NORWEGIAN MINISTRY
OF HEALTH AND CARE SERVICES

Report No. 20 (2006–2007) to the Storting

National strategy to reduce social inequalities in health

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Translation from the Norwegian. For information only.

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National strategy to reduce social inequalities in health

Report No. 20 (2006–2007) to the Storting

Recommendation from the Ministry of Health and Care Services, dated 9 February 2007, approved in the Council of State on the same date (The Second Stoltenberg Government)

1 Introduction

1.1 A fair distribution is good public health policy

The Norwegian population enjoys good health. However, averages conceal major, systematic inequalities. Health is unevenly distributed among social groups in the population. We have to acknowledge that we live in a stratified society, where the most privileged people, in economic terms, have the best health. These inequalities in health are socially determined, unfair and modifiable. The government has therefore decided to initiate a broad, long-term strategy to reduce social inequalities in health.

Many factors play a part in creating and perpetuating social inequalities in health. The situation is complex, but we can nevertheless state that it is generally social circumstances that affect health and not the other way round. Although in many cases serious health problems lead to loss of income and work and difficulties completing education, social status still has a bigger impact on health than health does on social status. An overview of current knowledge compiled under commission from the EU concludes that social inequalities in health in all countries in Europe, including Norway, are primarily due to inequalities in material, psychosocial and behaviour-related risk factors. Social inequalities in health are an expression of systematic injustices, and this is happening in a society that upholds the principle that everyone should have equal opportunity to achieve good health.

The Government believes that public health work needs to be based on society assuming greater responsibility for the population's health. Each individual is responsible for their own health, and it is important to respect the right of the individual to have authority and influence over their own life. However, the individual's sphere of action is limited by factors outside the individual's control. Even lifestyle choices such as smoking, physical activity and diet are greatly influenced by socioeconomic background factors not chosen by the individual. As long as systematic inequalities in health are due to inequalities in the way society distributes resources, then it is the community's responsibility to take steps to make the distribution fairer.

A fair distribution of resources is good public health policy. The primary goal of future public health work is not to further improve the health of the people that already enjoy good health. The challenge now is to bring the rest of the population up to the same level as the people who have the best health – levelling up. Public health work

entails initiatives to ensure a more even social distribution of the factors that affect health.

1.2 Comprehensive policy to reduce social inequalities

This Report to the Storting along with two other Reports to the Storting (Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*) form part of the Government's comprehensive policy for reduction of social inequalities, inclusion and combating poverty. The strategy to reduce social inequalities in health comprises the health aspect of this policy.

This Report to the Storting lays down guidelines for the Government and Ministries' efforts to reduce social inequalities in health over the next ten years. The strategy traces out the main framework and shall govern the Ministries' work on:

– Annual budgets
– Management dialogues with subordinate agencies, regional health enterprises, etc.
– Legislation, regulations and other guidelines
– Interministerial collaboration, organisational measures and other available policy instruments

Importance is attached to describing responsibilities in the individual priority areas and the measures to be used to help reduce inequalities in health. Measures to reduce social inequalities in health are largely linked to the follow-up of other Reports to the Storting, plans of action and priority areas, for example Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion*, Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning, The Action Plan to Combat Poverty, The Diet Action Plan* (2007–2011) and *The National Health Plan for Norway*. An important element of the future efforts to reduce social inequalities in health will be ensuring that this perspective is also integrated into subsequent initiatives.

1.3 Objective: To reduce social inequalities in health

Objective

The primary objective of this strategy is to:

- reduce social inequalities in health by levelling up

Work to reduce social inequalities in health will require long-term, targeted effort in many areas. The strategy lays down goals for this work in the following areas: income, childhood conditions, employment and working environment, health behaviour, health services and social inclusion. It will take time before we can measure the results of the policy in the form of reduced inequalities in health in all these areas. For this reason, time limits have not been set for achievement of the goals; rather they require continuous input over the next ten years.

The Government will monitor progress towards each of the goals in order to ensure that we are on the right track. Assessment indicators will therefore have to be found for each objective to allow annual policy review on efforts to reduce social inequalities in health (see chapter 9).

1.4 Four priority areas for reducing social inequalities in health

Complex problems require comprehensive solutions. There are many causes of inequalities in health, ranging from basic determinants such as personal economy and childhood conditions, via risk factors such as working environment and living conditions, to more immediate causes such as health behaviour and use of the health services. These various areas can be regarded as interrelated and partially overlapping causal chains. The conditions and surroundings in which children grow up affect their education and employment opportunities later in life, which in turn affect their health as adults. Moreover, access during childhood to resources such as a healthy diet, fresh air and physical activity have a direct impact on health in later life.

Work to combat social inequalities in health must be combined with targeted efforts aimed at particularly vulnerable groups through general

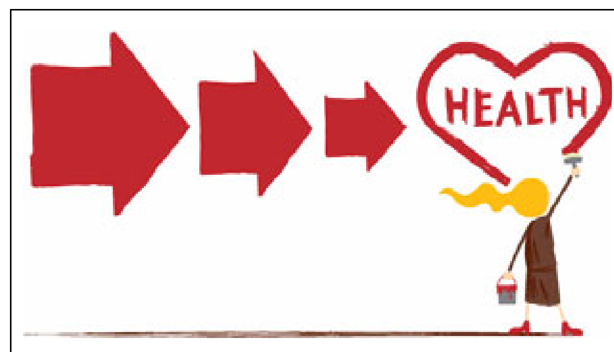

Figure 1.1 Interlocking causal chains

welfare schemes and special initiatives aimed at specific groups. Inequalities in health are most noticeable in groups with low income and little education, so it is important to give these groups priority. However, tailored measures targeted at specific populations are not always the most effective instruments. In many cases, targeting, for example on the basis of means testing, can have a stigmatising effect and actually undermine the purpose. General welfare schemes are less stigmatising and serve to prevent people ending up in high-risk situations. In addition, social inequalities in health affect all social classes, not only the most disadvantaged. We must therefore continue to build on the Nordic tradition of general welfare schemes and at the same time implement special measures to help the people with the most problems.

In keeping with the identified need for a broad approach, this strategy operates with the following four priority areas: 1) Reduce social inequalities that contribute to inequalities in health, 2) Reduce social inequalities in health-related behaviour and use of the health services, 3) Targeted initiatives to promote social inclusion, and 4) Develop knowledge and cross-sectoral tools:

1.4.1 Reduce social inequalities that contribute to inequalities in health

The social circumstances we live in form the foundation for our health. The basis for social inequalities in health is laid very early on, and childhood is a sensitive period in life. Early interventions are therefore necessary to prevent social inequalities in health developing. Good, safe childhood conditions for everyone, fair income distribution and equal opportunities in education and work are the most important investments society can make to reduce social inequalities in health.

1.4.2 Reduce social inequalities in health behaviour and use of the health services

Health behaviour varies according to social background and has an enormous impact on health. We have to respect the individual's right to make their own choices and judgements, but we must acknowledge that a healthy lifestyle is also a question of resources, motivation and energy. Attention needs drawing to the underlying, structural causes of behaviour in order to encourage healthy lifestyle choices. Policy instruments influencing cost and availability play a central role in reducing social inequalities in lifestyle diseases.

It is necessary to investigate more closely whether the Norwegian health service is serving to narrow or widen the health divide. Services should be accessible to everyone, regardless of their social background and should help reduce social inequalities in health.

1.4.3 Targeted initiatives to promote social inclusion

We have a special responsibility to include people who are at risk of being excluded from education, employment and other important arenas because of barriers created by society. Exclusion from society and being treated as inferior lead to deteriorated health and greater risk of early death. Many disadvantaged people need more targeted services. Universal schemes must therefore be supplemented with services and schemes tailored to the individual that take account of these special needs. User-oriented and specially adapted public services are essential to ensure that everyone, regardless of their background and circumstances, has access to equitable services. We must ensure inclusive work life, inclusive schools and adapted health and social services. The public sector must collaborate with voluntary organisations in this respect.

1.4.4 Develop knowledge and cross-sectoral tools

Social inequalities in health are closely related to social inequalities in other areas of life. Efforts to reduce social inequalities in health must therefore be followed up in all sectors. Systematic reporting is necessary to monitor the progress of work to reduce social inequalities in health. Health impact assessments and social and land-use planning will be important instruments to this end. The Partnerships for Public Health scheme will be strengthened and developed further.

We have enough knowledge to implement measures. However, we need to build up our knowledge about the causes behind social inequalities in health and effective policy instruments to ensure that the measures we implement increasingly achieve their intended purposes.

1.5 Limitations

This Report to the Storting deals with inequalities linked to education, occupation and income. Health problems in certain groups will be dis-

cussed to the extent that their health problems coincide with inequalities in health linked to education, occupation and income. For example, we know that chronic disorders occur more frequently in populations with little education and low income. We also know that gender, ethnic background and place of residence often play a part in social inequalities.

The correlation between gender and social inequalities in health is complex. Taking life expectancy as our starting point, social inequalities are less pronounced for women than for men. Measured using other health criteria however, such as mental health, social inequalities are much greater among women. Certain studies indicate that skew distribution of access to health services between the sexes.

Some of the indicators most commonly used to measure social background are traditionally harder to apply to women than men. Personal income, for example, does not always reflect women's social position. Many women have little or no personal income, but live in a high-income household. Household income – adjusted for the number of members – is therefore often a more apt expression of actual access to resources than personal income. Using occupation as an indicator of social position is problematic without also including gender, because choice of occupation is often coloured by gender.

Within most ethnic groups, we find many of the same social inequalities in health as in the population in general. Nevertheless, a number of more specific health problems are more widespread in some ethnic groups than others, and in some cases, they coincide with socioeconomic position. However, it is not the case that there are some health problems common to all ethnic minority groups. Access to health services may also vary between and within ethnic groups.

The correlation between social inequalities in health and place of residence is often more straightforward and obvious than it is for gender and ethnic background. The best example of this is perhaps Oslo, where differences in average life expectancy between different urban districts can be up to 12 years or more among men. There are also relatively large regional inequalities in mortality. These kinds of geographical inequalities in health often coincide with inequalities in living conditions.

1.6 Summary

In this Report to the Storting, we present a broad, long-term strategy to reduce social inequalities in health by levelling up.

Chapter 2 describes social inequalities in health in Norway. Average health in the population is good. Mean life expectancy is high, infant mortality is low and most people consider their health good. However, these averages conceal major inequalities: life expectancy has increased in most educational groups, but it has risen most in groups with a long education. We find social inequalities in health almost regardless of how we measure social position and almost regardless of the indicator we use to measure health.

Social, economic, physical and behavioural factors all affect the individual's health – positively and negatively. On the population level, there is clearly a correlation between social and economic circumstances and health. Whether we group the population by income or level of education, we see that the groups' health improves gradually in keeping with the increase in level of income or length of education. The link between social position and health forms a gradient and affects all levels in society. This chapter studies in more detail the significance of income, childhood living conditions, occupation, health behaviour and access to health services.

Education, occupation and income are used as the main indicators of social position. In some cases, however, other social and demographic background factors may affect socioeconomic status and health. In this chapter we look more closely at the particular challenges facing groups with lasting social problems, children and young people in high-risk situations, immigrants, people in areas with Sami and Norwegian settlement and people living alone.

Four main priority areas have been defined to help us attain the goal of reducing social inequalities in health by levelling up rather than down. In the introduction, we explain our reasons for choosing these four priority areas. The first priority area (part I) covers fundamental social factors that contribute to social inequalities in health. Here we present strategies to reduce social inequalities in income, childhood conditions and work. The second priority area (part II) covers factors that have a more immediate impact on health. This part lays out a strategy to reduce social inequalities in health behaviour and access to health services. The third priority area (part III) deals with targeted actions to promote social inclusion. The fourth priority

area (part IV) includes policy instruments to advance knowledge and raise awareness about social inequalities in all social sectors.

Reduce social inequalities that contribute to inequalities in health

Chapter 3 describes policy instruments to reduce economic inequalities in society. Income directly affects individuals' ability to take advantage of opportunities to improve their health – better living conditions, healthier food, health-promoting leisure activities, etc. However, the impact of investing in health diminishes gradually as income increases: the higher the income, the smaller the benefit of further increases in income. This means that fair income distribution helps level out inequalities in health and improve average health.

The Government is going to continue its work to ensure that the tax system promotes fairer income distribution in society. Trends in income in the population are reported in the annual budget propositions and via the special review and reporting system for social inequalities in health, as described in chapter 9.

In chapter 4, priority is given to ensuring that all children have equal opportunities regardless of their parents' financial situation, education, ethnic identity and geographical identity. The foundation for social inequalities in health is laid early on in life, and childhood is a critical period. Early action is therefore necessary to prevent social inequalities in health developing. The Government wants to create safe childhood conditions through kindergartens, schools and high-quality services for children and young people across social divides.

Chapter 5 discusses policy instruments linked to working environment legislation, the Norwegian Labour Inspection Authority, company health services, inclusion of the immigrant population in the labour market, national monitoring of work and health, and research on sickness absence in the health and care sector. With a view to reducing social inequalities in health linked to work, the Government will continue its investments to promote a more inclusive labour market and will take steps to ensure a healthier working environment in occupations with significant occupational stress.

Reduce social inequalities in health behaviour and use of the health services

Chapter 6 discusses policy instruments to reduce social inequalities in diet, physical activity, smoking and other health-related behaviour. Lifestyle varies with social background and has a major impact on people's health. This means that we need to focus attention on the underlying and structural causes of these behaviours and then introduce measures that will promote healthier choices. With a view to ensuring reduction of social inequalities in health behaviour, the Government is going to give greater priority to policy instruments that influence cost and availability in its efforts to prevent lifestyle diseases. The Ministry of Health and Care Services will also take steps to stimulate low-threshold activities.

Chapter 7 is about the role of the health service. Even though the most important determinants of health are outside the control of the health sector, the health services still play a crucial role. For example, there is a correlation between social background and the likelihood of surviving certain types of cancer, even if we take time of diagnosis into account. Since we have limited knowledge about the correlation between social background and treatment in the health service, it is necessary to investigate whether the Norwegian health service is helping to level out social inequalities in health or if it is actually reinforcing them.

The Government wants to improve knowledge about social inequalities in access to health services and further develop specially adapted schemes to ensure that everyone has access to equitable services.

Targeted initiatives to promote social inclusion

The emphasis in chapter 8 is on preventing social exclusion of groups that drop out of education and employment because of poor health or for other reasons. Many disadvantaged people need more targeted services. Universal schemes must therefore be supplemented with specially adapted services and measures tailored to the individual. User-oriented and specially adapted public services are necessary to ensure that everyone, regardless of their background and circumstances, has access to equitable services. The Government will take steps to promote inclusion in the workplace, inclusion at school and adapted health and social services. In this chapter, importance is attached to policy instruments for social inclusion linked to the labour market, health and social services, voluntary organisations and deprived geographical areas.

Develop knowledge and cross-sectoral tools

Chapter 9 deals with establishment of a review and reporting system for monitoring progress in the work on reducing social inequalities in health. Social inequalities in health are intricately linked to social inequalities in many different areas. The Government has therefore decided that efforts to reduce social inequalities in health shall be followed up in all sectors. The Ministry of Health and Care Services will collaborate with the relevant ministries to ensure annual policy reviews, which will also be used as the basis for presentations in the Ministry of Health and Care Services' budget propositions. These reports must discuss the main measures and strategies on the national level.

Chapter 10 describes in more detail the need to raise awareness among decision-makers in all sectors and on all administrative levels about the social distributional effects of social processes, strategies and measures. Cross-sectoral tools such as health impact assessments and social and land-use planning are important policy instruments, along with stronger partnerships for public health and building up local competencies about public health.

Chapter 11 underlines the fact that we have sufficient knowledge to implement measures where causal connections are obvious and proven, but that we still need more knowledge about causes and effective policy instruments in this area.

The Ministry of Health and Care Services will strengthen research on social inequalities in health. A monitoring system is also proposed to track developments in social inequalities in health.

2 Facts about social inequalities in health in Norway

«The Norwegian population enjoys good health.
However, averages conceal major, systematic inequalities.
Health is unevenly distributed between social groups in the population.»

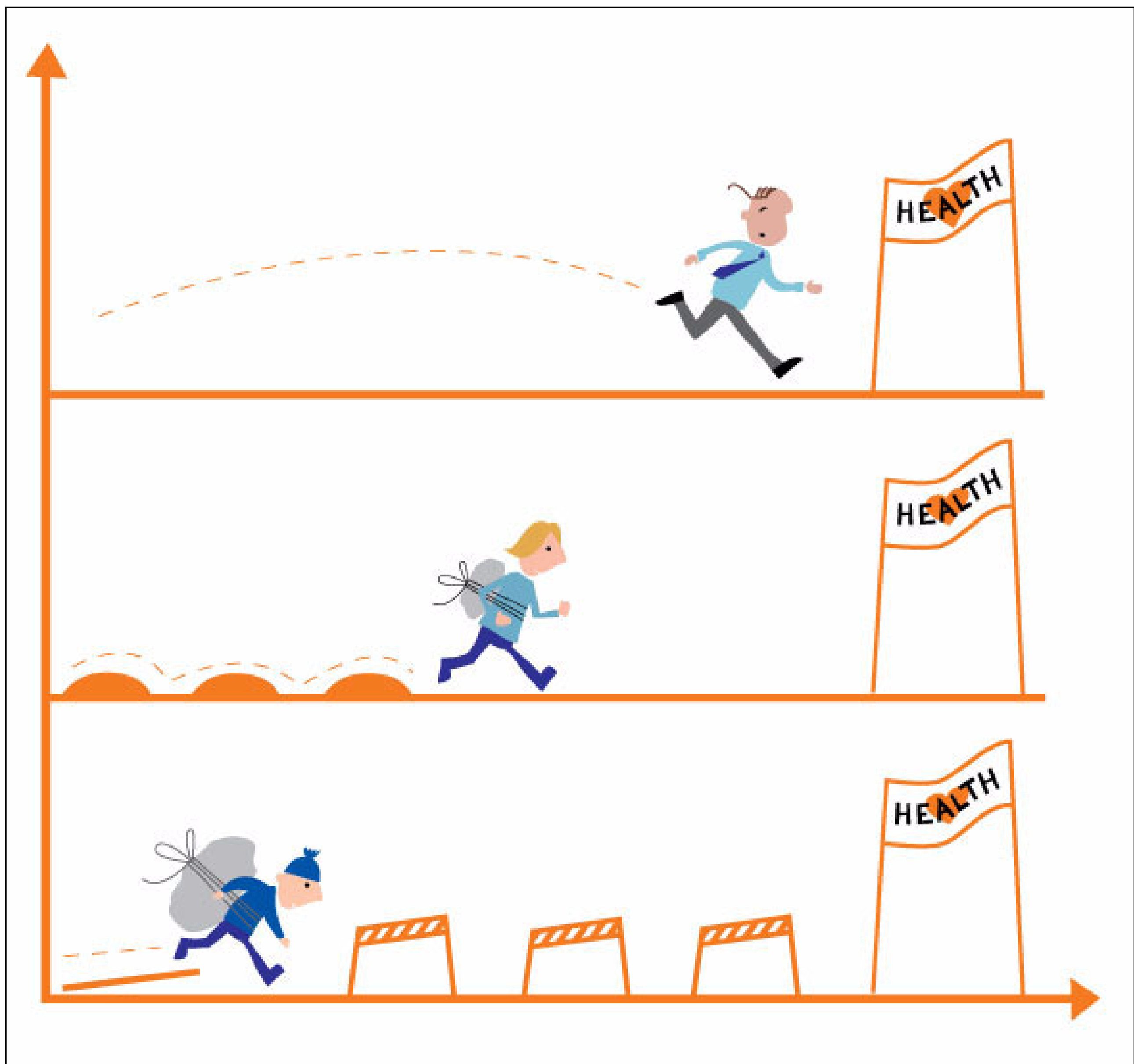

Figure 2.1 Social inequalities in health

2.1 Systematic inequalities in health

The correlation between social position and health is gradual and continuous through all social strata. In general, it is not the case that there is a cut-off point in terms of income or education where health suddenly improves dramatically. This means that social inequalities in health pose a challenge on all social levels.

It should be mentioned that hereditary factors do not explain social inequalities in health. Hereditary factors affect the individual's health, but have little effect on systematic variations in health that follow education, occupation and income. Social inequalities in health are mainly due to differences in material, psychosocial and behaviour-related risk factors.

2.1.1 Substantial and growing social differences in mortality among adults

Figures 2.2 and 2.3 demonstrate trends in mortality according to level of education among adults (45–59 years) from the 1970s to the present (note that follow-up time was shorter in the last period. The individuals monitored in this period will be slightly younger and thus have slightly lower mortality). In the period since the 1970s, mortality has dropped for most educational groups, but it has dropped most in the group with the longest education. The inequalities between the educational groups have therefore increased. In 2001, life expectancy for 30-year-old men who had completed lower secondary school (i.e. a total of nine years of education) was 71.8 years, compared with 76.7 years for men with a university education. The corresponding figures for women were 78.0 years and 81.4 years respectively.

Thedifferences in mortality are smaller for women than for men. This is primarily because women in this age group have lower mortality than men.

We find social inequalities in health pretty much regardless of how we measure social position. Here we have used education to indicate

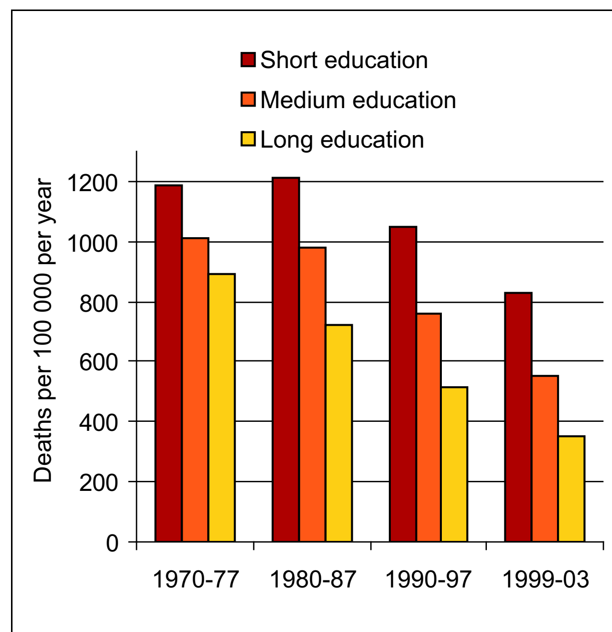

Figure 2.2 Mortality by education, men 45–59 years.

Source: The Norwegian Institute of Public Health

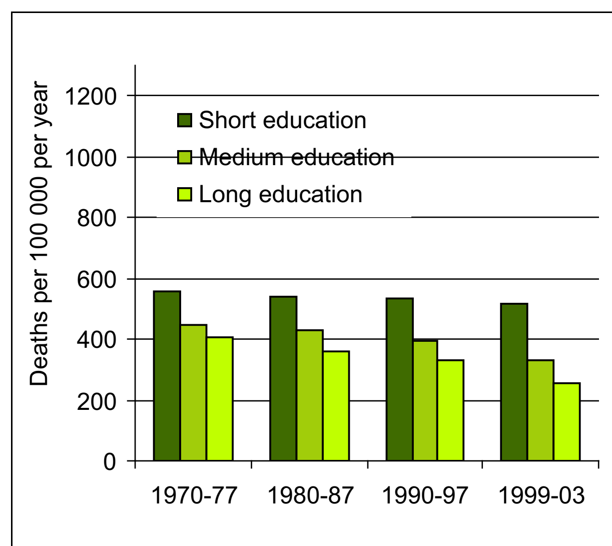

Figure 2.3 Mortality by education, women 45–59 years.

Source: The Norwegian Institute of Public Health

> **Box 2.1 Definitions**
>
> - Social inequalities in health: inequalities in health that vary systematically with level of education, occupational group or level of income.
> - In this chapter, we use education – short (7–9 years), medium (10–12 years) or long (13 years or longer) – as the main indicator of social position.
> - Mortality: the number of deaths per 100 000 inhabitants per year.
> - Life expectancy is calculated on the basis of the mortality rate in all age groups at a given time.

social position, but there are also clear inequalities in health if we use occupation and income as indicators. We will discuss this later in the chapter.

2.1.2 Most of the main causes of death are unevenly distributed in society

Figures 2.2 and 2.3 show differences in mortality regardless of cause. In the age group 45–59 years, cardiovascular diseases are the dominant cause of death for both sexes. Figures 2.4 and 2.5 show cause-specific mortality rates for the various educational groups based on mortality figures from 1990–1997. (The category «Other» includes respiratory tract diseases and accidents/violent deaths). These figures show that the differences in mortality between the educational groups appear in all categories of cause of death. This suggests common, underlying causes – living conditions and social factors – that manifest themselves via different disease mechanisms. This consistent pattern is the reason why the World Health Organization recommends paying more attention to social factors than disease-specific solutions.

Statistics Norway's health interview surveys, which are repeated every three or four years, include questions about self-assessed health. The results consistently show a higher percentage of people with a long education who regard their health as good or excellent than among people with a short education. The size of these differences has not changed significantly from 1995 to 2002 for men or women. Figure 2.6 shows the percentage of people in the different educational groups who

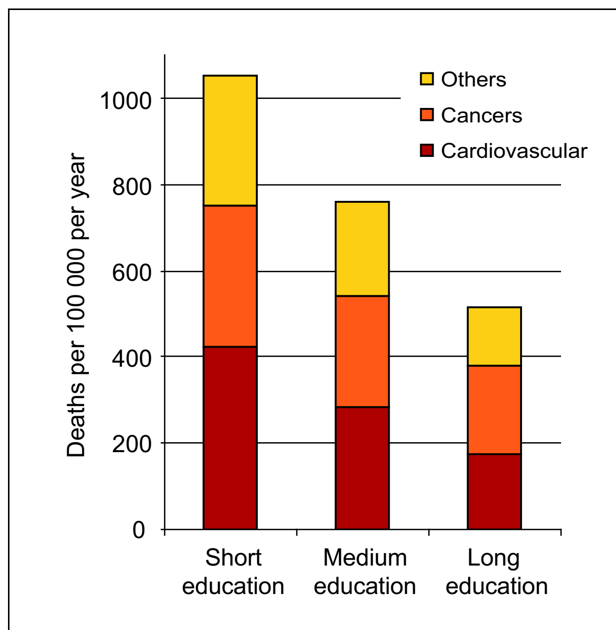

Figure 2.4 Cause-specific mortality by education, men 45–59 (1990–97).

Source: The Norwegian Institute of Public Health

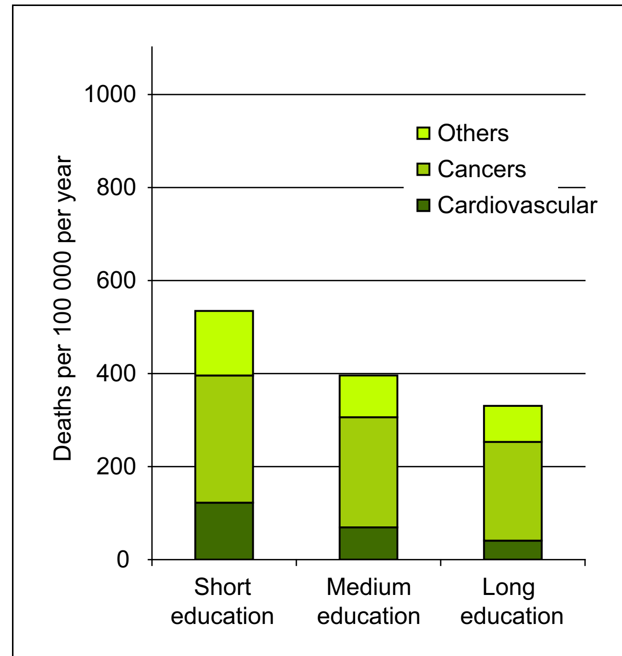

Figure 2.5 Cause-specific mortality by education, women 45–59 (1990–97).

Source: The Norwegian Institute of Public Health

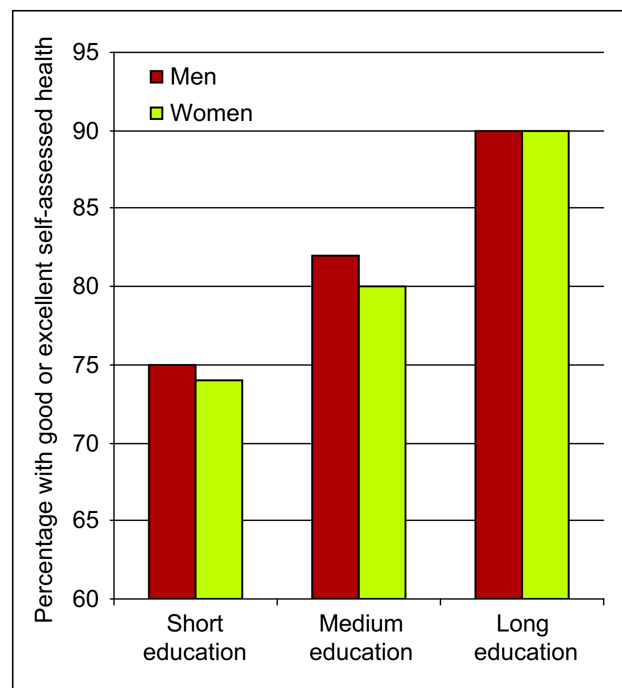

Figure 2.6 Percentage of people who assess their health as «good» or «excellent» by education, men and women 25–64 (2002).

Source: Statistics Norway and the Norwegian Institute of Public Health.

assessed their health as good or excellent in 2002. The differences between the sexes are insignificant.

These surveys also show that ever fewer people lose all their teeth. The number of teeth people have is used as an indicator of the population's dental status. Self-assessed dental health generally follows the same social patterns as self-assessed general health.

2.1.3 Significant social inequalities in mental health

Statistics Norway's health interview surveys also monitor mental health using a standardised battery of questions (*Hopkins Symptoms Check List*). A score above a certain level indicates significant symptoms of depression or anxiety. There are clear inequalities between educational groups. Figure 2.7 shows that the inequalities in this area are significantly greater among women than among men. There were no material changes between 1998 and 2002 in this area.

2.1.4 Inequalities in health through the life course

Social inequalities in health are manifest throughout the whole life course. Although there have been marked improvements in survival in connection with birth and the first year of life, there is still a higher risk of stillbirth and death in the first year of life among children of parents with a short education. Infant mortality fell substantially in the period 1967–1998, and inequalities in mortality in the first four weeks of life – *neonatal mortality* – by mother's education have also decreased. However, the inequalities in infant death after the first four weeks – *post-neonatal mortality* – have increased, mainly as a result of greater inequalities in sudden infant death syndrome and infections.

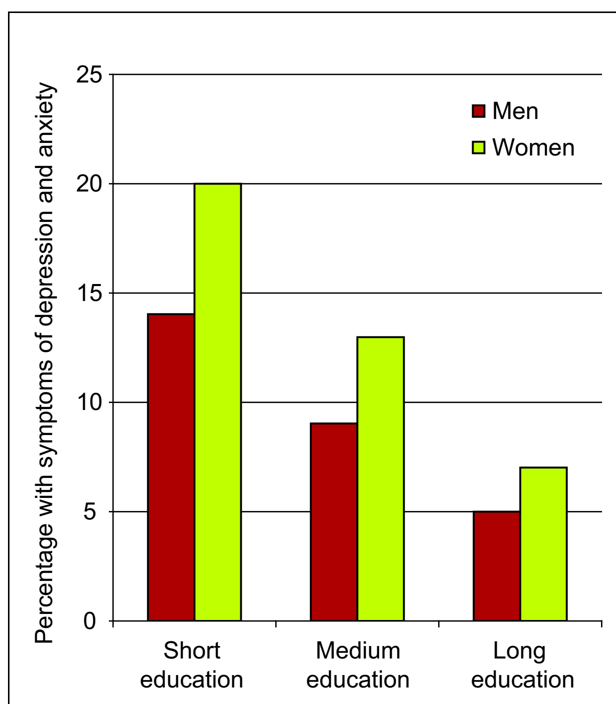

Figure 2.7 Significant symptoms of depression and anxiety by education, men and women 25–64 (2002).

Source: Statistics Norway and the Norwegian Institute of Public Health

Children and young people in Norway generally have good health, and there have been few studies of possible social inequalities in health in these age groups. Some studies have observed a higher frequency of chronic disorders such as asthma, allergies and eczema in households where the parents have a short education. Social inequalities have also been found in mental health, especially in certain risk groups. For example, children of parents with mental ailments, children of parents with alcohol/drug problems and children that experience violence in the family.

Social inequalities in health are more pronounced in adults than at other stages of life. Social inequalities in health among adults are described above.

Inequalities in health remain marked up to a very old age. The oldest age groups are dominated by women, and they more often live alone and have a shorter education than the men in this age group. In this age group, men tend to be healthier than women.

Many of the most common categories of disease in the population take a long time to develop and are due to detrimental influences that accumulate throughout life. A growing number of international and Norwegian studies demonstrate that living conditions during childhood have a major influence on health later in life. Therefore, although social inequalities in health are often most pronounced in the adult population, we need to consider the entire life course in order to reduce inequalities in health.

2.2 Social structures affect health

The causes of social inequalities in health are to be found in many sectors of society. Below we will indicate some of the most important mechanisms that affect health and the distribution of health in the population. The topics discussed in this chapter correspond to the four priority areas defined in this Report to the Storting.

2.2.1 Income

There is a clear correlation between income and health in Norway, and the causes of this correlation are probably numerous. These complex mechanisms are further complicated by the dimension of time: observed mortality today may be due to factors long ago.

Figure 2.8 shows mortality among 45–60 year olds distributed over 20 equisized income groups. The income group at the far left in the figure is the five percent of the population with the lowest income, while the income group at the far right is the five percent of the population with the highest income.

As is shown in figure 2.8, mortality gradually decreases as income increases. At the same time, the reduction in mortality gets smaller as income increases – the bars level out. The greatest differences in mortality are thus between the groups with the lowest income. This tendency is manifest for both sexes, although the mortality rate is lower for women in this age group.

The concave correlation between income and health is a well-known phenomenon and has been much discussed by researchers. One important explanation of the correlation is that access to financial resources directly affects the individual's health, partly because more money allows people greater opportunities to invest in health – for example better residential environment, healthier food, health-promoting leisure activities and better health insurance. The health advantages of income gradually decrease as income increases, because there are fewer and eventually no more opportunities to invest further in health.

This kind of direct causal connection between income and health entails that narrowing the income gap will lead to reduction of inequalities in health and better average health. The health of the people in the highest income group in figure 2.8 will not deteriorate much by moving down a level or two on the income scale, but the people in the lowest groups will experience substantial health gains by moving upwards. So transferring income or other resources from the most advantaged people to the least advantaged will increase average health in the population. How big an impact income equalisation has on inequalities in health depends on a number of factors, including how strong the direct causal connection is between income and health. Many studies demonstrate this kind of causal connection, but there is debate as to how strong it is.

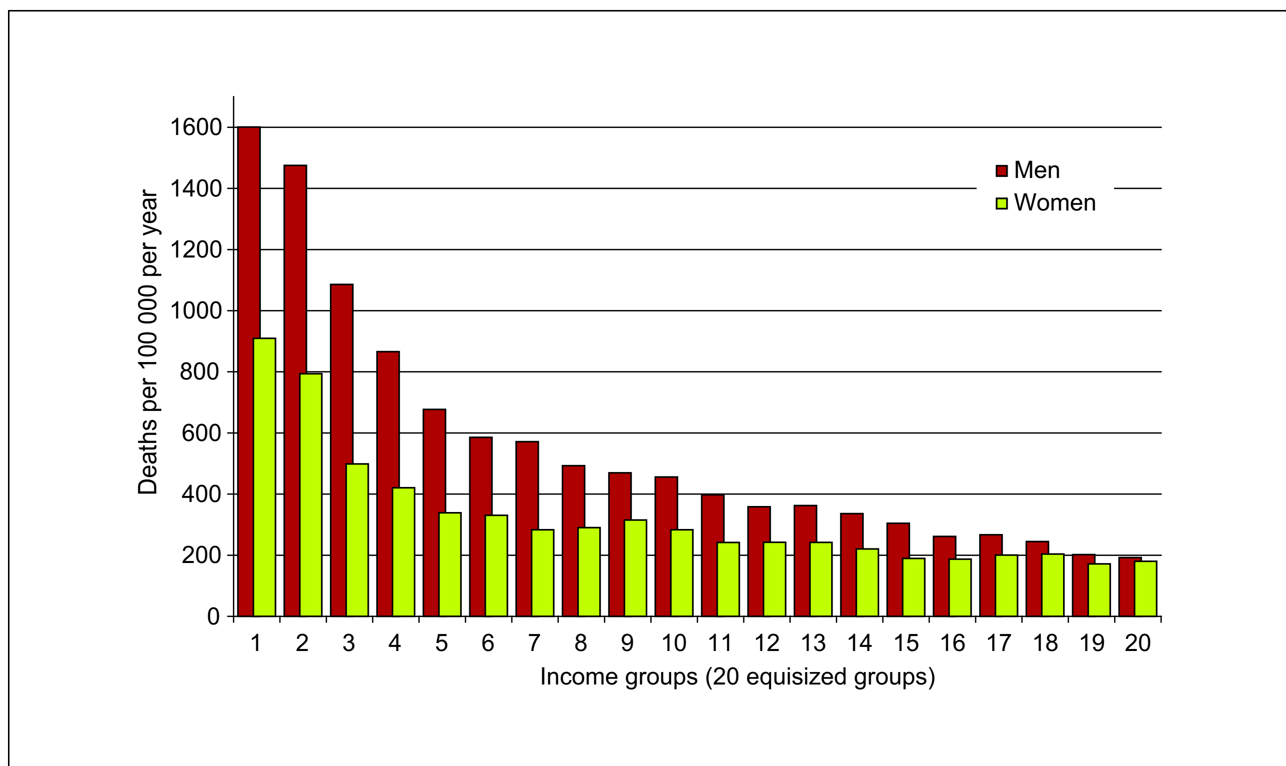

Figure 2.8 Mortality 1999–2003 for men and women 45–59 years, distributed over 20 equisized income groups.

Source: The Norwegian Institute of Public Health

Another explanation of the correlation between income and health is that health affects income. Researchers call this *health-related mobility*. Good health means people have more time and energy to invest in their education and career, while poor health can cause problems for education and work. Researchers do not agree on how important these mechanisms are for the correlation between income and health. However, most agree it has the strongest impact in the lowest income groups. In these groups, financial problems and health problems create a vicious circle whereby a lack of money leads to worse health, which in turn leads to even less spending power. In the middle and higher income brackets, it seems that income affects health rather than vice versa.

A third explanation of the correlation between income and health is that there are common factors affecting both. It used to be commonly thought that genetics might help explain social inequalities in health, because our genes determine both our abilities and our health potential. It was believed that the lower down the income hierarchy you went, the more susceptibility genes you would find. Today we know that genetics does not explain socially patterned variations in health in the population. Genetics may be decisive in connection with some diseases, but genes are fairly evenly spread across the different income groups and do not explain inequalities in health that systematically follow income. Social and environmental factors play a much larger part in the social patterning of health we observe in the population.

There may also be other factors affecting both income and health. For example, we know that there is a correlation between education and health. There is also a correlation between education and income, although this correlation is not as clear in Norway as it is in a number of other countries. Occupation is another factor that can influence both income and health. The occupational groups that incur the most work-related health problems often also have a relatively low income.

Evidence suggests that the income gap is widening in Norway. The Gini coefficient, which is a measure of income inequality, has risen steadily in Norway over the last ten years (see box 2.2). However, this image of the widening income gap needs nuancing. The reason for the increase in income inequality is that the richest people are earning relatively much more. From 1990 to 2004, income inequality in the population remained fairly constant – with one notable exception: in 2004, the people in the upper tenth in terms of income had a much larger proportion of the total income than they did in 1990 (see figure 2.9). So, the increase in income inequality in Norway is primarily due to changes in income distribution among the wealthiest people.

Box 2.2 The Gini coefficient

The Gini coefficient is a measure of income distribution in the population. Using an imaginary situation where everyone in the population has exactly the same income as its starting point, it measures how far actual distribution is from this situation. A Gini coefficient of 0 means perfectly even income distribution (everyone has the same income); while a Gini coefficient of 1 means maximum inequality (one person has all the income). Real populations have a score of somewhere between 0 and 1, and the greater the inequality, the higher the Gini coefficient. In Norway, the Gini coefficient rose from just below 0.22 in 1990 to roughly 0.26 in 2000. In 2000, Denmark had a Gini coefficient of approx. 0.23, the OECD average was just above 0.3, and USA was at 0.35.

One problem with using the Gini coefficient to measure income inequality is that it does not indicate where in the income distribution the greatest inequalities are. Another problem is that it is relative, i.e. it does not say anything about the absolute level of income in a country. In principle, an extremely poor country can have the same Gini coefficient as a wealthy country.

For some years now, there has been international debate as to whether the size of the income gap – in society as a whole – has a separate impact on health, in addition to the direct effects that the individuals' personal economy have on their health. The *income inequality hypothesis* suggests that average health is better in areas with small income inequalities than in areas with a large income gap. On the individual level, each individual will be best served by having the highest possible income, because this yields the best health; but if the income inequality hypothesis is correct, everyone will be better off if the individual inequalities are not too large. In areas where there are only relatively small differences between people, there may well be a stronger sense of community, less crime and less sense of impotence.

A Norwegian study published in December 2005 suggests that the income inequality hypothe-

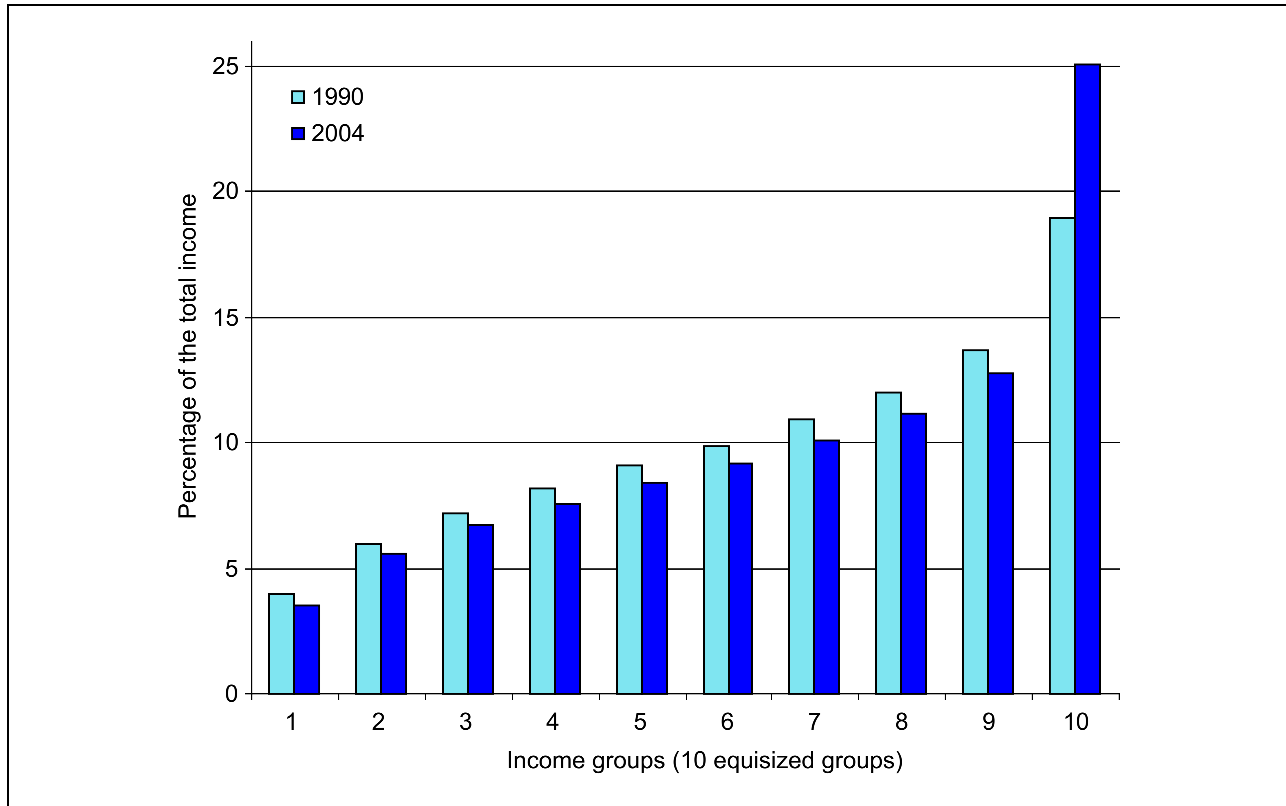

Figure 2.9 Distribution of household income (after tax, per consumer) for people, 1990 and 2004. Percentage of the total income per decile (tenth of the population).

Source: Statistics Norway

sis seems to apply, at least partly, in Norway. The study, based on deaths among adults (25–66 year olds) in Norway over a six-year period, found lower mortality rates in regions with smaller inequalities in income. This effect was primarily due to lower mortality among people with little education. Thus, the study did not confirm that everyone has better health in areas with less income inequality. What it did find was that people with less education and lower income benefit, in terms of health, from living in an area with a smaller income gap.

2.2.2 Childhood conditions

The World Health Organization's report *The Solid Facts,* detailing the significance of social circumstances for health, states that every stage in life is important and that children's and young people's development and education have life-long consequences for their health. Today's social inequalities in health are partly due to inequalities in childhood conditions several decades ago. The Norwegian Institute of Public Health has recently published a study confirming that social and economic circumstances in childhood indirectly (through the person's own education) and directly affect health later in life. The study demonstrates that for men there is a direct correlation between their father's level of education and premature death as a result of cardiovascular diseases in adult life. Sons of men with little education are more likely to die early because of cardiovascular diseases.

Research on social inequalities in health in a *life-course perspective* is usually based on one of two main models. The first model assumes that there is a *critical period in life* – usually very early – during which certain types of influence have major consequences for health later in life. An example of use of this model is the Norwegian doctor Anders Forsdahl's pioneering studies into the correlation between early childhood living conditions and mortality from cardiovascular diseases in adult life. Forsdahl's hypotheses have since been refined and confirmed in many varieties; for example, many studies have proven the significance of certain influences during pregnancy on morbidity as an adult.

The other main model within life-course studies of social inequalities in health is based on the idea that beneficial and detrimental influences on health *accumulate* throughout life. Detrimental

determinants of health are not randomly distributed in the population, but occur more frequently in some population groups than others. Each individual risk factor increases the risk of sickness and early death by a relatively small amount, but if the same people are exposed to many risk factors that accumulate, the final effect is significant.

These two main models – critical period and accumulation – are not necessarily mutually exclusive. It would appear that the health outcome being studied determines which of the models is most appropriate. Some diseases and conditions occur as a result of influences at certain periods in life, while it is more difficult to identify particularly sensitive periods for other diseases.

International summaries of knowledge suggest that almost all studies of social position in childhood (measured using the parents' social position) and mortality in adult life find a clear connection. The exact nature of the correlation varies. For some causes of death, for example lung cancer, the correlation tends to be described more indirectly, as a result of the individual's own health behaviour as an adult. For mortality from cardiovascular diseases, factors in childhood and adulthood both play a direct role. For some causes of death, for example stomach cancer and strokes, factors in childhood play a decisive role.

Children's living conditions are closely linked to the family's socioeconomic circumstances. A report from Norwegian Social Research (NOVA) about the impact of the family's income for children's living conditions, shows that children in low-income families (under 60 % of the median income) have a lower score on a number of indicators than children from a random control sample (see figure 2.10).

Education constitutes a major part of children's upbringing. As we stated earlier in this chapter, there are clear statistical correlations in the population between length of education and adult health. Nevertheless, research on social inequalities in health does not claim a causal relationship between *length* of education and health later in life. Over the course of life, however, a *lack* of education – by dropping out of the education system – may indirectly cause health problems. One in four pupils that started upper-secondary vocational training for the first time in 2000 did not complete their education (i.e. receive a certificate) in the following five years. We know something about who these pupils are: the percentage of young people who complete upper-secondary education increases with the parents' level of education. Almost 80 % of the pupils and apprentices that started their education in 2000 whose parents had a long education completed their upper-secondary

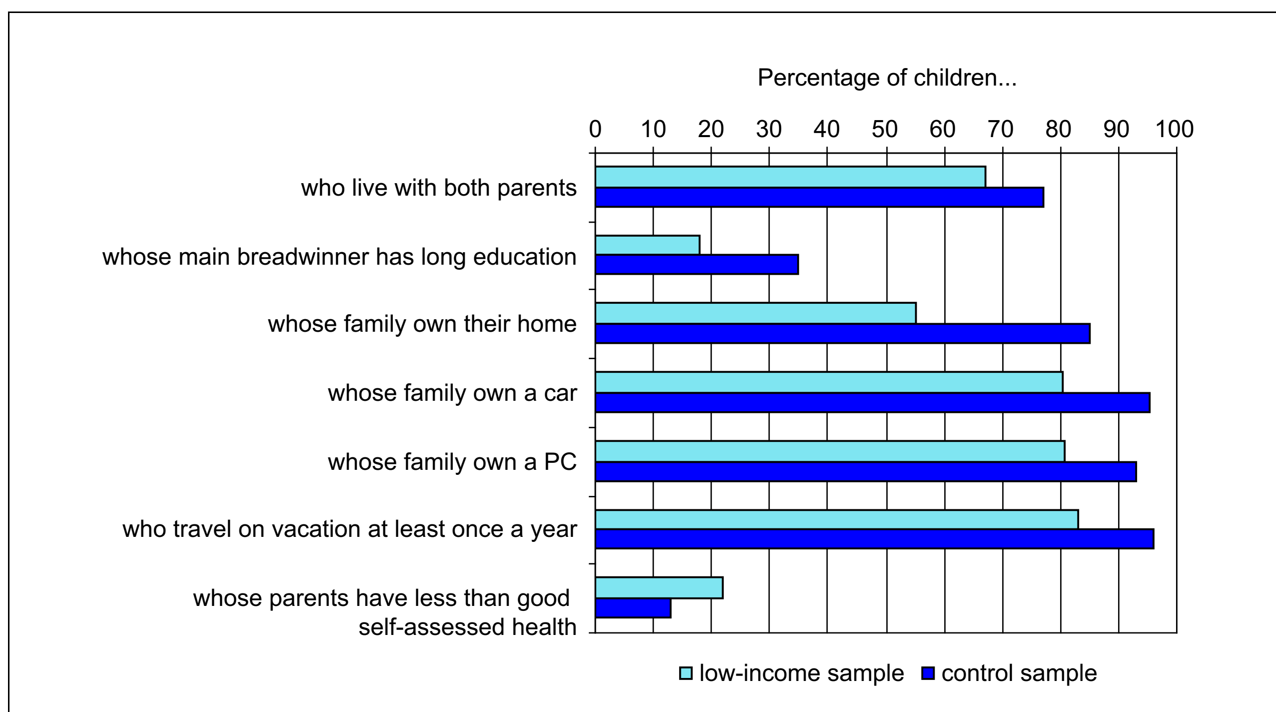

Figure 2.10 Selected indicators of living conditions for children in low-income families versus a random sample of families. Percentage.

Source: Norwegian Social Research (NOVA)

training in the normal time. By contrast, only 30 % of the pupils whose parents only have compulsory schooling completed their upper-secondary education in the normal time. We do not have much knowledge about what will happen to the pupils who did not complete upper-secondary schooling.

2.2.3 Work and working environment

Factors at work have an impact on health. These factors may be physical (ergonomic, chemical and biological), psychosocial or organisational. In keeping with other socioeconomic indicators (education and income), we find a continuous gradient of health according to position at work. We also find a gradient in exposure to harmful factors at work, within occupations and between different occupational categories. This exposure may be the risk of occupational strain injuries, the risk of accidents in the workplace, heavy lifts and gas or dust. However, there is insufficient documentation about the correlation between specific working-environment factors and the observed inequalities in health.

There are large variations in health between different occupational groups in Norway. Figures 2.11 and 2.12 show life expectancy for selected occupational groups in the population.

These two figures reveal fairly major differences in life expectancy between occupational groups, especially among men. While average life expectancy for a male chef is approx. 71 years, a male secondary school teacher can expect to live almost ten years longer. Statistically, waitresses live until almost 79 years, while female secondary school teachers live more than five years longer, on average.

There are several possible reasons for these kinds of correlations. Differences in working environment constitute one important explanation. Inequalities in health-related behaviour, such as smoking, diet and physical activity, also seem to vary according to different occupational groups to a certain extent. Finally, different forms of health-related mobility may also play a role. Health problems during education may, for example, cause an individual to fail to complete their chosen course of education, which in turn means that their choice of occupation is limited to jobs requiring little educa-

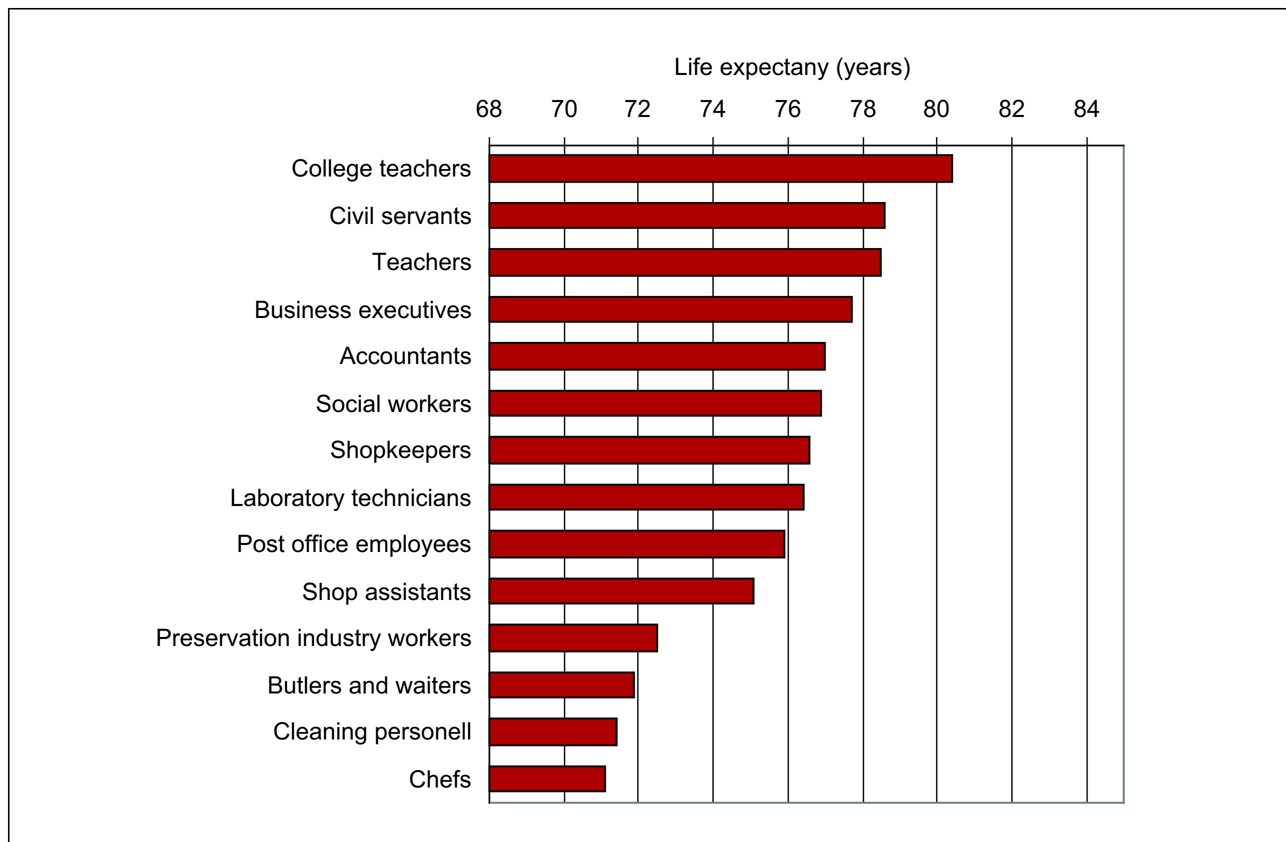

Figure 2.11 Life expectancy for a sample of occupations, men (based on occupation at the 1980 census and deaths recorded 1996–2000).

Source: Statistics Norway

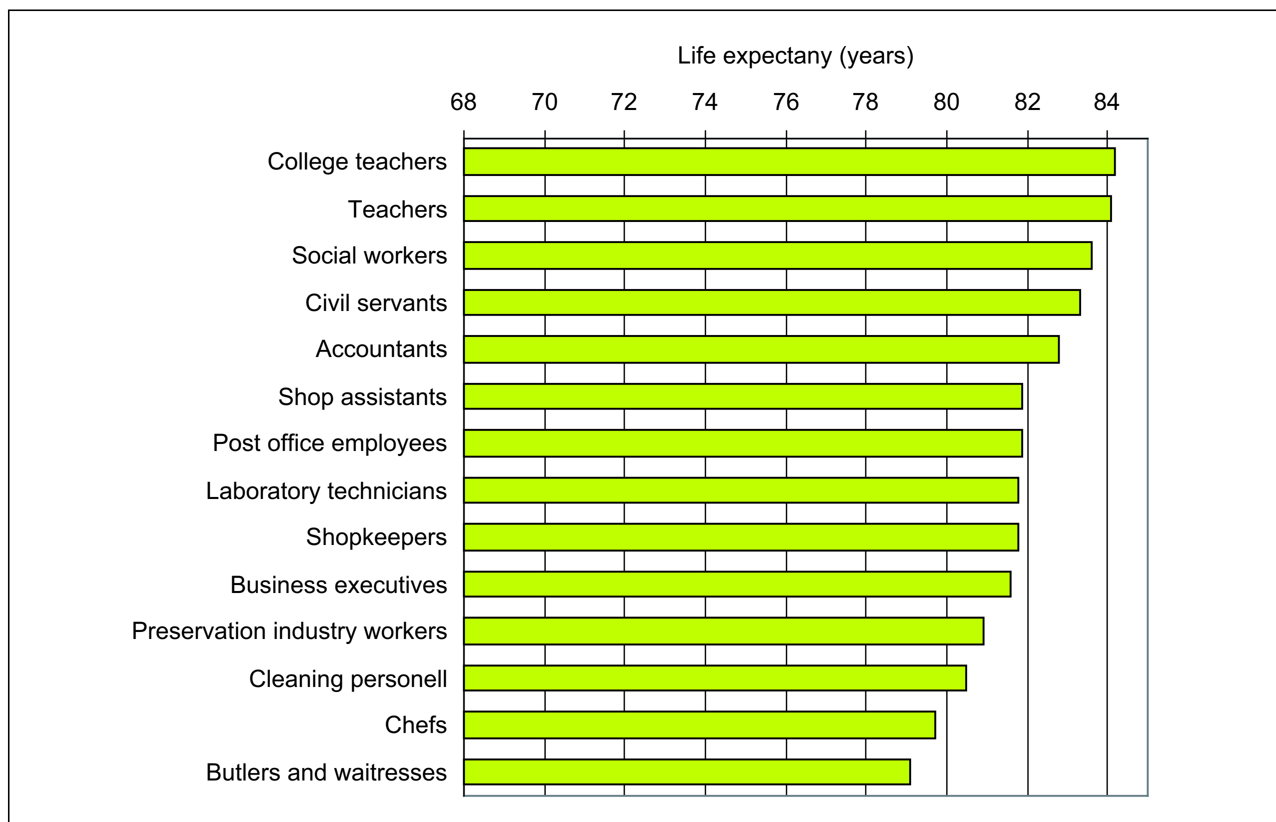

Figure 2.12 Life expectancy for a sample of occupations, women (based on occupation at the 1980 census and deaths recorded 1996–2000).

Source: Statistics Norway

tion. Inequalities in health between occupational groups are linked to education: the upper parts of figures 2.11 and 2.12 represent occupations requiring a relatively long education.

On average, around 30 000 work-related injuries are reported to the Norwegian labour inspection authorities each year, and in 2005, a total of 48 people died in accidents at the workplace in Norway. Almost all of the victims of fatal accidents were men, with the most at-risk industries being agriculture, forestry and the construction industry.

A Finnish study estimates that some 1800 deaths a year (i.e. 4 % of all deaths in all age groups) are due to factors in the working environment (sickness and injuries). Because mortality varies according to gender, age, occupation and industry and these vary from country to country, these figures cannot be applied to Norway without adjustment. However, we can be sure that the number of deaths as a result of work-related illness is much higher than the number of deaths due to workplace accidents. In the Finnish study, industrial accidents and other violent deaths (including murder and suicide) constituted only 4.5 % of all the work-related deaths.

The Norwegian Labour Inspection Authority receives reports of 3000–3500 cases of work-related illness each year. In Norway, all doctors have a duty to report all cases of assumed work-related illness to the Norwegian Labour Inspection Authority, but it is up to the individual doctor to interpret what exactly this means. In 2003, only 3 % of GPs and fewer than 25 % of company doctors reported one or more cases of work-related illness to the Norwegian Labour Inspection Authority, and there is substantial underreporting or misrepresentative reporting of work-related injuries and illness. The Petroleum Safety Authority Norway receives an average of some 650 reports of work-related illness each year, and reporting in this sector is regarded as more complete than for most onshore industries.

Statistics Norway's Survey of Living Conditions from 2003 shows that 44 % of the registered instances of sick leave during the last 12 months consisting of a continuous period of sickness absence of more than 14 days was stated as being work related. These surveys therefore suggest that a large part of absence from work due to sicknesses is work related. Women report the most

Box 2.3 The healthy worker effect

One methodological problem facing research on social inequalities in health based on occupation is the so-called «healthy worker effect». In occupations with major health problems, people who cannot bear the strain so well will disappear with time. This means that the remaining workers are healthier and have lower mortality. Thus, morbidity and mortality rates will often be underestimated in these kinds of occupations – which often entail heavy, manual labour. Some of the people who disappear from these kinds of physically demanding occupations will start working in less physical clerical occupations. Here the tendency will be that the health risk attached to these kinds of occupations is overestimated. In other words, the healthy worker effect entails underestimation of the inequalities in health between occupational groups.

health problems and are absent from work due to sickness more than men.

The business sector «health and social services» had the highest level of absence from work in Norway in 2005. Jobs in health and social services include considerable work-related strain, and a high proportion of women work in this sector. Women also tend to have more care tasks within the family. The high level of sickness absenteeism in the health sector is explained by work situations entailing strain and repetitive stress injuries and time pressure. Time pressure at work leading to extended working hours and overtime may in turn create problems in people's private life. Stress and the feeling of always being behind may also have negative consequences for people's health. Recent years have seen some major reforms, especially in the public sector, that may have led to more work-related strain in the health sector.

The largest diagnosis groups for exclusion from employment because of extended sick leave and being put on a disability pension are musculoskeletal disorders (which make up some 45 % of all instances of sick pay) and mental ailments (approx. 17 % of instances of sick pay). Among people over the age of 45 years, musculoskeletal disorders are the most common cause of people being put on disability pension; among people under 45 years of age, mental ailments are the main reason.

These diagnosis groups are often linked with organisational and psychosocial factors in the working environment and working conditions that prevail in the labour market these days: increasing rate of change, technological developments, time pressure, and high efficiency and competency requirements. Several studies demonstrate a correlation between mobility at work and the risk of exclusion. Staff cutbacks in particular increase the risk of exclusion and sickness absence – even among the employees that remain. A study conducted by Statistics Norway revealed that fulltime employees who in 1993 worked in companies where there were staff cutbacks in the period 1993–1998, had 28 % higher probability of being put on a disability pension in 1999 than comparable people working in companies where there were no cutbacks.

Life expectancy is short for people outside the labour market. According to the calculations of life expectancy summarised in figures 2.11 and 2.12, life expectancy for occupationally passive men was only 67 years. This is three years shorter than for the occupationally active group with the shortest life expectancy. Occupationally passive women could expect to live for 80 years, which is slightly longer than the worst occupationally active groups. This is because many of the occupationally passive women included in the statistics have worked in the home as homemakers.

2.3 Systematic inequalities in health behaviour and access to health services

2.3.1 Health behaviour

Diseases where health behaviour contributes to the development of the disease constitute a major health challenge in Norway. These include type 2 diabetes, cardiovascular diseases, Chronic Obstructive Pulmonary Disease (COPD) and certain types of cancer.

Diet and physical activity

Differences in the population's diet are linked to social background variables such as income and length of education. There are also substantial differences between women and men and between age groups. In general, we find that groups with a long education and high income eat a healthier diet than groups with a short education and low income. For example, groups with a long education have a higher intake of fruit and vegetables than

groups with a short education. It has also been shown that children of parents with a long education eat more healthily and have more regular meals than children of parents with a short education.

The Oslo Health Study (HUBRO) reveals that one in five women and one in four men are inactive in their free time. In general, the level of physical activity in the population is too low. At the same time, there are clear social inequalities in level of activity. The proportion of physically inactive people is highest in groups with a short education and low income. People with a long education exercise more often than people with a short education. Children whose parents have a long education exercise more often than children whose parents have a short education. Surveys of the level of physical activity among young people in Oslo demonstrate that young people from well-off families tend to be more physically active than young people from poorer families.

Immigrants from South-Asian countries such as India, Pakistan and Sri Lanka have a significantly higher incidence of type 2 diabetes than the rest of the population. The incidence of type 2 diabetes in the age group 30–59 in the Romsås and Furuset urban districts of Oslo in 2000 was 28 % among women and 14 % among men from South Asia. By comparison, it was 3 % among women and 6 % among men of Western origins. Among people with a Western background, the risk of developing type 2 diabetes was greatest among the people with the lowest income or shortest education.

Smoking

Smoking is the health behaviour whose correlation with health is best documented. At the same time, it is the factor where the social inequalities are most obvious. Smokers are overrepresented in population groups with low income, short education and manual occupations. More than twice as many people smoke daily in the group with only compulsory education as do in the group with higher education. There are fewest smokers in technical/scientific occupations and most among people employed in the industrial and transport sector and unemployed people. In the group with low income or short education, people smoke more and they more frequently use the most addictive tobacco products. In addition, the average age at which people start smoking is lower, tolerance for passive smoking is greater and there are fewer restrictions on smoking at home in the lower social strata. People in this group are more often misinformed about the health risks associated with the various different types of tobacco products.

In the period 1976–2005, the proportion of daily smokers with higher education dropped from around 30 % to 13 %, while the proportion of daily smokers in the group with only compulsory schooling remained relatively stabile at around 40 %. Since this group has got smaller, it means that there are now fewer daily smokers. Among young people, there are more girls than boys who smoke. The reverse is true among non-Western immigrants. Young people whose parents are divorced, young people whose parents smoke and young people planning on taking vocational training are more likely to smoke than other young people.

Because smoking is so unevenly distributed in society, diseases related to smoking are also unevenly distributed. According to the report 2006:4 *How lethal is smoking?* from the Norwegian Institute of Public Health, 6700 deaths in 2003 (16 % of all deaths) were due to smoking. Among women, smoking caused 26 % of all deaths in the age group 40–70 years, while the corresponding figure for men was 40 %.

Intoxicants

The correlation between alcohol use and social background is more complex than it is for physical activity, diet and tobacco use. Among men, there is a J-shaped curve with men with the shortest education and lowest income drinking more than men with a slightly longer education and higher income, before the curve rises once again, with men with the longest education and highest income drinking most. The pattern is different for women: women with a short education drink less than women with a long education. However, groups with a short education often have more harmful use of alcohol than groups with a long education, i.e. they drink more at a time. This means that more people in the population groups with a short education and low income incur acute alcohol injuries.

Some population groups are particularly prone to developing alcohol and/or drug problems. For example, children whose parents are addicted to intoxicants and children of mentally ill parents, as well as children and young people who themselves have mental ailments. Against the background of other knowledge about social inequalities in health, there are grounds to believe that these kinds of risk factors vary according to social background, but this is an area where we still need more knowledge. Drug addicts and alcoholics are

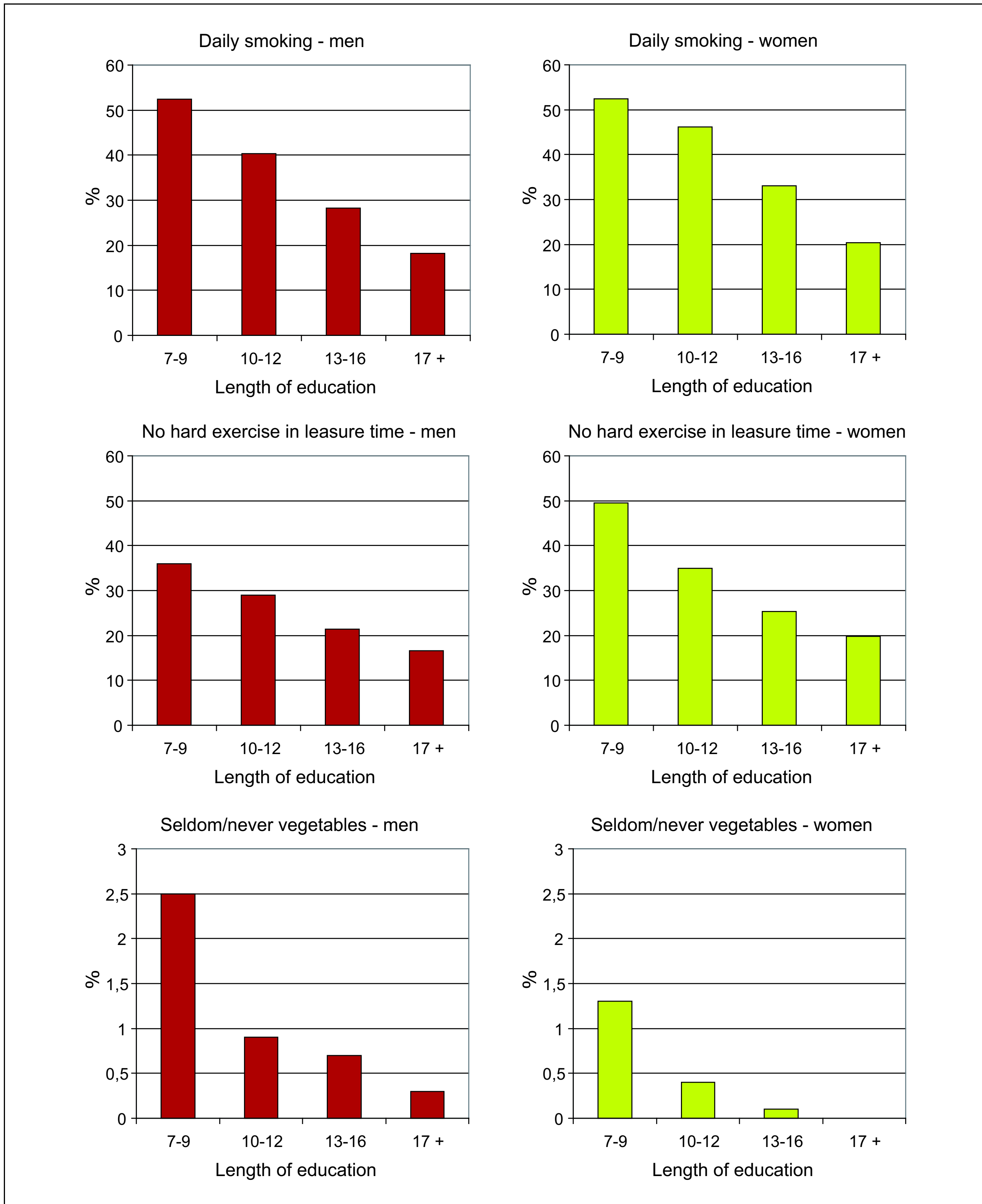

Figure 2.13 Inequalities in health behaviour by length of education, men and women 40–45 years.[1]

[1] The diagrams show the percentage of self-reported smoking, no hard exercise in free time and seldom/never eat vegetables for men and women in the age group 40–45 by length of education. The figures are taken from health interview surveys in Oslo, Hedmark, Oppland, Troms and Finnmark counties, 2000–2003. 40–45 year-olds are not representative of the population as a whole, but the figures do give a good indication of the relationship between length of education and health behaviour in the population. The diagrams show that health behaviour varies systematically with length of education for smoking, physical activity and diet. The same tendencies are found among women and men. Inequalities in health behaviour are an important cause of the inequalities we see in morbidity and mortality among social groups in the population.

Source: The Norwegian Institute of Public Health

overrepresented in groups with a short education and low income. In many cases, abuse of intoxicants results in people losing their job and social problems, which may in turn serve to reinforce the drug/alcohol problem.

Accidents and injuries

Accidents and injuries are the fourth most important cause of death in Norway. The number of deaths as a result of injuries has been on the decline for the last 30 years, but injuries from accidents are still a major public health problem. At the same time, this is a field where we have good knowledge about causes and effective preventive measures. There is room for improvement by means of efforts in several sectors. There is a lack of research in Norway about social patterns in accidents and injuries. A Swedish study from 2002 suggests that there are more traffic accidents in

Box 2.4 Experiences with supervision

Service providers, both public and private, have a duty to abide by statutory requirements concerning their services and staff. As an added security, the authorities carry out supervision to make sure this is being done and to make sure that companies providing services check that their activities are being performed in compliance with the authorities' requirements. State supervision is one of several policy instruments used to follow up the intentions in the legislation. Supervision focuses on organisations that provide social and health services. Health-care workers are also subject to supervision, and they are bound by a special professional law, the Health Personnel Act.

The experiences of the Norwegian Board of Health confirm that in many cases there are variations in the accessibility and quality of the services offered and that this affects different patient and user groups differently. There may be many causes of these variations. An underlying premise for large parts of the health service is that people requiring help must contact the health service themselves. Patients must also take the initiative to complain if they feel they have received poor treatment from the health service. This system works well for the majority, but it does tend to favour patients and next of kin with good resources: they know the health service, know what it can offer, and they know how to go about getting help. Basing access to services on self-selection entails that people who do not make their needs known, do not know their needs or are incapable of looking after their own best interests do not get help unless others take action on their behalf.

Supervision experiences from 2003 show that in many cases information about patients' right to choose which hospital they receive treatment at within the specialist health service was unsatisfactory. A survey carried out by SINTEF Health shows that patients with a high use of health services tended to make less use of the right to choose hospital than other patients. The survey revealed that the system is used mostly for one-off interventions or consultations within the somatic part of the specialist health service and to a lesser extent by patients with chronic and/or complex disorders. Thus, patients with large needs and/or patients with little knowledge about the health service made less use than others of the opportunity to influence waiting time for health assistance.

In 2005, the Norwegian Board of Health inspected the municipal services for drug addicts and alcoholics. The reports from these supervisions demonstrate numerous substantial deficiencies in the services. This and other supervisions revealed major challenges for the services when patients and users have several or complex problems, as this requires coordination between services and between different levels of service.

In 2006, the Norwegian Board of Health carried out a nationwide supervision of services within interdisciplinary specialised treatment for drug addicts and alcoholics in the specialist health service. The summary of these supervisions along with the evaluation of the drug reform will provide a more extensive and thorough description and assessment of the capacity, quality and organisation of the services available to this group of patients.

Source: Norwegian Board of Health

groups with a short education and low income than in groups with a long education and high income. There are grounds to believe that there are major social inequalities in accidents in Norway too. On the basis of figures provided by Oslo accident and emergency unit in 2001, the Public Health Authority in Oslo has calculated that the frequency of injury is highest in the eastern urban districts of the city (Romsås, Grünerløkka-Sofienberg and Gamle Oslo) and lowest in the western urban districts (Bygdøy-Frogner, Ullern and Vinderen). We need research that studies these patterns in more detail and considers policy instruments to reduce the social inequalities.

Gambling addiction

Studies reveal that gambling addiction often coincides with other social and health disorders such as suicidal thoughts, stress-related symptoms and emotional problems. There also appears to be a relationship between gambling addiction and drug/alcohol abuse. Young people from low-income families are particularly vulnerable. According to a study from 2005 carried out by the market research company MMI about Norwegians' gambling habits, the lowest income groups are overrepresented among people with gambling problems. This applies to slot machines in particular, but the ban on note acceptors introduced on 1 January 2006 has reduced slot machine turnover drastically. As is the case for consumption of tobacco and alcohol, accessibility is decisive for consumption. Groups with access to slot machines are more likely to develop a problem. We have insufficient knowledge about the situation with regard to social inequalities in addiction to online money games.

2.3.2 Health services

Little research has been done into the correlations between the use of the health services and social background in Norway. Of the studies that have been done, only a handful have attempted to study the use of services in connection with morbidity and patients' needs. The studies referred to below nevertheless suggest that there is skew social distribution in the use of primary and specialist health services – especially if we look at use in connection with presumed need.

Research on the use of the health services among children and young people suggests that use of the specialist health services increases with the length of the parents' education. As far as school health services and health centres for young people are concerned, it appears that use is determined more by needs than social position.

Among adults too, it seems that use of the specialist health services increases with length of education and size of income. The pattern appears to be reversed for use of primary health services, but not if we take morbidity into account, which is higher in groups with a shorter education and lower income.

Rehabilitation and habilitation services are often intended for people with low income (people receiving benefits and/or people with an unstable relationship with the labour market). Nevertheless, we have insufficient knowledge about the social component.

As regards mental health, few studies have focused on correlations between use of services and social background. One exception is the Oslo Health Study, which found more frequent use of psychologists or psychiatrists in inner city areas and in groups with lower incomes.

Few if any social inequalities have been found in the use of dental health services among children and young people in Norway. Among adults, there is a correlation between social background and taking contact with the dental health service, but once contact has been made, there do not appear to be any inequalities in use of services.

Statistics Norway recently carried out a study about the role of regular GPs as a gatekeeper for the specialist health service. This study suggests that there are few social inequalities in referrals if we overlook the fact that there are social inequalities in health in the different social groups. However, if the analysis takes account of the fact that people with little education have the poorest health, the study then shows that people with a short education are less frequently referred to a specialist than people with a long education.

Few studies have been undertaken in Norway to investigate whether different social groups receive different quality treatment. However, the issue of whether disparities in different social groups' survival rates for certain diseases can be linked to factors in the health services has been studied for cancer. One study found that patients with low income, only compulsory schooling or manual work had a lower rate of survival of a number of types of cancer. Mortality is higher even if we take account of the spread of the cancer at the time of diagnosis. This suggests that various factors in the health service may affect mortality.

2.4 Groups with special health challenges

2.4.1 Groups with long-term social problems

Complex, long-term social problems that are detrimental to health are more prevalent in certain population groups; e.g., prisoners, long-term recipients of social assistance, heavy drug addicts and alcoholics and some immigrant groups. These groups are not necessarily poor, but many people live in difficult circumstances and have extensive health problems. This pattern also applies to children whose parents belong to these groups.

People with long-term social problems often have little or no contact with the labour market. As a result, they have not earned the right to a guaranteed income from the National Insurance Scheme or they receive low social security benefits. Examples include people who have spent time in institutions and some recently arrived immigrants. Many of these people are long-term recipients of financial social assistance. Long-term recipients of social assistance have poorer health than the rest of the population. Prisoners often have low education and are much more likely not to have a home, work or income than the rest of the population. Many are encumbered with large debts, are addicted to drugs and/or alcohol and have physical and mental ailments. Problems with drugs and alcohol drive many people into poverty, and heavy drug addicts and alcoholics are among the most disadvantaged people in Norway. Mental illness can lead to poverty because the illness makes it difficult for the sufferer to complete a course of education and hold down a job. More than 40 % of the patients undergoing forced psychiatric health care do not have their own home. These patients often have little education, poor personal economy and weak social ties.

Growing inequalities between people with low income and the rest of the population

The Norwegian Institute of Public Health has looked at trends in mortality in the age group 45–59 in the period 1994–2003 and compared the low-income group with the rest of the population (see figures 2.14 and 2.15).

Mortality among men in this age group is decreasing in the low-income group and in the rest of the population, but the inequalities between the groups is increasing. This is because the decrease in mortality is greater among men not in the low-income group. Among women, mortality is actually *increasing* in the low-income group, while it is decreasing for women above the low-income threshold. Income is measured as annual household income adjusted for the number of people in the household. The low-income group consists of people with an annual income below 50 % of the median income.

Financial circumstances in groups with reduced functional capacity

As a group, people with reduced functional capacity have less money to live off than the average for the population as a whole. Three main factors determine people's financial circumstances: employment (and thus income from work), transfers from the state in the form of National Insurance benefits and social payments, and any extra costs incurred as a result of the individuals' disability.

Statistics Norway's Labour Force Surveys show that while around 75 % of the population as a whole are employed, only some 45 % of people with reduced functional capacity are employed. Add to that the fact that more physically disabled people tend to work part-time. There have not been any significant changes in this situation in the period 2000–2005.

Statistics Norway's Survey of Living Conditions shows that on average people with limitations in functioning and participation have an income that constitutes around 75 % of the average income for the population as a whole. Almost 50 % of the income of people in these groups comes from different types of transfers.

People with reduced functional capacity often have various types of extra expenses, for example because they cannot make use of simple, cheap options available to other people and because they necessarily have a higher consumption of some products and services to compensate for their reduced functional capacity. We do not have adequate information about the size of these extra expenses, but they vary widely, for example, according to place of residence. A recent survey performed by ECON (a market research company) charting user fees for social services reveals major differences in how the individual municipalities practise the system of user charges.

2.4.2 Children and young people at risk

Development of mental ailments and disorders in children is closely linked to family problems and a

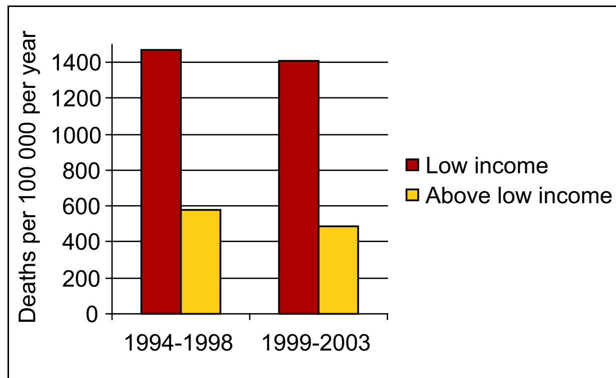

Figure 2.14 Mortality men 45–59 with and without low income, 1994–2003.

Source: The Norwegian Institute of Public Health

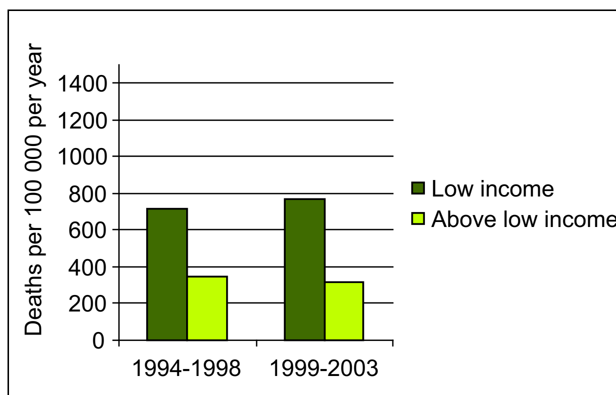

Figure 2.15 Mortality women 45–59 with and without low income, 1994–2003.

Source: The Norwegian Institute of Public Health

lack of social resources. Some children and young people grow up in such difficult conditions that they have a higher probability of developing mental ailments and disorders before they are even born. Children in families where the parents have mental ailments, abuse drugs and/or alcohol or are violent have an especially high risk of developing mental ailments. At least 15 000 children under the age of 18 live with one or two parents who are receiving some form of mental health care treatment. Add to this figure children living with parents with mental ailments who are not receiving treatment. It is difficult to calculate how many children are being affected by their parents' drug or alcohol abuse, as this is often covert, but we reckon that around 10 % of the population have an alcohol/drug problem and we know that many of these people live with children under the age of 18 years.

A survey by the Norwegian Institute for Urban and Regional Research (NIBR) shows that some 99 000 children and young people received assistance from the child welfare authorities in the period 1990 to 2002. This constitutes approx. 6 % of all the children and young people under 18 in Norway. Just over 10 000 of them had spent time in a child welfare institution. The survey showed that children and young people who are in contact with the child welfare authorities, and their biological parents, tend to have more health problems than other families. Recent studies show an overrepresentation of death due to illness and violent deaths (accidents, suicide, murder) in this group. Children receiving assistance from the child welfare authorities tend to have parents with a lower income, shorter education and poorer health. We also know that long-term clients of the child welfare authorities are more frequently boys, have parents with a short education and low income, are children of unmarried mothers and have more often been neglected or abused.

Half of all inmates in Norwegian prisons have children. This means that some 4000 children a year experience their mother or father being imprisoned. This may have serious consequences for the child's life situation and development, in the form of shame, grief, insecurity, anxiety, missing their parent, the risk of bullying and parental conflicts.

2.4.3 Immigrants

There are major inequalities in education and income between different groups of immigrants, and it seems that inequalities in morbidity and mortality vary more between immigrant groups than they do in the rest of the population. It is common knowledge that some immigrant groups are more predisposed to some diseases. The Oslo Health Study revealed that immigrants from non-Western countries have more psychiatric problems than other Norwegians. Refugees are particularly prone to a high frequency of mental ailments. Torture, incarceration and other traumatic events explain some of the increased frequency of mental ailments we find among refugees. The main social explanation seems to be unemployment on arrival in Norway, and to a lesser extent financial problems. Important psychosocial explanations include: lack of integration in Norwegian society, discrimination (for example in the housing market), and a general feeling of impotence. 24 % of immigrants from Asia and Africa have mental ailments. 12 % of immigrants from Western Europe and the United States have mental ailments. The corresponding figure for ethnic Norwegians is 10 %.

There is a higher incidence of certain communicable diseases such as tuberculosis, HIV, hepatitis A and B, malaria, typhoid fever and shigellosis in some immigrant groups. Self-reported morbidity is higher in some immigrant groups than in the population as a whole. Studies from Oslo suggest higher incidence of obesity among female immigrants from Turkey and Pakistan in particular. Type 2 diabetes is more common in many immigrant groups, especially among people from the Indian subcontinent.

There has been a positive turn in dental health in children and young people in the population. However, studies show that children with an immigrant background have three to four times poorer dental health than other Norwegian children.

Women from Sri Lanka, Pakistan and Vietnam smoke far less than women born in Norway. By contrast, smoking is much more common in some male immigrant groups than in the rest of the population.

Some immigrant groups are not very physically active and seem less inclined to use low-fat food products than the rest of the Norwegian population. Vitamin D deficiency is more common among immigrants from Pakistan, Turkey, Iran and Sri Lanka. Immigrants of Pakistani origins have a greater risk of stillbirth, sudden infant death syndrome and birth defects. Women from Somalia had more complications in connection with childbirth than other women. In Oslo, it was also found that immigrants were overrepresented among applicants for abortion. Further studies need to be undertaken to clarify socioeconomic factors and health among immigrants in Norway.

2.4.4 Areas with Sami and Norwegian settlements

We currently have little knowledge about the correlation between social factors and health in the Sami population, and few studies have been undertaken comparing Sami and Norwegian circumstances. This is partly due to the fact that many of the health and living conditions surveys that have been carried out have not taken sufficient account of ethnic background and special Sami living conditions. The Centre for Sami Health Research has conducted a survey into health and living conditions in areas with Sami and Norwegian settlements (SAMINOR). This study splits the sample population into three categories: 1) people who speak Sami at home and whose parents and grandparents speak/spoke Sami at home, 2) other people who state they are of Sami origins, and 3) people who state they are of Norwegian origins (including Kvens and immigrants). One purpose of this study was to ascertain the degree of satisfaction with the municipal primary health care service in areas with Sami and Norwegian populations. Patients who spoke Sami were generally less satisfied with the municipal medical services than the Norwegian-speaking patients. They were less satisfied with the doctor's command of the language and stated that there were more misunderstandings between doctor and patient caused by language problems. One third stated that they did not wish to use an interpreter. The results indicate that great importance should be attached to applicants' language skills when employing doctors in municipalities within the administrative area for the Sami language. This might improve satisfaction with the medical services.

Education is used as an indicator of social inequalities. There are major inequalities in education between the three categories, especially among the elderly. At the same time, it is important to underline that education as an indicator of social background does not necessarily reflect social inequalities in connection with indigenous peoples in the same way as in a monocultural Norwegian population. Within the same level of education, there are few inequalities in self-reported morbidity among the three categories once we have adjusted for age and sex.

There are major inequalities among the categories in terms of health behaviour, but preliminary analyses suggest that this is not so clearly reflected in self-reported sickness.

Preliminary analyses of the material in SAMINOR show that among the Sami population in category 1, one in three have experienced discrimination because of their Sami identity. This corresponds with other studies done to ascertain self-experienced discrimination among Samis. For example, a report from Norut NIBR Finnmark shows that one in four Samis have experienced ethnic discrimination during the last two years. In general, we know from other studies that ethnic discrimination is associated with lower health status. This association is most clearly connected with mental health, and there are grounds to believe that this may apply to the Sami population as well.

2.4.5 People living alone

Several studies appear to indicate that married and cohabiting people consistently have better mental and physical health than unmarried and previously married people. In particular, divorcees and wid-

ows/widowers have poorer mental health than others, often manifest in the form of more depression and anxiety, but also higher mortality. This may be partly related to the fact that marriage and cohabitation provide social support and partly due to the fact that married/cohabiting couples have fewer financial problems than people living alone.

Men and women living alone (age 45–59) with a short education and/or low income have a relatively high risk of death by Norwegian standards. Data from Statistics Norway's health interview surveys show that single people are particularly prone to financial problems and more frequently experience relationship breakdown. Single providers are the group that struggle the most with serious financial problems. Divorce also seems to triple the risk of long-term incapacity for work.

Since the percentage of people living alone in general, and in particular divorcees, is continuing to rise, health problems in these groups constitute a growing public health problem. This will also affect social inequalities in health. According to Statistics Norway, relationship breakdown is one of the factors that yield the greatest risk of low income. Children living in low-income families often have a single main provider with a short education. Lone providers' social problems can have a huge impact on their own and their children's mental and physical health. Although most children with single or divorced parents manage well, one Norwegian study has shown that divorce increases the risk of mental ailments during adolescence and adult life.

Part I
Reduce social inequalities that contribute to inequalities in health

3 Income

«As long as systematic inequalities in health are due to inequalities in the way society distributes resources, then it is the community's responsibility to take steps to make distribution fairer.»

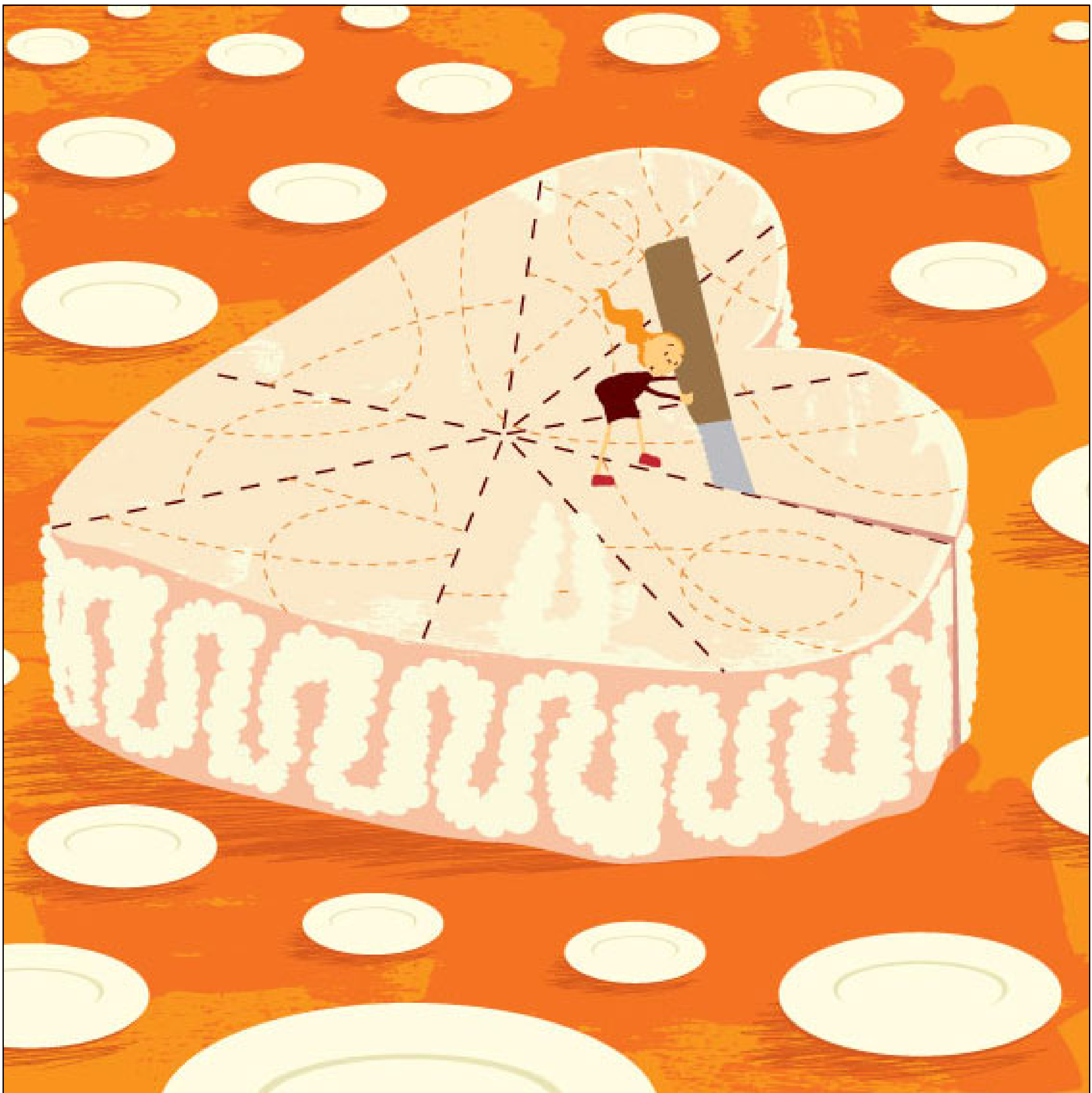

Figure 3.1 Reduce social inequalities that contribute to inequalities in health

3.1 Objective: Reduce economic inequalities

Objectives

- Reduce economic inequalities in the population
- Eliminate poverty
- Ensure fundamental economic security for everyone

3.2 Policy instruments

The Government is going to take steps to reduce economic inequalities in the population. There is a direct correlation between financial resources and health because people's personal economy affects their ability to take advantage of health-promoting products and services. The social groups with the lowest income experience the greatest health benefits from an increase in income. Societies with large income inequalities can generate inequalities in health by means of indirect mechanisms. Being relatively worse off than the people one is surrounded by can lead to exclusion from arenas and activities. Social exclusion of this nature often causes stress, which in turn leads to poorer health. This means that income redistribution may help reduce social inequalities in health and improve average health in the population.

It is important to prevent what is initially a health problem from triggering financial problems. For low-income groups in particular, health problems can easily lead to reduced income. A vicious circle of financial problems and health problems can develop.

The Government will take action to avoid development of a society with a widening income gap and greater inequalities among people. Increased social inequalities can undermine society's general willingness to support collective welfare schemes, for example, public health services and public schools for everyone. People with limited social and financial resources will be hardest hit by an unwillingness to spend public resources on these kinds of welfare systems. This would further exacerbate inequalities in health and income. Individuals have the best opportunity to achieve good health in a society with strong social cohesion and equality.

3.2.1 Taxation system

The Government will take steps to ensure that the taxation system provides stable incomes for the community, contributes to a fair distribution of resources, contributes to a better environment, promotes employment throughout the country and improves the efficiency of the economy.

The taxation system will be improved so it does more to ensure a fairer income distribution in society. To this end, the Government is attaching importance to maintaining and building up common public assets, as opposed to providing tax relief. Good public welfare schemes are especially important for the people with the lowest incomes. The Government has mapped out a new path in its taxation policy creating more space for public welfare services. The Government is going to keep aggregate taxes and duties at the same level as in 2008, to ensure that economic policy focuses on strengthening common assets. There will be no net tax relief.

Within allocation policy, the taxation system must be regarded in concert with investments in other areas. Low-income problems are often very complex, and direct support schemes are better suited than tax relief schemes for helping disadvantaged groups (low-income groups, disabled people, lone providers, etc.) or households in certain phases of life (families with young children, students, pensioners, etc.). See the *Action Plan to Combat Poverty* for targeted measures aimed at groups with low-income problems.

The Government has set itself the goal of further strengthening the general allocation of resources in the taxation system, and the Government's taxation policy has therefore been designed so that people with high incomes and wealth contribute more to the community. See the fiscal budget for 2007, where the Government increased surtax, the minimum deduction (especially for people with the lowest incomes) and wealth tax. These changes will influence distribution favourably.

3.2.2 Monitor developments in income inequalities

As part of the review and reporting system presented in this Report to the Storting, the Government will also monitor trends in income inequality in the population. In addition to summary indicators like the Gini coefficient, this kind of review and reporting system should also contain indicators showing *where* in the income distribution changes are occurring. Developments in this area will be reported in the Ministry of Health and Care Services' budget and in the annual reports on the drive to reduce social inequalities in health as described in chapter 9.

Box 3.1 Policy instruments: Income

The Government will:

- continue efforts to ensure that the taxation system does more to promote a fairer income distribution in society
- monitor developments in income inequality in the population
- implement measures to eliminate poverty, cf. Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and *Action Plan to Combat Poverty*

4 Childhood conditions

4.1 Objective: Safe childhood conditions and equal development opportunities

Objective

- All children shall have equal opportunities for development regardless of their parents' economy, education, ethnic identity and geographical affiliation

Other goals

- Full kindergarten coverage and reduced social inequalities in use of kindergartens
- Reduction in the number of pupils starting school with inadequate language skills
- Reduction in the number of pupils who finish their compulsory schooling without good basic skills
- Reduction in the number of pupils that do not complete upper-secondary training
- Early identification and good follow-up of children in high-risk groups
- Greater accessibility to the school health service

4.2 Policy instruments

Most children and young people in Norway grow up in good conditions. Nevertheless, there are children and young people living in families with such limited economic resources that they qualify as poor. They tend to be children whose parents have a short education or who are frequently unemployed. Also at risk of poverty are children who live with a lone provider and children with an immigrant background.

Public welfare schemes can help protect against and counteract the negative consequences of growing up in a financially disadvantaged family. General welfare schemes are most important for groups with few resources, and since they are intended for everyone, there is no stigma attached to receiving benefits. General schemes can also help prevent children ending up in high-risk situations. A well developed range of public welfare measures can ensure equal opportunities regardless of economic and other personal resources. Nevertheless, there is still a need for special measures aimed at children in high-risk situations.

According to the World Health Organization's report *The Solid Facts,* risk factors can be reduced by means of better preventive health services for mothers and children and by improving the level of knowledge among parents and children. Health and education programmes of this nature raise parents' knowledge about children's needs and give them more confidence in their own abilities. The World Health Organization also states that strategies providing equal opportunities for education are important in efforts to improve health. The report also underlines that better living conditions and social networks for parents yield better living conditions for children.

4.2.1 Kindergarten and school

Kindergartens and schools can help reduce social inequalities in health through reduction of social inequalities in learning. Kindergartens can identify children with special needs and help ensure they get the help they need at an early stage. Children that go to a good kindergarten do better at school. Good opportunities for education and work can help reduce the negative health impacts of poor childhood living conditions. At the same time, kindergarten and school are important arenas for measures promoting good health behaviour, for example by encouraging healthy eating habits and physical activity.

In Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*, the Government presents a policy to make better use of education as a tool for reduction of social inequalities. Compared with other countries, there are major inequalities in performance among school children in Norway, and Norway is one of the countries where family background has the greatest impact on children's academic performance. The main goal of this Report to the Storting is therefore to ensure that all pupils acquire basic skills regardless of their family background. Another goal is

that everyone, regardless of their social background, is rendered capable of making informed choices about their career and further studies.

In the Report to the Storting on early intervention for lifelong learning, the Government has decided to gradually lengthen the school day in the lowest grades from 21 hours a week to 28 hours a week. A longer school day will serve to improve the quality of all pupils' education, but this reform will have the greatest impact on pupils who receive little help with learning at home. A longer school day will allow more physical activity and assistance with home work, will give teachers better opportunity to assess pupils and will provide a good framework for meals. A longer school day will mean a gradual decrease in the need for day-care facilities for schoolchildren.

Continued investments in kindergartens form the cornerstone of the Government's work to reduce social inequalities. Efforts focus on improving the accessibility, price and quality of kindergartens. However, kindergarten is not an obligatory part of the education system, meaning offering children that do not go to kindergarten pedagogical stimulation is a major challenge. Alongside the focus on developing high-quality kindergartens, systems must also be developed aimed at children and parents that do not wish to take advantage of kindergarten facilities.

Children's language skills vary enormously when they start school, and these inequalities are often linked to family background. Norwegian and international studies show that the linguistic foundation laid during the early childhood years is critical for children's social skills and learning at school. Some children need extra language stimulation in early childhood. This applies in particular to children with delayed language development and minority-language children needing extra stimulation to help them learn Norwegian. In addition to the investments to develop more high-quality kindergartens, the Government also wants to study the possibility of introducing a municipal obligation to ensure children facilities for language stimulation if they need it, regardless of whether they go to kindergarten or not. This measure was announced in the Report to the Storting on early intervention for lifelong learning.

Children's language development is currently assessed in the medical check-ups at ages 2 and 4 at maternal and child health centres. The Government is also going to consider calling for a more systematic survey of language skills at the 2-year check-up and the 4-year check-up at all maternal and child health centres (see the discussion of maternal and child health centres and the school health service).

Box 4.1 FRI

FRI [FREE] is an anti-smoking educational programme in lower-secondary schools. Previously called VÆR røykFRI [BE smoke-FREE], FRI was reviewed and revised in 2006 in collaboration with the Norwegian Directorate for Education and Training.

More than 120 000 young people (over 60 % of the age group) take part in FRI each year. The programme has excellent results. It builds directly on the latest national curriculum (LK06) and is organised so that it does not entail extra classes, rather it replaces other classes.

Social inequalities manifest themselves in young people's career and educational choices and in recruitment to higher education. The most important tool for reducing these kinds of inequalities is giving greater priority to a reduction of social inequalities in learning throughout the entire course of education.

To prevent illness in the population, it is important to encourage a healthy diet and physical activity for children and young people. Children and young people are at a phase in life where there is a huge potential for preventing illness. Kindergartens and schools are therefore important arenas for establishing good health habits at an early age. A continuous school day provides a good framework for meals, and we are going to introduce a system of fresh fruit and vegetables for all pupils at primary and lower-secondary school. With a view to promoting good health and motor skills, schools are going to have to make sure there is time and facilities for daily physical activity. Research shows that physical activity at school encourages greater activity in leisure time and can even improve learning. Provisions for healthy meals and physical activity for everyone at school in itself can help level out social inequalities and improve the benefits of learning. School also plays an important role in efforts to prevent the harmful effects of tobacco.

4.2.2 Maternal and child health centres and the school health service

Maternal and child health centres offer general medical services for pregnant women and pre-

school children. The service also encompasses health centres for young people and the school health service in primary, lower-secondary and upper-secondary school. The service's main tasks include conducting health interview surveys, immunisation, providing information, advice and guidance, and implementing measures to help children and young people develop life skills and help guardians master parenting.

The service has adopted a comprehensive perspective on prevention and does a great deal of interdisciplinary work. This is key to efforts to prevent mental ailments and in dealing with complex social problems. The service collaborates with pupils, homes and schools to create schools that promote good health through a good learning and working environment. The service's work covers topics such as sexuality, relationships and contraception, protection against communicable diseases (including preventing HIV and STDs), diet, dental health, anti-smoking, drinking and drug campaigns, physical activity, and preventing accidents and injury. In order to meet challenges linked to obesity among children and young people, guidelines are currently being compiled for preventing and treating obesity. New guidelines are also going to be developed for measuring weight and height.

One of the service's tasks is to pay particular attention to pregnant women, children and young people with special needs. The service is constantly on the look out for early signals of ill-being, abnormal developments and anti-social behaviour and contributes to steps being taken. If necessary, the service refers patients for tests and treatment and collaborates with other bodies in connection with designing services. Maternal and child health centres collaborate with kindergartens, schools, the Educational-Psychological Service and the child welfare authorities.

Maternal and child health centres assess children's language development in connection with the check-ups at ages 2 and 4 using national guidelines for testing eyesight, hearing and language. Monitoring language development is crucial in identifying children who need extra language stimulation. This is part of the background for the project *Testing pre-school children's language skills at maternal and child health centres* – a scheme that is being tested out in connection with the 4 year check-up at maternal and child health centres in 12 municipalities. The project is intended to further develop language testing of children who speak minority languages. In the Report to the Storting *Early intervention for lifelong learning*, the Government announced that it is considering introducing a duty for municipalities to offer language stimulation. In this context, the government will assess whether to initiate measures to ensure more systematic monitoring of language skills in the maternal and child health centres on a national level. It is crucial that monitoring of language skills is followed up by remedial measures. There is no point in assessing language skills if there are no concrete measures available for children with a detected need for language stimulation.

In accordance with the *Regulations of 3 April 2003 regarding the local authorities' health promotion and preventive care in the maternal and child health centres and school health service*, the service shall assist schools in connection with providing instruction in groups or at parent–teacher meetings to the extent the school requests it. This means that it is up to the individual school to decide the extent to which they want to involve the school health service in the school's preventive work. It is therefore likely that there will be large variations among schools, which will in turn pose a particular challenge with regard to the goal of reducing social inequalities in learning and health. The Ministry of Education and Research is therefore going to consider amendments to the Act relating to Primary and Secondary Education and appurtenant regulations to ensure that the collaboration between maternal and child health centres and the school health service is more firmly established in legislation from the schools' point of view too.

The school health service plays an important supporting role in planning physical activity at school and provides advice in connection with arranging activities aimed at different groups of pupils, including pupils with chronic illnesses and pupils with reduced functional capacity. Arranging activities for pupils with reduced functional capacity requires an assessment of the school's physical environment. The service collaborates with homes, kindergartens and other relevant parties on measures for preschool children aimed at the physical environment, groups of pupils and individuals.

One advantage of the maternal and child health centre system is that it is the only arena that has contact with just about all children of preschool age. Almost all children, regardless of their parents' social position, take advantage of the services offered by maternal and child health centres during the first few years of life. The school health service and health centres for young people are low-threshold services available in children's and young people's own environment. Through its presence in schools, the school health service has the potential to reach children and young people in

all social groups. It is important for young people to have somewhere to go when they have problems without having to make an appointment and without having to involve their guardians.

The school health service's ability to reach all children is especially valuable in the work on reducing social inequalities in health. In addition to helping pupils via the school health service, the service can also refer children to the specialist health service and contact other municipal services for extra assistance. This means that the school health service needs to function well for other municipal health and care services to be able to perform their tasks satisfactorily. A number of studies have shown that the degree to which children and young people use other health services varies according to social factors. For example, a higher proportion of girls used psychologists/psychiatrists in the wealthier urban districts of Oslo inner west than in the more working-class Oslo outer east.

The school health service has insufficient capacity in very many of Norway's municipalities. Services are especially limited in upper-secondary schools. Capacity needs expanding by employing more people to ensure that children and young people experience the service as a low-threshold measure and that the school health service is able to identify children and young people with problems. Expanding the school health service will help ensure that the people who need the most help receive help from the municipal health service or some other municipal service, or are referred to the specialist health service. In this way, the service will serve to reduce social inequalities in the use of the health services. The Government is therefore going to further develop and build capacity in the school health service. The current situation will be assessed to ascertain required capacity and content of the service in the future.

Other identified needs include closer collaboration with other services and players, recruitment of staff with psychosocial competencies and updating existing employees' competencies. The goal is that the service shall identify children and young people with problems as early as possible, provide them with the help they need within the service, and refer individuals that need treatment in the specialist health service. Collaboration must be developed with school staff, other municipal services and the child and adolescent psychiatric clinics. Special attention must be paid to the inequalities between boys and girls and the fact that immigrants may have special needs.

4.2.3 Mental health services for children and young people

Mental health services for children and young people in the specialist health service have been expanded substantially since 2003. The Escalation Plan for Mental Health (1998–2008) defines a target of 5 % of the population under the age of 18 being offered treatment by mental health care services by the end of the escalation period in 2008. The degree of coverage in the mental health services for children and young people has increased from 2 % in 1998 to 4 % in 2005, and at the current rate of growth, it looks like this target will be met.

In the past, children and young people with mental ailments were generally treated and followed up within the specialist health service. In the future, a system is to be developed where the local authorities are more involved in prevention, treatment and follow-up of children and young people with mental ailments. The specialist health service will deal with cases requiring more specialised diagnosis and treatment. Low-threshold psychologist services are going to be established in the municipalities to improve accessibility for more groups in the population. Methods will be devised that go further in reaching out to children, young people and families in their own arenas. These kinds of measures will increase accessibility to services for groups that tend not to be served by the ordinary services offered by the health services.

Municipal services offered to children and young people have expanded enormously in the escalation period. At least 20 % of the ear-marked funds must be spent on measures aimed at children and young people. So far, a total of 29 % of the fulltime equivalents set up using earmarked grants are in services aimed at children and young people. Nevertheless, the services offered in the municipalities are still insufficient. There are serious inadequacies regarding diagnosis, treatment and follow-up of children and young people with mental ailments. There is also a need to improve competencies in violence and abuse and the harmful effects of growing up in a family with these kinds of problems. In light of these needs, interdisciplinary continuing-education courses in psychosocial work aimed at children and young people are being set up at a number of university colleges starting in 2007. This course of study will include learning about social inequalities in mental health.

Many children with mental ailments need assistance from several services, so the services need to develop good collaboration. To this end, the health enterprises and the state regional child wel-

fare services have formalised their collaboration in agreements. These agreements are intended to ensure that children needing assistance are offered co-ordinated services.

In the Soria Moria Declaration, the Government announced it was introducing a maximum waiting time and treatment guarantee for young people under the age of 23 with psychiatric and/or substance-abuse problems. In 2006, a working committee was formed, which has proposed a statutory time limit of ten days for assessment of the right to receive necessary health assistance. The working group also proposed introducing a statutory time limit of 90 days before treatment is started. In the spring of 2007, the Government will submit a proposition to the Odelsting suggesting introduction of maximum time limits for assessment and treatment. The purpose of this is to ensure young people with mental ailments and/or substance-abuse problems better access to specialist health services.

4.2.4 Child welfare service

The municipal child welfare service is responsible for implementing measures to prevent parental neglect and behavioural problems. The child welfare authorities provide special assistance for children and young people with these kinds of problems. The goal is to implement measures that help people receiving assistance live the best possible life within the family (or in a foster home or institution, as relevant), at school, among friends and later at work. The main challenges in this respect are intervening at an early enough stage with appropriate, preventive measures and monitoring these children as they grow into adulthood. The transition from child welfare to adulthood is a critical phase for many children receiving assistance from the child welfare authorities, and for this reason, the child welfare authorities are now also authorised to assist young people aged 18–23 years.

The child welfare service has a special responsibility to detect problems at an early enough stage to be able to implement measures to avoid permanent problems. As far as possible, assistance for disadvantaged children needs to be available in the usual arenas, with the child welfare authorities as a support. In order to provide timely assistance, the child welfare authorities depend on good collaboration with other municipal services that have contact with the children and their families in daily life, for example schools, kindergartens and the health service. The child welfare authorities have a statutory obligation to collaborate. For the child welfare authorities to be able to perform their tasks aimed at children and young people living in conditions that can harm their health and development, they need to receive information from other public services that have contact with the child and family. Other public services are bound by law to provide the child welfare authorities with any necessary information, the justification for this duty being the child welfare authorities' need to receive information.

This duty to provide information entails a duty to notify the child welfare service on their own initiative if there are grounds to believe a child is being mistreated at home or subjected to other forms of serious parental neglect, or if a child demonstrates lasting, serious behavioural problems. The duty to provide information applies to everyone working in public services and bodies, including schools, kindergartens and maternal and child health centres. It also applies to a number of professionals, such as doctors, nurses and psychologists. We know that schools, kindergartens and maternal and child health centres seldom report matters to the child welfare authorities. This is a sign that collaboration in this area is not working as intended. We do not know why this is so. A survey is therefore going to be undertaken to ascertain why other services tend not to report matters to the child welfare authorities.

The number of children receiving assistance from the child welfare authorities is rising. A report from the Office of the City Auditor in Oslo in 2006 expressed concern about the lack of capacity in some urban districts. It was also found that some employees claimed that sometimes the budget did not stretch to necessary measures being implemented pursuant to the Act on Child Welfare Services. The situation in Oslo is being monitored closely by the County Governor of Oslo and Akershus and the Ministry of Children and Equality. The child welfare authorities in the city of Oslo are currently being evaluated by an external audit body. The results of this evaluation will be available at the beginning of 2007. This evaluation will help provide a clearer understanding of the situation in the city of Oslo. Once the evaluation is completed, the development of the child welfare authorities in the city of Oslo must be assessed further. The Government's strengthening of municipal economies has resulted in improvements in the staffing situation in some municipalities and is expected to yield further improvements in 2007.

Pursuant to the Act on Child Welfare Services, the child welfare authorities have a duty to follow

up reports if there are reasonable grounds to assume that there are circumstances warranting steps being taken. We know that there are variations between municipalities regarding the number of reports dropped. The national average is 17 % of reports not followed up. While it is important to underline that some of the reports to the child welfare authorities concern matters not covered by the Act on Child Welfare Services, cases being dropped because of a lack of resources or for other reasons is a very serious matter. As a means of gaining better insight into the reasons why reports are not followed up, the municipalities will have to start reporting the reason for a case not being followed up from 2007. At the same time, the Ministry of Children and Equality is planning to initiate studies to ascertain whether too many matters reported to the child welfare authorities are being dropped.

The County Governor is charged with supervising that the municipalities/urban district councils carry out the tasks ascribed to them in legislation. The Ministry of Children and Equality is working on a joint project with the Norwegian Board of Health to develop methods and perform supervisions.

In many places, the municipal child welfare authorities do not have sufficient competence. The Ministry of Children and Equality wants to improve competencies. To address the need for more systematic knowledge in areas where there is a risk of deficiencies, written and electronic advisory materials and handbooks were compiled in 2006 for use in the municipal child welfare services on central topics such as foster homes, processing of cases and routines in the municipality, action plans and care plans for children receiving assistance, supervisors and internal control. The goal is to ensure equitable and knowledge-based child welfare services and to intervene at an early stage with appropriate help. The number of children receiving some form of assistance from the child welfare authorities is steadily growing. The child welfare services are having to deal with increasing numbers of complex cases involving drugs and alcohol, mental health care and children with a multicultural background. To meet these challenges, the municipal child welfare authorities need more knowledge about effective methods and tools through training of new child welfare workers and good continuing and further education for people already working in the child welfare services. In the first phase, efforts to raise competencies in the child welfare authorities will be used to develop a knowledge programme for municipal child welfare authorities. This will be achieved through a joint project involving university colleges, the municipalities and the employers' organisation in the municipal sector: the Norwegian Association of Local and Regional Authorities (KS). The university colleges need to be able to offer the local authorities better training and seminars for municipal employees in the region. Basic training for child welfare workers is also going to be reviewed with a view to implementing improvements.

Children and young people with an immigrant background constitute an important priority area for the Ministry of Children and Equality. We want to improve general competence about multiculturalism in the municipal and state child welfare authorities and ensure that this competence is applied in every-day work. Raising the level of competence in multicultural issues in the child welfare authorities is intended to ensure that this group of users is offered equitable services compared with other Norwegian children and young people. The Norwegian Institute for Urban and Regional Research (NIBR) has been commissioned to compile an overview of knowledge and assess research about available methods and tools for use in work with children, young people and families with an immigrant background. NIBR is also to identify factors that need to be present to ensure that interventions have their intended effect. The Ministry of Children and Equality will then use these findings to design a practical programme of competence raising in the local and state child welfare services.

In 2007, the Government is going to initiate a broad evaluation of the state child welfare authorities on the regional level. Against the background of this evaluation, the Government will then implement measures to improve interdisciplinary services offered to children needing support from the child welfare authorities.

The Government wants to focus on foster homes in coming years. Over 80 % of children and young people taken into public care are placed in foster homes. It is therefore crucial to ensure the highest possible quality in all aspects of foster-home work. Foster children are often very vulnerable and may have experienced a difficult breakdown of their biological family. Some of the children have behavioural patterns that are extremely challenging for foster parents. To avoid new, disruptive breakdowns and unplanned relocation of foster children, work has been started to improve follow-up and guidance of foster parents. Foster parents also need someone to turn to when con-

flicts arise – at any time of day or night. A helpline system is therefore going to be set up so that foster parents can contact the child welfare authorities quickly in acute situations outside normal municipal working hours.

Today's labour market has very high requirements regarding education and qualifications. Young people who have been under the care of or have received assistance from the child welfare authorities often need help and follow-up to set them selves up independently. Effective from September 1998, the Act on Child Welfare Services was amended to allow assistance given before a child has reached 18 (if the child consents) to be continued or replaced by other forms of assistance until the individual in question is 23 years old. There is now a statutory duty to evaluate the need to continue existing or introduce new forms of assistance for all young people who were taken into care by the child welfare services. In these cases, the child welfare service is also obligated to draw up a plan detailing planned forms of assistance in the future if the young person in question wishes to continue to receive assistance. Statistics show that many employees in the child welfare authorities believe child welfare clients need following up beyond the age of 18.

The Ministry of Children and Equality is once again going to take the initiative of informing the municipalities about their duty to provide information about the right to appeal in cases where the child welfare service rejects a young person's request to continue receiving assistance from the child welfare authorities after the age of 18 years. The Ministry is also going to investigate various aspects of after-care more closely. Using a variety of documentation, the Ministry is going to consider further measures to help make the transition to adulthood as smooth as possible. The idea is to identify good practices that can be shared with the local authorities. In connection with the current focus on poverty, development work has been started linked to after-care and rehabilitation after serving a sentence for young people up to the age of 23. The goal is to help the young person make the transition to independent adulthood.

4.2.5 Participation in organisations and cultural activities

The Government has set itself the goal of increasing participation in cultural activities and organisations in groups that currently do not participate. Cultural activities and voluntary organisations are important social meeting places and central arenas for participation and having fun. Participation in voluntary organisations forges contacts and creates social networks. Social networks and a sense of belonging are crucial for individual health. Participation in cultural activities is fun and gives a sense of achievement. Cultural experiences promote communication, a sense of community and well-being, and in this respect are an important part of growing up.

Voluntary organisations do not recruit equally from all groups in the population. Groups with high income and a long education tend to participate more actively than groups with low income and a short education. We know that children from low-income households participate less in activities in their free time and at school than other children and young people. Vast differences have been documented in the population regarding participation in cultural activities. A survey to determine who uses culture revealed that use of art and cultural facilities varies systematically with personal economy: people with low income make far less use of publicly financed art and cultural facilities. Positive childhood experiences of participation in organisations are decisive for activity in adulthood. Participation in organisations and cultural activities may be too expensive for families in a bad financial situation. The outcome is that the children may be excluded from important social arenas.

Young people with an immigrant background participate less frequently in recreational activities than other Norwegian children and young people, although these young people themselves report that they would like to participate in organisations. The Institute of Applied Social Science (Fafo) report «Young people's participation in organised leisure activities in multicultural Oslo» from 2005 claims that there is a positive correlation between the family's economy and young people's participation in sports teams. This correlation is most clearly observed among ethnic Norwegians and does not explain why ethnic-minority young people are less active in organised sports than average.

Music and arts schools

Municipal music and arts schools play an important role in nurturing a living, dynamic cultural life. The music and arts schools are a recruitment arena for future performers within the various arts – on the amateur and professional levels. These schools also provide towns and villages with access to cultural activities by making live concerts, theatre performances and other artistic expressions available to a broad public in large and small local

communities. In this way, the music and arts schools also recruit audiences to the field of art and culture. Open, inclusive music and arts schools with room for everyone who wants to learn will help dissolve inequalities by providing an arena for more young people to develop important aspects of themselves.

The Cultural Rucksack

The Cultural Rucksack provides children and young people with access to a wide range of cultural activities at school. School is a gathering place for everyone and is therefore ideal for ensuring that everyone is given a basic introduction to the arts as a foundation for future participation in and use of cultural activities. *The Cultural Rucksack* serves to level out inequalities in the use of culture among children and young people. The scheme helps ensure everyone has the opportunity to experience art and culture and provides pupils with the opportunity to express themselves through art and culture regardless of geographical factors and social divides. This scheme is currently only available to children and young people in primary and lower-secondary school, but in 2007 a number of pilot projects are being carried out in upper-secondary schools. Young people in this age group are in the process of changing from children into adults, and it is important that activities are designed so that they seem meaningful to the individual.

Traditionally, children encounter art and culture with their parents, and this use of culture has tended to reflect social inequalities. Schemes like *the Cultural Rucksack* help ensure that encounters with culture occur independently of social identity. In many ways, *the Cultural Rucksack* represents new content and new methods at school. This can be a positive experience for pupils who have difficulties adapting to ordinary teaching at school.

Other cultural measures

One of the priority tasks ascribed to the Norwegian Archive, Library and Museum Authority (ABM utvikling) is universal design. A network for universal design has been established, and an inspiration seminar for universal design has been held at five locations in Norway. The project *The accessible library* was carried out in the period May 2001 to December 2004. The purpose of this project was to give library users with reduced functional capacities the same access to libraries as other users.

Cultural organisations that arrange events throughout the country spread culture and create opportunities for equalisation in terms of cultural activities. The Norwegian Concert Institute, the State Touring Theatre, and the National Museum of Art, Design and Architecture, as well as other museums and libraries are taking steps to ensure greater openness towards the public and are implementing changes to make their facilities accessible to everyone.

A pilot project whereby young people in the age group 16–20 can buy a cultural card providing cheaper access to cultural events will help counteract social inequalities in use of cultural facilities. The culture card for young people scheme is being continued and expanded in 2007.

Volunteer centres

The many volunteer centres in Norway are important arenas for voluntary work, participation and generate a sense of belonging in the local community. They provide a wide range of social care services as well as offering cultural, recreational and local activities. The volunteer centres play a key role in creating good, lively local communities and coordinating local involvement, social responsibility and culture.

The volunteer centres have made it easier for more people to be involved in voluntary work. The centres have also tried innovative methods to get people involved in local voluntary projects. An active, welcoming attitude combined with concrete tasks linked to the volunteers' wishes and interests has yielded impressive results. The centres are also a meeting place for people with time on their hands in the day time. There are more homemakers, people on some kind of pension and unemployed people associated with the volunteer centres than in traditional voluntary organisations.

The volunteer centres aim to collaborate with the positive forces available locally: different teams and associations, congregations, public authorities and individuals. Forging contacts, developing networks and bringing together people who have something in common are important and useful tasks to stimulate and develop local voluntary activities, which can also have positive influence on the individuals involved.

Grants for schemes in cities

The Ministry of Culture and Church Affairs administers a grant scheme for activity development and social integration in local sports clubs in selected

urban districts and areas in the largest cities. The target group for this scheme is children and young people who because of economic or cultural barriers are prevented from participating in organised activities. The grant for activity development and social integration in local sports clubs is going to be increased in 2007.

The Ministry of Children and Equality administers a grant scheme for measures intended for children and young people in large urban communities. These grants are for measures aimed at groups of young people that do not make use of the existing cultural and leisure activities. The scheme is intended to contribute to qualification, inclusion and establishment of alternative arenas and to prevent anti-social behaviour such as violence and bullying, crime, drinking, drugs and racism. Within the framework of this scheme, there are earmarked funds for measures to tackle poverty problems. Children and young people with an immigrant background are given high priority. The grants can be used for holiday and leisure activities and for better contact with the labour market for young people with little or no education.

Box 4.2 Policy instruments: Childhood conditions

The Government will:

- initiate a study of the municipal duty to provide language stimulation to all children of preschool age that need it, regardless of whether they go to kindergarten or not, cf. Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*.
- gradually lengthen the school day at primary level to 28 hours of teaching a week, cf. Report no. 16 to the Storting (2006–2007).
- assess the current basis in legislation of the duty to provide adapted training in connection with a possible amendment of the objects clause of the Act relating to Primary and Secondary Education, cf. Report no. 16 to the Storting (2006–2007).
- implement new measures to reduce drop-out from upper-secondary education, cf. Report no. 16 to the Storting (2006–2007)
- evaluate measures to ensure more systematic language testing in maternal and child health centres at the 2-year check-up and 4-year check-up
- further develop and build capacity in the school health service
- improve municipal services for children and young people with mental ailments
- initiate measures to follow up young people over the age of 18 who have received assistance from the child welfare services
- build capacity in the child welfare authorities to ensure that children and their families receive help at an early stage
- continue and strengthen schemes designed to reduce social differences in children and young people's participation in organisations and cultural activities

5 Work and working environment

5.1 Objective: Inclusive working life and healthy working environments

Objectives

- A more inclusive working life
- Healthier working environments

5.2 Policy instruments

The Government regards two areas related to working life as particularly important for reducing social inequalities in health: continuing the focus on creating an inclusive working life and working for a healthier working environment in industries with major occupational stress.

We know that being in work is in itself good for health. People outside the labour market consistently have poorer health than the occupationally active part of the population. This does not only apply to recipients of health-related benefits, but also to people who have been unemployed for a long time and recipients of social assistance. There are therefore grounds to believe that a more inclusive working life will improve the population's health.

Policy instruments to achieve a more inclusive working life are described in chapter 8 in this Report to the Storting. In this chapter, we will focus on policy instruments aimed at improving working environments.

Major inequalities in health are also found among the working population. This is partly due to differences in physical and psychosocial occupational stress between occupational groups. People with a short education and repetitive, manual work tend to be more exposed to major health problems.

Although we have nowhere near enough knowledge about the correlations between working environment, health problems and exclusion from working life, it is fairly safe to assume that easily replaceable workers are the most likely to be excluded, i.e. people with the least education, and that people with few career options work in the most harmful working environments. These are usually employees with a short education, women in part-time jobs, immigrants and young people. Important policy instruments to improve the situation for these people include preventive working environment measures and better adaptation of the environment, especially in occupations and workplaces with much unskilled work, heavy work, time pressure and little possibility of choosing how the work is performed.

Efforts to prevent injury, improve working environments and adapt the workplace must be undertaken within enterprises. The authorities' role is to influence and support this work through policy instruments.

5.2.1 Working environment legislation

A new Working Environment Act came into force in Norway on 1 January 2006. The purpose of the Act has not changed, namely: to secure a working environment that affords full safety from harmful physical and mental influences, ensure sound conditions of employment and provide a basis whereby the employer and the employees of undertakings may themselves safeguard and develop their working environment. The new Act shall also:

- ensure equality of treatment at work.
- facilitate adaptations of the individual employee's working situation in relation to his or her capabilities and circumstances of life.
- provide a basis for a healthy and meaningful working situation and inclusive working conditions.

The new Act defines in more detail the duties of the employer and employee regarding health, environment and safety work. The Act also lays down requirements concerning greater participation in restructuring processes. It is spelt out that the requirements concerning the psychosocial working environment also include requirements concerning protection from violence and threats from customers, clients, etc. The Act is also clearer concerning the right to equal treatment in connection with appointment, for example, the new Act prohibits discrimination of part-time employees and temporary employees regarding pay and working con-

ditions. The employer's duty to adapt the working environment for employees with reduced capacity for work is laid down in the Act, and better follow-up of this statutory duty may help reduce occupational inequalities in health.

5.2.2 The Norwegian Labour Inspection Authority

The Norwegian Labour Inspection Authority is responsible for overseeing that enterprises comply with the requirements of the Working Environment Act. The Norwegian Labour Inspection Authority reaches around 8 % of enterprises in Norway through its inspections and must therefore prioritise its efforts after a risk assessment based on knowledge and experience about which occupational groups, industries and sectors have the most occupational stress. A large proportion of the resources available for inspections is spent on major projects aimed at high-risk industries, which in itself helps reduce social inequalities in health.

According to the Norwegian Labour Inspection Authority's risk assessments, the employees most exposed to occupational stress work in the health and social services, transportation, and commercial services such as cleaning. Many of the tasks within these industries involve lifting heavy items, awkward working positions, monotonous repetitive work and tight deadlines. Immigrant groups from non-Western countries are overrepresented in a number of these occupations.

It is the Norwegian Labour Inspection Authority's experience that changing attitudes and behaviour requires a strong, high-profile effort over time, and in a move to reach more workers, the Norwegian Labour Inspection Authority has developed a new strategy attaching greater importance to prevention in its capacity as an advisor and agenda-setter. By virtue of its role as a guide, for example, by providing good examples and tools for adaptation of the environment and risk assessment, the Norwegian Labour Inspection Authority aims to contribute to better compliance in enterprises with the requirements intended to ensure a safe working environment.

Cultural differences and language problems also affect the working environment situation. They can pose challenges in terms of organisation, adaptation of the environment and personnel management at all levels in companies. The Norwegian Labour Inspection Authority's 2005 campaign on working environment conditions for non-Western workers revealed major disparities in working life in Norway as a result of insufficient information and training. Speakers of minority languages from non-Western countries are overrepresented in working environments with multiple, different stresses and among people who have sustained injuries. The Norwegian Labour Inspection Authority is increasingly coming across problems and issues linked to the working environment and working conditions for employees from new EU countries. This applies to the building and construction industry in particular.

5.2.3 Company health services

Company health services are an important working-environment tool intended to help enterprises in their preventive and health-promoting work. A project has been undertaken in collaboration with the trade unions' and employers' associations and the affected authorities to assess the roles, responsibilities and tasks ascribed to company health services. This project will also assess which criteria should be used as a basis for deciding whether an enterprise should be obligated to establish a company health service and if there is a need for any quality requirements or some form of approval system. This project is due to be completed in autumn 2007.

5.2.4 Higher employment among immigrants

Immigrants represent a resource for working life in Norway. A current challenge is how the labour market can make better use of immigrants. The unemployment rate among immigrants is three times higher than among the rest of the population. Registered unemployment among immigrants dropped from 9 % in the second quarter of 2005 to 7.3 % in the second quarter of 2006. In the rest of the population, registered unemployment went down from 2.9 to 2.1 %. Among immigrants, the proportion of people in work rose from 56.6 % in the fourth quarter of 2004 to 57.5 % in the fourth quarter of 2005. In the population as a whole, there was a marginal increase from 69.3 to 69.4 % in the same period.

There are numerous reasons why immigrants have weaker contact with the labour market than the rest of the population. It may be because some groups of immigrants have inadequate qualifications and do not satisfy the requirements in the Norwegian labour market. It may also be because immigrants are more often subject to discrimination in working life. A lack of networks and attitudes towards women working outside the home

have also been cited as causes. Despite variations, immigrants' contact with the labour market seems to vary with where they come from and how long they have been in Norway.

It is a goal to reduce unemployment and increase employment among immigrants. Immigrant women are to be given first priority. A number of measures have already been implemented, for example one measure qualifies and adapts newly arrived immigrants' skills for the Norwegian labour market, and another measure aims to improve the labour market's ability to include immigrants. The main goal of the introduction scheme for immigrants that have recently arrived in Norway is to improve the ability of newly arrived immigrants to find work or embark on training quickly. It focuses on the individual's resources and offers qualification specially tailored to the individual's needs. From 1 September 2005, all adult immigrants have the right and duty to attend classes in Norwegian and civics. *A second chance* is a trial system of paid qualification based on the same model as the introduction scheme for immigrants who have still not established themselves in the labour market after several years in Norway and therefore still depend on social assistance. These projects focus on qualifying people for work and mediating ordinary work to people who need basic qualifications. Immigrants are a priority target group when allocating places in labour market measures.

The purpose of the Anti-discrimination Act is to combat discrimination and promote equality in a broader and more long-term perspective. The Anti-discrimination Act applies in all sectors of society, including working life. From 1 January 2006, a special enforcement system was set up for equality and discrimination through establishment of the Equality and Anti-discrimination Ombud and the Equality and Anti-discrimination Board of Appeals. These two bodies uphold several laws protecting against discrimination, including the Anti-discrimination Act. The Government is particularly keen to encourage recruitment to working life and is collaborating with the trade unions' and employers' associations to develop a proactive recruitment policy.

The Government's *Action plan for the integration and inclusion of the immigrant population and goals for inclusion* shall serve to ensure that immigrants contribute their resources to society as quickly as possible, to avoid the development of a stratified society where people with an immigrant background have poorer living conditions and lower participation than the rest of the population and ensure that immigrants and their descendents have the same opportunities as other members of society. The action plan contains measures for implementation in a number of areas, including a considerable strengthening of efforts aimed at getting immigrants into work.

5.2.5 Action Plan against Social Dumping

In May 2006, the Government introduced its Action Plan against Social Dumping to counter challenges entailed by the influx of migrant workers after enlargement of the European Economic Area. This action plan includes important measures that the Government believes can help achieve the goal of proper pay and working conditions for everyone and a well-functioning labour market. To this end, the government increased the resources and sanctions available to the Norwegian Labour Inspection Authority and the Petroleum Safety Authority Norway, and from 1 December 2006, these authorities are entitled to use orders, coercive fines and shutdown of operations in connection with inspections of pay and working conditions pursuant to the Act relating to general application of wage agreements etc. and the Immigration Act.

In December 2006, proposals detailing further measures to combat social dumping were circulated for review. These proposals concern measures to ensure proper conditions related to hiring and renting out labour and measures for stronger control and follow-up of pay and working conditions in industries with generally applied wage agreements.

5.2.6 National system for monitoring work and health

The knowledge we have about the working environment as a direct cause of health problems tends to be linked to certain industries, occupations and circumstances. In light of the broader patterns we observe in social inequalities in health, this knowledge is fragmentary and insufficient.

On 1 January 2006, a national system for monitoring working environment and health (NOA) was established at the National Institute of Occupational Health to gather and process relevant data and information about working-environment issues and make them available to other users. Relevant users include the public authorities, players in working life, researchers and the general public. The aim is to build up a corpus of knowledge for use by all the actors in the area, for designing poli-

cies and strategies, and to provide better opportunities for measuring and assessing the results achieved.

This monitoring system will enable the National Institute of Occupational Health to help quantify social inequalities in the distribution of positive and negative factors in the working environment (exposures) and possible work-related impacts on health.

The National Institute of Occupational Health will also be able to provide analytical studies to quantify the impact of factors in the working environment on social inequalities in health and help quantify what health selection associated with «the new workplace» means for social inequalities in health.

5.2.7 Increase research on sickness absence and exclusion from working life

We have a lot of knowledge about individual causes of sickness absence, but we do not know enough about the relative strength of the causes and how they interact. In light of this, the Government announced in Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* a new focus on this area with the intention of stimulating research collaboration across existing disciplinary boundaries. The new investment in research will start in 2007 and its objective is:

– to contribute to a more coordinated, stronger knowledge base about the causes of sickness absence, disablement and exclusion from working life.
– to ensure research-based knowledge about effective policy instruments in order to prevent sickness absence and disablement and help achieve the Government's goal of an inclusive labour market.
– to help ensure that teaching in relevant courses of education is more firmly anchored in research.

5.2.8 Sickness absence and exclusion in high-risk industries

As a means of reducing sickness absence in industries with a high rate of exclusion, the Ministry of Labour and Social Inclusion initiated a project in December 2006, one of the goals of which is to reduce sickness absence in two selected industries with especially high levels of sickness absence by focusing attention on specific challenges related to the working environment in the industry itself, and by making the trade unions' and employers' associations accountable. This work is to be coordinated by the Norwegian Labour Inspection Authority and carried out in close collaboration with the agencies' advisory councils made up of the affected associations and the Norwegian Labour and Welfare Organisation (NAV).

In addition to this project focusing on specific industries, the Government wants to study causes of sickness absence in the health and care sector. Many of the people exposed to the most working-environment strains work in the health and care sector. Many of the tasks they perform include heavy lifting, awkward working positions, monotonous repetition, tight deadlines and rotating shift work. Working conditions that are perhaps typical of «modern working life» (increasing rate of change, time pressure and efficiency and competency requirements) also play a role in exclusion through extended sick leave and being put on a disability pension in this sector. Any reductions in sickness absence and exclusion in the health and care sector will have a positive effect from a health-distribution perspective.

The state is the main employer within the affected industries and thus has a special responsibility. The Government will therefore initiate a study to ascertain the scope of, causes of and possible measures to avoid health-related absence in and exclusion from the health and care sector.

This study is to be undertaken by a committee made up of people from a wide range of spheres, and the trade unions' and employers' associations and the working environment authorities are invited to take part.

Box 5.1 Policy instruments: work and working environment

The Government will:

- target inspection activities at high-risk industries and groups
- make efforts to furnish targeted information for high-risk industries and groups
- make arrangements to ensure that enterprises fulfil their responsibilities regarding prevention and adaptation of workplaces to a greater extent
- in collaboration with the trade unions' and employers' associations, assess the roles, responsibilities and tasks ascribed to company health services, the possibility of requirements regarding the development of company health services and the need for quality requirements or an approval system for company health services
- prevent social dumping, cf. *Action Plan against Social Dumping*
- encourage raising levels of knowledge and better understanding of the broader causal connections between work and health, for example between health injuries and work-time arrangements
- follow up the more precise requirements in the new Working Environment Act regarding preventive and systematic health, environment and safety work to prevent exclusion from work
- investigate the scope of, causes of and possible remedies for health-related absence from work and exclusion from the health and care sector

Part II
Reduce social inequalities in health behaviour and use of the health services

6 Health behaviour

«Attention needs drawing to the underlying, structural causes of behaviour in order to encourage healthy lifestyle choices.»

Figure 6.1 Health behaviour

6.1 Objective: Reduced social inequalities in health behaviour

Objective

- Reduced social inequalities in health behaviour

Other goals

Reduced social differences in:

- diet
- physical activity
- smoking
- other health behaviour

Health behaviour means lifestyle and habits that have a major impact on health, such as diet, physical activity, smoking and drinking.

6.2 Policy instruments

Individual's health behaviour choices are largely determined by their social environment. Smoking, physical inactivity, unhealthy eating habits and abuse of drugs and/or alcohol are unevenly distributed among groups in the population. With the possible exception of consumption of alcohol, health behaviour that increases the risk of illness tends to be more common in groups with a short education and low income.

Health behaviour is closely related to social structures. Attention needs drawing to the underlying, structural causes of behaviour in order to encourage healthy lifestyle choices. For example we know that there are clear social inequalities linked to who manages to stop smoking. This is not merely a case of some groups having more knowledge about how harmful tobacco products are – it is also a question of resources, motivation and energy. Good public health work in this area therefore needs to focus on making it easier and more natural for people to change their health behaviour – from unhealthy to healthy habits.

Health information campaigns have played a central role in bringing about changes in the population's health behaviour, but we also know that health campaigns are often most effective in the parts of the population that already lead the healthiest lifestyle. It is therefore necessary to design new campaigns that are better able to reach the target groups from a social perspective. It is also crucial to ensure that good information is available to ethnic minorities, such as non-Western immigrants and Samis.

Measures targeting children and young people are very important because the foundation for good habits is laid early in life and because factors in childhood have a major impact on health later in life. Boys and girls react differently to the same measures. For example, studies show that boys benefit less from traditional information measures. It is therefore important that all strategies and interventions are assessed in view of the impact they will have on both sexes. This also applies to measures targeting the adult population.

The design of public health measures must take account of our multi-cultural society. A large proportion of the Norwegian population identifies with two cultures. Immigrants from non-Western countries often find that establishing themselves in

Box 6.1 Gender perspective in health information

Getting health-related information to young boys.

Studies show that young boys tend not to use traditional channels of information and services when seeking help or information. Boys think that they ought to deal with their problems on their own and that it is unmasculine to talk about them. This is particularly so for problems related to sex and relationships. Existing facilities are seen as aimed primarily at girls and not very relevant. Boys constitute only 5–10 % of the users of ordinary assistance facilities and information measures for young people, while the proportion of boys who use health-related Internet and telephone services for young people is around 50 %. Studies also show that boys need just as much help and information as girls.

The challenge then is how to design measures to meet boys' needs and that boys feel are useful. User surveys reveal three important elements: Help and information must be provided by professionals, and it must be possible to remain anonymous. Secondly, help facilities and information services must have built-in possibilities for user control and steering. Thirdly, they must be based on a design where the user is an active problem solver, as opposed to a passive recipient of information.

Source: The Directorate for Health and Social Affairs

a new country with a different culture and foreign language leads to detrimental changes in diet and less physical activity. Some immigrant groups have stopped eating their traditional varied diet with a high intake of healthy foodstuffs such as vegetables, fruit, lentils and beans in favour of food products containing high levels of fat and sugar. These changes manifest themselves in the higher incidence of certain health problems linked to nutrition, such as obesity and type 2 diabetes in some immigrant groups.

It is important that all significant considerations are included in assessments when proposing new initiatives, in the health sector and in other areas of society. In many cases, levelling out social inequalities will be an important consideration. The Government wants to underline that measures intended to influence health behaviour must always be assessed in light of the goal of reducing social inequalities in health. Health impact assessments are discussed in more detail in chapter 9.

International experiences from intervention studies suggest that structural measures affecting price and accessibility seem to be more effective at reducing social inequalities than information and health education measures. Information campaigns tend to work best in the parts of the population that already have the best health and thus often serve to widen the social gap.

The Directorate for Health and Social Affairs recommends general, broad-based, low-threshold measures and targeted measures aimed at the most deprived and vulnerable groups, especially children and young people. Low-threshold activities require little equipment and no special skills, they should be free of charge or cheap, and should be easily accessible physically, socially and culturally.

The Government wants to make healthier choices more readily available by increasing the emphasis on structural policy instruments in combination with health information measures.

6.2.1 Accessibility in schools and kindergartens

Examples of interventions intended to change health habits include daily physical activity at school and access to cold drinking water and fruit and vegetables at school. Kindergartens and schools are crucial arenas in the effort to encourage healthy habits because they make it possible to reach all children and young people. For example, increasing physical activity at school also leads to increases in physical activity after school hours and on weekends. This effect seems to last well into adulthood. This measure appears to have the greatest impact on children of parents with a short education and low income and non-Western immigrant children.

Major health gains are achieved, in terms of longer life and better quality of life, by offering fruit and vegetables to all pupils in primary and lower-secondary school. Fruit and vegetables for all pupils in primary and lower-secondary education helps establish a high intake of fresh produce in childhood. The evaluation of a pilot project providing children with free fruit and vegetables in schools in Hedmark county shows that this measure reduces social inequalities in intake of fruit and vegetables.

6.2.2 Measures in the local community

Helping smokers give up smoking is an important tool in the drive to prevent use of tobacco products. For several years now, the Directorate for Health

Box 6.2 Free fruit and vegetables at school – pilot project

In the project *Fruit and vegetables in 6th grade*, nine primary schools in Hedmark county took part in the «free fruit at school» scheme in the school year 2001–2002. The project was evaluated as part of Elling Bere's doctoral thesis at the Department of Nutrition, University of Oslo, 2004. Everyone ate more fruit, regardless of their previous eating habits, gender and social background. It was found that one year after the project, pupils were still eating more fruit and vegetables. Preliminary findings after three years appear to show the same tendency. This shows that free fruit can bring about permanent changes in children's eating habits. Children of parents without higher education who received free fruit also reduced their intake of unhealthy snacks such as fizzy drinks, sweets and crisps after the period of free fruit. Initially, these children ate far more unhealthy snacks than children of parents with higher education. The evaluation shows that a scheme that reaches all children and young people because it is free can help even out social inequalities in intake of fruit and vegetables.

and Social Affairs and the County Governors have been training people to hold courses in stopping smoking, and courses are now available throughout the whole of Norway. Many voluntary organisations make a major contribution: for example, the Norwegian National Health Association in Hedmark and Oppland counties collaborates with the local County Governors. This coordination of activities has led to more public health initiatives, and the model is now being applied in other counties.

As part of the follow-up to the *Action Plan on Physical Activity 2005–2009*, the Directorate for Health and Social Affairs has worked with local governments and other actors in four counties (Nordland, Buskerud, Vest-Agder and Oppland) on a joint project to develop systematic programmes for physical activity, dietary guidance and giving up smoking as tools in the municipal public health work. Municipal centres promotting physical activity for certain groups, called «*frisklivssentraler*» (FLS), and similar models have been set up to implement measures locally. This is a continuation of the low-threshold FYSAK measure, which is a measure implemented at the local level to encourage physically inactive groups in the population to be more physically active. Based in the municipal health service, the programme aims to develop models for systematic use of physical activity aimed at certain groups in public health work.

FYSAK Nordland was established as a model programme for physical activity in selected municipalities in Nordland County in 1995–96 and ran until 1999. The programme was continued as a permanent county-municipal sphere of work from 2000. The model is based on regional collaboration among a number of actors. The objective is to develop promotion of physical activity as part of the municipal health service's standard range of services, where activities are set up as a collaboration across government agencies and sectors. The target groups for individual measures are defined on the basis of the needs identified by the individual municipality. Evaluations have found very positive results. The Directorate for Health and Social Affairs is going to take steps to ensure that FYSAK and similar measures to promote more physical activity are incorporated into the Partnerships for Public Health in all the counties in Norway.

The Ministry of Health and Care Services is going to strengthen the grant scheme for physical activity to stimulate the development of more low-threshold activities.

It is a goal that Norway should have good residential environments that promote physical activity. Local communities are going to be adapted to encourage as many people as possible to exercise. For example, it should be easy and safe for people to get around on foot or by bicycle. Physical accessibility for people with reduced functional capacity is still substandard in many places, leading to exclusion and marginalisation. A lack of money is often an obstacle to physical activity. Simple outdoor activities and activities in the local environment are often very low cost and can be carried out in most places.

Local low-threshold measures are important in the work on further developing and evaluating the system of «green prescriptions». The municipal health service, the local community and workplaces are good potential arenas for prevention and intervention. In addition to the health service, voluntary organisations and private actors, the Norwegian Labour and Welfare Organisation (NAV) should also be considered as a potential collaborative partner. The activities offered must be based on the municipal land-use plan and must build on existing structures for the local government's or other actors' operations and services.

Box 6.3 Active During the Day

Active During the Day is a measure granting people who are partially or fully unemployed access to organised physical activities. Active During the Day focuses on the individual's abilities and skills. By gradually tapping into their own resources, participants can prevent loss of functional capacities, improve their health, and once again take active part in social life.

Active During the Day offers all-round physical activity on a daily basis. The measure is adapted for people with different physical and mental ailments. Bridging the gap between sport and health, Active During the Day is a low-threshold measure. It is open to people no matter how little exercise experience they have or what diseases or problems they have.

Active During the Day has been introduced in Fræna, Førde, Molde, Oslo and Akershus.

http://www.treningskontakt.no
http://www.apd.oslo.no

A system of dietary advice courses for patients is currently being tested. These kinds of low-threshold measures are to build on existing services and experiences, and effort should be made to coordinate new measures with existing measures like Active During the Day, measures coordinated by the county and municipal administration, voluntary organisations, municipal centres promoting physical activity (*frisklivssentraler*), etc. The Directorate for Health and Social Affairs is going to collect knowledge and arrange experience sharing so that more people have access to these kinds of measures.

The Government wants to prevent lifestyle diseases and improve dental health in high-risk groups in the immigrant population. As part of the *Action plan for the integration and inclusion of the immigrant population and goals for inclusion*, the Government is therefore going to stimulate establishment of measures to promote physical activity and good eating habits.

6.2.3 Work as an arena

Work is an arena where we can reach groups it has been difficult to reach through information campaigns and other policy instruments. For example, work can be a good arena for promoting healthy eating habits, physical activity and stopping smoking. Large workplaces that have a canteen can arrange courses and other events to raise levels of knowledge among canteen staff and can ensure fresh fruit and vegetables are available. The Ministry of Health and Care Services is going to consider joint measures with labour organisations and providers of food to promote healthier eating habits.

The project «Health-promoting workplaces» focuses on factors that have a positive influence on health in the working environment. When the project was started, a declaration was signed stating that health-promoting workplaces evolve through processes steered by participants and accept and accommodate the needs, resources and potentials of the individual. The inclusive working life idea bank has collaborated with other actors to collect experiences gained from projects and research on health-promoting workplaces.

In order to reach groups outside normal working life, the Ministry of Health and Care Services is going to collaborate with the Ministry of Labour and Social Inclusion on assessing how the Norwegian Labour and Welfare Organisation (NAV) offices can be used as an arena to make public health work more target-oriented.

Box 6.4 Hamarøy municipality: Broad collaboration on public health

Initiatives such as prescriptions for physical activity and exercise, close collaboration with municipal medical officers and NAV Welfare, and development of the managerial role have yielded good results in the work on reducing sickness absence in Hamarøy municipality in Nordland county. Since 2003, sickness absence has dropped from almost 10 % to 5 %. The success is due to:

- Routines for following up sickness absence
- Employees' immediate line manager is responsible for work regarding sickness absence
- Stronger management role
- All line managers attend a seminar on inclusive working life and preventive work
- Focus on working environment and preventive work and pay for safety delegates
- FYSAK centre offering exercise on prescription
- Close contact with the doctor and physiotherapist
- Physical exercise during work hours
- Strategic collaboration meetings between: personnel manager, municipal medical officer, NAV Welfare and NAV Working life centre
- Stable health service
- Municipal medical officers with fixed pay

Read more at http://www.idebanken.org

6.2.4 Lifestyle guidance in the health service

Giving information directly to individuals within the setting of the health services is often especially effective. Documentation shows that advice and interventions in the health services have been very effective for patients with high-risk use of drugs and alcohol. These kinds of interventions function as a supplement to information campaigns and other measures.

The «Learning and Activity Centres» at the regional health enterprises are an important arena for training patients with chronic disorders. Many

of the centres now have facilities for groups of chronic patients. Treatment often includes dietary advice and assistance in stopping smoking.

Health advice in the health services is a new focus area in the drive to prevent the harmful effects of tobacco use. The *National Strategy for Tobacco Control 2006–2010* defines improving health workers' knowledge about stopping smoking and one-to-one communication as main priorities. It is important to strengthen the input in the specialist health services vis-à-vis patients with smoking-related disorders. For large groups of patients – for example patients with COPD – stopping smoking is the most effective single form of treatment in curbing the development of the disease. The regional «Learning and Activity Centres» may be an appropriate arena for this work. Strengthening systematic work to help people stop smoking is an important priority. This means developing guidelines, providing healthcare workers with good training, and introducing economic incentives to encourage the health enterprises to give this work greater priority. The training of health care staff needs to include courses on giving advice regarding lifestyle changes in general and help stopping smoking in particular.

GPs and regular GPs advise patients on diet and physical activity. Diet is important in the treatment of many diseases. Giving advice on diet and nutrition takes time, and an ordinary doctor's appointment is often not enough. In these kinds of cases, doctors can use an hourly rate or, depending on the diagnosis, the rate for «green prescriptions». Green prescriptions can be used in connection with type 2 diabetes and high blood pressure not being treated with medicines, for example. The evaluation of the «green prescription» scheme reveals a great need for auxiliary measures to change health behaviour outside doctor's offices: many doctors cite a lack of expertise in the municipality to whom doctors can refer patients for further follow-up, for example physiotherapists and dieticians. Over half of doctors report that they have nowhere to refer patients to for further follow-up.

It is necessary to promote good health by improving dental health. The dental health service provides outreach dental health services for children and young people and for groups that are deemed to have special dental health needs. The dental health service is also charged with organising preventive dental health care. This may take the form of general schemes or targeted measures aimed at specific groups. In the spring of 2007, the Government is going to submit a report to the Storting on the dental health service. This Report to the Storting will discuss the issue of how better use can be made of the dental health service as a collaborative partner in public health work and how the dental health service can help reduce social inequalities in general health and dental health.

The health centre for young people is the most important local provider of contraception and advice for young people. Health centres for young people also have an important teaching function through their collaboration with schools concerning relationships and sexuality. The last few years have seen a major expansion in health centres for young people within the municipalities' primary health services, but it still seems that availability is inadequate in many places – especially in sparsely populated areas. Finnmark county and the other counties in northern Norway have particular problems in terms of availability of health services for young people.

The maternal and child health centres and school health service have been charged with providing guidance, advice and information. Important topics include guidance about diet, physical activity, tobacco, alcohol and drugs. The maternal and child health centres and school health service are an important driving force in preventive work by virtue of their contact with kindergartens and schools, and they are supposed to support and contribute to good eating and mealtime habits and arrangements for physical activity in these arenas. The close, early contact that maternal and child health centres have with families, especially during children's first year of life, plays an important part in the work to encourage breastfeeding and establish healthy eating habits from the outset. The service also gives advice on use of formula and general advice about nutrition for babies and young children.

6.2.5 Regulate access to goods and services

As part of the follow-up to *The Diet Action Plan*, the Ministry of Health and Care Services is undertaking a study to ascertain whether it might be appropriate to regulate advertising of unhealthy food and drinks aimed at children and young people. The Norwegian authorities participate actively in the debate about these issues, through the collaboration between the Nordic countries and within the EU and the World Health Organization.

Children and young people eat too much sugar and fat, and much of this comes from sweets, fizzy drinks, soft drinks and snacks. These food prod-

ucts have little nutritional value, but contain a lot of calories and should not make up a significant part of people's diet. These products lead to obesity among children and young people. Some parts of the food industry spend considerable sums of money marketing these goods, also to children and young people. Studies show that marketing of these kinds of food products constitute a large part of the television advertising broadcast in connection with television programmes for children and young people. It is a well-documented fact that marketing works. Children exposed to advertising and measures to promote sales of these products have a higher intake of these food products than other children. This is reflected in the amount of sugar and fat in their diet.

1 June 2004 saw introduction of the ban on smoking in cafes, bars and restaurants in Norway. Evaluations show that the air quality for employees in these establishments has improved dramatically, and that this has led to a reduction in the number of respiratory complaints and better health. In addition to less exposure to second-hand smoke, it is expected that the ban on smoking will also reduce smoking among employees. This group of employees has relatively little education and low income. A positive side effect is that an important recruitment arena for young people is now smoke-free. It is also likely that the amendments to the legislation have accelerated the decrease in the number of smokers in the population in general.

Despite a minimum age limit of 18 for buying tobacco products, studies show that around half the young people aged 13–17 who smoke have no problems buying tobacco. A proposal suggesting a new system for supervising selling to minors was circulated for review in autumn 2005 and is currently being considered by the Ministry of Health and Care Services. The Norwegian Food Safety Authority is the proposed supervisory authority. The Government is considering proposing introduction of a supervisory system. The Government is also considering a proposal to ban visible displays of tobacco products in retail outlets. This proposal is currently being developed. Steps are also being taken to get all the county municipalities in Norway to introduce a ban on smoking in school hours in upper-secondary schools for pupils and staff alike. This measure is important because it is at this age that most people start using tobacco.

It is well-documented that the most effective tools in alcohol policy are those that reduce availability and raise the price. The main elements in Norway's alcohol policy are a strong retail monopoly, high taxes and prices, an extensive system for inspecting retail outlets and licensed venues, and tight restrictions on the marketing of alcoholic beverages. Ours is one of the most restrictive alcohol policies in Europe. There are therefore grounds to assume that the alcohol policy we have adopted hitherto is an important reason why alcohol consumption in Norway is among the lowest in the Western world. The Act on the sale of alcoholic beverages assigns a major responsibility to the local governments, partly through their licensing authority. In recent years, we have seen a gradual increase in availability of alcohol. For example, according to the Norwegian Institute for Alcohol and Drug Research, SIRUS, the number of licences to serve alcohol in Norway has risen from 2439 in 1980 to 7231 in 2005. In spring 2006, the Directorate for Health and Social Affairs published a new handbook on drawing up municipal plans of action on alcohol and drug policy. Here, the local authorities are encouraged to see the entire alcohol and drug policy in context and regard their licensing policy as an important tool in the general efforts to prevent substance abuse, in order to counteract further increases in the number of licences to sell and serve alcohol.

On 1 July 2006, a ban was introduced prohibiting use of note acceptors in gambling machines. This measure is part of the Government's efforts to prevent gambling addiction until gambling machines are phased out altogether. The ban on note acceptors has already led to a marked decrease in turnover for gambling machines. The Government has decided to introduce night-time closing hours (midnight to 7 AM) on gambling machines and obligatory labelling of machines with information and warnings about the consequences of exaggerated use of the machines. Gambling machines are going to be banned completely starting 1 July 2007.

Changes in prices and taxes

Tobacco prevention work traditionally uses taxes as a tool. Research shows that young people are particularly sensitive to changes in the price of tobacco. Older smokers have a longer smoking history and established psychological smoking rituals as well as physiological nicotine dependence. Young people have less money to spend on tobacco, and young smokers do not have the same firmly established tobacco habits and are therefore easier to influence.

A review of research on measures to reduce smoking among young people (carried out by

Lund and Rise, 2002, on commission from the Directorate for Health and Social Affairs) shows that income is decisive for price sensitivity. Sensitivity to changes in price means that groups with limited financial resources generally reduce their demand to such a great extent that the group spends overall less money on tobacco. Groups with greater spending power – that are not so price sensitive – consume roughly the same amount of tobacco after a price rise and thus bear a larger part of the expense. Raised taxes can thus contribute to reducing social inequalities in health behaviour since this policy has the greatest impact in the poorest groups.

It is assumed that the most important effects of an increase in taxes will be fewer young people starting to smoke and adults stopping smoking altogether, as opposed to people who continue to smoke cutting down their daily consumption. People who continue to smoke despite increases in taxes will experience an increase in expenses. The economic burden of an increase in tax on tobacco will be greatest for people with the worst financial situation. The health benefits of an increase in the tax on tobacco must therefore be considered in light of the burden increased taxes will entail for people with limited financial resources.

Taxes are a key tool in Norwegian alcohol policy. Like changes in prices of other goods, an increase in the price of alcohol will have the greatest impact on consumption in groups with limited financial resources. It is therefore reasonable to assume that a reduction in taxes on alcohol and the price of alcohol would lead to the greatest increase in consumption – and therefore also injuries – in groups with limited financial resources. It is important to continue a restrictive alcohol policy with high taxes to avoid an increase in alcohol-related illness and injuries in these groups. When considering the level of tax on alcohol and tobacco, we must also take into account developments in unregistered consumption.

The population's diet can be influenced by making unhealthy products relatively more expensive. Special taxes on unhealthy products are one of several policy instruments that will help improve the population's diet. However, the impact of this instrument will depend on the degree to which the taxes affect the price and how sensitive the consumers are to price in their choices. The health impact will also be weakened if the price rise leads to consumers simply buying these products abroad instead.

Pursuant to proposals in Proposition no. 1 to the Storting (2006–2007) Decisions on taxes and customs, the Storting has changed taxes on non-alcoholic beverages so that drinks with added sugar and sweeteners are taxed, while bottled water and juice are exempt from taxes. We would prefer this tax only to apply if the sugar content passes a defined lower limit, motivating the industry to lower the sugar content in beverages. However, a lower limit would depend on requirements regarding labelling specifying the sugar content. The current EU regulations do not call for this kind of labelling, but Norway has proposed this solution to international bodies.

Calculations carried out by the Norwegian Agricultural Economics Research Institute demonstrate that a 12 % drop in the price of fruit and vegetables in Norway would cause an increase in the total demand of between 4 and 15 %. Among young people living alone and couples with children, total demand for fruit and vegetables is expected to rise by 11–12 %. These groups spend less of their food budget on fruit and vegetables than other households. However, it must be pointed out that there will always be a great deal of uncertainty associated with these kinds of calculations.

It is the Government's view that the interests of children and young people should be given priority. Cheaper fruit and vegetables will serve to increase consumption among young people and in families with small children in particular. These are important target groups for establishing good habits at an early age, which can help reduce the risk of illness later in life. As part of the follow-up to the Diet Action Plan, the Ministry of Health and Care Services will take the initiative to ensure that economic policy instruments are considered.

Box 6.5 Policy instruments: Health behaviour

The Government will:

- use pricing and taxation policy instruments to help reduce social inequalities in diet
- help facilitate daily physical activity and a good system for providing meals in primary, lower-secondary and upper-secondary schools
- introduce a scheme to provide fruit and vegetables for all pupils at primary and lower-secondary school
- assess measures to limit the availability of tobacco
- strengthen the grant scheme for physical activity in order to encourage low-threshold activities and assess similar measures to influence diet
- collaborate with the trade unions' and employers' associations to assess measures promoting physical activity and healthy food at work
- invest in lifestyle guidance in the health service, including improving maternal and child health centres and the school health service
- ensure that measures proposed to influence health behaviour are always assessed in light of the goal of reducing social inequalities in health

7 Health services

7.1 Objective: Equitable health and care services

Objective

- Equitable health and care services

Other goals

- Better knowledge about social inequalities in the use of health services
- Better knowledge about factors that contribute to social inequalities in the use of health services and factors that can counteract these imbalances
- Better health services for at-risk groups

Health and care services should be equitable in terms of availability, use and results. In this Report to the Storting, the term «the use of health services» covers all three central aspects of the service.

7.2 Policy instruments

Although the population's health is primarily influenced by factors beyond the control of the health sector, a well functioning health service is nevertheless an important prerequisite for good public health. In Norway, we have a very high level of ambition for our health services. We want high-quality services that are available within an acceptable waiting time and distance and that the services and facilities offered reach everyone regardless of their social background. Most of these high ambitions have been met, and Norway has one of the best health services in the world. Nevertheless, we must acknowledge that there are still deficiencies and challenges in many areas. There is broad consensus in Norway about the main goals of the health policy. The Government will work systematically to achieve these goals. Errors and deficiencies in organisation or services revealed by user experiences or supervisory activities will be followed up.

The Norwegian health service is constantly evolving. A report from *The European Observatory on Health Systems and Policies* summarises the main trends in Norway's health reforms over the last few decades thus: «Taking an aggregate view of health care reform over several decades, the general focus of the 1970s was on equity questions and the build-up of health services; the 1980s on cost containment and decentralization; the 1990s on efficiency and leadership; and the beginning of the new millennium on structural changes in the delivery and organization of health care.» All these considerations were important. In the future development of the health service, fair distribution is once again the focus of attention.

Possible distortion mechanisms

We know that there is a correlation between social background and use of the health service. We do not have sufficient knowledge to determine the causal connections between social background and the use of health services. We need to investigate further whether the Norwegian health service is serving to level out or exacerbate social inequalities in health. Although our knowledge about social inequalities in the use of health services is somewhat limited, hypotheses have been proposed in Norwegian and international research about possible distortion mechanisms that may affect different social groups' use of the health services.

In the primary health service, for example, one might expect to find social inequalities in the use of the regular GP with regard to treatment, follow-up and referral to the specialist health service. In the specialist health service, there may be mechanisms that make services less accessible to groups with a short education and low income. Legal, economic, organisational and pedagogical factors may play a part. A number of possible mechanisms that may obstruct equitable health and care services are discussed below.

Legal policy instruments such as patients' rights, the right to an individual plan, the right to be assessed and the right to receive necessary medical assistance may have a social bias. Patients'

rights are intended to ensure equal access to health services through the legal right to receive necessary medical assistance, freedom of choice (right to choose hospital, regular GP), the right to receive information, co-determination and the right to a second opinion. Since to a certain extent use of these kinds of rights requires resources in the form of knowledge (for example, about the application process and availability of the service), it is conceivable that defining these rights in law in fact perpetuate or even exacerbate social inequalities. The Norwegian Board of Health's supervisions have also found that the goals of the patients' rights legislation cannot be met unless sufficient effective steps are taken to make the requirements known and used in the specialist health service. Only limited research has been done in this area from the perspective of law and sociology of law. We need more knowledge about the significance of laws and regulations for the goal of equal access to health services.

How the health service is funded affects the distribution of services. The financing system influences the range of health services offered, and user charges for services and medicines affect demand.

The system of performance-related financing is intended to encourage more treatment activity, but can also lead to an unintended distortion away from patients and statutory tasks not covered by the system. Since chronic and complex ailments are unevenly distributed in society, too low prioritisation of these kinds of ailments can lead to greater social inequalities in health. So far, there is no evidence that the system of performance-related financing has actually led to unintended distortions in the range of services offered. The change in the block funding from 40 % to 60 % should help reduce any problems linked to these kinds of distortional effects.

The correlation between user charges and consumption of health services is well documented internationally. A study surveying use of user charges in the health sector in different countries (carried out by the Programme for Health Economics in Bergen) refers to a number of studies supporting the hypothesis that demand is affected by user charges. User charges reduce demand for both necessary and unnecessary services, and they tend to affect health and economy in a socially biased way. The studies indicate that people with low income and people belonging to certain social groups are hardest hit.

The organisation of the health service affects patients' access to the services. For some groups in society, the threshold into the health service seems especially high. This is the case for heavy drug addicts, alcoholics and prisoners, for example. Drug addicts and alcoholics are often in a situation where it is difficult for them to take advantage of the available health and care services. Access to health and care services is often particularly weak for drug addicts and alcoholics who developed substance abuse problems at an early age. They often have deficient or incomplete schooling, weak or no contact with the labour market and do not have enough money – background factors that are systematically linked to inequalities in health. For a person who spends all their available funds financing their addiction, user charges for health services often prevent them from using these services.

Medical insurance and privately financed health services can generate inequalities in the use of health services. Private insurance against user charges may serve to undermine the purpose of the system of charging users for certain services and medicines: i.e. to reduce demand for low-priority health services. This in turn exacerbates social inequalities. It is therefore important that the waiting time for publicly financed health services is not significantly longer than for privately financed health services.

Box 7.1 «The inverse care law»

In 1971, the British GP Julian Tudor Hart published an article in the *British Medical Journal* titled *The Inverse Care Law*. Hart claimed that the availability of good medical care tends to vary inversely with the need for it in the population served. In other words, the health service is best where the need is smallest.

According to Hart, the inverse care law will, be strongest where the health service is exposed to market forces. If health services can be bought with money, the people with the greatest spending power will be able to buy the best services. However, the correlation between income and health entails that the people with the least spending power have the greatest need for health services. The hypothesis is that a health service governed by market forces will function best where there is least need for it.

7.2.1 User charges

The Government has decided to reduce user charges on health services and keep them at a low level. In the fiscal budget for 2006, the second upper limit for user charges was reduced from 3500 to 2500 NOK from 1 January 2006. User charges for physiotherapy for people who were previously entitled to free physiotherapy on the basis of their diagnosis were discontinued from 1 July 2006, in accordance with the proposal in Proposition no. 66 to the Storting (2005–2006).

There is variation in the current exemption and cost-sharing schemes: for some services and products, individuals must cover all the expenses in full (for example normal dental treatment for adults and some medicines). For some services, the state covers the costs in full. This is the case for in-patient treatment in hospital, community nursing and technical aids. Certain treatments are free on the basis of diagnosis: GP services in connection with infectious diseases that pose a threat to public health, pregnancy and childbirth, and physiotherapy for patients with certain diagnoses. There is also a system of exemption by age. For example children under the age of 12 are exempt from paying for health services and children under 18 are exempt from paying for psychologists and services within child and adolescent psychiatric clinics. Pensioners on a minimum pension are exempt from paying for «blue prescription» (reimbursement scheme) medicines. Dental health services are free for children and young people up to the age of 18 (school dentist), for the elderly, for people on long-term sick leave and disabled people in institutions and receiving community nursing, for

Box 7.2 Reimbursement from the National Insurance Administration

The state reimbursement schemes do much to ensure equal access to necessary treatment. The «blue prescription» system regulates the right to reimbursement of expenses for medicines (cf. regulation no. 330 of 18 April 1997 on support to cover expenditure on important medicines and special medical equipment (the blue prescription regulation)).

Under the provisions of Section 5–22 of the National Insurance Act, contributions can be made to cover expenses for health services when these expenses are not otherwise covered pursuant to the National Insurance Act or other legislation. The main expenses covered by the reimbursement scheme (measured by the size of the expense) are medicines and dental treatment and glasses for children. In connection with reimbursement of expenses for treatment, any necessary travelling and overnight expenses can also be covered.

Box 7.3 Medicinal products

An important objective for Norway's medicinal product policy is that the population shall have equal and easy access to safe and effective medicinal products regardless of their ability to pay. The reimbursement system is intended to ensure that the population has access to important medicinal products regardless of their ability to pay.

Correct and effective treatment of diseases and health problems often requires use of medicinal products. The total costs per patient for treatment with medicinal products can vary from a few hundred Norwegian kroner (NOK) to several million NOK per year. Ability and willingness to pay for medicines varies from person to person, but at some point expenses can reach a level where the state has to step in and help. Without public support for medicinal products, effective treatment would largely depend on the patient's income.

Much necessary medicinal treatment is financed through the blue prescription regulation, treatment in hospitals and nursing homes, and through the contribution scheme. State budgets cover the costs of around 70 % of the total sales of medicines, which in 2005 was 16.1 billion NOK.

Access to safe products is assured via a well-functioning chain of distribution. Norway's 550 pharmacies and 1200 medicine outlets ensure satisfactory geographical availability of medicinal products.

Regular GPs issue the most prescriptions for medicinal products. Access to a regular GP is therefore decisive for sufficient medicinal treatment. Regular GPs also administer society's funds through the right to prescribe medicinal products on the National Insurance Scheme's account.

the mentally handicapped and for people receiving municipal treatment for substance abuse. People with occupational injuries and war injuries are also exempt from cost-sharing under certain circumstances.

The two-tiered system of upper limits for user charges provides exemption from expenditure above a certain level for services covered by the scheme. Exemption by income is a principle for municipal, home-based services and long-term stays in retirement homes and nursing homes. A flat rate is used for short-term stays.

Proposition no. 1 to the Storting (2006–2007) the National Budget for the Ministry of Health and Care Services, contains a review of the systems of user charges for health services. The Government is going to return to the problems and issues raised in this review in the budget for 2008. Reducing social inequalities in health will be an important element and will be taken into account when considering possible changes in the system of user charges for health services. Pursuant to proposals from the Government, the Storting (the Norwegian Parliament) has decided that from 2007 drug addicts visited by ambulatory teams from an outpatient service for drug abusers will not be charged user fees.

The state currently regulates the local authorities' right to take payment for care services through two different sets of regulations: one for home services and one for services in institutions. The Government has considered different alternatives to ensure more equal user payment. Overall, the Government does not find that the disadvantages of the current system justify an extensive reform. The consideration that users must not suffer from restructuring means that the system will be continued as it is for the time being. Nevertheless, the Government will monitor developments in the municipalities and continually assess the need for steps.

The Government wants to ensure that users of municipal services in a difficult financial situation are better protected against user charges and pay less than they currently do. Several municipalities have introduced cost-sharing on a number of services in a way that has not been in compliance with the regulations. This has happened in particular in connection with provision of a personal safety alarm, meals-on-wheels, and when setting user charges for these services. The Ministry of Health and Care Services has therefore sent out a special circular underlining that user charges for these kinds of services are covered by the exemption rule for people earning less than twice the national insurance basic amount (2G) when the services are to fulfil a need for help that yields requirements for services pursuant to Section 4–3 of the Act relating to Social Services. If a personal safety alarm is provided in these kinds of cases as a substitute for a daily visit from a supervisor, or meals are delivered instead of help cooking at home, the rules in the regulation on exemption by income apply. However, if the service is provided as an optional municipal service, the municipality is free to calculate user charges. Nevertheless, the municipality may not charge more than the cost of the service. Reference is also made to Report no. 25 to the Storting (2005–2006) *Long-term care – Future challenges* for a more detailed discussion of financing and user payment in the care services.

7.2.2 Governance and organisation of the health service

The health authorities are responsible for ensuring that everyone has satisfactory access to necessary health services. Nevertheless, we find that users such as, for example, old people in poor health, people with mental ailments, drug addicts, and mentally handicapped people are not always able to make their needs and rights known. This can lead to these groups not using the health services to the same degree as the population as a whole, despite the high morbidity rate in these groups. The Ministry of Health and Care Services wants to ensure equitable services for weak patient groups through optimum governance and organisation of the health service.

It is important to ascertain whether health-policy instruments – such as financing schemes, forms of organisation, regulation and guidance – perpetuate or exacerbate social inequalities in health. In the same way that the goal of reducing social inequalities in health must be made a priority in many areas in society, it is also necessary that the Ministry of Health and Care Services takes steps to ensure that reducing social inequalities in health is an important priority and is considered when introducing new or changing existing governance mechanisms in the health sector.

Most of the services offered by the specialist health service are provided under the direction of the public authorities. Contracted specialists are an important part of the specialist health service. Work has been instituted to study and develop the situation in order to ensure even better integration of the contracted specialists in the regional health enterprises' responsibilities for providing specialist health services, partly with a view to ensuring

correct prioritisation in keeping with the Patients' Rights Act and the prioritisation regulation, and to facilitate appropriate distribution of tasks between contracted specialists and the health enterprise and thus promote better utilisation of resources and ensure equal availability of specialist health services.

Social inequalities pose a challenge in the work on ascribing priorities in the health service. It is an explicit goal to counteract social inequalities in health by identifying the needs of groups in the population that require special measures, such as, for example, refugees, asylum seekers, prisoners and drug and gambling addicts. It seems some patient groups are more likely to be given low priority than others, and it is conceivable that this is due to the fact that there is a correlation between the status of the academic disciplines and the patients' socioeconomic status. We therefore need targeted efforts to ensure better distribution of resources between diagnosis and subject areas. There are currently large disparities in the way the prioritisation regulation is interpreted and applied. The Directorate for Health and Social Affairs and the regional health enterprises have therefore initiated the joint project *Riktigere prioritering* (*Getting priorities right)* in an attempt to contribute to more uniform practices.

Information and good communication are essential for a good outcome of treatment. There are strong, often unspoken expectations that the users of public services are the same, also in terms of culture, or that they ought to behave like the majority of the population when using health services. For Samis and non-Western immigrants, for example, this may result in their benefiting less from the services than other members of the population. This represents a breach of the political objective of equitable services and maximum equality in availability and outcome of services. With regard to minority-language patients, it is particularly important that health workers ensure that language or cultural differences are not causing misunderstandings that affect the treatment. It is also important to take into account the fact that differences in social background between patients and health workers can influence communication. It may be difficult for patients to talk about some disorders and ailments. The problems may then appear diffuse and difficult to treat. Cases of this nature include, for example, women and children who have experienced or are experiencing abuse and violence in close relationships.

Most homosexuals and lesbians have good health – like other minority groups and the population as a whole. However, as a group, homosexuals and lesbians experience more problems than the average for the population. This group is particularly prone to drug abuse, mental ailments and suicide. Although their health problems are not necessarily linked to social inequalities, it is important that the health service is aware of ailments and diseases that particular groups or minorities are predisposed to. This can prevent a vicious circle of health problems and social exclusion.

Information and communication technology is a valuable tool for getting information about health services and options out to the population. This technology can help increase accessibility to this kind of information among all groups in the population, for example through universal design of websites.

In the spring of 2007, the Government is going to submit a report to the Storting on the dental health service. Social inequalities in health are also reflected in dental health. The Report to the Storting on future dental health services will discuss matters such as availability of services, use of user charges and establishing rights in legislation. The significance of the dental health service for social inequalities in health in general and in dental health in particular will be evaluated in the report to the Storting.

The need for good, effective habilitation and rehabilitation services is growing. Rehabilitation can be decisive for the individual's quality of life and ability to lead an independent life after completed medicinal treatment.

The Government will guarantee rehabilitation and retraining for everyone who needs it after illness or injury. The Government will also work to ensure that children with restricted functional capacities or chronic illness are offered good, interdisciplinary habilitation services. The Ministry of Health and Care Services is going to propose a national strategy for habilitation and rehabilitation in the health and social services. This strategy will lay the foundation for clearer prioritisation of habilitation and rehabilitation as priority areas for local governments and health enterprises and ensure better collaboration between public service providers and private suppliers of rehabilitation services. Importance will be attached to ensuring greater geographical equitability in the range of institution-based services on offer, better quality services through qualification requirements and advancement of knowledge, and an individual approach to users. Users shall encounter services that are accessible and effective, safe and coordinated. The work on reducing sickness absence and

Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* will be followed up by means of collaboration with the Ministry of Labour and Social Inclusion on a joint focus on rehabilitation in order to get more people in work.

7.2.3 Research and advancing knowledge

We have inadequate knowledge about social inequalities in access to health services, the use of health services and the outcome of treatment. More research and surveying of this area are therefore necessary. Figures from Statistics Norway show that in 2005, almost 176 billion NOK was spent on health. This corresponds to an average cost per inhabitant of 38 000 NOK. Among the many areas where we find causes that help create and perpetuate social inequalities in health, the health services represent one of the areas with the most obvious impact on health. However, it seems that the health service is the area among those covered in this Report to the Storting that we know the least about with regard to social inequalities in health.

We lack data on how well the health service works for groups with a minority background. Work has been initiated to develop indicators to measure performance in relation to the goal of equitable health services for all groups in the population regardless of ethnic, linguistic or religious affilitation. We also need more knowledge about how able the health service is to identify the special health problems facing homosexuals, lesbians and bisexuals. Oslo has established a number of specially adapted health services for this group of users. Examples include the Olafia clinic's advisory service for homosexuals, lesbians and bisexuals and The city of Oslo's health centre for young lesbians, homosexuals and bisexuals.

In recent years, medical technology has developed rapidly, resulting in lower mortality from acute coronary arrest and a number of other diseases. Improvements in public health are closely linked to factors outside the health service, but according to the Norwegian Institute of Public Health, it is likely that medical technology will further reduce mortality, so that the health service will play an ever more important role in improving public health. It is therefore paramount that the health service does not exacerbate social inequalities, but rather serves to reduce social inequalities in health.

The Government wants to give high priority to the need for knowledge in this area. We therefore need a survey of social inequalities in the use of health services. This will then form the basis for further measures to reduce any social inequalities. Indicators need developing for the accessibility of the specialist health services in order to monitor and influence tendencies in social inequalities in accessibility.

Social inequalities in health will be a central consideration in current and new evaluations of health services. The drug reform has recently been evaluated. One of the main objectives of the drug reform was to increase access to the health services for a group of patients. A basic starting point was that treatment for drug addicts and alcoholics should be more easily available than previously and that specialised health services necessary to reduce somatic and mental problems should also be more closely linked to interdisciplinary specialised treatment of abuse and addiction. The evaluation demonstrates that more drug addicts have received treatment, the services within the specialist health service are better coordinated, and the quality of the services has improved. Nevertheless, there is still a long waiting time for treatment, there is still a need for increased treatment capacity, and the quality of the services still needs to be improved. Collaboration within the specialist health service needs improving – especially in connection with services for drug addicts and services within mental health care. The collaboration and interaction between the specialist health service and the municipal services also still needs improving. These factors will all serve to improve the availability of health services for drug addicts.

For a number of years, many of the municipalities have received central-government incentive funds for establishment and operation of low-threshold health measures for drug addicts and alcoholics. These are measures to meet this group of patients' needs for health services and help improve access to the other health services. This grant scheme, which is administered by the Directorate for Health and Social Affairs, is going to be evaluated in 2007, hopefully providing valuable knowledge about whether these measures have actually enhanced access to the health services for drug addicts.

Many of the questions we need answers to regarding the impact of the health services on social inequalities in health will require a more long-term research effort. This applies in particular to questions linked to which mechanisms contribute to the social inequalities we have observed in the use of health services.

In order to ensure equitable specialist health services, it will be important to strengthen the priority focus areas and programme plans under the direction of the Research Council of Norway, especially the programme for research on health and care services. A new research programme on substance abuse is in the process of being established, which will be relevant for research on social inequalities in the use of health services. Epidemiological research under the direction of the Norwegian Institute of Public Health and the higher education sector is also going to be strengthened. To improve research on social inequalities in the specialist health service, the Ministry of Health and Care Services is going to consider instructing the regional health enterprises to channel funds for research into this area.

Measures to build capacity in the school health service are discussed in more detail in chapter 4 on childhood conditions, and low-threshold health services are discussed in chapter 8.

Box 7.4 Policy instruments: The health service

The Government will:

- consider changes in the cost-sharing schemes with reducing social inequalities as an important aspect
- further develop low-threshold health services
- develop indicators of quality and priority in the specialist health services, including a way of measuring social inequalities in accessibility
- focus on distributional effects when introducing new or changing existing regulatory mechanisms in the health sector with regard to legal, financial, organisational and pedagogical governance tools
- survey social inequalities in the use of health services
- strengthen research on factors that contribute to social inequalities in the accessibility and quality of health services
- ensure that reduction of social inequalities is considered when evaluating potential reforms in the health service
- against the background of new knowledge, assess measures to reduce any social inequalities in the use of health services

Part III
Targeted initiatives to promote social inclusion

8 Targeted initiatives to promote social inclusion

«Universal schemes must be supplemented with individually tailored services and measures that take account of groups with special needs. User-oriented and specially adapted public services are essential to ensure that everyone, regardless of their background and circumstances, has access to equitable services.»

Figure 8.1 Targeted initiatives to promote social inclusion

8.1 Objective: Better living conditions for the most disadvantaged people

Objective

- Better living conditions for the most disadvantaged people

Other goals

- Reduce the number of adults who leave school with poor basic skills
- Enable more people to work
- Improve accessibility of health and social services
- Eliminate homelessness
- Reduce inequalities in living conditions between different geographical areas

8.2 Policy instruments

In its report *The Solid Facts*, the World Health Organization states that being excluded from society and being treated as inferior lead to poorer health and a greater risk of premature death. Living in a community marked by difficult living conditions, high unemployment and poor housing poses a health risk. Unemployment and unstable contact with the labour market in themselves entail a health risk. Relative poverty can also lead to social exclusion through a lack of accommodation, education and other factors necessary for full participation in society. Discrimination, stigmatisation and unemployment can also lead to social exclusion. These are all factors that obstruct participation in society. People who live or have lived in institutions, such as, for example prisons, child welfare institutions and psychiatric institutions, are particularly vulnerable.

Almost half of the income of people with limitations in functioning and participation comes from transfers. Many people with reduced functional capacity experience discrimination and marginalisation and are therefore at risk of getting caught up in a vicious circle of social problems and health problems. The passivity and dependence on services that marks the situation of many people with reduced functional capacity are to a great extent created by society through various obstructions and barriers preventing their independence and participation.

The overview of current knowledge *Social inequalities in health in Norway* published by the Directorate for Health and Social Affairs points out that there is limited knowledge about effective measures to reduce social inequalities in health, but that international experiences suggest that measures to combat poverty and unemployment are important. It is also pointed out that universal welfare schemes will probably have a buffer effect, and that broad initiatives aimed at specific groups to counteract social inequalities will probably help reduce inequalities in health and improve public health. Other potentially effective measures include low-threshold measures for certain specialist health services aimed at specific groups, health services without user charges, and cross-sectoral partnerships between the state and other actors in deprived areas.

Public assets such as education, health and social services, and kindergartens are decisive for distribution of resources and living conditions in the population. Many disadvantaged people also need more targeted services. Universal schemes must be supplemented with individually tailored services and measures that take account of groups with special needs. User-oriented and specially adapted public services are essential to ensure that everyone, regardless of their background and circumstances, has access to equitable services.

8.2.1 Inclusion in the labour market

Employment is vital to ensure income, feel valued by society and have a sense of inclusion and involvement. People who fall outside the labour market also tend to fall out of other parts of the welfare society.

The Government wants to eliminate poverty and reduce social and economic inequalities through universal welfare schemes, strong community solutions and by giving everyone the opportunity to participate in working life. The Government's policy to combat poverty and prevent development of a society with broad divides between people in work and people who are unemployed is laid out in Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and *Action Plan to Combat Poverty*.

Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* emphasises use of welfare contracts as a continuous and systematic principle to define mutual expectations, requirements and commitments between the administration and the user in concrete terms.

In the Report to the Storting, the Government paves the way for greater use of special work-oriented measures and services to lower the threshold into working life and raise the threshold out of

working life, including adapting measures to meet the needs of immigrants and people with reduced functional capacity.

The Report to the Storting gives notice that the use of policy instruments is going to be made more flexible and coordinated, based on the individual's needs. The Government is also going to introduce a new system with a temporary minimum income in the National Insurance Scheme to replace various rehabilitation benefits and temporary disablement benefit. This reform will also help steer use of resources away from administration of benefits and towards active interventions and follow-up.

The strategies and initiatives mentioned in the Report to the Storting along with the reorganisation of the labour and welfare administration constitute a major policy reform in the field of labour and welfare. The new labour and welfare administration, the Norwegian Labour and Welfare Organisation (NAV) forms a framework for comprehensive and coordinated services for job seekers and people who need special adaptation of the environment at work. The NAV reform's main objective of getting more people into work and activity and fewer people on benefits makes the local NAV offices important arenas in the work to prevent poverty and ensure social inclusion. The new labour and welfare administration entails coordination of several central-government and local-government services. This provides breadth in the portfolio of tasks ensuring a comprehensive labour and welfare policy and constitutes a better starting point for providing assistance to people on the fringes of the labour market. Users of NAV offices shall have easy access to services and receive quick, comprehensive clarification of needs, individual follow-up adapted to the needs of the individual and coordinated services.

The Government's *Action Plan to Combat Poverty* aims to improve the living conditions and opportunities of the members of society with the lowest incomes and the worst living conditions. In 2007, initiatives aim to ensure that everyone has the opportunity to work, that all children and young people are able to participate and develop, and to improve the living conditions of the most disadvantaged people.

Many of the most disadvantaged people need to improve their competencies and qualifications and require health and rehabilitation services before they can participate in paid work or measures preparing them for employment. In 2006, the focus on targeted labour market measures for long-term recipients of social benefits, young people and lone providers whose main income is social benefits and immigrants who need assistance to find work was made nationwide. The measures are run by the Norwegian Labour and Welfare Organisation (NAV) in close cooperation with the social services in the municipalities. The goal is that participants' contact with the labour market is improved through integrated assistance from service providers, good advice and guidance, and labour market measures based on individual needs. The investments in this area will be further strengthened in 2007.

Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and *Action Plan to Combat Poverty* propose establishing a qualification programme entitling participants to a qualification benefit for people with significantly reduced capacity for work and income and with no or very limited subsistence support from the National Insurance Scheme. The qualification programme and qualification benefit are intended to improve the opportunities of people whose main source of income over a long period is financial social benefits. The objective is to help more people in the target group find work. The scheme is meant for people who have been assessed as being able to hold down a job if they receive closer, more committed support and follow-up.

Social benefits will continue to function as a lower safety net linked to unforeseen high expenses, short-term and acute needs for assistance and in special transitional phases. The Government has raised the rates in the state advisory guidelines for apportionment of subsistence support in order to improve the economic situation and living conditions of people who need social assistance in a passing difficult situation.

One of the focus areas in the *Escalation Plan for Mental Health* (1999–2008) is improving the accessibility of work and labour market measures through targeted measures for people with mental ailments. The Directorate for Health and Social Affairs and the Directorate of Labour and Welfare are collaborating on a strategy for labour and mental health. The goal of the strategy is that people with mental ailments shall have better opportunities to make use of their capacity for work. The escalation plan for efforts to combatsubstance abuse is intended to help more drug addicts and alcoholics become socially and occupationally rehabilitated by strengthening and coordinating treatment and rehabilitation measures in the field of substance abuse.

Experiences from the Competence Reform in Norway reveal that the people with the fewest skills and least education to begin with benefited

the least from the reform. Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning* therefore paves the way for amendment to the Act relating to Primary and Secondary Education so that adults aged 25 or older who have not completed upper-secondary education are entitled to this education. The Government has also initiated measures to build capacity in and expand the programme for basic competencies in working life and measures to build capacity in education within the Norwegian Correctional Services. For prisoners, specially adapted training can be decisive for successful rehabilitation. For this reason, the Government has made arrangements to improve education for prisoners.

8.2.2 Health and social services

The health service shall offer good quality health and care services to everyone. The goal is equitable services regardless of place of residence, personal economy, gender, ethnic background and the individual's life situation. People with serious substance abuse problems, prisoners, women and children who have been exposed to violence in close relations and traumatised refugees and asylum seekers need specially adapted measures.

The NAV reform is intended to ensure that people who are completely or partially unemployed and receive public benefits because of illness, unemployment or social problems are offered coordinated services.

People with substance abuse problems

Drug addicts and alcoholics have a documented underconsumption of health services in the municipal health service and in the specialist health service. In recent years, extensive changes have been made regarding who is responsible for what in the health care services for drug addicts and alcoholics. The Drug Reform in 2004 entailed that the regional health enterprises took over responsibility from the county authorities for specialised services for drug addicts and alcoholics. This included medication-assisted rehabilitation. A number of street-based outreach health services have also been introduced to improve conditions for heavy drug addicts, such as dental health services and trial projects with field nursing stations and needle rooms.

Within the framework of the escalation plan for efforts to combat substance abuse, the Government will coordinate and bolster services offered to people with substance abuse problems. Tools include research, interventions to raise levels of competence and quality in order to improve services offered by the municipalities and specialist health service, improving the accessibility of the services, and enhancing coordination, user participation and facilities for next of kin.

Steps are to be taken to develop a more knowledge-based service. In this context, closer ties are needed between research and practice. Four social offices are being established at universities and university colleges in order to improve research on topics and methods in the social services and to ensure closer ties to practical experience. In addition, a new research programme is being set up under the auspices of the Research Council of Norway, and a substance abuse research centre is going to be established at one of the universities. The Directorate for Health and Social Affairs is going to collaborate with the Norwegian Association of Local and Regional Authorities (KS) on carrying out projects to investigate whether the organisation of tasks within the social services affects quality and accessibility.

Steps are going to be taken to improve social and health workers' competencies in substance abuse issues and their knowledge about the links between substance abuse, psychiatric problems and social problems. More expertise is necessary to render service providers better able to recognise substance abuse problems as early as possible and to be able to provide follow-up that is better adapted to the individual's needs. The central health authorities will contribute to raising competencies by developing survey tools and handbooks. In addition to strengthening research, a new course of continuing education in substance abuse is going to be developed at university colleges for social and health workers, and the current training in substance abuse medicine for doctors and psychologists is going to be improved. The Norwegian State Housing Bank has a grant scheme for continuing education in housing social work that is going to be continued.

Since drug addicts and alcoholics often have serious health problems and social problems, the «individual plan» is an important tool in ensuring coordination of the services they receive. Services must be designed to allow user participation throughout the entire planning process. In order to increase the use of individual plans, the central health authorities are going to attach greater importance to training and assistance in compiling these kinds of plans. The Directorate for Health and Social Affairs, the County Governors and the regional health enterprises have all been ascribed tasks linked to training and developing materials.

Box 8.1 The field nursing station

The field nursing station was established in January 2005 by the Salvation Army on commission from the Ministry of Health and Care Services. This is a three-year trial project fully funded by the state.

The field nursing station has ten beds and a few emergency places. It is intended for drug addicts and alcoholics who are not ill enough to require admission to hospital, but who need nursing and round-the-clock medical care in connection with prolonged illness. The field nursing station collaborates with the social and health services and the hospitals in Oslo.

The objective of the low-threshold measures within the municipal social and health services is to improve the life situation of substance abusers, including reducing health problems, reducing overdoses and taking steps to ensure that individuals can lead a decent life. Drug addicts and alcoholics often have major health problems and live in circumstances that make it difficult for them to make use of the ordinary health services. Preliminary reports indicate that low-threshold measures reach their target groups, that they improve health and that they may have contributed to a decrease in the number of overdoses. The low-threshold health services are important in preventing the spread of hepatitis and HIV. It also seems that use of special low-threshold health services leads to increased use of ordinary health services. Drug addicts and alcoholics also have problems using ordinary dental health services, because of a lack of money and other circumstances linked to their situation. For this reason, a special financing scheme has been set up for dental health measures for drug addicts and alcoholics undergoing treatment in the specialist health service or who receive municipal services. Arrangements have been made for these services also to include dental treatment. In 2007, the Government is going to initiate an evaluation, the findings of which will then form the foundation for further development of these measures.

Prisoners

Prisoners have many more problems than the normal population. Many prisoners have serious drug problems, psychiatric problems, little education, little contact with the labour market, are homeless, and had a very difficult childhood. These social problems are probably both a cause and consequence of criminality and substance abuse. There is therefore a great need to improve the general living conditions of prisoners. Half of all prisoners have children, and their families will often need extra help to be included in society.

Prisoners and convicts are entitled to the same services as the rest of the population. People who need long-term and coordinated health and social services are entitled to have an individual plan drawn up, detailing planned treatments and interventions. This right is laid down in the Patients' Rights Act, the Act relating to the municipal health services and the Act relating to social services.

Primary health services for prisoners are provided by the municipality in which the prison is located (cf. Section 1–3 of the Act relating to the municipal health services). Specialist health services are generally provided by the health enterprise where the prisoner is registered as living in the Population Registry. The municipality in which the prisoner was resident before incarceration is responsible for social services and other municipal labour and welfare services. Social services are particularly important when planning release from prison. The reality is that very many prisoners are still released with no home, no work, no training opportunities and no therapeutic contact person to go to, and they often revert to substance abuse and crime. In many cases, the prison a person is incarcerated in is a long way from their home municipality. This makes it difficult in practical terms to establish close contact between the prisoner and the responsible service providers. The individual plan is therefore often an important tool in ensuring a comprehensive, coordinated and individually tailored range of services. The Government is going to institute a process to assess how the services aimed at prisoners can be better coordinated, using the individual plan as one of several tools.

With a view to establishing good systems of collaboration and common plans regionally and locally, the Ministry of Justice and the Police and the Norwegian Association of Local and Regional Authorities (KS) have entered into an agreement on collaboration between prisons and municipalities regarding settlement. A circular has been drawn up clarifying responsibilities, tasks and coordination among the municipalities, the specialist health service and the Norwegian Correctional Services regarding incarcerated and convicted drug addicts, to enhance collaboration and ensure continuity in the measures (Circular G8/2006).

Through the escalation plan for efforts to combat substance abuse, the Government wants to help ensure that more prisoners with substance abuse problems have access to better rehabilitation and treatment during their time in prison. A goal has been set of increasing the number of days of their sentence that prisoners serve in institutions, i.e. in a rehabilitation or care institution or in other municipal facilities for prisoners with substance abuse problems. At present, the prisons in Oslo, Bergen and Trondheim have units offering prisoners with substance abuse problems the option of alternative means of serving their sentence. These units offer rehabilitation of people with substance abuse problems while they are in prison. These units also provide counselling and cooperate with the social services on individual plans for prisoners that need a number of different, co-ordinated services. Based on experiences from these units, three new drug rehabilitation units are being set up in 2007.

A three-year trial scheme, the Drug Programme under Court Control, is currently underway in Oslo and Bergen offering individually adapted rehabilitation as an alternative to prison for convicted drug addicts. The participants receive services from the municipality and the specialist health service as part of an active rehabilitation programme. This trial scheme is also helping develop models for cross-sectoral collaboration between the Norwegian Correctional Services and the participating health enterprises and municipalities. The trial scheme will be evaluated. The Government wants to increase the use of serving sentences in rehabilitation or care institutions (known as a «Section-12 sentence»: under section 12 of the Execution of Sentences Act, prisoners may, in certain cases, serve their sentence in an institution that is not a correctional service facility). In autumn 2006, the Ministry of Justice and the Police circulated a proposal called *Quick response, measures to reduce the prison queue and improve the content of serving sentences* for review. The proposal of increasing the number of «Section 12 days» is included in this draft proposal.

People with long-term psychiatric problems

Many people with long-term psychiatric problems are recipients of social assistance and are prone to social exclusion. One of the main goals of the Escalation Plan for Mental Health is to develop a range of services designed in a way that promotes the individual's possibilities for social inclusion through having a home of their own, work and participation in leisure activities.

Targeted work to reduce society's stigmatisation of the mentally ill is another important part of the plan. This is achieved indirectly by developing the possibilities for mentally ill people to live alone and participate in social arenas and in the voluntary sector, for example through interest organisations for the mentally ill. By the end of 2007, 3400 sheltered homes with staff that have competence in mental health care will be ready for habitation. Day centres and organised activities have been set up in many municipalities in collaboration with voluntary organisations. An information campaign aimed at children and young people is also going to be carried out in order to increase knowledge about mental health and prevent stigmatisation.

Victims of violence in close relations and traumatised refugees and asylum seekers

A number of initiatives have been implemented to strengthen the public services' competencies in sexually and physically abused children and women, children who have experienced violence in close relations, and traumatised refugees and asylum seekers. In 2004, the Norwegian center for studies on violence and traumatic stress (NKVTS) was founded, and in 2006, five regional resource centres on violence, trauma and suicide were being set up. Both the national and the regional centres are important in the drive to improve competencies in the health and social services, the child welfare authorities and the police, among others. NKVTS has been commissioned by the central authorities to start work on improving knowledge in basic and continuing education for various professionals. Special incentive grants have been allocated for building capacity in the health services for people who have suffered sexual abuse and violence in close relations. The goal is to have at least one or two accident and emergency units in each county with this kind of function.

Important strategies to prevent violence in close relations include early intervention by the police and public assistance agencies and expanding the treatment services available to perpetrators. Measures to look after women and children who have been victim to violence are discussed in the *Plan of Action to Combat Domestic Violence* and *Strategy to Combat Physical and Mental Child Abuse*.

More general policy instruments to reduce social inequalities in access to the health services are discussed in chapter 7 on the health service.

8.2.3 Housing policy

One of the main goals of housing policy in Norway is that everyone should live in good, safe conditions. Along with work, health and education, housing is a key element in the welfare society. Good housing provides a foundation for a decent life and is often decisive for people's health and participation in working life. Housing is especially important for children, the elderly, people with reduced functional capacity or poor health and people with little or no contact with the labour market.

Housing-policy instruments have contributed to the distribution of housing in Norway being better than might be expected on the basis of income distribution alone. The central government's main task in housing policy is to define housing-policy targets and facilitate implementation on the local level. The central government must ensure good, appropriate economic and legal framework conditions and provide measures to raise competencies. The local authorities have a statutory responsibility to provide housing for people who cannot find housing on their own or who are in an acute crisis situation. The municipalities facilitate construction of homes and take advantage of schemes from the Norwegian State Housing Bank for people that are disadvantaged in the housing market.

In general, Norwegian homes are of a high quality. This is the result of a conscious housing policy over many years based on the philosophy that even people with low income are entitled to live well. Nevertheless, some groups live in poor conditions. This applies in particular to people who can be categorised as homeless.

A study performed in 2005 shows that there are 5500 homeless people in Norway. Very many of these people also have other problems, such as substance abuse problems and psychiatric problems. The World Health Organization emphasises that homelessness entails especially high health risks. People who live on the street have a very high incidence of premature death. 15 % of the homeless people in Norway have somatic illnesses or reduced functional capacity. This proportion has remained unchanged since 2003. Homeless people over age 65 have more physical health problems than other homeless people. Three-quarters of the homeless people have mental illnesses and/or are addicted to drugs or alcohol. The proportion of drug addicts and alcoholics has dropped from 71 % in 2003 to 60 % in 2005. The proportion of homeless people with mental illnesses has risen since 1996 and in 2005 was 38 %. There are grounds to assume that somatic illnesses and perhaps also reduced functional capacity are underreported among homeless people.

The Government wants to bolster its efforts for homeless people through the *national strategy to combat and prevent homelessness The pathway to a permanent home* and has set itself the goal of eliminating homelessness. Priority is going to be given to providing people with permanent homes, instead of using hostels and other temporary accommodation. Services will be adapted more to the needs, abilities and situation of the individual, and steps will be taken to ensure good collaboration among the municipalities and the specialist health service, the child welfare service and the Norwegian Correctional Services.

The Government is basing its work on providing housing for homeless people on the principle that everyone has the ability to reside and that the follow-up services offered must be adapted to the challenges and resources of the individual. There is great variation concerning the degree to which individuals are capable of living in their own home and what kind of follow-up services they need. We must recognise that living in a home of one's own is not always only good; sometimes it also entails challenges, for example in the form of loneliness. The design of housing solutions and follow-up needs must take this into account. Researchers have also pointed out that assistance must not be stopped or reduced too early. It is often when the individual appears to be managing well and has acquired the skills necessary to live alone that they have the greatest need for assistance and support.

8.2.4 Voluntary organisations

Voluntary organisations are social meeting places where people can nurture common interests across social divides. Participation in voluntary organisations contributes to social inclusion because it provides opportunities for developing friendships and being included in a group with shared interests. Social inclusion means individuals are linked to social life through participation in different arenas. Voluntary organisations are arenas where people come into contact with social networks outside their own private sphere.

Voluntary organisations can help provide an alternative sense of identity and social inclusion for groups who drop out of ordinary social functions such as education and employment. Relevant examples include systems providing networks of contacts and volunteer centres. Peer-to-peer support systems organised by voluntary organisations

Box 8.2 Example of peer counselling: WayBack – Life after prison

WayBack is a foundation consisting of formerly convicted people who help themselves and others achieve a life without crime and drugs. The majority of the board of directors must always be formerly convicted people. In this way, the board of directors will always have first-hand knowledge about what is required of people who have chosen to start afresh. WayBack consists of people who are there for each other 24 hours a day.

WayBack describes the reality thus: people who have just been released from prison with new hopes and good intentions experience loneliness, emptiness and frustration. Getting assistance from the public services requires energy, motivation and knowledge of the rules, legislation and where to go. Wherever you go, you are labelled – ex-convict and/or drug addict – a status that means you are unreliable and dubious. This makes it difficult, if not impossible, to get a job. «Accommodation» often means a room in a hostel where you are surrounded by criminals and drug abusers. More than a third of formerly convicted people are homeless. Many of them have good intentions of starting over again, but few are met with any trust. Not many people understand how overwhelming this transition is. Public support people have limited resources, time and insight. People who feel insignificant and worthless in society may also fall prey to loneliness and the need to score after 4 PM.

WayBack works to ensure that formerly convicted people can lead a life without drugs and crime, are more easily reintegrated into society and working life through active buddy support, and can become responsible citizens. It also helps people released from prison find work and somewhere to live and offers meaningful leisure and social activities in a drug and alcohol free setting.

WayBack visits prisons and talks to prisoners about housing, education and work. A contact group is set up for each individual prisoner. The input required of prisoners who join WayBack is that they truly wish to lead a life without crime and substance abuse and that they make a positive contribution to the peer-to-peer support work in WayBack.

are often felt to be better at treating people as equals than the public support services.

In addition to the intrinsic value of participating in voluntary organisations, the voluntary sector also provides welfare services. Voluntary organisations supplement government efforts in the following ways:

- Helping identify and put on the agenda new needs that ought to be followed up through public initiatives
- Influencing the work on developing the welfare state by criticising the public authorities
- Tapping into resources and providing services that complement the public services and facilities

The Government wants to nurture and further develop its close collaboration with voluntary and non-profit organisations. Material security is important, but it is not enough to render life good and meaningful. The Government aims to make sure everyone receives care and security, through good public welfare services and by supporting and facilitating involvement in voluntary organisations and development of a vital civil society.

8.2.5 Deprived geographical areas

Geographical inequalities in health usually coincide with geographical inequalities in living conditions. In the work on reducing social inequalities in health, a geographical approach to designing measures is important, not least because it allows measures to be targeted without stigmatising certain groups. When measures are specifically targeted at defined areas that have major health and social problems, it is also easier for us to evaluate the effectiveness of the measures. This kind of approach can also help ensure that the implemented measures reach their intended target group. Oslo is a prime example of the correlation between social inequalities in health and geography. The inequalities in average life expectancy among urban districts vary by almost 12 years for men.

It is not only living conditions and health that are unevenly distributed geographically. Negative environmental factors also tend to be concentrated together in certain areas. If we rank areas in the municipalities according to the quality of the residential environment, clear inequalities will be found in most municipalities. In certain municipalities, especially urban municipalities, there are considerable social inequalities. Inequalities in health and the quality of the residential environment generally coincide and are socially determined: groups that

Box 8.3 The Stavanger statistics

The Stavanger statistics is a tool for surveying living conditions at a low geographical level in order to detect concentrations of social problems. Units smaller than urban districts will often be required to identify these kinds of concentrations. «Living conditions zones» *(levekårssoner)* allow us to study trends in living conditions in small geographical areas over time.

Stavanger has defined «living conditions zones» of approx 1500 inhabitants. It is important that as far as possible the zones have homogeneous types of buildings and residential environment. In Stavanger, the «living conditions zones» have been defined in collaboration with experts in the education, leisure, health and social sectors in the urban districts. The statistics consist of 16 indicators providing information about key aspects of the population's living conditions.

A survey of living conditions is undertaken each year. These surveys provide a detailed picture of the inequalities in living conditions in the municipality and constitute an important basis for discussion and reflection in planning processes. The survey of living conditions is used when allocating operating funds to the sectors. Extra resources for enterprises that serve areas with social problems or for infrastructure in these kinds of areas make the areas more attractive to all groups in the population. Using land-use planning and housing policy as tools, the municipality can help reduce social inequalities between geographical areas by influencing widespread relocation patterns.

score worse on some indicators tend to score worse on others too. Deprived urban areas are usually areas with a high proportion of recipients of social assistance, social security benefits, etc. Property prices reflect the quality of the residential environment and reinforce the pattern of people with high income moving to areas with a high-quality residential environment and low-income groups moving to areas with a poor-quality residential environment. These kinds of mechanisms result in a geographical concentration of vulnerable groups, which may in turn exacerbate social inequalities in health.

The municipalities have policy instruments at their disposal to prevent deprived areas becoming burdened with even more negative environmental factors, e.g. the Planning and Building Act. By choosing carefully where housing and business premises are located, it is possible to avoid traffic congestion and keep polluting, noisy industrial plants away from residential areas. Measures can also be implemented to improve environmental conditions, for example by ensuring that green spaces, parks and open outdoor areas do not disappear and by planting new green areas. In collaboration with the roads authorities, the municipalities can control traffic and protect particularly sensitive areas.

Local authorities can also improve the range of services offered and implement social measures in deprived areas. A prerequisite for this is that the local authorities have good tools for assessing the quality of the residential environment in the municipality at an appropriate geographical level. The approach used as a basis for the system of incentive funds for regional and local partnerships for public health is also a good starting point for implementing measures aimed at particularly deprived areas. In large towns and cities, the partnerships can set up sepa-

Box 8.4 The MoRo project

The MoRo project is a joint project undertaken by the Romsås urban district of Oslo, the Norwegian College of Physical Education and Sport, the Norwegian Institute of Public Health and Aker Hospital. It was initiated against the background of the special health challenges in the urban district, including a high incidence of type 2 diabetes and cardiovascular diseases. The main goal was to promote physical activity in the urban district, in the population of the urband district in general and in groups with especially high risk of illness.

Interventions were followed up by systematic evaluations of their impact. Romsås was compared with another urban district with a similar population. Two health interview surveys were carried out in the urban districts, one before and one after the measures were implemented. The evaluation showed that the proportion of physically inactive people was reduced by around 25 %, people put on less weight than in the neighbouring urban district, and more people stopped smoking. The measures were effective regardless of education, income and nationality.

rate Health Action zones, similar to the spearhead groups used in the United Kingdom (see appendix I). Tools to assess the quality of the residential environment and the Partnerships for Public Health system are discussed in more detail in chapter 10.

In the upcoming Report to the Storting on Oslo «the Capital Report», the Government will discuss central-government policy instruments for combating the increases in social inequality in the Oslo region. The Government wants to fight poverty, homelessness, unemployment, drop-out from upper-secondary education and social exclusion. The efforts in Groruddalen are one example of central and local government collaboration aimed at a defined geographical area with specific health and social problems. The municipality bears the main responsibility, but the Government wants to help prevent the trend toward a divided city with poor living conditions, environmental problems and ghettos of immigrant groups in certain areas. The policy for the capital will build on the Government's policy for inclusion and integration, the recent major investments in kindergartens and the Knowledge Promotion Reform. Another example of an initiative aimed at a delimited geographical area is the *Action Programme for Oslo Inner East*, which was terminated in 2006. Experiences from this action programme and suggestions for further follow-up will be discussed in the Report to the Storting on Oslo «the Capital Report». The Ministry of Health and Care Services wants to attach more importance to policy instruments for reducing social inequalities in health in these kinds of efforts. Efforts targeting specific geographical areas may also be an important channel for measures aimed at social groups with a high risk of health problems.

In order to improve knowledge about the effectiveness of measures to reduce social inequalities in health, it is important to evaluate the impact of preventive measures on these kinds of inequalities in health. In many cases, it will be possible to implement measures as trial projects in limited areas and compare the results with control areas. An example of this is the MoRo project that was carried out in the Romsås urban district of Oslo.

Box 8.5 Policy instruments: Targeted initiatives to promote social inclusion

The Government will:

- move away from passive minimum income to active measures and services based on individual needs for everyone who receives a temporary minimum income from the state, cf. Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and *Action Plan to Combat Poverty*
- follow up in a systematic and structured way people who lack or have insufficient work experience from before by means of measures, services and minimum income, cf. Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and *Action Plan to Combat Poverty*
- establish a qualification programme with a standardised qualification grant and implement other measures to ensure that everyone is given the opportunity to find work, cf. Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion* and *Action Plan to Combat Poverty*
- improve opportunities for adults to acquire basic skills and participate in basic schooling, cf. Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*
- evaluate and further develop the health services available for people with substance abuse problems and other groups who need specially adapted services
- implement measures to improve coordination between interdisciplinary specialised treatment for drug addicts and mental health care to ensure that patients receive coordinated treatment
- strengthen the efforts to combat homelessness, cf. *Action Plan to Combat Poverty* and the strategy *The pathway to a permanent home*
- stimulate greater participation among groups that are underrepresented in voluntary organisations
- in the upcoming Report to the Storting on Oslo «the Capital Report» provide a broad review of measures to reduce social inequalities in the Oslo region
- encourage implementation of measures to reduce social inequalities in health in especially deprived areas

Part IV
Develop knowledge and cross-sectoral tools

9 Annual policy reviews

«Social inequalities in health are closely related to social inequalities in other areas of life. Efforts to reduce social inequalities in health must therefore be followed up in all sectors»

Figure 9.1 Develop knowledge and cross-sectoral tools

9.1 Objective: Systematic overview of developments

Objective

- Ensure a systematic overview of developments in the work on reducing social inequalities in health

9.2 Policy instruments

9.2.1 Review and reporting system

The Government will monitor developments in the four priority areas defined in this Report to the Storting by means of a new review and reporting system, providing a systematic, regularly updated overview of developments in the work on reducing social inequalities in health. The review and reporting system will be based on the objectives and other goals described in the individual chapters in this Report to the Storting. One or more performance indicators will be developed for each of the defined objectives and goals enabling monitoring of developments over time.

The Directorate for Health and Social Affairs will be responsible for coordinating the design and development of these indicators. This work will be done in close collaboration with the relevant directorates and professional environments in the various sectors involved. The indicators must be selected against the background of common assessments of factors such as which data are available and what kind of indicators are best suited to reflecting trends in social inequalities in the area. Whenever possible, the indicators ought to build on existing sources of data.

It is important that the indicators of social position used in the different areas are compared and coordinated, with each other and with the reports on trends in health outcomes used by the Norwegian Institute of Public Health (cf. chapter 11). In many cases, it may be pertinent to use different indicators of social position in different areas, but it should be a goal that at least one of the three core indicators (education, occupation or income) is used in most contexts.

The Directorate for Health and Social Affairs will publish an annual report based on the review and reporting system. This report must be compiled in such a way that it can be used as a basis for the annual reporting in the budgets. The annual reports will contain a presentation of the main initiatives and strategies on the national level, in conjunction with the goals for reducing social inequalities in health, as well as comments on the trend of each indicator. The report will be compiled in close collaboration with relevant professional environments.

A joint report will be included in the Ministry of Health and Care Services' budget proposition. The Ministries must collaborate in connection with development of the performance indicators and compiling the budget presentation.

In addition, the Norwegian Institute of Public Health will publish regular reports on trends in social inequalities in health outcomes (mortality and morbidity). This is discussed in more detail in chapter 11 Advancing knowledge.

Box 9.1 Policy instruments: The review and reporting system

The Government will:

- establish a review and reporting system to monitor developments in the work on reducing social inequalities in health
- report on developments in the work on reducing social inequalities in health in the Ministry of Health and Care Services' annual budget propositions

10 Cross-sectoral tools

10.1 Objective: All sectors of society assume responsibility

Objective

- All sectors of society must do more to promote good health and reduce social inequalities in health.

10.2 Policy instruments

There is a documented need for awareness raising and sharper focus in all sectors and on all administrative levels regarding the social distributional effects of social processes, strategies and measures. Social inequalities in living conditions and welfare schemes may together have had a significant influence on the social inequalities in health. In the same way as we have often overlooked social inequalities in health, perhaps we may also be overlooking systematic inequalities in other basic welfare areas.

It is therefore necessary to render visible how policies in all areas of society have consequences for social inequalities in health. Cross-sectoral challenges of this nature require cross-sectoral tools. Health impact assessments are one such tool that can be used nationally, regionally and locally. Health impact assessments are a systematic assessment of how a decision can affect health and distribution of health in the population. Impact assessments do not simplify causal connections, but this tool does help generate knowledge more systematically. Impact assessment is a tool that helps us ask the questions necessary to evaluate the effects of a measure. This provides a better basis for making decisions and can help raise awareness in policy and strategy design. This does not mean that other sectors have to assess the health impact of every single measure they implement. In many cases, assessing the distributional effects will be enough, because we know that social inequalities in distribution of determinants of health generate social inequalities in health.

Regionally and locally, the municipalities' social and land-use planning are useful cross-sectoral tools. The purpose of planning pursuant to the Planning and Building Act is to coordinate physical, economic, social, aesthetic and cultural developments in the municipality. Municipal planning is a central arena for ascribing priorities in the municipalities and embraces developments within the municipality as a whole, and developments within individual sectors and areas of activity. The social part of the Municipal Master Plan defines targets for long-term developments in the municipality and thus forms the frame for the individual sector's activities. For example, defining a goal of reducing social inequalities in health entails that sectors such as schools, culture, business, social services and health must also develop targets and strategies for reducing social inequalities in health.

10.2.1 Health impact assessments nationally and locally

Official studies carried out by or for central-government administrative bodies must follow the rules laid down in the Instructions for Official Studies and Reports. These instructions define requirements concerning impact assessment of public reforms, amendments to regulations and other measures. Impact assessment shall include an assessment of all the considerations that are material to the case in hand. In addition to the economic and administrative impacts, other significant consequences must also be assessed. Impact assessment should be considered in areas such as health, equal opportunities and the environment. With regard to gender equality and environmental issues, special handbooks have been compiled describing how these considerations can be better incorporated into official studies. The Directorate for Health and Social Affairs is currently working on devising methods to ensure compliance with the provisions concerning health impact assessments in the Instructions for Official Studies and Reports. The Ministry of Health and Care Services will make sure that guidelines are drawn up and made available to all the ministries.

In general, the Instructions for Official Studies and Reports work best for economic and administrative impacts. Experiences from trying to inte-

grate the equality dimension suggest that work needs to be done to develop a broad set of policy instruments to ensure that equality is promoted in all sectors. For example, all ministries are supposed to assess equality within their own budget areas in connection with the fiscal budget. The requirement that equal opportunities be promoted is laid down in the Equal Status Act.

In strategies within the EU, WHO and many countries with which we can compare ourselves, impact assessments are being launched as a measure for reducing social inequalities in health. However, any tool is only as useful as the user makes it. Efforts to combat social inequalities in health require political willingness to put distribution issues on the agenda. The Government is therefore going to adopt a policy that strengthens the individual's personal safety through strong common welfare schemes and fair redistribution.

The Regulations of 1 April 2005 on Environmental Impact Assessment lay down that when necessary impact assessments shall include analysing the consequences for public health. This applies to consequences for public health due to significant changes in the composition of the population, the housing market, housing needs or the need for services (cf. Section 4 of the Regulations). These are key social determinants of health and social inequalities in health. The Directorate for Health and Social Affairs is working on developing methods and guidelines and building up competencies with a view to ensuring that these considerations are systematically assessed in impact assessments pursuant to the Planning and Building Act.

10.2.2 Municipal social and land-use planning

Local decisions affect childhood conditions, living conditions and health behaviour. The Planning and Building Act is the main tool available to the local and county authorities in their social and land-use planning. The population's health must be a prime concern in all social and land-use planning. Public health work entails measures to improve the population's health and measures to ensure a more even distribution of factors that influence health.

Pursuant to Section 1–4 of the Act relating to the municipal health services, the municipalities must have an overview of the state of the population's health and the factors that affect it. A good overview is a prerequisite for putting public health issues on the agenda in connection with decision making and for being able to implement target-oriented, quantifiable measures. This kind of overview or health profile can be based on national data, which is then broken down to the municipal level, and on surveys within the municipalities.

In collaboration with the Norwegian Institute of Public Health and Statistics Norway, the Directorate for Health and Social Affairs has set up a dedicated Internet portal for local authority health profiles that the municipalities can use as a tool in their planning. The portal contains key figures and indicators for determinants of public health, among others, as well as factual documentation, articles on a range of related subjects, examples of local measures and links to other relevant websites. The portal is under continuous development, and tools are being developed for use in municipal planning. The Ministry of Health and Care Services wants to ensure that social inequalities in health are a main priority in future developments.

The Ministry of Health and Care Services is going to consider policy instruments to make data about the quality of the residential environment more easily available to the local authorities. One relevant measure may be development of a better set of indicators for the quality of the residential environment that can be incorporated into the internet portal for local authority health profiles. Another solution is to compile guidelines and examples showing how the quality of residential areas can be assured.

It is a goal that measures to prevent social inequalities in health be ascribed greater priority in the social part of the Municipal Master Plan, the land-use part of the Municipal Master Plan, Municipal Area Plans on various topics and Local Development Plans. For example, there are indications of clear social inequalities in the distribution of environmental factors, such as noise, air pollution, access to green areas, traffic safety and recreation grounds. The Directorate for Health and Social Affairs has commissioned the Institute of Transport Economics, which collaborates with Statistics Norway, to develop a tool for comparing social and economic indicators with environmental indicators in a way that can be used in planning.

Planning expertise in the health sector

Greater advantage can be taken of the interdisciplinary planning arena in public health work, if the health service and the rest of the sector make more of their roles as contributors in the planning processes in counties and municipalities. In addition to good knowledge of the field and expertise in monitoring health and other public-health spheres, competence is needed in how this knowledge can

be exploited in ordinary planning and decision-making processes. The Directorate for Health and Social Affairs has noted that many municipalities, and especially the municipalities involved in partnerships for public health, request guidance concerning how they can make better use of municipal planning to promote health interests.

In collaboration with the Ministry of the Environment, the Directorate for Health and Social Affairs has set up a five-year development and trial project in a sample of municipalities to ascertain how the Planning and Building Act and the municipal planning system can be used as a basis for and instrument to improve public health work. This experiment, called the *Health in planning project* also includes improving the planning and processing skills of staff and experts working in the health sector, for example, through seminars and development of relevant courses of basic training, further education and continuing education.

10.2.3 Partnerships for public health

The state awards grants to counties and municipalities that organise their public health work in partnerships. The conditions for receiving this grant is that the county or municipality also contributes its own funds and that the public health work is firmly anchored in the municipal and county-planning system. The purpose of this grant scheme is to make local public health work more systematic and comprehensive by ensuring a stronger administrative and political grounding and by improving coordination between authorities and the labour market, schools, voluntary organisations and others.

In their capacity as a regional development actor and regional planning authority, the county administrations have been ascribed the role of prime movers in the partnerships. County planning is done across sectoral and hierarchical boundaries and is therefore ideal for raising public health issues that require a broad approach and that depend on the central government, county administrations, local government and voluntary sector all pulling in the same direction. Regional central-government agencies, regional health enterprises, university colleges and universities, and voluntary organisations are all important actors in the regional partnerships.

From 2006 on, 16 of Norway's 19 counties and a large number of municipalities in these counties are involved in the scheme. In the budget for 2007, the scheme has been expanded so that all the counties have the opportunity to apply for funds to establish these kinds of partnerships. The purpose of the scheme is to stimulate development of an infrastructure for local public health work. In addition, grant funds are channelled to local public health measures through the partnerships. These grants are intended to stimulate development of local initiatives to promote a healthy diet and physical activity, and to prevent the harmful effects of tobacco use.

The Directorate for Health and Social Affairs has a responsibility to further develop the partnerships as a way of working towards systematic public health work firmly rooted in social planning and with broad participation in the population. In light of the goal of reducing social inequalities in health, attention must be focused on underlying factors that influence health and how they are distributed. For example, good inclusive schools and inclusive working life play a large part in reducing inequalities in health. It may also be pertinent to bolster efforts aimed at geographical areas with concentrations of social problems.

The workplace is another important arena for preventing social inequalities in health. In addition to monitoring sickness absence and efforts to promote a more inclusive working life, anti-smoking, drinking and drugs campaigns and a health-promoting working environment can be developed as areas of cooperation.

The Government has decided that reducing social inequalities in health will be afforded greater priority in all public health work performed under the auspices of regional and local partnerships.

Box 10.1 Policy instruments: Cross-sectoral tools

The Government will:

- anchor the use of impact assessments and other tools to assess distributional effects in the management on the central-government, county and municipal levels through steering documents and the review and reporting systems
- ensure that the issue of distribution is integrated into tools from the Norwegian Government Agency for Financial Management
- further develop expertise in health impact assessments in the Directorate for Health and Social Affairs and ensure that the issue of distributional effects is given a central position in the work
- in collaboration with the Norwegian Association of Local and Regional Authorities (KS), develop tools that the municipalities can use in their efforts to take distributional effects into account in planning and policy design
- establish collaboration between the Ministry of Health and Care Services, the Ministry of the Environment and the Ministry of Local Government and Regional Development to ensure that social inequalities in health are given a more central position in planning regulations and planning tools
- develop sets of indicators for social determinants and the quality of the residential environment that can be incorporated into the internet portal for local authority health profiles that the Directorate for Health and Social Affairs has developed in collaboration with the Norwegian Institute of Public Health and Statistics Norway
- refine and bolster the system of incentive funds for regional and local partnerships for public health, and define requirements that social inequalities in health must be put on the agenda in local public health work
- contribute to knowledge about social inequalities in health being incorporated into courses and studies on public health and land-use and social planning
- through the «health in planning» project develop methods and tools to take social inequalities in health into account in the municipal planning processes

11 Advancing knowledge

11.1 Objective: Increase knowledge about causes and effective measures

Objective

- Increase knowledge about the scope of, causes of and effective measures against social inequalities in health.

11.2 Policy instruments

Social inequalities in health constitute a complex problem. Moreover, it is only in recent years that Norwegian research has started showing an interest in the social distribution of health. This means that there is still a large need for knowledge in this area.

11.2.1 Monitoring and surveys

This section deals with monitoring developments in social inequalities in *health outcomes* (mortality and morbidity) in the population. We know a fair amount about the scope of social inequalities in health in Norway (cf. chapter 2). Social inequalities have been well documented using many different means of measuring health and health outcomes, including total mortality in a number of age groups, cause-specific death, morbidity and self-assessed health. However, there is currently no system for monitoring and reporting trends in social inequalities in health over time. An important objective of this Report to the Storting is therefore establishing a system for monitoring this aspect.

Much of the work on developing specific health indicators for this purpose must be done by experts, not least because of the technical elements it entails, such as data accessibility and register linking. Existing sources of data represent a huge potential, but in some areas we still need to generate new data.

An EU working committee made up of people from a broad range of backgrounds prepared a proposal in 2001 suggesting guidelines for monitoring social inequalities in health in the member states. A Norwegian monitoring system ought largely to follow these recommendations. The working committee's proposal states that if possible a monitoring system ought to:

- include nationally representative data for mortality on the individual level
- include nationally representative survey data for self-assessed health
- use at least two of the three core indicators of social status (education, occupation, income)
- use the same classification of social status over time
- use both absolute and relative expressions of inequalities
- discuss any possible sources of error

The Norwegian Institute of Public Health bears the main national responsibility for monitoring health, including developing indicators of social inequalities in health outcomes.

Chapter 7 on health services proposed special monitoring of social inequalities in the use of health services. Chapter 5 on work and working environment included a discussion of national monitoring of work and health.

11.2.2 Research

A monitoring system will meet many of the needs we have for knowledge about the scope of and trends in social inequalities in health. However, it will provide little information about the causes of inequalities in health and which measures may serve to reduce them. In order to improve our understanding of social inequalities in health and develop effective political measures that can help reduce those inequalities, we need to know more about the underlying mechanisms. In the first instance, then, we need more knowledge about mechanisms and policy instruments. This also includes research on the health service's contribution to inequalities in health.

Social inequalities in health is a field of research with inherent, fundamental questions concerning what creates good health and what creates ill health. This is a field where researchers

apply theories and knowledge from a number of different disciplines, including demographics, sociology, psychology, epidemiology and medicine. This entails that research on the topic of social inequalities in health is not only useful as a foundation for political decisions, but has far-reaching relevance. It yields fundamental knowledge about mechanisms that promote health and mechanisms that induce sickness, and it is scientifically interesting for many different disciplines. It is therefore important that groups of researchers who do not usually define their research as related to inequalities in health (for example, clinical research or physical environment and health) are involved. Research on social inequalities in health ought to be multidisciplinary and interdisciplinary.

In many other countries and in the EU, the increased political attention being paid to social inequalities in health has been accompanied by greater investments in research in the field. For example, the Netherlands have had two nationally financed research programmes, the latter of which focused on testing and evaluating measures. In the United Kingdom, the national research councils have allocated large sums of money to several major programmes and projects dealing with various aspects of social inequalities in health. In Sweden, a special research institute has been set up with public funding: the Centre for Health Equity Studies (CHESS). The EU has financed a series of major projects on social inequalities in health, some with a focus on comparing the situation in different countries and trends within Europe, some with a focus on providing explanations, and some with a focus on the success of various measures and policies to reduce inequalities. The research being performed in other countries may be relevant for Norway, but the transfer value of this research will often be limited and uncertain because of differences between countries.

Some topics are especially important for the future design of measures to reduce social inequalities in health. Examples include social inequalities among children and young people that we generally know too little about. This topic entails particular challenges. For instance, what we called «core indicators» of social status above are not available for this group (children do not usually have education, an occupation or income), nor are the most commonly used indicators of health (mortality and self-assessed health) particularly apt. Since this is an age group that is given high priority in preventive work, research on social inequalities in health and social inequalities in the distribution of health determinants among children and young people ought also to be a priority.

Geographical perspectives on social inequalities in health are being afforded ever greater place in international research, and there is a need for better research in this field in Norway too. Knowledge about the significance of the local environment for health and inequalities in health may also be able to make an important contribution to the design of measures to combat social inequalities in health in the future.

In the past, there has been little health and social research on multi-cultural communities in northern Norway. This is reflected in the lack of knowledge about the challenges the health service faces regarding the Sami population. The drive to build up multi-cultural competencies within the health and social services and within research communities is therefore crucial.

Another research area that may be important for future policies is the significance of different types of prevention arenas for health behaviour – such as, for example, school, the workplace and leisure. This is an ideal area for intervention research.

The Government's research effort concerning sickness absence is discussed in chapter 11.

The need for better knowledge about social inequalities in access to and use of the health services is discussed in chapter 7. Focused research is needed to ascertain which organisational, legal and economic mechanisms contribute to inequalities in access to and use of the health services in particular.

Another topic requiring greater attention, but where we lack computerised systems that enable routine monitoring is dental health. We currently know too little about the scope of social inequalities in dental health in the population, and there is no straightforward way for us to gain an overview of this situation. Social inequalities in dental health are therefore a topic that requires more research.

The Government wants to improve the research on social inequalities in health. Research on social inequalities in health is currently spread over a range of different research communities and programmes. There is a need for more research on the distributional perspective in relevant research programmes. There is also a need for better coordination of research in this area. Many disciplines and perspectives have important contributions to make to our understanding of social inequalities in health, and interdisciplinary approaches are therefore vital.

11.2.3 Evaluation of measures

More and more of the public sector is becoming the object of evaluation. In the central government, requirements concerning evaluations are laid down in the Financial Management Regulations, where it is stated that «All agencies shall ensure that evaluations are carried out to generate information about the efficiency, effectiveness and results achieved within the whole or parts of the agencies' mandate area and activities.» In the sense it is used in the central government Financial Management Regulations, an evaluation is a systematic collection of data, analysis and assessment of a planned, ongoing or completed activity, an agency, a policy instrument or a sector. Evaluations can be carried out before a measure is implemented, while it is in operation, or after it has been completed. The requirements laid down in the Instructions for Official Studies and Reports concerning performance of preliminary assessments are an example of a preliminary evaluation intended to ensure good planning of measures and schemes. Ongoing evaluations are carried out to facilitate a change in direction and adjustments in the measure, while retrospective evaluations are usually undertaken to find out whether the measure fulfilled its intended objectives, and what, if any, other consequences the measure may have had.

Evaluations can be performed using a variety of different methods, by different evaluators and with different evaluation topics. Results and achievement of goals are usually central topics in most evaluations. However, many interventions have impacts other than those related to the explicit goals for the measure. For example, a number of measures have unintended consequences for the social distribution of health – or important determinants of health – in the population. If more evaluations of measures that affect health took social distributional effects into account, we would have more knowledge about how to go about reducing inequalities in health.

The Government is therefore going to take steps to ensure that more measures that may have an impact on the social distribution of health in the population are also evaluated from this perspective. In many cases, it will be possible to implement measures as a pilot project in a limited area and compare the impact with control areas. Control studies of this nature are considered a gold standard within research on interventions and measures. Knowledge of this type is in great demand internationally, and Norway has good opportunities for making a contribution here.

Box 11.1 Policy instruments: Advancing knowledge

The Government will:

- establish a system of monitoring trends in social inequalities in health in the population
- strengthen research on the spread and causes of social inequalities in health
- evaluate measures implemented to reduce social inequalities in health

12 Economic and administrative consequences

In this Report to the Storting, the Government has focused attention on factors within a number of social sectors that contribute to the creation and perpetuation of social inequalities in health. We need a broad-based approach to the problem, since factors affecting social inequalities in health are found in most social sectors. Many of the efforts to reduce social inequalities in health can be undertaken within the framework of existing economic constraints and administrative systems. For example, inequalities can be reduced by ensuring that the considerations of distributional effects and social inequalities in health are assessed when changing existing and designing new policies. Nevertheless, in some areas extra resources will be needed in the form of new grants.

The Government has attached importance to rendering the causal connections between income and health more visible and demonstrating that the policies we use to promote reduction of social inequalities are also an important element in the work on reducing social inequalities in health. The Government's decision to maintain and build up common public assets instead of offering tax relief is in part based on the ambition of reducing social inequalities in health. As part of the proposed review and reporting system, the Government will monitor developments in income inequality closely.

The main means of reducing social inequalities in childhood conditions is provision of high-quality kindergartens, schools and services available to all children and young people regardless of social divides. The key elements in the policy to create good, safe childhood conditions are presented in Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*.

In addition, the Government wants to further develop and build capacity in the school health service. The economic consequences of this step will be assessed in connection with the annual budgets.

The Government is also going to consider measures that can serve as a basis for improving coordination of services for children who need multidisciplinary assistance from the child welfare authorities. The economic and administrative consequences of measures to improve the situation in the child welfare authorities will be assessed in connection with the annual budgets.

The Government has initiated a number of processes to help reduce social inequalities in access to the labour market and social inequalities in the working environment through Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion*, the *Action Plan to Combat Poverty*, the *NAV reform (the reorganisation of the* Norwegian labour and welfare organisations) and in the follow-up to the report submitted by the commission appointed to find ways to reduce sickness absence. In this Report to the Storting, the Government is proposing commissioning an official study to assess measures to reduce sickness absence in the health and care sector in collaboration with the trade unions' and employers' associations. A follow-up to this study will be considered in connection with the ordinary budget process.

With the goal of reducing the social inequalities in health behaviour, the Government is going to attach greater importance in the future to pricing and accessibility policy instruments in the drive to prevent lifestyle diseases. Pricing and taxation policy instruments will be given special consideration in the work on reducing social inequalities in diet (cf. *The Diet Action Plan)*. The Government has set itself the goal of introducing a system of fruit and vegetables for all pupils in primary and lower-secondary education. The Government also wants to encourage daily physical activity and a good framework for meals in primary and lower-secondary schools. Reference is made to the more detailed presentation in Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*. Increasing the grants for local low-threshold measures to encourage more physical activity will also be considered in connection with the annual budgets.

We currently have limited knowledge about social inequalities in the use of health services, and the Government is therefore announcing new measures to build up knowledge in this field. A survey of social inequalities in the use of health services will be undertaken. Against the background of the findings of this survey, indicators of quality and priorities in the specialist health service will be devel-

oped, including indicators to measure social inequalities in accessibility. More research is to be done into factors that cause social inequalities in access to the health services. In addition, the distributional effects must be assessed when proposing changes in user charges, organisation and the funding system. The Government will return to the problems raised in the review of user charges for health services in Proposition no. 1 (2006–2007) to the Storting (the National Budget) for the Ministry of Health and Care Services in connection with the budget for 2008.

The policy instruments intended to promote inclusion of the most vulnerable groups will largely be rooted in Report no. 9 to the Storting (2006–2007) *Employment, welfare and inclusion*, *Action Plan to Combat Poverty* and Report no. 16 to the Storting (2006–2007) *Early intervention for lifelong learning*. In the current Report to the Storting, the Government is also proposing steps to build capacity in and further develop the health services offered to these groups. The Government is also proposing stimulating the implementation of measures in areas that have special health and social problems. The economic consequences will be assessed in connection with the annual budgets.

The Government is proposing objectives and goals in a number of areas and a new review and reporting system to monitor developments. Some of the objectives and goals are new, and some are taken from existing policy documents. For each objective and goal, one or more indicators will be developed enabling monitoring of developments in the area over time. The review and reporting system will be developed in close collaboration with relevant partners. A joint report on developments will be included in the Ministry of Health and Care Services' budget proposition. The Directorate for Health and Social Affairs is ascribed responsibility for coordinating the process of developing the indicators in collaboration with relevant directorates and experts. The Directorate for Health and Social Affairs will also publish an annual report based on the findings reported through the review and reporting system. This report must be able to serve as the basis for the annual reporting on developments in the field in the Ministry of Health and Care Services' budget proposition. The Norwegian Institute of Public Health will be commissioned to compile regular reports on trends in social inequalities in health outcomes (mortality and morbidity). Indicators of health outcome can be regarded as indicators of the overall objective of this Report to the Storting of reducing social inequalities in health. The Government will discuss changes in internal priorities and any other economic consequences of establishing a review and reporting system in the ordinary budget process.

In this Report to the Storting, the Government is announcing that it is stepping up its commitment to assessing the distributional effects of public policies centrally, regionally and locally. Importance is to be attached to developing simple tools to assess distributional effects. Measures will be implemented to render impact assessments more efficient as a tool and to improve competencies in the central government, county administrations and municipalities in this area. To a great extent, these will be measures that can be implemented within the existing economic and administrative framework.

It is necessary to improve the monitoring of trends in social inequalities in health, research on the causes of inequalities and research on effective policy instruments to reduce these inequalities. In order to advance knowledge about social inequalities in health, the Government has decided to establish a monitoring system to track developments in social inequalities in health, to improve research on the field, and to evaluate measures in terms of their impact on social inequalities in health. Knowledge in this area needs improving by means of a combination of changes in priorities and concrete allocations. The Government will return to the economic consequences of these steps in connection with the annual budget deliberations.

The Ministry of Health and Care Services

r e c o m m e n d s :

The recommendations of the Ministry of Health and Care Services dated 9 February 2007 concerning the national strategy to reduce social inequalities in health be submitted to the Storting.

Appendix 1

International experiences

The World Health Organization

The World Health Organization (WHO) was one of the first actors to put social inequalities in health on the agenda. A key starting point was the Alma Ata declaration from 1978, which underlined that «The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable…» Since then, the goal of reducing social inequalities in health has been included in a number of WHO documents. For example, WHO Europe aimed for a 25 % reduction in social inequalities in health by the year 2000 as one of its «Health for all by the year 2000» goals in 1985. In 1998, the WHO Regional Office for Europe published a new health policy: *Health 21* – Health for all in the 21st century, the second target of which deals with social inequalities in health: «By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in member states, by substantially improving the level of health of disadvantaged groups.»

Although these WHO initiatives served to put social inequalities in health on the agenda in a number of Western countries, the WHO recognises there is still much work to be done, not least with regard to developing countries. In March 2005, the Director-General of WHO Lee Jong-Wook set up a Global Commission on Social Determinants of Health. In its explanation of the background to the formation of this commission, the WHO pointed out that there is a large need in some countries for documentation that can be used in the development of measures to reduce social inequalities in health. The Commission has a three-year mandate period (2005–2008) in which to produce this kind of documentation. The Commission is also intended to function as a spearhead in the work to bring about political processes of change in the area. The Commission consists of 20 commissioners from different countries, social sectors and academic disciplines.

EU

EU work related to social determinants of health and inequalities in health spans many policy areas, including economic, labour and social policy; regional policy; research and public health. One of the main goals of the EU programme of Community action in the field of public health for 2003–2008 is reducing inequalities in health. This is to be achieved by developing strategies and measures aimed at socioeconomic determinants of health. An expert group on social determinants and inequalities in health has been set up under the Council of Europe's Public Health Committee, in which Norway is represented.

Sweden

Sweden has adopted an explicit equality and fairness perspective in all its public health policies. In 1995 a government committee was formed – the National Public Health Committee – to compile national objectives for developments in public health. According to the Committee's brief, the objectives and the strategies were also supposed to contribute to a reduction in inequalities in health between socioeconomic groups and other groups. The Committee's assessments and recommendations were presented in the Official Government Report «Health on Equal Terms – national public health objectives», which set up 18 national objectives for public health work. These objectives spanned from broad, socio-political areas such as «Strong solidarity and social community «, via lifestyle (for example «Greater physical activity»), to more specialised health-policy fields such as «Factual health information».

In December 2002, this report formed the background for a bill called «the Public Health Objective Bill», with the overall national public health objective «to create the social conditions to ensure good health on equal terms for the entire population». The inequality perspective was cen-

tral and in addition to social inequalities also included gender, ethnicity and sexual inclination. The bill emphasised how social structures on different levels can create ill-health and put less emphasis on the individual's choice of lifestyle as a determinant. This can be illustrated by the eleven domains of objectives for public health work defined in the bill:

- Participation and influence in society
- Economic and social security
- Secure and favourable conditions during childhood and adolescence
- Healthier working life
- Healthy and safe environments and products
- Health and medical care that more actively promotes good health
- Effective protection against communicable diseases
- Safe sexuality and good reproductive health
- Increased physical activity
- Good eating habits and safe food
- Reduced use of tobacco and alcohol, a society free from illicit drugs and doping, and reduced harmful effects of excessive gambling

The Swedish Parliament adopted the Government's public health objectives in April 2003, and the Swedish National Institute of Public Health was commissioned to coordinate the national follow-up within the eleven domains of objectives. The National Institute of Public Health has developed concrete, quantifiable determinants and indicators for the various health policy objectives. The results will be reported in public health policy reports every four years. The first report was published in 2005.

Denmark

In 1999, the Danish Government presented *The Danish Government Programme on Public Health and Health Promotion 1999–2008, An action oriented programme for healthier settings in everyday life*. The formulated targets are partially based on WHO's Health 21. The Programme formulated targets for risk factors, target groups (age groups and health-promoting environments) and organisation/structure.

In September 2002, the *Programme on Public Health and Health Promotion* was replaced by the new Government's programme, called *Healthy throughout Life – the targets and strategies for public health policy of the Government of Denmark, 2002–2010*. This programme paves the way for «a broader and more comprehensive approach to efforts to promote health and prevent disease, which increases the coherence in relation to major preventable diseases and disorders between primary prevention; individual self-care and health initiatives; and counselling, support, rehabilitation and other measures in relation to patients.»

Healthy throughout Life also stresses the objective of increasing life expectancy free of disability or illness for everyone at all ages:

- Life expectancy should be increased substantially
- The number of years with high quality of life should be increased
- Social inequality in health should be minimized

The Programme also operates with a number of targets linked to four main elements: risk factors (such as smoking, working environment, physical activity), environments (such as school and the workplace), target groups (such as pregnant women and chronically ill people) and major preventable diseases and disorders (such as cancer and mental disorders).

With «Healthy throughout Life», Denmark has chosen a slightly different public health strategy to Sweden, focusing on factors that affect the population's choice of lifestyle. *The Danish Government Programme on Public Health and Health Promotion* also placed a great deal of emphasis on local actions and clearly defined its goal of using local arenas like primary and lower-secondary schools, the workplace, local communities and the health service. The idea was that individual follow-up in these arenas would afford greater possibilities for reaching more social strata in the population. *Healthy throughout Life* continues this philosophy for the most part, also stressing the importance of involving voluntary organisations and establishing partnerships, but whereas *The Programme on Public Health and Health Promotion* attached importance to social inequalities in health and concrete strategies to reduce them, this aspect is less obvious in *Healthy throughout Life*. One exception is a special indicator programme, developed for the purpose of monitoring and documentation. The indicator programme operates with 14 key indicators, two of which are explicit measures of distribution of health («Social differences in mortality» and «Social differences in the quality of life»).

The United Kingdom

The first official study on social inequalities in health in Britain, the Black Report (after the chair-

man of the committee, Sir Douglas Black) was published in 1980. The report, which was commissioned by a Labour government, was not well received by the new Thatcher Government, which rejected the committee's proposals as unrealistically expensive.

Since the Blair Government came to power in 1997, social inequalities in health have once again been high up on the British agenda. An important prelude was a new independent inquiry of social inequalities in health and proposals for measures to reduce these inequalities, chaired by former Chief Medical Officer, Sir Donald Acheson. The objective of this study was also to survey the situation and identify the most pressing challenges. The Acheson report showed that inequalities in health had increased steadily and that inequalities in material conditions were one of the main causes. It contained recommendations for reducing social inequalities in many areas, including, for example taxation policy, education, work, housing policy, the environment and transport in addition to health policy in a narrower sense.

In July 1999, the Minister for Public Health and 11 other ministers presented *Saving lives: Our Healthier Nation*. This white paper defined the following two main goals for health policy in the United Kingdom:

- improve the health of everyone
- and the health of the worst off in particular.

The report focuses primarily on four causes of death: cancer, coronary heart disease and stroke, accidents, and mental illness (suicide).

In 2001, the British Department of Health defined objectives for its work on social inequalities in health. Two objectives were given specific targets in terms of reductions to be achieved and time limits:

- starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between the routine and manual group and the population as a whole, and
- starting with local authorities, by 2010 to reduce by at least 10 per cent the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and the population as a whole.

In 2003, the UK Department of Health and 11 other ministries presented *Tackling Inequalities in health: A Programme for Action*. This three-year programme has two objectives: to meet the targets defined above and to function as a broad strategy for reducing social inequalities in health and factors that create the health gap. The UK efforts to combat social inequalities in health have a prominent geographical dimension, in that many of the resources and measures are aimed at defined geographical areas (Health Action Zones) with poor living conditions.

1 July 1999 saw the official opening of the Scottish parliament, and Scotland was granted authority over a number of policy areas, including health. The new Scottish public health policy also has a clear objective of reducing social inequalities in health.

The United Kingdom has been an active pioneer in getting inequalities in health higher up on the international agenda. In autumn 2005, during its presidency of the EU, the UK arranged a major conference on social inequalities in health, *Tackling Health Inequalities.*

The Netherlands

In the Netherlands, the focus on social inequalities in health increased gradually during the 1980s, partly as a result of a study into inequalities in health between different boroughs of Amsterdam in 1980, plus the process linked to the WHO *Health for all* targets. The *Health 2000* report published by the Ministry of Welfare, Health and Cultural Affairs in 1986 included a paragraph on social inequalities in health. A subsequent conference resulted in the establishment of a national research programme (1989–93) under the aegis of a committee that reported directly to the Minister. The programme was to investigate the scope and nature of socioeconomic inequalities in health and their determinants.

When the programme ended in 1994, the committee recommended establishment of a new research programme, but now with a focus on developing and evaluating measures designed to reduce socioeconomic inequalities in health. At the same time, developments were to be monitored, and earlier studies were to be followed up. This second programme ran from 1995–2000. Reducing social inequalities in health continued to be defined as a political objective in various government documents. In March 2001, the programme committee of the second national research programme published its report. This document proposes policies and concrete measures, as well as summarising experiences and lessons learned from the programme. Four types of intervention are afforded special attention:

- Improving conditions in terms of occupation, education or income among the people at the bottom of the social hierarchy

- Minimising the effects of health problems on (downward) social mobility.
- Limiting risk exposure in the lowest social strata
- Extra health services for these groups

A Dutch public health report from 2003 attaches importance to prevention in general and highlights three specific preventive areas: smoking, obesity and diabetes. Examples of policy instruments to be used include information campaigns in lifestyle areas, collaboration with local authorities, collaboration with trade and industry, incentives for health insurance companies and developing healthy schools. The equality perspective is less explicit in the Dutch public health policy.

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