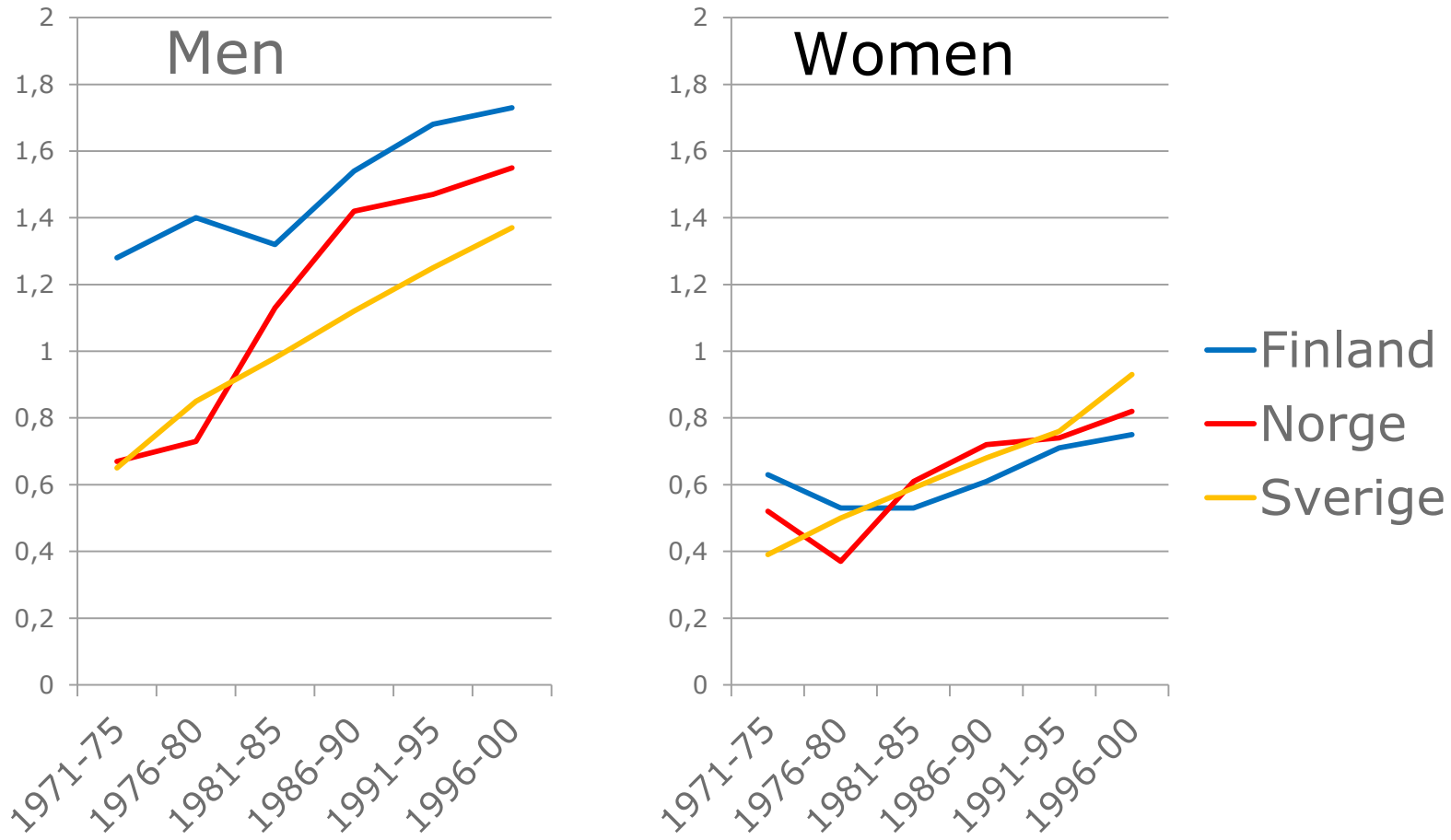
# ”Health equity in all policies” what can we learn from the Nordic countries ?

**Finn Diderichsen**
Institut for Folkesundhedsvidenskab
Københavns Universitet

# We share a challenge: Growing educational inequalities in mortality – in the Nordic countries

Shkolnikov et al: JECH 2012;66:372-78. Difference in deaths per 1000.



# Three empirical questions demanding an answer and a policy response

1. Why are there large socieconomic inequalities in health – even among the young people ?

2. Why have socioeconomic inequalities in mortality been growing during decades ?

3. Why do countries with smaller economic and social inequalities not have smaller socioeconomic health inequalities ?

# Why are inequalities persisting/growing – even in the Nordic countries ?

## Lack of knowledge or lack of implementation of knowledge?

1. To what extent is it related to growing inequalities in basic material conditions i.e. income, work, wealth, housing etc.

2. To what extent is it a question of steeper gradients of traditional risk factors – smoking and alcohol – generated by universal tobacco and alcohol policies?

3. To what extent is it a question of more indirect selection where early childhood development influences both health and social position – generated by increased social mopbility ?

4. To what extent is it insufficent implementation of existing effective interventions across sectors i.e. ”Health (Equity) in only some policies”. And what are the barriers for this implementation?

# How to tackle health inequalities:

Have we identified the determinants of social inequalities in health? Yes- some of them !

If so:

Do we know what policies and interventions are effective in changing the distribution and effects of those determinants? Yes – but evidence on effectiveness is fragmented !

If so

Do we understand why it is so difficult to implement those policies and interventions ?

No – that is badly understood !

# What have we learned so far from policy developments in the Nordic countries?

Necessary, sufficient and contributing causes….

The Swedish ”Hälsa på lika vilkor” proposal (2000) never got a strong impact national policies, but laid the ground for a strong local commitment – now often phrased as an issue of strengthening ”social sustainability”

The Norwegian ”Gradientutfordringen” (2005) made a strong multisectoral commitment for equity issues visible on the national health agenda.

The Finnish public health challenges generated early a strong national commitment to ”Health in All Policies” with a deep impact on WHO- and EU- policy recommendations

Denmark kept a more narrow focus on the role of health services and life-style interventions. Increasing local commitment to a broader agenda.

# Health policy laws in the Nordic countries – the role of municipalities:

Norge: ”Kommunen skal fremme befolkningens helse, trivsel, gode sosiale og miljømessige forhold og bidra til å forebygge psykisk og somatisk sykdom, skade eller lidelse, bidra til utjevning av sosiale helseforskjeller»

Danmark: ”Kommunalbestyrelsen har ansvaret for ved varetagelsen af kommunens opgaver i forhold til borgerne at skabe rammer for sund levevis … og at etablere forebyggende og sundhedsfremmende tilbud til borgerne”

Sverige: ”Målet för hälso- och sjukvården är en god hälsa och en vård på lika villkor för hela befolkningen”.

Finland: ”Lagens syfte er att främja och upprätthålla befolkningens hälsa, välfärd, arbets- och funktionsförmåga och sociala trygghet, minska hälsoskillnaderna mellan befolkningsgrupperna,…. förbättra samarbetet mellan de olika kommunala verksamheterna och med andra aktörer när det gäller att främja hälsa..”

# The recent legislation in Denmark, Finland and Norway has put a heavy responsibility for HiAP on municipalities:

Do they have the necessary powers to carry the responsibility ?

Do they have the necessary motivation – health as a mean ?

Do they have the necessary knowledge on what exactly they should do ?

Do they have necessary tools for implementation ?

Do they have the necessary governance structure ?

Are we decentralizing responsibility and centralizing power ??

# Determinant / policy matrix
# - "The implicit health in all policies"

| Deter-minants | Policy sectors | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Child/ family | Edu-cation | Labour market | Social policy | Environ. /Traffic | Agricult. /food | Economy Taxation | Health care |
| Early child development | ■ | | | ■ | | | | ■ |
| School achievement | | | | | | | | ■ |
| Housing segregation | ■ | | | | ■ | | ■ | |
| Unem-ployment | | | ■ | ■ | | | | |
| Work environment | | | ■ | | | | | |
| Income and poverty | ■ | | ■ | ■ | | | ■ | |
| Margin-alisation | | | ■ | ■ | | | | ■ |
| Environmental risks | | | | | ■ | ■ | | |
| Labour market exclusion | | | ■ | | | | | ■ |
| Tobacco | | ■ | | | | | ■ | ■ |
| Alcohol/drugs | | ■ | | ■ | | | ■ | ■ |
| Physical inactivity | | ■ | | | ■ | | | |
| Diet | | ■ | | | | ■ | | |

# Governance for health equity

(Brown & Harris. WHO-Euro 2013)

- develop the necessary legislation and regulations to strengthen **joint accountability for equity**, across sectors and decision-makers and within and outside of government;
- use mechanisms which actively promote **involvement of local people** and stakeholders in problem definition and solution development;
- ensure **regular joint review of progress**, which fosters common understanding and sustains commitment to deliver shared results over time;
- draw on **different forms of evidence** to ensure policies address the main causal pathways and are capable of adapting over time.

# 7 hypotheses on how to remove barriers for implementing health (equity) in all policies locally

1. All involved should feel an ownership for the potential solutions - through a shared understanding of goals and means

2. The health relevant intervention should be an integrated part of the core output in each sector

3. Very detailed understanding of what exactly should be changed in the current activities to influence health equity is needed

# 7 hypotheses ……(contd)

4. Estimates of costs are needed - and of effects too. HIA and CEA as critical tools.

5. Clarify when priorities are different when promoting average health versus reducing health inequalities. Visualizing trade-off issues.

6. Be prepared when the right political momentum is there – the ”window of opportunity”

# A comparative Nordic project will extract lessons learned with a focus on implementation at the local level.

Are these 7 hypotheses the key issues? We need a close dialogue with experienced local communities

Finn Diderichsen, Ingvild Gundersen Little, Christian Scheele