



INSTITUTE *of*  
HEALTH EQUITY



EXECUTIVE SUMMARY

**RAPID REVIEW OF INEQUALITIES  
IN HEALTH AND WELLBEING  
IN NORWAY SINCE 2014**

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# RECOMMENDATIONS

## A. GIVE EVERY CHILD THE BEST START IN LIFE

**Reduce the perpetuation of inequities from one generation to the next by:**

- Ensuring equal access to high quality early childhood education and care that are socially inclusive and culturally sensitive.
- Joining up service support by enhancing coordination, reducing bureaucratic barriers to access and developing coordination mechanisms for families.
- Increasing financial support proportionately to reduce child poverty.
- Ensuring resources are directed proportionately to meet the needs of children of immigrants, undocumented migrants and those in poverty. In particular through increasing access to high-quality maternity services and early years childcare and ensuring that stay-at-home subsidies do not act as a reward for keeping children at home.

## B. ENABLE ALL CHILDREN, YOUNG PEOPLE, AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

**Reduce the proportion of young people left behind by the education and training systems or who become socially isolated by:**

- Reducing inequalities in educational attainment.
- Ensuring an adequate balance between academic and vocational skills and reducing educational dropout rates.
- Adopting a whole-systems approach to schooling and education and ensuring meaningful learning activities and supportive environments that promote experiences of coping and mattering.
- Promoting the social integration and mental health of adolescents and young people through schools, tertiary education facilities and employers.
- Increasing public investment of, and business involvement in, apprenticeships and ensuring that there is greater inclusivity in all these programmes.
- Increasing proportionate investment in skills development across the life course, focused on addressing the needs of those with skill deficits that lead to labour market exclusion.

## C. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

**Strengthen measures to ensure all benefit from access to employment and good-quality work by:**

- Promoting the adoption of good management guidelines to reduce musculoskeletal injuries and work-related stress, in particular.
- Improving the quality and evaluation of active labour market programmes.
- Increasing participation in the labour market of people with disabilities and ill health by increasing access to work and adequate support systems.
- Ensuring that the level of minimum wages and working conditions are sufficient to support workers' health and wellbeing across all sectors and social groups, with particular attention to women and immigrants in vulnerable situations

## D. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

### Ensure a sufficient income for health and wellbeing by:

- Ensuring greater equity of income and wealth across the gradient, and that the poorest are not left behind, through a more integrated and proportionate tax and welfare system.
- Providing social security safety nets that are sufficient to guarantee adequate replacement income to people who cannot work, and for those most at risk of losing their jobs and reduce barriers to accessing these.
- Improving digital inclusion by increasing digital literacy and access to devices for those in vulnerable situations.

## E. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

### Ensure healthy and sustainable places by:

- Strengthening community co-creation and delivery of policies and interventions and supporting community participation and volunteering for all.
- Ensuring equitable access to local green spaces and meeting places.
- Extending an affordable public transport system across Norway, reducing reliance on road vehicles and supporting active travel infrastructure.
- Increasing the supply of social housing and improving housing affordability.
- Developing and enforcing a standard for healthy housing quality, including the private rented sector.

## F. TACKLING THE SOCIAL EXCLUSION OF MINORITIES AND OTHER LEFT BEHIND GROUPS

### Reduce discrimination and social and economic exclusion of minority groups in vulnerable situations by:

- Taking effective intersectoral action to reinforce the efforts of service providers to ensure equitable access, experiences and outcomes in health, education and employment.
- Ensuring effective engagement of minority groups in the development and delivery of services and interventions and in community development – working with cultural and religious sensitivities while recognising intra-group diversity and avoiding stereotyping.
- Ensuring that an asset-based approach is taken in the design and delivery of services to gain critical involvement of and feedback from minority communities including prisoners, the LGBTQI+ community and those with serious mental health and substance misuse problems.

## G. STRENGTHEN THE ROLE AND IMPACT OF ILL-HEALTH PREVENTION

### Improve health prevention measures by:

- Increasing resources for preventative health measures as a percentage of the total health budget in Norway to achieve greater intensity of action in reducing inequalities in determinants, public health measures such as vaccination, and behavioural outcomes.
- Basing health behaviour interventions on principles of proportionate universalism to reduce inequities in these behaviours.
- Using tax and regulatory measures rather than voluntary codes to influence health-related behaviours and ensure greater equity.

## H. PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

### Pursue environmental sustainability and health equity together by:

- Undertaking a far-reaching health equity impact assessment of the Climate Action Plan and adapting the Plan to ensure greater social, economic and health equity.
- Ensuring that commitments to active travel and other essential health equity and environmental measures are implemented.
- Developing legislation to reduce greenhouse gas emitting exports and require financial organisations and other businesses to invest only in companies and products which have committed to net zero.
- Ensuring that the health and health equity impacts of climate change are widely understood and that those with responsibility for public health incorporate these into planning and actions.

## THE IMPACT OF THE COVID-19 PANDEMIC AND THE COST OF LIVING CRISIS

### Reduce the inequitable social, economic and health impacts of the pandemic and the cost of living crisis by:

- Ensuring that the inequitable social and economic impacts from COVID-19 containment measures are considered in planning and implementing Government policies.
- Undertaking timely and regular assessments of the impacts of the cost of living crisis on social and economic position and on health.
- Providing the additional resources, programmes and interventions needed to address inequalities in health, wellbeing and their social determinants as the cost of living crisis impacts further.

## THE HEALTH EQUITY SYSTEM IN NORWAY

**A national strategy and subsequent policy on health equity should be developed to take action on the social determinants of health and prioritise health equity and wellbeing by:**

- Ensuring that the following key principles for action on the social determinants of health are adopted in the strategy:
  - > Developing the wellbeing economy approach.
  - > Public sector innovation.
  - > Democratic participation in national and local policy decisions.
  - > Strong partnerships between national and local governments and between sectors and organisations.
  - > Health equity impact assessments.
  - > Proportionate universalism.
  - > Strengthened accountability and effective monitoring for health equity.
- Developing a health equity system which comprises national and local governments, the voluntary and community sector, healthcare organisations, business and the economic sector, public services.

**The Voluntary Community and NGO sector should act as an equal partner in the health equity system through:**

- Resources to ensure that there is sustainability in the sector and that its service provision, advocacy and representative role is enabled.
- Being commissioned to provide evidence and information to policy makers and to service providers.
- Municipalities strengthening collaboration with the sector and supporting delivery of services and support to communities.

**The healthcare sector should contribute to greater health equity through:**

- Adoption of equity focussed anchor organisation approaches.
- Support for patients' and communities' living and working conditions.
- Acting as advocates for health equity nationally and locally.
- Supporting the healthcare workforce and suppliers and contractors to have healthy living and working conditions.
- Reducing inequities in access to health care services.

**Businesses should contribute to greater health equity through:**

- Supporting their own workforces.
- Ensuring products, services and investments are healthy.
- Their influence on wider determinants nationally and locally.

**Public services should be centrally involved in the health inequalities strategy by:**

- Developing strong partnerships and programmes with business, VCS and other sectors.
- Developing as equity focussed anchor organisations.

**The prioritisation of health inequalities should be strengthened in some municipalities by:**

- Developing municipal capacity and leadership for health inequalities to ensure greater focus on the social determinants and the gradient.
- Strengthening national accountability mechanisms to ensure that all municipalities are more accountable for health equity and there is greater coherence in action on the social determinants of health.



# INTRODUCTION

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## CONTEXT AND COMMISSION OF THE REPORT

This report of a rapid review of inequalities in health and wellbeing in Norway since 2014 was commissioned by the Norwegian Directorate of Health to inform the development of a National Strategy to Reduce Social Inequalities in Health. It is a joint collaboration between UCL Institute of Health Equity (IHE) and WellFare: Nordic Research Centre for Wellbeing and Social Sustainability, Department of Education and Lifelong Learning at the Norwegian University of Science and Technology (NTNU).

Norway is a country characterised by a high and increasing standard of living for much of the population, but with some significant and growing social and economic inequalities. Despite a long tradition of reducing these inequalities by introducing welfare policies and structural measures, inequalities in health and the social determinants of health persist and are widening for some groups (1,2). As in many other countries, social inequalities in health are widest in the largest cities, and positive and negative health drivers are clustered in different parts of the cities (1,3,4).

It has been 16 years since Norway adopted its first National Strategy to Reduce Social Inequalities in Health (5). Some key reforms initiated or implemented in connection with the Norwegian strategy to tackle health inequalities are the Public Health Act (2011), the Coordination Reform (2012), and the Inclusive Working Life Agreement (IA-avtalen). In Norway, there is renewed political interest in acting to reduce health inequalities which arise from social conditions and are, therefore, preventable.

## KEY QUESTIONS ADDRESSED IN THIS REPORT

The report provides up-to-date information on inequalities in health and its social determinants in Norway and proposes recommendations on policies, effective actions and the development of a Norwegian health equity system to address these inequalities. It highlights promising practices from examples in Norway, including from several different municipalities, which could be scaled-up or replicated.

The focus of the report is on inequities in health, that is systematic differences in health between social groups that are avoidable by reasonable means. These inequities are a result of the social determinants of health – the conditions in which people are born, grow, live, work, and age –, and the structural drivers of these conditions – the unequal distribution of power, money and resources which shape and drive the conditions of daily life (6).

Health and wellbeing are socially graded – people, as well as the groups and communities to which they belong, have progressively better health the higher their social position and the better their conditions of daily life. We are concerned here with two inter-related manifestations of inequities, namely the social gradient running through society and, at the extreme of this gradient, the worse health and social conditions of those left behind in the most marginal and/or vulnerable situations.

In addition to the above, the report was commissioned by the Norwegian Directorate of Health to answer several specific questions particularly relevant to the current Norwegian context:

- i. What might proportionate universalism look like, in a context where universal welfare is fairly common?
- ii. Which impact assessment tools can be used to understand and reduce social inequalities?
- iii. Which factors in childhood are important for intercepting the ‘inheritance’ of social position?
- iv. How can the healthy tax exchange contribute to reduce social inequalities in health?
- v. How does migration and migrant background interact with socioeconomic factors to produce health outcomes?
- vi. Has the pandemic raised new concerns for policies to reduce social inequalities in health and, if so, which?
- vii. What is the role of the health system in combatting social inequalities in health, and what might an equitable health system look like?

## THE SOCIAL DETERMINANTS OF HEALTH

The social determinants of health comprise a wide and complex range of social, economic, and environmental factors, as well as political and cultural factors. The WHO Commission on Social Determinants of Health conceptual framework summarised these as:

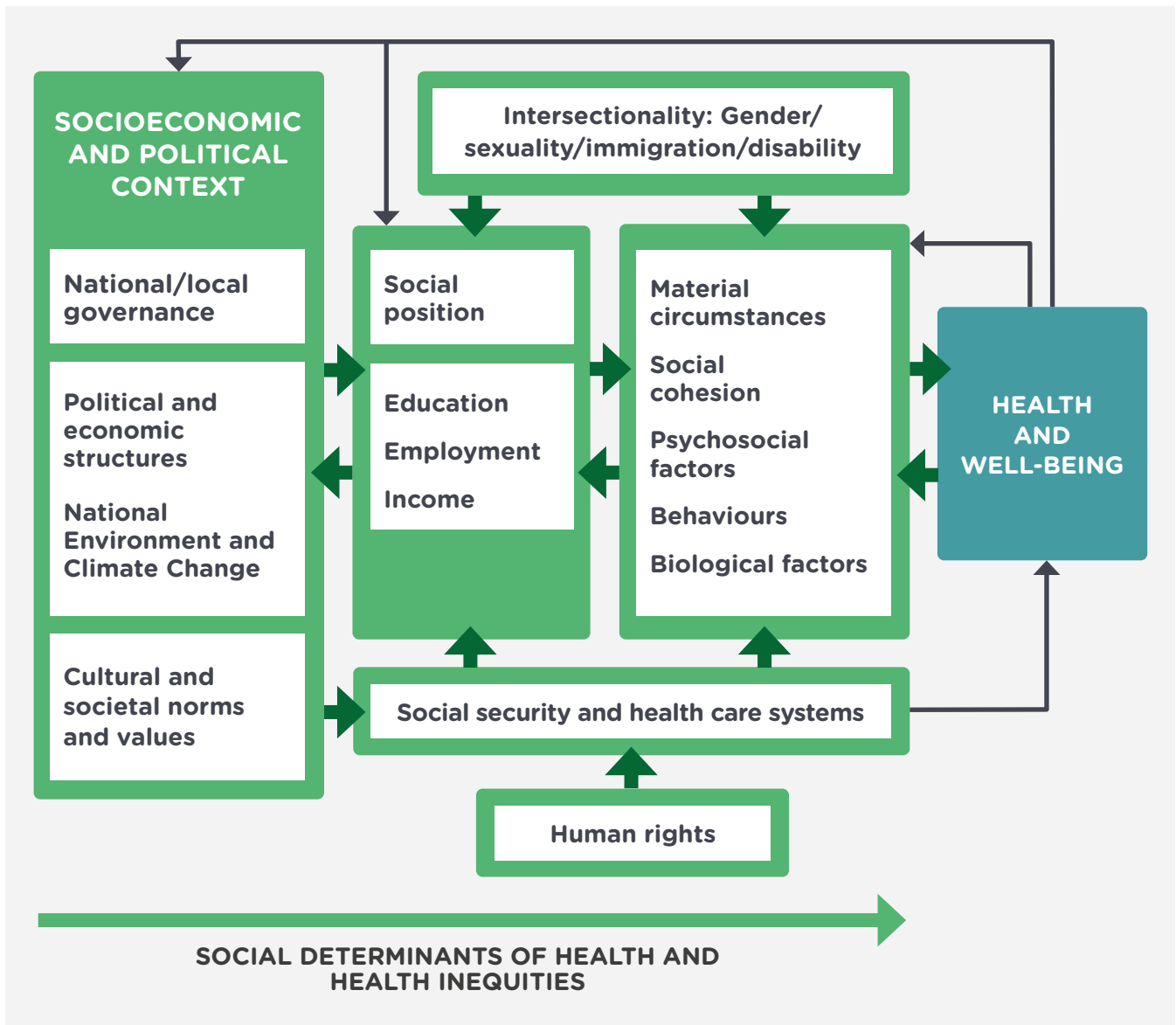
**Socioeconomic and political context** of a country can be understood as the main characteristics of a country that influence the form and magnitude of social stratification as well as the implications of stratification for the conditions in which people are born, grow, live, work and age.

**Social position** identifies key dimensions of social stratification and raises questions about how extensive stratification is along any of the dimensions in a particular society.

Based on their social position, the extent of social stratification and the socioeconomic and political context of a country, people experience different **types of exposures, vulnerabilities and consequences to health**.

Figure E.1 provides a modification of the 2008 WHO Commission on the Social Determinants of Health framework (6) to take account of subsequent evidence and discussions with experts and highlighting those that most affect Norway.

Figure E.1 Social determinants of health framework for Norway



## THE EIGHT MARMOT PRINCIPLES

Reducing health inequalities requires action on the six policy objectives outlined in UCL-IHE *Fair Society, Healthy Lives* and in the follow-up report, *Health Equity in England: The Marmot Review 10 Years On*. These policy objectives cover the main social determinants of health.

**The six Marmot principles are:**

- 1 → Give every child the best start in life
- 2 → Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3 → Create fair employment and good work for all
- 4 → Ensure a healthy standard of living for all
- 5 → Create and develop healthy and sustainable places and communities
- 6 → Strengthen the role and impact of ill-health prevention

**To this list of six, two additional principles have since been added:**

- 7 → Tackle discrimination, racism and their outcomes
- 8 → Pursue environmental sustainability and health equity together

They are similar to those identified in the Swedish commission and Norwegian Council on Social Inequalities in Health reports.

## THE STRUCTURE OF THIS REPORT

In the report, we:

- Review the key available evidence of inequalities in health and wellbeing in Norway.
- Describe the inequalities that exist in each of the eight areas covered by the Marmot principles, identify the policy mechanisms and life course processes giving rise to the inequalities.
- Describe how the recent COVID-19 pandemic has replicated and, in some cases, amplified these existing inequalities in health and wellbeing and their social determinants.
- Indicate the type of health equity system needed in Norway to address the inequalities identified in previous chapters.
- Provide key findings and recommendations for action.

We also provide case studies of promising practices. These case studies are not necessarily based on evaluations that demonstrate what works; rather they illustrate how key principles of action can be put into practice.

# HEALTH INEQUALITY INDICATORS IN NORWAY

## KEY FINDINGS: HEALTH AND WELLBEING INEQUALITIES

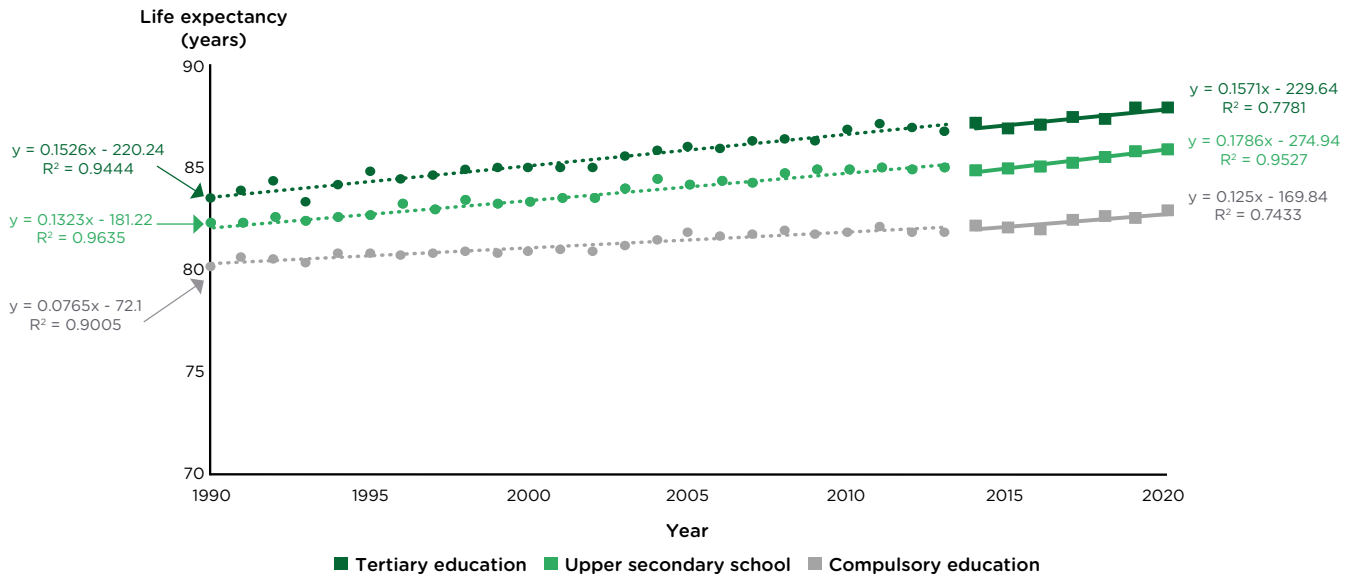
- There are persistent inequalities in life expectancy and death rates in Norway whether measured by educational level, occupation or income. These inequalities are on a gradient running from higher to lower social and economic position.
- The gaps between the most advantaged and disadvantaged groups are between 3.5 and 5.5 life years for women and 5.0 to 7.3 years for men, varying slightly by type of indicator used: education, occupation or income level.
- Individuals at the lowest end of the socioeconomic gradient suffer multiple disadvantages and have much shorter lives and worse health.
- There are clear inequalities in health related to level of education, indicated by surveys covering self-rated health, chronic illness and mental health.
- Among adults there are wide inequalities in reports of symptoms of psychological distress, related to level of education.
- The level of family affluence has a graded impact on the wellbeing of adolescents, as measured by loneliness, coping, making a contribution and psychological distress — as well as on their expectations for future wellbeing.
- There are several groups who are significantly worse off on all subjective wellbeing indicators compared to the general population. Groups who are particularly at risk of having low levels of wellbeing include people that have low income, no or low labour market attachment, low education, physical disabilities, symptoms of mental illness, the LGBTQ+, people in single households and people who are exposed to discrimination or social exclusion.

## LIFE EXPECTANCY BY EDUCATION

Educational level has been used for many years in Norway to monitor inequalities in health and many of its social determinants. In their analysis of health inequalities in 2015, Dahl and van der Wel used available data to point to the fact that inequalities in life expectancy by educational level of those aged 35 had been increasing in Norway since at least the 1960s (3). It can be seen from Figure E.2 that inequalities in female life expectancy by education widened between 1990-2020. In fact, over the period 1990 to 2013 the rate of increase

in life expectancy of women with tertiary education was almost twice that of women who had only attended compulsory education (women with tertiary education gained an extra 1.8 months of life expectancy each year compared to 0.9 months for those with only compulsory education). Among men, inequalities in life expectancy by education also widened, although the increase in inequality was less than for women: around 30 percent faster for those with tertiary education than those who only attended compulsory education.

Figure E.2 Female life expectancy at age 35 by education, 1990 to 2020



Source: NIPH Database (7).

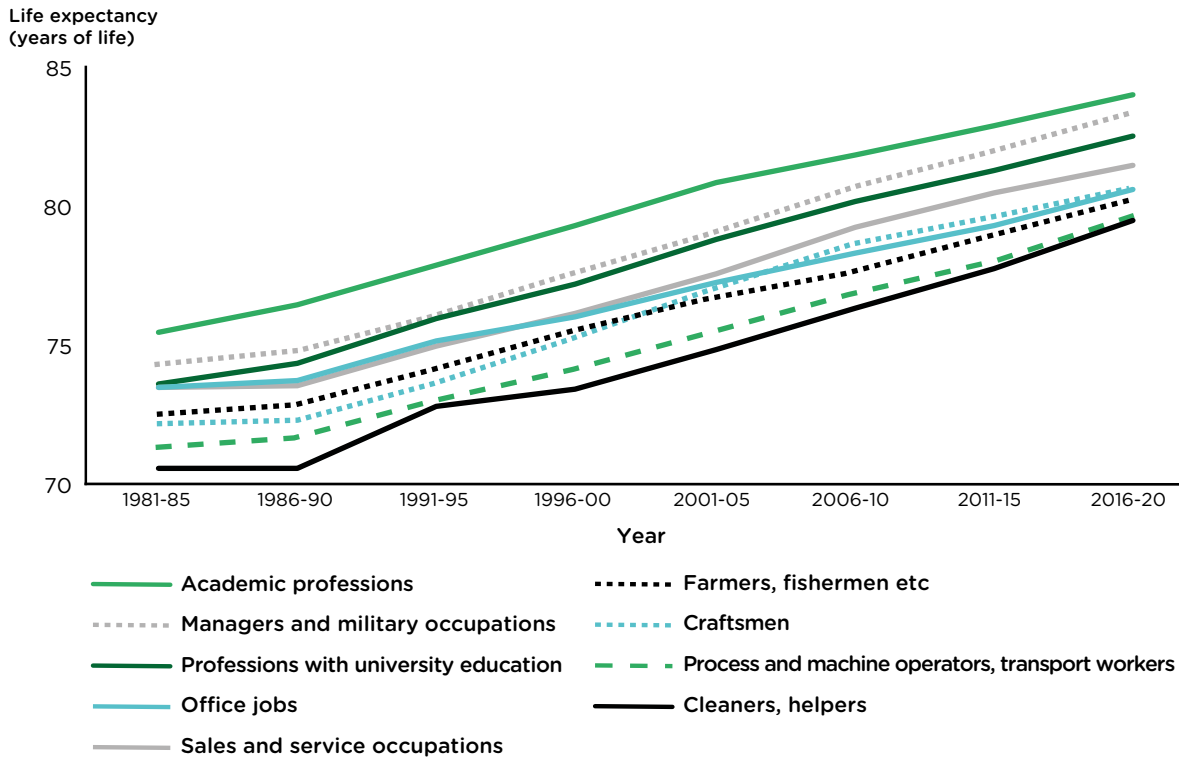
### LIFE EXPECTANCY BY BROAD OCCUPATIONAL GROUPS

An alternative method of classifying individuals to assess the extent of health inequalities is by using broad occupational groups. These figures were recently updated by the Statistics Bureau to cover the trend from 1981-5 to 2016-20 (8). Figure E.3 shows that, while life expectancy increased in every broad occupation group over the 35-year period, a clear and largely consistent gradient was sustained over time for males, with a gap

of nearly five years between academic professions and cleaners in both 1981-5 and 2016-20.

Among females, the gradient in life expectancy by occupation in Norway has been less steep throughout the period 1981-5 to 2016-20, but the gap between academic professions and cleaners has nonetheless widened - from around two years in 1981-5 to 3.5 in 2016-20.

Figure E.3 Male life expectancy at birth and broad occupational groups and five-year time periods, 1981-2020



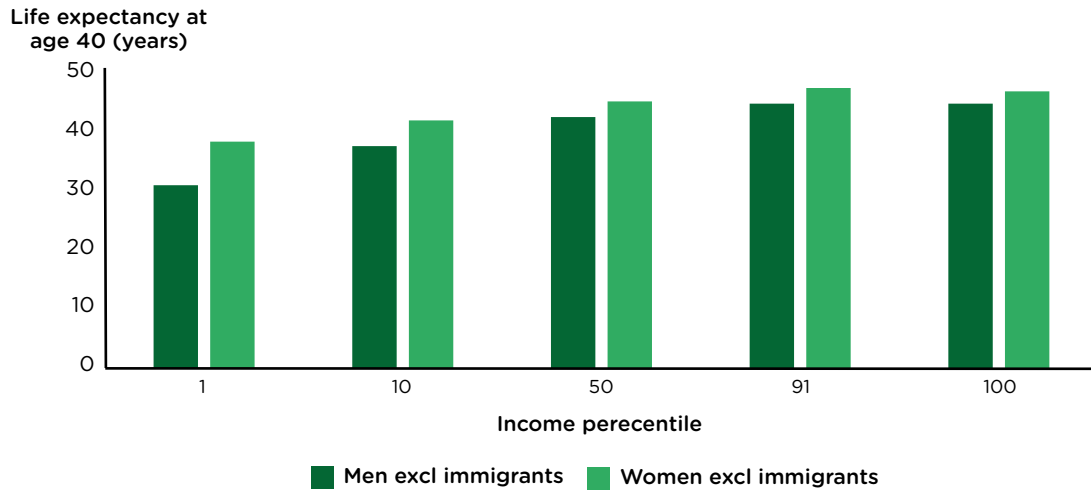
Source: Texmon (2022) (8).

### LIFE EXPECTANCY BY INCOME

There are also clear inequalities in life expectancy for both men and women related to household income. Kinge et al. (2019) used Norwegian registry-based data linking household income over the previous five years to mortality data in each of the years 2005 to 2015 for persons aged at least 40 years. Figure E.4 shows residual life expectancy at age 40 in 2011-15 for selected household income percentiles. There were steep gradients up to median income and shallower gradients thereafter for both men and women. The gap in life expectancy at age 40 between the first and 10th

percentile was 6.53 years for men and 3.56 for women. Further incremental gaps across the gradient resulted in an overall gap between the top and bottom percentiles of 13.8 years for men and 8.4 years for women at age 40. Kinge et al. point out that over half (50.6 percent) of individuals with income in the lowest one percent lived in single-person households and this figure falls exponentially across income percentiles with only 9.1 percent of households in the top one percent being single person households.

Figure E.4 Life expectancy at age 40 by household income percentile and sex, excluding immigrants, 2011-15



**Note:** The primary income measure was “equivalized household income,” defined as household income after tax divided by the square root of the number of household members, averaged across the preceding five years.

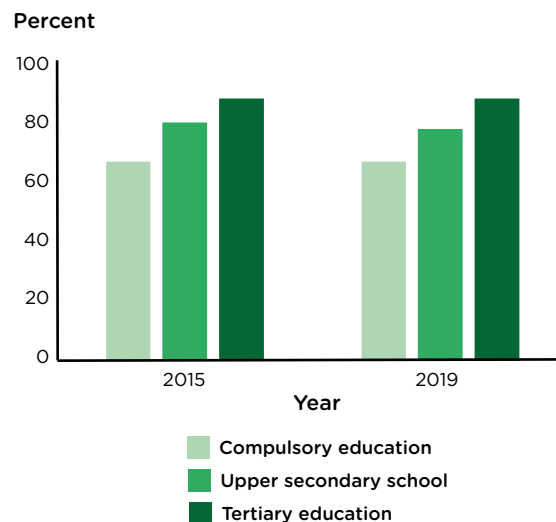
**Source:** Kinge et al. (2019) (9).

### SELF-REPORTED HEALTH

There are clear inequalities in health related to level of education, indicated by surveys covering self-rated health, chronic illness and mental health. Figure E.5 shows that the percent rating their health as good or

very good increased from 66 percent among those with only compulsory education to 87 percent among those with tertiary education in both 2015 and 2019.

Figure E.5 Age standardised proportion of survey respondents who perceive their health as very good or good, by educational level, Norway, 2015 and 2019



**Source:** NIPH Database (7)

Similarly, while 43 percent of those with only compulsory education reported a chronic condition

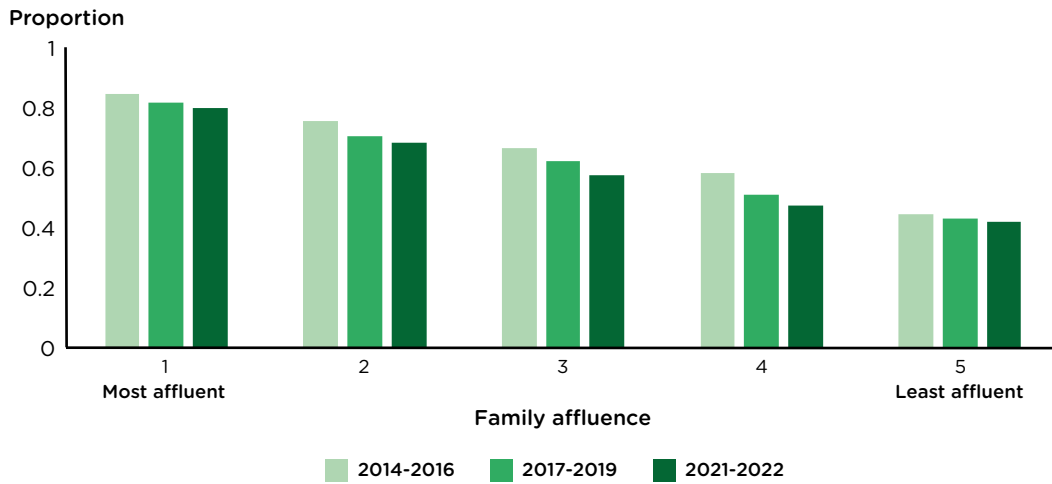
lasting six months or more, this was the case for only 30 percent of those with tertiary education.

## INEQUALITIES IN WELLBEING AND MENTAL HEALTH

While Norwegians on average enjoy high levels of wellbeing, there are clear inequalities related to socioeconomic position. Among those who have a university education, 18.6 percent report low life satisfaction, while among those who have compulsory education as their highest educational level, 38.6 percent report having low life satisfaction (10).

Level of family affluence has a graded impact on the wellbeing of adolescents, as measured by loneliness, coping, making a contribution and psychological distress, as well as on their expectations for future wellbeing as demonstrated in Figure E.6. The proportion of boys and girls currently in lower secondary education who expect to have a good, happy life has declined between 2014-16 and 2021-22.

Figure E.6 Boys in lower secondary school who expect to have a good, happy life by family affluence, 2014-16 to 2021-22



Source: Young Data (11)



# THE SOCIAL DETERMINANTS OF HEALTH IN NORWAY

## 3A. GIVE EVERY CHILD THE BEST START IN LIFE

### KEY FINDINGS:

#### MATERNITY CARE

- There are a range of high-quality universal services available during the pre- and post-partum period for mothers and babies. Despite this there are avoidable inequalities in outcomes during this period.
- While most inequalities in infant mortality have been eliminated in Norway as a result of prolonged, equity-focussed interventions and approaches, there are inequalities related to the experiences of migrant women.
- Undocumented women who received maternity care from NGO-run clinics have reported inadequate antenatal care.
- Poor understanding or lack of information provided by maternity staff is associated with low Norwegian language proficiency and the need for an interpreter as well as refugee status, low education and unemployment.

#### EARLY CHILDHOOD EDUCATION AND CARE

- Norway has a high participation rate in early childhood education and care (ECEC) as well as access to parental leave. But ECEC is not free.
- Attending high-quality kindergarten has a beneficial impact on children's development, especially for children from families with limited education and low income. However, children from families with limited education, low income and parents from minority backgrounds are less likely to attend kindergarten than other children.
- Children in families in which the mother is not in work are less likely to attend kindergarten than those whose mothers work outside the home.
- The child-care allowance allowing parents to choose their preferred form of care of children aged 13 to 23 months is disproportionately received by women and is likely reinforcing gender inequality associated with child care responsibilities.

#### CHILD POVERTY

- Child poverty has increased in Norway at a faster rate than that for the population as a whole and universal child allowances have not kept pace with inflation.
- In 2020, 11.7 percent of children in Norway lived in a household with persistently low income.
- Child poverty in Norway is associated with low levels of parental education, weak attachment to the labour market, single-parent households and to immigrant backgrounds. Among children in low-income households, 60 percent had an immigrant background in 2020.
- There is a clear geographic pattern to the distribution of child poverty, with higher levels in Oslo and surrounding areas.
- The rise in child poverty in Norway provides a strong rationale for increasing spending on benefits and services in line with the cost of living and for adopting proportionate universalism to level up the social gradient in child outcomes and health.
- The need to actively 'opt in' for receipt of certain benefits can disadvantage those with lower Norwegian language skills or financial management skills - many of the same households that are likely to be in poverty.

#### CHILD AND FAMILY WELFARE SYSTEM

- Children of parents with a low socioeconomic position are over four times as likely to be in the child and family welfare system than others and this can be linked to social determinants such as education, work, living conditions, health and minority-related situations.



The strength of evidence linking experiences in the early years to health and wellbeing throughout life makes giving every child the best possible start in life the highest priority area. First, it is well documented that inequalities in the early years have lifelong and often intergenerational impacts. Second, it is in this life stage when interventions to disrupt inequalities have been shown to be most effective for the individual child, but also for preventing intergenerational transmission of adversity. Third, and related to the previous two points, interventions in the early years have been shown to be cost-effective and to yield significant economic returns to investments (12).

Nordic countries have a long history of carefully safeguarding the wellbeing of children and supporting new parents throughout the most crucial years of child development. Maternity care services in Norway are widely regarded as high quality and a recent Norwegian study shows that the chance of an infant dying in their first year of life was the same among the 10 percent richest and the 10 percent poorest families in Norway after 2015 (13). However, while inequalities in the chances of surviving the first year have been levelled up and services are provided universally, there are persistent inequalities in early child development and the policies seem to be having only a limited effect on reducing inequalities in childhood development in the longer term.

An important issue among recent migrants is their understanding of health information provided by maternity care staff, since lack of understanding of health information may contribute to an increased risk of adverse maternal outcomes. Undocumented immigrant women in Norway are excluded from general practitioner care and from benefits.

Studies have found a strong and consistent social gradient in the distribution of ACEs which are more common among people who report low education levels, financial difficulties and/or receiving welfare benefits (14). Chronic stress due to ACEs can interfere with learning and the development of necessary skills in education or the workplace (15). Additionally, ACEs have a detrimental health impact.

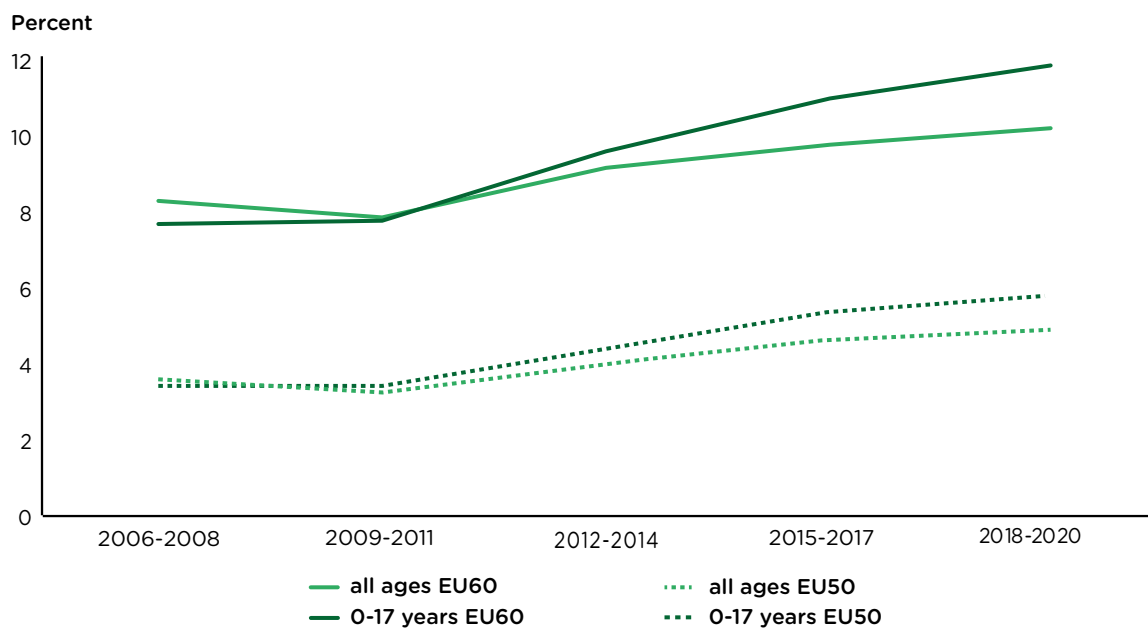
Norway has a high participation rate in early childhood education and care (ECEC) of children aged 1-5 and 97 percent of children aged 3-5 attended early childhood education in 2020. Children from families with limited education and low income and parents from minority backgrounds are less likely to attend kindergarten than other children (16) and parenting and the home environment for children from low-income families has consistently been shown to be less favourable to child development outcomes such as cognitive ability and

socio-emotional development than the home learning environment in more advantaged households (17,18). Therefore, from the perspective of children's outcomes, attendance at kindergarten is more important for children from low-income households than for children from more advantaged households (19,20).

Child poverty has increased in Norway at a faster rate than that for the population as a whole as shown in Figure E.7 and in 2020, 11.7 per cent of children in Norway lived in a household with persistently low household income (21).

Child poverty damages early development, which in turn affects a range of critical lifelong social determinants of health and health outcomes throughout life. Parenting approaches are often heralded as key to children's development in the early years, but it is important to recognise that parenting is also related to families' social and material circumstances. Put simply, it is easier to parent more effectively when social and economic circumstances are favourable and when stress and anxiety are lower, although positive and negative approaches to parenting apply across the socioeconomic gradient.

**Figure E.7 Percent of households in poverty levels (EU50 and EU60 indicators), all households and those with children aged 0 to 17, Norway, 2006-8 to 2018-2020**



Source: NIPH database (7)

Child poverty in Norway is associated with parental low level of education, weak attachment to the labour market, single-parent households and to immigrant background (22), with six out of 10 children in low-income households having an immigrant background in 2020 (21). In addition to having extremely low incomes, some of these families experience extreme income volatility. Housing costs also bear heavily on single parents – 45 percent report that high housing costs are a problem (10) – and these lead to shortages of resources for other essentials, increasing debt and other financial problems resulting in a higher risk of mental health problems. The value of allowances to families with children had been falling in real terms prior to the COVID-19 pandemic, particularly for single parents with children aged 0-5 and universal child allowances have not kept pace with inflation (10).

The need to actively 'opt in' for receipt of certain benefits can disadvantage those with lower Norwegian language skills or financial management skills – many of the same households that are likely to be in poverty.

The rise in child poverty in Norway provides a strong rationale for increasing spending on benefits and services in line with the cost of living and for adopting proportionate universalism to level up inequalities in early childhood and more broadly impact on the social gradient in health.

Norway has a long history of providing welfare services for children and families. However, the system and organisation of family and child welfare services is complex and the overall policy responsibilities are shared across different departments. There is a significant social gradient in the Norwegian child welfare services that can be linked to social determinants such as education/work, living conditions, health and minority-related conditions and services provided to different social economic groups also vary (23).

### 3B. ENABLE ALL CHILDREN, YOUNG PEOPLE, AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

#### KEY FINDINGS:

##### EDUCATIONAL ATTAINMENT

- There are steep inequalities in numeracy and reading based on parents' educational level among children in the fifth year of primary school and in secondary school.
- Family socioeconomic status is a strong predictor for children's educational attainment and performance at age 15.
- Learning support for children at age six has not been proportionate to need and has contributed to widening social gaps in educational attainment.
- Social relationships within secondary schools are systematically related to family affluence including bullying, and interactions between teacher and students.
- While 80 percent of the population completes upper secondary education, only 30 percent of those who have received assistance from child protection services do so.

##### SCHOOL MEALS

- Providing a free healthy school meal for one year improved the overall diet among children aged 10 to 12 in primary schools, especially children of parents with low educational levels.

##### MENTAL HEALTH AND WELLBEING

- There is a clear socioeconomic gradient, with more negative psychological symptoms, anxiety, distress, and depression linked with a lower socioeconomic position at ages 16 to 18.
- Surveys on loneliness and health have found the 18-20 and 26-35 age cohorts are the loneliest of all age groups analysed.

##### POST SCHOOL AND NEETS

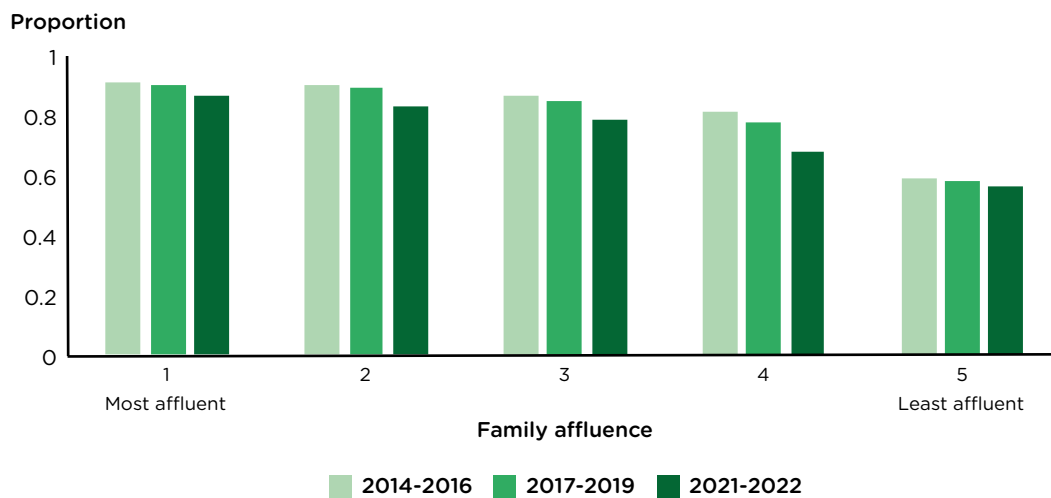
- A large proportion of young Norwegians not in education, employment or training (NEETs) have poorer mental health, and lower levels of education compared with other European NEETs.
- More than half of all NEETs in Norway are young people without an upper-secondary school qualification.
- Following schooling, students from lower socioeconomic position are more likely to enter vocational programmes rather than upper-secondary or tertiary education as young adults. This negatively affects their later life earnings and wellbeing.

The provision of high-quality schooling and ensuring that as many pupils as possible complete upper secondary school is of vital importance to levelling up social gradients in health and wellbeing (24). Although an important aim for universal and compulsory educational systems in Norway is to promote capabilities and social mobility, the evidence available shows that the schooling system, on the contrary, has in part contributed to widening social gaps and leaving young people behind, especially those groups in particular vulnerable situations. There are particularly concerning trends and wide inequalities in young people's mental health and wellbeing which are vital to address.

There are clear inequalities in attainment in numeracy and reading related to parental level of education for children in the fifth year of primary school in Norway that persist in secondary school. Family socioeconomic status is a strong predictor for children's educational attainment and performance at age 15 (25). Learning support for children at age six has not been proportionate to shortfalls in school readiness and has contributed to widening social gaps in educational attainment.

Social relationships within secondary schools are socially graded by family affluence- e.g. bullying, and interaction between teacher and students – as shown in Figure E.8.

**Figure E.8 Girls in lower secondary school who indicate that their teachers care about them by family affluence, 2014-16 to 2021-22**



Source: Young Data (11).

In Norway, a minority of schools offer a school lunch. Evidence shows the potential for universal free school meals to contribute to health equity. A study among primary school students found that providing a free healthy school meal for one year improved the overall diet among children, especially for children from households with a low socioeconomic position (26).

There are particularly clear inequalities in completion of education related to whether a child has been in receipt of child welfare or not; these inequalities have lifelong impacts. Following schooling, students from lower socioeconomic position are more likely to enter vocational programmes rather than upper-secondary or tertiary education as young adults (27). This, in turn, affects their later life earnings and wellbeing reflected in the higher proportion of those with only basic education reporting difficulties in making ends meet at working ages 25 and above (10). While the educational reform in 1994 succeeded in making vocational learning more accessible overall, it did not increase interest in pursuing an academic career (28). In the future, reforms need to be supported by stronger employment schemes and improvements in working conditions for people who do pursue higher education.

Norway has only nine percent of young people not in education, employment, or training (NEETs) however, more than half of all NEETs in Norway are young people without an upper-secondary school qualification (29). Being NEET, if only for a short period of time, reduces future financial prospects and outcomes in a range of social determinants, affecting future health and replicating risk factors for the next generation. A large proportion of young Norwegians not in education, employment or training (NEETs) have poorer mental health, and lower levels of education compared with other European NEETs (30). There are promising practices that showcase how processes of marginalisation can be disrupted and where young people are enabled to develop their capabilities and reduce their risk of becoming NEET.

### 3C. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

#### KEY FINDINGS:

##### UNEMPLOYMENT AND THE LABOUR MARKET

- There are negative health consequences related to unemployment, including worse mental and physical health and mortality.
- Although overall unemployment rates are low in Norway, there are a substantial number of people who experience persistent or long-term unemployment.
- Around 18 percent of those aged 18 to 66 were either out of work or not in education in 2019. They are increasingly comprised of people who have either never worked or been out of the labour market for a long period of time.
- At each educational level, those with a disability have markedly lower employment rates than others.
- The structure of the labour market has affected the low-skilled and those who have not completed secondary education, lowering their employment rates.
- People participating in labour market measures are also more likely than others to be unemployed subsequently.
- Weak labour market attachment increases the chances that an individual will not fully participate in other areas of society.
- The Norwegian unemployment insurance system provides a sufficient level of income and is supportive of good health. However, benefits are of limited duration and roughly half of all registered unemployed people in Norway are not entitled to benefits and many who are out of work but not registered as unemployed may also not be entitled to benefits.
- There is a lack of knowledge about which types of measures and follow-up work best for people with reduced work capacity.

##### OCCUPATION

- The longest life expectancy – up to 85 and 88 years for men and women, respectively – is seen in the most highly educated occupations. Conversely, the lowest life expectancy – 79 and 82 years for men and women, respectively – are seen in workers in hospitality such as hotels and restaurants.

##### WORKING CONDITIONS

- Despite high average levels internationally, working conditions vary considerably in Norway by occupation – with gradients in some factors linked to work stress, including decisions on how to carry out work tasks and the extent of repetitive work tasks.

##### PAY

- Being covered by a collective agreement is key to protecting workers from being low paid. In companies not covered by a collective agreement, low-paid jobs increased by eight percentage points between 2008 and 2018, while they decreased by four percentage points in companies covered by a collective agreement.
- The proportion who are low-paid is greatest in the private sector (nearly 30 percent) and lowest among state employees (around seven percent).

Work and employment are of critical importance to the health and wellbeing of individuals in several interrelated ways (31). Participation in, or exclusion from the labour market determines a wide range of life chances, mediated through income from employment and people's social status and social identity. Threats to social status due to job instability or job loss affect health and wellbeing. Material deprivation (e.g. associated

with unemployment, economic inactivity or low paid jobs) and feelings of unfair pay contribute to physical and mental ill health. In addition, exposure to physical, ergonomic, and chemical hazards in the workplace, physically demanding or dangerous work, long or irregular work hours, shift work, and prolonged sedentary work can adversely affect the health of working people. The same holds true for an adverse psychosocial work

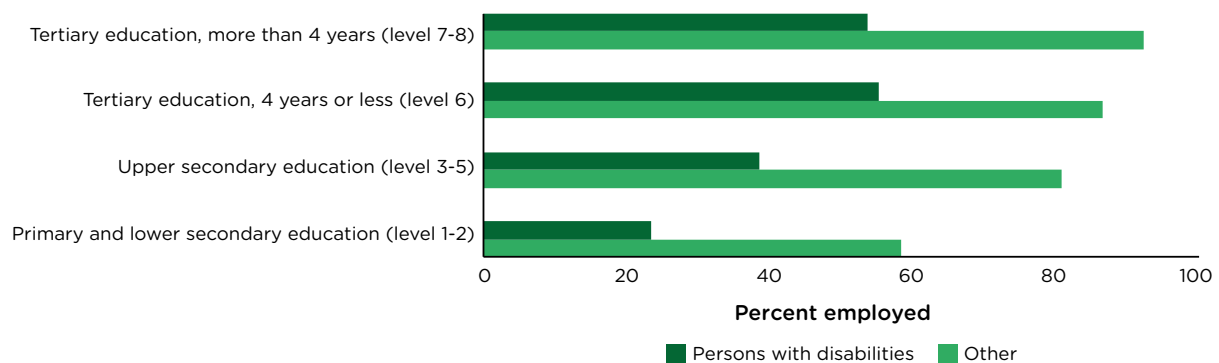
environment defined by high demand and low control, or an imbalance between efforts spent and rewards received. Experiences of discrimination, harassment and procedural injustice aggravate stress and conflict at work. A job in which all these negative attributes of work and the work environment are minimised can be regarded as ‘good quality work.’

The Nordic countries have been successful in combining universal welfare states with a compressed wage structure, continuous skill development, high rates of labour market participation and high productivity and innovation (32). Key to sustaining these Nordic models has been providing full-time, permanent jobs for a majority of the labour force. However, there are inequalities in labour market participation with related impacts on health and health inequalities. Lower educated women and those with disabilities are particularly affected.

With a decreasing number of jobs that do not require formal qualifications, the structure of the labour market has affected the low-skilled and those without higher education, lowering their employment rates because of high demand for skills and more competition for jobs (33). There is a clear gradient in employment rates at ages 30-54 by educational level that has widened over time – with markedly lower levels for those with basic education, especially among women. Around 18 percent of those aged 18 to 66 were either out of work or not in education in 2019 (34). They are increasingly comprised of people who have either never worked or been out of the labour market for a long period of time (35).

At each educational level, those with a disability have markedly lower employment rates than others – see Figure E.9.

**Figure E.9 Percent aged 15 to 66 employed by educational level and whether or not with a disability, 2021**



Source: SSB table 13492 (10).

There are negative health consequences related to unemployment, including increased mental and physical health and mortality. Although overall unemployment rates are low in Norway, this includes a substantial number who experience persistent or long-term unemployment. People participating in labour market measures are also more likely than others to be unemployed subsequently (10). By ensuring a high-income replacement rate, the Norwegian unemployment insurance system is supportive of good health by limiting poverty and material deprivation and mitigating socioeconomic inequalities in health, by providing a safety-net for the employed at risk of unemployment and for those who do become unemployed. However, many people out of work in Norway are not entitled to unemployment benefits due to the strict eligibility criteria and this significantly weakens its protective effects on health and health equity. Unemployment benefits are also of limited duration, roughly half of all registered unemployed people in Norway are not entitled to benefits and many who are out of work, but not registered as unemployed, may also not be entitled to benefits.

Weak attachment to the labour market and inactivity are multidimensional problems that are related to an accumulation of disadvantage throughout the life course, including adversity in childhood, having low levels of education and skills and subsequently developing health problems. The impact of increased digitalisation, automation and the use of new technologies can worsen the situation of the most disadvantaged groups in the labour market. These disadvantaged groups are increasingly comprised of people who have either never worked or been out of the labour market for a long period of time (35). Women, immigrants and people with low education levels more often find themselves in longer spells of inactivity. Receiving health-related benefits is also associated with longer term inactivity (36). Transformations in the occupational structure and changing skills requirements requires policies that deliver a greater scale and intensity of effort to address inactivity than is currently the case. Support for vocational skills that are geared to the current and likely future labour markets, to those who lack, or are unlikely to obtain, advanced academic qualifications is needed.

Structural change, most evident in the growth of the service sector, has led to the emergence of new workplace risks. There is increased awareness about the negative impact that psychosocial risks have on workers' health and wellbeing. In Norway, musculoskeletal diagnoses are one of the main causes of sickness absence (37). These are often linked to stress arising from the psychosocial work environment as well as the physical and ergonomic characteristics of work. Despite high average levels internationally, work conditions vary considerably in Norway by occupation – with gradients in some factors linked to work stress, such as decisions on how to carry out work tasks and the extent of repetitive work tasks (10). Among men, the longest life expectancy – 85 years – is seen

in the most highly educated medical occupations, followed by others mainly in occupations requiring a university education. Conversely, the lowest levels of life expectancy are seen in hospitality workers such as cooks and kitchen staff – 79 years. Among females, the highest life expectancy, of 88 years, is among academics, and the lowest is seen among hospitality service personnel at slightly below 82 years (8).

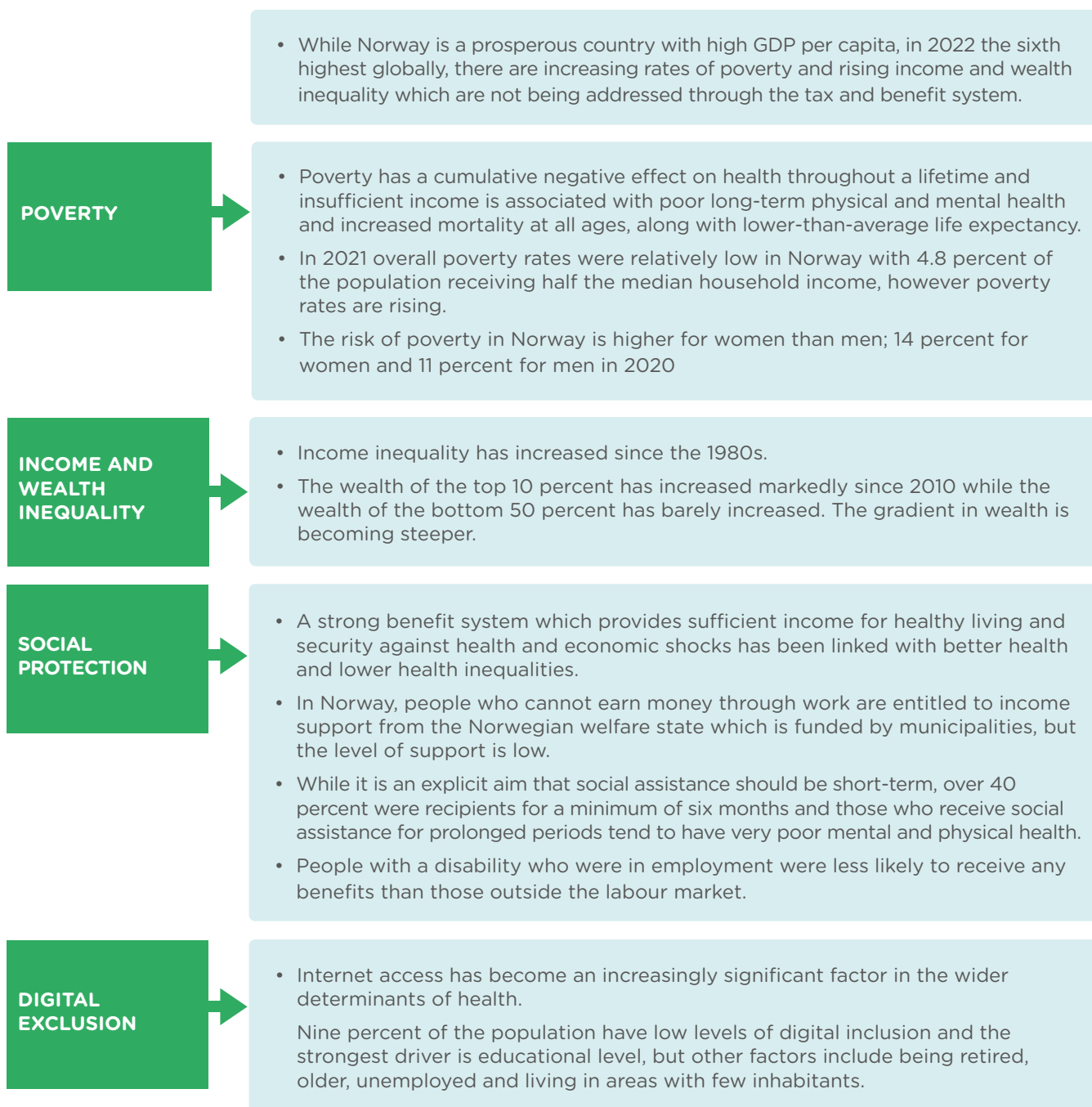
The proportion who are low paid is greatest in the private sector (nearly 30 percent) and lowest among state employees (around seven percent) (38). The proportion of people with only primary or lower secondary education are overrepresented in the low pay sector (39).





### 3D. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

#### KEY FINDINGS:



While Norway is a prosperous country with high GDP per capita, there are increasing rates of poverty and rising income and wealth inequality which are not being addressed through the tax and benefit system. While poverty levels are low by international standards, there are some concerning trends which have negative impacts on health and health equity particularly, rising child poverty,

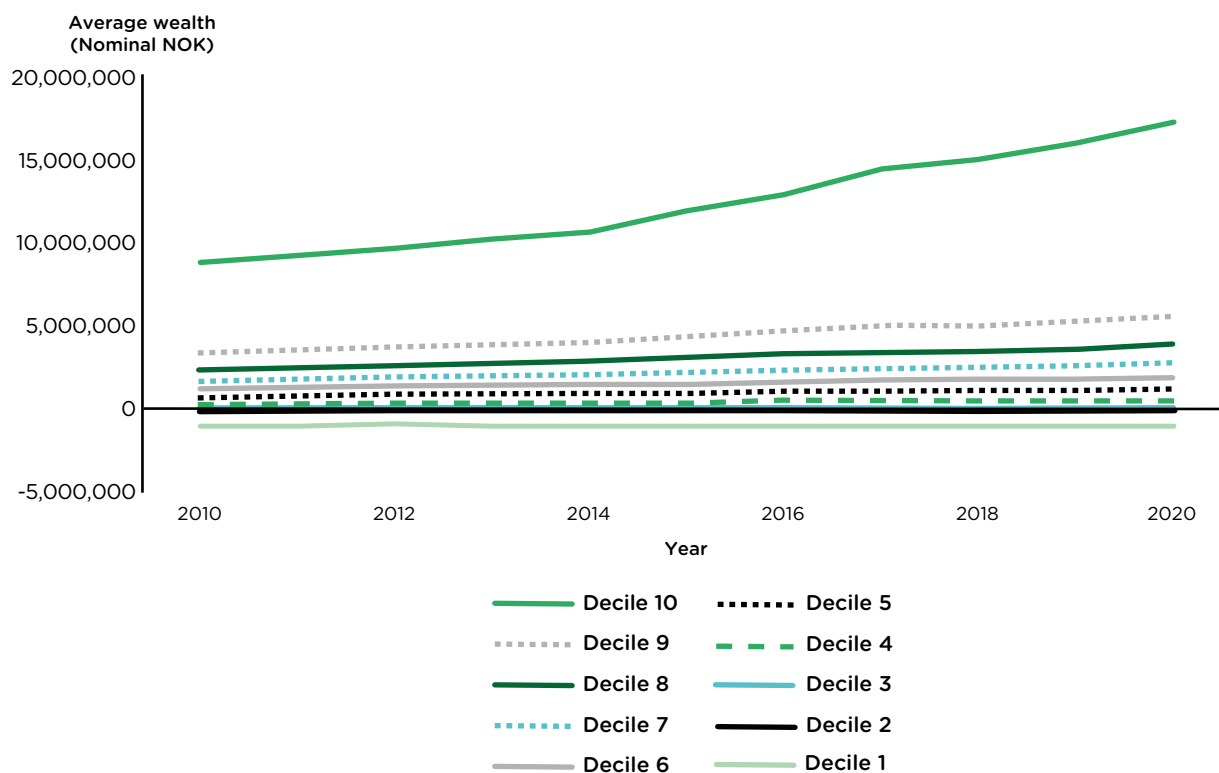
greater poverty among women, particularly single parents and higher poverty levels among immigrants.

Income inequality has increased since the 1980s - the Gini coefficient has increased since the 1980s, albeit with substantial year on year variation from this trend, from 0.21 in 1986 to 0.256 in 2014 (10).

The wealth of the top 10 percent has increased markedly since 2010 while the wealth of the bottom 50 percent has barely increased. The gradient in wealth is becoming

steeper - shown in Figure E.10. While the poorest 20 percent have no accumulated wealth, wealth has increasingly accumulated among the very richest.

**Figure E.10 Average net wealth of households, by decile 2010-20**



Source: SSB table 10318 (10)

A strong benefit system which provides sufficient income for healthy living and security against health and economic shocks has been linked with better health and lower health inequalities. In relation to people out of work who are not entitled to unemployment benefits, there is only one other income support option: social assistance. This is a meagre, means-tested income maintenance scheme, which is often described as the 'final safety net' in the Norwegian welfare state. In particular, for people with no or minimal previous employment record, the benefit provided is considerably lower than common thresholds for poverty. While it is an explicit aim that social assistance should be short-term, over 40 percent were recipients for a minimum of six months (10) and those who receive social assistance for prolonged periods tend to have very poor mental and physical health (40,41).

The main eligibility criterion for disability pension is that work capacity must be reduced permanently by a minimum of 50 percent because of sickness and/or injury. Over time, the proportion of people with disability-related benefits has increased more for women than for men (42). While it has increased among those aged 18 to 54, it has decreased at ages 55 to 67, due to factors such as better health and the ability to draw a retirement pension at age 62 (43). People with a disability who were in employment were less likely to receive any benefits than those outside the labour market (10).

Digital exclusion is important to consider as internet access has become an increasingly significant factor in the wider determinants of health. Nine percent of the population have low levels of digital inclusion - the strongest driver is educational level, but other factors include being retired, older, unemployed and living in areas with few inhabitants.

### 3E. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

#### KEY FINDINGS:

##### PHYSICAL AND SOCIAL COMMUNITIES

- Healthy places and communities are central to levelling up the social gradient in health and wellbeing. This includes improving community capital and reducing social isolation across the social gradient.
- Access to networks of support is unequally distributed in the population and follows a social gradient whereby people with lower levels of income and education experience less support than those with higher levels.
- Norwegian citizens and communities are often seen as beneficiaries and ‘consumers’ of public welfare rather than being involved as co-creators; there are some signs of progress in co-creation which needs to be accelerated and expanded.

##### VOLUNTEERING

- There is a strong culture of volunteering and people engaged in volunteering report substantially lower levels of loneliness and better health and wellbeing. However, the proportion of people volunteering has decreased from 63 percent in 2019 to 55 percent in 2021 and there are socioeconomic inequalities in participation.

##### TRANSPORT

- The long-term transportation development plan is focused on connecting the population, mainly using private (electric) vehicles. It does not address the inequalities in access between and within municipalities and does not present solutions to connecting the most remote areas of the country sustainably.
- No specific plans are provided on how to achieve the planned goal of increasing cycling in urban areas.

##### HOUSING

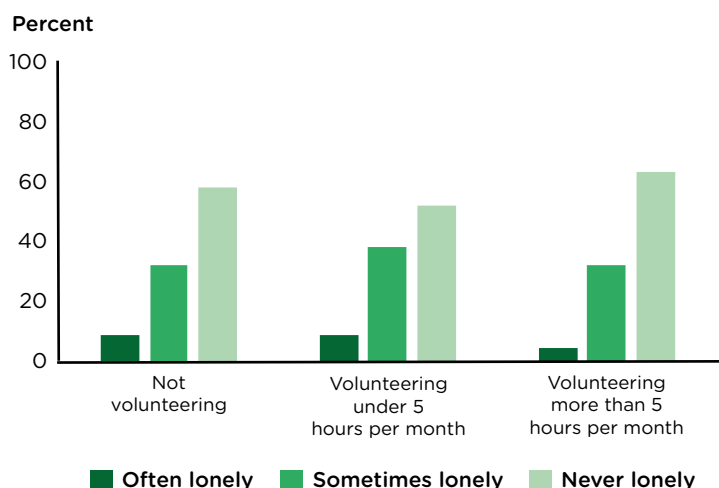
- Housing affects health, wellbeing and inequalities in many ways including housing security, affordability and quality.
- In 2020, 19 percent of children between 0-17 years of age lived in households with cramped living conditions affecting health, rising to 36 percent in Oslo.
- The number of long-term tenants has increased due to rising costs of ownership around the major urban areas. However, the main priority of Government has been an increase in home ownership, rather than affordable or social housing. This risks leaving behind increasing numbers of the lower income population.

Empowering and sustaining healthy places and communities is central to levelling up the social gradient in health and wellbeing. This includes improving community capital and reducing social isolation across the social gradient. In combination with social economic drivers, the everyday life settings where people live, and the community they belong to, play a critical role in their wellbeing and health (44). Communities can, through common interests or shared spatial location, enable people to form relationships which are a resource for health and wellbeing across the life span and in several domains: they provide emotional support through companionship, access to valuable information and learning, and also give practical support. However, access to networks of support is unequally distributed in Norway and follows a social gradient.

Norwegian citizens and communities are seen as beneficiaries and ‘consumers’ of public welfare rather than being involved as co-creators, there are some signs of progress which needs to be accelerated and expanded.

There is a strong culture of volunteering and people engaged in volunteering report substantially lower levels of loneliness and better health and wellbeing, Figure E.11. However, the proportion of people volunteering has decreased from 63 percent in 2019 to 55 percent in 2021 and there are socioeconomic inequalities in participation.

Figure E.11 Distribution of the experience of loneliness by time spent volunteering, 2021



Source: Frivillighetsbarometeret (2021) (45).

Socioeconomic differences in participation in voluntary sector activities are also pronounced in children and adolescents: about 70 percent of adolescents with well-off parents participate in at least one organised activity. For children of the poorest families, this is true for about 50 percent of boys and only 38 percent of girls. Children from high SES families participate more in activities like sports, music and other cultural activities and children from lower SES backgrounds are more likely to participate in youth clubs and other kinds of organisations (46). Participation also varied between municipalities based on the proportion of people with low levels of education in the municipality – the greater the proportion, the lower the level of participation (11).

### TRANSPORT

The Norwegian Government has recently renewed its transportation plan (NTP) for the next ten years. The plan is less concerned with increasing accessibility to open, green spaces and is more focused toward connecting the population, concentrated in a few hubs and seems to remain particularly focused on private vehicle transportation. It also remains unclear how the plan would result in more cycling and walking, although incentivising this mode of transport represents perhaps the most important improvement which can be made to urban mobility to reduce emissions as well as improve the health of the population.

### NEIGHBOURHOODS

The physical qualities of a place are of importance to health equity. Living in a poor local environment can affect inequities in health and wellbeing through various determinants. Green areas provide opportunities for leisure and social recreation activities, which in turn can affect health and wellbeing. In addition, feeling safe at home and where you live is important for people’s living conditions and their wellbeing (47,48).

Housing affects health, wellbeing and inequalities in many ways including housing security, affordability and quality. Housing affects health inequities directly, particularly through cost, housing conditions and security of tenure. In 2020, 19 percent of children between 0-17 years of age lived in households with cramped living conditions affecting health in the immediate and longer term, rising to 36 percent in Oslo.

Increases in house prices have completely surpassed income growth. As a result, the number of long-term tenants has increased due to rising costs around the major urban areas. However, the main priority of Government has been an increase in home ownership, rather than affordable or social housing, risking leaving behind some of the most vulnerable.

### 3F. TACKLING THE SOCIAL EXCLUSION OF MINORITIES AND OTHER LEFT BEHIND GROUPS

#### KEY FINDINGS:

##### THE HEALTH OF IMMIGRANTS

- Although immigrants in Norway are doing relatively well compared to immigrants in other countries, there are persistent social and health inequalities both between immigrants and the rest of the population and within the immigrant community.
- Factors such as country of origin, in particular, Africa and Asia compared to Europe, North America and Australia, the reasons for migrating and status, namely refugees and asylum seekers compared to economic migrants as well as the length of residence in Norway are associated with inequalities in living conditions and health.
- Both higher education and higher income of immigrants are associated with better self-assessed health, a lower risk of cardiovascular disease among women and a lower risk of diabetes. A low income is associated with mental health problems
- Data and research on health and health care use among people with an immigrant background are scarce and inadequate.

##### SOCIAL DETERMINANTS OF HEALTH AND IMMIGRANTS

- Children with an immigrant background are more likely than other children to live in families with a persistently low income.
- Kindergarten attendance rates are lower in children aged one to two years who speak a minority language than in other children. While the number of minority language children are concentrated in Oslo and Drammen, the rate of increase in numbers has been greater elsewhere.
- Boys born abroad are the group with the lowest levels of lower secondary school outcomes.
- Boys who are immigrants and those born in Norway of immigrant parents face difficulties obtaining apprenticeships, indicating that discrimination is likely to be a factor.
- At ages 16 to 25, levels of NEETS among immigrants are around three times those for all Norwegian-born young people.
- Earning levels of immigrants at every level of education are lower than for others in society, with particularly low levels for female immigrants.
- The most common welfare problem among immigrants is overcrowding or unsatisfactory housing conditions, followed by having no or very low income from work.

##### THE SAMI POPULATION

- While the overall health of the Sami people is similar to the general population, they experience higher risks of obesity, diabetes, stroke and suicide.
- The Norwegianisation policy has subjected the Sami population to discrimination for centuries and Sami adolescents continue to experience more discrimination than the non-Sami. The Truth and Reconciliation Commission is tasked with investigating the policy and its adverse consequences for Sami culture, identity and living conditions.

##### LGBTQ+

- The LGBTQ+ population has a higher level of mental health problems than the heterosexual and binary populations.
- LGBTQ+ groups experience discrimination, harassment and bullying and greater economic deprivation compared to the majority population.
- Those with a migrant background are vulnerable to discrimination on the basis of both their gender or sexual orientation and their migrant background.

## PRISONERS

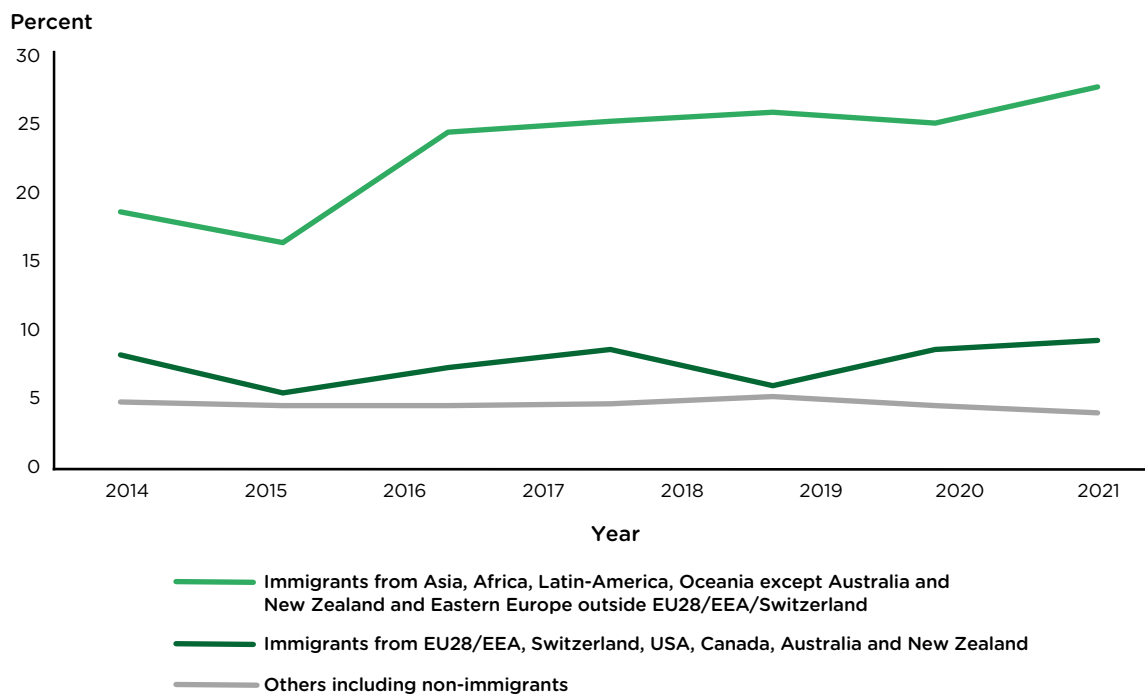
- Prisoners have a higher probability of having experienced deprivation in childhood and adult life than the general population.
- Incarceration seems to exacerbate inequalities through isolation, stress, stigma and by reducing employment prospects, which in turn impacts on their families and children.
- Many prisoners have complex mental health challenges and addiction problems. A lack of suitable treatment means that the health of many inmates deteriorates while they are in prison.

There are persistent social and health inequalities between immigrants and the rest of the population and within the immigrant community. There is a social gradient in health among immigrants. Higher education and higher income are associated with better self-assessed health. Having a higher education level is also associated with a lower risk of cardiovascular disease among immigrant women. Higher income is also associated with having a lower risk

of diabetes, while having low income is associated with suffering mental health problems (49).

Factors such as country of origin, reasons for migrating (refugees and asylum seekers compared to economic migrants), and length of residence in Norway are associated with inequalities in living conditions and health. Figure E.12 shows the relation with difficulty in making ends meet.

**Figure E.12 Percent of those aged 16 years and older having difficulty making ends meet by country background, 2014-21**



Source: SBB Table 13645 (10).

There are inequalities between immigrant and non-immigrant students in measures of readiness for upper secondary education, shown by the student's grade points achieved in lower secondary school. While the highest possible score is 60 points, average grade points for immigrant children were 39 in 2020, while those without an immigrant background achieved 44 points on average (50). This is important because grades at lower secondary level are the most important factor in predicting whether a student will complete upper secondary level and not completing upper

secondary has become an increasingly important factor for explaining disadvantage in Norway. Boys born abroad are the group with the lowest levels of lower secondary school outcomes.

Both boys who are immigrants and those born in Norway of immigrant parents face difficulties obtaining apprenticeships, indicating that discrimination is likely a factor. At ages 16 to 25, levels of NEETS among immigrants are around three times those for all Norwegian born young people.

Employment rates among immigrant workers are lower in Norway than those for the native-born, and those from outside the EU27 have the lowest levels. While longer stays are associated with improved outcomes, some inequalities do persist. Earning levels of immigrants at every level of education are lower than for others in society, with particularly low levels for female immigrants. The most common welfare problem among immigrants is overcrowding or unsatisfactory housing conditions, followed by having no income or very low income from work (51).

The Sami have been subjected to ethnic discrimination and assimilation policies from the State for centuries through the Norwegianisation policy - for example, the Sami language was banned in schools. In recent decades there has been an improvement in the political situation of the Sami, as they have been recognised as indigenous people of northern Scandinavia, and a National Sami Parliament has been established in Norway, Finland and Sweden. However, Sami adolescents continue to experience more discrimination than the non-Sami. While the overall health of the Sami is similar to the general population, they do have higher risks of obesity, diabetes, stroke and suicide.

LGBTQ+ groups experience discrimination, harassment and bullying and greater economic deprivation

compared to the majority population. Those with a migrant background are vulnerable to discrimination on the basis of both their gender or sexual orientation and their migrant background.

Incarceration of prisoners exacerbates existing inequalities through isolation, stress, stigma and by reducing employment prospects, and this in turn impacts on their families and children. Many prisoners have complex mental health challenges and addiction problems. A lack of suitable treatment means that the health of many inmates deteriorates while they are in prison.

Mortality rates in persons with severe mental illnesses and substance use disorders are excessively high, and studies indicate up to 35 years of reduced life expectancy, compared to the general population. For this group, the risk of suicide and overdose is higher than for any other group in society. Many patients with substance use disorders and mental illnesses experience a feeling of loneliness and lack of social belonging, and their economic situation is a barrier to participating in the community. The most significant measure to alleviate this would be to ensure that more people in these groups are in regular employment so that they can earn their own money. Those who cannot work should be supplied with decent disability pensions and offered debt relief.



### 3G. STRENGTHEN THE ROLE AND IMPACT OF ILL-HEALTH PREVENTION

#### KEY FINDINGS:

##### HEALTH BEHAVIOURS

- While overall smoking rates have decreased since 2005, there remains a clear gradient in smoking rates related to level of education – the odds that someone with only compulsory education smokes is over five times that for someone with tertiary education.
- Smoking rates are similar for men and women at each level of education.
- There are clear inequalities in levels of obesity associated with education level.
- Since 2012, levels of obesity have increased – from 14 to 21 percent in 2019 among those with only compulsory education and from eight to 11 percent among those with tertiary education.
- Groups with a lower education and occupational position have higher consumption of sugary drinks and salted food and lower consumption of fruits, berries, and vegetables than those with higher positions.
- While 20 percent of those with low education actively searched for the healthier alternatives within a given type of food, 46 percent of those with high education did so and the trust in marking of products as healthier was highest among the highly educated.
- There is a clear educational gradient in physical activity which slightly narrowed between 2015 and 2019 as levels of physical activity increased generally.

##### EFFICACY OF MEASURES TO REDUCE INEQUALITIES IN HEALTH BEHAVIOURS

- While taxes and subsidies affecting the price of food items have the potential to reduce inequalities in healthy eating, interventions directly targeting individuals' dietary behaviour increase inequalities in healthy eating.
- Consumption of sugar and sugary products in Norway fell from 45 kg per person in 1979 to 24 kg person in 2019 following the introduction of sugar taxes in 1981. The taxes were repealed in 2021.
- Parents with low educational levels or who are unemployed have less confidence in childhood vaccination and this group has more concerns about vaccine safety than other parents.

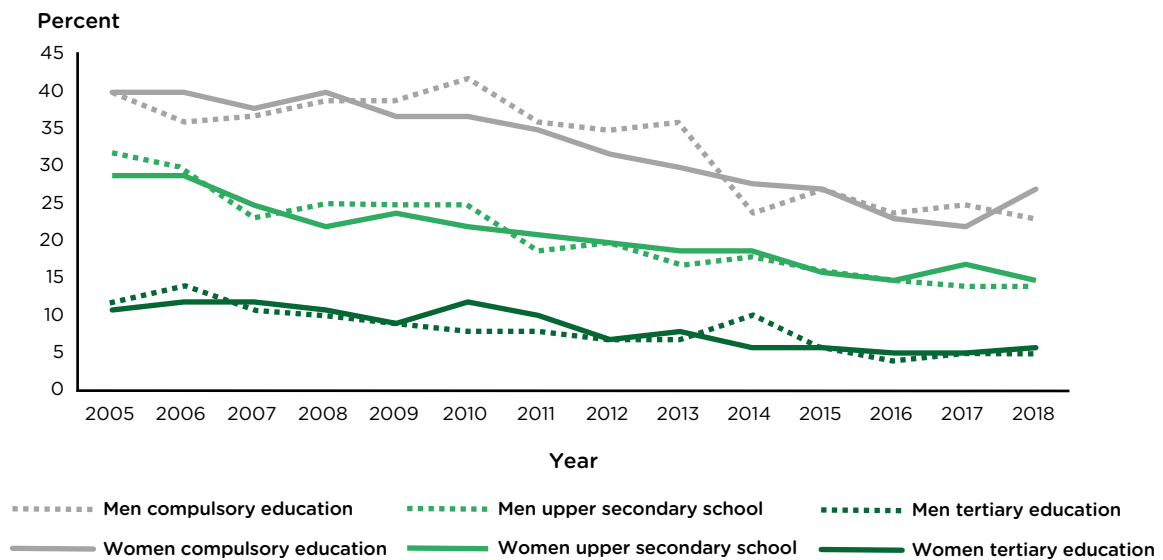




The conditions of daily life affect people's behaviours and these then impact on their health and longevity. Although there is a strong social gradient in the proportion of people smoking daily, with those with tertiary education smoking least, there has been a decrease in smoking

across all educational levels. In 2018, the odds that someone with compulsory education smoked was over five times that for someone with tertiary education – as shown in Figure E.13. Within each education category, the proportion of men and women smoking has been similar.

**Figure E.13 Percent smoking daily by sex and educational level, Norway, 2005-2018**



Source: NIPH database (7).

There are also clear inequalities associated with education level in obesity, consumption of sugary drinks, salted food and fruits, berries, and vegetables as well as physical activity. The proportion who are obese has risen sharply since 2012 – from 14 percent to 21 percent in 2019 among those with only compulsory education and from eight percent to 11 percent among those with tertiary education. While the gradient in daily fruit consumption narrowed between 2015 and 2019, this was only because of declines in fruit consumption among the more educated, consequently levelling down the gradient. Randomised control studies in schools showed that the National Free School Fruit scheme, which ran between 2007 and 2014, was effective in increasing consumption of fruit and vegetables among school children.

While taxes and subsidies affecting the price of food items have potential to reduce inequalities in healthy eating, interventions directly targeting individuals' dietary behaviour increase inequalities in healthy eating. A systematic review of modelling tax changes suggested that a ten percent increase in price could decrease fizzy soft drink consumption by 0.6 percent. And a ten percent reduction in the price of fruit and vegetables could increase consumption by 2.1 percent. Regarding saturated fat, a one percent increase in price

could decrease energy consumption from saturated fat by 0.02 percent on average. The review also indicated the potential for food pricing policies to reduce diet-related inequalities at the population level (52).

Sugar taxes, introduced in 1981, along with other measures likely contributed to the fall in consumption of sugar and sugar products in Norway, from 45 kg per person in 1979 to 24 kg per person in 2019. The taxes were repealed in 2021.

Health literacy concerns the basic skills, knowledge and motivation that enable the individual to find, understand, appraise and apply health information to make informed health-related decisions in everyday life(53). Many Norwegians lack the knowledge and skills necessary to obtain health services and realise the concept of patient-centred health services. In one study it was found that women and those with an education above upper secondary school might have slightly better skills. Parents with low educational level or unemployed have less confidence in childhood vaccination and this group has more concerns about vaccine safety than other parents.

### 3H. PURSUE ENVIRONMENTAL SUSTAINABILITY AND HEALTH EQUITY TOGETHER

#### KEY FINDINGS:

##### HEALTH EQUITY IMPACTS

- Environmental sustainability and health equity are inextricably linked because climate change, environmental degradation and loss of biodiversity all impact on physical and mental health and disproportionately affect poorer people and communities.
- The direct impacts of climate change include the health consequences of more frequent, extreme weather events.
- The indirect impacts of climate change on health and inequalities include increases in the price of food, water and domestic energy and subsequent increases in poverty, unemployment and anxiety.

##### EQUITY IN REDUCING HARMFUL ENVIRONMENTAL PRACTICES

- Decision-makers in local governments, civil society and business can support a 'triple-win' approach to protecting and improving the environment and promoting health and equity.
- Key areas in which environmental sustainability, health and equity are overlapping priorities include in the management of green spaces and the natural environment, air pollution, transport, physical activity, housing and buildings, healthy and sustainable diets and within a healthy and sustainable economic model including the wellbeing economy approach.

##### PROGRESS ON CLIMATE TARGETS AND AREAS FOR IMPROVEMENT

- Renewable energy comprises 98 percent of Norway's energy sources and the country is a world leader in the adoption of electric vehicles.
- A positive move towards meeting the goals of the Paris Agreement was taken by Norges Bank in 2022 by setting a target of achieving net zero emissions by 2050, at the latest, across all the companies in its portfolio.
- However, although committed to reducing emissions domestically, Norway's crude oil and gas exports constituted 60 percent of the total value of Norway's exports in 2021.
- The Climate Action Plan 2021 to 2030 sets out the need for Norway to undergo a major transition to achieve climate targets and support the climate. While many measures will have a beneficial impact on health equity, the plan needs to incorporate a greater focus on reducing socioeconomic inequalities.
- Commitments towards net zero emissions need to be matched by actions to achieve them. According to an independent assessment, Norway will need to enhance its current climate policies if it is to achieve its national goal to reduce greenhouse gas emissions by at least 50 percent and towards 55 percent by 2030 compared to 1990.

Key areas in which environmental sustainability, health and equity are overlapping priorities include green spaces, outdoor air pollution, transport, housing and buildings, healthy and sustainable diets, and a healthy and sustainable economic model including wellbeing economies. While committed to reducing emissions domestically, Norway's crude oil and gas exports constituted 60 percent of the total value of Norway's exports in 2021. Commitments towards net zero emissions need to be matched by actions to achieve them.

Evidence shows that decision-makers in local governments, civil society and business would support a 'triple-win' approach across sectors to protect and improve the environment and promote health and equity (55). Key areas in which environmental sustainability, health and equity are overlapping priorities are:

- Green space – people with a low socioeconomic position have less access to good quality accessible green spaces but benefit more from them.
- Outdoor air pollution – people living in deprived residential areas are exposed to greater levels of air pollutants.
- Active transport (cycling, walking, use of public transport) – a shift to more active transport has environmental and health benefits and has the potential to reduce air pollution and carbon emissions, and to increase physical activity.
- Energy efficient housing and buildings.
- Healthy and sustainable diet and food waste – people with a low socioeconomic position consume less healthy diets. Production of plant-based food contributes less CO<sub>2</sub> than meat production, while increasing fruit and vegetable consumption.
- Healthy and sustainable economic model – the economic model fuelled by carbon and built on a cycle of production, consumption and disposal, needs to transition to an economic model that prioritises the wellbeing both of people and the planet, now and for future generations.

Environmental sustainability and health equity are inextricably linked because climate change, environmental degradation and loss of biodiversity impact on physical and mental health and disproportionately affect poorer people and communities. The direct impacts include the health consequences of more frequent, extreme weather events. The indirect impacts of climate change on health and inequalities include increases in the price of food, water and domestic energy and subsequent increases in poverty, unemployment and anxiety.

## 4. THE IMPACT OF THE COVID-19 PANDEMIC AND THE COST OF LIVING CRISIS

### KEY FINDINGS:

#### THE HEALTH EQUITY IMPACTS OF COVID-19 INFECTION AND THE VACCINATION PROGRAMME

- The COVID-19 pandemic exposed and amplified inequalities in both health and socioeconomic conditions.
- The Coronavirus Commission indicated that Norway had one of Europe's lowest mortality rates from the COVID-19 pandemic.
- Vaccination rates were lower among immigrants and the authorities were slow in putting in place additional measures to reach them.
- The immigrant population, especially those of African and Asian origin, and lower socioeconomic groups, were overrepresented among those infected and among those who became seriously ill.

#### INDIRECT SOCIAL AND ECONOMIC INEQUALITY IMPACTS OF THE COVID-19 PANDEMIC

- Control measures had a major impact on children and young people, especially those in more vulnerable situations who experienced an accumulation of disadvantage.
- Services for children were significantly reduced and families in the most vulnerable situations were most affected.
- The prison population was also particularly negatively affected by the pandemic and containment measures.
- Unemployment increased more steeply for those with low levels of education, young people and immigrants born outside the EU.
- The pandemic reinforced the social gradient in NEET status.
- Strict travel restrictions and closed borders affected the Sami people disproportionately. The Coronavirus Commission highlighted that Sami artists, craftsmen and other entrepreneurs suffered job losses as a result of travel restrictions.

#### GOVERNMENT AND SOCIETAL RESPONSES TO THE PANDEMIC

- The socioeconomic consequences of the pandemic were ameliorated through action taken by the Government, including support schemes for individuals, companies and the voluntary sector, as well as public grants.
- Norway has been a 'high performer' in tackling the pandemic related to its status as a high-trust society with a reliable and professional bureaucracy, a strong state, a good economic situation, a large welfare state and low population density.
- The containment measures had a strong economic focus and more could have been done to ensure continuation of support services and to focus on those in vulnerable situations.

#### THE COST OF LIVING CRISIS AND HEALTH AND SOCIAL AND ECONOMIC INEQUALITIES

- The cost of living crisis is deepening health and social and economic inequalities – impacting those who were already disadvantaged the most and increasing the number of households experiencing problems.
- In August 2022, 130,000 Norwegian households (five percent) were in serious economic difficulty and an additional 280,000 (11 percent) were struggling financially, both figures having doubled in just over a year.
- The most affected groups are those living on low incomes, families with children, people with disabilities and those with serious illnesses.

From the initial months of 2020, the COVID-19 pandemic caused damage to society and the economy as well as health and impacted most heavily on many of those in vulnerable situations. Since then, the cost of living crisis has added pressure to many households in the form of increased costs and associated health damage. There is evidence that those who were already disadvantaged are being impacted the most, but also that the number of households experiencing problems is increasing.

## THE COVID-19 PANDEMIC

The Coronavirus Commission indicated that Norway had one of Europe's lowest mortality rates from the COVID-19 pandemic but inequalities were seen in infection, vaccination, serious illness and death. It concluded that the immigrant population was overrepresented among those who caught the virus and among those who became seriously ill (56). It also found that vaccination rates were lower among immigrants and that the authorities were slow in putting in place additional measures to reach them.

Analysis by the Norwegian Institute of Public Health (NIPH) found that higher socioeconomic groups were more often tested for COVID-19, while lower socioeconomic groups were more often infected and had higher risk of severe disease – hospitalisation, ventilator use and death (57). With the improvement of register data and a rise in the number of COVID-19 cases, overrepresentation among immigrant groups was clearly established from the early autumn of 2020 (58).

The control measures taken had significant socioeconomic consequences although these were ameliorated through action taken by the Government, including support schemes for individuals, companies and the voluntary sector, as well as public grants. The measures taken had a strong economic focus and more could have been done to ensure continuance of support services and to focus on those in vulnerable situations. In particular:

- The COVID-19 pandemic exposed and amplified inequalities in health and socioeconomic conditions. Among households initially classified as most vulnerable economically, 40 percent of experienced a loss of income during the pandemic, compared to 13 percent among the most secure households.
- Unemployment increased more steeply for those with low levels of education, young people and immigrants born outside the EU.
- Control measures had a major impact on children and young people, especially those in more vulnerable situations who experienced an accumulation of disadvantage during the pandemic.
- Strict travel restrictions and closed borders affected the Sami population disproportionately.

The experience of the pandemic has illustrated the urgent need for bridging political divides to address common ambitions and legitimise public strategies and responses. The experience has shown that joint and multi-level action is possible. Among its conclusions, the Coronavirus Commission recommended further work on improving the living environments for children in deprived urban areas, as well restoring the role of schools in lifting the most vulnerable children academically and socially (56).

## THE COST OF LIVING CRISIS

Rises in the consumer price index driven mainly by increases in food prices, fuel and electricity (59) and several increases in interest rates by the Norwegian Central Bank (Norges Bank) have created problems for many households in Norway, increasing the number experiencing financial problems. Between January and June 2022, the financial situation of around 35 percent of Norwegians is reported to have worsened, with around 25 percent in a vulnerable financial position in June 2022. The most important single reason for the increase in the cost of living was the rise in electricity prices (60).

The crisis is hitting those who were already disadvantaged hardest. For example, while only six percent of households with the best economic trajectories between January and May 2022 reduced their budgets to buy food, 47 percent of those households who experienced the worst trajectories in this period have done so (59).

The most affected are those living on low incomes, families with children, people with disabilities and those with serious illnesses. As one expert explained:

***What we see now in Norway is huge pressure on the voluntary services handing out food and clothes and toys because the price of everything is increasing – electricity, loans, food. There is a new group of people with low incomes that can't make ends meet.***

*Tormod Bøe, University of Bergen*

The cost of living crisis is impacting on the wellbeing of those in the worst position. Among those in the most vulnerable situations, 58 percent experienced increased trouble sleeping at night because of the rise in the cost of living (61).

## 5. THE HEALTH EQUITY SYSTEM IN NORWAY

### KEY FINDINGS:

#### DEVELOPING THE HEALTH EQUITY SYSTEM REQUIRES

- An equitable wellbeing economy approach.
- Greater public sector innovation.
- Increased democratic participation and involvement of communities in decisions about programmes and policies through co-creation.
- Strong partnerships between national and local governments and between sectors and organisations.
- Implementation of health equity impact assessments.
- Ensuring proportionate universal policies.
- Strengthened accountability and effective monitoring for health equity.

#### THE PUBLIC HEALTH APPROACH IN NORWAY

- Norway has embedded a strong whole-of-Government approach to ensure that reducing social inequalities in health is included in policy development. However, inequalities persist.
- Ensuring adequate focus on the social determinants remains a challenge – with concrete policies and measures frequently taking more individualistic approaches.
- The Nordic countries provide a gold standard for welfare regimes. However, there are people left behind who experience exclusion and poor health and social and economic outcomes.
- There are differences in the capacity and willingness of municipalities to take action forward on health inequalities, partly related to the high level of autonomy that local municipalities have.

#### THE WELLBEING ECONOMY

- The wellbeing approach holds potential for further action on the social determinants and improving health equity, but equity must be the priority consideration in these approaches.

#### PUBLIC SECTOR INNOVATION

- Public sector innovation is required to ensure the sustainability of the welfare system and its adaptation to new challenges.
- While democratic participation, essential for the continuation of the welfare state and strong public sector, is relatively high in Norway there are inequalities related to income and age which undermine social cohesion and trust.
- Greater community participation is needed in the development of appropriate and effective programmes.

#### PARTNERSHIPS

- Action on the social determinants requires an effective health equity system comprising the whole of society - the voluntary sector and communities, health care, business and the economic sector, public services as well as national and local governments.

#### HEALTH EQUITY IMPACT ASSESSMENTS

- Health equity impact assessments build on health impact assessments and should be implemented more in the development and implementation of all policies in order to support greater health equity.

## PROPORTIONATE UNIVERSALISM

- Proportionate universal approaches are required to reduce health inequalities in Norway and for the provision of universal services. Allocation of resources should be tailored more proportionately across the gradient.

## ACCOUNTABILITY AND MONITORING

- Accountability for health inequalities needs strengthening through an integrated approach across national and local government and other sectors in the health equity system.
- Effective monitoring for health inequalities requires regular reporting of indicators of the social gradient in both health and its social determinants at each level of government. To achieve this data should, where possible, be linked so that it can be disaggregated by income, education, occupation, area of residence and migrant status.

## THE VOLUNTARY COMMUNITY AND NGO SECTOR

- Voluntary and Community Sector Organisations and Non-Governmental Organisations (VCS) are vital partners in action to reduce health inequalities and inequalities in the social determinants of health. Involving the VCS sector in the design and delivery of public services is important to ensure that services are appropriate, relevant and bring benefits to local communities.
- The VCS is an important advocate locally and nationally highlighting the position of many excluded communities and holding governments and other sectors to account for inequitable impacts and outcomes.
- The VCS is trusted in Norway and supports democratic participation and social cohesion.
- The VCS needs long term, sustainable funding to meet its potential to reduce health inequalities and inequalities in the social determinants of health.

## THE HEALTH CARE SECTOR

- There is great potential for healthcare organisations and personnel to take action to improve conditions in the social determinants of health resulting in improved health, lower inequalities in health, reduced burdens on the health care services and greater efficiency for the sector.
- Healthcare organisations can support the living and working conditions of patients through social support and by improving conditions in the local area.
- The healthcare workforce can better understand and support patients' living and working conditions in order to improve health.
- The healthcare workforce can be powerful advocates for healthy living and working conditions and can contribute to the scrutiny of national and local government policies to ensure they support greater health equity.
- There needs to be greater attention to reducing inequities in access to and outcomes from healthcare services in Norway and there are clear differences related to socioeconomic position and immigrant status for some services

## BUSINESS

- Businesses affect the health of:
  - > their employees and suppliers through the pay and benefits they offer, hours worked, job security and the conditions of work.
  - > their clients, customers and shareholders through the products and services they provide and how their investments are held.
  - > individuals in the communities in which they operate and in wider society, through local partnerships, procurement and supply networks and in the way they use their influence through advocacy and lobbying.
- Norway has strong regulations on advertising of unhealthy products.
- There is potential for businesses and the whole economic sector to take action to support better health for employees, customers and communities and work in partnership with other sectors.
- Health effects on wider society encompass environmental impacts, including carbon footprint and air pollution, as well as the taxes paid by businesses to local and national governments.

## PUBLIC SERVICES

- Public services are an essential partner in making improvements in the social determinants of health.
- Many of the recommendations made in this report are for public services, but public service organisations can also develop as anchor organisations to support greater health equity.
- Partnerships between public services, VCS, business and healthcare as well as with Government are vital to the health equity endeavour.

## LOCAL GOVERNMENT

- Municipalities in Norway have a great deal of responsibility for levelling up the social gradient in health and tackling the social determinants of health.
- There are clear differences in both how different municipalities take forward action and their level of leadership on health inequalities.
- There is oversight from national Government, but this can be strengthened with greater accountability to ensure that all municipalities prioritise health equity and wellbeing.

Norway has embedded a strong whole of government approach to ensure that reducing social inequalities in health is included in policy development. However, inequalities persist.

Ensuring adequate focus on the social determinants remains a challenge - with concrete policies and measures frequently taking more individualistic approaches, often related to lifestyle factors.

The Nordic countries provide a gold standard for welfare regimes. However, there are people who are left behind and experience exclusion and poor health and social and economic outcomes, even in the context of a system that is supposed to be universal.

The purpose of the national Norwegian Public Health Act (2011), which came into force on 1st January 2012, was to ensure that public health and reducing social inequalities in health were at the centre of public

policy and there was a strong focus on the social determinants of health. However, there are limitations to its effectiveness.

***The Public Health Act has been very important in raising awareness that reducing social inequalities is also a task for local governments, and that they can address some of the determinants of health, with a broader focus than only poverty reduction among the most disadvantaged groups. On the other hand, like other Acts in Norway on local government, it has not been followed by any prescriptions and there are no explicit funds in the national budget to implement it.***

*Elisabeth Fosse, University Of Bergen.*

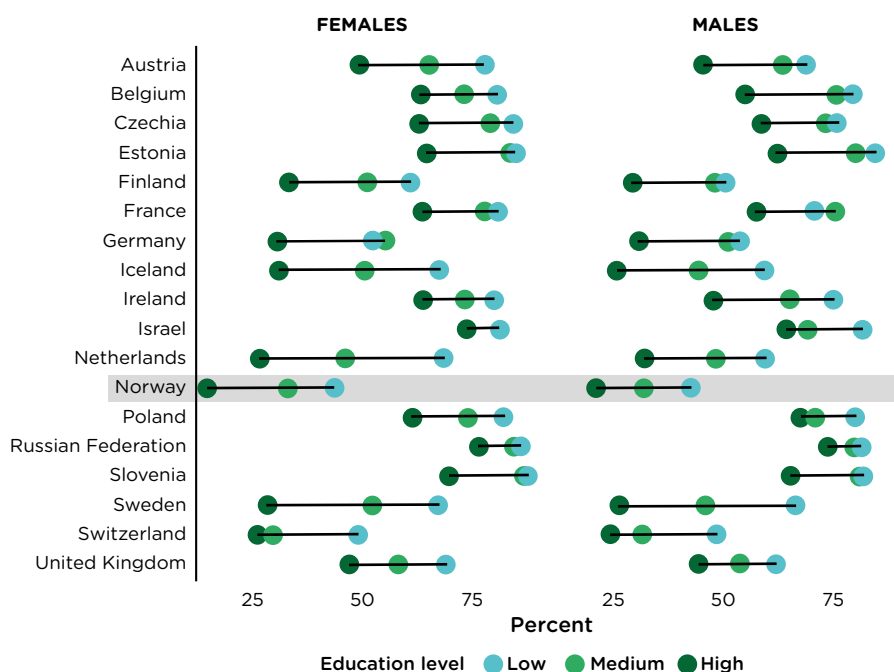


It is essential that there is appropriate, proportionate allocation of funds to support the reduction of social inequalities by municipalities and greater coherence between central and local governments to ensure that municipalities do address these inequalities within a framework of stewardship by the national Government. However, imbalances in the capacity and willingness of municipalities to take forward action on health inequalities are partly related to the high level of autonomy that local municipalities have. Public sector innovation is required to ensure the sustainability of the welfare system and its adaptation to new challenges.

## DEMOCRATIC AND COMMUNITY PARTICIPATION

While democratic participation is relatively high in Norway there are inequalities related to income and age which undermine social cohesion and trust – see Figure E.14. Greater individual and community participation and voice are needed. They help in the prioritisation, design and delivery of policies which are relevant and appropriate to the population and important for health.

Figure E.14 Percent reporting an inability to influence politics by level of education, 2016



Source: WHO (2019) (62)

## HEALTH EQUITY IMPACT ASSESSMENTS

Health equity impact assessments build on health impact assessments and should be implemented more in all policy development and implementation to support a health equity focus. There are a number of tools to ensure that equity and health are prioritised in policy development and implementation.

## PARTNERSHIPS

Action on the social determinants requires an effective health equity system comprising the whole of society - the voluntary sector and communities, health care, business and the economic sector, public services as well as national and local government. To take system-wide action on the social determinants of health and wellbeing there is a need for comprehensive, multi-level action that intersects local measures with upstream structural and political conditions for justice and social sustainability.

## A WELLBEING ECONOMY

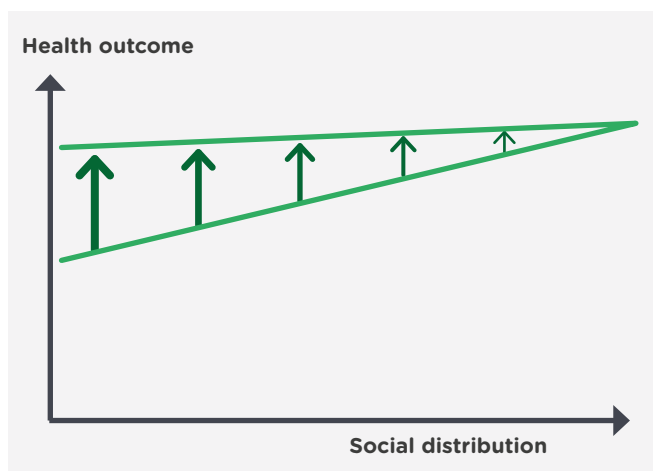
Advancing a wellbeing economy provides decision-makers with political and investment tools to go beyond the siloed, budget-based thinking where sectors compete over priorities and seeks to build alliances that can advocate for the distribution of economic resources which have a positive impact on health and wellbeing for all, generating high societal value returns on public investment. In 2021 the Norwegian Government announced that it would develop a new national strategy for wellbeing (63), to provide important opportunities to pursue greater health equity within a framework of universal wellbeing and a wellbeing economy.

## PROPORTIONATE UNIVERSAL APPROACHES

Proportionate universal approaches are required for reducing health inequalities in Norway, for the following reasons. Approaches that are purely universal are commonly either taken up equally across social groups, resulting in overall health improving but inequalities persisting, or taken up more by those who are already benefitting from good health so that the impact is regressive. Conversely, very targeted approaches improve outcomes in only the most disadvantaged, leaving the majority of the population, who also have worse health than the most advantaged, untouched by the action taken.

Often, the selection of the targeted population also creates a cliff edge in terms of eligibility. In order to reduce these issues and tailor the welfare state and public services to ensure a healthy standard of living for everyone and better support those marginalised and excluded, the formulation of universal but proportionate approaches to service design, delivery and resource allocation is required to level up the gradient – see Figure E.15. Continued high levels of investment in the welfare state is a pre-requisite but must be better tailored to need.

**Figure E.15 Proportionate universalism - levelling up the social gradient in health**



Source: WHO 2014 (64).

## ACCOUNTABILITY AND MONITORING

Accountability for health inequalities needs strengthening, including across national and local government and involving other sectors in the health equity system. According to the Public Health Act, municipalities must have sufficient overview of the population's health and the positive and negative factors that may influence this. However, a large proportion of municipalities still do not identify health inequities as a main challenge for them. For all to do this effectively requires suitably disaggregated indicators to monitor health inequalities. This requires indicators based on data that is, as far as possible, disaggregated by income, education, occupation, area of residence and migrant status. Without appropriate indicators, there can be no accountability for either the scale of the problem or the progress that is made in reducing inequalities – the scale of the impact achieved by strategies, policies, programmes or other interventions. Equally, since inequalities are often sustained or widened by external factors, there can be no assessment of the scale and intensity of action needed to counteract the effects on health and wellbeing of external events that adversely impact on health and wellbeing.

To inform national and local decisions for developing policies and interventions and/or assessing the impact of policies on health equity, health equity impact tools should be used with the available data and mathematical modelling techniques to assess the potential scale of the impact of planned interventions on population subgroups and to predict the impact of socioeconomic or other inequalities on population health.

## THE VOLUNTARY AND COMMUNITY SECTOR

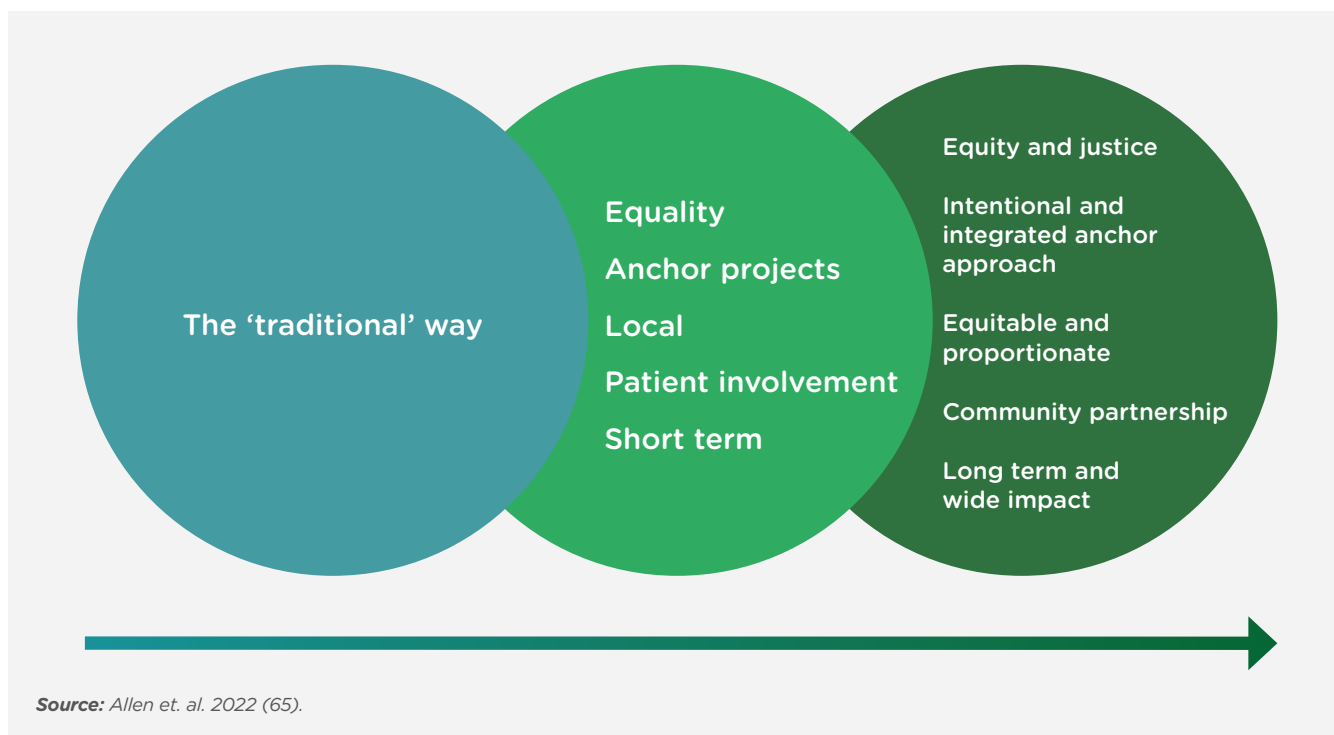
The voluntary and community sector also has an indispensable role to play in reducing health inequalities and inequalities in the social determinants of health. Its importance was particularly apparent during the COVID-19 pandemic, where the sector filled vital roles in supporting communities and excluded groups. In addition, the VCS sector is an important advocate locally and nationally, essential for highlighting the position of many excluded communities and holding Governments and other sectors to account for inequitable impacts and outcomes.

## HEALTH CARE ORGANISATIONS

There is great potential for healthcare organisations and personnel to take action to improve conditions in the social determinants of health resulting in improved health, lower inequalities in health and reduced burdens on the health care services and greater efficiency for the sector.

Health care organisations can support the living and working conditions of patients through social support and by improving conditions in the local area anchor institutions as in Figure E.16.

Figure E.16 Five principles for moving anchor institution work towards equity



## THE ROLE OF BUSINESS

The COVID-19 pandemic made clear the close interdependency of health and wealth and that neither could thrive without the other. The economy requires healthy workers and healthy customers, and a failing economy, high unemployment and poor working conditions damage health. Involvement of business in taking action on health inequalities is a recent development, but one that is gaining momentum.

## PUBLIC SERVICES

Public services are an essential partner in making improvements in the social determinants of health. Many of the recommendations made in this report are for public services, but public sector organisations can also develop as anchor organisations to support greater health equity. Partnerships between public services, VCS, business and healthcare as well as with Government are vital to the health equity endeavour.

## THE ROLE OF MUNICIPALITIES

In Norway responsibility for many of the services that affect the social determinants of health, such as schools, day care, elderly care and social services, are devolved to municipalities (66). Municipalities are free to prioritise spending in their areas of responsibilities within the constraints of the total funding available to them, derived from both national resource allocation and local taxes. While almost all the municipal budget goes toward the provision of national welfare schemes and provision of services which are universal to the Norwegian population, the spending is not tied to any

specific objectives, nor does it require municipalities to address inequities in any specific ways. The future relationship between national Government and local municipalities is therefore key to addressing health inequities. The split in their accountability does not provide citizens a single authority to hold responsible for the lack of implementation.

## CONCLUSION

A national strategy and subsequent policy on health equity should be developed to take action on the social determinants of health and prioritise wellbeing and health equity. These need to involve different sectors and organisations in order to make a significant difference to reducing inequalities in the health and wellbeing of the population. They include the voluntary and community sector, healthcare system, business and the economic sector, public services and local government. Both the strategy, policies and involvement of organisations should be based on the key principles for ensuring effective action on inequities in health and in the social determinants of health and wellbeing. These include developing the wellbeing economy approach, public sector innovation, democratic participation and involving communities, stronger partnerships between national and local governments and between sectors, health equity impact assessments, proportionate universalism, accountability and effective monitoring for health equity.

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