk/>

Statens Institut for Folkesundhed

<https://www.sdu.dk/da/sif>

Sundheds- og Ældreministeriet – Forebyggelse

<https://www.sum.dk/Sundhed/Forebyggelse.aspx>

Sundhedsstyrelsen – Forebyggelse

<https://www.sst.dk/da/planlaegning/kommuner/forebyggelsespakkr>

Sundhedsstyrelsen – Danskernes sundhed – Den nationale sundhedsprofil 2017

[https://www.sst.dk/da/udgivelser/2018/~/\\_media/73EADC242CDB46BD8ABF9DE895A6132C.ashx](https://www.sst.dk/da/udgivelser/2018/~/_media/73EADC242CDB46BD8ABF9DE895A6132C.ashx)

Sundhedsstyrelsen – Ulighed i sundhed

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## Norway

Folkehelseinstituttet - Helsetilstanden i Norge 2018.

Folkehelse rapporten

<https://www.fhi.no/publ/2018/fhr-2018/>

KL – Center for Forebyggelse i praksis

<https://www.kl.dk/Kommunale-opgaver/Sundhed/Center-for-Forebyggelse-i-praksis/>

KS - Program for folkehelsearbeid 2017–2027

<https://www.ks.no/fagomrader/helse-og-omsorg/folkehelse/om-program-folkehelse-20172027/>

## Sweden

Folkhälsomyndigheten – Mötesplats social hållbarhet

<https://www.folkhalsomyndigheten.se/motesplats-social-hallbarhet/om-motesplatsen/>

Regeringskansliet – Folkhälsa och idrott

<http://www.regeringen.se/regeringens-politik/folkhalsa-och-idrott/>

Regeringskansliet - God och jämlik hälsa – en utvecklad folkhälsopolitik

<https://www.regeringen.se/rattsliga-dokument/proposition/2018/04/prop.-201718249/>

Regeringskansliet – Regeringen tillsätter Jämlikhetskommission

<https://www.regeringen.se/pressmeddelanden/2018/08/regeringen-tillsatter-jamlikhetskommission>

## International

WHO: Rio Political Declaration on Social Determinants of Health

<https://www.who.int/sdhconference/declaration/en/>

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