

# Health inequalities and health policy: The Norwegian case

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## NORSK SAMMENDRAG

Hovedtemaet i denne artikkelen er hvilken plass sosial ulikhet i helse har hatt i norsk helsepolitikk over de siste ti år. Det argumenteres for at eksistensen av sosial ulikhet i helse er et alvorlig problem i Norge: Det er et folkehelseproblem, det leder til sosialt differensiert utstøting fra arbeidsmarkedet, og det medfører store kostnader både i menneskelig og økonomisk forstand. Til tross for dette er problemet viet liten politisk oppmerksomhet. Myndighetene, under skiftende regjeringer, har ikke lagt for dagen noen vilje til å gjøre noe med det. I et komparativt perspektiv er Norge et tilbakeleggende land når det gjelder politikk og forskning på sosial ulikhet i helse. Det argumenteres for at dette dels skyldes hvordan sosial ulikhet oppfattes av de toneangivende politiske partiene, der oppmerksomheten er avgrenset til "vanskeligstilte" grupper, og der forskjeller mellom sosiale lag og klasser ignoreres; dels at Arbeidslinja i sosial- og velferdspolitikken er utviklet uten sideblikk på ulikhet i helse; og dels at folk flest i løpet av 1990-tallet ser ut til å akseptere en utvikling mot større sosial ulikhet. Selv om vi ikke kan se bort fra brå politiske stemningsskifter, som under fattigdomsdebatten forrige år, er det lite sannsynlig at det vil skje store endringer på dette helsepolitiske feltet i overskuelig framtid.

## INTRODUCTION

The purpose of this article is to discuss the existence of health inequalities in Norway and public policies to reduce these inequalities over the past ten years. More specifically, three questions are raised: Are social inequalities in health a problem in this country, in comparison with other European countries? How does Norway compare with other European countries in terms of policies to reduce health inequalities; where is the country located within the so called "action spectrum" (Whitehead 1998). Finally, how can we understand the particular political treatment of health inequalities in Norway; what is the role of the view of the political elites and the popular culture?

For reasons of ease I will use "health inequalities" as a short-term for health inequalities according to socioeconomic positions like occupational class, income, education, and/or area of residence as far as it is determined on the basis of socioeconomic criteria. This focus means that other kinds of inequalities are omitted, such as those between genders or geographical areas for example. It is likely that part of health inequalities between counties or smaller areas may be attributed to socioeconomic inequalities. However, in official documents geographical inequalities are seldom conceptualised in socioeconomic terms.

## HEALTH INEQUALITIES IN NORWAY

In Norway as in other western countries, ill-health, illness, and premature mortality are inversely related to

socioeconomic position. Let me summarize the current evidence in six points:

(1) Health inequalities apply to most age groups, may be with the exception of adolescence, and are most pronounced in the working ages (Arntzen 1996, Dahl and Rognerud 1999, Dahl and Birkelund 1997, Finnvold and Nordhagen 1996, 1997).

(2) Both men and women are affected by health inequalities, but men seem harder hit than women. To some extent one reason for this is artefactual, i.e. difficulties in classifying women by socioeconomic status. In particular occupational class may be an inappropriate measure of socioeconomic position among women. This is because occupational class is insensitive to women's socioeconomic circumstances and because health related and class specific selection occur more frequently among women than among men (Dahl 1991, 1993). However, part of the explanation is also related to substantive issues, as the different relationship between education and mortality among men and women indicates (Zahl 2001).

(3) Health inequalities are related to a whole variety of socioeconomic indicators. They are evident regardless of whether one applies occupational class/group, employment status, income, education, or any composite measure made up of any of these indicators (Dahl 1994), and area of residence: deprived versus affluent area, especially in the capital, Oslo (Rognerud and Stensvold 1997).

(4) Health inequalities form a social gradient. Not only are the lowest social groups worse off than those at the top, there is a graded pattern: as one moves up

the social scale, the health improves step by step (Adler et al. 1994, Dahl and Rognerud 1999, Socialvetenskapliga forskningsrådet 1998). This phenomenon is known as the “challenge of the gradient” and has invoked much discussion among inequality researchers because it is hard to explain within a traditional, medical frame of reference.

(5) Health inequalities are persistent. A cautious, perhaps conservative statement is that health inequalities in Norway are persistent and fairly stable, although recent evidence is meagre (Dahl and Elstad 2001). Recent evidence is rather in favour of an increase, at least in relative terms, than a decrease in health inequalities: Inequality in mortality according to educational achievement appears to be wider in the early 1990s than in the early 1980s (Zahl 2001). One advantage and an innovation in these two studies are that changes in health inequality are measured by indices that take account of changes in the number of incumbents in each educational category.

(6) Health inequalities in Norway are not significantly smaller than in other European countries. Comparative research shows that health inequalities in this country are at the same level, or at least so, as in other countries we often compare with among manual and non-manual workers in selected European countries. Mackenbach et al. (1997) have shown that inequality in mortality in Norway is on par with most other European countries. Use of alternative measures of socioeconomic position and several indicators of self-reported health give a similar picture (Cavelaars 1998).

Inequalities in health are a problem in various ways: First, it is a problem for public health, i.e. in terms of lives lost and life expectancy. Norway does not stand up to its full health potential when there is a difference in life expectancy between the high and the low educated of three years (Hofoss and Waaler, personal communication 2002). Second, quality of life and well-being among a significant share of the population is less than desired in terms of suffering, pain and distress caused by ill-health. Third, health inequalities manifest themselves as lost opportunities for work, social participation and self-sufficiency, and reduced life chances, all values that are highly appreciated in the Norwegian culture (Borgan 1997, Dahl and Birkelund 1999). Fourth, health inequalities are problematic in economic terms: Recent White Papers on disability pension and sickness absence document that low status groups make use of these benefits to a much larger extent than those who are better off. In fact, social inequalities in disability pension and sick leave exceed by far those of ill-health (NOU 2000:27). This indicates that the social consequences of ill-health among low status groups are much more severe than among more privileged groups. Yet, in public debate these “exclusion” problems are discussed almost completely disconnected from the inequality issue (NOU 2000:27).

The bottom line is that social inequalities in health

in Norway do persist and represent a significant problem in a number of ways. In light of this account of the facts, one would guess that health inequalities would be a high-priority task among health authorities, and enjoy a high ranking on the political agenda. This, however, is far from the case, an issue which we will turn to in the next section.

## POLICIES TO TACKLE HEALTH INEQUALITIES

What are the indicators that reflect official commitment to action by national bodies on the state level? I have scrutinised and reviewed official documents like Government Reports, Parliamentary statements, reports from Commissions of inquiry, and other relevant official publications and activities. A number of documents addressing public health issues have been prepared during the 1990s. Since research activity and research-based knowledge are part of policy, I will also give a brief review over this field. Here are the most important documents listed in chronological order, and which form the basis for my assessment:

- Green paper on Public Health: NOU 1991:10, Flere gode leveår for alle.
- White paper on Social Welfare 1995, St.meld. nr. 35 (1994-1995) “Velferdsmeldingen”.
- Ministry of Health and Social Affairs: Public Health Account and Report 1997.
- Green paper on Public Health Initiatives in the Municipalities, NOU 1998:18, “Det er bruk for alle”. Styrking av folkehelsearbeidet i kommunene.
- White paper on Social Welfare, St.meld. nr. 50 (1998-1999) “Utjæmningsmeldingen”.
- Ministry of Health and Social Affairs: Public Health Account and Report 1999.
- White paper on Values in Norwegian Health Care, St.meld. nr. 26 (1999-2000) “Verdimeldingen”.
- Social Committee in the Parliament, Innst. S nr. 222 (1999-2000).
- National Research Council: Medicine and Society Research Program 2001.

### Policy

The main picture that emerges from the policy documents may be summarized in five points.

(1) The existence of socioeconomic inequalities in health is acknowledged. It is recognised that the inequalities in this country are as large as, or larger than, in other European countries. There is a call for more knowledge about the development and what policies, programs and interventions that might be effective in reducing health inequalities.

(2) The fact that the issue is mentioned, described and commented upon does not mean that it is considered as important or of high priority among the health authorities. On the contrary, I will claim that it isn't. Compared with other health issues social inequalities

in health are not in the forefront. The White Paper on Values in Health Care is particularly disappointing since a paper that addresses values is expected to address also health inequalities. However, this issue is hardly mentioned at all. The discussion of equality makes a distinction between equality of access/use, and equality of health outcome. It fails to distinguish social inequality in health care from health, and that this offers special problems. True, the White Paper addresses problems of different population groups such as those between the genders, age groups and ethnic groups. Socioeconomic groups are, however, completely omitted. Thus, from a health inequality perspective, the White Paper on Values in Health Care is disappointing, but quite symptomatic of the situation and the state of the art in Norwegian health policy.

(3) In official documents, there is much more debate and concern over other problems and inequalities than the socioeconomic. Examples are gendered differentials in health, an issue which has been devoted an entire Green paper (NOU 1999:13), and geographical inequalities in health care provision. Also health and health care problems associated with selected socio-demographic groups like children, adolescents, elderly, and immigrants are discussed in particular. Areas of high priority are often framed in medical terms, such as accidents and injuries, psychiatric disorders, and asthma and allergy. For these areas action plans are developed, and targets are set, but not so for health inequalities.

(4) The role of the health services is seen as limited in levelling social inequalities in health. According to the green papers on public health, health promoting activities have to be a joint effort of different public policies and sectors. The primary arena for this kind of public health effort is the municipalities (NOU 1991:10, NOU 1998: 18). By taking this approach, the central Government more or less writes off its responsibility for the entire problem.

(5) There is no formulation of specific targets to reduce social inequalities in health. One should keep in mind that in the WHO context, in 1985 the European countries, Norway included, endorsed the public health objective to reduce social inequalities in health by the year 2000. This was the first target out of 12 (Helse-direktoratet 1987). Recently, due to lack of achievement of this target, it was reiterated, and the time limit was extended to 2020. This objective was not and is not manifested in national policies in this country. Neither is there any commitment to the objective of reducing health inequalities: Thus, no concrete proposals for strategies or action are put forward. A typical example is a statement taken from the Report on Public Health (NOU 1998:18). Here the vague question is raised: "Are we prepared to reduce health inequalities ...", instead of stating for example: Within x years mortality between those with basic education and those with university education shall be reduced by y per cent.

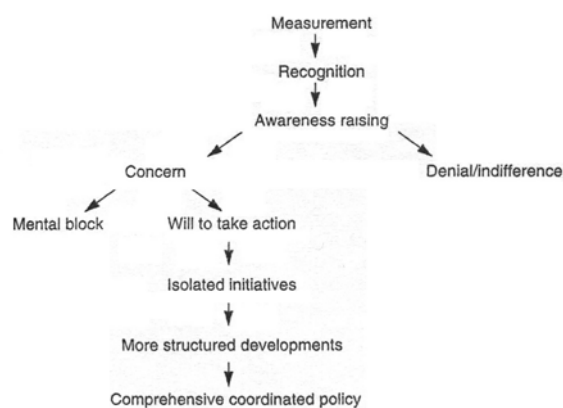
### Research activities

There is no separate programme funded or organised by the National Research Council (NRC) devoted exclusively to research on health inequalities. NRC has a research program called "Medicine and Society" which includes research on health inequalities as one of a number of research themes. This should come as no surprise since the Research Programme takes as its point of departure the official documents listed above and the ensuing policies. The programme includes themes such as risk perception, gender roles and health, health culture, nutrition, health prevention, perception of health and illness, and more. Thus, research on health inequalities has to compete with a lot of other topics for attention and money. Under this research program, six out of about 70 current projects have health inequalities as their main subject. Thus, health inequality research is low on the agenda in the NRC.

The National Institute for Public Health has a monitoring project funded by the Ministry of Health. The project is a response to the call by the National Health Authorities for more knowledge of the state of the art and the latest developments. This is, of course, a valuable initiative. On the other hand, it is a clear illustration of how little we know about the present state and the latest developments in this area.

Compared with other European countries like Finland, Sweden, the Netherlands and the UK, the scientific production in this country is meagre, although the quality is quite high as judged by the relatively high number of publications appearing in international refereed journals. In year 2000, a review of the scientific empirical production on health inequalities identified about 30 publications issued during the 1990s. Most of them were descriptive in nature (Dahl 2000). This is a small amount. For instance, in Finland, about 250 titles were published on this subject during the same decade (Forssas et al. 1999).

Where does this leave Norway in an international perspective? In order to locate Norwegian policy within a broader policy context, I will apply Whitehead's (1998) framework depicted in Figure 1.



**Figure 1.** Action spectrum on inequalities in health (Whitehead, 1998).

Norway is located at the lower end of Whitehead's action spectrum – somewhere in the area around “measurement”, “awareness raising”, and “indifference”. It would be an exaggeration to say that the attention is on the move towards concern. If it has become a concern, it is verbally and has not so far reached the level of will to action or actual action. This statement needs qualification: There is no will to take action on socioeconomic health inequalities. However, among the major parties in Norway, there is now a will to take action to improve the living conditions among the “poor” or the “truly disadvantaged”, a point I will return to below.

Norway's humble position in the action spectrum stands in contrast to an increasing number of European countries. Let us sweep over a few of the more advanced countries. In the Netherlands, a comprehensive research programme was launched for the period 1993-97. It was replaced by a program initiated in 1994 that focused on interventions and policies to reduce socioeconomic inequalities in health (Programme Committee on Socio-economic Inequalities in Health 2001). In the Netherlands, there is a lively debate, and there is a political consensus on the objective to reduce health inequalities. In the UK, research on health inequalities has been tremendous over the last 20 years. After a new research programme on Variations in health was launched in the late 1990s, the research activity has accelerated even more. The Blair Government has made reduction in health inequalities a prime objective. In Sweden, in 1996 the Parliament passed a bill announcing a long-term research plan and commissioned studies to inform policy development. The Swedes have worked on the topic on policy level over the last years. For a number of years, several research institutions and individual researchers have published high quality papers on the subject. Last year, a separate research institute, CHESS, i.e. Centre for Health Equity Studies, was established to lead the research efforts in this field, and to educate younger generations of researchers (<http://www.chess.su.se/>). In Finland the theme has been debated on a high political level for some years. For a decade or more, the research activity has been high resulting in an impressive number of papers in international journals. Several institutes are involved in this kind of research. In Denmark, the current Danish Public Health Program which was launched a couple of years ago, targets reduction in health inequalities as one of two main objectives. In Spain, the topic was put on the agenda lately as a national scientific Commission on inequalities in health was established. Even the USA, a country infamous for its tolerance to social inequalities, is on the move. Two recent initiatives made by the US Department of Health and Human Resources address social inequalities in health. One of them, the Healthy People 2010 report, which was issued a few years ago, has a number of specific targets related to reducing health inequalities. Several US researchers are currently

pushing the research front in search for explanations for health inequalities. On the international level, the EU has funded several research projects on the topic. The European Scientific Foundation has funded and created a multidisciplinary and international network of researchers to push the knowledge in this particular field forward (<http://www.uni-duesseldorf.de/health/>).

To sum up: In Norway, the Government and the National Health Authorities recognise that socioeconomic inequalities in health do persist. This recognition, however, is not translated into any commitments or specific policy targets. No policies, actions, programmes, or initiatives are pursued aiming specifically at reducing socioeconomic inequalities in health. There is little public debate over the issue. The knowledge base is meagre and research funding and activity are limited. Several European countries are far ahead of Norway in terms of public debate, policy initiatives and research efforts. These empirical observations justify that Norway be labelled a laggard in health inequality policy.

## WHY IS NORWAY A LAGGARD?

Why is a social democratic, highly egalitarian country like Norway so ignorant or indifferent about social inequalities in health? How can we understand that there is so little awareness and concern in a situation where socioeconomic inequalities are a serious problem in a number of respects?

Clearly, the problem itself is not very different from that in other countries. Inequality patterns resemble those found in Sweden, the Netherlands and Finland, all countries in which the issue has stirred much debate and concern. In Norway as elsewhere, the problem is well known and acknowledged. Thus, the answer has to be sought in the ways the problem is defined, assessed and evaluated. In this section I will put forward a cultural interpretation, namely that it is deeply rooted in beliefs in the Norwegian culture and the policies that may be derived from these beliefs.

In the late nineteenth century, the French philosopher Toqueville talked about the “Passion for Equality” after having visited the USA. This expression fits also the self-image of Norwegians: “We are equal”, seems to be an unquestionable credo. And, quite correctly, we are indeed according to national income statistics ([http://www.nsd.uib.no/data/katalog97/Kap4\\_5\\_7.shtml](http://www.nsd.uib.no/data/katalog97/Kap4_5_7.shtml)). Although income inequality has increased slightly over the past ten years, we are still one of the most egalitarian countries in the world (St.meld. nr. 50, 1998-1999). So, one might argue that it is not so much more to do with this. If one wants to redistribute income even more, one will very soon reach a point beyond which further redistribution becomes counterproductive. According to the ruling economic orthodoxy, work will not pay, extra effort will not pay, so economic growth will be hindered, and we all will be worse off, also underprivileged groups.

Another point is that the widespread belief that “we are equal” makes it difficult to see inequality when it presents itself. This is an interpretation in line with the Thomas theorem: “If you define the world as real, it is real in its consequences”. In this interpretation, the belief that we are equal prevents us from seeing inequality. The “equality glasses” do not let the “inequality” rays pass through. And if they pass through and become perceived, they tend to be rejected because they do not fit the mental map many have of the Norwegian society. This interpretation might be questioned, however. Sweden has a more egalitarian income structure than Norway, and probably also an equally egalitarian culture. But, in Sweden health inequalities have been a hot topic for years.

So, neither a narrow income distribution nor an egalitarian culture in themselves will necessarily lead to a neglect of health inequalities. In Norway, it has to be something else and/or more to it. Let us take a look at how social inequality has been perceived in Governmental documents over the past decade.

### *The “official” view on social inequality*

A careful reading of the most recent White Paper on Levelling Social Inequalities, and the accompanying response from the Parliament, reveals some interesting traits on how inequality is perceived among the political elites these days (St.innst. nr. 222 1999-2000).

Inequality is mainly perceived of in terms of disadvantaged, vulnerable, or marginalized groups and individuals. The White Paper on Levelling Social Inequalities identifies nine target groups for public intervention: households with long-term low incomes, disadvantaged immigrants, disadvantaged families with small children, people with psychiatric illness, people with long-term illness, long-term unemployed, and occupationally impaired, disadvantaged pensioners, disabled, drug addicts, and finally homeless. This view is endorsed by almost the entire political establishment, at least as the political parties represented in the Parliament are concerned. This means that inequality in terms of social stratification or social class is hardly mentioned, and if so, it is relegated to minor importance.

A telling and typical example is a speech given by the former Minister of Social Affairs, Guri Ingebrigtsen at a meeting in 2000: “The universal system of benefits and services is not sufficient to deal with the problems of these people. In addition, we need to focus more on marginalization and poverty. During 50 years we have built a welfare state for the majority. Now our task is to lift the minority”... “Our main focus is the most disadvantaged”. It is noteworthy that these statements are put forward by a Labour Party politician. It would come as no surprise that this view is endorsed by the current conservative Minister of Social Affairs (see for example: <http://www.dagbladet.no/nyheter/2001/11/21/296461.html>). This reflects that prominent representatives from both left and right hold

the view that the main problem of social inequality is that it is a marginal phenomenon, and not one of class or stratification. Social inequality is seen as equivalent with, and confused with poverty and or social exclusion. Of course, the poverty perspective is important, also in an advanced welfare state. It is, however, limited in scope. It focuses on the 5, or 10 per cent at most – at the lower end of the ladder, while leaving the remaining 90-95 per cent in the shadow.

This means that the political establishment ignores the “challenge of the gradient”, as a problem for social policy and for public health. In recent health inequality research the gradient has received considerable attention (Adler et al. 1994, Dahl and Rognerud 1999). What has fascinated the research community is the intriguing question why those next to the top have worse health than those right on the top, as long as the material and social conditions of the former are excellent too. Also, the renewed interest in income related health inequalities both at the individual level and at the contextual level differs from the current view on social inequality in Norway. This research has produced evidence that living in an inegalitarian community is harmful to one's health, regardless of one's own income level (Mackenbach 2002, Wilkinson 1996). These fresh insights into the health damaging effects of stratified economic and social inequality are completely lost in the current Norwegian debate.

For more than a decade, the so-called Work Approach has been the corner stone of Norwegian welfare policy. The essence of the Work Approach over the last decade is that work should be the first option of all adult Norwegians. This is good for the society as well as for the individual. “We have learned that the most important cause of poverty and social exclusion is weak links to the labour market” (former Minister of Social Affairs, Guri Ingebrigtsen 2000). The Work Approach is embraced by the entire political establishment in Norway. In the present context, it is important to point out that the Work Approach has been developed virtually without any concern about its relationship to health inequalities. The prime purpose has been to make work, any work, the first choice of adult people.

In a health inequality perspective there are two flaws with the Work Approach. First, if unsuccessful, people living on public benefits may be left in (relative) poverty. Thus, their health may deteriorate further. Second, being workless is the primary diagnosis made by the Work Approach. Lack of work is the single most important cause for people's lousy living conditions. So what is the medicine? Obviously, it is work, that is paid work in the ordinary labour market. The Work Approach has, however, very little to say about what kind of work. It appears that most kinds of work will do. This view is problematic. It is well documented that low status and low skilled jobs expose people to health hazards and high levels of job strain, deprive them of rewards and limit the decision lati-

tude. Karasek's "Job Strain" model and Siegrist's Effort/Reward imbalance model both point to the health risks inherent in low status jobs (Karasek 1979, de Jonge et al. 2000). Thus, moving people from welfare to work, even if proved successful, does not necessarily enhance their health, although it might, at best, improve income and living conditions.

Further, a narrow focus on disadvantaged groups has the shortcoming that it overlooks that many individuals who belong to these groups often are recruited from the lower social strata, such as unskilled workers and low skilled salaried employees. Thus, one tends to neglect that there is a high inflow and outflow between the lower occupational strata in society and the non-employed. To a high degree it is the same people, but social policy is primarily concerned as long as they are outside the labour market. By focusing so one-dimensionally on the jobless, one misses the opportunity to prevent in the first place that some people move from lower occupational strata into the echelons of the non-employed. And if these people become re-employed, as we have observed during the recent economic boom, they are still considered a problem because they generate high sickness absence rates. In a Work Approach perspective, however, this should rather be seen as a success indicator, since it tends to reflect that people with chronic health problems have (re-) entered the labour force.

Put briefly, the dominant strategy in social policy over the past 10 years, i.e. the Work Approach, is inadequate to tackle health inequalities. It remains to be seen if the new joint initiative made by the Government, and the organisations of the employees and employers to form a more inclusive labour market will be successful, and if it reduces social inequalities in health.

#### *Changes in the popular view on inequality?*

Recent research indicates that the public has changed their view on social inequality over the last decade. An increasing number of people recognises that the Norwegian society has become less egalitarian. However, the population accepts larger inequalities in earnings,

and care less about them today than it did eight years ago (Knudsen 2001). One reason seems to be that a larger proportion of the population have higher socio-economic status: Today, more Norwegians have higher incomes and are better educated. Further, Knudsen interprets this finding as an adaptation to the real increase in income inequality over the same decade. Briefly put: Increased economic inequality and social mobility result in less concern for social inequality. It is very difficult to assess whether the greater acceptance of inequality influences the public's view on health inequalities. Maybe there is no connection at all. But if there is, it is hard to imagine that concern for health inequalities would move in a direction opposite to that for economic inequality in general. Thus, one might perhaps say that there is a kind of correspondence between the view of the political elites on health inequalities and that of the public: No one cares much about it.

## CONCLUSION

This discussion leads to three conclusions:

Social inequalities in health remain a serious problem in contemporary Norway, both in terms of population health and in terms of expulsion and long-term exclusion from the labour market and associated social, human and economic costs. Despite this, there is little political concern over this, or will to act upon the situation. In a comparative perspective Norway is a laggard in health inequality policy. The current political elite consensus on what constitutes inequality and how it should be dealt with, combined with evidence that suggests that the public care less about systematic social inequalities than before, makes it unlikely that public policies in this area will change notably in the foreseeable future. However, political winds may shift rapidly and without warning, so this prediction might be proven wrong.

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