



EUROPE

Setting the political agenda to tackle health inequity in Norway

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Studies on social and economic determinants of population health, No. 4



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Abstract

The WHO European Office for Investment for Health and Development, Venice, Italy of the WHO Regional Office for Europe is organizing national policy–learning case studies in an effort to support the advancement of policy–relevant knowledge on tackling the social determinants of health and health inequity in the WHO European Region. Norway is one of the first three case studies to be carried out. This report presents the Norwegian experience in implementing strategies to reduce socially determined health inequity and highlights the key lessons learned from this process. It describes how a series of factors and action taken over a period of time came together to create a window of opportunity that enabled the introduction of a comprehensive, intersectoral policy to tackle the social gradient in health. It seeks to provide a tool that allows reflection on progress to date and options for the future, and to shed light on critical areas of learning that can be useful to and adapted by other countries in advancing their own national policies, strategies and capacity to reduce socially determined health inequity.

Keywords

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Socioeconomic factors
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Foreword

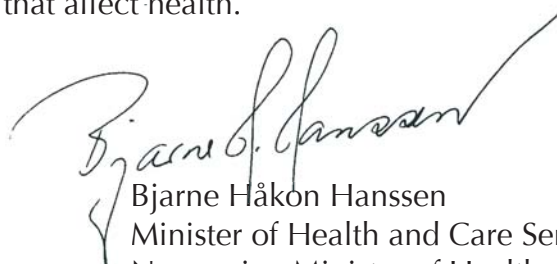
Even though the Norwegian population enjoys good health, averages conceal serious, systematic inequities. Health is unevenly distributed among social groups in the population. The most privileged, in economic terms, are those with the best health. These inequalities in health are socially determined, unfair and modifiable. My Government has, therefore, in White Paper No. 20 (2006-2007) to the Storting (Parliament), initiated a broad, long-term strategy to reduce social inequality in health. The strategy is part of the Government's comprehensive policy on reducing social inequalities, promoting inclusion and combating poverty. The strategy to reduce social inequity in health represents the health aspect of this policy.

Reducing health inequity is a whole-of-government challenge. It requires intersectoral action, which is demanding. Nevertheless, it is the only way forward if we are to achieve our aim of reducing health inequity that is socially produced and unfair. The Norwegian Government is committed to action for a society in which there is equal opportunity for a healthy life for every individual.

Many factors play a part in creating and perpetuating social inequity in health. Although the situation is complex, we can state that it is generally social circumstances that affect health and not the other way round. Although serious health problems often lead to loss of work and income, and to difficulties in completing education, social status has a greater impact on health than health has on social status. Social inequities in health indicate systemic injustice. This cannot be tolerated in a society that upholds the principle that everyone should have equal opportunities to achieving good health.

All individuals have a responsibility for their own health. It is important to respect their right to make their own choices and influence their own lives but their spheres of action can be limited by factors outside their control. For example, lifestyle choices, such as smoking, physical activity and diet, are greatly influenced by socioeconomic background not chosen by the individual. The Norwegian Government believes that public health work needs to be based on society's assuming greater responsibility for the health of the population. As long as systemic inequalities in health are the result of an unequal distribution of resources, it is the responsibility of the community to take steps to make the distribution fairer.

Distributing society's resources fairly is good public health policy. The primary goal of future public health work is not only to preserve the good health of those who already enjoy it but also to bring the level of health of the rest of the population in line with that of the people who are in the best of health – in other words, to level up. Public health work entails initiatives to ensure a more even social distribution of the factors that affect health.



Bjarne Håkon Hanssen
Minister of Health and Care Services
Norwegian Ministry of Health and Care Services

September 2009



1. Executive summary

1. Executive summary

In 2002, Espen Dahl referred to Norway as a laggard in its approach to social inequity in health¹(1). This was because, while there was an acceptance of the problem at government level and in the research community, there was a lack of political will and clear entry-points for policy. Since then, however, considerable progress has been made towards developing a comprehensive, coordinated policy to address social inequity in health.

The first step in the process was the inclusion of a small chapter on social inequity in health in White Paper No. 16 (2002–2003), *Prescription for a healthier Norway – a broad policy for public health*, which was published by the Government in 2003 (2). It introduced a top-down oriented process with specific emphasis on increasing knowledge to develop this policy area further. The Resource Unit of the Norwegian Directorate of Health took on the role of bridging research and policy by introducing an expert group to inform policy-makers and provide evidence-based policy entry points. The plan of action, entitled *The challenge of the gradient* (3), prepared the basis for an intersectoral strategy at ministerial level. This new concept and its policy implications demanded broad ownership in order to become a priority on the political agenda. The Resource Unit played a key role in what was referred to as “softening up the system” by bringing about a common perspective on the social determinants of health and health inequity and creating commitment in professional communities and among the public. The election of a new government in 2005 provided a window of opportunity, which allowed the rapid development of this policy.

The Norwegian strategy to reduce social inequity in health was launched in 2007 in White Paper No. 20 (2006–2007) (4). Its implementation is based on a combination of intersectoral efforts and short- and long-term goals relating to health determinants and designed to maintain the issue on the agenda until 2017. The Norwegian case illustrates that it is possible to transform national public health targets in only a few years.

Several key factors were important in stimulating the process to develop policy on health inequity and the social determinants of health.

- **Country-specific research on the prevalence and causes of health inequity and on related policy interventions**

It is necessary to have standardized statistics on the prevalence and causes of health inequity. In Norway, the problem was initially confounded by measuring only average levels of health inequity. Obtaining data on the distribution of health status in a population was necessary for a solid formulation of the problem. A clearly defined problem has a better chance of moving up on the political agenda.

Assigning the role of monitoring and reporting on the problem to the Norwegian Institute of Public Health ensured a formal mechanism for systematically tracking the problem and reviewing the impact of interventions. This also served to inform ongoing policy direction and helped to keep the issue on the policy agenda.

¹ Also referred to as health inequity.

An expert group appointed by the authorities translated research and evidence into intelligence suitable for the Norwegian context. Using international evidence in a country-specific context and developing national evidence increases the relevance of and receptivity to action on complex problems, such as health inequity.

- **Creating an arena in which experts or communities of specialists and practitioners can interact and generate common ground, capacity and receptivity for tackling complex issues**

The forum of experts created within the Directorate of Health functioned as a think tank on how to bridge research and policy and present scientific rationale in an area that might be considered very political. In order to create a sense of ownership at both the political and the public sector levels, it was important to illustrate that the approach to dealing with inequity was based on both technical and theoretical points of view.

- **Consistency in framing the policy challenge**

The policy process is complex and entails negotiations among many actors. In order to ensure a consistent understanding of the problem, and hence an appropriate response throughout the policy process, it is important that “the problem” and the policy options to deal with it are clearly framed. In the Norwegian case, an intervention map was used for this purpose, which made it easier to argue the rationale for creating comprehensive policies in situations where some actors tended to focus too narrowly on specific issues, target groups or topics.

- **Creation of a strong team or network of policy entrepreneurs to communicate the problem and bridge the equity goals of the health and other sectors towards the achievement of broader governmental agendas**

Making a communication plan and carrying out a stakeholder analysis are considered important elements in creating alliances. Research expertise within the health field may not be sufficient on its own. It is crucial to have the necessary skills and capacity to analyse policy processes and to influence the priorities of the different sectors in the policy-making environment through technical messages on health equity transmitted in a language comprehensible to them. In Norway, the network of policy entrepreneurs ensured communication and the bridging of stakeholder interests and sectoral goals at different stages and across different streams in the policy making process.

- **The need to align policy objectives with other parts of government systems**

Aligning intersectoral mechanisms with other formal governance systems, such as national budget and standard regulation frameworks, is important in helping to keep the strategy on track and reducing strategic drift. In Norway, a deliberate choice was made to base the process of developing the national strategy, as far as possible, on existing structures.

Reorienting existing mechanisms and systems to reflect the policy objectives also helps to mainstream an issue or problem. For example, allocating a budget explicitly for action to reduce social inequity in health would have undermined an acceptance of the need to reorient existing policies and investments to the policy goal.

- **An infrastructure conducive to maintaining intersectoral collaboration beyond the policy formulation phase**

A formalized structure of collaboration can facilitate implementation and stimulate health equity concerns in different policy areas. In Norway, when outlining the national strategy (4), the structure of interministerial collaboration was important not only in connection with its formulation but also to mainstreaming health equity policies relating to the social determinants of health at the point of its implementation.

- **A continuous obligation to keeping the issue of social inequity in health on the political agenda through different political governances**

In Norway, a review and reporting system was introduced to assess progress made towards achieving the targets, thus creating a dynamic between short-term and long-term goals. The system was designed to monitor inequalities in health determinants, rather than inequalities in health outcomes. This was in line with overall policy goal to act on cross-government and structural factors of health inequity.



2. Introduction

2. Introduction

2.1 National policy-learning case studies on reducing social inequity in health

In line with the recommendations of the WHO Global Commission on Social Determinants of Health (CSDH) report, *Closing the gap in a generation* (5) and the commitments made by global health leaders in endorsing World Health Assembly resolution WHA 62.14 on reducing inequities in health through action on the social determinants (6), the WHO European Office for Investment for Health and Development, Venice, Italy of the WHO Regional Office for Europe is organizing national policy-learning case studies in an effort to support the advancement of policy-relevant knowledge on tackling the social determinants of health and health inequity in the WHO European Region. The first three case studies have been carried out in Norway, Scotland and Slovenia and further studies are in progress. The aim of the case-studies is to synthesize relevant learning from the experiences of the countries in developing policy to deal with the social determinants of health and health inequity. The reports will analyse the roles and functions of the key stakeholders and the tools, methods and intelligence used at the different stages of the policy process, including: (i) agenda-setting; (ii) the generation and testing of policy options; (iii) implementation mechanisms and delivery systems; and (iv) approaches to monitoring and evaluating impact in the short and medium terms.

2.2 The Norwegian case

This report presents the Norwegian experience in implementing strategies to reduce socially determined health inequity, and the lessons learnt from this process. It describes how a series of factors and action taken over a period of time came together to create a window of opportunity that enabled the introduction of a comprehensive, intersectoral policy to tackle the social gradient in health. In this way, it seeks to provide a tool that allows reflection on progress to date, options for the future and the critical areas of learning that can be useful to and adapted by other countries in advancing their own national policies, strategies and capacity to reduce socially determined health inequity.



3. Frameworks used in analysing the Norwegian policy experience

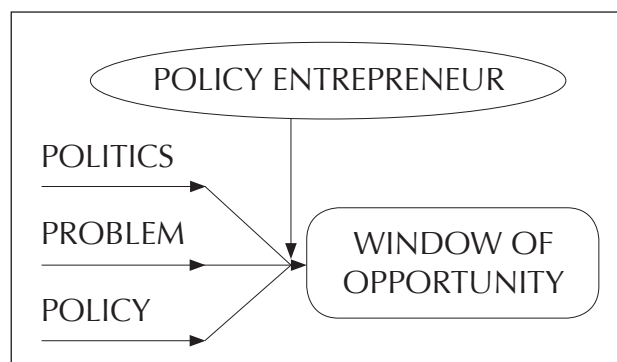
3. Frameworks used in analysing the Norwegian policy experience

This report draws upon some of the elements of the works of a number of policy scientists including J.W. Kingdon's *Multiple streams model of policy-making* (7) and M. Whitehead's action spectrum on inequalities in health (8). The CSDH conceptual framework (5) was also used as a reference point in discussing the development of social inequity.

3.1 Kingdon's model of policy-making

As one of the analytical frameworks, this model (7) is used to explain the Norwegian policy-making process. It focuses on the flow and timing of policy action taken along three streams: the problem stream, the policy stream and the political stream. These are largely independent throughout the process and each has its own dynamic and pace, though the actors in each can overlap. It is when the three streams converge, linking a compelling problem to a plausible, politically feasible solution, that a policy window opens.

Fig. 1. Model of policy-making



Source: based on an interpretation of Kingdon (7).

Policy entrepreneurs play a significant role in defining problems and connecting them with political agendas (7). Some, such as persons representing institutions or networks or individuals working within public policy-making, move among the different communities of practitioners involved in the policy development and implementation processes. Policy entrepreneurs are particularly important in the contexts of cross-sector and whole-of-government approaches, one of their key functions being to act as “translators”, i.e. to facilitate collaboration between the health and other sectors. They do so using a number of formal and informal approaches, such as policy scanning, policy mapping, informal discussions, etc.

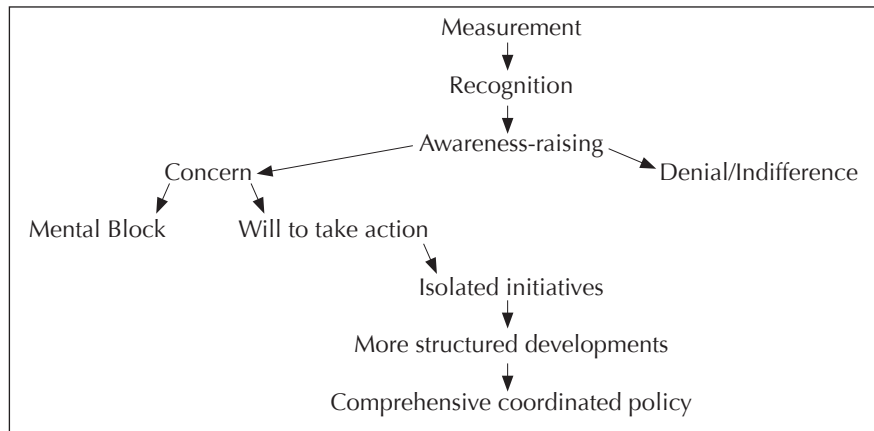
Policy entrepreneurs are leaders in government, academia or other sectors who “are willing to invest their resources in return for future policies they favour” (9). They can be people in the public eye, such as members of the political arena or formal lobby groups. In addition to these visible participants are those referred to as hidden participants, such as people working in research and academia, public servants and members of interest groups.

In Norway, the main policy entrepreneurs involved in the process of developing policy on social inequity in health were the Ministry of Health (Secretariat), the Directorate of Health (Resource Unit) and the Norwegian Expert Group on Health Inequity (Expert Group).

3.2 Whitehead’s action spectrum on equalities in health

This framework (Fig. 2) (8) gives a good insight into the process of diffusing research in the area of socioeconomic inequity in health and of creating a general awareness of the seriousness of this inequity and recognition of its momentum in political and policy arenas.

Fig. 2. Whitehead’s action spectrum on equalities in health



Source: Whitehead (8).

According to this model, policy development moves from the primordial stage, where socioeconomic inequity in health is not measured, to the stage at which inequity is recognized and there is an awareness of the health determinants involved and their consequences. The spectrum includes the following stages: measurement; recognition; awareness; denial/indifference; concern; will for action; isolated initiatives; and comprehensive coordinated policy.

Developing a comprehensive, coordinated policy to reduce social inequity in health implies developing a stand-alone policy to address the problem, ensuring the synergistic implementation of separate initiatives in this area (10).

These two frameworks are complementary and together support the identification and analysis of factors critical to developing and implementing policies to reduce social inequity in health drawing on the current and relevant experiences of the Member States of the WHO European Region.

3.3 Methodology

The Norwegian case builds on the stakeholders’ experiences in influencing the political agenda in the area of health equity. These experiences were captured through an analysis of relevant documents and through informal interviews and correspondence. A semi-structured questionnaire was used to guide the process.

The main author was contracted jointly by the WHO European Office for Investment for Health and Development, Venice, Italy of the WHO Regional Office for Europe and the Norwegian Directorate of Health. The co-authors represent these institutions.

The authors had internal access to policy documents available within the Directorate of Health that shed light on details that may have been difficult to discern through an external analysis. The portrayal of this information should be viewed as a narrative intended to benefit policy-makers in other countries.

The report has been reviewed by political and technical stakeholders dealing with health equity in Norway and through an international peer review.



4. The Norwegian context

4. The Norwegian context

4.1 Governance and policy development

Norway is located in northern Europe. In 2008, the population totalled 4.8 million (11). The country is a constitutional monarchy and has a parliamentary form of government, which operates at three interdependent levels: national, county and municipal. Administratively, Norway is divided into 19 counties and 435 municipalities. It is not a member of the European Union (EU).

Norway is a well-developed welfare state in which equity is an explicit political and cultural goal and, thus, the basis for including health inequity in the political agenda is in place. For example, the welfare arrangements are characterized by the principle of universalism, and social equity is promoted through a distributive social security system comprising a large public sector with extensive social transfer programmes, universal social policy programmes, commitment to full employment, income protection and a strong labour movement. These mechanisms were designed to safeguard egalitarian health outcomes and sustain political consensus in terms of ranking and priority (12). Norway has a high degree of gender equity within education, the labour market and political life. An even income distribution, especially post-tax and post-transfer disposable income, is an important feature of the welfare state model.

Although differences in income levels have tended to increase in recent decades (13,14), Norway has much lower poverty rates in comparison to countries where there is an emphasis on residual and targeted social policies (15).

Equity in society is the cornerstone of sustainable growth and development and does not equate with poor economic performance. Ensuring universalism in implementation may have provided the starting point for Norway's action on the social gradient in health and for scaling up an inter-sectoral approach.

4.2 Governance of health and health care: institutional roles and mechanisms

The Norwegian Parliament and the Government are responsible for specifying the objectives of the health sector and establishing its budgetary framework. The Ministry of Health has the overall responsibility for government policy on health and care services in Norway. It directs these services by means of comprehensive legislation and annual budgetary allocations (approximately NKR 110 billion in 2007), and through various governmental institutions. The Directorate of Health, which is subordinated to the Ministry of Health, is a professional body with administrative powers and legal authority in certain health areas. It contributes to the implementation of national health policies and serves as an advisory body to the central authorities, the municipalities, the regional health authorities and voluntary organizations. Responsibility for the public health services in Norway is divided between the municipalities and the state, the municipalities being responsible for all primary health services and the state for the specialized health services. The state has organized specialized health services in four regions. The regional health enterprises own the hospitals (4). The public health services are financed through taxation.

Health is a priority for the Government and for society. In 2007, 8.9% of the gross domestic product was spent on health care (16). Equal access to health services has been a long-standing core value for the provision of health services. Life expectancy in Norway is among the highest in the world. Diseases of the circulatory system and cancer are the primary cause of mortality. Pat-

terns of mortality show a clear social gradient that is somewhat more pronounced for men than for women (17). The social gradient for cancer mortality is growing and a persisting gradient is evident for circulatory diseases (18).



5. The Norwegian strategy on social inequity in health: brief overview

5. The Norwegian strategy on social inequity in health: brief overview

This section provides a brief summary on the Norwegian strategy on social inequity in health and is intended to orient the reader about the policy-learning process in the country. Later sections elaborate on the policy entrepreneurs involved, the mechanisms used, the key challenges, and the critical factors and areas related to policy learning.

In 2003, the Government announced in White Paper No. 16 (2002–2003) (p. 47) to Parliament (Storting) (2) that it is “an obligation for a democratic country to try to influence the conditions that create social inequity in health”. As reducing social inequity in health was acknowledged as a separate political objective, action was initiated in a few identified areas.

Following White Paper No. 16 (2002–2003) (2), the Directorate of Health established the Resource Unit on Social Inequities in Health (hereafter referred to as the Resource Unit). Its role was to coordinate the development of this policy area by collecting evidence and building competence. In 2005, based on a review of the international evidence on the determinants of health and health inequity, and in consultation with Norwegian researchers, the Directorate of Health presented an action plan entitled, *The challenge of the gradient* (3). The evidence review clearly supported the need for a strategy to inform action within and outside the health sector, taking a whole-of-government policy approach. The plan outlined the need to increase knowledge about social inequity in health, to develop concrete measures to reduce it and to create policy entry points. It did not include proposals for concrete action but was more of an agenda-setting document constituting the preparatory phase of a comprehensive strategy that needed deep commitment across various sectors.

In May 2005, on the same day that *The challenge of the gradient* (3) was published, the Norwegian Expert Group on Health Inequity (hereafter referred to as the Expert Group) was set up comprising leading scientists from complementary research fields. Its task was to inform the Government about the prevalence and causes of health inequity and suggest evidence-based interventions. The Directorate of Health became the formal meeting place of the Expert Group. In November 2005, it developed a set of principles to be adhered to in planning action to tackle social inequity in health. According to the Expert Group, strategies should be comprehensive, coordinated and based on a gradient approach.

In 2005, the newly elected Government started an intersectoral process that resulted in White Paper No. 20 (2006–2007) to Parliament, *National strategy to reduce social inequity in health* (4). The process, which was coordinated by the Ministry of Health, also involved the Ministry of Finance, the Ministry of Local Government and Regional Development, the Ministry of Labour and Social Inclusion, the Ministry of Children and Equity, the Ministry of Justice and the Police, the Ministry of Culture and Church Affairs and the Ministry of Education and Research.

The main approach of the strategy (4) is to combine universal measures and general welfare schemes with special measures to target the most vulnerable. The underpinning concept is “fair distribution is good public health policy”.

The strategy (4) operates in four priority areas and aims: to reduce social inequity that contrib-

utes to health inequity; to reduce behaviour-related health inequity and inequity in access to the health services; to target initiatives to promote social inclusion; and to develop knowledge and intersectoral tools. It has a ten-year perspective and includes initiatives to be implemented by the Ministry of Health and through the strategies and action plans of other ministries. The national and international milestones relevant to the development of the strategy (4) are listed in the Annex.



**6. Development prior to 2003 –
from low-level awareness to
growing recognition of the problem**

6. Development prior to 2003 – from low-level awareness to growing recognition of the problem

This section covers critical analysis and learning on:

- communicating the problem through country-specific information on the prevalence of health inequity and its main determinants;
- conceptualizing the problem through dialogue with research: a clearly defined problem has more chance of moving up on the agenda.

Recognizing that health inequity is a problem introduces the question of how to have it included in the political agenda and the challenge of finding the reasons for its existence.

J.W. Kingdon highlights that the success or failure of an issue, in terms of its political importance and policy relevance, depends on how it is defined or on, as he calls it, the problem formulation (7). Thus, only when the issue of social inequity is defined in a way that has political resonance will it rise on the political agenda and become eligible for political action (19). The complexity of reducing health inequity requires multisectoral action and political decision-making in terms of a government-owned agenda.

The Norwegian case is an example of a top-down government-owned policy process comprising a series of stages leading towards the recognition of social inequity in health as a political priority and reflecting the typology put forward by H. Graham in 2004 (20). This included the initial period when there was little or no political will or recognition followed by a period of increasing recognition of the gap in health outcomes and, finally, intersectoral recognition of the need to focus on reducing the socioeconomic gradient in health.

6.1 Period of little or no recognition of health inequity

Prior to 2003, when the objective of reducing social inequity in health was gradually being included in various strategies across Europe, Norway was lagging behind in terms of policy formulation and implementation in this area. It is particularly surprising that it took so long for the issue to gain prominence in Norway, a welfare state with a particular concern about equity. The trend may reflect the fact that, after the Second World War, there was consensus that Norway had attained a relatively equal society (1). Therefore, during a time when Norway was experiencing enormous improvement in public health, the generated research was focusing on the average levels of health, thus disguising the distribution of health status in the population. As a result, the problem was not recognized, public opinion remained silent and other stakeholders, such as labour unions and nongovernmental organizations (NGOs), did not raise the issue explicitly (21).

This lack of recognition may also be a reflection of the changes in political ideology throughout the 20th century. For example, Norwegian health politics was primarily dominated by judicial and redistribution policies. From the 1970s, there was at the same time a trend in mainstream politics and academia to push for individual responsibility for health, with growing public acceptance. Targets addressing individual behaviour and lifestyles from a health perspective were considered more manageable than targets dealing with the social, economic and structural factors that produce differential health (22). One consequence of this was an underestimation of the significance of the social and economic factors in relation to health. This lack of recognition of the social de-

terminants of health, combined with the belief that egalitarian policies were effective, meant that the focus of public health policy was limited to altering patterns of health behaviour.

As a result, formulation of the problem of health equity and the social determinants was poorly developed leading to a limited entry-point for policy in this area and a lack of agenda-setting initiatives (1). Perhaps more importantly, the situation reflected a lack of political will to intervene (21). Although, the phenomenon of social inequity in health was described as early as 1987 in a key Norwegian policy document, White Paper No. 41 (1987–1988), *Health policy towards the year 2000. National health plan* (23), it remained low priority in the political environment.

Throughout the 1990s, policy documents continuously described and commented on social inequity, but no comprehensive interventions were proposed. When discussed politically, the conception of the problem was mainly understood in terms of health gaps, regardless of political colour (24). As a result, suggested policies mainly concerned targeting individual risk, vulnerable groups and the health implications of poverty (25). Thus, the policy stream during the 1980s and 1990s reflects a budding awareness of the problem, the formulation of which had not yet matured to becoming an agenda-setting initiative (21).

In the 1990s, the comments of two ministers of health on the challenge of reducing health inequity reflected the development of the problem formulation:

- statement of minister of health, Gudmund Hernes, to Parliament on 30 April 1996: “The improvement of public health through preventive efforts is one of the largest success stories of the 20th century.....Disease prevention has to a large degree had an equalizing effect across the population as it has reached almost all social groups” (26);
- statement of minister of health, Dagfinn Høybråten, to Parliament on 10 May 1999: “A broad range of research has shown that health status follows a stairway pattern. The higher the social position, the lower the mortality, self-reported illness and consequences of diseases. We know now that there are social differences in the level of exposure to physical, psychosocial and material factors that may determine health negatively. Social differences in lifestyle patterns, e.g. diet, smoking, alcohol and physical exercise, also play a role” (27).

The statement made in 1996 conveys the conviction held publicly that Norway had attained an equal society. In a period of only three years, as a result of research and documentation, the problem formulation of health inequity in Norway started to develop towards recognition of a social gradient.

However, the problem was not clearly defined during the 1990s nor was it considered pressing enough to gain broad political support. Although attempts were made to explain the phenomenon, the social determinants of health/health inequity perspective had still not entered the mainstream political arena.

6.2 Policy entrepreneurs

The Norwegian case is very much the story of how the various stakeholders in and around the decision-making processes of policy-making worked towards creating mechanisms that would lead to the inclusion of health inequity in the political agenda during a time of political feasibility. They did so by demonstrating their recognition of the problem, developing alternative policy

options and linking policy and politics. These stakeholders are also referred to as policy entrepreneurs owing to their ability to move across different communities of practice, cross-fertilize ideas, create opportunities and entry points for influencing decisions, and use their legitimate role to formally and informally create conditions conducive to moving a particular issue from idea to action in the policy arena.

In the early stages, the stakeholders involved in raising awareness about social inequity in health were primarily researchers and civil servants within the Ministry of Health and the Directorate of Health. They played a significant role in framing the problem and giving it visibility in Norway. Researchers were important to problem formulation but they were initially faced with institutional obstacles as the research capacity was scattered among different Norwegian universities. Also, the many research institutions involved were approaching the problem from different fields of enquiry, such as medicine, sociology, health economics, etc. A few of the researchers gradually became political advocates by discussing input strategies with public civil servants. They did not, however, themselves have the means of putting the problem on the agenda. This changed, however, when the different stakeholders were able to form alliances and create a common forum.

6.3 Putting health inequity on the political agenda: recognition of the problem

The most influential factors and the breakthrough in problem recognition actually came from outside the country in the form of an article by J.P. Mackenbach published in *The Lancet* in 1997 (28). The article documented a relatively large health gap in Norway as compared to other European countries and battered Norway's stronghold conviction of being an equal society. Although some Norwegian researchers were strongly aware of the problem, the prevalence of health inequity in Norway still came as a surprise to actors both inside and outside the research community, where there was controversy about the article's exclusive reliance on relative measures. Researchers could even show that, using the same data but presenting inequity in absolute terms (absolute risk difference and absolute mortality levels), the levels of health inequity in Norway and Sweden were comparatively low (29). Nevertheless, the article functioned as a national wake-up call because the level of inequity was greater than expected. This had a profound impact on national self-esteem and might have created a sense of pressure to respond and preserve Norway's reputation as country free of inequity. It raised two important points: firstly the impact of international comparisons, particularly when the results conflict with a nation's view of itself; and, secondly, the importance of having the necessary data available to allow such comparisons to be made.

Although researchers had played a vital role in formulating and documenting the problem of health inequity up to this point, J.P. Mackenbach's article (28) legitimized furthering research efforts in this area. The Norwegian research environment responded accordingly. Towards the end of the 1990s, several European networks, conferences, research projects, etc., had a major influence on the Norwegian researchers, including the network financed by the European foundation called Social variations in health expectancy in Europe (1998–2002, approximately). During the 1990s, several medical journals, among them *The Scandinavian Journal of Public Health*, *Norwegian Epidemiology* and *The Journal of the Norwegian Medical Association*, published an increasing number of articles on health inequity, thus drawing the attention of the professional communities to the problem. This channel was explicitly used to call for standardized statistics on the prevalence and causes of health inequity. The large health gap documented in this period in Oslo, the capital of Norway (30) was an equally important factor in triggering attention and reaction. Therefore, applying research in the Norwegian context and continuously commenting on the problem through these forums may have generated the increased interest (21), which was

soon to attract attention at governmental level.

The new documentation of the problem made civil servants and politicians more aware of and receptive to the problem of health inequity. During the preparation of White Paper No. 16 (2002–2003) (2), one of the initiatives taken was to organize discussion seminars involving professionals, civil servants and national and international researchers. However, although these seminars were important, the researchers lacked a common forum and a common voice to inform policy options. A major consequence of this was seen in 2002 when researchers were invited to advise the Government on action to tackle health inequity. Without previous dialogue and a strong set of perspectives on the issue, they called for more research and stronger evidence. This represented a missed opportunity of the scientific community to shape the policy making process and is a commonly observed problem. As a result, it was largely left to the Ministry of Health and the Directorate of Health to identify a way to introduce the reduction of social inequity in health as a policy objective.

Representatives of the Ministry of Health and the Directorate of Health joined forces to discuss policy options and negotiate the inclusion of a section on health inequity in White Paper No. 16 (2002–2003) (2). This development coincided in timing with a meeting of the Government at which the Minister of Health signalled his openness to the objective (which he had addressed in Parliament in 1999) (27). More importantly, the Minister of Health represented a political programme with a focus on poverty and groups with particular care needs (31), a profile that fitted relatively well with the challenges related to health inequity. As a result, a short chapter on the reduction of social inequity in health was included in the White Paper (2) that was launched by the Government in 2003 and the issue was included among the public health policy objectives. These were:

- to ensure that measures aimed to improve lifestyle are assessed with respect to their impact on social inequity in health;
- to assess the impact of new interventions to reduce social inequity in health directed at socially or geographically vulnerable groups;
- to introduce health inequity concerns in health impact assessment;
- to establish a central resource unit to develop policy on social inequity in health;
- to develop an action plan to reduce social inequity in health, responsibility for which would be with the Directorate of Health.

White Paper No. 16 (2002–2003) stated that it is “an obligation for a democratic country to try to influence the conditions that create social inequity in health” (2). This statement was significant because it formally recognized the legitimacy of intervention by the state to create conditions conducive to equitable health. It specified that there had been a national discrepancy in the 1990s between the egalitarian values of the Nordic welfare state and the impact of policy, which had strategically drifted away from these values in terms of avoidable health inequity, such as that brought about by social position, circumstances and lack of opportunity. The violation of values and the resulting discrepancy between the expressed welfare state ideal and the status quo became an important determinant of problem formulation. This is important because one of the common challenges across Europe and globally in tackling social inequity in health is to strengthen coherence between policy values, evidence, policy strategies and programmes.

Although White Paper No. 16 (2002–2003) (2) did not place health equity high on the agenda, it was important in starting the process towards doing so. Particularly important was that it introduced a top-down oriented approach with specific emphasis on increasing knowledge to develop this policy area further. However, the increased legitimacy of the problem in Norway was not matched by structural and institutional mechanisms to generate and test policy options to sustain action to tackle the social determinants of health and health inequity. To generate such policies, it is necessary to have mechanisms in place to create synergy between the different (policy) institutions. At this point, the main focus was rather on tackling lifestyle determinants and poverty implications of health.

The lack of recognition of the 2003 White Paper (2) as an entry point for a social determinants of health/health inequity policy resulted in a missed opportunity to shape the problem and influence the mainstream strategy at this point. Similar situations have been observed in other countries within and outside Europe (32).

6.4 Key lesson

The issue of reducing social inequity in health was barely recognized on the political agenda in Norway prior to the release of White Paper No. 16 (2002–2003), *Prescription for a healthier Norway* (2), in which health equity was legitimized as a political priority area in a small chapter (2). In the initial phases of policy development, researchers were the main driving force in setting the agenda, identifying the problem, producing research and interacting with the central administration. The new documentation of the problem made it legitimate for the policy entrepreneurs within the Government to raise the objective further on the political agenda. At this point, the gap had not yet been bridged between research and policy, which was needed to achieve a comprehensive entry-point for intervention. However, although the policy entry-point of the 1990s still had a bearing, the 2003 White Paper (2) was particularly important in connection with initiating the process of increasing knowledge and developing this policy area further.

In 2003, the situation was similar to that described by Kingdon (7) where there was a partial link between the problem stream, the policy stream and the political stream. There can be situations where the link between the problem stream and the politics stream results in a call for action while there is no acceptable solution or policy entry-point, regardless of how pressing the objective is.

This is also in line with the action-spectrum theory developed by M. Whitehead (8), in that the policy process moved from the stages of “measurement”, “awareness-raising” and “indifference” in 2002 (1) to those of “concern” and “will-for-action” in 2003. However, reaching the stage of “concern” does not necessarily determine action and, without outlining the right strategic options, initial concern could have led to a collective mental block or, rather, the development of a few targeted initiatives along the lines of White Paper No. 16 (2002–2003), *Prescription for a healthier Norway* (2).



7. Development of a comprehensive strategy: 2003–2009

7. Development of a comprehensive strategy: 2003–2009

This section covers critical analysis and learning on:

- conceptualizing the problem;
- combining selective and universal measures to create entry points for policies related to the social determinants of health;
- carrying out a stakeholder analysis;
- making a communications plan;
- creating ownership and softening-up the process (critical for policy change).

7.1. Alternatives specification and policy options: bridging policy and research

Following White Paper No. 16 (2002–2003), *Prescription for a healthier Norway (2)*, the Directorate of Health was made responsible for developing a plan of action and was allocated Nkr 2 million to set up the Resource Unit on Social Inequity in Health. Compared to the funding of other public health programmes, these were limited financial resources. For example, in the Parliament's budget proposition no. 1 (2004–2005), the action plan for physical activity was granted over Nkr 12 million.

7.1.1 Resource Unit

The academic and professional backgrounds of the two persons appointed to the Resource Unit may have influenced the Norwegian process: one held a PhD the focus of which was the utilization of medical experts in policy processes, and the other, who was transferred from the Ministry of Health, had been involved in developing White Paper No. 16 (2002–2003) (2). Their skills in communication, pedagogy and networking and their academic legitimacy may have helped to drive the policy process forward in Norway and functioned as a bridge between the research and policy communities. Together with an official mandate, these factors were probably important for the success of the Resource Unit, allowing it to act as a policy entrepreneur and to communicate with other sectors of government on the connection between health and equity.

7.1.2 Plan of action: the challenge of the gradient

The first task of the Resource Unit was to outline a plan of action. Inspired by national and international evidence, it made the deliberate choice to push forward a policy proposal to address the social gradient in health and call for intersectoral action at ministerial level. The plan of action, entitled *The challenge of the gradient (3)* and published in 2005, illustrated that sufficient knowledge was already available for policy-makers to take action.

Acting as a policy entrepreneur, the Resource Unit took specific steps to set the political agenda. The requirement to develop a plan of action presented a challenge. Being an advisory body subordinated to the Ministry of Health, the Directorate of Health was not in a position to draw up

an intersectoral plan of action that would address the social determinants of health inequity. The organizational structure of the Directorate of Health consists of divisions that centre on lifestyle determinants and health services and its mandate does not include addressing the structural determinants of health. Therefore, the Resource Unit had to overcome internal barriers.

Although it may have been tempting for the Directorate to try to keep control of the whole strategy, this could have resulted in an action plan with limited authority and lifestyle-oriented initiatives. Determined to avoid this pitfall, the Resource Unit took on the task of creating the necessary conditions and mechanisms for establishing an intersectoral strategy anchored at top political level.

Thus, although White Paper 16 (2002–2003) (2) did not project policy development beyond the elaboration of the plan of action, the Government signalled this as the first phase of development towards a comprehensive national strategy to reduce social inequity in health. The following phase of development, i.e. formulation of the strategy, was passed to the Ministry of Health in 2006.

7.1.3 Action towards inclusion of social inequity in health in the agenda

In order to safeguard the new approach to addressing health inequity, it was necessary to do what Kingdon (7) labelled “softening up the system”. In the Norwegian context, this involved creating demand and ownership, and a willingness to adopt and implement a long-term strategy. To do so necessitated integrating the different policies, targets and action of the various sectors of government within a framework conducive to the social determinants of health/health inequity approach, and carrying out a stakeholder analysis to map out formal and informal authority and structures.

The Directorate of Health also made strategic efforts to introduce the social determinants of health/health inequity perspective at ministerial, county and municipal levels. Action was taken on many levels and efforts were made to involve as many sectors as possible. The Resource Unit took on a strong technical and political role in advocating for a smooth transition from a health-specific approach to an intersectoral effort.

One of the initial tasks of the Resource Unit was to overcome internal barriers in communicating the problem. In order to shift the focus to the social determinants of health, the Unit held internal seminars in the Directorate of Health on the challenge of health equity. The Director-General of Health followed up by stating “it is necessary to clean our own house first”. As a result, an equity check was introduced to guide the process of following professional advice. The close collaboration between the leadership and the Resource Unit was the key factor to its success.

Among the significant efforts made in 2005 to raise awareness and push the issue of social inequity in health to the top of the agenda in Norway was the publication by the Directorate of Health of the following documents and official policy briefs:

- *The challenge of the gradient* – plan of action of the Directorate of Health to reduce social inequity in health, published on 16 June 2005 (3);
- a Norwegian translation of WHO publication *Social determinants of health: the solid facts on social inequity in health*, published in cooperation with the Norwegian Healthy Cities Network on 23 June 2005;

- *Socioeconomic inequity in health – theories and explanations*, published on 30 August 2005;
- *Social inequity in health in Norway*, published on 19 December 2005;
- *Social inequity in health as part of health impact assessment*, published on 21 June 2006;
- *Utdanning og helseulikheter [Education and health inequity]*, published on 4 November 2008 in Norwegian only;
- *Principles of action to tackle social inequity in health*, published on 8 January 2009;
- *Likt for alle? Sosiale skilnader i bruk av helsetjenesten [Equity for all? Social differences in the use of health services]*, published on 19 August 2009 in Norwegian only.

Linked to these official documents was the media advocacy spearheaded by the Directorate of Health. An analysis was carried out to determine the phases in which media strategies could be beneficial.

They can be difficult to use in cases characterized by complex problems and complex solutions and, since the issue of social inequity in health falls into this category, steps were taken to ensure that the information submitted to present the problem would be comprehensible to the public. In addition, seminars were arranged for researchers and professionals in various fields.

Publishing articles in key Norwegian newspapers was the strategy most used in 2005 as an initiating process. The Secretary-General of the Norwegian Red Cross, Mr Jonas Gahr-Støre (who became Minister of Foreign Affairs the same year), responded in a newspaper article to the argument surrounding the point of view of refocusing health policy to include the social determinants of health, labelling it the most important input to the Norwegian health debate in 2005 (33). This marked the start of NGO participation in the drive for action to tackle social inequity in health in Norway.

7.2 Supportive mechanisms in agenda-setting

In the Parliament's budget proposition no. 1 (2004–2005), resources were allocated to set up the Expert Group on Social Inequity in Health. It was decided that the Group should be appointed by the Directorate of Health, which would allow it more independence than if it had been appointed directly by the Ministry of Health. Simultaneously, this signalled that the group was given less political influence.

In contrast to the earlier scattered structure of research advocates, the Expert Group was given a common arena for debate and concept development. It comprised nine experts from different disciplines and geographically diverse research institutions covering medicine, sociology and health economics. It was given a formal mandate from 2005 (Table 1) to provide the authorities with policy-relevant advice related to the prevalence and causes of social inequity in health. Despite seemingly strong differences in the theoretical approach to health inequity between, for example, selectionists and causationists, psychosocialists and materialists, etc., considerable common ground materialized. To experience this degree of commonality among different research communities was unusual and also one of the keys to success.

**Table 1. Mandate of the Norwegian Expert Group on Social Inequity in Health
January 2008 – December 2010**

1. The Expert Group on Social Inequity in Health is an independent knowledge and competence unit established by and administratively connected to the Directorate of Health.
2. The Expert Group will by mandate from the Directorate of Health or on its own initiative provide technical advice on:
 - (a) the prevalence of social inequity in health;
 - (b) the causes of social inequity in health;
 - (c) the consequences of social inequity in health; and
 - (d) relevant strategies and measures to reduce social inequity in health.
3. The Expert Group will work for a better understanding of social inequity in health in society and contribute to better communication between research communities, decision-makers and the population.
4. The Expert Group is composed of ten members who collectively will represent a broad competence regarding social inequity in health. The members, including the leader, are appointed by the Directorate of Health for a three-year period. Reappointments may occur.
5. Statements of the Expert Group will be made public unless it is pledged to professional secrecy.

Source: *Mandate of the Norwegian Expert Group on Social Inequity in Health*, Oslo, the Norwegian Directorate of Health, 2008.

As one of its first tasks, the Expert Group was requested by the Directorate to develop evidence-based principles of action indicating entry-points for policy interventions. These were elaborated along the lines of the principles outlined in Whitehead's document, *The concepts and principles for equity and health* (34), which the Resource Unit decided to adapt to the Norwegian context. Although the Expert Group comprised researchers from very different disciplines and institutions, and with different research traditions, the task proved to be very manageable and the resulting principles surprisingly substantial. The Expert Group identified six principles of action on which to base the development of a Norwegian strategy to tackle social inequity in health (Table 2).

The principles of action were important because, for the first time, leading scientists in Norway were speaking with one voice. The importance of this expert advice can hardly be overestimated because it created a strong argument and provided direction for outlining policy options to tackle social inequity in health.

The principles conveyed the key message that policies in this field should be comprehensive, coordinated and based on the fact that the challenge of social inequity in health is one of tackling the gradient. This argument was supported by growing national evidence on the prevalence and causes of health inequity. Analyses of Norwegian data by the Norwegian Public Health Institute showed a correlation among income, educational attainment (as measured by number of years of education) and mortality patterns in the country. In relative terms, they also indicated that there had not been a decline in social inequity but that it was persisting and, in some cases, increasing

(17,18). Thus, the significance of the social gradient in health in relation to health inequity was established. In addition, results indicated that the magnitude of health inequity in the Norwegian welfare state was not markedly lower than in other European countries, and that it could no longer be referred to exclusively as a health gap (3)

Table 2. Principles of action to tackle social inequity in health in Norway

1. It is a defined goal to reduce social inequity in health. It must be achieved without lowering the average level of health or the level of health of the higher economic groups. The targets for reducing inequity must be quantified and time limits for milestones defined.
2. Policies adopted to reduce social inequity in health must be evidence-based. The situation must be monitored, policies and measures must be evaluated, and health impact assessments carried out as a basis for important decisions to be made within and outside the health service. If existing knowledge is inadequate, only measures that are expected to have a positive effect, and very unlikely to have negative consequences, should be initiated. Such measures must be evaluated very thoroughly.
3. Strategies to reduce social inequity in health are anchored in “the gradient”. This means giving priority to universally oriented population strategies. It may also be necessary to initiate special, target-oriented measures aimed at disadvantaged groups.
4. To achieve the objective of reducing social inequity in health in the short term and in the long term, direct measures aimed at specific health problems should be combined with indirect measures aimed at minimizing the structural causes of health problems.
5. Strategies to reduce social inequity in health should be comprehensive and coordinated. This means combining a number of different public health perspectives and coordinating measures across social sectors and administrative levels.
6. A policy to reduce social inequity in health means attaching importance to reducing the unfortunate social consequences of disease and impaired health, such as loss of work, especially in occupational groups with lower socioeconomic status.

Source: Principles of action to tackle social inequity in health, Oslo, The Norwegian Directorate of Health, 2008.

The Expert Group became a progressively important resource for the Directorate of Health in building knowledge with a view to developing the national strategy to reduce social inequity in health (4). Apart from providing the important policy advice contained in the principles of action, the Expert Group published documents and newsletters reflecting the areas of their mandate on the web page of the Directorate of Health. It became the driving force in gathering international and national intelligence at national conferences at which the findings of the Group were presented. This increased attention to the issue and encouraged more research within the field. A positive side-effect to the work of the Expert Group that helped to shift policy focus and bring

about acceptance of solutions proposed was that it created interest and demand at the national forums and conferences at which it presented its findings.

The close alliance between the Resource Unit and the Expert Group was also important in a subtler way. The Expert Group was able to advance the strategy through what might be termed its “enlightening role”. It was involved in discussing a number of cases concerning social inequity in health, including those where no clear conclusion or outcome was expected. This was based on the fact that, although meetings with the Expert Group may not always be the right forum for decision-making, discussion with them could serve to inform the Resource Unit and strengthen its competence in raising the issue further. As it is, too many expert advisory groups seem to be geared towards making decisions, when what is really needed is enlightened argument. Therefore, during the Norwegian process, the threshold for involving expert groups was lowered, as was the pressure on them to arrive at firm conclusions.

This is in line with Kingdon’s (7) description of the need to create an arena in which experts or communities of specialists and practitioners can interact and cross-fertilize ideas. The forum created within the Directorate of Health functioned as a think tank on how to bridge research and policy and present scientific rationale in an area that might be considered very political. It was important to illustrate that the argument was based on both technical and theoretical points of view as this created a sense of ownership at both the political and the public sector levels.

Both the work carried out by Expert Group and the information derived from international experiences played a vital role in formulating coherent policy advice. One of the key aspects of preparing the strategy (4) was the review of international documents in developing policy and formulating action plans in the area of social inequity. WHO in particular had a much longer history of addressing the issue than Norway. When the Resource Unit was set up in 2004, however, the issue was not as high on the international agenda as it is today. The Resource Unit was inspired by documents, such as the *Declaration of Alma-Ata* (35), the WHO health for all policy (36), the *Black Report* (United Kingdom) (37), *Reducing inequalities in health: a European perspective* (a comprehensive review of the strategies of different European countries) (38) and the WHO Regional Office for Europe publication, *Social determinants of health. The solid facts* (39). These provided entry points for policy on health inequity in Norway. It was evident that preventive efforts should focus on the whole causal chain of inequity, with an emphasis on the social determinants of health.

When the WHO CSDH was launched in 2005, chaired by Professor M. Marmot, the Resource Unit became increasingly involved in international cooperation, particularly when one of the themes of the United Kingdom EU presidency was “Action on tackling health inequities”. These connections were immensely useful in many ways. The application of international experience makes for good arguments nationally; the Norwegian authorities were influenced by the fact that WHO and the United Kingdom had put health equity on the agenda.

WHO also provided a platform for Norway to address health inequity proactively at the international level. When Norway hosted the Tenth Futures Forum on steering towards equity in health in August 2006 (40), the Director-General of Health and Social Affairs, Dr Bjørn-Inge Larsen, who led the meeting, became an important advocate of putting social inequity in health on the agenda and of promoting the Norwegian strategy in this area. The Futures Forum programme provides a networking opportunity for health officials in 24 Member States of the WHO European Region through which to stimulate debate among policy-makers on emerging public health issues.

7.3 Modelling policy options

7.3.1 Intervention map

The framing and conceptualization of comprehensive, intersectoral strategies are of paramount importance if they are to be grasped. Therefore, the Resource Unit developed an intervention model (Table 3) to guide the policy process in a strategic direction. Upstream policies, such as macro-environmental policies and social justice policies, deal with the wider determinants of health present in society as a whole, while midstream policies focus on, among others, psychosocial factors, behavioural risk factors and risk conditions (38) and downstream interventions focus on the health system. Policy areas within each of these categories are exemplified in the map.

Table 3. Intervention map for comprehensive policies on reducing social inequity in health

Measures	Social reform upstream	Risk reduction midstream	Effect reduction downstream
Universal	Public system of education, taxes, labour market policies, etc.	Working and living environment, broad lifestyle measures, etc.	Health systems
Selective	Means-tested social benefits, etc.	Targeted lifestyle measures, etc.	Targeted health services

Source: Torgersen, Giæver & Stigen (41).

In Norway, the Resource Unit used this map to present the rationale for comprehensive policies and how it addresses the whole causal chain of health inequity by combining selective and universal policies. It clearly illustrates how to make the transition from selective and lifestyle-related targeting to an entry point for health policy based on the gradient (social determinants of health) approach, according to which attention is given to all of the areas mentioned in the six cells of Table 3. The implications of the gradient approach are further elaborated in Box 1.

7.3.2 Key lesson

According to Kingdon (7), the process of alternatives' specification narrows a wide range of possible items down to a selected few to be pushed for inclusion in the agenda. In order to move up on the agenda, a policy proposal is dependent on various factors, such as whether it reflects the values of society, has the necessary level of public and political support and is technically feasible.

During the first phase of policy development, which was anchored in the Directorate of Health, alternatives and proposals were generated for the next phase to be carried out at ministerial level. The documents, *Principles of action to tackle social inequity in health* and *The challenge of the gradient* (3), constituted an important premise for a comprehensive national strategy. Using ex-

pert advice in the policy-making process resulted in an increasing recognition of social inequity in health as a legitimate area for research and policy development.

Efforts were introduced to create broad ownership at government level and to communicate the problem to the public. The Directorate General of Health also became an advocate for tackling health inequity internationally. These developments influenced the process of softening up the system to accepting a new set of policy entry-points based on the social determinants of health/health equity approach that is critical to promoting policy change.

However, according to Kingdon (7), for a new policy to be implemented, the coming together of three factors is required: recognition of the problem, identification of policy options, and political support. While the first two of these were in place by the time the strategy was passed to the Ministry, the last-mentioned factor was still missing (41).

Box 1. The gradient approach

In the Norwegian context, the gradient approach distinguishes itself from a disadvantaged groups approach and a gap approach in several ways.

1. The gradient approach focuses on the upstream determinants of health inequity, such as income, education and work. When the gradient pattern is so apparent for risk factors like lifestyles, there are underlying social causes for this. Determinants of health that are unequally distributed over the socioeconomic scale are also important determinants of inequity in health.
2. The gradient approach implies a combination of broad universal measures with targeted high-risk strategies. An approach targeting only disadvantaged groups would not alter the distribution of health determinants across the whole socioeconomic scale.
3. Objectives need to capture the fact that social inequity in health forms a gradient throughout society. Therefore, it is important to base objectives and milestones not only on mortality and morbidity but also on the determinant. Targets based solely on mortality and morbidity tend to stimulate downstream action focusing too narrowly on individual lifestyle and health care services. Thus, they should be set with a view to tackling determinants, such as income inequity, poverty, inclusion in the work force, work environment, inequity in education, etc.
4. Measurement of the problem and assessment of progress need to be sophisticated and must combine various complementary measures. These include relative and absolute measures of inequity across socioeconomic groups and absolute levels within the different socioeconomic groups. In Norway, indicators of the socioeconomic distribution of the determinants are now under development in all policy areas of the national strategy.

7.4 Outlining policy options: Ministry of Health, 2006

By taking timely action and having, at the same time, a feasible policy proposal at hand, policy entrepreneurs can open windows of opportunity.

In 2005, a new government was elected on promises of fighting poverty and ensuring fair distribution of income and fair systems of education and health services.

The research and policy modelling already carried out to tackle health inequity were very much in line with the new Government's political mandate and priorities. Although reducing health inequity was not explicitly mentioned in the Declaration of Assent (42) nor had it been raised in the election campaign, the softening-up process at government level had paved the way for this particular problem to become a top political priority in accordance with the political focus on equity. The evidence-based expert advice and theoretical entry-point for policy formulation provided by the Directorate of Health, plus the demand that had been mobilized, were the essential components used by the Ministry of Health to create a window of opportunity and include the aspect of social inequity in health in the new governmental strategy.

The softening-up phase had also created receptivity to and a sense of ownership of the process both in the public sector and the political environment. This paved the way for the acceptance and support of the other ministries. However, there was no significant public pressure in this regard.

The Government decided to go straight into the process of developing the White Paper on the strategy to reduce social inequity in health (4). In January 2006, a cabinet decision to this end was the formal starting point of the process.

Earlier, when white papers on public health policies were developed for Parliament, they were preceded by professional investigations resulting in reports like, for example, the Acheson report (*Independent inquiry into inequalities in health*) (43). In this case, because of the work already done by the Directorate of Health, the ground had been prepared and the Ministry of Health was able to proceed without going through the time-consuming phase of setting up a committee.

As well as securing government involvement in developing policy, it was also important to engage NGOs. To this end, at a very early stage of the process, nine workshops were held in which more than 80 actors from NGOs, labour organizations, research institutions and regional and local authorities took part. The contributions of the various stakeholders were thus incorporated in the strategy from top political level. The workshops focused on various health determinants, such as: work and the working environment; social inclusion and social exclusion; health behaviour, health services and lifestyle; childhood and adolescent conditions and research and policy formulation (emphasizing the tools that support intersectoral action at the governmental, regional and local levels) and health impact assessment. They provided a better understanding of the challenges and the participants expressed a clear demand for action.

This whole-system concept has been used effectively in a wide range of disciplines across the public and private sectors for many years, particularly in relation to addressing complex strategic and social issues. The key features of this system include its ability to facilitate: (1) a better understanding of the different ways in which people perceive the problem, depending on their roles in the system; and (2) solutions to the problem both within and across organizational boundaries (44). NGOs play a significant role in such processes. Conversely it has been observed interna-

tionally that an increasing number of consumer rights groups tend to advocate for action on single issues. This is also true of professional groups working in the health sector and has been seen to hinder consensus-building. However, the engagement and advocacy of the NGOs at the beginning of the policy process in Norway provided strong support for a broad determinants approach. This can also be said of organizations that traditionally might be expected to promote a narrower, single-interest perspective.

7.5 White Paper No. 20 (2006–2007): national strategy to reduce social inequalities in health

The White Paper on the strategy (4) was developed over a 14-month period (January 2006 – February 2007) in cooperation with the Ministry of Finance, the Ministry of Local Government and Regional Development, the Ministry of Labour and Social Inclusion, the Ministry of Children and Equity, the Ministry of Justice and the Police, the Ministry of Culture and Church Affairs and the Ministry of Education and Research. It was presented to Parliament on 9 February 2007.

The primary objective of the strategy (4) is to reduce social inequity in health by levelling up. Its rationale that “equity is good public health policy” reflects the social determinants of health/health inequity perspective. It implies that public health policies need to aim for a more equal distribution of the positive factors that influence health, with a focus on interaction among upstream, midstream and downstream interventions. The overall strategy covers the following four priority areas, each of which has defined objectives.

1. Reduction of social inequity that contributes to health differences

This priority area is mainly concerned with income redistribution, childhood conditions and the working environment.

Objectives

- *To reduce economic inequity in the population, eliminate poverty and ensure basic economic security for everyone*, the Government will continue to work towards ensuring a tax system that promotes fairer income distribution in society.
- *To ensure equal opportunity for the development of all children, regardless of parental economy, education, ethnic identity and geographical affiliation*, the Government aims to create safe conditions for children in kindergartens and schools and high-quality services for children and young people across social divides.
- *To ensure a more inclusive work life and healthier working environments*, the Government will continue to invest in promoting a more inclusive labour market and take steps to ensure a healthier working environment in occupations associated with significant stress.

2. Reduction of social inequity in health behaviour and improvement in access to health services

Objectives

- *To reduce social inequity in health behaviour*, attention needs to be focused on the under-

lying and structural causes of health behaviour and on measures introduced to promote healthier choices. The Government will give greater priority to policy instruments that influence price and availability in an effort to prevent lifestyle diseases.

- *To provide equitable health and care services*, the Government aims to improve knowledge about social inequity in accessing health services and develop schemes to ensure equity in this respect.

3. Targeting efforts for social inclusion

Objective

- *To improve the conditions of life of the most disadvantaged*, user-oriented and specially adapted public services are necessary to ensure that everyone, regardless of background and circumstances, has equitable access to services. The Government will take steps to promote inclusion in the workplace and in schools and to adapt the health and social services as relevant.

4. Increasing knowledge and developing tools for intersectoral collaboration and planning

Objectives

- *To hold annual policy reviews*, the Government will establish a review and reporting system to monitor progress made in reducing social inequity in health.
- *To develop intersectoral tools*, there is a need to raise the awareness of decision-makers in all sectors and at all administrative levels about the distributional effects of processes, strategies and measures. Intersectoral tools, such as health impact assessments and social and land-use planning, are important policy instruments, along with stronger partnerships in public health and local competencies in the area of social inequity in health.
- *To advance knowledge about social inequity in health*, the Ministry of Health will strengthen research on social inequity in health and set up a monitoring system to track development in this area.

Although the targets in White Paper No. 20 (2006–2007) (4) are measurable, there was some discussion on whether or not they should be quantitative. Other countries, such as England, had used quantitative targets (e.g. “we shall reduce social inequalities in health by x per cent by the year y”) and the Expert Group recommended following suit in Norway. The main advantage of quantitative targets is that they are easily tracked and, in theory at least, more binding. On the other hand, working with social determinants is not a straightforward matter; it can take a very long time for the effects of interventions to show and, when they do, they can seldom be traced to a specific intervention. A policy that is successful in the long run might not show measurable results in the short run. Macro-economic developments may also be unpredictable, such as those that raise unemployment levels in a period of economic downturn caused partly by factors outside the control of the national politicians. For this reason, the Government chose to set defined objectives and to establish a reporting system, which would feed back into the policy. The intention was that if certain indicators did not improve over time, the policy would be adjusted.

The Intervention Map developed by the Directorate of Health illustrates how conceptualizing the

issue provided the other sectors with the health rationale for their own policies on social equity (Table 4). Using it as a guide in outlining White Paper No. 20 (2006–2007), *National strategy to reduce social inequalities in health* (4) provided policy entry-points. Priority areas no. 1–3 of the strategy are in line with the explicit priorities and measures indicated in each of the cells of the map. The map also shows the importance of creating synergies in implementing policies.

Table 4. Policy priorities in accordance with the Intervention Map

Measures	Social reform upstream	Risk reduction midstream	Effect reduction downstream
Universal	Education, taxes, labour market policies, housing 1	Working and living environment, Structural lifestyle measures	Universal health service 2
Selective	Means-tested social benefits 3	Targeted lifestyle measures	Targeted health services

Source: Torgersen, Gjaever & Stigen (41).

7.6 Institutional structures necessary for outlining and implementing intersectoral policy

In order to ensure intersectoral cooperation on and coordination of the process, the Minister of Health established a secretariat in the Department of Public Health of the Ministry of Health. Two of the four persons appointed to the secretariat were from the Resource Unit. Their technical expertise and experience and the political expertise of the representatives of the Ministry of Health were important in forming the strategy.

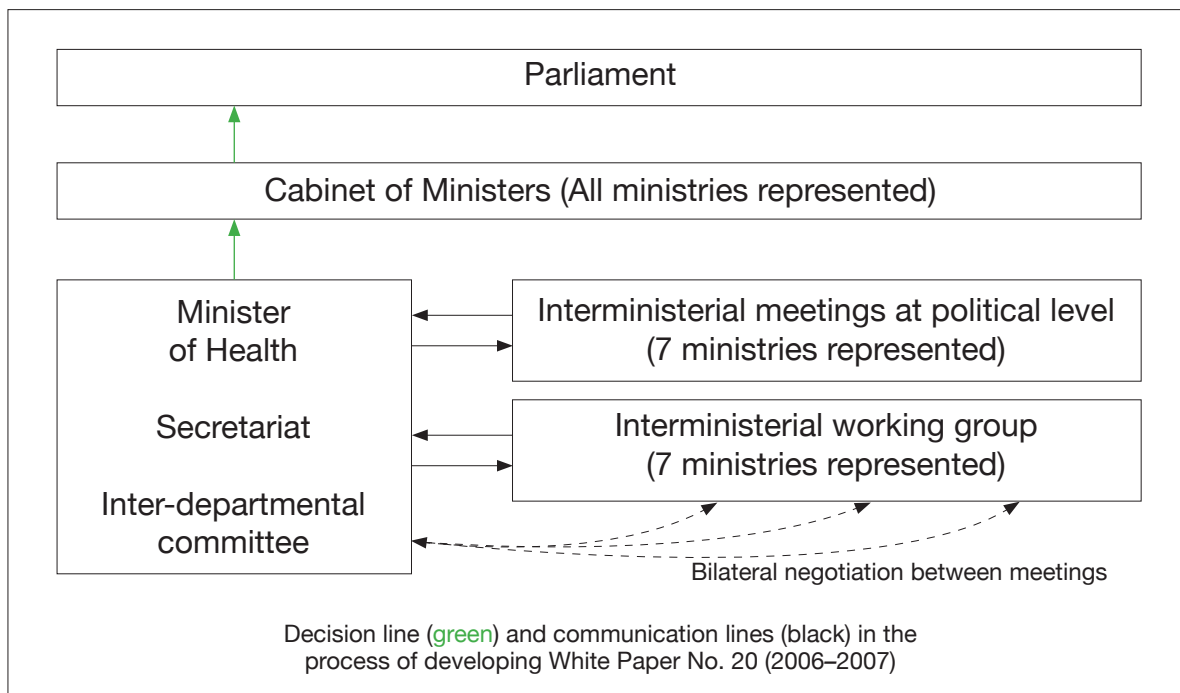
Creating an infrastructure for intersectoral collaboration presented a challenge. In order to create sustainable intersectoral action and interministerial collaboration, there was a need to strike a balance, on the one hand, between using and adapting the existing decision-making and organizational structures and, on the other, setting up additional mechanisms to address critical gaps and promote intersectoral action. All too often, systems of governance are established, which can unintentionally reinforce sector isolation and create what are frequently referred to as “vertical silos”. This works against policy coherence and joint delivery mechanisms that are crucial in tackling social inequity.

A common response in many countries is to establish intersectoral committees. The challenge, however, is to ensure that such committees are continuously anchored in the sectors represented. Otherwise there is a danger that they themselves become silos (4).

Taking these considerations into account, it was decided that the secretaries of state (politicians) of each of the seven ministries most closely involved in the process would meet regularly throughout the strategy development to discuss milestones and progress. The ministries represented were: the Ministry of Finance; the Ministry of Education and Research; the Ministry of Labour and Social Inclusion; the Ministry of Children and Equity; the Ministry of Justice and the Police; the Ministry of Local Government and Regional Development; and the Ministry of Health and Care Services.

In addition, a working group comprising representatives of the same ministries was set up to coordinate operations according to directions received from the political level. To support the work of this group, the Ministry of Health set up a committee comprising representatives of each department in the Ministry (Fig. 3).

Fig. 3. Interministerial collaboration on developing national strategy to reduce health inequity



Source: Norwegian Directorate of Health and Social Affairs (Torgersen and Giæver).

The political leadership was effective in mainstreaming a consistent equity policy across sectors and reflected broad political commitment to the process. A deliberate choice was made to base the process of developing the national strategy as far as possible on existing structures. The need for an upstream determinants perspective in working to reduce social inequity in health was recognized; however, the challenge was to reorient the fundamental areas of existing social policies (income distribution, inequity in education and work, etc.). To this end, rather than implementing initiatives in these areas through separate action plans with separate budget allocations, they were integrated in the national strategy and financed through the national budget. Allocating a budget explicitly for action to reduce social inequity in health could have undermined understanding of the need to reorient existing policies. The Expert Group, the Directorate of Health and the Department of Public Health of the Ministry of Health constituted the driving force behind the process of policy implementation (41).

The coordination team in the Ministry of Health was responsible for ensuring that health equity aspects were included in the policies of other sectors. This entailed close collaboration and careful navigation and, therefore, the composition of the group was important. What may have ensured its success was the combination of their skills in leadership, negotiation and communication, their complementary roles and their academic competencies. The team also hired a communications specialist to ensure that information for the public on the main challenges of the strategy was clear and precise.

Rather than insisting that all sectors take on the health perspective, the approach was framed so that the health and other sectors would work towards the common goal of social equity. The process was facilitated by the fact that there were several parallel programmes on equity in other sectors so that aligning the overall objectives of these programmes would allow for a common approach. Recognition by the health sector that social determinants are relevant to health was important but the approach taken here also demonstrated that the health sector appreciated the expertise of the other sectors and their achievements in improving equitable human development. In fact, the health sector was often slowest in accepting a social approach to health and well-being.

Interministerial collaboration created an “infrastructure” for the synergy of the different sectors. In the educational sector, there was an initiative to develop policies on reducing social inequity in learning. The Government launched White Paper No. 16 (2006–2007), *And nobody was left alone; early intervention for lifelong learning* (45), presenting a policy on making better use of education as a tool for reducing social inequity. The Ministry of Labour and Social Inclusion developed White Paper No. 9 (2006–2007), *Work, welfare and inclusion* (46). These documents introduce numerous measures for addressing the social determinants of health and health inequity. An important example is the Nkr 250 million qualification programme to benefit people with loose or no ties to the labour market introduced in the White Paper No. 9 (2006–2007) on work, welfare and inclusion (46), the rationale being that inclusion in the labour market positively affects economic welfare, social capital and health. Together, these three White Papers represent the Government’s comprehensive policy on reducing social inequity, promoting inclusion and combating poverty. In addition, the Ministry of Health has submitted white papers and action plans relating to health behaviour and the perspective of social determinants of health and health inequity.

7.6.1 Key lesson

In line with Kingdon (6), Norwegian experience shows the power of the bargaining process in achieving policy coherence that leads to development at political level. Aligning intersectoral mechanisms with other formal governance systems, such as national budget and standard regulation frameworks, was important in helping to keep the strategy on track and reduce strategic drift. Also, it was necessary to counteract sector isolation, frequently referred to as “vertical silos”. Allocating a budget explicitly for action to reduce social inequity in health could have undermined acceptance of the need to reorient existing policies. However, the approach was framed to allow the health and other sectors to work together towards the common goal of social equity. The policy stream was evidenced by the synthesis of the different processes in motion.

7.7 Specific outcomes of the policy process

In Norway, several important policies can be linked directly to the process of implementing the national strategy on social inequity (4). Some examples of action taken in its priority areas are outlined below.

7.7.1 Income

The redistribution of income through taxation has been strengthened through the National Budget. Income tax for those with low incomes has decreased, whereas it has increased for those with

high incomes resulting from savings and investments. The net level of tax revenues has been kept stable in order to support the social welfare system.

7.7.2 *Childhood conditions*

Full coverage of demand for kindergarten places (i.e. places for all applicants) by the end of 2007 was a national target. The upper limit on kindergarten fees was reduced by some 18% in 2006 and most municipalities have progressive, means-tested fee systems. Pilot projects have been established whereby preschool children (4–5-year-olds) in multi-ethnic or disadvantaged areas are given the opportunity to attend kindergarten free of charge at specified times during the week. Special attention is paid to preschool children with a low command of the Norwegian language.

All public education in Norway is free of charge up to and including the upper-secondary level but pupils at the secondary level have had to provide paper, books, etc., themselves. As of 2007, these are gradually being provided free of charge. Various efforts are being made to reduce secondary school drop-out rates and to provide help with homework. In addition, several projects targeting children from disadvantaged backgrounds have been introduced.

7.7.3 *Work and working environment*

In the National Budget for 2007, funding was considerably strengthened for labour market initiatives, particularly those aimed at people with loose or no ties to the labour market. Other groups targeted under this budget were immigrants and people with mental illness.

A new working environment act with stronger emphasis on requirements relating to systematic health, environmental and safety activities in enterprises took effect in 2006. Extended requirements regarding employer follow-up of employees on sick leave came into effect in March 2007. The mandatory employee health service scheme is under revision.

The establishment of the Norwegian Labour and Welfare Administration on 1 July 2006 led to one of the largest administrative reforms in recent times. The aims of the reform, which is still in progress (47), are:

- to have more people in work and useful activity, and fewer on benefits;
- to simplify procedures to meet the users' needs;
- to attain a uniform and efficient labour and welfare administration.

7.7.4 *Health behaviour*

The Ministry of Health has issued individual action plans for physical activity, nutrition, tobacco control and substance abuse.

The action plan for nutrition, *Recipe for a healthier diet*, in particular, was developed bearing in mind the content of the strategy to reduce social inequity in health (4). One of its two main targets is the reduction of social inequity in nutrition. An example of the direct impact of the strategy (4) is the gradual expansion of the programme on free fruit and vegetables in schools. Since August

2007, all children in grades 8–10 receive free fruit daily and in some deprived areas all children up to and including grade 10 are included in the free-fruit programme.

The action plan for physical activity, covering the period 2005–2009, includes 108 interventions to raise the level of physical activity in the population.

Norway has a longstanding tradition of restrictive alcohol policy, which limits consumption through availability and price. The renewed focus on health inequity has provided arguments for the maintenance of this policy in the face of international pressure to liberalize alcohol policies. Table 5 depicts the development of restrictive licence policies on sugary products.

Table 5. Licensing of sugary beverages in Norway

Year	2002	2003	2004	2005	2006	2007	2008	2009
NKkr per litre	1.52	1.55	1.58	1.58	1.61	1.64	1.68	2.71

Source: Norwegian Directorate of Customs and Excise, 2009.

7.7.5 Health services

The strategy to reduce social inequity in health (4) has generated a stronger focus on potential inequity in the health services and, as a result, the Ministry of Health is looking, for the first time, into the social distribution of health services in the country. In 2009, the Directorate of Health published a document on the accessibility and use of the health services. In addition, the mental health services, the school health services and the out-of-pocket payments system are receiving renewed attention.

7.7.6 Social inclusion of vulnerable groups

Funding for the national action plan to combat poverty were increased in the National Budget for 2007, as were initiatives aimed at the inclusion of immigrants and the rehabilitation of convicts. White Paper No. 31 (2006–2007) (48) deals with interventions to reduce geographically produced inequity within the Oslo region during the period 2007–2017.

Issues of implementation and the tools and mechanisms used are further elaborated in section 8.

7.7.7 Key lesson

A window of opportunity opens when the political, policy and problem streams merge. The changes made in the political administration in 2005, when the Government pledged to fight inequity, represent the movement of the political stream towards such a merge. At the same time, the policy stream was evolving as an intersectoral political strategy built on the evidence-based policy proposals prepared by the Directorate of Health (The challenge of the gradient (3) and the concepts and principles of action). Policy options were thus coupled to the problem. The policy entrepreneurs took advantage of a politically favourable moment to present the policy options as solutions. Once there was the political momentum, the long planning phase led to rapid implementation.

A comprehensive policy on social inequity in health means having a stand-alone policy that assures the coordinated implementation of the relevant initiatives of all sectors (10).

The pledge of the Government to tackle inequity provided the dynamic necessary for intersectoral collaboration without which some of the policies of the different sectors would have been implemented without reference to health equity. Linking the interventions resulting from intersectoral collaboration to the national strategy (4) illustrated the commitment of all sectors to evaluating and adjusting the strategy (4) according to the health equity targets.



8. Managing implementation

8. Managing implementation

This section covers critical analysis and learning on:

- establishing an infrastructure conducive to maintaining intersectoral collaboration beyond the policy formulation phase;
- measuring progress by creating a dynamic between short-term and long-term goals;
- maintaining social inequity in health on the political agenda.

There can be general commitment to health inequity issues across government without there being a formal mechanism to implement relevant policy (10). Therefore, it was important to establish a reporting system and formalize coordinated action. In Norway, prior to the publication of the White Paper No. 20 (2006–2007) on the national strategy to reduce social inequity in health (4), there were few mechanisms for dealing with health considerations in other sectors. Since its publication, measures to reduce healthy inequity have largely been linked to the follow-up of white papers and action plans related to other areas, which would otherwise have been implemented without reference to health equity. The strategy (4) defines the framework and direction of governmental and ministerial efforts to reduce social inequity in health up to 2017. It commits the work of the ministries with regard to:

- annual budgets;
- dialogue between management and subordinate agencies, regional health enterprises, etc.;
- legislation, regulations and other guidance;
- interministerial collaboration, organizational measures and policy tools.

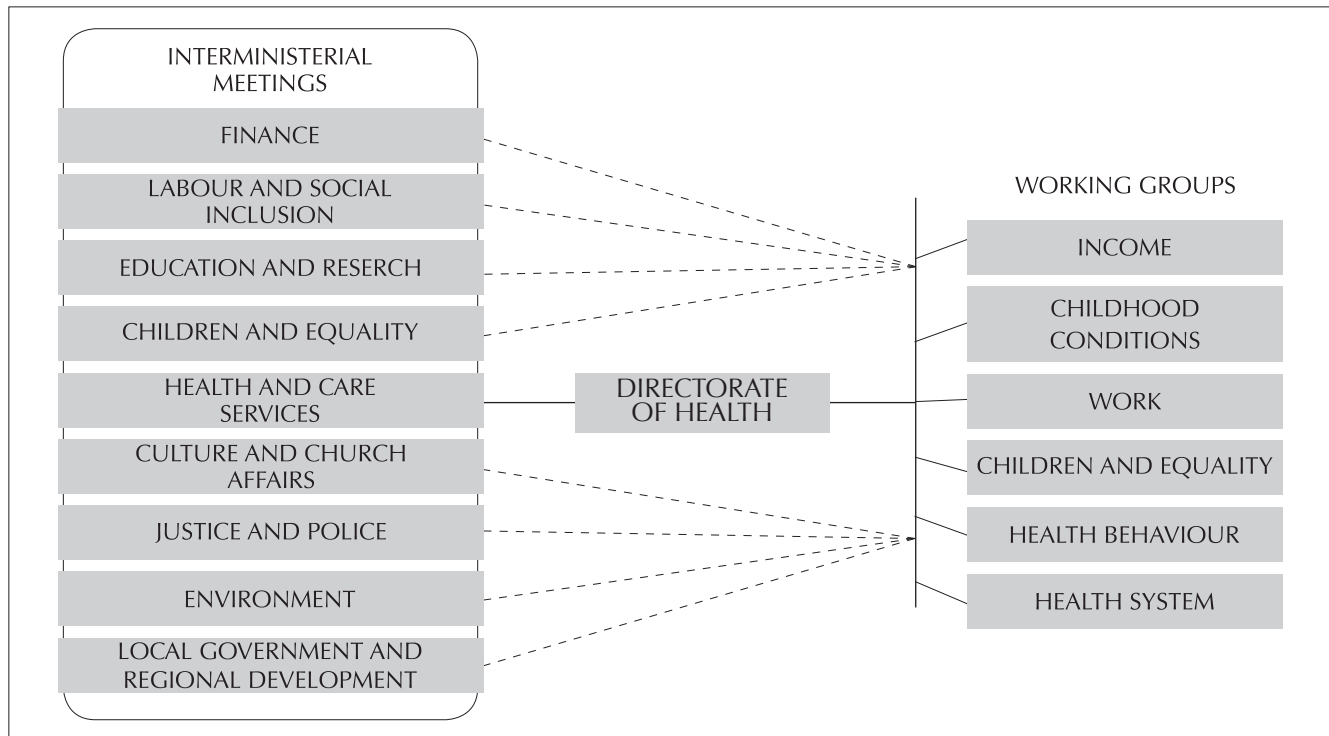
8.1 Horizontal mechanism

The main mechanism used to ensure intersectoral action to combat health inequity is the annual review and reporting system. Involving at least ten national ministries and directorates, this system provides a systematic, regularly updated overview of developments in the work being carried out to reduce social inequity in health. Annual reports prepared by the Directorate of Health are to be published each year from 2009 to 2017, which will keep social inequity in health on the political agenda in the years to come. They will present the main strategies, initiatives and goals for reducing social inequity in health at national level and the trend of each performance indicator that is developed. The reports will form the basis of the Ministry's annual report on intergovernmental work in this area that, in accordance with the strategy (4), is included in its annual budget proposal to Parliament.

Fig. 4 illustrates the annual review and reporting process. The Ministry of Health has overall responsibility for and plays an important role in securing and maintaining the commitment of the other ministries. Meetings involving nine ministries are held on a regular basis. There are six working groups covering the target areas presented in the strategy (4): income, childhood condi-

tions; work and work environment; health behaviour; health care services; and social inclusion.

Fig. 4. Annual review and reporting system



Source: Norwegian Directorate of Health, 2008.

The Directorate of Health was given the task of managing the review and reporting project, which included establishing and coordinating the system. It is responsible for the design and development of the indicators, which are carried out in close collaboration with the relevant ministries, directorates and professional bodies. In accordance with the project plan, a risk assessment was carried out. The risks identified included: insufficient engagement of the sectors involved; cooperation and coordination problems; insufficient resources; insufficient indicator data; changes in political priorities; lack of common concepts across sectors; staff turnover, and insufficient competence. Different ways of overcoming these challenges were discussed and the conclusion was that it was important:

1. to have a clear and indisputable mandate based on high-level support and direction (political and governmental);
2. to focus on the improvement and further development of relevant data and research bearing in mind that this requires a long-term perspective and economic resources;
3. to come to a common, intersectoral understanding of the essential concepts and principles of the social determinants of health and to define the link between these and inequity in health.

The goal of the Ministry of Health is to mainstream health equity concerns across all sectors and, therefore, it is necessary to create win-win situations in this context and in terms of identifying common goals. This is one reason why reporting will be carried out by the sectors themselves, rather than by an independent third party. However, this will unavoidably result in more subjec-

tive reporting. Promoting a public debate on the reports could be a way of avoiding this. The review and reporting exercise could prove to be an important mechanism for providing feedback on the effect of policies developed to reduce the social determinants of health and health inequity, and for identifying policies that have no impact.

In parallel to this system, a comprehensive system for monitoring the outcomes (mortality and morbidity) of social inequity in health is being further developed by the Norwegian Public Health Institute.

8.2 Vertical mechanisms

8.2.1 Public health partnerships in counties and municipalities

To support the counties and local municipalities in their efforts to reduce social inequity in health, the Government awards grants to those working in regional partnerships for public health. In each county, there are public health advisers to support such partnerships. The purpose of the scheme is to better systemize public health work at local level by ensuring stronger administrative and political support, and to make it more comprehensive by improving coordination between the authorities and the labour market, schools, voluntary organizations and others. Each partnership develops an intersectoral plan of action and there is a local coordinator in each of the participating municipalities. The Directorate of Health provides professional support and advice on health determinants, monitoring, health impact assessment, tools for use in health planning across sectors, etc. Evaluation is an ongoing process and there are indications that the partnership model has strengthened the preventive aspect of the public health work being carried out (49).

8.2.2 Health impact assessment

A future challenge is to incorporate and mainstream health impact assessment in national policies as an intersectoral tool. According to the instructions for official studies and reports (50), the impact of national health policies and strategies should be assessed. The implementation of intersectoral tools is systematically stimulated by the national authorities through resource allocation but their use is ultimately left to the discretion of regional and local government. As a result, assessment of the impact of health inequity on national policies is seldom carried out and needs further development. However, the new plan and building law, effective 1 July 2009, explicitly states that health development is determined by physical and social conditions, the environment and the economy, and that these determinants should be taken into consideration in all official planning exercises (51). As a result, the legal basis was developed for taking the impact of the social determinants of health into consideration in all health impact assessments.

8.3 Key lesson

The plans for a review and reporting system were approved by Parliament indicating broad political commitment to this initiative. Setting up an infrastructure for interministerial collaboration and institutionalizing the various processes through a reporting system, budget allocations and legislation, assures the continuity of social inequity in health as a political target. Nevertheless, there is always the danger that the situation might change with a change of government, regardless of its political ideology. One way to counter this danger is to ensure well-structured, intersectoral implementation. The report of the first annual review will be published in 2009.

As the review and reporting system is new, challenges to the process are yet to materialize. The system is intended to enable evaluation of the implementation of policies on reducing health inequity and, thus, to provide the opportunity of adjusting them for optimal impact.

The partnership model is evolving and showing promising intermediate results. However, further development is clearly needed with regard to mainstreaming health impact assessment across national and local policies. A promising development is presented in the new plan and building law (effective 1 July 2009) that provides the legal basis for also including the effects of the social determinants of health in health impact assessment.



9. Conclusions

9. Conclusions

Stewardship and non-linearity were the two most distinct features of the Norwegian policy-making process towards setting a political agenda to reduce health inequity. Stewardship by exerting influence through regulation and by collecting and using intelligence to identify issues and monitor and assess performance is the very essence of good governance (52). This encompasses defining the vision and direction of health policy where the government is the prime mover in ensuring coherence across departments and sectors.

The Resource Unit was very much the driving-force behind policy change in Norway. In bridging research and policy, it made explicit use of vision and intelligence to identify the challenges confronting the health sector and suggest evidence-based intervention options to meet them. Researchers were vital in identifying the problem but did not themselves have the means of putting it on the agenda. The recommendations of the Expert Group were thus important during the initial phase of policy-making, particularly those outlined in the concepts and principals of action. The action plan, *The challenge of the gradient* (3), contained evidence on the role of the gradient in health and the social determinants of health inequity and was, therefore, important in achieving a coherent formulation of the problem. During this phase of policy-making efforts were initiated to educate the public about health inequity and create alliances among civil servants. Stimulating cooperation with international bodies became increasingly important. The Ministry of Health facilitated intersectoral cooperation and introduced a reporting system to monitor and assess progress. The Government was the driving force behind intersectoral collaboration towards the goal of achieving equity in health.

The flow and timing of policy action is important and policy entrepreneurs need to handle this aspect carefully in order not to miss windows of opportunity that can open unpredictably and close rapidly. They created such a window by softening up the system and introducing evidence-based, politically feasible problem formulation regarding the social determinants of health and health inequity and by having their policy proposals to hand prior to the political shift. When the new Government came into power in 2005 with promises to fight inequity (not health inequity explicitly), the opportunity to link problem, proposals and politics presented itself. These three elements came together to form the basis of a coherent strategy and fighting health inequity became incorporated in the political agenda. The Government immediately started to work on White Paper No. 20 (2006–2007), *National strategy to reduce inequity in health* (4), launched in 2007. The Ministry of Health facilitated intersectoral cooperation and introduced a reporting system to monitor and assess progress. The Government was the driving force behind intersectoral collaboration towards the goal of achieving equity in health. The rapid implementation phase illustrates a non-linear process.

Using the action-spectrum (8) may not necessarily result in linear progress either and it is possible that countries do not go through all of its stages (37). In Norway, progress through the action spectrum might have gone from the “will-to-take-action” phase to the phase of “mental block”, and the plan of action elaborated by the Directorate of Health could well have comprised interventions based on limited targeted initiatives and lifestyle interventions, described by M. Whitehead as “isolated initiatives” (8). However, these pitfalls were avoided by reformulating the problem of health inequity as a “challenge of the gradient” demanding intersectoral action. In order to progress through the action spectrum (8), intersectoral cooperation is required in numerous areas to determine the policy implications and distributional effects of the different health determinants

and to tackle them simultaneously. Through interministerial negotiation, consensus was reached on coordinating the equity policies of the different sectors. As a result, a formal mechanism was established to create intersectoral commitment to health equity and implement relevant policy.

The review and reporting system makes it possible to monitor and assess the impact of new policy. Although this mechanism is now institutionalized, further policy development is clearly needed, for example, in connection with incorporating health inequity impact assessment in national policies. Norway may be in the process of moving from the stage of “more structured development” to that of having a comprehensive, coordinated policy on social inequity in health. Since the publication of White Paper No. 20 (2006–2007) (4), measures to reduce social inequity in health have largely been linked to those of other ministries in following up white papers and action plans related to different determinants’ areas in line with the health equity targets. These would otherwise have been implemented without reference to equity in health. The collaborative implementation of a stand-alone equity policy in other policy areas is a vital element of policy development and a necessary component for introducing a comprehensive coordinated policy according to Whitehead’s model (8). The reporting system enables an evaluation of implementation.

Finally, fighting inequity in the midst of a global recession presents certain challenges. How macroeconomic trends will influence the further development of national policy on equity (32) and the prevailing values related to policy development is difficult to predict. However, many people have emphasized the opportunity created by the recession to stimulate and strengthen global cooperation on tackling larger issues, such as health inequity, poverty and climate change. The Norwegian case may provide an input to the global debate on how to tackle such issues. At the WHO meeting on health in times of global economic crisis, held in Oslo on 1–2 April 2009, the Norwegian Minister of Foreign Affairs, Mr Jonas Gahr Støre, expressed the need to reorient health policy and base it on an intersectoral approach:

The crisis began as a financial crisis, which has moved to the real economy, the political world and now to real life. As the architecture of international cooperation is redefined, the links between health, poverty, development and security call for health to break out of its box. Prime ministers, foreign ministers, finance ministers – we are all in a sense health ministers (53).



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Annex

Annex

National and international milestones relevant to the development of the Norwegian strategy to reduce inequity in health

Area	Date	Milestone
Problem recognition	1978	Declaration of Alma-Ata (WHO)
	1980	The Black report (United Kingdom)
	1986	The Ottawa Charter (WHO)
	1987–1988	<i>White Paper No. 41 (1987–1988)</i> – Health policy towards the year 2000. National health plan
	1992–1993	<i>White Paper No. 37 (1992–1993)</i> – Challenges in health promotion and disease prevention Statement of the Minister of Health (G. Hernes) to Parliament
	1997	Article by J.P. Mackenback – Socioeconomic inequalities in morbidity and mortality in western Europe published in <i>The Lancet</i>
	1998	Report of Sir Donald Acheson – <i>Independent inquiry into inequalities in health</i> (United Kingdom)
	1998	Adoption of WHO health for all targets
	1999	Statement of Minister of Health (D. Høibråten) to Parliament
Alternatives specification	2002	Espen Dahl: <i>Health inequalities and health policy. The Norwegian case</i> , stating Norway is a laggard in terms of policy formulation and interventions
	2002–2003	<i>White Paper No.16 (2002–2003)</i> – Prescriptions for a healthier Norway
	2003	Proposition No. 1 from the Ministry of Health to Parliament. The Directorate of Health and Social Affairs was allocated the responsibility of establishing a resource centre on social inequity in health and was allocated Nkr 2 million for this purpose

Area	Date	Milestone
Alternatives specification (continued)	2004–2006	First phase of policy development (Norwegian Directorate of Health and Social Affairs)
	2004	Establishment of the Norwegian Resource Centre on social inequity in health in the Norwegian Directorate of Health and Social Affairs
	2005	Launch of the action plan of the Norwegian Directorate of Health and Social Affairs, <i>The Challenge of the Gradient</i>
	2005	Establishment of the Norwegian Scientific Expert Group
	2005	Launch of the Commission on Social Determinants of Health
	2005	Expert, evidence-based advice, <i>Principles for action to tackle social inequalities in health</i> , provided to policy-makers
	2005	Participation of Norwegian Director General (Bjørn-Inge Larsen) in the Tenth WHO Futures Forum where health inequity was one of main topics
	2005	“Tackling health inequalities” was theme of United Kingdom EU presidency summit (October 2005)
	2005	Norwegian Government decision to develop a national strategy to reduce social inequity in health
Modelling policy	2006	Cabinet decision to present the strategy as a White Paper to Parliament (January 2006) (second phase of policy development)
	2006	Secretariat of four persons established by Minister of Health in the Department of Public Health of the Ministry of Health to coordinate the interministerial process
Implementation	2007	White Paper No. 20 (2006–2007) to Parliament: launch of national strategy to reduce social inequity in health

Area	Date	Milestone
Implementation (continued)	2007	WHO European Forum on Tackling Socially-determined Health Inequities – Learning from Countries’ Experiences to Date – within the framework of the Commission on Social Determinants of Health (CSDH), London, England, March 2007
	2008	Mandate of the Expert Group extended for a three-year period
	2008	Release by CSDH of report, <i>Closing the gap in a generation</i>
	2008	Establishment of a Norwegian reporting and monitoring system on social inequity in health
	2009	First report on the reporting and monitoring system (due in 2009)



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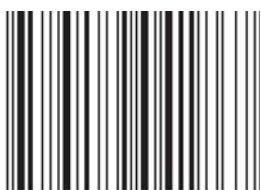
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