SUSANNE HAGEN, NAIA HERNANTES,
KJELL IVAR ØVERGÅRD

The Norwegian Public Health Act and its implementation

Norway is known for its egalitarian society – it emphasizes solidarity, universalism and redistribution of resources among social groups. However, there is a social gradient in health in Norway, which is currently experiencing increasing inequalities. Since the social gradient is related to an unjust distribution of socio-economic factors, the Norwegian government has for decades developed policies to reduce these inequalities. This aim is highlighted in the recent Public Health Act that took effect in January of 2012. The act follows the principles of health equity and the »Health in All Policies« (HiAP) approach. Following the Ottawa Charter, the Act takes into account that health is shaped by the conditions in which people live, learn, love and work. The Act aims to tackle the gradient in health by addressing the social determinants of health.

The Act also transfers the responsibility for reducing social inequalities in health from the national to the local level. In Norway, there are three administrative levels: first the national, second the regional with 19 counties and third the local level with 428 municipalities. In the municipalities, the chief executive officer, head of the administration, and the mayor have the main responsibility for the population health, reflecting that the responsibility for public health relies on all sectors, not on the health sector alone.

What does the Act say?
The Public Health Act requires municipalities to do the following:

- **1)** To ensure coordination across different sectors. The coordination is supposed to glue together the municipal, private and voluntary sector, and to create synergies and avoid double structures. Overall, a public health coordinator is supposed to be a knowledge broker in the field of local public health.

- **2)** To develop health overviews of the citizens' health and the positive and negative factors that may influence public health. The overview shall be based on information from the central and regional government, knowledge from the local health services, and knowledge of factors and development trends in the environment and the local community that may influence the population health by its different determinants. The overview shall identify challenges to public health, assess possible causal factors and their impact, and always have a special focus on social inequalities in health.

- **3)** To incorporate policy and health promotion initiatives aimed at reducing inequalities in health in the local planning systems and master plans. Masterplans are the basis for local policies. These plans should take into account the health implications of local policies to improve public health and reduce health inequalities. Masterplans shall be based on the health overviews.

Researching the implementation of the Act
From 2012 to 2016 the Norwegian Research Council funded the research project »Addressing the social determinants of health among families with children« (SODEMIFA). Based on both qualitative and quantitative data, this project evaluated the implementation of the Act. Data were collected from case municipalities, from two surveys covering all Norwegian municipalities (N=428) and from register data, which were used in several publications and one PhD-study. The study was set to explore:

- the relationship between the HiAP approach and municipal strategies addressing the social determinants of health at the local level, i.e. the use of the public health coordinator, and fair distribution of social and economic resources among social groups;

- whether Norwegian municipalities address living conditions (economic circumstances, housing, employment and educational factors) in local health promotion and what factors are associated with that;

- how changes in municipal use of HiAP tools (which includes the employment of a public health coordinator and the development of health overviews) was related to a fair distribution of social and economic resources among social groups.

Study results
Overall, the study found that municipalities employing a public health coordinator were eight times more likely to have partnerships with the county council, compared to municipalities not having a coordinator. Municipalities having located the coordinator in the staff of the chief executive officer were three times more likely to have established collaboration with the private and voluntary sector. Municipalities involving the public health coordinator in the municipal planning process had more often established health overviews.

The research also found that HiAP strategies like cross-sectoral working groups and inter-municipal collaboration were associated with addressing living conditions, while the existence of a public health coordinator had little effect on them. Further findings showed that developing health overviews and collaboration with external actors was associated with municipalities prioritizing a fair distribution of social and economic resources among social groups in political decision-making at the local level. However, there appeared to be no differences between municipalities that employed a public health coordinator and municipalities that did not make use of this function when it came to prioritizing a fair distribution of resources at a local level. So, the employment of a public health coordinator had no direct effects on a fairer distribution of social and economic resources among social groups.

One possible interpretation of the overall findings of the study is that – even though the position of a public health coordinator may not directly relate to the social determinants of health – the public health coordinator may play a central role in establishing health overviews and intersectoral collaboration, which are two important tools in the HiAP approach. We suggest that investigating this relationship and the structures further ought to be the object for future research to continue developing the HiAP approach to promote equity in health.

Literature available from the authors
Susanne Hagen und Prof. Dr. Kjell Ivar Øvergård, Department of Health, Social and Welfare Studies, University of South-Eastern Norway
Naia Hernantes Colias, University of Navarra, School of Nursing, Department of Community, Maternity and Pediatric Nursing; Pamplona, Spain
E-Mail: susanne.hagen@usn.no

PAUL DALZIEL

Wellbeing Economics in New Zealand

Given the enormous diversity of the lives led by the nearly eight billion people on planet earth, how can we design policies that we are confident will expand wellbeing, both for current and for future generations? This question is at the heart of a research field called wellbeing economics. In New Zealand, it has led to the world's first »Wellbeing Budget«, which represents a paradigm shift in the practice of public policy. It requires all new policy proposals to be analysed for their impact on a broad range of statistical indicators for wellbeing.

Choice-making for Wellbeing

Wellbeing economics recognises diverse levels of choice-making in society. Individuals continuously make choices they expect will promote wellbeing. These choices are made in social contexts, so that this personal agency is an exercise of »relational autonomy«. People choose to create households, families, neighbourhoods and communities, for example, expanding capabilities for wellbeing through voluntary collaborations. Participation in the market economy is a further stimulus to wellbeing, although market failures can diminish wellbeing. Local and national governments can make distinctive wellbeing contributions, by addressing problems of market failure, for example, and through participation in coordinated initiatives addressing global challenges (such as the climate crisis).

From Growth to Wellbeing

For a long time, economists considered their best contribution to public policy was to explain how a growing market economy can expand wellbeing. That view is hard to defend in the face of rising economic inequalities and clear scientific evidence that growth is driving the climate crisis. In 2008, a Commission led by Joseph Stiglitz, Amartya Sen and Jean-Paul Fitoussi re-examined how economic performance is judged. It famously recommended a shift in emphasis from measuring economic production to measuring people's wellbeing. Many countries now monitor trends in carefully chosen statistical indicators of wellbeing among their populations. »Gut leben in Deutschland« (www.gut-leben-in-deutschland.de) is a good example.

The New Zealand Initiative

Following this worldwide trend, the New Zealand Treasury created a wellbeing measurement framework called the Living Standards Framework Dashboard. This monitors statistical indicators of current wellbeing in 12 domains:

- Civic engagement and governance
- Cultural identity
- Environment
- Health
- Housing
- Income and consumption
- Jobs and earning
- Knowledge and skills