Tackling health inequalities locally – the Scandinavian experience

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The Scandinavian challenge:

Translating small inequalities in wealth into small inequalities in health

Combining equality and efficiency in economy

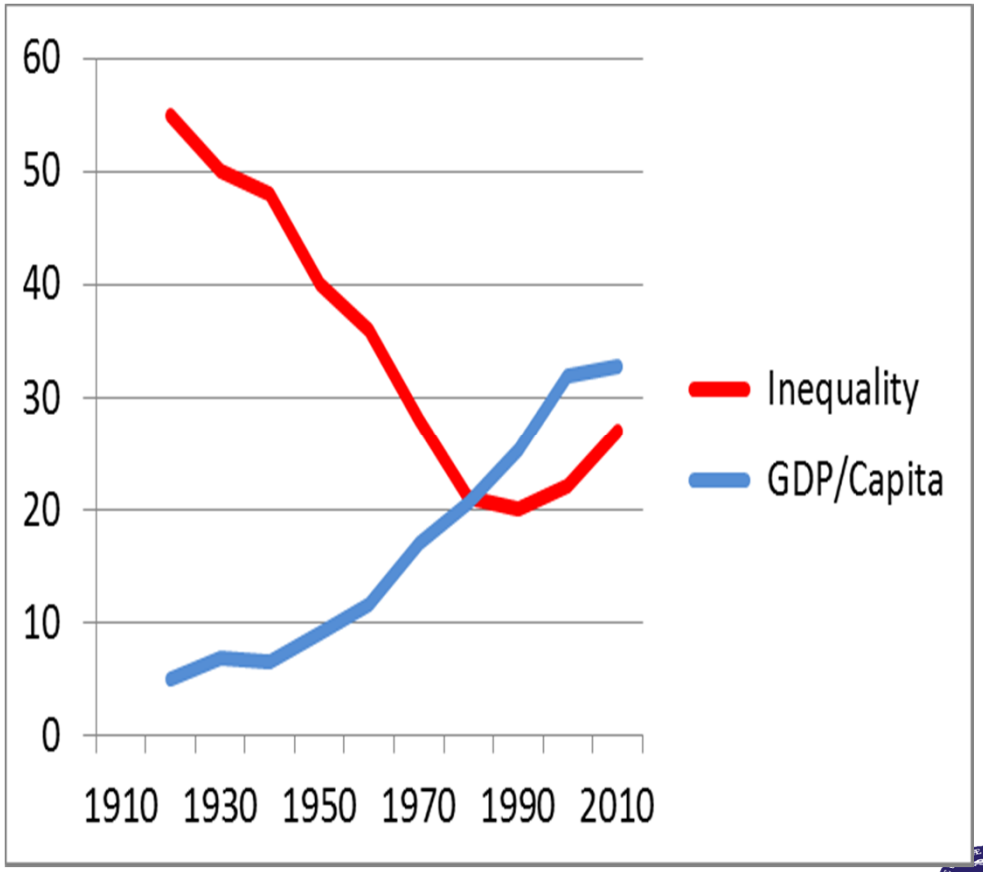
Declining income inequality and increasing GDP .

Denmark 1920-2010

Inequality = Ginicoefficient *100

Growth = GDP in thousands of inflation adjusted USD per capita

Kilde: Viby-Mogensen 2010

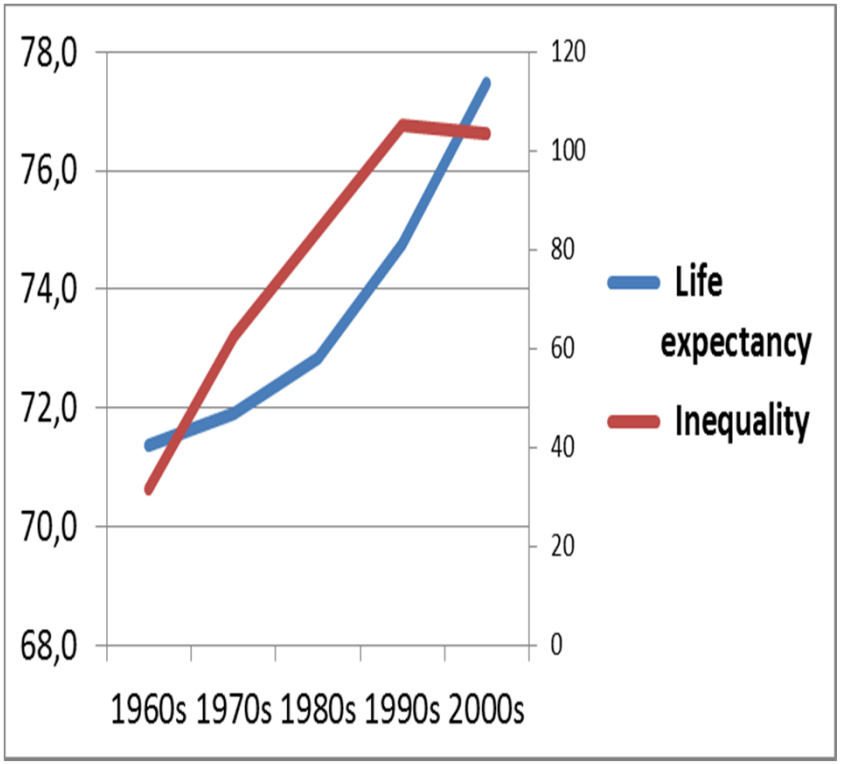


Combining equality and efficiency in health ?

Increasing life expectancy but growing inequality.
Norway 1960-2010.

Life expectancy in years.

Inequality measured as difference between high and low educated in deaths per 10.000. Agestandardized.

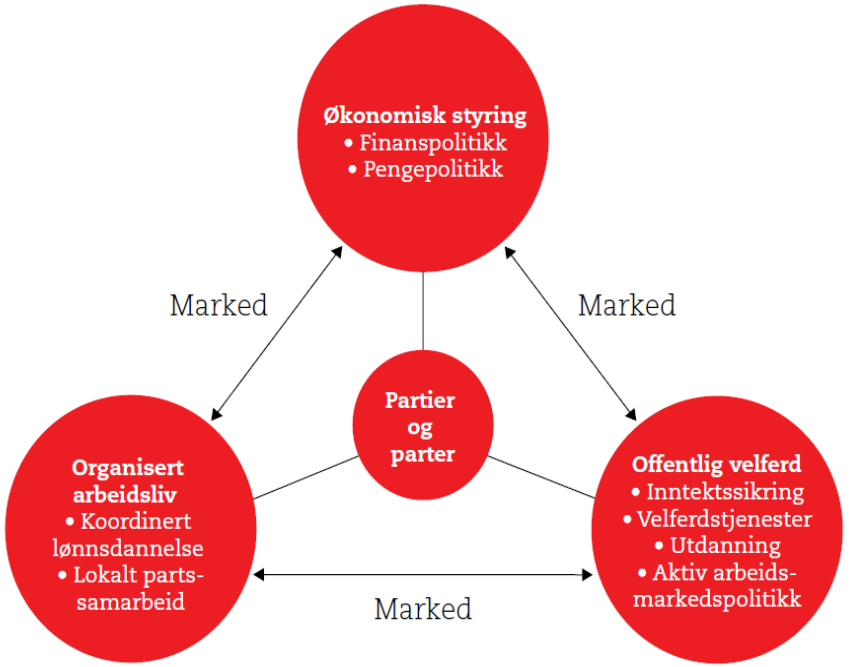


The Scandinavian welfare state

Economically it depends on a high employment rates based on i.a. social investments in education and health

Politically it has been based on strong political acteurs and institutions that can collaborate (Dølvik 2014)

Legitimacy of welfare provision is based on trust and ”treating people equally and with respect” (Rothstein 1994)



Dølvik m.fl. 2014

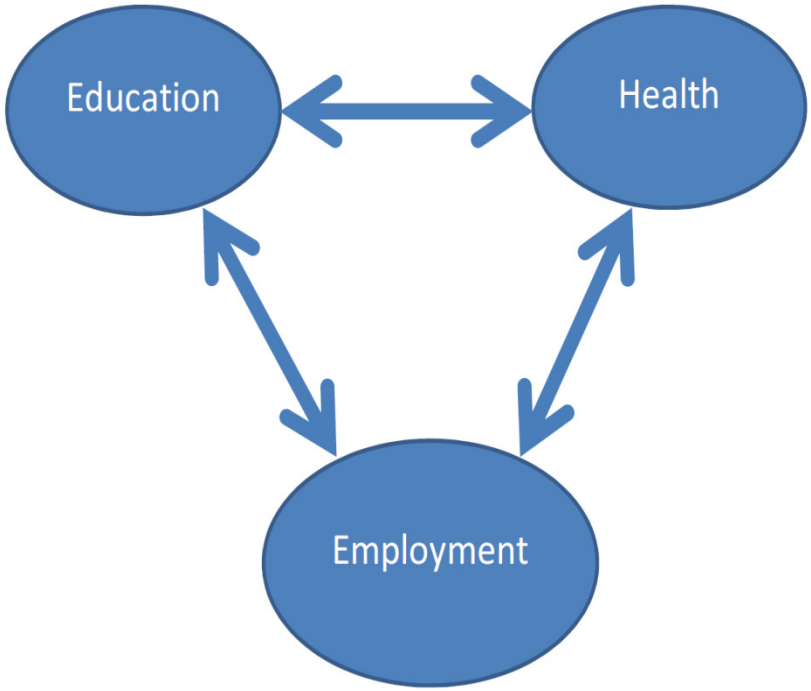
The Nordic welfare state is challenged:

Growing health inequality:

When short education, ill health and no employment is increasingly associated the welfare state is challenged.

Why?

Because it becomes increasingly difficult to make effective social investments in education and health to sustain the high employment rate



Three political motives for tackling health inquality in Scandinavian municipalities:

Human rights: If ill health limits peoples freedom to live the lives they value, then systematic health inequalities are unfair

Social sustainabilty: If a health as a central welfare component is increasingly unequally distributed, then the social sustainability of the welfare state is threatened

Social investment: Growing expenditures to medical care and disability benefits raises a quest for prevention among those at greatest risk i.e. a social investment in health equity.

Three aspects of the ”health divide”:

I. The social gradient in the risk of getting ill

II. The social gradient in the consequences of being ill

III. Illness among the mariginalized – ”the gap”

Responsibilty for public health is in Scandinavia shared between state, regions and municipalities

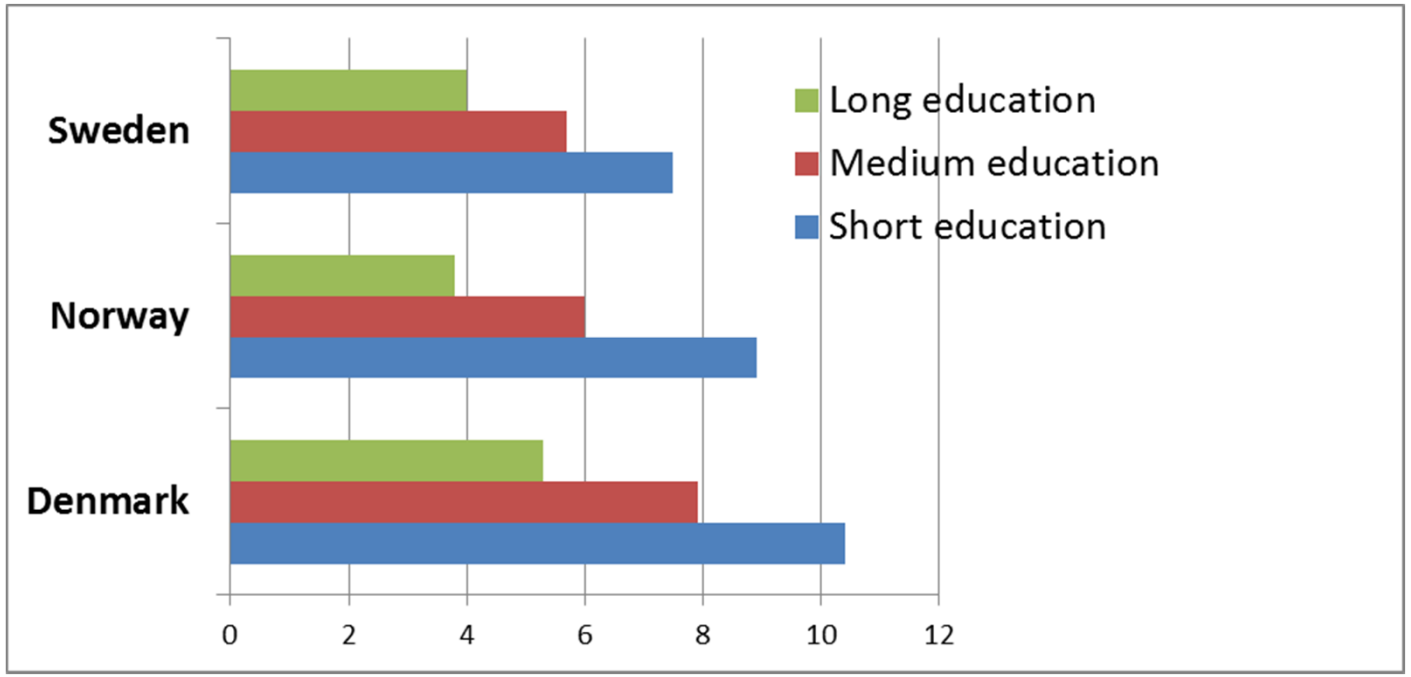
Responsibilty for health promotion is recently devolved to municiaplities

Municipalities and regions have a double role:

They shall both implement central policies and meet local needs and priorities

The educational gradient in mortality

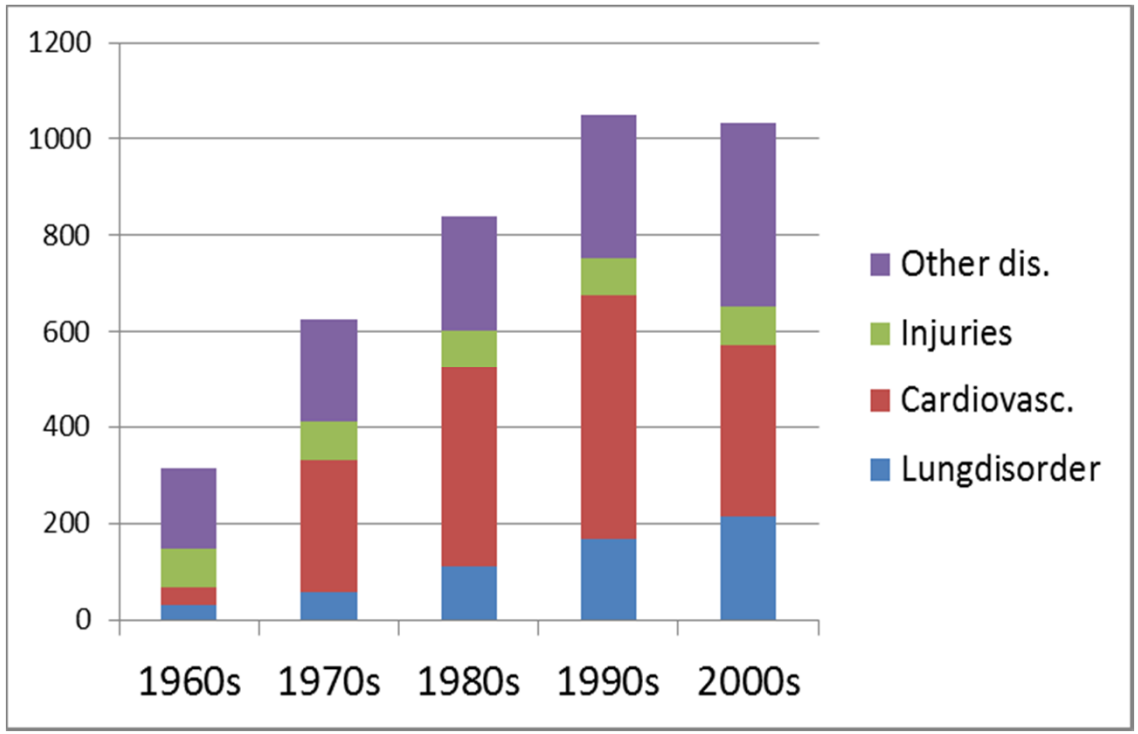
(Deaths per 1000. Age and sex standardized)



Growing inequality in mortality – until now

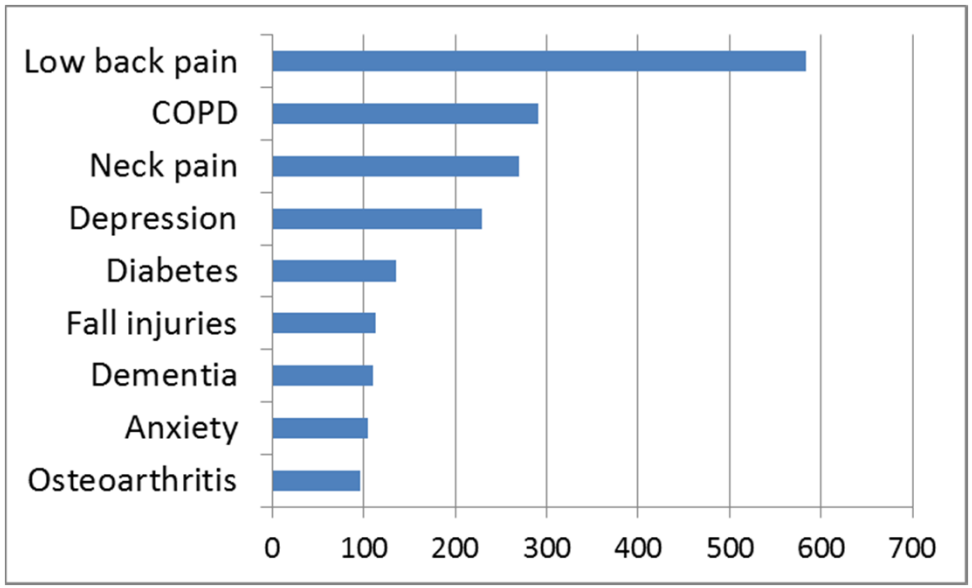
Educational difference in mortality. Deaths per 100.000.

Norway 1960-2010



Strand BH et al: BMC Public Health 2014:14.1208

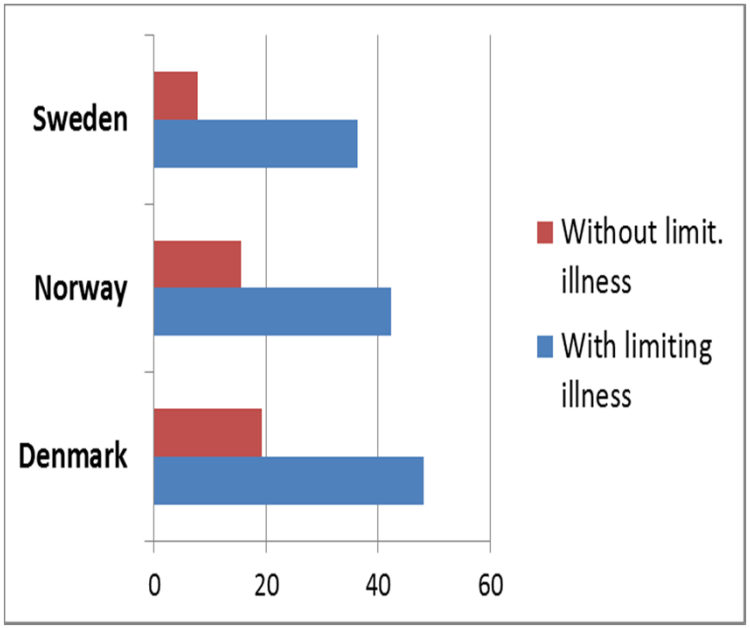
What diseases generate the unequal burden of disability? – Denmark 2013 (Educational difference in YLD per 100.000)



Unequal employment consequences of illness

Educational difference (in % units) in employment rates among people with and without long standing limiting illness.

Women 25-59 years 2005.



Source: Holland P et.al.: Int J Health Serv 2011:41:395-413

National and local reviews:

All three countries have made scientific reviews of health inequalities – their determinants and about policies to tackle them.

Four engines driving health inequalities:

- Social stratification – to unequal possibilities
- Differential exposure – to environmental and behavioural causes of ill health
- Differential vulnerability - to the health effects of these causes
- Differential consequences - of ill health

5 priorities in tackling health inequalities

- Promote early child development
- Avoid school drop-out
- Regulate smoking, alcohol, diet and physical activity
- Regulate work environment and labour market exclusion
- Ressource allocation to services according to need (proportional universalism)

Health equity in all policies

Health care ”own” the effects but other policy areas ”own” most of the solutions

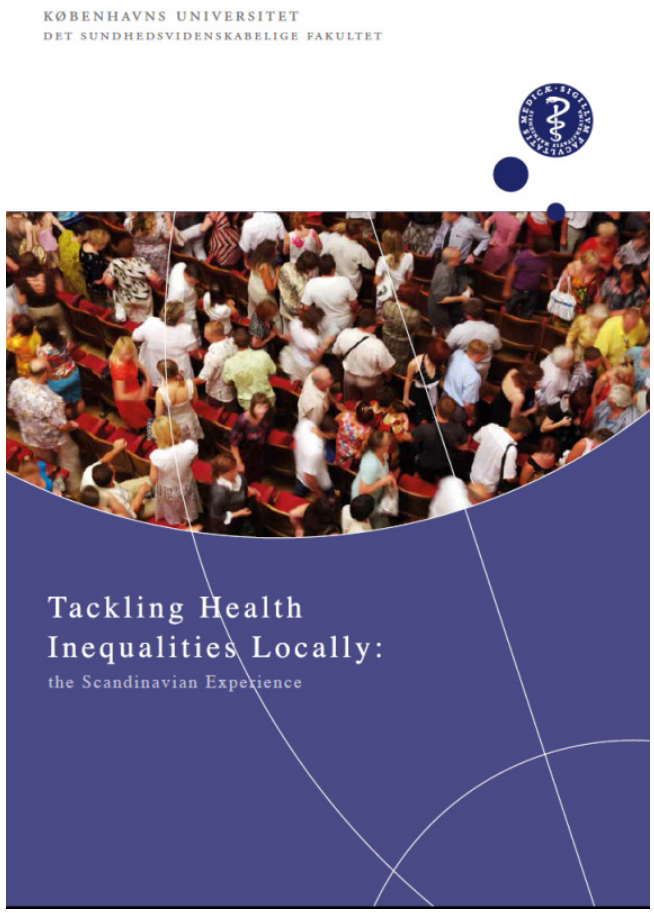
Each determinants can be influenced by different policy sectors

Health policy matrix

Determinant	Education	Labour market	Social policy	Environment	Health care
	Policy area				
Early child development	■		■		■
Residential segregation	■		■	■	
Unemployment		■	■		
Physical activity	■			■	■
Tobacco/alcohol	■				■

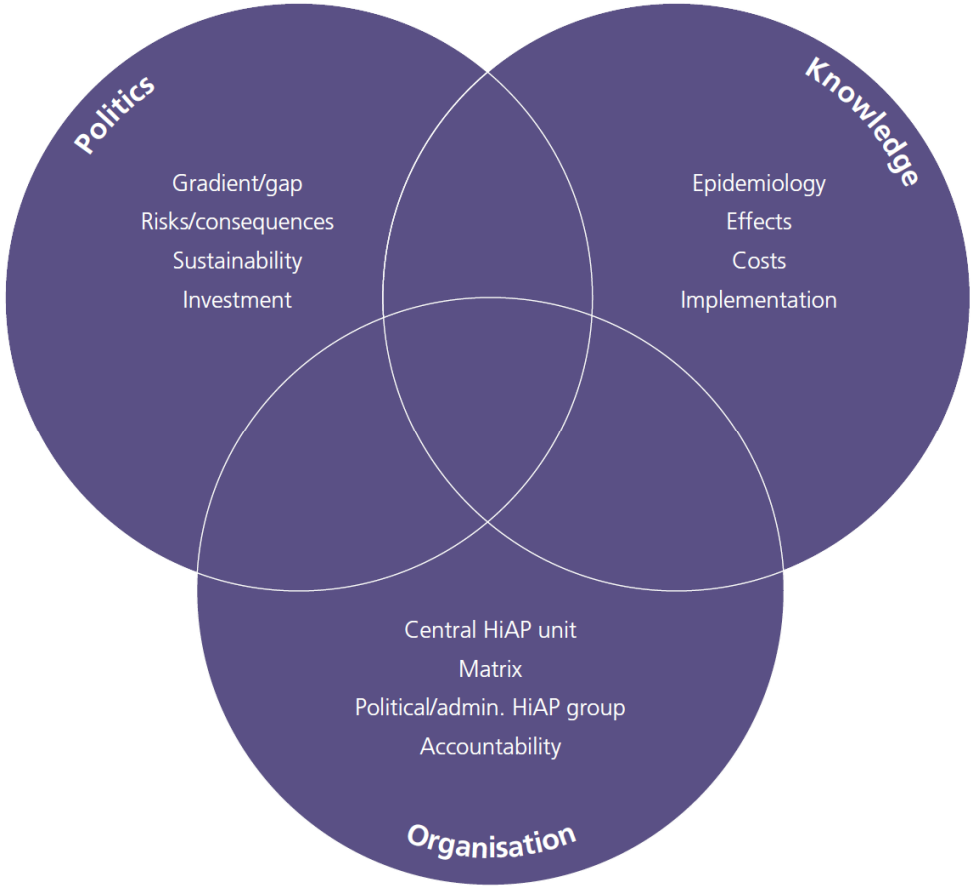
The empirical study:

Interviewing
health planners and
policy makers
in Scandinavian
municipalities
and regions



Politics, **knowledge** and **organisation**

- all three are necessary for implementation



I: A comprehensive approach

Observation:

Three different perspectives exist:

- Focus on health of the marginalized (DK)
- Focus on the social gradient of health (NO)
- Focus on social sustainability (SE)

Recommendation:

All three perspectives are relevant and should be combined in a comprehensive approach. The social sustainability approach, including a health *for* all policies perspective, promotes ownership across sectors. But since health is about people's possibility to live the lives they value, it should not divert focus from the most effective interventions for reducing inequality in the burden of disease

II: Policies build on the premises of each sector

Observation:

Different policy sectors have very different culture, language, legislation and rationality

Ownership exist when each sector has developed their own contribution to health equity

Recommendation:

Developing and adjusting policies in different sectors must be done on the premises of each sector, but in dialogue with public health professionals. Choice of determinants is made on epidemiological grounds, but choice of action to change them must be developed by each sector.

III. Support with generic policies

Observation:

International and national reviews have provided broad guidelines, but concrete interventions and policy changes in different sectors are needed and in demand.

When policies are developed locally they become very concrete.

Recommendation:

The national and regional levels should support municipalities with generic interventions and policies (policy briefs) to tackle health inequalities across policy sectors. Estimates of the potential health inequality impacts (HIIA) of such proposals would be a great help. There may also be a need for support when adapting generic proposals to the local context

IV: Knowledge on costs and effects

Observation:

Cost-effectiveness evidence is surprisingly seldom used - maybe du to low supply.

But many ask for this to be used in intersectoral budget negotiations.

Equity concerns important

Recommendation:

There is a low but increasing demand for cost estimates and, when possible, potential health impacts. Policy proposals should to a greater extent be supplied with this type of cost-effectiveness estimates ("business-cases") to strengthen their position in budgetary negotiations.

V: Equity indicators linked to each sector

Observation:

”What is implemented depends on what is monitored”

Implementation and quality of clinical work is closely monitored.

That tradition does not exist for intersectoral prevention.

Recommendation:

Indicators on determinants linked to various sectors should be used broken down into socioeconomic groups within municipalities. Shared targets for indicators are useful. Indicators on implementation of interventions and policies in various sectors should be developed.

VI: Build policy making skills

Observation:

Multisectoral policy making demands skills in public health, needs assesment and health (equity)impacts assesment. Skills in epidemiology, economy, health promotion and prevention are relevant.

It also demands insights in the cultures of different sectors.

Recommendation:

Teaching programmes should be developed and offered that provide participants with both skills in local policymaking and in utilising public health evidence as well as in the terminologies, traditions, and evidence used in various sectors relevant to public health.

VII: Legislation matters

Observation:

In Norway legislation (2012) on HiAP has had a strong impact locally.

In Sweden unregulated local initiatives has come very far

Why is it that clinical guidelines often ”must” be implemented (DK), while preventive guidelines only ”may” be implemented if it happens to be a local priority?

Recommendation:

In order to support the development of health equity aspects in all policies, central national guidelines are needed to sustain a high and equal level of evidence in the locally implemented policies.

VIII: Whole-of-Society-Approach

Observation:

Still limited involvment of acteurs outside the public sector in many municipalities.

Many examples that partnerships may increase legitimacy, outreach and effectiveness e.g. in nudging efforts

Recommendation:

A whole-of-society-approach to local health promotion is needed. It should involve not only the public sector but also a wide range of interest groups, NGOs, civil society, and commercial actors.

Careful concern for equity aspects is important.

IX: Involve all sectors early ”on equal terms”

Observation:

The tradition where the health administration is leading have beeen necessary in early stages, but cannot establish ownership in other sectors.

The lack of clear intersectoral policies for health equity on the national level is not helpful.

Recommendation:

The ownership of health equity policies across sectors benefits when sectors are involved “on equal terms” from an early stage. The broader social sustainability agenda serve this purpose well. Implementation at the local level benefits from bringing top-level administrators from the various sectors together in a long-term collaboration. A parallel process at the national level would greatly support the local process.

X. Vertical collaboration and suport

Observation:

WHO documents (CSDH) are a major source of inspiration even locally.

No clear division of labour where regional specialists serve as ”second level” public health staff supporting local level.

No national monitoring and benchmarking exist

Recommendation:

The municipalities require that regional and national authorities support their work with not only the medical public health aspects of policies for health equity (i.e. epidemiology, environmental and social medicine) but also with regional planning.

XI: Long term commitment

Observation:

Municipalities whith long term political and administrative leadership focusing on health equity have advanced quite far.

Political conflict around the health equity agenda has not been helpful on the local level.

Recommendation:

Developing a locally sustainable process for health equity in all policies requires a long-term political and administrative commitment. Some concrete actions and policies will necessarily be controversial, but a long term process of developing compromises, rather than turning them into bipartisan issues, benefits the process

Thanks to the Scandinavian team who helped us:

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Thank you
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