

**IMPLEMENTING THE PUBLIC HEALTH ACT IN A
LOCAL SETTING: ADDRESSING THE SOCIAL
INEQUITIES IN HEALTH IN A NORWEGIAN
MUNICIPALITY**

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DECLARATION OF ORIGINALITY

I hereby declare on oath that this thesis is my own work and that, to the best of my knowledge, it contains no material previously published, or substantially overlapping with material submitted for the award of any other degree at any institution, except where due acknowledgement is made in the text.

Olin Blaalid Oldeide

Bergen, May 19, 2014

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ABBREVIATIONS

SIH	Social Inequities in Health
HiAP	Health in All Policies
WHO	World Health Organization
SODEMIFA	Addressing the social determinants of health: Multilevel governance of policies aimed at families with children
NIBR	Norwegian Institute for Urban and Regional Research
HiVe	University College of Vestfold
EU	European Union

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ABSTRACT

Background The increasing presence of social inequities in health defies the values of solidarity and justice. In an attempt to address this challenge The Public Health Act was adopted 2012 in Norway. The Act proposes to reduce the social inequities in health through a Health in All Policies approach, which reflects that health is to be promoted through the contribution of all societal and political sectors. The Act reflects the need for a comprehensive health promotion profile in the municipalities, as the conditions affecting peoples' everyday lives are strongly influenced by the municipality through public policies and services. Therefore this study seeks to investigate how the municipalities are implementing the Public Health Act, with particular focus on how they are addressing the SIH.

Objectives The main objective is to gain insight into how the municipality is addressing the responsibilities proposed by the Public Health Act, with particular focus on the SIH. To fulfil the objectives of this study, the following research questions are presented:

RQ 1: What policies are in place at the municipal level concerning health promotion and SIH?

RQ 2: Do the plans and interventions at the municipal level include the HiAP approach and intersectoral collaboration?

RQ 3: Which efforts are taken at a municipal level to reduce SIH?

RQ 4: What challenging- and success factors does the municipality experience associated with implementing the Public Health Act, with special considerations connected to SIH?

Theoretical framework The theoretical framework for this study is compiled of literature connected to health equity and the Social Determinants of Health model.

Methods The study takes form as a case study. The data was collected through qualitative face to face interviews with the political and administrative leadership in one municipality and a document analysis of the municipal plans.

Results and discussion The findings from the municipality illustrates that the social determinants view is implicitly represented there. This implicit understanding is discussed in relation to the political history of the municipality. The efforts connected to addressing SIH can be characterized as proportionate universalism. There is on the other hand little evidence of successful HiAP approach in the municipality. The surrounding structures of the municipal organization may be limiting the progress of health promoting policies at a local level. In conclusion the municipality adheres to some of the principles of the Public Health Act.

Conclusions

The notion that health promoting principles have grown from within the organization and are now reinforced from a national angle may bode well for the future of health promotion within the municipality. An important lesson to learn is to build on the existing structures of health promotion principles and further encourage the principle of HiAP to more effectively address SIH in local governments.

1. Introduction and study objective

1.1 Problem statement

The World Health Organization (WHO) states that all individuals should have an equal opportunity to reach their full potential of health, but reality falls far from this goal (Koh et al., 2010). The WHO reports an average health status improvement in Europe, but these improvements are not equally distributed across countries, or across social groups within the same countries (WHO, 2013a). There is a systematic correlation between social status and health status, which forms a gradient throughout the population (Stegeman & Costongs, 2012). These inequities in health are considered unfair and modifiable (Marmot, Friel, Bell, Houweling, & Taylor, 2008). Evidence shows that the level of health inequities is increasing in the EU, the implications of this is that the health status of those 'better off' is improving faster than those who are less well off, leading to a widening of the health gap between the social economic groups (Stegeman & Costongs, 2012). The increasing levels of inequities in health and the social gradient defy the values of justice and solidarity, and are particularly unfair for children as the effect of being born into relative disadvantage can have long-lasting consequences of deprivation and ill health. (Stegeman & Costongs, 2012).

Within the field of health promotion there has always been strong ties to social justice and equity. Already in 1986 the World Health Organization defined social justice and equity as a prerequisite for health in the milestone Ottawa Charter (WHO, 1986). 25 years after the creation of the Ottawa Charter the themes of social justice and equity are still acknowledged as an urgent

public health challenge. The term 'public health' is linked to health promotion principles.

The WHO has highlighted the social determinates of health as a main cause of these social inequities in health. The social determinants are the conditions in which people are born, grow, live and age ("Lov om folkehelsearbeid," 2012; WHO, 2013b). Social and economic policies have a determining impact on these conditions (Marmot, et al., 2008). The Norwegian government has established that reducing the SIH is a long-term goal. The Public Health Act was adopted in 2012 as an effort to reduce the SIH. In the Public Health Act ("Lov om folkehelsearbeid," 2012) one goal is to reduce the social gradient through a HiAP approach, which reflects that health is to be promoted through contributions of all societal and political sectors ("Lov om folkehelsearbeid," 2012). A central aspect of the Public Health Act is the focus on the municipalities' role in the public health work. The conditions affecting peoples' everyday lives are strongly influenced by the municipality through public policies and services ("Lov om folkehelsearbeid," 2012).

While the Norwegian national public health policy is regarded as comprehensive and coordinated, some have pointed out that the municipalities' autonomy have led to a divide between national and local priorities (Tallarek née Grimm, Helgesen, & Fosse, 2013). Tallarek née Grimm et al. (2013) stresses the necessity for more information on the gap between national and municipal approaches, as there is a need for coordinated public health policies at all levels to successfully reduce SIH.

Therefore this study seeks to investigate how the municipalities are implementing the Public Health Act, with particular focus on how they are addressing the SIH. This thematic is inspired by the project: Addressing the social determinants of health: Multilevel governance of policies aimed at families with children (SODEMIFA). The SODEMIFA project is done in collaboration with Department of Health Promotion and Development (Hemil-senteret), Norwegian Institute for Urban and Regional Research (NIBR) and University College of Vestfold (HiVe). There is also cooperation with The University of Brighton and The University of Mälardalen. The main preoccupation of this project is researching how the different levels of a multilevel system of governance handle the challenges of addressing the social determinants of health and the social gradient in a structure of multilevel governance. This study seeks to contribute to this project and provide information from the municipality level.

1.2 Study purpose

Responding to the knowledge gap outlined above, this study aims to contribute to the understanding of how the SIH are addressed by local government, and investigate the effectiveness of the measures compared to the relevant theories and literature. This will provide information as to how the Public Health Act is being implemented in Norway. The study takes form as a qualitative case study of one municipality. The data consists of interviews with the overall political and administrative leadership and a document analysis of the key municipal plans.

1.3. Objectives and research questions

The main objective is to gain insight as to how the municipality is addressing the responsibilities proposed by the Public Health Act, with a particular focus on the SIH. To fulfil the objectives of this study, the following research questions are presented:

RQ 1: What policies are in place at the municipal level concerning health promotion and SIH?

RQ 2: Do the plans and interventions at the municipal level include the HiAP approach and intersectoral collaboration?

RQ 3: Which efforts are taken at a municipal level to reduce SIH?

RQ 4: What challenging- and success factors does the municipality experience associated with implementing the Public Health Act, with special considerations connected to SIH?

1.4 Significance and contribution of the study

There is a wide array of literature connected to the SIH and in Chapter 2 the central literature connected to this field is highlighted. Although the importance of reducing the SIH is frequently stated, there is minimal literature connected to how to reduce the SIH (Graham, 2009). The SIH are increasing in Norway; simultaneously the need for knowledge about how the SIH are addressed and if the strategies are effective, also increases. This study will provide insight into how the local administration works with SIH.

The study will also shed some light on the dimension between the state and the local government when faced with implementing a new law, as the implementation of the Public Health Act is at the centre of the study.

The information presented in this study can prove useful to other municipalities, as there is today minimal research connected to how the Public Health Act is implemented in municipalities in Norway. This study provides insight to the responsibilities the Public Health Act proposes to the municipalities, and conveys how these are met at a local level.

2. Scientific Background of the study

2.1 Theoretical Framework

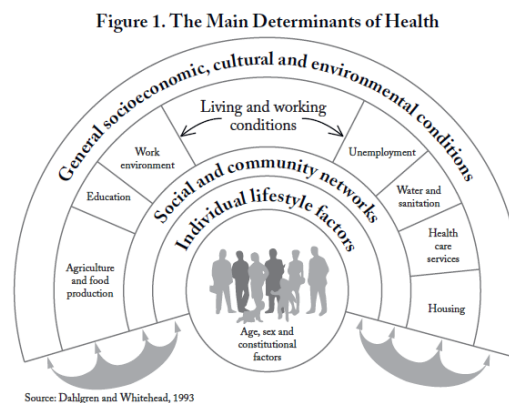
This section gives an introduction to the theories and literature which is related to the key points of this study. The theoretical framework is compiled of literature connected to the social determinants of health and equity in health.

2.1.1 The Social Determinants of Health

Already in the 19th century social-epidemiologist investigated the distribution of health and disease, and which factors influence these (Dahl, Bergsli, & van der Wel, 2014). The focus on the structures surrounding the individuals' health faded away. In the 1980's the focus of the public health field was connected to the individual lifestyle factors which influence health, particular associated with risk behaviours (Baum, 1998). As a critique to the one sided research effort and health expenditure connected to the individual, the term 'Determinants of health' was launched in the 1970's (Graham & Kelly, 2004). The public health field turned from a focus directed at the individual level with emphasis on health services and disease outcomes, to the social policies and the social determinants of health (Graham & Kelly, 2004). The social determinant of health approaches sees the organization and distribution of economy and social resources as providers of the mainsprings of health (Raphael, 2009). Among the most prominent theories is Dahlgren and Whiteheads model 'The Social Determinants of Health' which reflect a more comprehensive view of health (Stegeman & Costongs, 2012). The model is inspired by the WHO (1946) definition of health which is "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (p. 100). This definition

encompasses a more holistic view of health and subsequently the model reflects that health is determined by a wider aspect of determinates than the health care which is provided.

In 1991 Dahlgren and Whitehead developed a background document for the WHO titled “Policies and strategies to promote social equity in health”. This document set out to outline a strategic approach to promote greater equity in health between different social groups (Dahlgren & Whitehead, 1991). To develop effective policies addressing health Dahlgren and Whitehead (1991) developed a model illustrating the main influences on health. In this model the different factors that influence health are portrayed in rainbow-like layers of influence. Figure 1 is an illustration of the different influences on health and how they are categorized into layers, one on top of the other.



At the centre of this model are the individual characteristics such as age, sex and genetic make-up. The next layer represents the actions taken by individuals labelled individual lifestyle characteristics; this includes among others dietary choices and exercising habits. Support from social and community networks is represented in the next layer. In figure 1 the material and social conditions in which people live and work in is represented in the following

layer, these include various sectors such as housing, work environment, education and health care. The overall major structural environment is represented at the outer level of the model; here general socio-economic, cultural and environmental conditions are represented. (Dahlgren & Whitehead, 1991).

It is important to note that the factors in all the layers can be connected and influence each other; and typically the ‘borders’ between the layers are not as clear. This conceptualization represented by Dahlgren and Whitehead may facilitate characterization of different approaches connected to public health and health promotion policies; as this model demonstrates the importance of understanding the broad nature of policymaking (Fosse, 2009).

These conditions external to the human body, referred to as the social determinates of health, are responsible for inequalities in health (Marmot, 2005). There is a wide array of literature exploring the relation between socio-economic status and health (Marmot, Friel, Bell, Houweling, & Taylor, 2008; Stegeman & Costongs, 2012; Stegeman, Costongs, & Needle, 2010). The research confirms that rich people are healthier than poorer people; and people higher in the social hierarchy, measured by education, profession or income; both live longer and have a better health than people from a lower social class (Directorate of Health and Social Affairs Norway, 2005). These disparities exist, not only between the lowest and highest in the socio-economic classes, but rather follow a gradient pattern through the population (Stegeman & Costongs, 2012). This means that mortality and morbidity increase with declining social position (Whitehead & Dahlgren, 2006). When referring to the gradient, it means the health gap between the populations associated with socio-economic class. The concept of the gradient directly relates to the equity of health as it is stated in the WHO

Constitution (1946): “... *the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...*” (p. 1). According to the social determinants model of health by Dahlgren and Whitehead; the surrounding determinants define the health of the individual, and by there being a systematic differences in the surrounding environment it restricts the individual from achieving the highest attainable health. This gradient of health is therefore directly connected to the term equity in health. It is worth to note that there is a difference in terms connected to the social determinants of health and the social determinants of health inequality. Policy which improves the public’s health through addressing the social determinants is not necessarily the same as policies directed at levelling the inequality in health between the different social groups, as that would require tackling the uneven distribution of health determinants (Dahl, et al., 2014; Graham, 2009; Graham & Kelly, 2004). Modern public health is concerned with the social determinants of health perspective and it is well-used in policy development and research (Graham & Kelly, 2004).

2.1.2 Equity in health

It is important to note that there are different terms connected to the field of health equity. The fact that poorer and/or more disadvantaged groups are more likely to have illness, injuries, disabilities and live shorter lives than those who are more affluent is referred to as ‘health inequalities’ (Stegeman & Costongs, 2012). The term ‘health inequality’ is described as an objective measure of health differences, while the term ‘inequity’ is used to describe that these inequalities are unjust and unfair (Marmot et al., 2010). They are described as unfair and unjust as they are a result of the conditions surrounding the individual

and not the individual's behaviour; also they are unjust as they can be avoided by reasonable means (Marmot, et al., 2010; Marmot, et al., 2008; Stegeman & Costongs, 2012). Whitehead (1991) describes seven main determinants of health differentials distinguishing between avoidable and unavoidable; consequently unjust inequities in health, such as exposure to unhealthy, stressful living and working conditions; and just inequalities in health, such as biological, natural variation and effects of freely chosen, health damaging behaviour. Vallgård (2006) argues that it is not possible to make a clear distinction between avoidable and unavoidable differences, as the extent of which differences are considered unfair depends on political and normative standpoints. From a liberal standpoint inequity in health, while not desirable may be seen as an inevitable effect of the desirable individual freedom of action. While for those who value solidarity and equality, inequalities are signs of society's failure of creating reasonable conditions for all citizens (Vallgarda, 2006). McCartney, Collins and Mackenzie (2013) oppose this view by stating "*The broader, politically determined social inequalities, which in turn determine health inequities, are not inevitable... Health inequalities have grown in synchrony with income and power inequalities and are highly likely to diminish if income and power is redistributed.*" (p. 225).

It is important to note that there is some inconsistency in the use of the terms 'inequality' and 'inequity', not always referring to the argument of avoidable or unavoidable differences. Whitehead (1991) points out the ambiguity connected to the term "... some use it to convey a sense of unfairness, while others use it to mean unequal in a purely mathematical sense" (p. 219). Graham (2009) notes that in the North European context, health inequalities

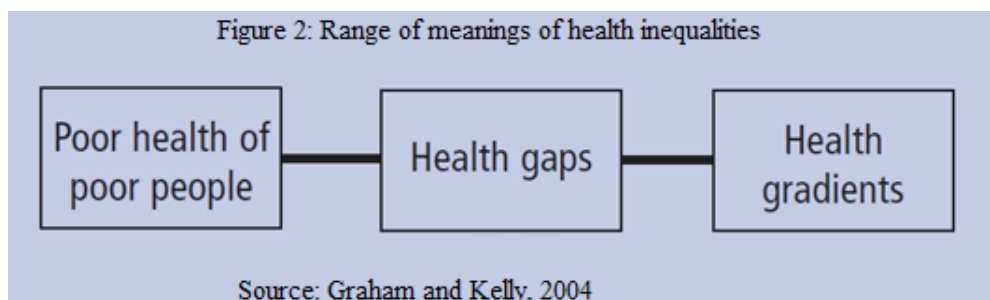
typically refers to socioeconomic differences. In Norwegian and other European languages there is only one word for the two terms, causing some inconsistency when adopting terminology from for example the UK (Judge, Platt, Costongs, & Jurczak, 2006; Whitehead, 1991; Whitehead & Dahlgren, 2006). Throughout this study the term Social Inequities in Health (SIH) will be used, but in direct quotations divergent terms will be respected. Graham and Kelly (2004) stress the need for an agreed upon understanding for the term, as different actions are associated with different definitions of inequity.

There are different explanation models connected to inequities in health. Dahl et al. distinguish between three overarching categories when describing the inequalities of health; causal explanations, alternative casual models and overarching perspectives. Causal explanations refer to the different health determinants and the social distribution effect on health, i.e. the social position affects health. The second type, alternative causal models, is preoccupied by the social distribution and health related selection. For example that an individual's health and upbringing determine the social position one has. The last perspective is a compilation of complex models such as time and socio-geographic context, meaning that the life courses can vary greatly from one generation to the next and health inequities can over time and in different countries have different explanations. As Dahl and colleagues illustrates, social inequities in health can be described and operationalized many different ways but we see that the social environment plays a meaningful role in explaining the social inequities in health. Dahl, et al. (2014) describes that “...*political intervention to change “environmental factors” which is connected to the different positions of the*

socioeconomic structure therefore has a great potential to level social inequities in health” (p. 80, own translation).

2.1.3 Addressing social inequities in health

The reasons for levelling up the socioeconomic gradient in health are many and widely accepted, yet the gradient as a phenomenon is complex and related to general inequities in society (Stegeman & Costongs, 2012). Graham and Kelly (2004) highlight that there is a plethora of literature connected to health inequalities, but minimal literature connected to how to reduce health inequalities. They further state that the goal of greater equality in health has been interpreted in various ways. Tackling health inequality usually refers to three following actions: Improving the health of poor groups, reducing the health difference between poorer and better of groups and lifting the levels of health across the socioeconomic hierarchy closer to those at the top. These three understandings can be viewed as a continuum of complementary goals where improving the health of the poorest is the first stage in narrowing the health gap which will contribute to reducing the health gradient. This is represented in figure 2: (Graham & Kelly, 2004).



Graham and Kelly (2004) describe that focusing on improvements made in the health of the poorest have some policy advantages as it is a clear goal which can be monitored. On the other hand, this strategy offers limitations as

following the principles presented by the gradient of health, health disadvantages does not only affect those worst-off. Interventions aimed at bettering the health of the poor only reach a minority of the population, and can be associated with a widening of the health gap between them and the rest of the population. Since the rates of health improvements occurs more rapidly in better-off groups, improving the health of the poorest can lead to them slipping behind. This focus on the disadvantaged groups can also be referred to as target policies or “downstream” which are policies aimed at vulnerable or marginalized groups (Whitehead & Dahlgren, 2006).

At the centre of the continuum presented in figure 2. lies narrowing the health gaps, which means the gap between the health of the best-off and the worst-off groups. Narrowing the gap means raising the health of the worst-off the fastest. Although this strategy has some policy advantages, the focus still lies on a too small proportion of the population. The danger is that focusing on disadvantaged groups can obscure the effect that the socioeconomic inequality has on the entire population, and not only the disadvantaged groups. (Graham & Kelly, 2004)

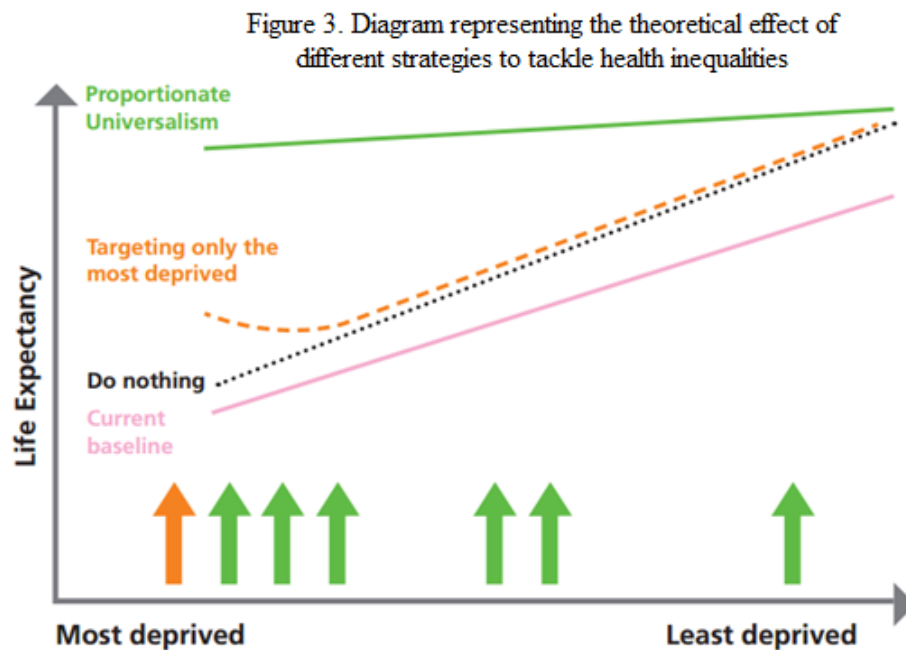
Reducing the gradient which lies to the far right in the continuum describes measures which recognize that health improves each step up the socioeconomic ladder (Graham & Kelly, 2004). This includes directed attention to the entire population, but it also includes the previous mentioned strategies, both improving the health of the poorest and narrowing the gap. This broader framing of health inequalities requires broader framing of policy goals which involves a comprehensive policy strategy (Graham, 2009). Aiming policies at wider population is referred to as “upstream” by Whitehead and Dahlgren

(2007), to address the social gradient it is important to note that upstream and downstream efforts are interdependent. Marmot and colleagues supports the need for recognizing the gradient and proposes the concept of proportionate universalism:

“To reduce the steepness of the social gradient in health actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.” (Marmot, et al., 2010, p. 16)

In a public health perspective the difference between targeted efforts on disadvantaged groups and universal efforts are significant (Dahl, et al., 2014). Below, in figure 3, there is a model representing the theoretical effects of the different strategies when addressing health inequalities (Asquith, Shaffelburg, Adepoju, & Griffiths, 2011). The model depicts the difference between the most and least deprived populations and the life expectancy between the two groups. The pink line illustrates today’s current baseline, where there is a clear gradient of health inequity. The black line demonstrates the effects of doing nothing and consequently the gap in health between the social groups is still present. The orange dotted-line illustrates efforts only directed at the most deprived. Theoretically this will lead to a small increase in life expectancy but no effects on the gradient in general. The green line indicates actions with an approach of proportionate universalism, which results in a solid reduction of the health

gradient across society. If the goal is a flattening of the gradient, a population wide, universal strategy will be the most effective (Dahl, et al., 2014).



Source: (Asquith, Shaffelburg, Adepoju, & Griffiths, 2011)

Traditionally there has been a discrepancy between efforts directed at individual and population based efforts (Dahl, et al., 2014). The efforts directed at individuals are characterized by a more comprehensive approach and precise knowledge, than effects of populations based efforts (Khaw & Marmot, 2008). Addressing health inequalities can be described as wicked problems as they are complex problems with no simple solutions. Sabatier (as cited in Jansson, Fosse, & Tillgren, 2011) describe that it is difficult to implement policies which require substantial change in power reactions or organizational routines than policies aiming at minor change. Dahl, et al. (2014) argues that it is not a case of either-or, as in the Nordic countries there are significant elements of both universal and selective efforts.

2.2 Literature review

Building on the knowledge presented in the section above, this section presents some of the research connected to the terms of social determinants of health and equity in health. This section further attempts to illustrate how inequities in health have been addressed and follow the development of equity in health from an international-, to a national-, and finally to a local level. Some key policy documents are also presented such as The Public Health Act, with special regard to the principle of HiAP. Finally, attention is given to the recent literature which is connected to the implementation of the Public Health Act.

2.2.1 Public policies addressing SIH in an international setting

Public policy is described as “... *the broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem.*” (Brooks, 1989, p. 16). Throughout the health promotion field there has been strong links to the terms connected to equality of health and the policies aimed at reducing them. Already in 1978 the health inequalities were described as “inacceptable” in the milestone Alma Ata-declaration (WHO, 2014). In 1985 WHO Euro adopted the “Global Strategy for Health for all by the Year 2000” agreement which called for a 25% reduction of health inequalities within the year 2000 (WHO, 1981). The Ottawa Charter from 1986 described tackling the inequities in health as a commitment for health promotion practitioners (WHO, 1986). In the WHO Euro “Health 21” it renewed the focus of the report from 1985 and called for ¼ reduction in the health gap within the year 2020 (WHO, 1998). WHO’s World Commission on Social Determinants of Health (2005-2008) produced the report “Closing the Gap in a

generation” where the gradient in health is clearly attributed to social causes, and therefore possible to act on (Marmot, et al., 2008). Since then followed several resolutions and Ministerial conferences which all have led to a further focus on inequities in health in the world and Europe particularly.

In 2006 an independent report commissioned by the UK Presidency of the EU reviewed the national-level policies and strategies which have been developed to address inequalities in health in a European setting (Judge, et al., 2006). They found that a number of countries lacked formally articulated principles or goals to guide their actions at the national level. Furthermore, the review indicated that the more focused and integrated the cross-governmental strategy for action is, the greater the probability is for change in the desired direction for the health outcomes (Judge, et al., 2006). The report concludes that no EU country has made a concentrated effort to implement the most radical approach to health inequalities, whereby addressing the health gradient in the population (Judge, et al., 2006).

As the gradient is related to the entire population, SIH is an issue which concerns the population as a whole. By viewing the inequities of health as a product of the surroundings, the role of the political context is important to understand when concerned with addressing SIH. Navarro et al. (2003) reflect that reducing social inequalities in health is a highly political issue. Rittel and Webber (1973) add that social policies addressing SIH are bound to fail as there is no objective definition of equity. To address SIH there is a need for a political agenda which regards social inequalities as unfair (Navarro, et al., 2003). Different nations associated to different types of welfare states handle the challenges of SIH differently. Research suggest that political traditions

associated with redistributive policies, such as social-democratic parties are more successful in improving health of the population and reducing social inequalities in health (Stegeman & Costongs, 2012).

England was one of the first European countries to pursue a systematic policy to reduce socioeconomic inequalities in health, much attributed to the labour party entering into power in 1997, with a clear intent to reduce health inequities (Mackenbach, 2010). Mackenbach (2010) analyse the strategy as partly unsuccessful and argues for more advocacy, more research and more focused policy efforts in the future to successfully reduce SIH. Koh et al. (2010) analyse the many initiatives put in place to reduce health disparities at an international level. Koh et al. (2010) point out that despite the recent efforts to reduce the gap between research evidence and practice, there is still a need for a stronger public policy agenda, and public support for eliminating health inequities. Bambra and colleagues (2010) conducted a systematic review of interventions based on the wider determinates of health. They found that the effects of the interventions on health inequalities were unclear, and highlight the need for more research on how to tackle the determinants of health, and particular on which interventions are effective and for whom. By the evidence being less apparent and less accessible to policy makers, the action consequently is more focused on modifying lifestyle issues which is connected to a stronger evidence base (Bambra, et al., 2010). McCartney, Collins and MacKenzie (2013) concludes that health inequalities cannot be expected to reduce substantially as a result of policies aimed at changing health behaviour, they further state that *“As a matter of scientific clarity and intellectual honesty, there should be no*

pretence or illusion that health inequalities can be eliminated or even meaningfully reduced without a primary focus on structural factors” (p. 225).

Graham (2004) note that in England the goal of tackling health inequality is prevalent, albeit the meaning of what this means has changed. In an analysis of national policy documents, Graham (2004) suggests there has been a move from a focus on disadvantaged groups towards a broader orientation to health gradient. While a study of policy development and implementation at the local level in England shows that the definitions of health inequality were broad, the goals were often vague and considerable work needed to be done to understand a broad definition of social determinants in health (Benzeval & Meth, 2002). This may suggest a divide between national and local strategies.

2.2.2 Norwegian policy development connected to addressing SIH

In comparison with other European countries Norway started late with focusing on the inequities in health (Fosse & Strand, 2010). Dahl (2002) characterized Norway as a laggard in its approach to social inequity in health, as there was an acceptance of the problem at governmental level and in the research community, but there was a lack of political will. Fosse and Strand (2010) provides a review of Norwegian policies aimed at social inequities in health and describes that the first reports on social inequality came in 1980 only to disappear and resurface as a topic at the end of the 1990's and early 2000's. In 1999 a centralized coalition government launched a focus on bettering the situation for marginalized groups in Norway. In 2002 an action plan against poverty was launched, the plan reiterates the individual's responsibility for their own life (St.meld. nr. 6, 2002-2003). In the White paper nr 16 “Prescription for a healthier Norway”, working

with vulnerable groups is still described as a priority. Social inequities in health are mentioned in the document, although only on 5 of 179 pages (Ministry of Health Norway, 2002-2003). The White paper nr 20 “National strategy for reducing social health inequalities” represented a new turn for the public health field in Norway. It presented a clear gradient perspective by stating that equity in health is good public health policy and the society as a whole is responsible for health inequities (Norwegian Ministry of Health and Care Services, 2006-2007). The White papers indicate that the change of government reflect a change in strategies for tackling health inequities. In 2007 Vallgård reviewed the White papers of the Scandinavian countries and Norway’s policies are described as social-liberal, which is in tune with the liberal coalition in power at that time. The following White paper nr 20 is characterized by moving away from focusing on the disadvantaged groups and recognizing the gradient, which is in tune with the political direction of the governing parties, which was the social democratic party.

Norway is a part of a social democratic welfare state model, which is known for its emphasis on solidarity and redistribution among social groups (Fosse, 2009). Fosse (2009) reviewed the national policies in Norway the last two decades and labelled the strategies ‘upstream’ or ‘downstream’ in keeping with Whitehead and Dahlgren theory presented in Chapter 2. Fosse (2009) stated that until 2003, policies were traditionally characterized by a ‘downstream’ approach. But after a policy shift and with a left-wing coalition in 2005, it is argued that the shift represented a revitalization of universal and structural measures, which is in line with a social democratic welfare state model (Fosse, 2009). Although Norway came late to the health inequalities policy arena,

Whitehead and Popay (2010) remarks that this might have given the country an opportunity to learn from others and state that Norway is among the few nations which have a national strategy explicitly addressing the whole gradient. Navarro (2004) states that in European countries which have a social democratic government there is better health. The theme of social inequities in health touches at the core of political contrasts between the left and right axis of politics, and is therefore a highly politicized topic (Fosse & Strand, 2010). This is reflected by there being a change in the political direction of the government, it will have a clear influence on the strategies of addressing social inequities in health. In a recent analysis of the Nordic welfare states Raphael (2014) identifies threats to the Nordic welfare state which include: immigration, economic globalization and 'welfare state fatigue'. 'Welfare state fatigue' represents the weakening support for social democratic parties including the values of universalism and solidarity. These threats may cause a reduction in policies which include a social determinants perspective on health, and as a consequence lead to a deteriorating population health (Raphael, 2014). Sweden has experienced shifts in the welfare state, characterized by a growing acceptance of income inequality and a growing emphasis on the importance of individual health (Raphael, 2014). Raphael (2014) suggests that this development in Sweden represents a picture of the declining Nordic welfare state. Raphael (2014) advocates for acknowledging the important role the Nordic welfare state has played with regard to health promotion. In 2013 Norwegian voters ended eight years of Left-wing coalition rule and a coalition from the Conservative party and the Progressive party was elected. Whitehead and Popay (2010) state that the progress made in Norway will be followed closely from an international

viewpoint as it is argued that Norway is one of the most favourable positions to reduce SIH.

In a recent article by Mackenbach (2012) the paradox of persisting socioeconomic inequalities in health in highly developed 'welfare states' is discussed. In some countries the health inequalities have not only persisted, but on some measures the health gap has widened. Despite the universal welfare efforts the socioeconomic inequities have increased in Norway (Fosse & Strand, 2010). In a recent review of welfare states typology and health inequalities, the researchers found that there is little support to the notion that social democratic 'welfare states' have better public health and less inequalities than others (Brennenstuhl, Quesnel-Vallée, & McDonough, 2012). Dahl, et al. (2014) argues that the developments proposed by Mackenbach does not necessarily conclude that the Nordic welfare state have not had an effect on health inequities, rather it could be slowing down a development which occurs in a larger extent in other countries. Dahl and colleagues (2014) also proposes different explanations to the paradox such as; the social determinants perspective may not be as important as first assumed, there is a time-lag connected to addressing SIH and the results of studies connected to inequality and socioeconomic position is affected by the methodological selections and operationalized of variables. Dahl, et al. (2014) remarks, with these explanations in mind, the current empirical and theoretical knowledge in the field still holds that: *"The persisting social inequalities in health are due to relatively stable traits with social inequality in material (income) and immaterial goods such as education and social and cultural resources in the Norwegian society, as well as health habits..."* (p. 312-313).

2.2.3 The Public Health Act

01.01.2012 The Public Health Act was adopted. The act came as a part of a bigger “Coordination Reform”. The reform is described as the biggest health reform in Norway since the Second World War and consists of judicial and organizational changes (Kassah, Tønnessen, & Tingvoll, 2014). The reform seeks to meet the challenges of the demographical development which threaten the society’s economic capacity, by developing a more comprehensive and coordinated health and care sector and improve the public’s health (“The Coordination Reform,” 2008–2009; Kassah, et al., 2014). Changes include that the municipalities are responsible for primary health services, social services, rehabilitation and strengthen the preventative work in health across different sectors (“Public Health Report,” 2012–2013). The rationale behind strengthening the public health is that it will lead to a reduced need for health services. Mæland (2010) reports that preventive efforts have lost the battle of the resources and that the commitment to prevention have been decreasing the last years, estimating that only 2% of the collected health expenditure are relayed to preventive services. The Public Health Act is one of the laws which govern the initiation of the Coordination Reform (Lorentsen, Kassah, & Kassah, 2014). The Public Health Act is based on five founding principles: Social equity in health, Health in All Policies, Sustainability, participation and The Precautionary principle. The act represents a move for public health work from the municipal health care sector, to the municipality as a whole, with aid from the county and the national level. Povlsen, et al. (2014) describes the Public Health Act as a culmination of years of work addressing the SIH and include both ‘upstream’ and ‘downstream’ measures, which is described as addressing the gradient

clearer than seen elsewhere in the Nordic countries. The law further states that all sectors of the municipality should promote health, the municipality should keep an overview of the health status and the factors which influence health, and initiate actions to address these ("Lov om folkehelsearbeid," 2012). To get an accurate overview of the health status it requires good collaboration between the different levels of governance (Fosse, 2013). And all the principles described in the Public Health Act require interprofessional- and intersectoral collaboration (Fosse, 2013).

2.2.4 HIAP – Health in All Policies

In the 1970's and 1980's the socio-environmental approaches emerged, such as the concept of social determinants of health, which emphasized the reciprocal nature of the context in which people live (Puska & Ståhl, 2010). This development paved the way for an understanding of how social and cultural environments affect people's health and how a broad range of policy measure is needed for successful public health (Puska & Ståhl, 2010). There is solid evidence that health can be influenced by policies of other sectors and that health has in turn important effects on the goals in other sectors such as economic wealth (Ståhl, Wismar, Ollila, Lahtinen, & Leppo, 2006). Health in All Policies (HiAP) is described as

“...an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies and avoids harmful health impacts, in order to improve population health and health equity...It emphasizes the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for

health impacts at all levels of policy-making.” (Adapted from WHO Working Definition prepared for the 8th Global Conference on Health Promotion, Helsinki, 10–14 June 2013. Referenced in Leppo, Ollila, Peña, Wismar, & Cook, 2013, p. 6).

HiAP is an encompassing approach which goes beyond the boundaries of the health care sector and seeks to make policies more consistent on an overall level; and subsequently affecting the determinants of health which again influences the population’s health (Ståhl, et al., 2006). HiAP approach is not only characterized by recognizing the social determinants for health, but it also concerns addressing policies at all levels of governance; from a global, national, regional and local level (Ståhl, et al., 2006). The term ‘intersectoral action for health’ is closely related to HiAP as they are both connected by a core message of the need to integrate health considerations into other policies and sectors beyond the health care sector (Ståhl, et al., 2006).

Rigorous research indicates that coordinated action at multiple levels to promote health is more effective than singular interventions (Green, Richard, & Potvin, 1996; McQueen, Wismar, Lin, Jones, & Davies, 2012; Richard, Gauvin, & Raine, 2011; Stokols, 1996). A realist-informed review, which reviewed how interventions work, found that in 2010 there were 16 countries or subnational areas where there were examples of HiAP approach. The approach to HiAP varied significantly between the countries (Shankardass et al., 2011). A study conducted by Puska and Ståhl (2010) concluded that HiAP is a sound and important framework for promoting public health in modern societies, but evidence-based guidelines are needed for HiAP to be successful. McQueen, et al. (2012) reflect that although there has been a lack in producing evidence, HiAP

has continued to gain momentum and has not stopped policy-makers and governments from experimenting with intersectoral governance structures as a means to support HiAP approach. Kickbusch (2010) describes the HiAP governance system as far from in place and points to a lack of strategies to overcome the sector-based approach to governance. Koivusalo (2010) further this description by stating that implementation of HiAP has been a challenge and *“HiAP has at a European level remained mostly as rhetoric...”* (p. 500).

2.2.5 Intersectoral collaboration

As the determinants of health reside in many different fields and sectors within the society, there is a need for extensive interdisciplinary- and intersectoral collaboration between these to preserve public health (Fosse, 2013). In most welfare state systems the services have been criticized for being ‘fragmented’, Axelsson and Axelsson (2011) attribute this to the growing specialization of the welfare services and professionalization among the organizations involved. The principle of New Public Management controls the organization of many municipal services (Fosse, 2013). This organization method requires clear documentation for time spent and there is little room to evolve collaboration. Fosse (2013) remarks that this organization can easily become a negative reinforcing spiral where the organization of the administration and services itself becomes the problem. Helgesen and Hofstad further states that the new organizational forms based on New Public Management adds to the growing focus on economic profitability and efficiency and can be a hindrance for collaboration (as cited in Fosse, 2013). Bihari Axelsson and Axelsson (2009) describe that barriers connected with collaboration can be divided into structural barriers, in form of organizational rules or administrative boundaries, and

barriers connected to cultural differences between professions and organizations, for example specialized language. A barrier which is given special attention is the barrier connected to territoriality behaviour, which can be described as leaders regarding the responsibility areas as territories which they have to defend (Bihari Axelsson & Axelsson, 2009). Altruism is suggested as an alternative to the territoriality and it is thought that it will generate a more holistic approach and bridge the ongoing fragmentation of the welfare services (Bihari Axelsson & Axelsson, 2009). The altruistic approach may be regarded as unrealistic as the boundaries between organizations and professions are strong and altruism may come in conflict with the competition for resources and the evaluation of leaders and professionals (Bihari Axelsson & Axelsson, 2009). Axelsson and Bihari Axelsson (2006) describe that intersectoral collaboration is usually organized as multidisciplinary teams, but highlight that multidisciplinary teams are a fragile and volatile forms of organization and managing these teams are challenging. Koivusalo (2010) reflect that challenges connected to HiAP implementation at a European level is likely to continue to remain an issue as things have not moved fast so far. It is important to note that HiAP should not be interpreted as merely administrative cooperation, but also extended to process of political decision-making and accountability (Koivusalo, 2010).

2.2.6 HiAP in the Norwegian context

Norwegian municipalities have for a long time been responsible for the main health care services and public health work. Although the principle of intersectoral collaboration was mentioned already in 1984 in the Law of Municipal Health Services it has generated minimal practical policies ("The Coordination Reform," 2008–2009; Fosse, 2013). Several reports and key

documents point out the need for strengthening the holistic perspective when providing services and increase the inter-professional and intersectoral collaboration (Glavin & Erdal, 2010).

In 2011, before the Public Health Act was adopted, Helgesen and Hofstad conducted a survey which reflects that public health work is still a primary concern of the health sector. Public health is described as a difficult field as there is limited understanding of what works, the time lag before results appear are long and to effectively work with public health requires a holistic and long-term effort not singular actions (Helgesen & Hofstad, 2012). Fosse (2013) highlighted several challenges for the intersectoral collaboration within public health. The first challenge is connected to the Public Health Coordinator in the municipalities, which is often organized with a small employment percentage (Fosse, 2013). Helgesen and Hofstad's (2012) survey indicate that many municipalities did not have a Public Health Coordinator and many are employed in part time positions in combination with other tasks connected to administrative or user oriented positions in health department. Fosse (2013) adds that another challenge is the placement of the Public Health Coordinator within the municipal organization. The survey reflects that the public health work is mainly assigned to the health sector and the supervisor of the Public Health Coordinator is often the health sector leader (Helgesen & Hofstad, 2012). Another study examining health promoting programs implemented showed that projects which were administrated by the health service were unfortunate for the crosssectoral collaboration (Fosse, 1999). Research further indicates that structural barriers and professionalization are present and by each profession having to reflect their contribution, it limits the collaboration as when partners

collaborate, each contribution becomes less visible (Fosse, 2013). Experiences from an evaluation of different projects concerned with public health indicate that collaboration depends on a strong anchoring in the leadership and there is a greater chance of success if the collaboration is systematized by having clear routines and appointments (Glavin & Erdal, 2010). Fosse describe the third challenge, connected with intersectoral collaboration within the public health field, as the demand for public health data to guide the local work and the need for competency in gathering, analysing and initiating efforts based on these (Fosse, 2013). The survey reports that 60% of the municipalities describe a need for more knowledge about the health state and health determinants in their municipality (Helgesen & Hofstad, 2012). The county should make overviews of the health status available for the municipality and play a supporting role for the municipality in public health work through for example partnerships ("Lov om folkehelsearbeid," 2012). Hofstad and Vestby (2009) describes that in an evaluation of partnerships between municipalities and the county it is indicated that having a partnership increased the municipalities' access to counselling and guidance than municipalities without partnership agreements. Although crosssectoral work is evidently challenging, people in the study saw the need for cooperation (Fosse, 2013). The literature reflect that there is a need for coordination, focus and long-term horizon as developing the HIAP approach is complex (Kickbusch, McCann, & Sherbon, 2008). Intersectoral and interprofessional collaboration is described as a key element of the Public Health Act. Fosse (2013) problematizes the fact that the act gives no clear signals as to how this can be achieved. Literature reflects that clear health targets and

instructions on how to reach these targets can stimulate intersectoral collaboration (St-Pierre, 2010).

2.2.7 Research done on implementation of HiAP

A study from Netherland measured the effects of coaching program in municipalities on intersectoral collaboration, which is required for developing HiAP. The study shows that municipalities show little initiative in developing intersectoral-collaboration and revealed that there are few mechanisms that stimulate sectors, other than the health sector, to consider health determinants and health impacts (Steenbakkers, Jansen, Maarse, & de Vries, 2012). Managers reported that they felt themselves as hierarchically responsible for public health, but their involvement on content is very limited and delegated. In the in-depth interviews with municipal managers it was stated that they were prepared to invest time and personnel if the merits of collaboration with other policy domains were made clear. The lack of HiAP work in the municipalities was among attributed to powerlessness and lack of expertise in the domain of public health and not so much reluctance from non-public health domains (Steenbakkers, et al., 2012). The authors continue to remark that there is little research with municipal stakeholders both locally and internationally on HiAP (Steenbakkers, et al., 2012). The study concludes by stating that HiAP proposals are not given a high priority at a strategic or local level. The authors reflect that more support and involvement from stakeholders at each system level is important (Steenbakkers, et al., 2012).

Another study from the Netherlands investigated the opportunities for reducing health inequalities by HiAP approach at a national level (Storm, Aarts,

Harting, & Schuit, 2011). 38 policies was identified to have an impact on the determinants of health inequalities, only 11 of these policy resolutions were identifies as intersectoral collaboration, which means most of the policies with an effect to reduce health inequalities were developed and implemented in isolation (Storm, et al., 2011). HiAP approach is still in its infancy in most countries, but is highlighted as a suitable approach to reduce health inequalities (Storm, et al., 2011). The authors highlight the importance of having a ‘whole government approach’ as such formal elements play an important role with a government-wide strategy on addressing health inequities, and Sweden and Norway are mentioned as countries which explicitly address health inequalities through HiAP (Storm, et al., 2011).

A study from Sweden examined the implementation process of public health policy with focus on addressing the broader determinants of health and HiAP (Jansson, et al., 2011). The study concludes by stating that the implementation of the public health policy was hindered, in terms of governance and content, by the incoherence between national and local levels. Due to the government structure the municipalities have to perceive the goals to be needed, they have to be implementable and in concurrence with other responsibilities. The study indicates that within the multi-governance and decentralization it is difficult for national government to have a strong influence on the implementation of policies and the authors point out a possible conflict between national equality and local need (Jansson, et al., 2011).

2.2.8 Implementing the Public Health Act in Norway

Tallarek n e Grimm, Helgesen and Fosse (2013) conducted a study based on expert interviews at a national level, document analysis and questioners sent to municipalities in 2011, before the Public Health Act was adopted. The study points out that there is a divide between national and municipal public health strategies. The research indicates that municipalities focus on a life-style and health-care related measure, and only a few municipalities acknowledges the social determinants of health. Tallarek n e Grimm, Helgesen and Fosse (2013) advocates for further research illuminating the gap between the national and municipal approaches and focusing on challenges and success factors faced at a local level. In a multilevel governance system the willingness, policy understanding and sufficient and appropriate resources at a local level is imperative for successful implementation of national guidelines (Van Meter & Van Horn, 1975). Therefore to understand whether the core principles of the Public Health Act are implemented in Norway it is essential to seek knowledge from the municipal level.

This study seeks to investigate the implementation of the Public Health Act at a municipal level. Research suggests that municipalities experienced some hindrances at a local level, already before the implementation of the act. T nnessen (2011) described that implementing the political aspirations of the Cooperation Reform, which the Public Health Act is a part of, was obstructed by municipal priorities. The Cooperation Reform has brought with it challenges connected to prioritization and responsibilities and the political and administrative leaders play a key role in making the investments needed (Kassah, et al., 2014). Lorentsen and colleagues (2014) describe that the public health aspect of the reform is underrepresented in the debate and in

municipalities there are concerns about the financial aspect, especially connected to public health. The Coordination Reform is regarded as an attempt to bridge the fragmented government, but Lorentsen, et al. (2014) emphasize that collaborating in the municipalities will be challenging.

In Norway there are 428 different municipalities and as the local autonomy is strong, there are a myriad of different ways of working with public health. This study seeks to understand how local governments implement the key aspects of the Public Health Act. The study is based on a determinants perspective and the social gradient, which includes a focus on SIH and HiAP. The next chapter describes the research methodology used to investigate the themes of the study.

3. Research methodology

3.1 Study design

The goal of this study is to understand how municipalities are addressing the responsibilities proposed by the Public Health Act especially connected to SIH. This type of inquisitive questioning is closely linked to the qualitative tradition. Creswell (2009) highlight that “*Qualitative research is a means for exploring and understanding the meaning individuals ascribe to a social or human problem*” (p. 4). The study had a case study design as the goal is to understand a real-life phenomenon in depth (Yin, 2009). The study was organized as a qualitative case study of a Norwegian municipality with interviews and document analysis as sources of evidence.

3.2 Participants and sampling strategy

The municipality, at the centre of the case study, was selected on basis of some criteria. In Norway there are 428 municipalities (Kartverket, 2013). Yin (2009) points out if there are several candidates appropriate for the case study it would be fruitful to choose the case that would yield the best data. Therefore the municipality was recruited on the basis of their experiences with addressing SIH and other health promoting initiatives. This was to ensure that the municipality have had experience with interventions and plans to maximize the learning experience. Yin (2009) also argues that the availability and the accessibility to information should enter into consideration. When selecting a municipality, the possibility of a being aided by gatekeepers was included.

The participants of the study included employees at the municipalities' overall political and administrative level. This included the Mayor and Chief Municipal Executive. Also the leaders of the different sectors were recruited: health and care sector, culture and communication sector, school and upbringing sector, and plan and technical sector. In addition to the leaders two more participants were chosen due to their connections to public health work in the municipality. The selection of the participants was aided by a gatekeeper, the previous Public Health Coordinator, as she had experience and knowledge as to who was important in the work. She sent out an email on the researchers behalf to the intended participants. After the Chief Municipal Executive had agreed on behalf of the municipality, the researcher assumed direct contact with the participants to organize the interviews. The Public Health Coordinator was new to the job and did not have the possibility to be a part of the study. The interviews involved 8 participants after an agreement with the respective municipality and the individual participant.

3.3 Methods of data collection

3.3.1 Interview

Green and Thorogood (2009) describe interviews as “*a conversation that is directed, more or less, towards the researcher’s particular needs for data*” (p. 94). Within the field of qualitative health research, the form called semi-structured interview is frequently used. The researcher sets the agenda for the interview, but there is also room for probing- and follow up questions in this semi-structured form (Green & Thorogood, 2009). The interviews were organized as a semi-structured face to face interview. During the interview the

participants produced data that consists of personal accounts of the world. It is important to note that it is not direct representations of that world (Green & Thorogood, 2009). Although the aim of the study involved investigating a municipality's action on SIH, it is not empirical evidence on what they will in fact do.

The interviews were can be described as 'expert interviews, where the participants possess specific knowledge regarding the topic. These interviews took place in October 2013 and were held in Norwegian, transcribed, analysed and then translated into English. The interviews were carried out in the participants' offices and lasted about one hour each. The interviews were also audio-recorded to assist in the transcribing of the material. During the interview some notes were taken to describe the non-audio perceptions that were relevant for the study. The interviews followed a structured interview guide facilitating a semi-structured interview situation (See Appendix I: Interview Guide). The interview guide was tested in a pilot test before the interviews are carried out to optimize the interview guide. The participant in the pilot test was a previous Public Health Coordinator in a neighbouring municipality to add to the authenticity.

3.3.2 Document analysis

Local plan and policy documents were treated as a data source in its own right in a document analysis. They were analysed as they would give insight as to how public health was addressed from a municipal level and could be used to triangulate the information provided from the interviews.

Using existing documents as a source of information is frequent in qualitative studies (Green & Thorogood, 2009). The abundance, availability and credibility of public documents are incentives to use such data. The unobtrusive nature of acquiring the data and the possibility of the documents being available for repeated analysis are also strengths associated with document analysis (Yin, 2009). There are also limitations connected to using existing data. Green and Thorogood (2009) consider the lack of information about the production of the document as a drawback. In connection with the production of policy process documents there are often debates, and there is little information on what led to the policy or the roles of different groups or individuals in its formation (Green & Thorogood, 2009).

The documents included in the document analysis were local public documents concerning policies, plans and actions addressing the thematic of social inequities in health. The document analysis was not a traditional text analysis, but rather a content analysis. The analysis included documents explicitly or implicitly aimed at social determinants of health, documents aimed at disadvantaged groups and other formal documents which are available through the internet. In this context it is the strategies and values reflected in the documents which were of interest. The local municipal plans represent what a municipality wants, more than concrete results.

3.4 Data management plan

The gathered audio data from the interviews were manually transcribed using office software. Notes which were taken during the interview were considered separately. The records and notes were securely stored on the computer during

the work period, where the researcher is the only one with access. After one year after its collection the gathered data will be deleted.

3.5 Data Analysis

A type of qualitative analysis is the thematic analysis, where the recurring statements are organized into themes. Through transcribing and coding the data, the researcher gets closer to understanding what really the segment is about. Ritchie and Lewis (2003) describe an analysis method referred to as Thematic Framework Analysis. This method was developed in connections with applied policy research in the 1980's and has gained popularity among qualitative researchers (Ritchie & Lewis, 2003). The method is associated with having concepts developed before the analysis starts, either inspired from theoretical framework or research questions. The following steps of analysis include: familiarisation with the data, identifying thematic framework, indexing, charting, mapping and interpretation (Ritchie & Lewis, 2003). The data has a hierarchal structure developed in a transparent way, which allow the analyst to move between different 'levels' without losing sight of data. The analysis of the interviews was inspired by this approach and the interview guide topics served as a theoretical framework. Throughout this process it was necessary to contentiously revise thematic framework and construct new indexes. Although making sense of the data relies on the method or tool which is used when analysing the data, Ritchie and Lewis (2003) highlight the role of the analyst and the degree of rigour, clarity and creativity associated with the study. Therefore it is important to have a transparent work process where it is clear why choices were made as they were. The interviews organized into the computer program OpenCode 4.02 which aided in the indexing and mapping of the data.

After indexing the main themes which emerged were:

- Public health work in the municipality
- HiAP
- The Public Health Act
- SIH
- The Public Health Coordinator

3.6 Validity

Maxwell (2005) states that validity is a goal rather than a product and that it refers to the “...*correctness or credibility of a description, conclusion, explanation, interpretation, or other sort of account*“(p. 106). Efforts to strengthen the validity of the study included revising the codes in collaboration with the supervisor. Smith (2008) states that by revising the coding in collaboration with someone it is probable that the discussion will identify potential themes not yet discovered, and highlight clarifications or modifications of codes that will increase the consistency of the analysis.

The document analysis aided in assessing the credibility of the participants’ statements by comparing the findings from the different interviews with the local policy documents. This process can be labelled as triangulation of data (Smith, 2008). While different participants disclosed opposing views in the interview situation, this does not necessarily decrease the credibility of the statements, rather it adds on multiple views to be addressed in the analysis.

The participants were also given the opportunity validate their own contribution; this process is referred to as respondent validation (Maxwell,

2005). By having the participants revising quotes of their contribution, the room for misunderstandings diminishes, but as Maxwell (2005) remarks, *“participants’ feedback is no more inherently valid than their interview responses; both should be taken simply as evidence regarding the validity of your account”* (p. 111).

3.7 Reliability

Whether or not a study can be replicated and produce the same outcome, is referred to as the reliability of a study (Smith, 2008). In qualitative methodology reliability typically refers to whether or not the operations of a study, such as the data collection procedures, can be repeated, with the same result (Yin, 2009). It should be noted that although similar procedures are followed when replicating a study, similar conclusions aren't always drawn. The interviews done in connection with this study were done in Norwegian, and subsequently translated to English in writing up the final thesis. The translations were done with special considerations to the cultural and contextual meanings to ensure the reliability of the data.

3.8 Generalizability

Generalizability within the qualitative tradition refer to that the insight derived at from studying one context would prove useful in other contexts, and assist in the development of theory that can be extended to other cases (Maxwell, 2005; Smith, 2008; Yin, 2009). This project will investigate how one Norwegian municipality addresses the challenges of SIH. While this study might not be valid for other political and cultural contexts, the study's findings will contribute to further the understanding of how SIH is being addressed. The theoretical

approach utilized in this study could prove valuable for other research sites and therefore be relevant for research in similar contexts.

3.9 Role of researcher

Kvale and Brinkmann (2009) highlight the importance of a reflective and skilled interviewer as the knowledge is produced socially in the interaction between the interviewer and interviewee. The independence of the researcher is important to ensure the integrity of a study; therefore it has been important to be aware of the danger of being 'co-opted' especially by the participants. Throughout the research process it has been imperative to constantly reflect on the researcher 'self' and identify possible biases. Meetings with the supervisor and fellow students in research groups have facilitated the reflection of my role as researcher.

3.10 Ethical considerations

This study has followed Norwegian National Committee for Research Ethics in the Social Sciences and Humanities ("Forskningsetiske retningslinjer for samfunnsvitenskap, humaniora, juss og teologi," 2006). The ethical clearance of the Norwegian Social Science Data Services was given before the data collection started (See Appendix II: NSD approval). Following these institutions ethical guidance, informed consent from the participants was required. The municipality's identity is kept anonymous to ensure the confidentiality of the participants of the study.

Homan (1991) describe informed consent as the principle that participation of individuals in research should be based on voluntarism, and on a full understanding of what the implications of participation are. This includes

informing the participants about the purpose of the study and the involvement needed from the participants. It also includes giving the participants the right to refuse to answer any questions and to withdraw from the study at any time. The participant's confidentiality and anonymity will be aided by not disclosing information such as names or sex in any publication of the study. There can be a possible threat to anonymity because of the participants 'high ranking profiles' and the participants might be recognizable. The researcher has strived to exclude identifiable information in the thesis.

As another effort to ensure confidentiality and anonymity, the gathered data was securely stored on a password protected computer where only the researcher had access to the data. The data was then transcribed and analysed. One year after its collection the gathered data will be deleted. This is to ensure that the researcher has enough time to maximize the correctness of the interpretations and also allow time to possibly publicize an article. The participants were asked to sign an informed consent form which was written in Norwegian and included all the above mentioned measures to assure an ethical process. Before the interview began the participants were asked to read and sign the document. The practical information regarding length of interview, location and contact persons at the University of Bergen was also disclosed in the informed consent form. (See Appendix III: Informed Consent Form)

3.11 Limitations

The present study takes form of a case study; to investigate how the national Public Health Act is adopted locally. Case studies have been criticized for a lack of objectivity and generate large amounts of data, since there is only a single

case being studied (Yin, 2009). Case study designs are ideal when the research object is complex, dynamic and impossible control as the design offers a systematic way of managing the data (Yin, 2009). By virtue the case study design is limited in its scope, and may hinder transferability, but as there are 428 municipalities in Norway and each of them have a unique way of working with public health, this study gives insight to how one works with the topic and enables readers to evaluate their own opportunities for generalization into other contexts.

The interviews reveal what the municipal leadership think and plan about public health, but it is not empirical evidence for what they in fact do. Therefore it has been important to evaluate the municipal plans, which offers a possibility to triangulate the data. Although the municipal plans and the interviews harmonize, it is still not guaranteed that the plans will translate into action. To investigate closer what is actually being prioritized in the different municipalities conducting economic analysis of the municipal budget might be relevant.

4. Case study

This section includes a description of the municipality at the centre of the case study and the results from the document analysis and the interviews. The results from the document analysis are presented in connections to each plan. Finally the results from the interviews are presented in connections with the central themes following the analysis.

4.1 Description of the municipality

The municipality has a population of 4200 and is as a medium size municipality when it comes to population. The municipality can be described as a traditional industrial municipality, characterized by a strong unionization and the labour party being in majority in municipal council ever since the Second World War. During the 10-15 years the industry has been downsizing and a bankruptcy struck the municipality which led to a historically high unemployment rate 6% in 2009. By 2012 it has reduced to 1,6% where 30% of the workforce is employed in the industrial sector. The municipality inhabitants have a less educated population than the county and country average. This can be explained by the historical need for workforce in the industrial sector. In the period 2000-2010 the municipality has lost 10% of their population and relocating of youths (ages 20-39) is most prevalent cause. This population decrease coinciding with an aging population will influence the workforce in the coming years. The population decrease represents a challenge many municipalities in the county experience.

The municipality has for a long time been organized as a “Safe Community” in WHO Safe Communities network. This status indicates that

there has been goal oriented and systematic with preventing injuries and accidents following 6 “rules” set forth by the WHO.

4.2 Document analysis

These documents are analysed in connections to the terms connected to the Public Health Act such as the social determinants of health, reduction of SIH and HiAP operationalized through intersectoral collaboration. These documents are essential for understanding the political priorities of the municipality and together with the interviews will provide an insight as to how these terms are worked with at a municipal level.

Report for the public health work in the county of the municipality 2011 – 2012

In a report concerning public health on a county level the municipality report reduction of SIH, drugs- and tobacco, nutrition and physical activity and accidents and injuries as priorities. The list of actions done in the municipality reflects these priorities. Most of the following actions done by the municipality are connected to nutrition and physical education, exemplified by actions such as all kindergartens are organized in a program promoting eating more fish and having a program promoting water as a beverage for children. Some of the actions are connected to accidents and injuries, and drugs and tobacco, such as providing the elderly with sand to prevent slipping on the ice. Fewer actions are associated with reduction of SIH. This may be the case due to reduction of SIH is complex and actions directed at the other priority areas are more well-known.

Municipal plan for sport and physical education 2008-12

The municipal plan for sport and physical activity includes a central goal is to include everyone in activities, and this is seen as a common responsibility for the municipality, organizations and the individual inhabitant.

The plan was written in 2007 and have since then been subjected to very few changes. Among others documents, which have inspired the plans, is the White Paper nr 16 “Prescription for a healthier Norway”. This White paper makes no explicit reference to population wide health gradient, but rather focuses on vulnerable groups. Also the White paper makes no reference to the determinants of health. The municipal plans contrast somewhat the White paper as in the municipal plans the determinants of health are somewhat addressed, and there is little focus on vulnerable groups, but rather the plan is preoccupied by including everyone.

The trend that children are more in intuitions like kindergartens and SFO¹ is described in the plans; where these structures are seen as possible settings for influencing children to do physical activity. The plan further argues that physical activity is very important for public health. By acknowledging that structures around the individual have an effect on people’s health it can be argued that the municipality shows signs which compares with the social determinants of health model. This becomes clearer in the plan when it is stated *“In a public health perspective it is crucial that one plans so that everyone should be able to be active and use the nature from their own conditions.”*(p.13) In other words; through action from the municipality it is possible to create an environment where more people can participate. Throughout the plan there are few strategies oriented at only disadvantaged groups.

¹ After school programme

In the plan the social economic variables are seen in relation to different levels of physical activity, but they do not go further in describing this since the differences are not as big. The equipment package is described as a preventative measure as it has, according to the plan, made it easier to offer activities.

Social element of the municipal master plan 2013-2026

This plan involves long-term challenges, goals and strategies for the municipal society as a whole and the municipality as an organization. It gives guidelines on how the goals and strategies are to be worked with. The Public Health Act is mentioned as an overall framework for the plan and is introduced with a particular focus on equalize the social inequities in health. Two white papers associated with public health are also mentioned as an overall framework. This is White paper nr 16 “*prescription for a healthier Norway*” and White paper nr 20 “*National strategy to reduce social inequalities in health*”. White paper nr 20 establishes health equity as a central political goal, which is to be reached through an equal distribution of factors promoting health. Moreover, the necessity of intersectoral communication in promoting health is clearly stressed. (Grimm, 2012)

The plan itself adheres to the ideas presented in the White paper nr 20 by stating that public health is a key strategy to reach the goal for making the municipality an including society. The municipality has chosen some areas with special priority for the public health work, these are: Reduction of SIH, physical activity, nutrition, tobacco, drugs and preventative measures to reduce injuries. The notion of reducing the gap in health connected to social class is also prevalent when it is written that: “*Through being a local promoter for a*

including society, one shall make sure equal possibilities and rights are provided, both in work and spare time, for all inhabitants. Without regard to gender (sex), age, ethnicity, level of abilities and sexual orientation, religion and ev. Social belonging. (p. 19, own translation)”

This goal is going to be reached by working with promoting good cooperation between the sectors in the municipality. The connections to the Public Health Act is clear as reduction of SIH is high on the agenda and is to reduce by intersectoral work which is connected to the principle of HiAP. Another measure mentioned in connection to promoting good public health is to involve and collaborate with schools, volunteers, communities and work life; this could allude to the fact that they recognize the social determinants of health and see these as influential on public health.

One interesting find is that the municipality highlights health impact assessment among six overall goals: *“The municipality should be a good and safe place to live for every one of the municipalities inhabitants. In decisions, which are of importance for the inhabitants, the health impacts and health consequences should be considered”* (p. 14, own translation). Although it is mentioned here, the participants interviewed stated they had not heard of such a consequence analysis being done. This discrepancy between plans and what is said can be a symptom of plans not corresponding with actions.

The municipal plan all in all, shows that the municipality plan correlates with the Public Health Act and acknowledges the social determinants, seeks to promote health and prioritizes the reduction of SIH. Although the plan is approved by all the different sectors and been through a thorough resolution-

process it is interesting to see how much of the plan resonates with the municipal leadership.

4.3 Interviews analysis

In the quotations the name of the municipality, reference to the county it is in and the participants' names have been removed. In some sections of text it is relevant to disclose the participants' work title. This analysis describes the participants' perceptions to the following points:

- Public health work in the municipality
- HiAP
- The Public Health Act
- SIH
- The Public Health Coordinator

4.3.1 Public health work in the municipality

Perceptions on public health

The participants expressed a broad understanding of public health by highlighting that the different sectors and services of the municipality are important for good public health. This contradicts the notion that public health is owned by the health sector. The participants mention a broad spectre of the municipalities' services such as schools, kindergartens, culture activities, and work as components important to create good public health.

“It embraces most things, if we have a good cultural events, then I think that it stimulates for good public health, if we have good welfare services [...] good

kindergarten coverage, good schools, and with quality in this I think it will be good in a public health perspective.”

“Public health is about people having a good life and good health [...] if people lose their jobs; I definitely think it affects public health. Definitely because it is about having a predictable economy which means you can send your kids to camp and activities which costs money and so on. So everything is connected if you use the public health perspective [...].”

When discussing public health it became clear that well-being plays an important role on the perception of health. The traditional view of absence of disease is not represented, as the participants highlight well-being and stating that health is much more than absence of health.

“Well I think that everything people do which has a positive effect on people’s spare time and work, with regard to mental health and so on, well-being, if it is in your spare time or at work, I think it is all public health. When we arrange activities for youths, and trips then it is public health.”

“[...] it means the health status of a population and not first and foremost the diseases in the population, but about the well-being, and how people are doing.”

“[...] I have always been interested in this kind of work, and I believe health is much more than the absence of disease, but how health is distributed in the population.”

One participant expressed the importance of public health work by highlighting the need for a preventive focus and the need for resources directed to the work.

“Public health is consistently throughout our society, so we can’t just stand on the ledge trying to save most we can, we have to work further in and work with prevention! I think it is essential, because if we only do lifesaving I think we will have a problem. I really believe we have to afford and work with public health [...].”

The participants explain that they have a focus on public health due to several factors. Stable government in a classic industrial society, extra income to the municipality through energy income and a tradition from being organized as a Safe Community is mentioned as success factors for their work with public health.

“We have many millions yearly from energy income, and all this is used to provide services for the inhabitants best.”

“The municipal society is built on a stable government, with labour party ruling since the war; it is almost unthinkable with another government. I won’t say that it can never happen, but it is about fundamental things which have been in connections with the industry, where everyone is the same. Very few have managerial positions...”

Policy and plans involving public health

Mapping the views of the municipality is essential as it gives an impression as to how the municipality works with public health. The plan documents are an expression of what the municipality will work with and through the understanding public health’s place in the plans we come closer to understand how public health is worked with. When asked how public health was anchored in the municipality overall plans the participant’s views differed. One

participant expressed that public health was a central part of the plan structure, and had been for a long time, while other argued that traditionally public health did not have a central role in the plan documents, while recently things had changed and now public health was more integrated. It was also pointed out that the public health was mentioned in overall plans, but not that there was any clear strategy in working with it. This can reflect a symptom of plans not translating into action and it not being regarded as a priority for the municipality.

“Public health has been a project which have been prioritized in the municipal plans and in the municipalities’ priorities, actually for a long time”

“[...] it is present in overarching municipal plans, but it is not expressed in the municipality that this is something one should work consciously with [...].”

“I think it has been somewhat difficult to work with, but I see that it is more integrated, I see a big difference from then and now. Public health is definitely represented in the social element of the municipal master plan. So I see there have been some pretty big changes, it was not like this before.”

In the Public Health Act it is stated that the municipality should have an overview of the population’s health in the municipality and also of the positive and negative factors which influence health. The participants report utilizing national data, regional statistics and municipality specific statistics. One participant highlights the importance of not only noting the statistics but also identifying the factors which affect health.

“[...] I think at least that it is important to use the statistics we have at hand. Numbers and statistics are important, but it is also important to know what

affects health and that is important to consider because we know quite a lot about the social factors and psychosocial factors, and try to facilitate for these factors. I think it's not just about the numbers."

A key component of the public health plan-process is the participation of the different stakeholder. One participant states that it is a goal to get as many of the stakeholders involved in the plan-process so that the plans are used and not stored away in a drawer. The participants point out that the plans are put through a hearing process where both the local business life and organizations can voice their opinions. The fact that the Public Health Coordinator is involved in the plan-process is seen as positive.

"[...] our plans are put to a hearing and got input from the different towns and organizations. We try to have a democratic process where we ask for input. The business sector has also contributed by having working groups."

"...The goal is to get the most contributors involved in the plan process so that it is not a plan which no one feels ownership towards. Plans which are made by hired consultants often get put in a drawer, we want a more participatory role locally when making plans and using the plans."

«The Public Health Coordinator is a part of the plan group for the municipality, so that is very positive. So the Public Health Coordinator has the possibility to effect the overarching plans."

Public health work in the municipality

The trend of public health gaining more recognition in society is also noted by the participants stating that previously it was not a topic but today it is more integrated in everything the municipality does.

“There has been an increasing focus on public health work in the period I have worked in the municipality. When I started in the 70’s it was not a concept, I have the impression that it is now more included in everything we in the municipality do, and I think that is very positive. I think it is an important work.”

“Public Health is definitely a part of the municipal plans, so I can see it has changed, it was not like this before.”

Many challenges are pointed out by the participants when working with public health. The low education and unemployment of the inhabitants are challenges mentioned which are connected with the municipality seeing a connection with the determinants of health.

“Jobs do not grow on trees and it is a challenge. And as an industry municipality we see that the education level compared to the county is lower...”

“[...] it is a challenge in a public health perspective that we have a population which have a lower education level compared to others.”

But the challenges most of the participants mention connected to public health work in the municipality is need for public health work to permeate through the organization and be a priority from top to bottom in the organization. The participants also mention the need for earmarked funds to reflect the priority of public health.

“The public health work needs to come down and out through the organization; we have a massive challenge with this. But we do not need more money to work with this.”

“[...] we need better coordination on the top level, so that people further down in the system knows what they should be working with and directed towards. I think the municipality has a challenge in giving input on this and guiding the work. I feel there is somewhat a lack of this in our municipality. It is somewhat random work which gets done, a more comprehensive policy would be better, where there was a focus.”

“I think it is well established in the organization, but to get further in the work, I think innovation and to raise the topic to the top in the organization and out through the sectors is needed in this work. A renewal in the work is needed since we have been doing this for so many years, we need to choose some roads, and then social inequities in health might be more important than the physical environment, which we have worked a lot with.”

“[...] I think we need more resources. I think the work demands more than a 50% position. This is more work [...] if we are to get better cross-sectorial collaboration and lifting the topic to a higher administration level I think we need earmarked funds. This requires more resources [...] more systematic work is needed. There has to be something more than words, the priorities in the plans has to be reflected in positions and economy. We all have to want it more, not just some; we have to be better at working with it, because the public is very aware of our role as public health municipality. So I think it should be more prioritized in the system.”

The participants request a more solid strategy on public health from top to bottom. A reason for why this hasn't been a clear strategy can be that it is not so visible if you don't do health promoting or preventing initiatives. While if you do not do other services it would be front-page news. The need for municipalities to document clearly might be a hindrance as health promotion is not as easy to measure. This need for documentation can be linked with the New Public Management style prevalent in society today.

“I think that although this is a ‘must’ work, still it’s not as if we didn’t do it it would be front page news, in many of our services we get exposed if we don’t do the services. [...] So in our daily run of things, we are more focused on the necessary cases and the prevention work gets less priority. It should not be this way, and some of us have to make sure this does not happen, but for many in the organization one would take more lightly the task which are concerned with prevention, and rather prioritize the tasks which are critical to services.”

“We have some indicators which are connected with public health [...] but it is hard to measure.”

“It is difficult to measure [...] fewer broken bones, fewer smokers, fewer which develop coronary heart disease, but is it really this easy to measure it [public health]? We should have some measurable indicators which are real. [...] the percentage of smokers in the municipality is a too vague indicator.”

When asked about whether the work directed at public health was a consequence of single enthusiasts or a more systematic initiative from the municipality the answers varied. The participants pointed out that enthusiasts do a lot of work but also it is now more an integral part of the municipal system.

“We have had a Public Health Coordinator for a long time, so this has been an organized work for many years. There has been a plan system to work out from, which the Public Health Coordinator has had the responsibility for, so I think a bit of both, there are plans which are followed up and reports being written so there is some systematic work as well.”

“It has been a lot of single enthusiasts, but I believe it has become more integrated in the system, at least in our municipality. But I believe one will always depend on single enthusiast in addition to the system.”

4.3.2 HIAP

In a municipality context HiAP can be operationalized as intersectoral collaboration as HiAP refers to seeking synergies to improve health. This includes cooperation both across sectors but also from top to bottom in the organization. Most of the participants reflect a view which correlates with a HiAP approach as the statements include that the responsibility of health should lie in all sectors and reflected throughout the organization.

“[...] you can't say that one sector has the responsibility alone, because it needs to permeate through the organization, everything from health to education, to technical, and the services we have in the municipality, the responsibilities can't be placed in one place, it needs to permeate the entire culture.”

“It means it (public health) should lie as a red thread in everything we do.”

These views correspond with the Public Health Act. However one participant views corresponds with the tendency that public health is owned or connected to the health sector and not the responsibility of all sectors

“So it is clear that money, people and organization should be organized with the goal of public health, but who has this as a goal? And I’m sure that the health sector has this in their papers. So I think that they have it, and we get included when they need it, but of course the meeting places may be too few.”

Although most participants describe the value of HiAP as important, all the participants express that the municipality has not reached their full potential when it comes to intersectoral work.

“[...] it is probably the most difficult job of the Chief Municipal Executive to get all the sectors to collaborate and see the big picture. Many times the Chief Municipal Executive has enough with the everyday tasks, and the people in the sector work with what they are measured by. [...] We have improved on this the last years.”

”I don’t think we are bad at it, but as with others, we get very sector focused and think about our own tasks, I’m sure we are not exploiting our full potential for team work and seeing the bigger picture.”

“We are maybe not as good to collaborate in the municipality, we sit in our own sector and the topics are not lifted to the level it is needed to make the right decisions, because it has to do with economy and so on. So we register that sometimes things get clogged in the system”.

“It works pretty good individually in each sector, but I miss a more comprehensive direction from the leaders to what direction we should be moving in.”

Some of the participants indicate that the intersectoral collaboration has increased, but still there is a way left to go.

“I think we could be better. But I do think things have changed, and it is definitively better than it used to be. But I think we should be even better, one never becomes good enough. But we definitively have better intersectoral understanding than we had for a couple of years ago.”

“I think we have improved, but there is still a long way to go. Still, the health sector owns the field of public health. We have a local collaboration group which started 2 years ago and meets every 6-7 week, the intention was for it to be an intersectoral group, but health is very central.”

It is important to note that HiAP does not only refer to intersectoral collaboration, but also collaboration between the different levels of the municipality. The participants highlight the need for more coordinated efforts from top to bottom in the organization.

“A more comprehensive strategy is needed, and that everyone works towards that goal, not just one sector leader, but that everyone has a common understanding which is reflected in the budget and in positions. We have many good initiatives in the municipality, but we are not as good in collaborating. We do a lot of good work in our own sectors.”

4.3.3 The Public Health Act

Some of the participants describe little knowledge of the content of a Public Health Act, and not all of the participants had heard about it. The ones who

know the act describe that the Public Health Act has brought with it a stronger focus on public health work in general and formalized the topic.

“It is clear that this public health perspective has been enhanced after this Act, much more so then before, and this is something we need to be aware of. And it is good that we have had a focus on public health perspective for many years, and we get a stronger focus since there is something new.”

“I think it is good that a new Public Health Act came. I’m not so sure there are many new responsibilities in it, I think the municipality has had this responsibility: it says in the Law of Health Services in the Municipality that there should be an overview of the health status in the municipality, but it has in a way become more evident in the new Act. [...]so I see it as the Act has made the field more evident and formalized, even though it was there before, some of it within the health sector. Also I think it is good that one has expanded the health terminology and that now one sees that many things other than absence of disease are really important for a population’s health.”

“[...] we have become more preoccupied with the commitments we have in accordance to the health prevention work. I think that those who have traditionally done the health prevention work, see their focus has been prioritized after the new Public Health Act. It has become more legitimate to spend the health money on the preventative work, rather than the curative, so we are turning the service a bit.”

Although the participants agree with the content and mission of the Public Health Act they describe that municipalities will struggle in keeping up with the

responsibilities connected with the law as there are no earmarked funds connected to the work.

“[...] I believe that the public health perspective and the Public Health Act is sensible, I won't underestimate that, but there are many municipalities which will marginally be able to fulfil it as there is no finance which accompanies the Act. [...] Public Health should be included, but there are no measurable indicators, as there is within the curative service, if we don't do work within the curative service it will very rapidly become very evident.”

“I don't think people out in the municipalities care or think that much about the Act, I don't think so. It is a minority of municipalities which sees the use of this work in a societal perspective. [...] in the long term good public health work have good effects, but the people initiating this have to save money somewhere in the stream of expenses. I think there is elite which can prioritise this work, a narrow group. I'm not sure municipalities care, of course they understand that it is important in the long run, but I don't think it something which is under many people's skin.”

“I think there should be more earmarked funds for this work from the state when they pass a law which imposes more work on the municipality, because people are often in combination positions and resources are scarce. Sometimes we get extra finance connected to positions connected to substance abuse, so why not a Public Health Coordinator position? [...] I believe we need more subsidies from the state which are earmarked; this cannot go into the municipality drain.”

While discussing the Public Health Act many participants described the governance system and describing a misrepresentation between the national expectations and the local reality.

“It is of course a challenge, and perhaps our times big challenge the disempowering feeling one feel’s locally and the national perspective. I understand that the Stortinget² needs to impose things and that they have to make someone responsible. What usually happens is that there are some earmarked funds which come with a new project becomes a part of the total municipality expenses. [...] When the economy is tight and people are, for example seniors, are forced to move home against their will from an institution or are put in a double room against their will, profiled politicians will say that they don’t have the detail knowledge, but that it is up to the single municipality to run a sensible health service and they will refer to that they have done their part by creating a law. It’s a long line of thought, but often there is not a correlation between expectations and the amount of funds transferred, and the demands they ask of us.”

4.3.4 SIH

The participants report that there is a correlation between socioeconomic group one belongs to in the society and health in the municipality.

“[...] I believe we have to be very aware that there are differences and even I a society like ours there are people of all social classes and we have poor people in our municipality who falls out of the society. In many circumstances we see that children of those who are not as well off and perhaps have parents with a

² Stortinget is the Norwegian Parliament.

*low degree of education, we see that their kids refrain from organized activity
[...] It is connected with economy, because it is expensive to have active
children.”*

*“[...] if you have a bad economy or a low education, nutrition, the possibility to
partake in activities is hindered as it costs money, and the differences are
increasing [...]”.*

*“It means that the socio-economic group one belongs to have a connection with
the health status in a population, we see there are differences. This is something
one knows and sees, and unfortunately these differences have increased in
Norway, and our policy and governance are kind of ideal for us to have equal
opportunities and still we see the inequities increasing.”*

The participants state that it is the responsibility of the municipality to provide the inhabitants with equal possibilities. One participant describes an equipment package which is the municipality's property, but for inhabitants to ensure that everyone has the possibility to participate in sporting activities.

*“I think that the municipality has a principle which is in our plans that one
should not pay for children's and youth's sporting activities, they should not
have to pay rent for sporting facilities and so on. It is things like that which I
believe can aid in providing everyone with the possibility to partake.”*

*“In around the year 2002 we established the equipment package for outdoor
activities. Where one can borrow for free equipment, the idea behind this was
the social inequities in economy, and the fact that not everyone can afford
equipment. This is what I think of when you ask about social inequities, those
who can partake and those who can't. [...] We experience that there is some*

social inequities. [...] One year when there was ice on a local pond, we provided children with skates, and then we could see that some had perfect equipment, but there are in fact children who don't have it, and can only dream of owning their own pair of skates or other things like skis."

"The equipment package is a part of this; there everyone has the possibility to borrow equipment, like tents, sleeping bags and everything, so it should not depend on the lack of equipment for children who want to partake, and I think that is a concrete example of the municipality working with this."

One member of the municipal leadership describes an alternative view, stating that it is not the responsibility of the municipality to reduce the inequities in health. This can correspond with a more liberal view of health where inequalities in health are seen as an unfortunate side-effect of free choice. Or it can represent that the municipality is limited in its scope of action and will not be able to effectively reduce the inequalities.

"Interviewee: Do you believe it is the municipality's responsibility to level these social inequities in health?"

Participant: No I don't believe so. I think that regardless of what the municipality does the inequities in health will persist."

When asked about efforts initiated by the municipality which address SIH, two participants mentioned efforts against parents taking their children out of kindergarten as a consequence of a local bankruptcy which left many parents without work. By removing the fee of kindergarten for the affected families all the children kept their places in the kindergartens. This effort can be described as proportionate universalism as it provides relief for the affected families and also

is a benefit for the others. One participant supports this view stating that the kindergarten fee is harder on some families and by removing the obstacle of economy it aided in reducing the social inequities.

“The bankruptcy came; I discussed it with the Chief Municipal Executive saying that now we will have a rush of people taking their children out of kindergarten because they won’t be able to afford it. And then the municipality made efforts so that we were able to secure that everyone could keep their children in the kindergarten. So that rush of parents did not come, but we got requests pretty much instantly, but the municipality made it unnecessary for people to take their children out of kindergarten. [...] This was a good effort also seen in a public health perspective.”

“The fact that we didn’t problematize economy, we were aware of this and there were no public debate about it. The Chief Municipal Executive and the Mayor agreed with the effort and understood that there would be a deficiency on the budget. There was no conflicts connected to this [...] this was done do to having some social antennas in the system and leaders which saw it as a little problem financially, but an important effort for people self-worth. Those parents who would have to take their children out would become very visible and that does something with their self-respect. It would be a loss for the children because their parents’ situation was so radically changed”.

“I perceived it as an effort which may level the social inequities, because the kindergarten fee is harder for some than others, I’m sure.”

Traditionally efforts of reducing SIH are directed at only the disadvantaged groups. Some of the participants, on the other hand, report that the efforts locally are aimed at the entire population.

“I think it is invisible work, for example with the equipment package, we don’t direct it to particular youths, but rather at everyone. We experience that many kids which have more access to resources also uses the equipment, I hope that we could become more included in the work of integrating refugees.”

“[...] having an offer which is there, first and foremost for everyone. It is not first and foremost for the disadvantaged groups, but I believe that some of our offers should be directed at disadvantaged groups. But I believe it is valuable to reach everyone.”

The municipality has describes the priority of working with social inequities in health in relation to being a labour party municipality and that this is a conscious policy. One participant states that the fees should not be discriminating and people should have a possibility to participate even if they can’t afford it.

“You asked about social inequities, well, we are a labour party municipality so that has always permeated our policy and social inequities in health are not very welcome in our society. So that has influenced our policies and the way we work Not only that we are a labour party municipality, but also that we have had the majority for many, many years, [...] It reveals itself in the way we set fees, that it should not be discriminating, you should pay equally.

“[...] this is a conscious policy, because nothing develops without someone wanting it, but if its health promotion or whatever which have been the reasons

for doing it this way, I don't know, but as I said previously, you should have the possibility even if you can't afford it."

When asked about what is needed to work more effectively with reducing the social inequities in health many of the participants stated that there is a need for more cross-sectorial work. Although the finance situation is tough in the municipalities, the participants claimed that more understanding and intersectoral work is the key.

"If we were, or can become better at working across the sectors, across disciplines this would likely level social inequities, as I see it. There we have a massive challenge."

"It is important with more understanding between the different sectors when we plan things and lay out a budget, even though we are a small municipality, we see that also in small municipalities that there are inequities in health and to realize that. Let alone in the planning work this is very important."

"Interviewee: So you believe that the most important effort the municipality could do is intersectoral work and understanding?"

Participant: Yes, I believe so.

Interviewee: What about more money?"

Participant: Well, it could be, but I often believe that it is just as much about how we prioritize the money because one can't always ask for more money. I'm sure it would help, but I believe it is also about seeing how we spend the money."

4.3.5 Public Health Coordinator

All the participants mentioned the Public Health Coordinator when asked which resources the municipality aimed at public health work. The coordinators role proved to be an essential part of the public health work. The Public Health Coordinator is organized as 50% of full time employment. Previously this position has been done in combination both as the Public Health Nurse and as a SLT-coordinator³ (which is also 50%). And previously the Chief Municipal Executive was the closest leader to the Public Health Coordinator. When the position was in combination with the SLT-coordinator position the positions were organized under the department of culture and communication, now the position of Public Health Coordinator is organized to the health and care department and has the Public Health Nurse as closest leader, but rapports to the Chief Municipal Executive. The placement of the Public Health Coordinator in the organization is relevant as the coordinator should be on an overall level; it is problematic sitting in a sector as the position should be promoting cross-sectorial work. One participant expresses the need for an active Public Health Coordinator.

“[...] like the Public Health Coordinator, hanging above us like a bell, reminding us that we should have a public health perspective in everything we do.”

In the municipality there had been one Public Health Coordinator for many years, who laid the foundations for the public health work being done by a new Public Health Coordinator now. Some of the participant’s problematizes the fact that the position has been 50% in a combination position. And describe that two 50% positions is more work than one in a 100%.

³ SLT-coordinator is a person responsible for the intersectoral collaboration to prevent crime locally.

“Yes it’s of course a challenge to have two jobs; it is often more than one job so that can be challenge on its own.”

“To have a 50% combination position is a bit difficult, because the person has so many tasks. [...] now the position is 50% not in combination with anything. In a way I think that is the best, that it is not in combination, but it should be a 100% position.”

When asked where the Public Health Coordinator should be placed in the organization the participants state that it is more important that the person can lift the work to a leader level, than the explicitly where the person sits.

“I don’t really have any strong opinions about where it should be placed. It is important that it is cross-sectorial, and that the person who has the position can include everyone, maybe the position should be placed directly under the Chief Municipal Executive, between all the sectors, that could be a thought [...] the most important is that it works, and it is lifted to a leadership level.”

One participant disagrees in principle for the position placement of today but that the reason for this restructuring is that the new coordinator can learn from the previous coordinator, which has the role of Public Health Nurse. The participants problematizes that the coordinator is placed in the health sector and it is easy for public health work to become solely a health sector matter.

“Previously the Public Health Coordinator had the Chief Municipal Executive as the closest leader. Now there has been a restructuring with the Public Health nurse as the closest leader. In principle I disagree with it, because I believe it should be the Chief Municipal Executive which should be the closest leader,

because this position should include the entire municipality. But the way it is now, it is located in the health sector, and organized with the Public Health Nurse as the closest leader.”

“It is easy that it becomes a health matter in a way, but the intent behind the restructuring was that it is a difficult job, and it is important for the new coordinator to get advice from the previous Public Health Coordinator. But ideally the Public Health Coordinator should report to the Chief Municipal Executive. In our system in a way the Public Health Coordinator reports to the Chief Municipal Executive, but in the practical everyday life it is not the Chief Municipal Executive which is the closest leader.”

The Chief Municipal Executive points out that the Public Health Coordinator does not have to be located in his staff, because if the needs are there it is possible to meet. The Chief Municipal Executive further argues although many believe it is better reporting to the top, it does not mean you are attended to; however, when the need arises, it is important to be available.

“We have a practical approach to the organization. Some will say that the public health work should be directly located under the Chief Municipal Executive because it should be intersectoral, I don’t see the problem in the Public Health Coordinator having a base in the health sector, then it is up to us to include the Public Health Coordinator and for that person to contribute, it is not like the person can’t meet us or others if there is a need.”

“Everyone thinks in a municipality, and probably elsewhere, that if you report to the top that is the only thing which works, but the problem is that my tasks are so varied that no one gets attended as bad the people who report to the top,

because I'm everywhere. So if you need counselling then you need to go a bit further down in the system. That's why I don't think it's a good idea to have a flat organizational structure, that means you only get little attention, but if you go a bit further down, there are people who can guide you in the daily life [...] But you should of course have the possibility when the need is there, to report cases and participate."

One participant states that the Public Health Coordinator was relocated from the Chief Municipal Executive staff as a result of a feeling of loneliness. By relocating the coordinator to the health sector there were more discussion partners and a sense of belonging. The participant states that coordinator is organized under the Chief Municipal Executive but is locally seated in the health sector. The participants show an understanding for the importance of a Public Health Coordinator being on an overall level in the organization. One participant problematizes the fact that the coordinator actually sits in a service area of the health station stating that it is easy to get lost in a sector.

"What happened was that we had the Public Health Coordinator physically placed in the City Hall, and then the coordinator experienced it as a lonely role. One felt that there was no discussion partner and sense of belongingness. It was difficult to get people along with initiatives, and people in the other sectors didn't speak as much about health. So this time we have organized the Public Health Coordinator under the Chief Municipal Executive, but is physically placed in the health sector, more accurate in the health station, which works with prevention, and we thought the leader of the health station who was previously the Public Health Coordinator and a very experienced Public Health Nurse could aid the new coordinator with counselling and advice in an initial

phase. And then we can see how it goes. Because we were pretty sure that having a new Public Health Coordinator outside the Chief Municipal Executive was not very good.”

“I believe if there should be a Public Health Coordinator in a municipality, it should not be a part of the staff in a service area of health and care. The Public Health Coordinator should be a part of technical planning and building for example. The Public Health Coordinator should be a part on every level. Of course the Public Health Coordinator has to prioritize some of its resources, but to an extent be present and available for everyone. It is very easy to disappear in the health sector.”

4.3.6 Summary of findings

The main findings include that the municipality seems to have an implicit focus on the determinants of health. This implicit focus can be associated with the social democratic state tradition of the municipality. The municipality also seem to promote proportionate universal strategies, which can reflect an implicit understanding of the gradient. These proportionate universal strategies are however not expressed as explicitly connected to public health. The interviews suggest that the municipality is not fulfilling its potential in intersectoral collaboration. The implication of this is the HiAP principle is not fully practiced. An expression of this can be the placement of the Public Health Coordinator which is not organized in the Chief Municipal Executive’s staff. The findings will be discussed in depth in the following chapter.

5. Discussion

This chapter seeks to highlight and discuss the main findings of the document analysis and the interviews. The content is structured after the themes of the findings. The first section presents the municipality's perception on public health and discusses this in combination with the history of the municipality. The second section describes how the municipality has anchored public health and health promotion in the municipal plans. The third section highlights some of the challenges local government experience when working with public health. In the fourth section the municipality's experience with the principle of HiAP and intersectoral collaboration is investigated. This leads to the fifth section which describes the role of the Public Health Coordinator. The sixth section describes the municipality's initiatives for addressing SIH, and compares them to the theories presented in Chapter 2. In section seven the tension between the municipality's reality and the national expectancies is discussed. In section eight a short summary of the discussion is presented.

5.1 The local government's view on public health

The findings indicate that both the municipal plans and the interviews correspond with a view of public health and health promotion which is connected to the social determinants of health. The participants highlight a broad spectre of the municipalities' services as important for good public health. Although this research consists of the perceptions in one municipality, the findings somewhat contradict the research done by Helgesen and Hofstad (2012) which state that health promotion work in municipalities is mainly health oriented, and not oriented at the determinants of health. Further the municipality

emphasizes that well-being plays an important role with regard to public health. This can correspond with the municipality moving away from the traditional view of health connected to absence of disease, and moving towards a more health promoting view of health. The value of prevention of disease is strongly pointed out by a participant. In a review of municipalities' impression of the Coalition Reform, to which the Public Health Act is connected, the municipalities express a clear desire to work with prevention and an increasing commitment to preventative efforts (Abelsen, Ringholm, Emus, & Aanesen, 2012). The findings from the present study harmonize with the general trend of stronger focus on prevention and health promotion.

The municipality leadership attributes their focus on public health to stable government, history of being a classic industrial society, some free assets and being organized as a Safe Community. By being organized as a both the Safe Community and the partnership agreement with the county, the municipality has had years of experience with health promotion work, before the Act came into action. The partnership agreement is a governance-partnership which is a committed collaboration between independent parties in a negotiated setting of shared interest (Ouff et al., 2010). In an evaluation of the partnership agreement the municipalities experienced among other things; an increase in competence, more intersectoral collaboration, better collaboration between the levels of government and an increase in the number of practical public health initiatives (Ouff, et al., 2010). Research indicates that successful implementation of public policy depends on serious commitment, occupying a position of power and professional expertise (Guldbrandsson, Bremberg, & Back, 2005; Sabatier & Mazmanian, 1979). It is therefore likely that the knowledge and experiences

from being a Safe Community and the partnership with the county will aid the implementation of the Public Health Act in the municipality.

The history of the municipality is essential for the development of public health policies. Industrial societies are typically trademarked by strong unionization, few leaders, low education and a strong presence of the labour party. Within the labour party the notion of universal distribution is an ideological principle. Raphael (2014) reviewed health promotion in modern welfare states such as Sweden, Finland and Norway. Raphael (2014) describes the Nordic states as leaders in developing health promoting public policies, due to similarities between the Nordic concept of welfare state and the key principles of health promotion. The Nordic social democratic tradition is connected with reducing social inequalities and providing citizens with the means to reach their full human potential (Raphael, 2014). Fosse (2008) states that the experiences in Norway illustrates that universal welfare measures such as income adequacy and provision of social security are more important than specific contributions from the health sector to promote health and reduce social inequalities in health. Fosse (2012) remarks that the main advocate for a universal welfare state was the labour movement, especially after the Second World War, when development of the welfare state became a main political project. As the political leadership of the municipality in the present study is strongly influenced by the labour party with a firm focus on universalism, the efforts administrated by the municipality are thought to be connected to the key aspects of health promotion. It is worth noticing that although the labour party has played a significant role in this municipality, the notion of supporting the Norwegian welfare state model is somewhat bipartisan. Fosse (2012) remarks that there is broad support across

political parties for the Norwegian welfare state model. Dahl, et al. (2014) describe the social inequities in health as a cross-party concern that should be reduced; there are however divergent views on the means of addressing it.

5.2 Public health in the municipal plans

The plan documents are important steering mechanisms for the municipalities. The plan documents are an expression of what the municipalities' goals are and describe strategies on how to reach them ("Lov om planlegging og byggesaksbehandling," 2008). The municipal plan of the social element from the case study expresses an acknowledgement of the social determinants of health, seeks to promote health and prioritizes reducing the SIH. This description harmonizes nicely with the key aspects of the Public Health Act. Although the plan is approved by all the different sectors and has been through a thorough resolution-process, there are some indications that the principles of the plan are not equally visible in the participant's statements. This will be discussed closer in the section connected to HiAP and intersectoral collaboration.

While some participants stated that public health was anchored in the plans, and had been for quite some time, others remarked that this was a new development. One participant reflected that the public health was mentioned in the overall plans, but there was no clear strategy describing how to work with it. Van Meter and Van Horn (1975) describe that when municipalities are expected to solve problems without clear guidelines or incentives, policy implementation becomes problematic and conflict-ridden. Findings from Abelsen and colleagues (2012) indicate that the informants from the municipalities find working with public health difficult, and feel a sense of bewilderment as to which efforts

would be effective. The Public Health Act calls for public health to be integrated in the municipal plans. Integrating major goals, which are perceived to be non-specific or unclear, is problematic as there is a risk of the goals being integrated solely on a symbolic level, which entails a formal adoption, but only with a superficial finish (Fosse & Røiseland, 2002; Jansson, et al., 2011).

Several of the participants' statements in the present study point to the trend of public health gaining more recognition in society in general and that previously it was not a topic but today it is more integrated in everything the municipality does. Abelsen, et al, (2012) findings reflect a similar view as public health and prevention is something which has been prioritized for years and is something the municipal leadership express a desire to work with. Abelsen and colleagues (2012) reflect that this indicates that the municipalities' work is not subdued by governmental control mechanisms and the Public Health Act acts as an instigator for a development which is desired and have existed for years in the municipalities. This alludes to the notion that the Public Health Act is wanted and this is thought to aid the implementation process.

5.3 The local government's challenges with public health work

The findings from the present study reveal some of what the municipality considers to be challenges with the public health work. The participants frequently mentioned the need for public health work to permeate through the organization and be a priority from top to bottom. In an article describing implementation of efforts to reduce health inequalities in the UK the authors reflected a need for comprehensive strategy both on a national level and a local level (Exworthy, Berney, & Powell, 2002). The authors drew on Kingdon's

model of 'policy stream' to indicate that not only is there a need for a 'policy window' at the national level, but also on a local level (Exworthy, et al., 2002). This indicates that the surrounding structures such as party-political composition and administrative organization plays role in the implementation (Exworthy, et al., 2002; Jansson, et al., 2011). The participants in the present study requested a more solid strategy on public health from top to bottom in the organization. A participant reflects that the reason for why there has not been a clearer strategy can be related to the visibility and measurability of health promoting- or preventing initiatives. Other services within the municipality are easier to measure and therefore if the municipality refrained from that it could easier be front-page news. The need for municipalities to document clearly might be a hindrance as health promotion is not as easy to measure.

Much of the organization reforms in the public sector the last decades can be related to New Public Management (Christensen, Læg Reid, Roness, & Røvik, 2004). A key element within the New Public Management is objective- and result management which is a structural instrument for political and administrative leadership (Christensen, et al., 2004). Christensen and colleagues (2004) highlight three main components which the governance technique builds on: First there needs to be clear consistent, and concrete objectives. Secondly performances need to be measured and reported to a level higher up; and lastly, following up the results rewarding the successful achievements, and punishment for a lack of performance (Christensen, et al., 2004). This notion of objectives and result management is in somewhat contradictory to the nature of public health, where the goals are hard to measure and efforts are characterized by a time-lag. Abelsen and colleagues (2012) found that participants struggle with

properly prioritizing the public health work, within the municipal framework, due to a the time-lag before results appear and little knowledge connected to what works. The results from the present study seem to harmonize with the study of Abelsen and colleagues. Abelsen, et al. (2012) notes that a main finding in their research was that the municipal leadership request a comprehensive, coordinated and long term efforts directed at public health, and not just projects of limited durability. On the basis of their research Abelsen and colleagues pose the question: *“It is an open question how the municipalities’ concrete will organize their efforts for public health and prevention in the years to come. Will they chose broad efforts with a long time horizon, or will they primarily seek solutions which can give reduced costs in the short term?”* (Abelsen, et al., 2012, p. 56, own translation). The authors conclude that given the economic incentives of the reform, the preventive and health promoting initiatives will be instrumental in preventing hospital admissions for specific groups, which are relatively easy to measure (Abelsen, et al., 2012). The authors further state that without more subsidies to this field, the municipalities will to a lesser extent work with general health promotion and preventive efforts (Abelsen, et al., 2012). This development will be detrimental for the public health work and efforts connected to levelling the gradient as the work requires a comprehensive strategy.

Previous research has highlighted intersectoral collaboration and the presence of a locally committed key person as success factors for implementation of local health promotion (Jansson, et al., 2011). The participants in the present study describe that the public health work is a result of systematic work and single enthusiast. Fosse (1999) remarks that there is a need

for these enthusiasts to create support for the ongoing work, but also to anchor the work into the organization.

5.4 HiAP and intersectoral collaboration

Among the key features of the Public Health Act is the notion that the responsibility of public health work is no longer solely in the health care sector, but rather directed at the entire municipal organization (Fosse, 2013). A consequence of this is that all the sectors within the municipality are to promote health and intersectoral collaboration is prerequisite for this work (Fosse, 2013). Most of the interviewees reflect that health should be a concern of the whole municipality and permeate through the organization. Although most of the participants reflect an attitude in line with the HiAP approach, in practice there is little indication of it being an integrated aspect of the organization. By their own account all the participants described that the municipality has not reached its full potential with regard to intersectoral collaboration.

HiAP not only refers to cross-sectorial collaboration but also collaboration between the different levels of the municipal hierarchy. A participant highlight the need for more coordinated efforts from top to bottom of the organization to create a unified understanding. Fosse (2013) states that it is particularly important for the public health work to become a responsibility throughout the organization. Hovik and Stigen (2008) report that Norwegian municipalities have the last years changed the organisation of the administration, moving from a sectored and hierarchical structure to a flatter structure. In this structure there is no administrative level between the executive sector level and the Chief Municipal Executive (Ouff, et al., 2010). The notion behind the

organizational restructuring of the municipal administration it that it is thought to enable collaboration across the sectors. Research however indicates that municipalities which have a flat structure have not collaborated as much as anticipated (Ouff, et al., 2010). The sectors themselves are associated with certain barriers of collaboration. The sectors in a typically flat municipal structure focuses on what we can call a vertical and economic collaboration with the Chief Municipal Executive and not so much a horizontal collaboration with other administrative sectors in the municipality (Ouff, et al., 2010). This sectorization has led to fragmentation of tasks and a lesser ability to see comprehensive solutions (Jacobsen, 2004). The collaboration is obstructed by the tendency that professions claim jurisdiction over fields which is referred to as professionalization. While public health is regarded as a field in and of itself, it is also a field which interacts and operates within a wide array of fields and requires intersectoral collaboration (Fosse, 2007). Fosse (2007) illustrates that although the service areas are keen to collaborate, the surrounding structures of the organization hindered it and specialization and bureaucracy hampered the collaboration. Hjern (2001) ascribe this development to a historical ideal of a government which is neutral and characterized by professional competence, which over time has led to a sectorized and professionalized government; and as the need of collaboration increases the ideal of the governmental organization becomes more and more outdated. The findings from the present study seem to harmonize with the notion of structural barriers being in the way of the collaboration with regard to public health. Krumsvik (2011) stated, in an evaluation of collaboration between municipalities and private health services, that it is a future challenge for the municipalities to lift the preventive work to a

system level. Krumsvik (2011) explains this is due to an organization challenge and the ability to coordinate especially in connections to preventive work is low. It is important to note that although intersectoral collaboration is a goal for the Coordination Reform, there are no clear guidelines as to how the collaboration will be achieved (Fosse, 2013).

5.5 The role of the Public Health Coordinator

Fosse (2013) conducted an evaluation of two health promoting initiatives, where the goal was to develop interprofessional and intersectoral collaboration. The evaluations of these and other initiatives concluded that the coordinated function plays a significant role and these positions should be placed in a sector outside the health sector (Fosse, 2013). In the White paper nr. 16 Prescription for a healthier Norway, it is stated that a Public Health Coordinator can act as an impetus for initiating intersectoral collaboration, and the Public Health Coordinator functions as glue in the local public health work. Fosse (2013) remarks that the coordinating function should be placed high in the hierarchy as the public health aspect should be anchored in the municipal plans to ensure an intersectoral organization. In a study by Helgesen and Hofstad (2012) they found that municipalities hire Public Health Coordinators in positions with small work percentage, and are often in combination with service oriented tasks. Ouff and colleagues (2010) reports that Public Health Coordinators perceive that the public health work is dependent on a high priority in the municipal organization, but also the placement of the coordinator position. It is stated that the Public Health Coordinators experience the higher the position is placed, the larger focus the public health work gets both in terms of administration and politics (Ouff, et al., 2010).

In the present study there have been recent changes in the Public Health Coordinator position within the municipality, but it is currently a 50% of full time employment and organized with the Public Health Nurse as the closest supervisor. The placement is explained due to practical reasons such as; the new coordinator could serve from the experience of the Public Health Nurse, which previously had the position of Public Health Coordinator, and the Public Health Coordinator might feel lonely being located in the Chief Municipal Executive staff. During the interviews a participant problematized the fact that the position was placed in the health sector as it might lead to public health work becoming solely a health sector matter. Fosse (2013) states as public health should be a represented in each sector, the organization and placement of the Public Health Coordinator is important, and should be located centrally in the leadership. Ouff and colleagues (2010) highlight that a central placement in leadership gives status and increase the prestige of the Public Health Coordinator and can contribute to a greater impact in the different sectors. Helgesen and Hofstad's (2012) research indicates that in most municipalities with a Public Health Coordinator, the organizational anchoring is mainly in the health department. This is viewed as extension of the notion that public health is connected to disease prevention, and not what determine health positively and negatively (Helgesen & Hofstad, 2012). The placement of the Public Health Coordinator could be regarded as the intersectoral collaboration not working at its full potential as literature suggest it should lie at a top administrative level.

There is some research connected to the mandate or the content of the position of Public Health Coordinator. Ouff, et al. (2010) describes that many Public Health Coordinators spend time on defining their own role as there few

guidelines as to what exactly the work entails. Ouff (2010) states that the coordinators enjoy the fact that they are not detail controlled, but that the different tasks the position requires is demanding. Hofstad (2011) remarked that there was a need for a planning competency in the municipalities before the Public Health Act was adopted, which was not present in many municipalities thus far. For future research it would be interesting to map how the roles of the Public Health Coordinator are interpreted in different municipalities, and how the position has impacted the public health work.

5.6 Addressing SIH

The findings indicate that the participants are aware of the correlation between the population's health and the socioeconomic group one belongs to and that the municipality has a responsibility to provide the inhabitants with equal opportunities. These attitudes coincide with the content of Public Health Act as addressing SIH should be a priority in the municipality. An unexpected finding was therefore the alternate views of one member of the municipal leadership. The participant stated that it is not the responsibility of the municipality to reduce the inequities in health. This view can correspond with what Vallgård (2006) describes as a liberal ideological view of health, where health is seen as an unfortunate side-effect of the individual freedom of action. The participant's statement may also refer to a perception that the municipality itself is limited in its scope of action and will not be able to effectively reduce the inequities in health.

When describing efforts initiated by the municipality to address social inequities in health several initiatives came up. One participant highlighted an

equipment package as an initiative which gives everyone a possibility to partake in sporting and other activities. The equipment package is owned by the municipality and consists of different equipment for outdoor activities, such as tents, skies and ice skates. The initiative was initiated on basis of that not everyone had the finance to get the right equipment and described as social inequality as some could partake and others could not. The initiative itself is directed to all of the inhabitants of the municipality, and not directly at disadvantaged groups of the population. It is important to note that it is likely that people who already have the equipment will not need to borrow from the municipality and therefore the initiative will reach people targeted groups, who for some reason do not own equipment. In connection with the literature presented by Graham and Kelly in Chapter 2; to successfully reduce the gradient of inequity there is a need for strategies which include the entire population, but also strategies which address the targeted groups. The equipment package will therefore in accordance to the theory be an initiative which can aid in reducing the gradient of health inequity.

An initiative which can shed more light on how the municipality addresses SIH is the efforts taken to prevent parents from taking their children out of kindergarten as a consequence of a local bankruptcy, which left many parents without work. Two of the municipal leadership describes this initiative as an effort to reduce the social inequities. When a big local employer closed its doors, the municipality responded by reducing the fee of kindergarten for the affected families. Kindergartens are important settings for health promotion and for levelling of SIH (Ministry of Health and Care Services Norway, 2010-2011). As kindergartens are services provided to all the children in a municipality they

serve as a universal arena. By reducing the fees for the affected families it provided relief for them as the kindergarten fee is harder for some than others, and it acted as a mechanism for keeping the affected families in the universal systems. Marmot, et al. (2010) describes the concept of proportionate universalism as action which is universal and includes a scale and intensity proportionate to the level of disadvantage. In accordance with this theory the initiative of the municipality can be characterized as proportionate universalism, and therefore be effective strategy to level the SIH.

Hofstad and Vestby (2009) conducted a study of Norwegian municipalities, which indicated that public health efforts are directed at the population as a whole, and not targeted groups. There is an indication that children and young are somewhat prioritized which Vestby and Hofstad (2009) remark that the strategy suggests that public health can be defined as general health promotion with an focus on prevention. The participants in this study reports that generally initiatives from a local level are aimed at the entire population and the two specific initiatives presented above also harmonize with this notion. The findings from this study and Hofstad and Vestby study seem to coincide. Hofstad and Vestby's (2009) research indicate that municipalities which have partnership agreements with the county have an increased access to counselling, than municipalities who do not have these partnerships. This indicates that the counties have a central role in the development of the public health field (Hofstad & Vestby, 2009). An interesting finding in this study was that the participants attribute their effort on addressing SIH to a conscious policy and their political heritage. The municipality has had a majority of labour in the municipal council the last decades and the social democratic tradition of

universalism is thought to have had an effect on for example the notion that fees should not be discriminating and people should have a possibility to afford to participate.

5.7 Municipal reality and national expectations

The Scandinavian countries have a long tradition with decentralized of local government, where the local governments have the authority to prioritize how to spend resources. The term multilevel governance captures the fact that centralized leadership is no longer carried out through a hierarchical system of sanctioned rule-following, but rather a more indirect regulation where the actors are self-regulating (Osborne, 2009). Implementation of national policy are dependent on the decisions made and priorities set by the municipalities in their own local setting, as these are related to competing or similar laws, policies, stakeholders and needs (Jansson, et al., 2011). Local actors have an important function in the implantation process (Fosse, 1999). When municipalities are expected to solve problems without clear guidelines or incentives the policy implementation often becomes problematic and conflict-ridden (Fosse & Røiseland, 2002; Van Meter & Van Horn, 1975). Jansson, et al. (2011) conducted a study of the implementation of a public health policy in Sweden, which proved to be hindered, in terms of governance and content, by the incoherence between national and local levels. Due to the government structure the municipalities have to perceive the goals to be needed, they have to be implementable and in concurrence with other responsibilities (Jansson, et al., 2011). The study further indicates that within the multi-governance and decentralization it is difficult for national government to have a strong influence on the implementation of policies and the authors point out a possible conflict

between national equality and local need (Jansson, et al., 2011). The participants in this case study described little knowledge of the Public Health Act, those who knew of it describe that it has brought a stronger focus on the public health work in general. These findings seem to harmonize with Jansson, et al. study in which participants from the municipal leadership was interviewed in connections to the public health policy which was implemented, and few of the participants in the study knew of the new public health policy. Jansson, et al. (2011), remark that although few of the municipal leadership had knowledge of it, the objectives connected to the public health policy was already on the political agenda in the municipality before the introduction of the new policy. The findings from this study may harmonize with Jansson and colleagues' findings as few in the municipal leadership had specific knowledge of the Public Health Act, but findings indicate that key aspects of law such as social determinants perspective and efforts connected to the SIH are present before the act is established.

In Jansson and colleagues' study the participants who expressed an awareness of the policy regarded the objectives as too extensive, diffuse and non-implementable (Jansson, et al., 2011). In this study all of the participants agree with the content and mission of the Act, but some of the participants remark that few municipalities will be able to abide to the responsibilities proposed in the law, as there are no earmarked funds for this work. Throughout this discussion some participants describe a misrepresentation between national expectancies and the local reality. In a report investigating the relationship between the municipal sector and the national government it was reported that the local autonomy is under pressure, and the inhabitant's expectancies do not correspond with the municipality's resources to meet these expectations

(Drøpping, Dehli, Knudsen, & Pape, 2011). A key argument for the local autonomy is that the municipality is the most qualified to prioritize on the basis of local needs (Drøpping, et al., 2011). In 2012 an evaluation of the Coalition Reform was conducted with both an interviews of 8 case study municipalities and survey's sent to 86 municipalities. The Public Health Act came as a part of the larger Coalition Reform and the findings from the evaluation are therefore applicable for this study. The findings from the evaluation revealed that all the municipalities which participated were disappointed over the lack of earmarked funds directed at the public health work (Abelsen, et al., 2012). The municipalities explained that it was difficult to prioritize within the budgetary restraints, the time-lag before results would appear and a lack of knowledge about what would work are also described as problematic (Abelsen, et al., 2012). Abelsen, et al. (2012) describe that the municipality is given more responsibilities after the Public Health Act, and the municipality is expected to initiate initiatives with broad spectre to meet the health challenges in the population. The authors question the economic incentives connected to the reform, as there seem to be an assumption that altering an entire practice of municipal health service with a larger focus on preventative and early intervention will be "free" (Abelsen, et al., 2012). Drøpping, et al. (2011) describes in the evaluation of the relationship between municipalities and the national government that there is a clear tendency that governments exudes more and more governmental control over the municipalities. This is illustrated by the state to an increasing degree formulating resolutions which makes the municipality legally obligated to provide the inhabitants with services (Drøpping, et al., 2011). Fimreite (2001) describes that the local autonomy ideal

has been systematically weakened and the most pertinent task of the municipality is to implement national policy and the role of local policy organ is severely diminished. Fimreite (as cited in Abelsen, et al., 2012) explains that the Coalition Reform is an attempt for the state to use the municipalities to reduce expenditure from the public expenditure growth. Drøpping, et al. (2011) conclude that tendencies such as these are a threat to the local autonomy, which is an important fundament for the welfare state, and it is important to make the municipalities capable of fulfilling the inhabitants increasing expectations of the welfare services. Although earmarked funds are requested by the municipality, there is some research which indicates that earmarked funds is mainly favourable to municipalities with a strong economy, and in general the accuracy of governmental funding is poor (Drøpping, et al., 2011). Abelsen and colleagues (2012) remark that without more subsidies to the field of health prevention and health promotion, the municipalities will to a lesser extent work with general health promotion and preventive efforts.

5.8 Summary of the discussion

The findings from the present study illustrates that the social determinants of health perspective is present in the municipality. The participants' statements and the municipal plans reinforce the notion that health promoting ideals such as well-being in health and the social determinants perspective have increased in recognition over time. This can be attributed to the municipality's political history and experience with health promotion initiatives such as being organized as a Safe Community. The municipality is experiencing difficulties with intersectoral collaboration which can be attributed to the structural barriers present in today's municipal organization structure. The difficulty of creating a

comprehensive public health policy may also be hindered by the goals of the New Public Management organization style. The study indicates that there may be a divide between national and local expectations; this in combination with surrounding structures of municipal organization may limit the progress of health promotion policies in the municipalities.

Literature indicates that the Public Health Coordinator plays an important role in the work and should be placed high in the municipal hierarchy. The efforts of addressing SIH from the municipality can be characterized as proportionate universalism and thought to be an effective measure.

6. Conclusion

The field of public health has received an increasing level of attention. From a national perspective the interest culminated in the Public Health Act, an Act which is unique in its kind. The Act includes strengthening the preventative work across sectors in the municipalities and reducing the SIH. This study provides insight to how a municipality is implementing the principles of the Public Health Act.

The study indicates that the municipality has an implicit perception of health which corresponds to the model of Social Determinants of Health. The municipality reveals an implicit understanding of the gradient and the efforts described in connections to addressing SIH can be characterized as proportionate universalism. Finally the municipality experiences difficulties in intersectoral collaboration and the principle of HiAP are therefore not fully in place. Summarized these findings indicate that the municipality is adhering somewhat to the principles of the Public Health Act. The surrounding structures of the municipal organization and the relationship with the national government may be limiting the progress of health promoting policies at a local level.

While this study is focused on one municipality, the implicit understanding the municipality has may be prevalent in other municipalities. The findings from this study can be useful for other municipalities to compare and contrast.

The role of the Public Health Coordinator proved itself to be an important part of the health promoting work in this study. Previous research indicates that this role is instrumental in the local health promoting work, and the local differences in work percentage and placement in the organization is relevant for future research. There also seems to be some uncertainty about the job description of a Public Health Coordinator, which would be interesting to investigate further.

There has been a debate ongoing for several years connected to a restructuring of municipalities in Norway and creating larger municipalities. It would be interesting to investigate further the relation between public health work and the size of the municipalities.

In the study the political tradition of the municipality is discussed in relation to the implicit social determinants perspective prevalent in the municipality. For future research it would be interesting to investigate municipalities with different political tradition to see further if and how the political tradition has an impact on the public health work.

The study indicates that the municipality has an implicit understanding of health promotion principles such as the gradient and the social determinants of health perspective. While these seem to be present in the municipality before the Public Health Act came, the participants express an increased level of attention dedicated to these principles. The notion that health promoting principles has grown from within the organization and is now reinforced from a national angle bodes well for the future of health promotion within the municipalities. An important lesson to learn is to build on the existing

structures of health promotion principles and further encourage the principle of HiAP to more effectively address SIH in local governments.

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APPENDIX I: INTERVIEW GUIDE

Intervjuguide

1. Innleiing: Stilling, utdanningsbakgrunn, år i jobben og kor lenge ein har arbeidd med folkehelse.
2. Kva betyr disse omgrepa for deg:
 - Folkehelse?
 - Helse i alle politikkområder?
 - Sosiale helseforskjeller? (helseforskjeller som følger sosiale skillelinjer)

What policies are in place at the municipal level concerning health promotion and social inequities in health?

3. Korleis er folkehelse forankra i kommunens planstrategi?
 - 3.1 I kva planer?
 - 3.2 På kva måte bygger planarbeidet på faktakunnskap om helsesituasjonen i kommunen?
 - 3.2.1 Har kommunen utarbeida helseoversikt, i tilfelle korleis?
 - 3.2.2 Har du hatt mulighet til å delta i oversiktsarbeidet?
 - 3.2.3 Kva datakjeldar er nytta?
 - 3.3 Korleis deltar kommunelege/folkehelsekoordinator eller andre med ansvar for helse i planarbeidet?
 - 3.4 Kva andre aktørar (kommunale, frivillige organisasjonar, fagmiljø, private) deltar i planarbeidet?
 - 3.5 Korleis er hensynet til sosiale ulikheter ivaretatt/omtalt i planarbeidet slik du ser det?

In which ways are the social determinants of health addressed from a municipality level?

4. Kva einigar/avdelingar/sektorar i kommunen meiner du er viktigast for folkehelsearbeidet?
 - 4.1 Kvifor?
5. Er det etablert tverrsektorielle grupper som samarbeider om folkehelse? (både i og utanfor den kommunale organisasjonen)
 - 5.1 Om ja, kva grupper er det og på hvilket beslutningsnivå?
 - 5.2 Er det noko partneskap med fylket eller andre kommunar?
6. Kva ressursar (finansielle og stillingar) er retta inn mot helsefremmende arbeid?
 - 6.1 Korleis blir dette (folkehelsarbeidet) finansiert? (Kommunens egne midler/Fylkeskommunale stimulerings midler/Midler frå fylkesmann?)

What interventions are taken to reduce social inequities in health?

7. Korleis arbeider kommunen med å utjamna sosiale helseskilnader?
 - 7.1 I kva grad meiner du at å utjamne sosiale helseskilnader er prioritert i kommunen/sector?
 - 7.2 Kva grupper er prioritert i dette arbeidet?
 - 7.3 Kva effekt har tiltaka hatt sett frå din ståstad?
 - 7.4 Korleis er gruppene/brukerane tatt med i utforminga av tiltaka?
 - 7.5 Av alle tiltaka dykk iverksetter, kva fungerer best?

- 7.6 Kva utfordringar opplev dykk i møte med dette arbeidet?
- 7.7 Kva tenker du at din sektor kan bidra med i arbeidet for å utjamne sosiale helseskilnader?
- 7.8 Korleis kan kommunen gjere meir for å utjamne sosiale ulikheter i helse?
 - 7.8.1 (Meir..: data/statestikk om helsesituasjonen, kunnskap om effektive tiltak, pengar, personell, kompetanse innan omfattande/tverrsektorielle folkehelse tiltak?)

Does the plans and interventions at a municipal level include the HiAP approach?

- 8. I kva grad synst du dei ulike einingane/avdelingane/sectorane er flinke å arbeide med folkehelse?
 - 8.1 . Korleis samarbeider einingane/avdelingane/sectorane om:
 - 8.1.1 Å belyse/få frem helseutfordringa?
 - 8.1.2 Å utforme politikk og strategiar?
 - 8.1.3 Å gjennomføre tiltak?

What challenging –and success factors does the municipality experience associated with implementing the Public Health Act, with special consideration to SIH?

- 9. Har den nye folkehelselova ført til noko endring i korleis kommunen arbeider med folkehelse?
 - 9.1 På kva måte?
 - 9.2 Folkehelselova medfører nye ansvar til kommunen (som inkluderer at alle sektorar skal fremme folkehelse, ein skal føre ein oversikt over helsetilstanden og iverksetter nødvendige tiltak) kva syns du om det?
 - 9.2.1 I kva grad føler opplev dykk at dykk har nok resursar til å gjennomføre desse oppgåvene?
 - 9.2.2 Kven verte råka ved at arbeidet ikkje har nok resursar?
 - 9.2.3 Kva skal til for at dykk kan meir effektivt arbeide med sosiale helseskilnader?
- 10. I kva grad tenker du at folkehelsearbeidet i kommunen er eit resultat av eldsjel arbeid eller ligger det i systemet?
 - 10.1 Arbeider kommunen med HIA/ Helsekonsekvensutredning?
 - Har kommunen vurdert ulike tiltak sin effekt på folkehelse?
 - 10.1.1 I kva grad verte helsekonsekvensutredning nytta?

Tillegg spørsmål:

- 11. Kven er folkehelsekoordinatorens nærmaste leiar?
- 12. Kva tenker du at din sektor kan bidra med i forhold til folkehelsearbeidet?
- 13. Er det noe du vil tilføre?

APPENDIX II: ETHICAL APPROVAL BY THE NORWEGIAN SOCIAL SCIENCE DATA SERVICE (NSD)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



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nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Elisabeth Fosse
HEMIL-senteret
Universitetet i Bergen
Christiesgt. 13
5015 BERGEN

Vår dato: 04.07.2013

Vår ref:34549 / 3 / IB

Deres dato:

Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 15.05.2013. Meldingen gjelder prosjektet:

34549	<i>How can Municipalities reduce social Inequities in Health? A qualitative Case Study exploring the Role of a Norwegian Municipality with Regard to social Inequities in Health</i>
Behandlingsansvarlig	Universitetet i Bergen, ved institusjonens øverste leder
Daglig ansvarlig	Elisabeth Fosse
Student	Olin Blaalid Oldeide

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.


Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 15.06.2014, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen


Vigdis Namtvedt Kvalheim


Inga Brautaset

Kontaktperson: Inga Brautaset tlf: 55 58 26 35
Vedlegg: Prosjektvurdering
Kopi: Olin Blaalid Oldeide, Ibsens gate 26, 5053 BERGEN

APPENDIX III: INFORMATION LETTER AND INFORMED CONSENT FORM

SKRIFTLEG SAMTYKKE

Informasjon til deltakarane i studiet:

“How can municipalities reduce social inequities in health? - A qualitative case study exploring the role of a Norwegian municipality with regard to social inequities in health.”

Dette studiet er ei masteroppgåve som ser på korleis norske kommunar har implementert folkehelseloven frå 2012. Den undersøker dei politiske og administrative strategiane i arbeidet for å redusere sosiale ulikheter i helse blant familiar og barn. Vi trur at din erfaring kan bidra med viktig informasjon for å forstå desse samanhengane. Studiet inkluderer både analyser av politiske dokumenter og intervjuar med leiarar for forskjellige etatar. Masterprosjektet inngår som ein del av eit større prosjekt: **"Addressing the social determinants of health. Multilevel governance of policies aimed at families with children"** (SODEMIFA) på HEMIL-senteret ved Universitet i Bergen.

Det blir brukt bandopptakar under intervjuet. Lydopptaka vil slettast og datamateriale vil vere konfidensielt når oppgåva er ferdig, seinast innan 15.06.14. For å garantere at vi har forstått dine opplysningar riktig, får du moglegheit til å sjekke resultatkapitlet før rapporten publiserast.

Personidentifiserande opplysningar vil verte behandla konfidensielt og anonymiserast ved publikasjon. Dei personidentifiserande opplysningane og lydopptaka vil berre veileiar og student ha tilgang til.

Det er frivillig å delta i denne studien. Om du deltar i denne studien har du rett til å nekte å svare på dei spørsmål du måtte ønske. Du kan også velje å avslutte din deltaking når som helst medan intervjuet er i gang, i så fall vil alle opplysningar slettast med det same.

Dersom du vil delta, vær snill å lese og signere vedlagte samtykkeerklæring.

Takk for samarbeidet,

Olin Blaalid Oldeide, Master student ved programmet ”Master of Philosophy in Health Promotion” ved Universitet i Bergen (UiB)

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Telefon: 924 62 636

Veileiar: Prof. Dr. Elisabeth Fosse, Førsteamanuensis ved UiB

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Telefon: 555 82 758

Adresse: Christies gate 13, 5020 Bergen

SKRIFTLEG SAMTYKKE

Eg har mottatt skriftleg informasjon og er villig til å delta i studien.

Namn:

Signatur:

Dato: