KØBENHAVNS UNIVERSITET
DET SUNDHEDSVIDENSKABELIGE FAKULTET

Tackling Health Inequalities Locally:

the Scandinavian Experience

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Foreword: why this report?

The Scandinavian countries and their welfare policies have long been known for their ability to reduce income inequality while boosting economic growth. Recent research from OECD has indicated that the Scandinavian countries are indeed examples of a more general positive relationship between equality and growth (64). Health equity has been an explicit political goal in Scandinavia for decades. Nevertheless, in the health domain, average improvement has not been followed by reduced inequality – at least not between socio-economic groups. It has in other words turned out to be a challenge of translating small inequalities in wealth into small inequalities in health.

Denmark, Norway and Sweden all have legislation that in different ways offers local governments key roles in public health. This is partly due to local governments' responsibility for many policy areas of great relevance to health and health equity. National governments have thus largely made the WHO and EU recommendation of 'Health in All Policies' a local responsibility.

In his analysis for the Nordic Council of Ministers, former Swedish Minister of Health Bo Könberg identifies tackling health inequalities as one of 14 prioritised areas for future Nordic collaboration on health (94). The fact that all of the Nordic countries share this growing problem as well as a political ambition to deal with it brought the issue onto Könberg's list. The Nordic Council of Ministers also recently listed the sustainability of the Nordic welfare state model, including its health policy, as an area of Nordic collaboration (104).

However, realising the principle of health (equity) in all policies is no simple matter. The national authorities and local government federations in Denmark, Norway and Sweden have therefore initiated various activities to support local governments in this process. One has been to ask the Department of Public Health at the University of Copenhagen to undertake an explorative study on what we can learn from experiences so far in regions and municipalities in the three countries. Political, professional, and organisational issues are all relevant here.

Can we identify obstacles to and means of promoting the involvement of local policymakers within education, social care, labour market, environment etc. in a coordinated effort to tackle health inequalities in a Scandinavian context?

The present report is the result of this study. It is based on three sources:

1. Interviews with policymakers (administrators and politicians) within healthcare administrations, childhood/education, and labour market administrations from September 2014 to March 2015*.
2. Textual analysis of available policy documents from regions and municipalities.
3. Meetings with an expert group** of individuals from the three countries, who possess considerable experience of research and/or policymaking within the area.

It is important to emphasise that because we have only been able to include a small number of municipalities, our results must be regarded as exploratory and not representative. The conclusions do not represent the positions of any of the involved authorities or experts but of the authors alone.

The study was commissioned by:
Danish Health and Medicines Authority *(www.sundhedsstyrelsen.dk)*
Norwegian Directorate of Health *(www.helsedirektoratet.no)*
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Local Government Denmark *(www.kl.dk)*
Local Government Organisation of Norway *(www.ks.no)*
Swedish Association of Local Authorities and Regions *(www.skl.se)*

* The municipalities have been selected by the national authorities to represent those, both large and small, which have experience in developing intersectoral policies to tackle health inequalities.
Denmark: Copenhagen, Ishøj, and Vordingborg
Norway: Innherred Samkommune, Fredrikstad, and Kristiansand.
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Background: from WHO manifestos to municipal practice

Good health is highly valued in its own right by both individuals and societies. It increases people's freedom to live the lives they value, while poor health limits these possibilities (1). Scandinavian societies have a tradition of not only helping their most marginalised citizens but also of taking shared responsibility for preventing the negative effects of a socioeconomic development that generates wealth and health for many but poverty and poor health for some (2). Seen in this light, it is unsurprising that systematic and persistent social inequality in health has attracted significant political awareness and raised demands for action. But even if the reasons for acting have long been obvious, health inequality has proved to be a difficult policy challenge to tackle. The causes and mechanisms have turned out to be complicated, and the necessary actions must involve numerous sectors in a way that our societies have had difficulty managing. In addition, the subject might raise politically controversial issues.

Throughout most of the 20th Century, there was a widespread belief that making healthcare accessible for all would solve the problem with health inequality. But the WHO Alma Ata declaration in 1978 and the British Black Report in health inequalities in 1980 called for *"comprehensive health strategies that not only provide health services but also address the underlying social economic and political causes of poor health"* (3). The emerging facts showed, however, that the Scandinavian welfare states, which during the second half of the century had achieved high living standards and small socioeconomic

inequalities, had only managed to reduce health inequalities to a limited extent over this period. This triggered extensive research into understanding what was called *"the Scandinavian welfare paradox of health"* (4).[1]

Growing social inequalities in mental health, diabetes, health related dropout from schools and the labour market, as well as functional decline among elderly illustrate that social inequalities are constantly reproduced in new forms with new causes. Even if the underlying mechanisms and fundamental causes of health inequalities might be the same, the challenges of developing new policies *and of implementing them* are growing.

Health equity in all policies: transforming the insights from WHO to local governments

There was an intellectual understanding of the core problem already in 1978: Health development and the burden of disease are caused by factors outside the control of health services. The health system ends up 'owning' the health effects without being able to address the causes, as the answers are neither medical nor clinical but instead social and environmental (6). The process of bringing this insight from WHO's intellectual discussions into every day politics in small Scandinavian municipalities has been a long one. It has, moreover, followed quite different pathways in Denmark, Norway, and Sweden. These differences are important for understanding today's local health policy practice and implementation.

National healthcare plans were a Scandinavian tradition, but broader health policy plans were not. This changed in the 1980s. Much inspiration came from the regional WHO office in Copenhagen's launch of its Health for All Strategy in 1980 and its 38 Health for All Targets in 1984. Sweden produced a national plan for the 1990s already in 1984 (SOU 1984:39, Prop 1984/85:181). In this plan, both health inequalities and multisectoral aspects where brought onto the agenda. These priorities were also clearly laid out in a report (in which Sweden had a significant impact), Intersectoral Action for Health (7), delivered to the World Health Assembly 1986. Norway highlighted the inequality issue in a national health policy plan in 1987 (Meld.St.41:1987-88) but focused at that stage entirely on health services. Denmark produced a multisectoral prevention plan in 1989, involving 12 different ministries in the process, which was an innovation at the time.

All of these documents were produced in a process involving only a narrow circle of people in ministries and national authorities (8). Sweden changed that in 1995 with its Public Health Commission. This commission was not only given the time and resources to involve a much broader spectrum of stakeholders from Swedish society but also emphasised the involvement of academia, regions, municipalities, NGOs, etc. in a process in which preliminary proposals were subject to broad discussion (9). It formulated policy proposals and targets for 11 determinants, which were later approved by parliament (SOU 2000:97, Prop 2002/03:35). Yet the proposal for a specific public health law with local and multisectoral responsibilities did not advance further in the political process. That step was, however, taken ten years later by the Norwegian government (10) (Meld.St.34:2012-13), which by that point had also made levelling up the social gradient in health a clear political priority (Meld.St.20:2007-08).

Although it is much more detailed in the Norwegian legislation, all three countries have placed a heavy responsibility for public health on the municipalities. It is important to understand that the policy development in recent years in all three countries has been strongly inspired by the WHO Reviews on Social Determinants of Health (12, 13). As recommended by WHA (62:14), national reviews have been made, or are underway, in all three countries (14, 15).

The political processes in the three Scandinavian countries have been quite different although many ideas and principles have been shared. This has created different backgrounds for understanding how local governments today implement health equity in all policies (HEiAP). Sweden started 30 years ago with strong involvement of local and regional political levels, combined with central support from its National Institute of Public Health. Over a ten-year period, Norway has created firm legal and political frameworks for the local HEiAP process, with strong support from national authorities.

1 With today's knowledge about the health effects of a changing social patterning of tobacco smoking, the development of mortality might actually not be so paradoxical.

In Denmark, national authorities laid out guidelines for HEiAP five years ago (16). Denmark has experienced growing local political interest, but the national political commitment has been relatively weaker than in Norway and Sweden.

LOCAL GOVERNMENTS AND HEALTH LAWS IN SCANDINAVIA

All three countries have two levels of local government: municipalities and regions/counties. In Denmark, there are five regions and 98 municipalities. Norway has 19 counties and 428 municipalities. Sweden has 20 counties/regions and 290 municipalities. In Norway 76% of the municipalities have fewer than 10,000 inhabitants, compared to 25% in Sweden and 4% in Denmark.

In *Norway,* the municipalities are responsible for primary healthcare, and since 2012 a public health law (*Folkehelseloven* 2012) has specified that the municipality "shall promote population health, and good social and environmental conditions, and contribute to the prevention of mental and somatic disorders, injuries, and suffering as well as contribute to the reduction of social inequalities in health." Every four years, municipalities must make an overall plan in which "the population's health and the positive and negative factors that might influence this shall be included as a basis for work on the municipaliity's planning strategy." *Samhandlingsreformen* (2012) is designed to promote closer integration between different sections of primary care.

The *Norwegian* counties previously (1969-2002) possessed responsibility for secondary care and hospitals, but this has now moved to the national level. Counties are required to support municipalities in their overall planning for sustainable community development but also have certain controlling functions. National authorities must support municipalities with data on local health conditions and knowledge about effective interventions and policies.

In *Denmark,* new legislation in 2007 *(Sundhedsloven 2007*) moved responsibility for public health prevention and health promotion from counties to municipalities in order to achieve better integration with other local social and educational services. The legal formulation is that *"the municipalities are responsible for creating environments that promote healthy lifestyles and for establishing preventive services to the citizens."* Danish counties were merged into five larger regions with responsibility for hospitals and primary healthcare. The regions and municipalities make agreements every four year on collaboration, including the regions' support to municipalities with regard to the local health data from surveys and registries. National authorities support municipalities with knowledge on effective interventions.

In *Sweden,* the healthcare law (*Hälso- och sjukvårdslagen* 1982) states that counties must offer healthcare to their citizens, including both primary and secondary care. The law states that "Healthcare aims for good health and care on equal terms for the entire population." In 2014, a paragraph was added that states that "healthcare shall aim to prevent ill health." A municipality must, according to law (*Kommunallagen* 1995), *"promote welfare of its citizens."* Welfare implicitly includes public health. National authorities and the Swedish Association of Local Authorities and Regions provide extensive support in terms of epidemiological data and knowledge concerning health impact assessments and effective interventions to both counties and municipalities. They have also recently initiated a network with counties and municipalities, promoting policies for social sustainability and health equity.

The health legislation in all of the countries is formulated not in terms of citizens' rights rather in terms of obligations on the part of municipalities and counties. The legislation likewise provides national authorities with rights to inspect the clinical healthcare activities and to intervene with sanctions when this is not performed in accordance with certain standards. However, the content of public health prevention and health promotion is subject to very few standards and very limited control and regulation.

Pursuing health in all policies is based primarily on a large number of laws regulating all policy areas of public health relevance, such as care for children and the elderly, education, environment, agriculture, labour market, consumption, and physical planning. Concern for health is more often implicit than explicit in this legislation.

A DUAL ROLE: IMPLEMENTING CENTRAL POLICIES AND PROMOTING LOCAL PARTICIPATION

The Scandinavian context represents a specific challenge due to its decentralised governance structure, in which municipalities represent more than just an arena for implementing central policy goals. The municipalities also represent independent local democratic arenas in which it is decided how to use national and local revenues in accordance with local preferences and needs (17,18).

This dual role means that local municipalities must be efficient from a functionalist perspective, delivering services responsive to both local demands and central policy goals. At the same time, they are a forum for citizen integration and participation in the local community. Both aspects are central to developing policies for health equity. This process requires both high levels of professionalism and a high degree of participation since health policies involve so many changes among citizens and other local private and commercial actors.

Health policy governance: development in a three-wave process

It is illustrative to compare developments in the three countries with Ilona Kickbush's description of the development of health in all policies as a three-wave process (5). This began in the 1980s with the first wave of intersectoral action for health, encouraging the health sector to look beyond its responsibility for providing medical care and consider how to deal with the actual causes of population health. Health policy in Sweden in this period provides an early example. Healthcare services were encouraged to develop methods for collecting and mediating information that could help promote health in other policy areas (Prop. 1981/82:97).

These ideas were reinforced in the second wave, starting with the Ottawa Charter's call for healthy public policy. This considered policy changes in all sectors to bring about improvements in health and health equity. The emphasis in the Ottawa Charter on strengthening community action was, for example, clearly expressed in 1988 in Norway. Here the legislation on 'environmental health' was introduced in the municipal healthcare act. The legislation stated that the local health services should contribute by ensuring consideration was also given to health consequences of public policies in other sectors (69). Particular emphasis was placed on modern health problems, including the psychosocial environment, and the co-responsibility of all sectors for public health was highlighted.

Finally, there was the third wave, with today's notion of health in all policies. This wave takes a different perspective by changing the focus from analysing the role different sectors can play for public health, to regarding population health and health equity as central to sustainable community social development. It seeks to address health challenges through an integrated policy response across portfolio boundaries. "Health is no longer in the centre but, by incorporating a concern with health impacts into the policy development process of all sectors and agencies, it raises the importance of health status. It allows governments to address the key determinants of health in a more systematic manner as well as taking into account the benefit of improved population health for the goals of other sectors" (5). This is a perspective of health for all policies. The increasing tendency for Swedish municipalities to regard health equity as a precondition for socially sustainable development (20) is an example of this. This last perspective was set forth in Sweden 15 years ago (9) and has now found its way to the regional and local levels, with detailed local applications (19, 20, 46).

Governing health equity: why is it so difficult?

It is worth noting that 30 years of discussions concerning the health-equity-in-all-policy agenda has gradually developed its understanding of health governance. There are still challenges, however, in actually gaining insight into its local implementation (21). The problem is threefold:

First, our understanding of the engines that shape the distribution of the social determinants of health may be poorly understood. Changing the social determinants at the national and local levels can be an uphill battle when the larger dynamics of

social determination operate in the opposite direction (22). The effects of globalisation on a range of social determinants might be such a dynamic process as to render national and local policies acting upon specific local determinants less efficient. In Denmark, for example, tobacco and alcohol are important determinants mediating the effect of social position on health. However, strong commercial interests are linked to the consumption of tobacco and alcohol as well as dietary patterns. In these areas, where international collaboration is important, commercial forces act strongly on the EU level, limiting the range of effective policies on the national and local levels.

For 20 years, economic inequalities have been growing in the Scandinavian countries, partly because of deliberate policies. Social segregation in housing and educational institutions, inequities in healthcare, and social consequences of illness are also growing, particularly in Sweden (71, 72). If the balance between market forces and equity-oriented policies is altered, the effect of local policies will be changed as well.

Second, our understanding of effective interventions and policies remains limited. This is not made easier by the fact that the Scandinavian welfare states have long regulated several social determinants of health in a manner assumed to reduce health inequalities. There are few experimental studies with a controlled design, and many policies of relevance to health inequalities are difficult, if not impossible, to test in controlled experimental designs. Studies on some of the ongoing natural experiments have yielded very mixed results (24, 25). The basic assumption that the epidemiological evidence on the health effects of several of the determinants is well established limits our ability to question whether policies designed to alter the level and distribution of those determinants are indeed working. But there is still a severe lack of evidence regarding policies tackling health determinants in many sectors such as education, the health system, food and agriculture, and from policies that are more macroeconomic in general. A arge 'natural experiment' of national policies to tackle health inequalities in UK between 1997-2010 has, however, recently been evaluated: Even if the results are mixed, a strong reduction of child poverty and reallocation of healthcare resources to less privileged areas did turn out to have an impact on health inequalities (25, 90).

Third, the process of developing or adjusting local policies to tackle inequalities and implement them across sectors might be faulty. Policies that could act in synergy might not have been coordinated. Our knowledge of the actual state of affairs is very limited, particularly at the local level. Deficient implementation has been a cause of poor health policy results before. Scandinavian health policy has long had an infamous example: The lack of implementation over the past 50 years of policies that are widely recognised as effective in limiting industrial influence on tobacco and alcohol consumption is a well-known cause for the low life expectancy in Denmark.

The European WHO review of social determinants (13) concludes that "the understanding of local government's role and the potential range of actions available is more developed in themes traditionally associated with inequalities in health such as services for children, and young people and with vulnerable communities. Relatively little evidence indicates that this [HEiAP] agenda has significantly penetrated into more mainstream local government work such as urban development or antipoverty initiatives." The present study thus builds upon the assumption that the policymaking process and difficulties with implementation and coordination at the local level are among the explanations for the difficulty involved in reducing health inequalities. What, then, are the obstacles to implementing policies to tackle health inequalities on the local level?

These issues, as they apply to the national level, have recently been subject to international reviews (28-32). However, all three Scandinavian countries have now placed important public health responsibility on the local level of municipalities. Scandinavian municipalities have at the same time a relatively high degree of freedom for implementing their own public health policies without too much central control. This could generate differences, which might lay the groundwork for fruitful comparisons.

Conceptualising the health equity problem

Health inequality in today's Scandinavia

Today's health inequalities are large. The death rate (mortality) in different socioeconomic groups is the most comparable measure of health inequalities. Table 1 illustrates the differences in mortality according to educational level in the three Scandinavian countries (5). It is no surprise that social health inequalities exist. A society based on division of labour and incentives for education and work will inevitably produce inequalities in working conditions and income. It is easy to highlight factors in childhood conditions, work, income, housing, consumption, and healthcare that are of importance for health and have strong linkages to social position.

What must be done, and by whom, depends on the causes of the health disparities. Three different types of determinants generate health inequalities. They represent entry points for policies to tackle inequalities and are linked to three mechanisms (15):

a) *Shaping hierarchies:* Determinants connected with perinatal conditions, early childhood development, and education influence health in childhood as well as health later in adulthood. Some of the effect on adult health occurs because childhood conditions influence educational attainment and social position in adulthood. Some conditions in childhood influence health in adulthood because they generate vulnerability to the health effects of conditions later in life.

b) *Unequal exposures:* Several determinants of health are unequally distributed across individuals in different social positions in adulthood. These include working conditions, income, housing, social support, and health behaviours. They are all linked to social position and therefore mediate social position's effect on health.
c) *Unequal consequences:* There are determinants that affect the unequal consequences of illness in terms of survival, disability, quality of life, and participation. Inequities in healthcare are linked to lack of labour market flexibility to accept people with both low education and debilitating illness. For some diseases, such as mental disorders and addiction, the social consequences may be so serious that they lead to marginalisation not only from the labour market but also from the housing market and other aspects of social life.

Health inequalities are politically conceptualised in different ways in the Scandinavian national and local policies. These concepts are linked to the above three mechanisms:

#2.1: The social gradient in risk of ill health is linked to mechanisms (a) and (b): Many diseases occur throughout the population in accordance with a social gradient on which incidence rises with falling length of education, lower occupational status, or falling income. The causes are often vulnerability generated by exposures early in life, combined with living conditions and health behaviours later in life. The people who are more vulnerable due to adverse childhood conditions are also often more exposed to problems later in life, leading to a double suffering.

Table 1 illustrates the gradient in mortality across educational levels. Inequalities in mortality are a result of two phenomena: social differences in the risk of getting ill and social differences in survival among those with illness.

Table 1: Mortality rates (age standardised) per 1000 according to education in the Scandinavian Countries. Men and Women, 15-74 years, 2001-2006. Source: EURO GBD SE 2012 (5).

	Denmark		Norway		Sweden	
	Men	Women	Men	Women	Men	Women
Low	10.4	6.5	8.9	4.0	7.5	4.7
Middle	7.9	4.7	6.0	3.3	5.7	3.4
High	5.3	3.6	3.8	2.4	4.0	2.5
Excess low/high	5.1	2.9	5.1	1.6	3.6	2.2

There are considerable educational differences in mortality in all Scandinavian countries, but they are slightly smaller in Sweden compared to in Denmark and Norway. The social differences in mortality correspond to a more than 20-year lag in health development for the low educated compared to the high educated. Another way of illustrating the size of the problem is to recalculate the above figures as approximately 3000 excess deaths per month in working age individuals (15-74 years old) in Scandinavia that could be avoided if everybody had the mortality rates of the highest educated. Differences in mortality between the countries are more pronounced among the low educated and among men. Recent data from Norway indicates that mortality differentials among men are now stagnating and slightly reduced.

#2.2: The social gradient in consequences of illness is linked to mechanism (c). Both survival and other consequences of illness such as disabilities, labour market participation, and participation in other areas of social life occur more frequently among patients who have a low education. Table 2 illustrates educational inequalities in employment among people with and without debilitating long-term illness in the three countries (95).

Here the causes are more related to inequities in healthcare, social policy, and a labour market less open to people with the combination of poor health and low education. Groups that more often suffer from severe medical and social consequences of illness are frequently the same as those suffering from higher morbidity because the same factors, such as high work demands and low physical activity, can be causes of both.

Table 2: Difference (in percentage) in employment rates between low- and high-educated individuals with and without long standing limiting illness. Age standardised 25-59 years. 2005. Source (99).

	Denmark		Norway		Sweden	
	Men	Women	Men	Women	Men	Women
With long standing limiting illness	16.9	48.2	24.6	42.3	29.2	36.3
Without long standing limiting illness	5.2	19.2	7.4	15.5	3.4	7.8

There are considerable educational differences in employment rates between men and women and between educational levels. Employment rates among low-educated Danish men with long-term illnesses is 55.6%, and among long-term ill high-educated men it is 72.5%. That results in the difference of 16.9% listed in the table. The differences between the Scandinavian countries are not significant.

#2.3: The health of the marginalized – "the gap." Some people (in Scandinavia around 1% of the population) have very early in life serious social conditions and early mental and somatic problems that marginalize them in relation to education and later the labour market, housing market and family life. In addition, they are often not covered by universal welfare benefits because they have not been qualified to them according to the rules. Their life develops into a vicious circle of social causes and consequences of ill health linked to all three mechanisms above (a), (b) and (c). They frequently suffer and die from diseases that would be amenable to treatment if they had better contact with the health services, such as infectious disease (see table 3).

Table 3: Death rates in different causes of death among the highly marginalised (homeless alcohol addicts, drug addicts, other severe mentally handicapped. N=1041) in Denmark 2007-12. Source: (96).

	Percentage of all deaths in the marginalised group	Death rate relative to population average (=1)
Alcohol related deaths	29.3	18.6
Drug related deaths	17.2	47.7
Cardiovascular disease	9.5	2.9
Cancer	8.6	1.6
Injuries incl. suicide	7.8	7.4
Infectious diseases	6.0	29.4

A study of mortality among people who are highly marginalised shows extremely high excess mortality rates not only in alcohol-related and drug-related deaths but also in injuries and infections. As a consequence, life expectancy in this group is 22 years shorter than for the population as a whole.

There are thus three different ways of conceptualising the problem. They are all phenomena existing in Scandinavia today, and they are all formulated as health policy problems. They do not exclude each other, and they can be dealt with in parallel.

Societal motives for tackling health inequalities

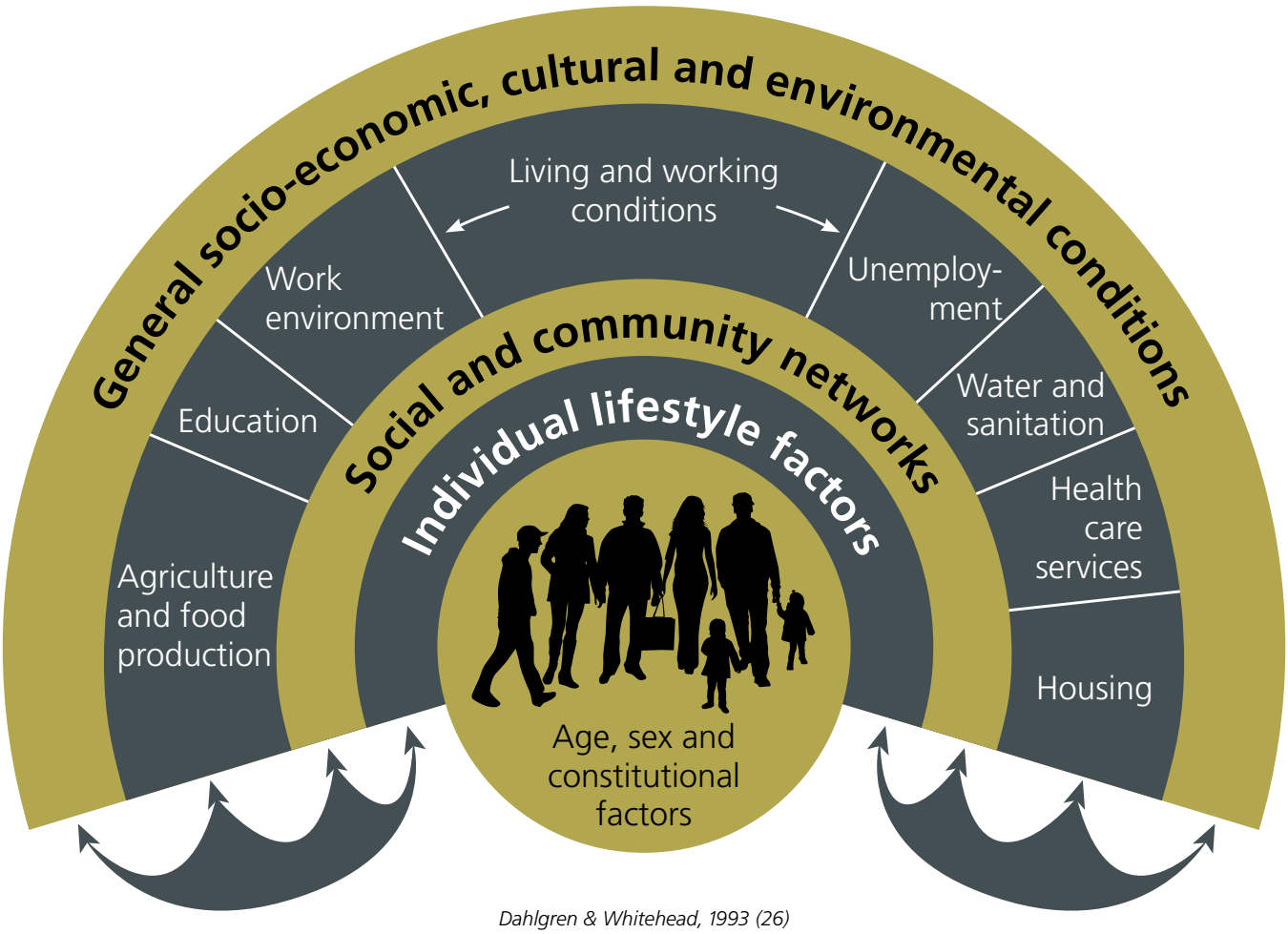
A society that can afford to help its most vulnerable citizens and reduce inequalities is a society with a certain degree of economic strength. Such a society necessarily has an extensive division of labour and incentives for education and work. This generates a stratification with inequalities in working conditions, income, etc. However, even if these inequalities might be necessary and unavoidable, the health consequences are neither necessary nor unavoidable. All common health problems have multiple causes. The effect of one cause, including social determinants such as unemployment, is dependent on the presence of other causes, for example economic stress or availability of alcohol and tobacco (15). Even if it is sometimes difficult to change the social determinant itself, the effect of a social determinant can be modified, i.e. through policies that block some of the effects mediated through health behaviours or through stress and biological risk factors such as hypertension.

We observe three different types of motives behind efforts to tackle health inequalities in Scandinavia today:

#2.4 Human freedom and rights. If good health is one of the most important preconditions for people's freedom to live the lives they value, then systematic social disparities in health is unacceptable from a freedom perspective. It contradicts principles of equal human freedom and rights. When these differences are avoidable, they are seen as unfair. Whether they actually are seen as avoidable depends on what their causes are considered to be (26).

#2.5 Social sustainability. According to the Brundtland Commission, sustainable development is a development from which one generation gets the best conditions without sacrificing the possibility of future generations to get the same. Sustainability has not only environmental but also economic, social, and political aspects. The political sustainability of the Nordic welfare states has, among other things, been ensured by universalism and their ability to combine economic growth with low inequality (104). But if the development of a central welfare component such as health moves towards greater inequality, social sustainability and integration is threatened. Increasing marginalisation threatens social cohesion and perceived participation in society (27).

#2.6 Economical sustainability. Modern societies face more than just challenging rises in medical expenditures. A growing proportion of the population is leaving the labour force due to health limitations, often in combination with low skills. The economic potential of tackling health inequalities lies not only lie the potential illustrated by the relatively good health of more privileged social groups. There is also potential in social investments that can be made early in life to later increase health and workability for all. The concept of social investments is well established in the Nordic welfare states (2) but has recently come under enhanced focus (102), particularly in Sweden. In a period of growing economic inequality, it has become increasingly clear that low inequality is not only an effect of welfare in rich societies but also, as recently pointed out by OECD, a cause of economic growth (64).



Dahlgren & Whitehead, 1993 (26)

Municipal health equity governance: a multisectoral challenge

Determinants generating health inequalities involve many policy areas

Educational policies influence children's development. Particularly for those children who come from homes with low social and cultural capital. Labour market policies influence the risk of unemployment among people with low education. And working environment legislation has an impact on working conditions, particularly among those exposed to physically and psychosocially adverse working environment. Housing policies and regional planning influence housing segregation and the social environment accessible to people with different incomes.

Regulation of prices for and access to smoking, alcohol, and healthy diets has impact on how social determinants influence people's health. User fees and geographical resource allocation of healthcare are examples of determinants of inequities in access to care. A labour market that is unwilling to employ people with low education and vulnerable health is also a determinant that generates inequalities in the consequences of illness (12-15, 19).

Many policy areas are thus involved, and a health policy matrix can be constructed to provide an overview of the sectors invol-

ved in handling the many determinants (Figure 1). The policy sectors are involved in the sense that they are responsible for specific conditions that are determinants of health and health inequality. This does not necessarily mean that they feel responsible for implementing the changes needed to promote equity in 'their' determinant. The policy sectors with responsibility for particular determinants differ between countries and municipalities. Figure 1 thus primarily illustrates that many determinants have an impact on health and health inequality and that many sectors are involved.

Figure 1: Health policy matrix: Major determinants of health inequalities and the relevant policy sectors that have the responsibility and power to deal with them (12-15, 19).

	Policy sectors:								
Determinants:	Child/ family	Education	Labour-market	Social policy	Environ./ Traffic	Agriculture	Financial	Phys. Planning	Health care
Early child Develop.	■	■		■					■
School performance		■						■	■
Segregation	■		■		■		■	■	
Unemployment		■	■	■					
Work environment			■						■
Income/pverty	■		■	■			■	■	
Marginalisation	■		■	■					■
Environmental risks					■	■		■	
Tobaco	■	■					■		■
Alcohol/drugs	■	■		■			■		■
Physical inactivity	■	■			■			■	
Diet	■	■				■	■		■

The health policy matrix could also include a policy *level* dimension because intersectoral action on health involves national, regional, and local levels with different responsibilities and opportunities. Although much of the international literature on HEiAP deals with the national level, the present legislation in Scandinavia allocates important responsibility to regions and municipalities. In addition, there is a dimension related to the *target population*. It is often relevant to target policies and interventions at *individuals* with identified high levels of exposure or vulnerability or to *groups* with high average exposure or vulnerability: As we shall see, however, it is sometimes relevant to target the *entire population* even when the goal is to reduce inequalities.

Decentralised responsibility and centralised effectiveness

It is important to note that even if legislation in the Scandinavian countries has decentralised responsibility for public health in all policies to the municipal level, the efficiency of that policy depends strongly on what is done at both the national and regional levels as well as the actions of civil society and market actors.

The most effective policies for tackling health inequalities are still in the hands of national policymakers. The examples are many: policies involving school, unemployment, income inequality, and poverty as well as policies to reduce the consumption of tobacco, alcohol, salt, and fat. Other examples

concern geographical resource allocation to healthcare, user fees, and access to private health insurance. If governments increase income inequality, increase housing segregation, lower alcohol prices, etc., the municipalities will face a double challenge: The effect of the local policies will be much weaker. And the legitimacy of health in all policies will be seriously weakened in the public's eyes if public institutions argue that people should take more responsibility for their own behaviour while at the same time negatively changing the conditions for which these institutions are responsible. A number of national policies have had major impacts on social determinants, and these are often the most cost-effective measures on which a society can spend ressources (52). Without moving these policies in a pro-equity direction, the local policies will face an uphill battle.

Implementing health in all policies on the local level is, however, dependent on the participation of several actors from civil society, NGOs, and the business world. Commercial actors involved in the production and distribution of tobacco, alcohol, and food are those with the strongest impact here (105), and again international and national actions have the strongest effect. In this case mostly by their influence on EU policy. Nevertheless, commercial actors can – and often do – play a health-promoting role on the local level by supporting efforts to 'nudge' people into healthier behaviour (68). Social support for more vulnerable groups or partnering for community development are areas in which various NGOs play a key role. A coordinating role for local health policymakers is, however, important in order to avoid a multitude of messages from a multitude of actors with very different interests.

Economic incentives: a sharp instrument with risks

A different but important perspective is the economic one. All three countries have incentivised the municipal prevention of hospitalisations through a co-payment to the hospital sector by the municipalities. But preventing hospitalisations is not the same as preventing disease. From an equity perspective, the most efficient means of reducing hospitalisations may not necessarily benefit less-privileged groups. Incentives to reduce use of healthcare are seldom effective incentives for prevention, as has been shown by the extensive recent international research on "payment by results" (106). A different but related problem is that various administrative levels and sectors partly work as communicating vessels. A health investment in one level or sector (for instance, schools or labour market) might yield benefits in another level and sector (for instance, regional healthcare). In addition, such benefits may often (but far from always) occur many years later. Cuts at the national level (for instance, in active labour market policies) may result in increased costs (for instance, on social benefit spending and healthcare) at the local and regional levels (95).

A quite new way of involving commercial actors is on the financing side through so-called *social impact bonds,* which have been widely discussed in Sweden in particular. This involves three partners: the commissioner of a particular social outcome (for instance, a municipality), a service provider organisation that delivers an intervention, and private investors that undertake the initial investment and the financial risk. Such an arrangement will typically be limited to individual-level interventions, and it immediately brings a range of issues on the table: How should outcomes be measured, and how should prices be estimated? Potential inequity perspectives of such an arrangement might be far reaching, but these seem thus far to be absent from the discussion.

In all three countries, the regions or counties are responsible for specialised care, often including units for community medicine, epidemiology, and other public health disciplines. In many places, there is a long tradition of these units supporting municipalities in their health planning. This regional support is also increasingly being provided by universities. A shared learning process in which universities develop more public health relevant research together with municipalities and in which municipalities introduce a more evidence-based practice is of great mutual benefit. The Scandinavian work with commissions on social determinants and social sustainable health policies are excellent examples (15, 19, 46).

Examples of concrete interventions and policies

To illustrate the kind of policies and interventions in question when discussing what should be implemented, we have in Table 4 given 17 examples of important interventions that are relevant at the local level in a Scandinavian context. Most of these target underprivileged groups, but some are universal and target the entire population (#3.1, #3.6, #3.9, #3.10, #3.12, #3.13). They are still relevant in reducing inequalities since they will often produce differential effects that benefit underprivileged groups most.

Table 4: Examples of local policies to tackle health inequality (12-15, 19, 24-26, 60).

#3.1: Reduce inequality in children's social environment through reduced residential segregation via physical planning, mixing tenancy types, etc. (69, 76).

#3.2: Local political action cannot directly reduce child poverty. But poverty can indirectly be reduced by reducing the number of vulnerable families who lack more than basic education, are unemployed, or are at risk of being evicted from their homes (70).

#3.3: Ensure help for parents with impaired mental health or emotional bonds to infants: Home visits to all families with new-born babies, with systematic screening for mental health problems among parents and impaired emotional bond with the child. Increase the capacity to discover social problems and motivate families to seek help (70, 77, 78).

#3.4: Improve early child development: Active and systematic recruitment of parents in need to parenting education groups (79, 80). #3.5 Improve early child development: Active recruitment of children from underprivileged families to preschool programmes. Ensure high-quality care in daycare centres in underprivileged areas through need-based resource allocation to childcare (81).

#3.6: Reduce mental health problems that influence educational achievement: Systematic screening for mental health problems in school age children. Recruitment to evidence-based parenting programmes focused on strengthening parenting skills and fostering parental involvement in children's school experiences (82, 83).

#3.7: Reduce school dropout and reduce the proportion that achieves neither occupational skills nor qualifications for further studies: Close follow-up with young people (age 16-25) in neither employment nor education. Develop and promote initiatives to ensure enrolment in some type of education or employment (84).

#3.8: Improve working conditions for low-educated groups employed by local governments: Identify and regulate workplaces with high proportions of employees with low influence on how to meet demands, with effort/reward imbalance. Improve mobility possibilities to avoid locking people into jobs in which they cannot succeed (85, 86).

#3.9: Implement local alcohol policies for restricted access by reducing the number of licenses, alcohol restrictions at educational institutions, responsible serving, and implementation of age restriction for sale (87, 89).

#3.10: Implement local policies for restricted access to tobacco as well as no smoking policies at educational institutions and other public places (88, 89).

#3.11: Increase access to physical activity in underprivileged areas by increasing the number of cycling paths, green areas, obligatory physical activity in schools, safety for the elderly, etc. (75).

#3.12: Screening and preventive treatment for cardiovascular risk factors in primary care is effective, but only by ensuring full coverage and full adherence (even from underprivileged groups) can it reduce inequalities. (89, 91, 97).

#3.13: Increase equity in primary care: Ensure that resource allocation to budgets for primary care is proportional to needs at a low geographical level (90, 91).

#3.14: Increase access to somatic and psychiatric care for marginalised and vulnerable groups with extensive multi-morbidity (92, 93).

#3.15: Increase employment opportunities for individuals who have a low level of education and reduced workability: expansion of job opportunities with flexible work demands, especially for the growing group with mental health symptoms (98).

#3.16: Preventive home visits to the elderly should target those living in underprivileged areas, with high risk of rapid functional decline and hospitalisation (99,100).

3.17: Marginalisation: Systematic outreach to marginalised groups, including the homeless, to improve their access to somatic and psychiatric care.

The quest to implement health equity in all policies

Studying the process of developing and implementing health policies requires theoretical guidance to direct and focus the empirical questions. Various influential theories of the public policy process exist (33, 34, 37-41). These theories focus on how the process can be promoted and when health equity gets on the agenda and implementation occurs. They include the classic incremental model, with a policymaking cycle in which issues are identified, policies to tackle them are developed and coordinated, decisions are made, and actions are implemented. The result is subsequently evaluated, and new issues are identified. However, policy processes rarely develop in such a linear and organised manner. The process often breaks down in the implementation phase, creating a gap between what was planned and what has occurred as a result of the planning. This way of thinking is closely linked to a top-down approach toward implementation in which there is a clear division between policy *formulation* and policy *implementation* (performed on a lower level than that on which it was formulated). Clear and consistent objectives, adequate causal theory, appropriate incentives, skilful implementers, and support from stakeholders are seen as important conditions for successful implementation (39).

The experience that the incremental model is insufficient for understanding when and in what sequence policy development

occurs is particularly true when dealing with a complex problem such as implementing policies across sectors (6). Alternative ways of understanding and guiding the process have therefore been suggested.

Multiple-streams theory

The 'when' question of agenda setting has been handled by Kingdon (40), with his multiple-streams theory, which has been used in the HiAP context (30, 41). Policymaking is here seen as three separate 'streams' of activity (see Figure 2): A *problem stream* consists of issues that the policy makers have decided to interpret as problems. Certain political options present themselves. The *policy stream* consists of different solutions to tackle the problem. The *politics* stream consists of political opinions; leadership; actions; and conflicts between political forces, interest groups, *etc.* According to Kingdon, these streams often flow largely independently of one another, but sometimes an issue gains traction in the agenda setting when at least two of the separate streams of activity couple with a choice of opportunity. Kingdon calls such moments a "window of opportunity." It can be when politicians finally find a solution to a long-standing problem, but it will often be when 'implementers' identify problems that fit the solutions they have developed. This points to an understanding of policymaking as much more of a 'bottom-up' process in which implementers play an important role not only for the way in which a policy is implemented but sometimes also in redefining the problem and the objectives of the policy. When many stakeholders on the same level are involved, as when developing health policy across different sectors, a network model rather than a *linear* model of policy development and implementation is relevant for understanding *how* implementation gets into place (31).

Top-down and bottom-up approach

Implementation research has often been based on the distinction between a top-down implementation approach and a bottom-up approach. In a top-down approach, focus is on how we can ensure that the necessary actions (for example, those listed in Table 4) can be implemented with fidelity to what was shown to work in the original efficacy studies. However, in a bottom-up approach, which might generate ownership and should involve professional knowledge in different sectors, it is crucial that mechanisms and contexts generating health inequalities are understood by implementers in all sectors. Only in this manner will they be able to identify changes in their own sectors that can contribute to reducing inequalities. Health inequality is a complex problem, and as a result, the knowledge needed to participate in the development of HEiAP is far from simple (see Section 7).

In summary: The theoretical background and earlier empirical studies on implementation have made it clear that the political conceptualisation of the problem, the knowledge about potential solutions, and the administrative infrastructure for cross-sectoral governance are all critical conditions for successful implementation.

In order to understand how Scandinavian municipalities are manoeuvring in this context, it is important to understand which options they actually have. In the following (Sections 5-7), we will present the framework that has guided our examination and formed the results from the Scandinavian municipalities.

Politics of health equity: the political choice of perspective

Tackling health inequalities is a political choice. There is strong agreement on this point among local public health professionals and policymakers in Scandinavia. This became clear from the present study's interviews as well as the Trondheim Declaration made at the Nordic Public Health Conference in 2014.

Political choices do not necessarily imply conflicts, but the issue has the potential to be controversial. Health inequality concerns differences in health between population groups. Political actors such as unions, patient organisations, and political parties might feel obliged to represent the interests of some of these groups more than others. Social and economic determination may involve strong commercial and public economic interests. This could be an obvious source of political conflict, as has indeed been the case on the national level in the UK in the 1980s and in Sweden in the 2000s. The strength of the political energy linked to the health inequalities also depends on the extent to which they are considered unfair and avoidable. This will again depend on how the causes of the inequalities are understood.

FROM THE TRONDHEIM DECLARATION (2014):

EQUITY IN HEALTH AND WELL-BEING – A POLITICAL CHOICE!

The status of health and well-being in the population is an indicator of how well public policies succeeded in one of its key missions. Health and well-being is both a prerequisite and an investment for good lives, a result and an indicator of socially sustainable societies.

- We know that social inequalities in health which form a systematic pattern (gradient) through the whole population are caused by the unequal distribution of power, money and resources in the society. Health inequities are unacceptable and unjust and arise from the social and material conditions of human birth, adolescence, adulthood and old age.
- The Nordic countries have a strong public responsibility for conditions that are essential to health and well-being, as economic security and distribution, housing and childhood environments, education, employment and working life and environment, health and welfare services, and recreation and culture.
- We need investment in universal welfare like housing and childhood environments, education, employment, working environment, health and welfare services for good living conditions.
- Efforts in the areas of nutrition, physical activity, tobacco, alcohol and substance abuse, injuries and violence and mental health must also be directed towards underlying causes based on an understanding of the political and commercial driving forces.
- Gains can be achieved by investing in a good start in life by promoting adolescent health, efforts in working life and active, healthy and safe aging.
- Governance is about commitment and leadership that give results. Strategies, plans and goals are never better than implementation can prove. Policies for equitable distribution of health and well-being without resources, structures and genuine political commitment will have little effect.
- In order to be held accountable we need measurable goals to promote health and well-being with the intention to reduce social inequalities.
- Societal development for health and well-being requires collaboration across sectors on equal terms with mutual respect for different sectors societal goals. We must seek mutual benefits and synergies through partnerships and alliances but also identify potential conflicts and negotiate solutions accordingly.
- We need transparency and participation for better results and to trigger people's and civil society's own resources.
- Impact assessments must include equity in health and well-being.

www.nordiskfolkehelsekonferanse.no/lib/tpl/nfh-6/assets/trondheim/nordisk-folkehelse-engelsk-a4-oppslag-highres.pdf

If the focus is on genetic and behavioural factors, inequalities might be considered less unfair than if they are seen as a result of unequal childhood conditions or unequal access to health-care. The question is whether such a conflict equips the question with political energy or if it instead blocks the potential for long-term policy development when political majorities shift.

Whether local governments and other actors give the issue political priority may also depend on whether the identified causes are seen as amenable to local actions. Some people may argue that if major causes of health inequalities are tobacco smoking, alcohol abuse, and working environment, then the responsibility lies with national authorities and the industry as they control more powerful instruments for regulating these risks. Others might argue that since the municipalities have political responsibility for childcare, schools, and local environment, the local level is the right level for implementation. Furthermore, the local level is responsible for several welfare services with close contact to the population groups that have the greatest needs, and local authorities have more possibilities for adjusting various levers that influence health inequality. Greater possibilities result in greater responsibility. If social sustainability is emphasised, it can be argued that local long-term visions are needed for integrated sustainable policies on childcare, education, labour market, the elderly, including for tackling health inequalities (19, 20).

There is also a political choice in terms of the extent to which health inequality is seen as a separate agenda, distinct from efforts to improve the average health of the population. It depends on the understanding of causes, but if there is a conception that there may be a trade-off between the two goals, then we are dealing with a clear political choice.

This brings us to the political options concerning which aspects of health inequalities (#2.1 - #2.3) are in focus and which of the three motives (#2.4 - #2.6) for tackling the inequalities are seen as most relevant. The empirical question comes down to: What difference does the choice of these options make in the implementation process? From this perspective, we find interesting differences between the Scandinavian countries and municipalities.

Norway: focus on the gradient in morbidity and determinants

In Norway, the National Directorate of Health focused in 2005 on levelling up the social gradient in risk of ill health (#2.1), which has been a central political priority since 2007. This has had a clear impact on the way in which municipalities conceptualise the problem. This focus has been strengthened by the Public Health Act (*Folkehelseloven* 2011), which mandates the inclusion of public health in the overall strategic plan that every municipality must produce every fourth year (11). With this combination of an explicit policy focus (including a list of specified determinants on which to act in various policy sectors) and a legal framework created by the public health act, Norway has created a systematic framework of health equity in all policies within which the municipalities can take action. None of the other Scandinavian countries has made a similar central structure for this work.

This focus brings the challenges of coordinated multisectoral action to the forefront, and some of the difficulties in implementing HEiAP become clear. Most Norwegian municipalities are very small (75% have under 10,000 inhabitants). Small size does not, however, seem to exclude the possibility of dedicated and qualified work. The work involved in developing and implementing policies is not proportional to the size of the municpality, and it is obvious that in many places the capacity for developing local policies is quite limited. National authorities are, however, providing support in terms of local epidemiological data on health and determinants. The legislation specifying that health (equity) should be included in overall local long-term and economic planning has legitimised the introduction of these issues across different policy areas. There might nevertheless still be several questions regarding how policy details should be adjusted to be more equity oriented.

> Public health officer in a Norwegian municipality: *"The intersectoral responsibility for health equity is now very well anchored in the overall economic plan for the municipality. It is very much due to the realisation of the life course perspective – that our policies for all ages play a role. There is a clear understanding that it is not only a responsibility for the health administration. But it is only due to the thorough processes and recurrent dialogues that we have had across sectors that this is now realised by all parties."*

Policy goals in Norway (and in the other countries) highlight that health inequalities should be reduced through (more rapid) health improvement in underprivileged groups (41). This means that reduction of inequality can only be combined with an overall improvement in average health. Interviews from Norway also illustrate that it might be problematic to distinguish sharply between policies aimed at improving average health and policies aimed at reducing inequalities. It is argued that the *proportional universalism*[2] approach addresses both.

> Public health leader in a Norwegian municipality: *"Our main challenge is, however, that the general health level of our population is at the lower end of the national gradient compared to other parts of Norway. So we have to be careful that our health equity efforts are not entirely focused on the underprivileged areas in our municipality, which would be wrong. We have to focus on the universal aspects too. It tells us that the relevant strategy is proportional universalism. It should be for everyone, but with an extra effort for those most in need. That is our strategy."*

The centrally formulated health policy strategy is well understood locally, at least in the interviewed municipalities: The strategy consists of a combination of universal and selective targeted measures as well as a combination of more

2 Proportional universalism is a characteristic of service provision or intervention that is universal with a scale and intensity that is proportional to needs (12).

upstream structural measures and downstream measures focused on behavioural and clinical issues (41). Detailed central directives have reduced confusion regarding concepts and strategies. This does not, however, ensure that these principles are easily translated into concrete action and adjustment of existing policies. Both our interviews and other recent studies, including a large sample of Norwegian municipalities (66), have found (in 2011) that approximately 40% of Norwegian municipalities take health equity into account in child, family, and social policies. The figures for other policy areas were lower. There are obviously considerable difficulties when it comes to translating general principles into concrete actions in different policy areas. It should, however, be noted that very few years have passed since these policies were introduced and the legislation was implemented.

There is explicit demand for support in understanding how the political principles can be translated into details in policymaking. Because the new legislation with a clear HEiAP responsibility for Norwegian municipalities was only implemented in 2012, it is rather surprising how much progress some municipalities have made.

As we shall see, Norway's policy development has been quite top-down in comparison with that of Sweden. This is partly a result of the fact that Norwegian municipalities are relatively small, and central policymaking has been relatively explicit and forceful, including legislation that did not occur in Sweden, even if it had previously been proposed by the Public Health Commission.

Norwegian health policy has on the national level been developed over a decade in which political majorities in government have shifted. However, there have until recently been no signs of political conflict concerning the prioritisation of health equity. Even if priorities can shift somewhat between white papers from different governments (Conf. Meld. St.20:2007-08 and Meld.St.19:2014-15), there seems to be very little conflict surrounding the issues of social health inequality. And those conflicts that have arisen have not inhibited local implementation.

Sweden: local activity with weaker adherence to central policy

According to Swedish legislation, county councils or regions hold primary responsibility for population health. Municipalities have, however, primary responsibility for many policy areas of relevance to major health determinants. This presents increasing problems for the implementation of HEiAP.

The national policy from 2002 (9) focused on 11 broad health determinants, but the experience after 10 years was, unsurprisingly, that regional plans focused on determinant Number 6: "A health-promoting health care service" (42). The focus within the growing efforts made by regions and county councils, and increasingly also by NGOs, was on health behaviours such as alcohol, illicit drugs, doping, and tobacco (43, 44).

The work of the Commission on Social Determinants has, however, recently had a strong impact on regional and local health policy thinking in Sweden. It links strongly to traditions of welfare policies in Sweden, and many determinants (such as early child development, segregation, and marginalisation) have long been prioritised by local policies.

Swedish regions have established commissions with an explicit focus on HiAP and the gradient in risk of disease (#2.1) (20, 45, 46). Nevertheless, the regions have difficulty dealing with specific questions of precisely how and where to implement policies outside of the healthcare sector. Municipalities are responsible for implementing such policies, and one region may cover several municipalities. When a municipality makes a plan with similar starting points, the result is very different in terms of details about what to do and who should do it (19, 58). Interviews with responsible leaders in the regions illustrate this very clearly. The regions have the knowledge and the administration but not the political responsibility. Without this, there is little they can achieve. Regions can address inequalities in the consequences of illness (#2.1), but they also wish to address the broader issues. An evaluation by the Swedish commissions on social determinants likewise concluded that even if their task did not primarily involve implementation, it would be more productive to start with actual degrees of freedom for action within different sectors in the municipalities

than to start with a list of evidence-based interventions and policies (107).

> Public health officer in a Swedish Region: *"Our region includes 49 different municipalities, so of course we cannot be very concrete in terms of what each municipality should do. And they don't like us telling them what to do."*

Sweden has a strong tradition of self-reliant municipalities, and this tradition provides the municipalities with a certain degree of freedom to develop their own health policy plans (17, 42). More and more often, the starting point has been outside the health administration, i.e. in educational, social, and environmental administrations. Perspectives related to sustainability (#2.5) and social investments (#2.6) are now much more present on the municipal level (102). This is true not only in those municipalities we examined but also in a broader network of municipalities and regions, as recently formulated in a programme for sustainable development to reduce health inequalities (20). Several municipalities are working in accordance with the HEiAP network model, applying a very broad concept of health. That said, Botkyrka, Malmö, and Luleå have developed their policies particularly far.

> Public health leader in a Swedish Municipality: *"I wonder how important it is that we call it 'public health work'. Because I think we have adopted much of the thinking, and we do a lot of the right things, but we call it something else. I think it gave us an advantage that we started out in environmental and social policy. We worked for sustainable development and ensured the political support. And then of course public health exists in the background, as an underlying factor. When dealing with job opportunities, housing segregation, etc. in the different areas, it is all about public health. But the health questions are not very visible in our plans. But it could be helpful with instruments like HiAP to translate the proposals into results in health terms."*

This means, however, that the narrower focus on health in terms of inequalities in diseases and injuries has been somewhat sidelined relative to in the Norwegian municipalities. *"The region takes care of the diseases!"* as a public health director in one Swedish municipality expressed it. This means that more disease specific knowledge and research on causes, costs, and interventions – which is the majority of public health research – is difficult to incorporate.

It is clear from our interviews that focus on the broader aspects of health makes broad ownership across sectors easier. Many policy areas can easily relate to the issue of sustainability and the question of how to accomplish equal human rights, including health. Environmental, social, and childhood policy all include aspects of intergenerational sustainability, equity, and social investment. This process does not start from a health perspective, and it seeks to incorporate other policy areas. The starting point is that of sustainability and human rights, which all sectors can embrace, feel ownership for, and work further with (31).

The risk, however, is that this more general sustainability perspective pushes aside the more specific question of how to reduce the unequal burden of disease. Quantitative assessment of a policy option's potential impact on health inequalities (HIIA) within each sector could be an instrument for retaining that focus, but this is not widely used even though the Swedish Association of Local Authorities and Regions has long supported the idea.

It is worth noting that the strong local engagement in health equity issues has occurred despite (or as some would argue, because of) a rather weak central role in policy development in recent years, at least compared with Norway. In some related areas, there is a stronger degree of central policy development. The central Swedish authority managing a many health-related social benefits *(Försäkringskassan)* has placed increased focus on preventive aspects since many risk factors of illness are also risk factors for consequences of illness in terms of reduced workability (Conf. #2.2). Nevertheless, preventing sickness absence is not the same as preventing illness since many economic factors are involved in determining absenteeism and since absence can be a means of coping with excessive work demands. The impact on health inequalities thus remains unclear.

Denmark: still a narrow focus on lifestyle

In Denmark, particularly at the local level, there has traditionally been a strong focus on the health 'gap', i.e. the health of marginalised groups (#2.3). This has been the case even if central authorities have sought to shift more focus to the gradient (47). Already in the early prevention policy programmes of the 1990s, the inequality problem was formulated not as a gradient but as a 80:20 problem, with 20% of the population described as marginalised in terms of social life and health (8).

For Danish municipalities, efforts targeting alcohol and drug addicts, social psychiatry for the mentally handicapped, and homelessness have long been major concerns. In a recent government paper on social sustainability, the focus has remained on this aspect of marginalisation (48). This priority is not completely rational for the municipalities. From a short-term perspective, the major problem for the marginalised groups is their prevalence of disabling mental and somatic multi-morbidities, which can often be treated – at the regional level. However, people with a multitude of mental, somatic, and social problems fit poorly into the highly specialised healthcare system and often have only sporadic contact with primary healthcare. On account of this, these people's medical needs are given insufficient care.

Various initiatives have been undertaken to improve contact with marginalised groups, for example by employing nurses with the special task of helping marginalised people gain adequate contact with the health services. When medical and social problems, as in these cases, represent both cause and consequence of each other, implementation of more integrated care across sectors seems warranted. This presents a clear challenge for a structure in which the responsibilities for social and medical aspects of the same health problem are divided between regions (including GPs) and municipalities. Marginalised groups also have major problems with health behaviour, but dealing with them can sometimes lead to further difficulties.

> Social worker dealing with marginalised groups: *"When the municipality mostly offers participation in a stop-smoking course, then it is my reflection that it might not be their [the target group's] first priority in life when they are without work, money, and a place to sleep."*

Denmark has a tradition, also in relation to broader population groups, of focusing on health behaviours (49). When the perception of determinants of inequalities and the relevant actions are so focused on behavioural factors, it opens space for discussion in various policy sectors as to how they can help promote healthy lifestyles. At the same time, however, this tends to limit discussion regarding other sectors' primary responsibilities to act on more upstream determinants such as education, poverty, and environment.

Since 2012, Danish national governments have focused on the social gradient in access to and quality of healthcare (#2.2). This has pushed municipalities toward focusing on whether preventive and rehabilitation services reach groups with low education or low income. These might be relevant priorities since the few studies that have been undertaken on this issue indicate that there exist substantial social inequalities when it comes to the use of preventive services and return to work

after illness. However, due to a lack of local data on the use and implementation of services in relation to different population groups, the municipalities have very little empirical assistance in targeting their efforts. These efforts are likewise dependent on close collaboration between the private GPs in primary healthcare and the municipality. Such collaboration is not easily achieved, with a relatively weak and fragmented governance structure in primary care. As in Norway, however, there are systems in which agreements *(Sundhedsaftaler)* are made every four years to improve collaboration between hospitals, GPs, and healthcare in municipalities.

> Leader in the employment administration: *"We have a lot of young people who all have a whole range of mental and somatic problems, and if we want them to take a job, we need to invite the healthcare department to help us. So we have arranged this intersectoral collaboration with local municipal health centres. So when we can we have the full range of offers: educational, vocational, GPs, health centres, and social services we get better results."*
>
> *"It is complicated because if there are two people with the same health disabilities, one will be able to work and the other will not. But if we have no contact with the workplaces, and an understanding of the processes going on there, we will not understand why."*

Employment and 'return-to-work' administrations are strictly regulated by national legislation, with a strong emphasis on economic incentives to work. In contrast, the health administration (which lacks much detailed legislative regulation) focuses on the individual's health related workability and how this can be improved. Denmark, Norway, and Sweden are all facing an increase in mental problems among those out of work, particularly among those on means-tested rather than health-related benefits, which illustrates the scope of the problem. When different policy sectors share goals but work in accordance with different professional traditions, legislative frameworks, and rationalities, a close dialogue is needed to develop a shared understanding and to make coordination possible. The Danish rehabilitation teams in which municipalities and regions collaborate in getting people back to work following illness are examples of this kind of development.

> Employment officer: *"It is so obvious when we have to handle all of these citizens who have had long sickness spells… later they are often unemployed and in addition have severe social and economic problems ... the three administrations [employment, health, and social] have to work together – everybody has realised that, but it is not easy."*

The gradient in morbidity perspective (#2.1) is, however, also present in Danish municipalities (16, 50), particularly since 2011, when it was highlighted by the national health authorities (47). How high it is placed on the political agenda is difficult to estimate. As health equity interventions do not appear as such in budgets, it is difficult to assess its genuine priority. Even in a large municipality with a strong political focus on health equity, a politician makes this rather sobering yet important statement:

> Danish health politician: *"At the end of the day, the most important factor is how high the topic [health equity] is placed on the political agenda. I don't think you can find one Danish municipality where the topic is so high on the agenda that it spills over to all of the other administrations."*

An interesting example of a reform with broad intersectoral ambitions is the 2014 Danish school reform. A longer school day, with space for more diversified activities, aims not only to improve academic achievement (particularly for pupils from underprivileged backgrounds) but also to provide more time for physical activity and activities involving the local community (108). This is one of the few recent Danish examples of a major political initiative that prioritises a range of targets, including health and equity.

The overall picture is that, if it could be said that developments in Sweden risk missing more specific health aspects due to a broad sustainability agenda, developments in Denmark instead risk too narrow focus on a few behavioural factors, such as tobacco and physical activity.

Knowledge: what is needed, demanded, and utilised?

What knowledge is needed – in principle?

When aiming to reduce health inequalities as much as possible within a given budget, it is necessary to be knowledgeable about which policies and interventions will provide the most health equity for the money invested. This knowledge is relevant independently of whether one takes a top-down or bottom-up implementation approach.

The knowledge that is needed to develop evidence-based policies on how the most health equity can be achieved for the available resources includes seven types of data (see Table 5):

Table 5: Seven types of knowledge for evidence-based policies (15)

#6.1 What is the occurrence of different diseases and disease consequences in different socioeconomic groups?

#6.2 What are the causes and mechanisms in determination of health inequality?

#6.3 What is the development and distribution of the main determinants of health inequalities?

#6.4 What interventions and policies are effective in changing occurrence and distribution of the main determinants of social health inequalities?

#6.5 Who is responsible for implementing these different policies?

#6.6 How much do these policies cost, and how large are their expected impacts on determinants for different groups?

#6.7 Which policies are already implemented, and which groups do they influence?

Two distinctions are relevant here:

- Some information is nice and interesting while other information is more critical for the prioritisation process.
- Some information needs to be about conditions in the local community while other information can be taken from national or global literature.

Table 5 summarises the types of knowledge that are ***in principle*** necessary for making a rational health policy process and optimising resource use. In the following, we will provide a few comments on each of these types of knowledge in relation to how necessary they are and how local they need to be.

Ad 6.1: A description of the size and development of health inequalities is the basic starting point and identifies 'the problem'. Geographical variations are often secondary to social inequalities but are important since they provide the political energy to prioritise equity-oriented health policies. Information on local social inequalities is often unavailable but might be very similar from area to area. The importance of different diseases for the inequality in burden of disease is poorly described internationally but is an important element of knowledge.

Ad 6.2: Knowledge on causes and mechanisms is described in international and national reviews (12-15), and there is little to indicate that there is a need to develop further context-specific local knowledge on this point. However, the relative importance of different determinants might vary across populations due to variations in the determinants' levels and social distribution.

Ad 6.3: Data on local distribution of the main determinants of social health inequalities is highly relevant as it may differ considerably across municipalities and can serve as an indicator in local evaluation of policies to influence these determinants. Some determinants are linked to local geographical conditions such as air pollution and injury risks.

Ad 6.4: Knowledge about which interventions and policies actually work to influence the occurrence of – and vulnerability to – causes and determinants in various socioeconomic groups is a research question for which international and national evidence is relevant. For very specific interventions, the effect may not be particularly context dependent, but for interventions that are more complex there might be significant variations in

effect – often because implementation differs. Local experiments and projects frequently have a strong political impact, but it is more effective to rely on good scientific evidence than on local uncontrolled projects.

Ad 6.5: Knowledge of which policy sectors or non-governmental organisations may be able to influence determinants will typically vary locally but will be well known without the need for extensive further inquiry (see Figure 1).

Ad 6.6: Knowledge of the effect size and costs of different interventions and policies is in principle necessary for efficient resource allocation, and more and more such knowledge is available internationally (51-53). Knowledge about whether effects differ across socioeconomic groups (differential effectiveness) is nearly non-existent. Effects and costs might actually be highly context dependent and vary considerably locally, but it is unrealistic to expect local estimates of this kind. The growing interest in social investment in Sweden and elsewhere, however, increasingly brings cost-effectiveness onto the agenda (102).

Ad 6.7: HEiAP often does not imply brand-new policies and interventions but instead adjustments to existing policies. Knowledge concerning their local implementation and impact on different groups (differential implementation) will be relevant. However, data on implementation of activities in different sectors with an impact on health only exists in very fragmented forms within various policy administrations. There is a lack of instruments to categorise this data and to indicate the 'dose'. Such instruments are, however, under development, for instance in the Norwegian *Kostra* system (Meld.St.19, 2014-15)[3].

Consequently, local, national, and international data and findings are needed. In order to avoid unnecessary work at the local level, it is important to explore the possibilities of drawing upon existing data and findings from external sources. Although all Scandinavian countries have surveys that provide local data on municipal averages for some behavioural determinants, there is not yet data on inequalities within each municipality. Many determinants, including social determinants, are described in national public health reports. Both Norway and Sweden have IT systems in which data on determinants and health indicators is accessible at the local level (for instance, the Swedish *Öppna Jämförelser*), but they include only a very limited amount of data on social inequalities within a municipality. Furthermore, both Norway and Sweden have developed public health *policy* reports that provide data on many social determinants and on policy implementation at the national level (55, 67). Generally speaking though, none of the countries provide much data on implementation.

What knowledge is actually demanded and utilised?

Having a list of knowledge that in principle is needed to optimise resource allocation is not quite the same as the type of knowledge that is actually demanded and used in the much less systematic process in which local health policies are developed.

Local descriptive data on determinants (#6.3) is often produced and made available by regional or national authorities. Even if levels and distribution are seldom used in a quantitative manner for resource allocation to achieve 'proportional universalism', local data of this kind does contribute to local political energy.

> Public health officer in Norwegian Municipality: *"The politicians had not realised the size of the health inequalities in our small community. They thought that it might be an issue in other countries like Russia. But the figures from the youth data showed a very steep social health gradient among our youth. And it is our young people. That became quite an eye-opener… that it also exists in our community. And when we regarded it from a life course perspective – from cradle to grave – we all realised that we have a responsibility."*

The knowledge most explicitly in demand regards the kinds of interventions and policies that efficiently reduce health inequalities (#6.4).

> Head of public health in Danish municipality: *"We are acting in the dark. We have arrived at a stage where we really want to do something, but we do not know what exactly that should be. It would be very helpful to have a catalogue of evidence-based concrete interventions that we know would work."*

3 KOSTRA (Kommune-Stat-Rapportering) provides statistics on resources used, priorities made, and benchmarking indicators in municipalities, city-districts, and counties. It covers areas such as care of children and the elderly, physical planning, and employment activites. Comparisons can be made across municipalities and relative to the national average.

Municipalities in all three countries ask first and foremost for detailed advice on identifying effective interventions and policies. At first glance, this might appear surprising since both international and national reviews on social determinants of health inequalities list several recommendations.

Let us take the example of early childhood development: The European review (13) recommends the provision of *"universal, high quality and affordable early years education and child care system"* and more specifically of ensuring *"universal access to a high quality, affordable, early years education and child care system as the essential bedrock in levelling social inequalities in educational attainment, poverty reduction and gender equality"* (13, p. 68). In the Danish national review, this ambition is formulated as providing *"complete coverage and active recruitment of children with special needs to daycare institutions and kindergarten classes"* (15, p. 87). In a Scandinavian and Danish context, these policy measures are not radically new since daycare coverage among the 3-5 year olds exceeds 95% (albeit somewhat lower among children of immigrants). There is also an active screening for, and individual support to, children who have weak language development at age six. One could ask: Is there something in the quality and pedagogical profile that should be changed? There is very limited guidance for those responsible for childcare in a municipality.

When looking at municipal recommendations made by the Malmö Commission, the situation becomes clearer. Here it is stated that new funds should be allocated to *"the educational institutions with the greatest needs,"* which are defined on the basis of a number of criteria, including socioeconomic background, number of pupils with native languages other than Swedish, achievement of objectives, *etc.* This will provide resources to a higher staff/children ratio in these areas. Furthermore, the Malmö Commission states that *"special interventions should be made to recruit and retain university-trained staff in socially vulnerable areas"* (19, p. 81). This guidance is more detailed than usual but still less detailed than many clinical guidelines. This often complicates attempts at administration. Several other examples from other policy areas could be mentioned with the same overall conclusion.

Public health officer in a large Swedish municipality: *"We can see from the statistics that we have a growing number of young people with obesity, without post-primary education, and without jobs. And they are all running a major risk of getting diabetes at a very young age. But what can we do to stop that development? We do not know! They are not sensitive to health education because they are more concerned about their unemployment, but their obesity makes it difficult for them to get a job."*

Public health officer in a Norwegian municipality: *"We realise that reducing health inequalities is not an easy task. The cookbook on that issue is very thin. If you turn to the researchers, you will find very little, and what you find is very difficult to translate into something useful for a municipality. You find this kind of more general advice – very superficial."*

The level of detail regarding what needs to be done cannot be identified by the public health administrations or public health professionals alone. It requires insights from professionals in the other policy areas. However, this dialogue is not always easy. Different languages, professional traditions, and views on what is 'evidence' are among the many potential complications. For example, developing employment policies for reduced health inequality requires public health insights on how we can modify the health effects of unemployment and improve employment among the ill. It also, however, requires insights on how employment can be achieved for those with low levels of education and other difficulties in a modern labour market. What are the demands of available jobs in the labour market? How can a match between work demands and individual resources be found? This necessitates a qualified and close dialogue between professionals on both sides.

Public health officer in a Norwegian municipality: *"The Public Health Act provides us with a legitimacy that is very important, and when we can support our proposals with scientific evidence it gives the political leadership more confidence in allocating the money. When we show up with more assumptions than evidence, we seldom get much money."*

Is it necessary for this dialogue to take place in each municipality? Much is, no doubt, dependent on context, and in the case of employment policies for health equity, the answers may depend on local labour market conditions. The process in Malmö, where this dialogue has been possible within the

Malmö Commission's framework (19), illustrates this potential. But what is possible in a large municipality is not always possible in a small one. There is little doubt that guidelines in the form of 'policy briefs' by national authorities could assist in policy development at the local level. The present tendency of allowing national policy development to take place primarily within national health authorities represents a limitation that is open to change.

Some municipalities, however, argue that their need for this type of evidence is not acute. They find that many of the interventions and policies that we know to be effective in improving average health (and that are present in national guidelines, where such exist, for instance the Danish 'Forebyggelsespakker', focusing on health behaviours) are also effective for reducing inequalities when they are targeted correctly.

Interventions to reduce inequalities seldom require doing entirely new and different things. It is more often a question of doing more of existing activities and doing them in a slightly different manner. Furthermore, the key is often to ensure that interventions reach those most in need. In addition, more universal structural interventions, such as environmental regulation, might have a stronger health impact on those groups that are more vulnerable and exposed.

> Leader in child administration: *"Instead of the highly standardised schemes of numbers of visits, etc., we want to let the home visiting nurses be more free to use their professional judgement when they decide where they find the greatest needs for their services and to be more free to allocate their time and activity accordingly."*

Knowledge of potential policy impacts: health inequality impact assessment

When different options are considered in various policy areas, it is useful to estimate the potential health effect (#6.6) of these options in average (health impact assessment) and for different socioeconomic groups (health inequality impact assessment). Such an estimate is based on two types of knowledge: The estimated effect of a certain policy change on determinants in different groups and the estimated effect of changing levels of the determinant on health outcomes. This has been used extensively in traffic policy. In Copenhagen, for example, the

effect of building more bicycle paths on burden of disease has been estimated (103). Even if there are several assumptions in and caveats to such estimates, they serve a useful function in rendering concrete the contributions of different policies. Estimating quantitative net effects is particularly important when policies might have both positive and negative effects. Such estimates are, however, relatively seldom used in Scandinavian municipalities, partly because the technology remains complex.

Knowledge of existing activities

This brings us to the other critical type of information: namely, knowledge of what is actually being done in various policy areas that has a relevant impact on health (equity) (#6.7).

As proposed by the Swedish Public Health Commission, the Swedish National Institute of Public Health published a *Public Health Policy Report* in 2005 and again in 2010 (55). As a complement to the public health report describing health problems, these reports aimed to describe what has been done to tackle the problems. The description covered all of the different policy areas involved in HEiAP. Norway has published similar reports (67), which since 2009 have focused on health equity. These report the trends and distribution of determinant indicators and describe policy developments. They also illustrate the challenges associated with describing – and quantifying – which activities are actually being implemented in various sectors. This is possible for the clinical sector. In other sectors, the degree of implementation and the 'doses' of the intervention in relation to different socioeconomic groups are less clear. The necessary categories and statistics are lacking.

Public health officer in a Norwegian municipality: *"I know we are doing public health work when we are preventing school dropout, but is it necessary for me to call it that? At the same time, I use the words 'public health' every time I talk to the politicians about our strategies, etc. I just want to use other headlines when I talk to the school people. They want to talk about bullying, strengthening pedagogical programmes, motivating students, etc."*

Knowledge concerning costs?

Knowledge of cost-effectiveness is in principle needed to optimise the effect on health within a certain budget. There are municipalities that request this type of knowledge:

Health politician in a large Danish municipality: *"I really need to find the evidence and the business cases I can bring with me to the big table for budgetary negotiations. I really need these cases where I can with confidence say: 'this will pay off'."*

In one Norwegian municipality, it is ensured that a cost-effectiveness and social investment analysis has been undertaken within a programme to tackle health inequalities among children: *"The arena for the decisions is the annual budget. Everything ends up there. We have been very aware that we should not have a specific public health budget. It is the overall budget for all sectors in the municipality that is our public health budget. But then, of course, all activities have a price, and all activities will be evaluated in relation to how they contribute to the overall strategies."*

Allocating resources among all of the relevant activities that might be capable of tackling health inequalities would ideally require the availability of cost-effectiveness knowledge for all of these activities. However, there exists only fragmented international data on this (51-53), and its relevance to a specific Scandinavian municipal context is at times unclear. These calculations can still prove helpful when arguing in the budget for specific activities. Cost-effectiveness in the healthcare sector is increasingly brought onto the agenda due to rising costs for medical drugs. Public health policymakers might thus need to be better equipped with cost-effectiveness arguments than before, when such arguments were rarely used in Scandinavia. Yet efforts to actually calculate the economics of the different local stakeholders of health promotion have indeed been difficult (56, 57). Even if these studies indicate that there are benefits for the municipality itself, benefits for other local partner seem more limited.

Indicators, accountability, and learning

Accountability is a challenge when results often occur in a different administration and a different time period than implementation and costs. Independently of whether you work with a hierarchical leadership or a more network-based model, with a shared learning process across sectors (63, 64), there is a need for information on some key indicators. In Table 5, we highlighted out different knowledge types. For two of these, up-to-date local data was critical: Data on development and distribution of determinants and data on implementation of actions. It has also been em-

phasised that bringing together policy areas in a coordinated effort requires shared targets and benchmarking (28, 30, 31, 65), necessitating data on these aspects of policy.

The international and national reviews have also provided lists of indicators, not only for determinants but also for implementation. These are not, however, widely used by municipalities.

> Administrator in a Norwegian municipality: *"Indicators and benchmarking: We have deliberately avoided that. With new public management, they introduced a hell of a lot of instruments, hierarchies of targets, etc. We have left that and focus instead on values and dialogue. If we develop a system of indicators, and we need four people to run it, then we have failed."*

In Sweden, there is often reference to the 11 broad health determinants and the indicators introduced for each of them in the national policy from 2002 (9). This has laid the groundwork for a now-established routine of thinking in terms of determinants rather than health outcomes.

> Public health leader in a Swedish municipality: *"Since 2002, we have had the 11 determinants, and that has been a key factor behind the implementation of HiAP. The targets are linked to these determinants, but they have been quantified at the national level. That is, however, increasingly being done at the regional and local level. And it means that focus is constantly kept on the social determinants. I think the national targets have been relevant, even if it took many years before they were used locally.*

But measurement of implementation is still a challenge, and without data on implementation and outcomes, accountability will suffer.

> Leader in child/youth administration in a Danish municipality: *"We have a target concerning an early multi-professional effort, but we find it really difficult to measure. It quickly turns it into indicators, which are too far from what we actually do."*
>
> Administrator in a Norwegian municipality: *"I don't think the politicians are demanding enough evaluations and evidence. It is, of course, also my role to ensure that things work. We spend nearly 1 billion NKK every year, and what do we get out of it? It is the routine: Here you have a certain amount of money, so you need to run a certain activity. But what is the result? We do not demand feedback on results."*

Table 6 provides a list of indicators of determinants linked to the 17 policies listed in Table 4.

Table 6: Examples of indicators for determinants for each of the 17 policies in Table 4 (13, 15, 55).

1 Measure of social segregation: inequality in proportion of poverty, unemployment, low education, non-OECD immigrants.

2 Proportion of children living in poor families, according to OECD criteria.

3 Number of parents with mental problems, identified through screening, according to family income

4 Proportion of children with impaired cognitive development at age 7.

6 Proportion with high score according to Strengths and Difficulties Questionnaire (SDQ) at age 14, according to family income.

7 Dropout rates from primary school and proportion of youths aged 16-25 not in education or employment.

8 Proportion with high Effort/Reward score or high physical demands at municipal workplaces, according to education.

9 Proportion with high alcohol consumption, according to age and education.

10 Proportion with high tobacco consumption, according to age and education.

11 Proportion with low spare time physical activity, according to age and education.

12 Proportion with cardiovascular risk score >10% without contact with health centre, according to education.

13 Resource allocation in primary care proportional to socioeconomic indicators of need.

14 Number of avoidable somatic hospitalisations and deaths among mentally ill.

15 Employment rate among those with low education and debilitating long-term illness.

16 Proportion of elderly with preventive visits, according to socioeconomic area indicators.

17 Marginalisation: proportion in the working ages marginalised from labour, housing, and universal benefits.

Organising governance for health (equity): how is it possible in Scandinavia's decentralised multilevel structure?

Managing the complexities of health inequalities is not made easier by the fact that policy development must occur across governmental sectors, each occupied with their own agenda. Ownership of their own agenda will often be actively defended, as will funding, reporting arrangements, administrative cultures, and specific languages and terminology. This represents a major challenge. As formulated by Kickbush (5), although policy departments are often said to work as silos, they more often work as castles than as silos. Kickbush points to a number of challenges for HEiAP: It is one thing for the health sector to strive to solve its wicked problems, but why would other sectors wish to join these efforts? Health is often the greatest single expenditure for a government, so why should other sectors be asked to spend their scarce funds on health? How should the power dynamics between health and other sectors be managed in order to develop a fruitful collaboration and sense of ownership across sectors? Which party is leading the drive, and which parties are following? Without common goals, the process will most likely fail, but how can such goals be developed? And how can a culture of collaboration be created, given that sectors and their leaders are often in competition over resources and visibility? How can accountability be arranged in a situation in

which the costs occur in different sectors and time periods than do the effects and benefits?

Research has thus far identified a need for actors to collaborate and for the organisations to create the opportunities, trust, and capacity that is essential to such collaboration. The planned actions should be well conceived and clearly possible to implement and evaluate, and there should be plans to monitor and sustain outcomes (32). It is part of the complexity but also something that increases the potentials of HEiAP. The fact that policies in one sector might have synergy with what happens in another sector simultaneously makes HEiAP more complex and more capable of producing significant results.

Individual pieces of advice from the health sector to citizens promoting increased physical activity will be less effective if they are not combined with the construction of more bicycle paths and better access to green areas in underprivileged areas. If employment policies for the many unemployed individuals with reduced workability are not coordinated with health programmes for the same groups, they will be less effective. Without national legislation on alcohol, local efforts toward responsible licensing and serving will have a limited effect on traffic injuries. Many such examples illustrate that not only are many policy areas involved, but they also need to be *coordinated.*

The administrative and organisational issues thus partly concern how to achieve ownership, collaboration, and sometimes even coordination horizontally across sectors and vertically across administrative levels. There is also the question of how the competence needed to manage the knowledge issues discussed in chapter 6 can be made available to municipalities of varying sizes and with varying resources. How can an optimal and context-sensitive use of resources be achieved, and what role does collaboration between municipalities and with the regional and national levels play in today's Scandinavian reality?

Scandinavian municipalities have a great degree of freedom, not only to set their own political priorities but also to organise how they wish to achieve them. Because national governments, counties, and municipalities are all involved in making and implementing health policies, the governance structure has been characterised as both decentralised and multilevel (17). Norway has detailed legislation that sets many specific demands on municipalities regarding the integration of HEiAP into overall planning processes. However, national authorities and municipalities in the three countries follow very different models for how to achieve this and how to structure the internal organisation (50, 58, 59). The literature has, as we have also been forced to conclude, been unable to produce clear conclusions as to whether some models work better than others. Often, the models have changed over time in a single municipality, not because evaluations showed inefficiency but obecause a new leadership had different ideas than the previous one.

The public health area is also complex due to the fact that it is influenced by a mixture of traditions from governance of health services, with strong professional dominance, and traditions from social policy and physical planning, where detailed legislation is more prominent and where there is more political than professional dominance.

Horizontal coordination

There seem to be two methods of organising multisectoral health policy in Scandinavian municipalities. The most widespread is to create a unit within the health administration to manage development work and contact with all of the other administrations. The other method is to create a matrix organisation in which responsibility is more evenly spread between the various administrations. Both methods are represented in all three countries. A strong unit might increase visibility and possess stronger developmental force (50) when formulating health in all policies. However, even then it might be difficult, at least in the beginning, to create equal ownership across sectors. The more and better HEiAP is driven by the health administration, the more other administrations will tend to lean back and think that the others will take care of health.

Danish health politician: *"The fact that there is one agreed-upon health policy for all administrations within the municipality does not mean that everybody follows it. We had plenty of goals with specific guidelines. The committee for children and adolescents confirmed that policy, as did the people responsible for integration. However, that has not ensured much action behind the words so far."*

In a matrix organisation, responsibility for formulating policies is shared between sectors from the start of the process. The health aspect may be less visible yet more efficient from a whole-of-government approach:

Public health leader in a Swedish municipality: *"The intersectoral work with formulating visions, direction, and programmes has created much stronger ownership of the proposals across sectors. The whole process has meant that the public health issue has penetrated much deeper into the thinking of all administrations. For the school administration, it has now become very natural to think about the role of schools in the public health program. But the challenge is still to find the right organisation for daily administration after the developmental work. It is important to repeat many of the initial discussions because administrations change all the time. The staff turnover is high, and the challenge is to find a structure that is sustainable even in periods of change.*

We previously had a public health group with executive leaders from all of the administrations, but we now have a group of politicians. The previous solution was much better because they were very action oriented and made things happen. The politicians more often end up in long discussions on issues they then have to take back to the parliamentary party groups. The central political leadership is decisive. Without a long-term strong political leadership following the same path, we would not be where we are today with all policy sectors involved."

Furthermore, the insights from a whole-of-society approach, or what is sometimes called a 'super-setting approach' (63), are gradually becoming more prevalent:

Public health official in a Norwegian municipality: *"Health inequality is a wicked problem with wicked solutions. We need to involve all sectors, not just within municipal responsibilities. It involves voluntary organisations and private firms in different industries. We have to work in many directions. We have been very aware of relating the public health targets to their own sectoral interests and targets. Our experience is that there has been very little resistance when we have taken the time to explain and develop a shared understanding of what this is all about. I think the important thing has been showing a lot of respect to everyone's perspective and knowledge and framing the process in the right way."*

When the municipalities start thinking about these possibilities, it makes the whole-of-society approach more possible: Accomplishing 'nudging' of food choices and dietary patterns involves local food markets. Working environment issues are relevant for many employers in the community. Many NGOs play a major role in trying to prevent loneliness among the elderly and handicapped as well as shaping the local social environment for children. Many NGOs, like unions, tenant's organisations, and environmental interest groups, have considerable political energy and interest, which are congruent with elements of HiAP and can bring a strong participatory aspect into the process.

It has become increasingly common to involve commercial demand-driven service providers in the process. There may be strong potential in this, but there should be awareness that demand-driven services might be biased in relation to equity targets because the more resourceful groups tend to have stronger and more explicit demands than others.

Conclusions and recommendations

This report has aimed to assist the Scandinavian countries and municipalities in learning from each other regarding how to solve a shared problem. This has only been possible because the countries differ in how they have tackled health inequalities so far. The Scandinavian countries differ in terms of legislation, conceptualisation of the health inequality issue, and interplay between central and local policymakers. These differences are partially rooted in history. The fact that Sweden has had the health equity issue on the policy agenda for over 30 years, Norway for 10 years, and Denmark for even less could be used to interpret the differences between the countries as a question of development stages. There is a sense in which this description fits well with the three HiAP development stages (6, 101) presented in Section 1. But there might also be differences in tradition, for instance in terms of how universal welfare policies and multisectoral responsibility for health have stronger traditions in Sweden.

In those Swedish municipalities where HEiAP for many years has been subject to strong political commitment, the political direction has been toward a broad social sustainability agenda (#3.2). This clearly fosters a shared learning process (63) across sectors and makes many policy areas feel ownership. There seems to be a tendency for this to also mean that issues concerning disease prevention are pushed aside and become the sole responsibility of regions/counties, with their more limited range of individual-level programmes.

There is no doubt that clear national leadership and legislation, as in Norway, promotes HiAP at the local level. However, transforming this into specific local policies represents a special challenge.

The direction of development in Denmark is less clear. Shifting governments have not taken a clear stand, and although Danish legislation is clear in terms of municipal responsibility for public health, it does not mandate how this responsibility should be fulfilled. A few larger municipalities are slowly moving forward on the HEiAP agenda, with some support from central authorities (16,47).

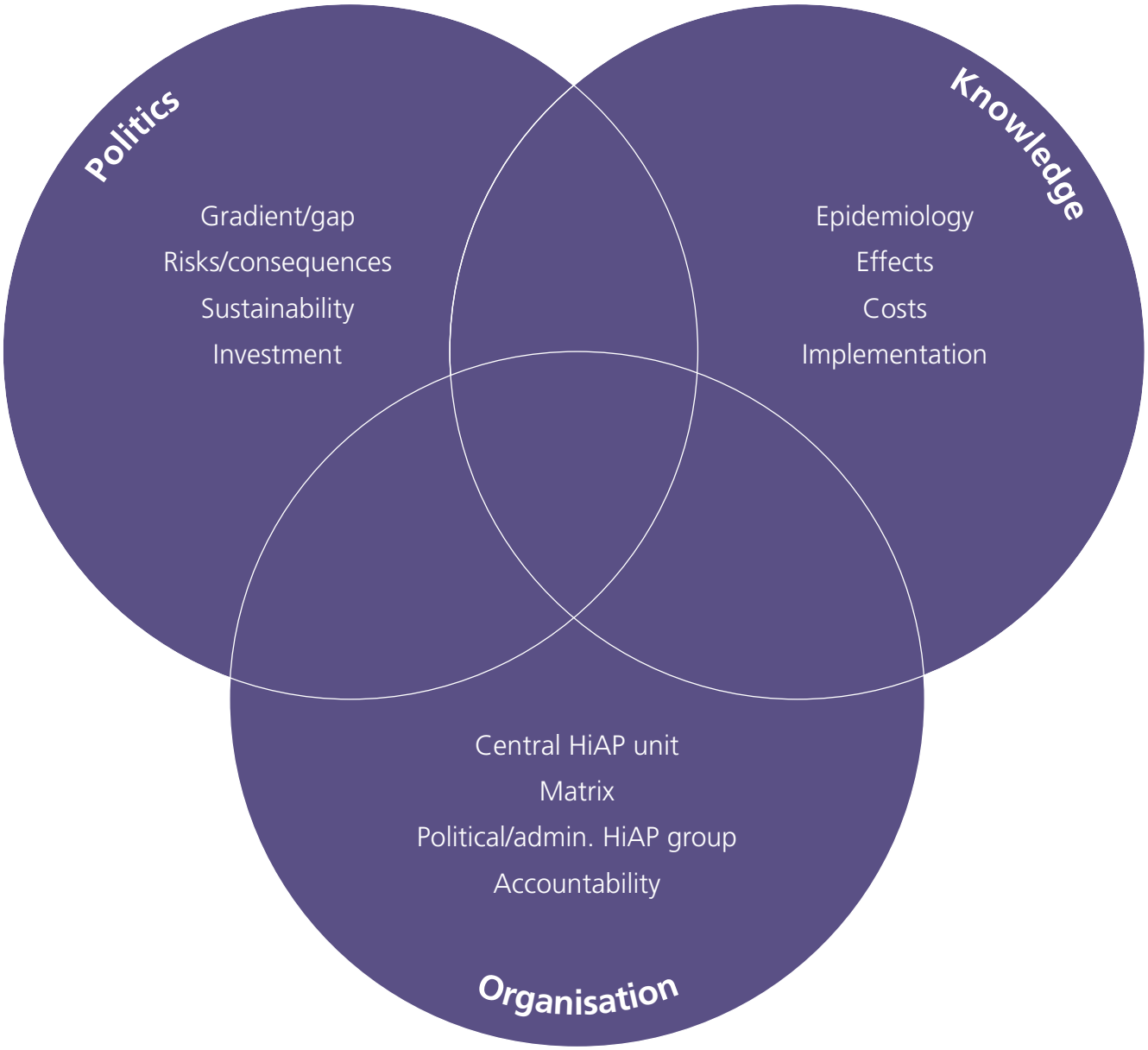
In Chapter 4, we mentioned the Kingdon model of agenda setting. American politics serve as the empirical basis for this model, and we in fact find few examples confirming the theory in our local studies from Scandinavia. At the national level, there are certainly examples, as in Norway (41), but the patterns we observe are different. In municaplities, where health equity has been brought onto the agenda in many sectors, it is much more a result of long-term political will and commitment, where the problem has occasionally been slightly reformulated to fit a sustainability policy agenda but where party politics have played a limited role. We do not observe typical windows of opportunity in this context. Maybe this is because the problems are not particularly mature as 'problems' and because there are not a large number of solutions – particularly not in Scandinavian welfare states, where many of the international 'solutions' were implemented long ago.

Three aspects important for implementation

When seeking to identify the specific obstacles to and promoting factors for implementation of a policy across sectors, we have pinpointed three aspects. We summarise these in Figure 3. It is clear that none of the obstacles or factors are themselves sufficient preconditions. *Knowledge* alone is not enough. The numerous international and national reviews on social determinants and health inequality have been studied extensively – even at the local level – and have inspired strong political interest. But this has not been sufficient. The *administrative* capacity of Scandinavian municipalities is relatively strong, and even in small municipalities, there have been highly qualified HEiAP analyses.

Some Swedish regions in which commissions have presented considerable knowledge and administrative capacity illustrate that when *political* responsibility for the relevant policy areas are not in place (because this is located in the municipalities), then only limited action can be expected. Political responsibility alone is not enough; political *will* to manage health inequalities is crucial in Scandinavian municipalities and regions.

All three aspects are important for implementation. When only knowledge and administration are available, implementation is hampered by the lack of political responsibility for the relevant policy areas. In some municipalities where all three aspects intersect, a 'sweet spot' for implementation can be achieved. All three are necessary but none is itself sufficient to make things happen.



11 recommendations

I: A comprehensive approach

The political prioritization and definition of what health inequality is and why it should be changed have a major impact on what is implemented and how:

When the problem is defined in terms of the health of marginalised groups or the social gradient in consequences of illness, the implementation issue is narrowed to the health services and their collaboration with social services. This is the case despite the fact that the definition in principle involves aspects of labour and housing policy.

When the problem is defined as the gradient in risk of illness, broader perspectives open up. But since the focus is still on health, it tends to be a matter of determining how the health administration can influence other policy areas. This makes it more difficult to achieve a clear sense of ownership in the other policy areas.

When the health equity issue is reformulated as a question of social sustainability of the current community development, it becomes obvious for all policy areas that they are involved and part of the solution. This sense of ownership is also promoted by the perspective of health *for* all policies, i.e. that good health might benefit some of the other policies' own goals. This argument must, however, be used with caution because when health is seen more as a means for improved learning, production, growth, *etc.,* the next step will be to shift interest to the health conditions of the population groups that can most contribute to these goals. This could increase health inequalities rather than reduce them.

In contrast, when health is seen as a value in itself because poor health limits people's freedom to live the lives they value, then the functional aspects of health are in focus, i.e. disability and burden of disease. In order to benefit from all of the public health knowledge on determinants of inequalities in disease burden and (cost) effective interventions to tackle them, it is important not to let the sustainability perspective serve simply as an overarching principle. It is necessary to develop the perspective into concrete preventive actions and make use of all of the existing knowledge from public health science.

Recommendation I: All three aspects of health inequalities and all three motives to tackle them are relevant and should be combined in a comprehensive approach. The social sustainability approach, including a health for all policies perspective, promotes ownership across sectors. But since health is about people's possibility to live the lives they value, it should not divert focus from the most effective interventions for reducing inequality in the burden of disease.

II: Policies build on the premises of each sector

The framework presented in international and national reviews of social determinants and health inequalities are made primarily from a public health perspective. The details of what should actually be implemented, how existing policies in various sectors can be adjusted, and how resources can be reallocated require technical skills and experience from each sector. The languages, rationalities, and scientific and professional traditions differ strongly between sectors. It is important that the possible adjustments to, for example, labour market policy be developed within that sector. But since effective measures must also build upon knowledge of causes and consequences of disease, a dialogue with health professionals is likewise needed. So the type of *policy briefs* that will be useful must take their point of departure from the various sectors. It is also important that the national policies within each sector be taken into account as the foundations upon which local policies must be built.

Recommendation II: Developing and adjusting policies in different sectors must be done on the premises of each sector but in dialogue with public health professionals. Choice of determinants is made on epidemiological grounds, but actions to change them must be developed by each sector.

III: Support for generic policies

Some sectors, like national traffic policies, have developed extremely detailed and qualified health impact assessments for their policies. This is much more difficult for other sectors,

particularly at the local level. The details in terms of what exactly should be done as well as where, when, and for what groups it should be done are dependent on local needs, political priorities, and knowledge about what actions are already undertaken. But they will often also involve a certain amount of technical knowledge, which might not be available in all municipalities, in part because it is a relatively new responsibility for the municipalities. Our study illustrates that highly qualified analyses are already being undertaken in both large and small municipalities, but there are also many places that may still require considerable support in this process. There is a demand for further generic examples of interventions and policies that are nevertheless more concrete than those provided by national reviews.

Recommendation: III: The national and regional levels should support municipalities with generic policies and interventions (policy briefs) to tackle health inequalities across policy sectors. Estimates of the potential health impacts of such proposals would be a great help. There is also a need for support when adapting generic proposals to the local context.

IV: Knowledge of cost-effectiveness

Knowledge about costs is necessary for budgeting, even if there often seems to exist an assumption that HEiAP is a principle without costs or reallocation of costs. In principle, knowledge of potential health impacts – and thus *cost-effectiveness,* or even better, differential cost-effectiveness across groups – is important for prioritising, budgeting, and reallocating resources. In spite of this, we find limited (though slowly growing) demand for this type of knowledge in the municipalities. This might be because the HEiAP agenda seldom advances to the stage of concrete policy proposals. But the low demand might also be due to limited supply, in the sense that the literature still only provides fragmented knowledge.

The experience so far is, however, that HEiAP benefits substantially from being inserted into different types of municipal economic planning documents. More knowledge and use of cost-effectiveness would probably strengthen the position of health (equity) policies in budgetary negotiations. An increasing focus on this aspect is, however, evident in the discussion concerning social investment.

Recommendation IV: There is a low but increasing demand for cost estimates and, if possible, potential health impacts. HEiAP proposals should to a greater extent be supplied with this type of cost-effectiveness estimate to strengthen their position in budgetary negotiations.

V: Equity indicators linked to each sector

Population, administration, and political leadership require feedback on the development and distribution of both relevant determinants of health and the implementation of actions. The Scandinavian countries all have national authorities that support

municipalities by collecting indicators from registries and surveys on morbidity, mortality, and (mostly behavioural) determinants. This data can be broken down into socioeconomic groups by education, employment, *etc.* or geographical units such as regions and municipalities. It cannot, however, at present be broken down into both dimensions simultaneously.

The international and national reviews have suggested a wide range of indicators covering many types of determinants, but we find that, at present, they are seldom used at the local level. Monitoring implementation is much more difficult because most preventive interventions in sectors outside of health services are not systematically classified in the manner of, for instance, clinical interventions. There may be good reason for this since such classification can be both context dependent and difficult to construct.

Implementation of clinical programmes is subject to extensive benchmarking with national guidelines and standards for different diseases. This is not the case within public health, and we have noted significant differences between municipalities in development and implementation of preventive initiatives. These variations are unacceptable from an equity perspective and do not benefit public health policies' quality and legitimacy.

Recommendation V: Indicators on determinants linked to various sectors should be more widely used and should be broken down into socioeconomic groups within municipalities. Indicators on implementation of preventive interventions and policies in various sectors should be developed. It is important that these indicators be developed within the relevant sector or at least in close collaboration with it. A set of minimum standards for preventive policies, including health equity aspects, should be implemented.

VI: Build policymaking skills

Because different sectors have different terminologies, cultural and professional traditions, etc., it could be relevant to offer courses for municipal and regional public health staff introducing the various relevant policy areas. In the long term, it can be noted that most Scandinavian universities have bachelor and masters programmes in public health, though the contents of these programmes differ widely. The skills needed for the policymaking discussed in this report are strongly underrepresented.

Recommendation VI: Teaching programmes should be developed and offered that provide participants with both skills in local policymaking and the utilised public health evidence as well as in the terminologies, traditions, and evidence used in various sectors relevant to public health.

VII: Legislation matters

Norwegian legislation (Folkehelseloven 2011) is very explicit in terms of defining municipal responsibility for integrating health and health equity into overall planning and various policy areas. This provides a uniquely strong juridical basis for implementation. But without the resources and skills to carry out these responsibilities, legislation is not enough. Similar legislation would probably make local policy development in the other countries slightly less *ad hoc* than it is at present, when it depends largely on local political priorities, professional interests, and enthusiasm.

Swedish and Danish legislation is not explicit in the same way. In Sweden, however, years of experience with centrally produced programmes, information, and data support have enabled many municipalities to progress quite far in their HEiAP work. Sweden has, without legislation, developed a level of local activities that is much higher than that of Norway. The combination of a long tradition of welfare policies dealing with central social determinants, the tradition of a determinant approach from the National Public Health Commission, and recent inspiration from the work of the international Commission on Social Determinants of Health has played an important role. So even if legislation seems to have a positive effect on HEiAP in Norway, it might not be the same in the other countries.

In Denmark, national authorities have provided some guidelines (16, 47), but these do not meet the level of support provided in the other countries.

Recommendation VII: In order to support the development of health equity aspects in all policies, central national guidelines are needed to sustain a high level of evidence in the implemented policies.

VIII: Whole-of-society approach

Broad stakeholder involvement plays an increasingly important role. The integration of activities from different stakeholders (including academia, public institutions, private enterprises, non-governmental organisations, and civil society) contributes to making policies more effective. This strengthens participation and empowerment while broadening the available knowledge base. The traditional focus on the municipalities' own activities might limit policy scope and outreach. There should, however, be constant awareness that the strength of organisations is based on the strength of their members. This means that underprivileged groups need public institutions to make their voices heard. To the extent that private and commercial providers deliver preventive services, it is important to consider the type of financing involved since this will influence how they will work from an equity perspective.

Recommendation VIII: A whole-of-society approach to local health promotion is effective and should be pursued. It should involve not only the public sector but also a wide range of interest groups, such as NGO, civil society, and commercial actors.

IX: Involve all sectors early 'on equal terms'

The important aspect of HEiAP is that sectors in which policy options have a great impact on health equity adjust their policies to optimise this potential. This does not necessitate horizontal policy collaboration and coordination. However, such collaboration and coordination may often prove necessary, in which case it is important that the organisation can facilitate such a process. It may be that the process of shared learning is more vital than the implementation of predefined interventions. Many different ways of organising such learning have been tested in Scandinavian municipalities, and there is no clear consensus as to what is best.

In the 1990s, large numbers of Swedish municipalities established intersectoral public health councils, with varying compositions of politicians and/or civil servants. Our impression is, however, that it is most productive to bring top-level administrators from the various policy areas together in a long-term collaboration and coordination process. It might be a process in which the first initiative is naturally undertaken by the health administration. We have nevertheless witnessed some of the best results in terms of cross-sectoral ownership when all policy areas have been involved 'on equal terms' from an early stage. From a longer perspective, a process that includes a strong element of learning across sectors is efficient.

Recommendation IX: All relevant sectors should be involved 'on equal terms' from an early stage in order to improve the development and ownership of health equity policies. Implementation at the local level would benefit from bringing top-level administrators from the various policy areas together in a long-term collaborative process. A parallel process at the national level would greatly support the local process.

X: Vertical collaboration and support

Vertical collaboration between administrative levels (international, national, regional, and municipal) can be productive if there is a clear division of labour. WHO's numerous documents on the subject, starting in the 1980s and now including the Social Determinants of Health-reviews 30 years later, have served as a unique source of inspiration. They have also supported the professional interest in health equity, surprisingly more often at the local than at the national level. The recommendations in these documents have, of course, been very general, and there is a need for up-to-date national and/or regional reviews, taking into account local context dependence.

Local epidemiological data on health and determinants is available, but municipalities may in some cases need regional support in interpreting and using such data. Generic lists of interventions might need to be supplemented with advice on adaptation to the local context, which could be regarded as an appropriate task for regional government. The natural role for public health specialists at the regional level will be to act as 'secondary-level' specialists, supporting the primary-level public health planners and practitioners. Communicating up-to-date knowledge on

preventative, environmental, occupational, and social medicine would thus be a regional task. Since the municipalities often lack skills in the medical public health disciplines, the regions (in Denmark and Sweden) play an important role in supporting them in these areas. In Norway, the national level has a similar task. It is important to ensure that such a process does not narrow the discussion to one between public health professionals only but that other sectors remain involved.

Recommendation X: Regions and counties, and in some cases national authorities, should support the municipalities' work with not only the medical public health aspects of HEiAP (i.e. epidemiology, environmental medicine, and social medicine) but also regional planning.

XI: Long-term commitment

Health inequality is about differences between population groups in which several political actors may come into play. Health inequality could thus become a source of political conflict, as has been the case in national politics in the UK and Sweden. This might fuel strong political energy towards implementation, but the experience from municipalities in Scandinavia is that health equity is seldom politically controversial at the local level. This is perhaps because the issue is rarely sufficiently advanced in the administrative and political processes for concrete details in politics of income, poverty, unemployment, environment, and resource allocation proportional to needs in schools, healthcare, *etc.* to reach the political agenda. It seems, however, that a strong, long-term leadership with many years of political commitment is better for implementation than conflicts between shifting majorities.

Recommendation XI: Developing a locally sustainable process for health equity in all policies requires long-term political and administrative commitment. Some policies will necessarily be controversial, but the process would benefit from a long-term focus on fostering compromise rather than stirring up bipartisan dispute.

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