National strategy to reduce social inequalities in health

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

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(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
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 interconnected 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
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.