UK HEALTH PREVENTION FIRST FORUM

Case study:

The Norwegian Public Health Act

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Produced by the UK Health Forum and commissioned by the Health Foundation.

Authors: Alison Giles, Danielle Costigan, Hannah Graff, Rebecca Stacey and Modi Mwatsama

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Summary

This case study was picked to exemplify how a problem, a set of policies and politics came together in Norway during two windows of opportunity, and how national and local parliamentarians and civil servants used the democratic system of government to achieve a common goal.

The problem had been one of health inequalities, recognised by Norwegian policymakers since 2003. Initially, the problem was framed among particular disadvantaged groups, and related to individual lifestyle choices. At this time, public health was the responsibility of the health service, although efforts were emerging to informally broaden responsibility to the county and local municipalities.

A dedicated unit of civil servants was tasked with setting out the policy interventions to address health inequalities and they were heavily influenced by the work of the World Health Organization's (WHO's) Commission on the Social Determinants of Health. As a result, they began to adopt the WHO's framing and began to promote health inequalities as a multi-sectoral problem across government. An unexpected change of government in 2005 to a more left-leaning administration, elected on promises to tackle poverty and create a more equitable society, gave the civil servants the opportunity to garner political support for the social determinants approach and a White Paper was published in 2007 that focused on reducing the gradient by addressing the wider social determinants of health.

Critically at this time, the duty to address health inequalities was written into the Building and Planning Act, making it a requirement of municipalities through their strategic planning cycle. A separate Act set out the requirements on county councils to deliver public health. However, there remained a lack of coordination across the different departments of local government and in the health system.

In 2008, when a new Minister for Health and Care Services commenced health system reforms, parliamentarians and regional and local elected members successfully argued for a standalone Public Health Act to maintain a focus on tackling health inequalities and to enshrine the principle of Health in All Policies (HiAP) across national, regional and local government. The Act has led to a greater understanding, more coordination and an increased focus on addressing the social determinants of health in local government.

Lessons for UK public health include:

1. afford freedom to local authorities to set their own priorities within the legislative framework
2. frame the principle of HiAP as a tool to support other ministries to deliver on their own objectives
3. advocate the need for strong political leadership and senior level coordination at the local level to exert influence across the different council departments
4. provide additional resources for public health interventions and to enable local authorities to create the capacity to adopt a HiAP approach.

Introduction

This case study describes the circumstances leading up to the publication of Norway's Public Health Act in 2012. The Act was designed to be comprehensive, interdisciplinary, cross-sectoral and multi-level (national, county and local), promoting a Health in All Policies (HiAP) approach to tackling the social determinants of health (timeline below). The case study is informed by interviews with two former civil servants in the Directorate of Health, Ministry of Health and Care Services.

Timeline

Year	Event
1984	The Municipal Health Care Act was introduced[1]
2001–05	Centre-right Coalition government: Conservative, Christian Democrat, Liberal
2003	Public Health White Paper, *Prescriptions for a Healthier Norway,* published.[2] This underscored the balance between individual and societal responsibility. Social inequalities were identified as a problem for particular groups rather than the whole population.
2004	Programme of work launched to drive the role of county municipalities in promoting public health
2005–13	Centre-left Coalition government: Labour, Socialist Left, Centre
2005	The *Challenge of the Gradient* action plan[3] was released. It shifted the presentation of health inequalities from a problem for some population groups to a focus on the social gradient.
2006	White Paper, *Regional advantages, regional future*, published by Ministry of Local and Regional Government. It prompted advocacy by the county councils for a public health role[4]
2007	Government published a White Paper on social inequalities in health[5]
2008	The Planning and Building Act enacted,[6] requiring consideration of health inequalities in the statutory regional and local planning process
2008	The Coordination Reform programme commenced
2010	A Public Health Act for County Councils was introduced[7]
2012	The Public Health Act was enacted, setting out the legal framework for public health at all levels of government and promoting HiAP[8]
2013	Government published a White Paper to guide implementation of the Public Health Act[9]
Oct 2013	Right-wing Coalition government: Conservative, Progress Party
2014–	Evaluations of the Coordination Reform programme and Public Health Act[10 - 14]
2015	Public Health White Paper, *Coping and Opportunities,* published,[15] shifting the emphasis back to individuals and away from addressing the social inequalities gradient

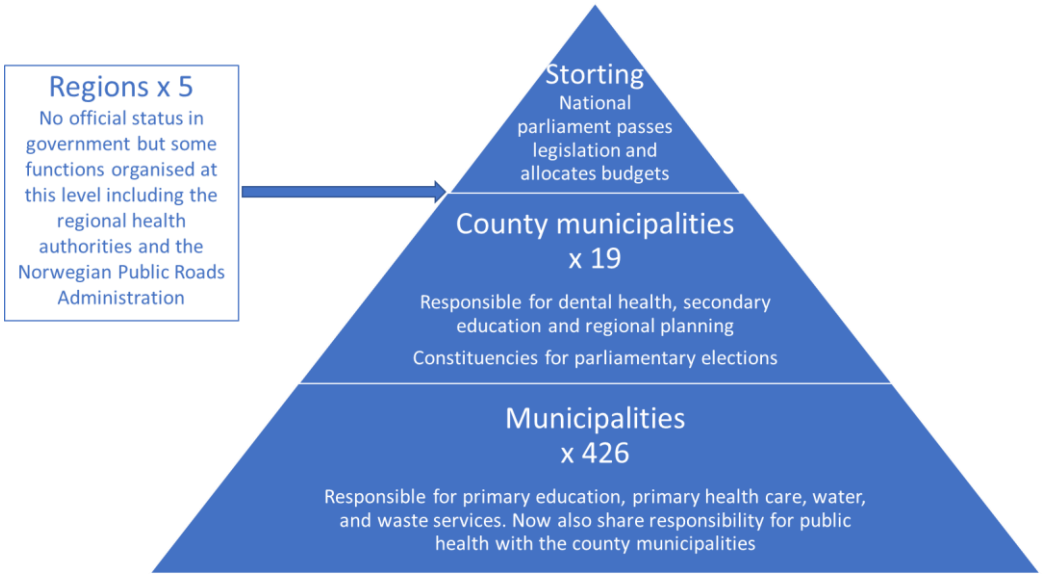
Description of the policy

Context

Norway is a country with a population of 5 million and has historically been described as a social democratic welfare state, owing to its emphasis on solidarity, universalism, equality and redistribution of resources through a progressive tax system.[10] It has become increasingly wealthy over the last 30 years as a result of its growing oil economy, yet there are significant health inequalities among Norwegians.

Similar to the UK, the country has three democratically elected levels of government[16]: the Storting (national parliament) passes legislation and allocates budgets. 19 county municipalities (councils) at the regional level are responsible for areas such as dental health, secondary education and regional planning. At the local level, 426 municipalities are responsible for policies such as primary education, primary health care, water, and waste services. More recently, county and local municipalities have been given responsibility for public health, as outlined in Figure 1 below.

Figure 1: Public health structures and responsibilities in Norway



At the national level, the Ministry of Health and Care Services formulates and implements national health policy.[17] The Norwegian Directorate of Health is a specialised agency of the Ministry of Health and Care Services and is responsible for areas of legislation, national guidelines and campaigns. It also advises the ministries concerned on health policy and legislation. Its administrative activities involve management of grants for projects and research, the implementation of statutes, and delivery of projects designed to promote public health and improve living conditions in general. [17]

Public health policy 1984–2004: a focus on disadvantaged groups

In 1984, the Municipal Health Care Act[1] made the Norwegian health sector responsible for public health. At the municipal level, responsibility was held by the medical officer for health and delivery was through the primary health care system that they were responsible for.

In 2003, the Norwegian government was represented by a three-party coalition, the Christian Democratic Party, the Liberal Party and the Conservative Party.[18] This government launched a political programme with a focus on poverty reduction and excluded groups with particular care needs. In 2003, a White Paper was launched that included an objective to reduce social inequalities in health.[2] The White Paper recognised for the first time the role of other sectors in the population's health. However, while the White Paper recognised the gradient in health inequalities, the solutions it described were targeted at disadvantaged groups and lifestyle interventions as a result of the prevailing centre-right political ideology.

In 2004, a Ministry of Health and Care programme encouraged the 19 county municipalities to partner with and to fund their local municipalities to take action on public health.[10] This represented the beginning of a more cross-sectoral approach to public health. In many cases, the counties required local municipalities to recruit a public health coordinator. However, since there was no mandate to take action, public health remained low profile.

Following publication of the 2003 White Paper, the Directorate of Health established a dedicated Equity Unit to develop concrete measures and an action plan to reduce social inequalities in health. The Unit was influenced by international evidence, particularly the World Health Organization's (WHO) Commission on the Social Determinants of Health, and it started to reframe the problem of social inequalities to include multi-causal mechanisms. Having originally been intended to ensure that inequality considerations were included in health sector planning, the Unit became a driving force for promoting the idea of health inequality considerations across government.[18]

Public health 2005–07: a focus on the inequalities gradient and county-level action

In 2005 an unexpected change of government, from centre-right to centre-left led by the Labour party, gave political momentum to tackling the social gradient in health.[18] The government won power on promises to fight poverty and work for a more equitable society, in terms of fairness in income distribution, education and health. This provided the Ministry of Health and Care and the Directorate of Health with a window of opportunity to implement the policies they had been formulating. An action plan was published, *The Challenge of the Gradient,* which indicated a shift away from a focus on marginalised groups.[3]

The Challenge of the Gradient action plan was followed in 2007 by an ambitious White Paper setting out a ten-year strategy to reduce social inequalities in health.[5] The strategy took a cross-ministerial approach covering childhood/adolescence/education, work, income, health services, health behaviours and social inclusion. Norway was unique among EU countries at the time by targeting the gradient in health rather than focusing on particular disadvantaged groups. The 2007 White Paper was widely consulted on through a series of regional events. The bulk of public responses came from the voluntary sector, expert groups and academics, all of whom were supportive of the proposals.

To strengthen cross-sectoral action further, the Planning and Building Act of 2008[6] made tackling health inequalities part of the planning process at the regional and local levels.

Meanwhile, in autumn 2006, the Ministry of Local Government and Regional Development published a White Paper[4] that proposed a reorganisation of the Norwegian regions in terms of size and functions. At an open hearing of the Committee for Local Government and Public Administration in the Norwegian Parliament in February 2007, one of the county councils (Østfold), in conjunction

with the Norwegian Healthy Cities network, argued that public health should be made a mandatory function of the county councils.[19] This proposal was also promoted by policy entrepreneurs within the Ministry of Health who saw it as an opportunity to enshrine the principle of public health as the responsibility of all sectors within Norwegian law. This resulted in the Ministry of Health preparing a consultation paper on a statutory public health responsibility for Norwegian regions. The proposals were supported by statutory bodies at both the national and county level as it supported the devolution agenda at the time.

In 2010 the Norwegian Public Health Act for County Councils came into law.[7] This set out three functions for county councils:

1. Councils are to motivate and coordinate in respect of municipalities, by developing alliances and partnerships and by supporting the municipalities' public health initiatives.
2. Councils are to possess the necessary overview of the general state of health among the county population – and factors that influence this – including characteristics that can create or maintain social differences in the public's health.
3. Health in all policies: Public health initiatives shall be included in the county council's ordinary operations and enterprises.

As stated previously, the adoption of this Act enabled the principle of public health as the responsibility of all sectors to be established within Norwegian law, and this principle was later used to inform the adoption of the national Public Health Act which would extend these responsibilities to all levels of government. The quotes in Box 1 on page 8 summarise how this process unfolded.

Public health 2008–2012: a focus on HiAP

Following a ministerial reshuffle in the Labour-led government in 2008, the new minister of Health and Care favoured a more direct, centralised approach than his predecessor, influenced by both the need to tackle the increasing expenditure on health, and by policy learning from WHO and Denmark.[20] He set in train a series of health reforms (the 'Coordination Reform') to improve the coordination between primary and acute health services and as part of this, wanted the health sector to have a greater focus on and resources for prevention and reducing health inequalities.

> *'[The new minister wanted to introduce] something called the coordination reform, which meant that it was a coordination problem between the state or the different level of health care systems, because the hospitals are owned by the state, but the primary health care are the responsibility of the municipalities. So there has been a kind of coordination problem between the municipalities and the primary health care and the hospitals. As an example he said that resources was used in the last part [of the pathway to illness] when you needed a new kidney or things like that, and not to prevent it.'*
>
> Source: Commentator from the health sector

However, this approach threatened to undo previous efforts to make tackling health inequalities a multi-sector responsibility. In response to the reform proposals, the county and local municipalities mobilised to argue for a standalone Public Health Act that was comprehensive, interdisciplinary, cross-sectoral and multi-level (national, county and local).[19] Their lobbying activities included work with the media, written submissions from 16 out of 18 county councils, the engagement of The

Norwegian Association of Local and Regional Authorities, a note to the Health Minister from all the County Mayors, and a meeting of the County Mayors with the Secretary of State in the Ministry of Health and Care Services.

> *'So actually it wasn't the Minister himself who wanted to create a Public Health Act, but it was a response from other [regional and local actors] that if you want to reform health care […] you need the reform to fill the whole spectrum, from social determinants, health equity, public health and health care.'*
>
> Source: Commentator from the health sector

Initial government proposals stated that the new Public Health Act would apply to municipalities, county authorities and the central government's health (care) sector. The Norwegian counties and municipalities again mobilised and coordinated written submissions to express concern that, given one of its four stated principles was HiAP, the Act should apply to all ministries. [19] They also called for the adoption of a fifth principle: participation.

The Public Health Act 2012

The Public Health Act[8] came into force in January 2012. The Act's stated aim was 'to contribute to societal development that promotes public health and reduces social inequalities in health' and it defined public health work as 'society's efforts to influence factors that directly or indirectly promote the health and well-being of the population; prevent mental and somatic illnesses, disorders or injuries; or that protect against health threats; as well as efforts seeking a more equal distribution of factors that directly or indirectly affect health.'

The Act had five principles:

Health equity	Level up the gradient by action on the social determinants of health.
Health in all policies	All sectors have responsibility. Promotion of Health Impact Assessment.
Sustainable development	Take a long-term perspective.
Precautionary principle	If an action or policy has a suspected risk of causing harm to the public or to the environment, then act to prevent such harm.
Participation	Inclusion of all key stakeholders, including civil society.

Locally, the Act provided the legal mandate for municipalities to deliver public health and disease prevention, with responsibility now given to the chief executive rather than the medical officer. Municipalities were required to take a HiAP approach and include public health measures in their local strategic plans, developed every four years, across a specified list of social determinants including housing, education, employment and income, and physical and social environments. The Act encouraged municipalities to employ a public health coordinator to initiate and secure cross-sectoral action at the local level and to facilitate cooperation with the voluntary sector.

According to one of the key informants interviewed, the Ministry of Health and Care established a relationship with The Norwegian Association of Local and Regional Authorities and framed the Act as a means to promote and support a more effective way of working at the local level. The freedom afforded to municipalities to set their own local public health priorities, rather than have these mandated by the state, was well-received across political parties.

'We have a hearing on the Public Health Act and we have 450 I think letters of interest to the Public Health Act so it was very participatory. And because the Public Health Act doesn't say what the political solution is, it says only how you should run broad […] efforts based on local overview or challenges. Then you didn't have this divide between different political parties, because everyone thinks that public health is important.'

Source: Commentator from the health sector

Regionally, the Act incorporated and superseded the previous Public Health for County Councils Act.[7] The new Act required counties to identify their public health challenges and any trends that could lead to or maintain social or health-related problems or social inequalities in health. This county-level public health overview was to form a basis for work on the regional planning strategy required by the Planning and Building Act.[6]

Nationally, the Act required the Directorate of Health and the Norwegian Institute of Public Health to support municipalities with data on local health conditions and knowledge about effective interventions and policies. In addition, following the successful lobbying by the municipalities, it required the adoption of a HiAP approach across government.

'…most municipalities were extremely positive. But they say when we are about to do health in all policies you should also do it on the national level, and that's why there was one more paragraph put into the Act that should commit national authorities to act more according to health in all policies approach as well.'

Source: Commentator from the health sector

To achieve this, the Ministry of Health and Care framed the Act as a tool to support other sectors to meet their objectives.

'And that's for other sectors as well. When we are working with other sectors we have to not try to compete or do something different, but look at what's in it for you? How could we with public health way of working support you or the way you work? And of course this is a long way, but that makes it possible to develop our system [...] It's easier to get it through the parliament or whatever, and it's easier to implement it, because you have an alliance between different actors who are involved in the process.'

Source: Commentator from the health sector

A key informant described how, in taking this approach, the Act was seen as an enabler rather than a burden, in particular by those Ministries with less power such as Culture and Sport, and Children, Family and Equity.

According to a key informant, the Ministry of Finance was initially concerned about the potential increased costs on other ministries to assess health impacts and make any resultant changes to policies. The Ministry of Health and Care successfully argued that since health impact assessment was an existing internal requirement of government ministries then the Public Health Act was in line with this and did not represent an additional financial burden.

The Act also applied to other sectors and public and private entities and property where these directly or indirectly influence health. A White Paper was published in 2013 setting out the government's approach to the implementation of the Public Health Act.[9]

Box 1: Summary of how the principle of public health as the duty of all sectors was enshrined in Norwegian law

In 2008, a new health minister embarked on a 'coordination reform' of the Norwegian health system to address the challenge that the majority of resources were spent on treating conditions in hospitals during the later stages of the disease process, as opposed to being invested in preventing them. This was partly because responsibility for the determinants of health, such as roads, rested with municipalities as opposed to the hospitals controlled by central government (see Figure 1 on page 3). This sparked a national debate on how to reform the system to increase the priority of prevention.

At the same time, the Department for Local Government was exploring reforms to regulations governing the roles and responsibilities of municipalities at the county level. Public health actors identified an opportunity to promote the principle of public health as the responsibility of all sectors as part of this regulatory reform process in local government.

'[we] suggested the act should have more responsibility for public health on a municipal level, and because the ministry was looking for things to filter into the county level, [they] said yes, we would like to include the public health in our county level.'

These proposals were welcomed by the Department for Local Government and actors in the regional counties as it fitted with the devolution agenda. The county actors were keen to have their responsibilities and power increased.

'[…] And of course this was a very tiny act just on the county level and the [counties were]… happy to get something to do. There was no problem so to speak to get this act through the parliament.'

The Department for Communities Public Health Act for County Councils was passed with the additional public health responsibilities for other sectors enshrined within it. This was the first time such a principle had been enshrined in Norwegian law.

'[…] So in the regional setting this was the first time we have a kind of, in a legal way, ensured public health cross-sectoral, not only in the health sector but stated that public health was the responsibility of all sectors just in the county level, not in the state and not in the municipal level.'

As a result, when the Ministry of Health was finalising its 'coordination reform' and a new national Public Health Act was proposed, public health actors were able to successfully call for the inclusion of the principle of public health in other sectors to also be enshrined in the new Act so that it could complement what was in the county level Act.

'But the principle was now stated. So when we go further to the more broader, […] to look into the more general regulation on the municipal level, on state level, we used the same principle within this process.'

Source: Commentator from the health sector

Evaluation

A number of formal evaluation studies have been undertaken into the coordination reform, the impact of the Public Health Act, and how it has been implemented among the county municipalities[10] and local municipalities.[11 - 14]

Outcomes

Local impact

A number of outcomes have been identified at local level:

- Following publication of the Act, the prominence of public health in municipal planning increased.[11]

> *'The Public Health Act has contributed to health promotion, and preventive work has gained greater legitimacy in the organisation. And this focus that also involves inter-sectorial working methods is also a product of the Public Health Act, and insofar the Health and Care Act, and it helps to provide legitimacy.'*
>
> Source: Elected Councillor, Local Municipality[12]

> *'The Public Health Act has maybe not led to a great change, but it has certainly contributed to a greater emphasis on the health promotion thinking.'*
>
> Source: Head of Department (Children and Adolescents)[12]

- A third of municipal managers reported that there had been an increase in resources spent on public health work.[11] This was largely on organisational and planning work, such as creating new positions for public health coordinators and participating in forums and working groups. There was limited evidence that resources had been invested in increasing the number of preventive or health promoting measures, which suggests a mismatch between aspiration and budgeting.
- Collaboration between municipalities and county authorities has been strengthened by the Public Health Act, which has helped increase clarity about the roles of the different partners.[1, 16] However, the timeframe of the evaluation study was too short to demonstrate an effect on cross-sectoral public health work within the municipalities.[16]

> *'But the evaluation shows that it takes time because this Act is […] connected up to the planning cycle on the municipal level, it will take at least four years before we can see the actual impact.'*
>
> Source: Commentator from the health sector

- The proportion of municipalities that produced a comprehensive overview of their population's health (one of the requirements of the Act) increased from 18% in 2011 to 38% in 2014, with a further 48% of municipalities reporting that this was in progress. Only 11% of municipalities reported no overview in 2014.[13]
- The proportion of municipalities with a coordinator in post increased from 74% in 2011 to 85% in 2014.[18] While a public health coordinator is not a requirement of the Public Health Act, it is a strong recommendation. This post appears to have played a significant leadership role, providing expertise and facilitating collaboration, able to communicate the importance of public health throughout the organisation and assign responsibility to different sectors.

> *'We have a public health coordinator, and that's great because then we have a person with an overall perspective on things who makes sure that the various other services are on their*

toes regarding health promotion measures which are implemented in plans. If we are all located in 69 separate sectors and only work with health promotion by ourselves, then it might be easier to forget it. […] Having a public health coordinator helps us to be more aware. Without this position each of us would sit alone and think about public health every now and then, right?'

Source: Municipal Mayor[12]

'Yes, well, it means a lot to have a public health coordinator! As much as you have a finance manager who coordinates financial services organisation, we have a public health coordinator who puts together a whole organisation's work and can both make a plan and also coordinate the service in it. And, in that respect it is a valuable position.'

Source: Elected Councillor[12]

- The extent to which the public health coordinator was able to significantly influence public health activity may have been determined by their terms of employment (full-time or otherwise). Only 23 percent of municipalities employed a coordinator at 0.7 full-time equivalent or greater.[18] One municipality that employed a coordinator full-time further boosted their influence by locating them in the municipal building together with the Mayor, the Councillor and the majority of sector leaders.

  'We have placed health promotion in the Councillors' staff to provide an organisational position that demonstrates the affiliation and the level of importance, so it is not a resource that we have hidden in the health and social services far out in an office, but we want to have a central placement of the position.'

  Source: Elected Councillor[12]

  In contrast, most municipalities located the public health coordinator within the health sector and this was felt to have limited their impact.[13]

- The Public Health Act appears to have increased attention on the social determinants of health. The majority of the Norwegian municipalities (82%) believe they are capable of reducing inequalities in health and, in 2014, 48% of municipalities reported that they specifically addressed living conditions as part of their health promotion activities.[19] This increased from 6% before the Public Health Act was introduced.[20] The municipalities that prioritised action on living conditions had, in the main, established cross-sector collaborations on health promotion both internally and with their neighbouring municipalities. They were also taking a HiAP approach.[14]

  Prioritising action on living conditions was positively correlated with the size of the municipality; [14] 37% of Norwegian municipalities have less than 3,000 inhabitants. Larger municipalities are more urban and therefore have more complex social needs to address, and may also have greater internal competency and capacity to devote to addressing socioeconomic issues.

- At the municipality level, public health leadership appears to have played a significant role in the successful implementation of the Act. Where elected councillors prioritised public health

and health promotion, staff gained the knowledge and understanding about the health challenges facing their municipalities and accepted the need for a HiAP approach.

> *'We have something we call municipal day – the Councillor has, and there the topic for discussion very often is health promotion [...] It has been repeated many times, even this legislation.'*
>
> Source: Head of Technical Sector[14]

Regional impact

At the regional level, the county municipalities prioritised support to the municipalities.[10] Their efforts to advocate for HiAP at the county level were less successful. In part this was because of competition between the different policy areas they were responsible for. However, it was also because they found it challenging to influence both their own and other sectors to change the focus from the classical lifestyle issues to a focus on the social determinants of health. This seemed to be further hampered by what was perceived as conflicting approaches coming from the Directorate of Health, which continued to launch lifestyle-focused campaigns and offered little guidance to the county municipalities on how to coordinate and influence other sectors.

> *'The Directorate still talks about physical activity, diet and a little bit about alcohol, and tries to say something about mental health. This does not contribute to an understanding of the new public health in the municipalities, particularly not for the CEO and his staff.'*
>
> Source: County Municipality Officer[10]

National impact

At the national level, the Act is seen as a useful tool for securing HiAP.

> *'When we see suggestions from different ministries and think this might maybe have some health consequences. Then we could go back to the ministry and say that we think that this might have some health consequences, you should assess the impact and we can help you with that. And sometimes they say yes, but sometimes they say no, then we could go to the politicians and say that according to this act they are obliged to do so.'*
>
> Source: Commentator from the health sector

There is some limited evidence that the Act has led to ministries adopting the HiAP approach.

> *'For example, when I was in a meeting with a researcher from the Labour sector who had developed a new report on inclusion to the Labour market, they looked at the Public Health Act, and said that all these things are so interconnected so we should collaborate better towards regional and local level. You have some initiative based on that.'*
>
> Source: Commentator from the health sector

Further, one of the key informants suggested that this would increase over time as the culture being adopted by politicians locally would migrate to the regional and national levels as those politicians progressed in their careers.

> *'And also to some extent it helped that because particularly now when you see… because it's a very important Act on local level, and politicians that enter Parliament, they start off on the local level, so all of a sudden Secretary of State from the [health] have a meeting with the Secretary of State in the transport sector, and then it just comes out that, well I was very involved in developing this public health or health equity plan in our municipality or in the region.*
>
> *'So I think because of the Act, I think there will be a change over the years that there is a bottom up process, because the municipalities that are now in the lead working with health in all policies, and starting to work well, and I think we will see more in the future. This is the long, yeah, process.'*
>
> Source: Commentator from the health sector

Recent developments

In 2013 the Conservative party took the majority in government and in 2015, the government published its White Paper on public health called *Coping and Opportunities*.[21] This prioritised mental health, healthy lifestyle, active elderly, children and young people, and cross-sectoral public health work and it re-emphasised the goal to reduce health inequalities. However, critics suggest the focus has shifted back to individuals and efforts to narrow the inequality gap rather than promoting policies to address the gradient.[22]

Elsewhere the government has made other policy changes that are felt to have undermined action on the social determinants of health. For example, in 2015 the Working Environment Act was amended to introduce more temporary work. Advocates suggest this gives greater employment flexibility and more opportunities for vulnerable groups like young people and the disabled to enter working life. However, critics believe it simply increases job insecurity in the labour market and is detrimental to mental health. [22]

In 2016, the government introduced a cut in the child allowance to parents who receive disability benefit, making it likely that low income earners with several children will lose significant income. [22]

The adoption of a HiAP approach required capacity to review all draft policies and legislation across the different sectors as these arose. Smaller municipalities in particular lacked the capacity and competency to achieve this and to implement actions on the wider determinants of health. In Norway, according to a key informant, the Ministry is now working with the Institute of Public Health and other organisations to develop a system of support to the municipalities. This will provide information, guidance and training to increase local knowledge to implement the Act.

Lessons learned

What worked

The lessons from the case study based on what worked include:

1. It was useful to anchor public health to the statutory planning process at the regional and local levels (through the Planning and Building Act). Greater success in delivering HiAP was reported where the public health coordinator was based in the planning department.
2. Framing public health and HiAP as a means to meet the needs of other government departments helped to secure cross-sector buy-in.
3. Giving municipalities the freedom to set their own local public health priorities, rather than have these mandated by the state, achieved political buy-in.
4. Making municipalities responsible for HiAP nurtured a culture change among local politicians that has started to filter up to county and national levels as they move up in their careers.

What didn't work

The lessons from the case study based on what did not work include:

1. Legislation alone was insufficient to drive and maintain a cross-sectoral approach to public health. Continued efforts are required to engage elected policymakers to direct their organisations' focus and resources on the adoption of a HiAP approach.
2. A lack of dedicated capacity at a sufficiently senior level to drive HiAP across departments and with other municipalities limited progress and impact, at least in the short term.
3. Without additional, dedicated funding from national government, local action was largely limited to the deployment of a coordinator post, and on supporting joint ways of working, rather than to the implementation of new initiatives.

   'The link to the budget is probably not so good – there is an inadequate link between what is decided and what is being implemented. So, now we have tried to link the new budget and our action program closer together.'

   Source: Public Health Coordinator [11]

4. Beyond health protection and environmental health concerns, the Act did not give powers to curb private sector actions that undermine health. Therefore, the impact that the commercial determinants of health have on the inequalities gradient could not be addressed.

   'You could imagine that we should use this means on the public health factors as well. And that is a weaker part of the regulations. It's basically on environmental health when it's a threat to human health, environmental [factor], the municipalities have very strong regulatory means to stop or demand correction of the industries. So this is more to ensure or safeguard human health, not so much health promotion.'

   Source: Commentator from the health sector

Implications for the UK

1. A Public Health Act can articulate clear responsibilities at each level of government. Long-term partnerships with representative bodies such as the Local Government Association will be vital for capacity-building and securing and sustaining lead elected member buy-in and focus on HiAP.
2. The inclusion of the requirement to consider health inequalities in the Norwegian Planning and Building Act may represent a model for the UK if it could confer local powers to curb the impact of the commercial sector on health outcomes, for example through licensing and planning committees.
3. Small and/or rural councils may lack the capacity or capability to tackle inequalities. However, the emergence of city regions and the closer integration of health and local government may create the scale needed.
4. The Norwegian case highlights the critical function of public health coordination at a senior level. This has implications in the UK where the Director of Public Health role, while statutory, is not always at executive level. However, there are interesting examples in the UK where the public health function has been distributed across the council. It would be interesting to investigate if this has led to better coordination of public health and the HiAP approach compared to councils where public health is a discrete function.

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