



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

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CHAPTER 1

INTRODUCTION

CONTEXT AND COMMISSION OF THIS 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).

Evidence from around the world shows that health is a measure of how well a society is functioning, and that when there are social and economic inequalities, there are also inequalities in health (1).

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 persist and are widening for some groups (2,3). As in many other countries, social inequalities are widest in the largest cities, and positive and negative health drivers are clustered in different parts of the cities (2,4,5).

It has been 16 years since Norway adopted its first National Strategy to Reduce Social Inequalities in Health (6). The strategy was characterised by 1) a holistic, broad cross-sectoral approach, 2) an explicit focus on the gradient and 3) the principle of 'proportional universalism', i.e., universal policies in combination with more targeted measures (4,7). Applying a cross-sectoral approach implied that the aim of reducing health inequalities is integrated in several policy fields and ministries. As such, the strategy targeted selected domains of action to reduce health inequalities, such as: childhood/adolescence and education, work and working conditions, income, health services and health behaviours, as well as social inclusion (7).

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). The Norwegian Public Health Act, developed at the national level, came into force on 1 January 2012.

While the Ministry of Health has the overall responsibility for public health, there is an aim that all sectors of society should be responsible for policy development in this field. The Public Health Act has a strong focus on the social determinants of health. The purpose of the act is to contribute to societal development that promotes public health and reduces social inequalities in health. It has created new foundations for strengthening systematic public health work in the development of policies (the health-in-all-policies approach) and planning for societal development based on regional and local challenges and needs (3,8).

Norway – as well as countries around the world – has been confronting societal turbulence and a series of interconnected crises, that are both causing and escalating social inequalities. Climate change, disease outbreaks (most recently the COVID-19 pandemic), economic shocks, war and consequent migration are some of the complex problems the world is facing which have damaged health and widened health inequalities in many countries. Such problems urgently require a whole-of-society and multi-level response to 'leave no one behind' and 'reach those furthest behind first', as stated by the UN (9) and to reduce unjust and unnecessary health inequalities.

Health and wellbeing for everyone in both current and future generations is not only an ethical imperative, but also a prerequisite for sustainable development. The relationships between social, environmental and economic sustainability and equity, on which health inequalities depend, requires readdressing social justice and equity in societal development. In Norway, there is renewed political interest in acting to reduce health inequalities that arise from social conditions and are, therefore, preventable. This report will provide an important basis for the development of a new strategy in accordance with current challenges and opportunities to build a fairer, healthier and more socially sustainable Norway.

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 (10).

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 (11).

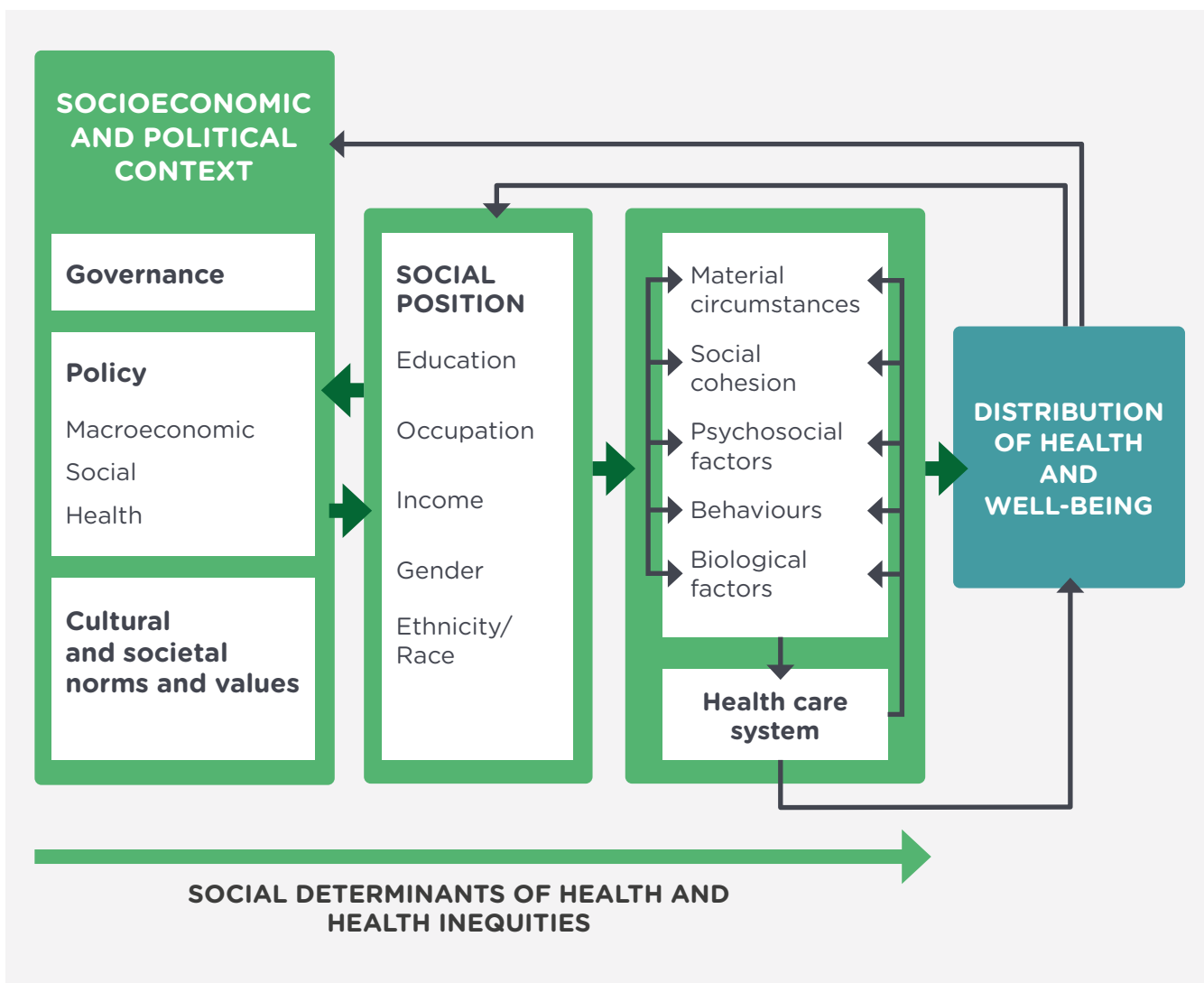
In addition to the above, the report was commissioned by the Norwegian Directorate of Health to answer several specific questions particularly relevant to the current Norwegian context:

- 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 illustrated in the WHO Commission on Social Determinants of Health conceptual framework in Figure 1.1.

Figure 1.1 CSDH conceptual framework



Source: WHO CSDH final report (10)

The 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.

The next box in framework 1 lists **types of exposures, vulnerabilities and consequences** that people experience differently based on their social position, the extent of social stratification and the socioeconomic and political context of a country. These include the material conditions in which people are born, grow, live, work, and age, the extent of social cohesion in a society, psychosocial factors, such as sense of control, health-related behaviours and biological factors. The health care system plays a role in ill health prevention, health promotion and treatment of ill health. Combinations of these factors, in particular the accumulation of positive and negative influences on health from before birth and throughout life, affect health and wellbeing and the risk of premature mortality.

Finally, **inequalities in health and wellbeing** can be identified. Where health inequalities are considered to be avoidable by reasonable means they are inequitable: taking action to reduce them is a matter of social justice.

Since the original formulation of this framework, several subsequent formulations have emphasised different aspects of the causal pathway from structural drivers through to health outcomes. We highlight some of the most important for this review and the Norwegian context.

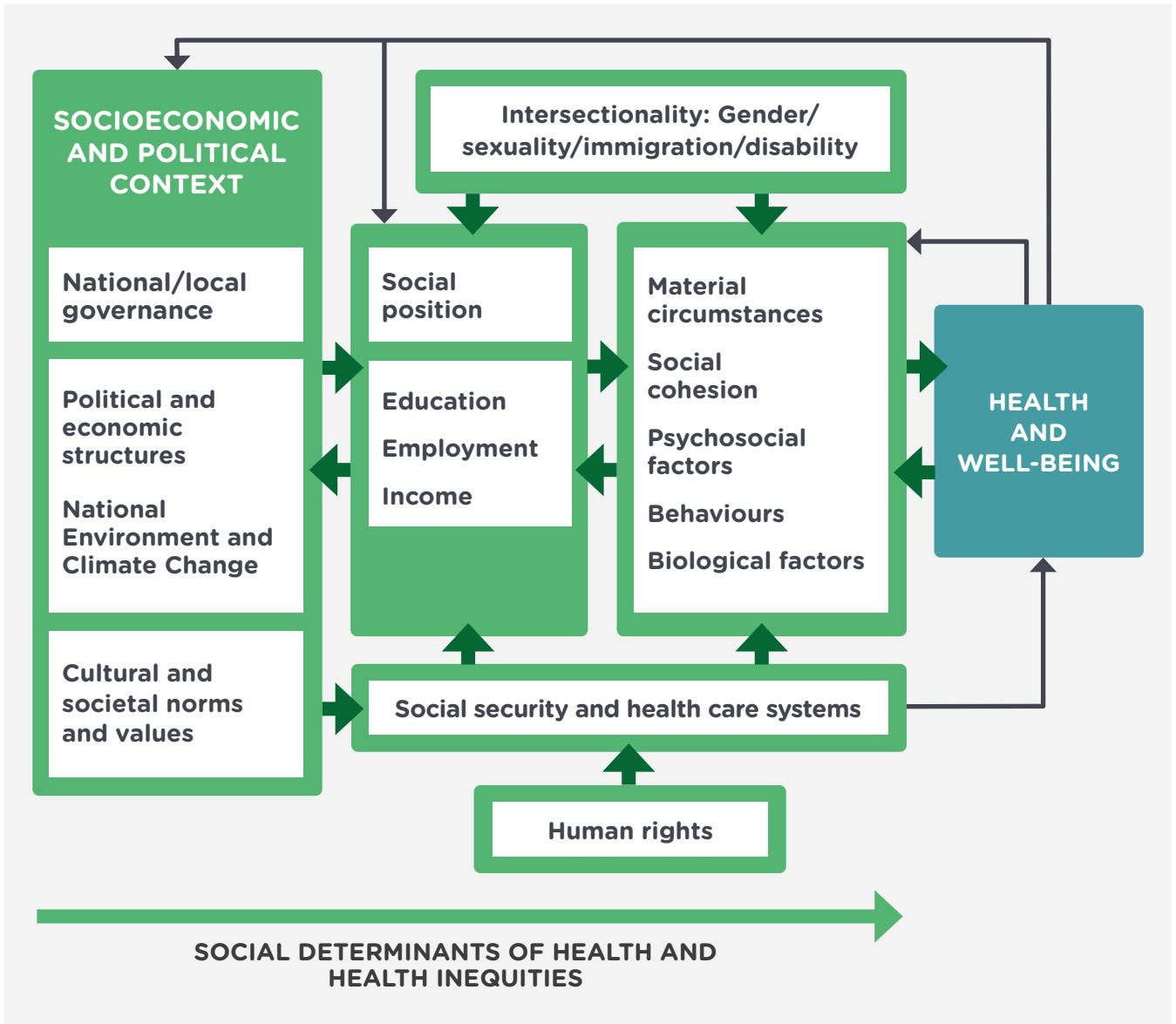
First, there is the notion of the life course. In essence, the conditions to which an individual is exposed have a cumulative effect over their life - from the conditions of life and environment exposures of their parents when they are conceived, right through to their own conditions and health care as they near the end of life. Because they influence much of what follows, inequities in early life are the most important, but every

subsequent exposure leads to a further accumulation of advantage or disadvantage. This, and the role of parents and grandparents in the intergenerational transmission of inequalities, was highlighted in the framework adopted in the WHO review of health inequalities in the European Region (12).

A second development is an emphasis on the role of cultural factors in driving the exclusion of some groups within a country, and xenophobic attitudes between countries that give rise to conflict. While this structural driver has a direct impact on the social and economic conditions of those adversely affected, the impact on their life chances, health and wellbeing is generally greater than can be accounted for by their material conditions. Recognition of this can be seen both in attitudes to migrants throughout Europe and the need for the establishment of Sami Truth and Reconciliation Commissions in three countries across Scandinavia. Globally, structural racism largely contributes to the unfavourable social and economic position and exclusions of many minority ethnic groups and migrants. Disability discrimination and the exclusion of people living with disabilities is a further dimension contributing to health and social and economic inequality, alongside both gender discrimination and that against LGBTQ+ communities. Many people experience multiple forms of discrimination and exclusions relating to gender, ethnicity, disability and sexual orientation which adversely affect health and the social determinants of health.

The wider influences of society on the social determinants of individual health are fundamental in enabling people to have the freedom to lead a life that they have reason to value (13) and the capability to maintain good health and wellbeing. In particular, an individual's resources and capabilities for health are influenced, not only by the social and economic arrangements of the society, but also by the collective resources provided by the communities of which they are part and by welfare state institutions (12). Figure 1.2 provides a modification of the CSDH framework to take account of subsequent evidence and discussions, giving more emphasis to these issues and highlighting those that most affect Norway.

Figure 1.2 Social determinants of health framework for Norway



The frameworks above characterise drivers of health inequalities, without exposing the decisions which are underpinning them, and which are driving health inequities so that the focus remains on description, not on identifying solutions and taking action. The WHO European Region's Health Equity Status Report (HESR) developed a technique for understanding what drives the trends and status of health inequities within countries across the Region. The report captured and analysed the relationships between health inequities, the conditions that are essential to be able to live a

healthy life, and the degree of investment, coverage and uptake of policies that influence health equity outcomes. It identified five conditions (Figure 1.3) that impact on health equity; shortcomings in each of the areas are significant in their own right in explaining health inequities between men and women across social groups and geographical areas.

Figure 1.3. HESR health equity conditions

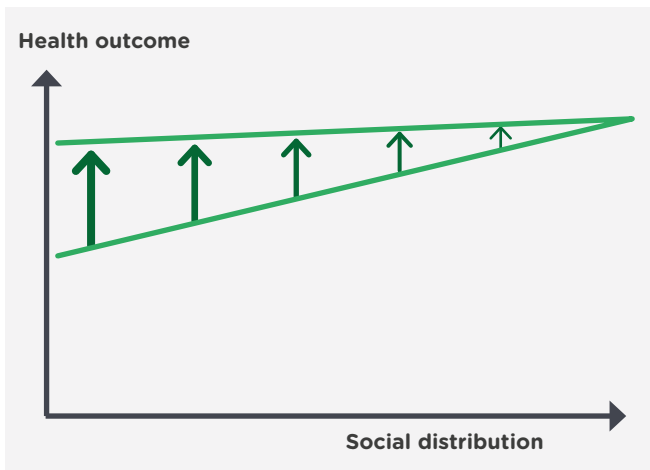


Source: WHO European Region Health Equity Status Report (14)

It is important to design policies that act across the whole social gradient, to 'level up the gradient' as well as addressing the needs of those in the most vulnerable and excluded situations. Central to this is the concept of 'proportionate universalism' – developing policies, actions and the methods of allocating resources that are designed to be implemented universally but are delivered to individuals, groups and organisations with an intensity that is proportionate to their needs. This is illustrated in Figure 1.4.

In Chapter 5, we provide examples of implementation of the principle of proportionate universalism and how it could be developed in the Norwegian context of strong universal social welfare and its individual rights system.

Figure 1.4 Proportionate universalism - levelling up the social gradient in health



Source: WHO European Social Determinants Review (15)

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.

Subsequent to the report *Fair Society, Healthy Lives*, several reviews of health inequalities in the Nordic countries have identified similar principles. The Swedish Commission for Equity in Health argued that conditions and opportunities in key areas of life differ substantially between people in different social positions and that resources in these areas are translated into inequalities in health. They pointed to seven key areas of life (11):

- Early life development
- Knowledge, skills and education
- Work, working conditions and work environment
- Incomes and economic resources
- Housing and neighbourhood conditions
- Health behaviours
- Control, influence, and participation

In 2019, the Norwegian Council on Social Inequalities in Health produced 29 recommendations to combat social inequalities in health. The recommendations focus on the entire social gradient rather than just poverty and the socially disadvantaged (16). Recommended measures were related to the following main policy areas and aimed to facilitate a possible re-orientation of policy away from redistribution to universalism. The recommendations are listed thematically and have not been prioritised (16):

- A good childhood impacts on the entire life cycle
- Good schools and education for all
- Healthy working life and high employment rate
- Fairer distribution of income
- Health-promoting behaviour in all social groups
- Governance — structural measures and implementation
- Health services that reduce social differences in health

This report builds on these recommendations to identify some of the specific actions, mechanisms and promising examples needed to achieve these goals. It links these to the specific questions posed by the Directorate of Health (see above).

THE STRUCTURE OF THIS REPORT

In this report, we review the key available evidence of inequalities in health and wellbeing in Norway in Chapter 2. In Chapter 3 we describe the inequalities that exist in each of the eight areas covered by the Marmot principles and identify the policy mechanisms and life course processes giving rise to the inequalities. In Chapter 4 we describe how the COVID-19 pandemic has replicated and, in some cases, amplified these existing inequalities in health and wellbeing and their social determinants. Finally, in Chapter 5, we indicate the type of health equity system needed in Norway to address the inequalities identified in the previous chapters.

In each chapter, we list the key findings, for ease of reference, together with our 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.

CHAPTER 2

HEALTH INEQUALITY INDICATORS IN NORWAY

In this chapter we describe, for the main indicators of inequalities in health and wellbeing available in Norway, the most recently published analyses of data on the extent of inequalities and key trends in the last few decades. We set out some of the strengths and limitations of this data.

**KEY
FINDINGS:
HEALTH AND
WELLBEING
INEQUALITIES**



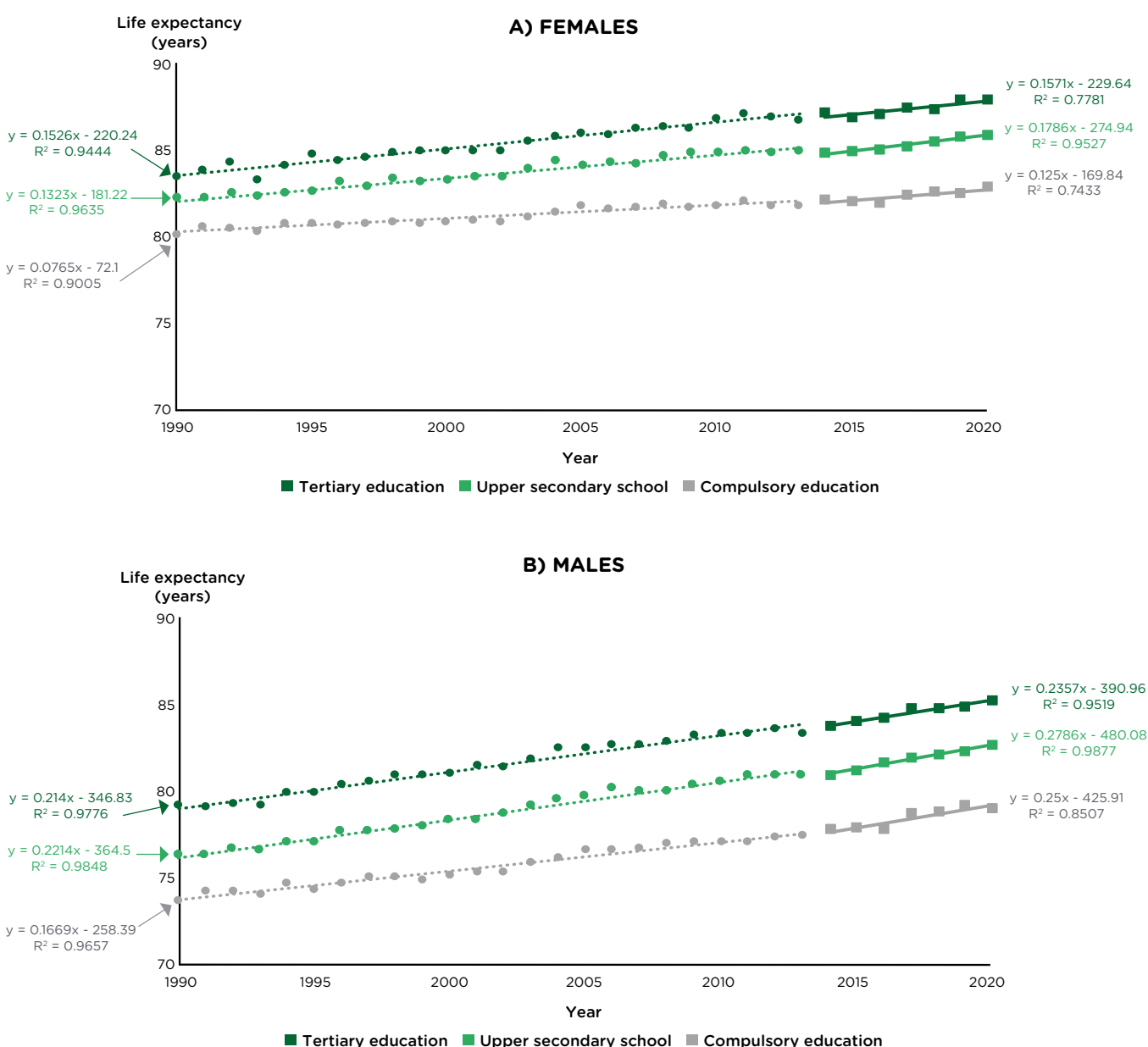
- There are persistent inequalities in life expectancy and death rates in Norway whether measured by educational level, occupation or income. These inequalities are on a gradient running from higher to lower social and economic position.
- The gaps between the most advantaged and disadvantaged large 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 socio-economic 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.

CURRENT STATE AND TRAJECTORIES OF HEALTH INEQUALITIES IN NORWAY

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. It is also used as the standard source of comparison of mortality and morbidity across Europe (17). Its strength as an indicator of these outcomes lies in the fact that, for most people, educational level does not change beyond the age of 30. 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 (4). It can be seen from Figure 2.1 that this continues to be the case for females, for whom inequalities have widened still further since 2014.

Figure 2.1 Life expectancy of men and women aged 35, Norway, 1990-2020



Source: NIPH Database (18)

INEQUALITIES IN LIFE EXPECTANCY BY EDUCATION, 1990-2013

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 attended only 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, inequality in life expectancy also increased, although less rapidly than for women: men with tertiary education gained an extra 2.5 months of life expectancy each year while those with only compulsory education gained two months per year.

There are also clear gender inequalities, with women having longer life expectancy than men in Norway, as in most countries globally. These gender gaps have closed since the 1990s as life expectancy increased faster for men than it did for women in every educational group although inequalities continued to widen for men as well as for women. The effect of this was that while women with only compulsory education could expect to live 6.4 years longer than their male counterparts in 1990, by 2013 this gap had reduced to 4.3 years.

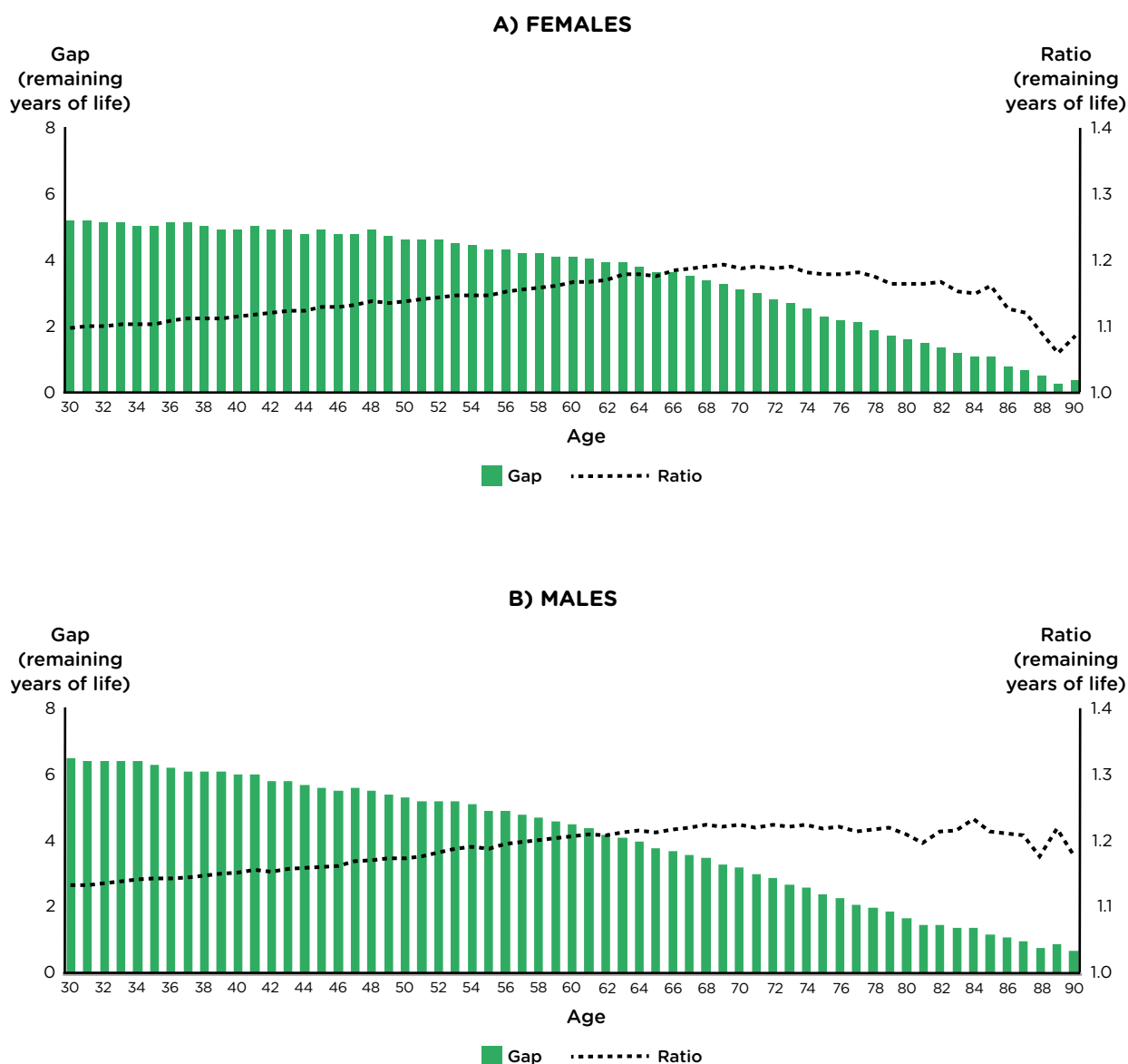
INEQUALITIES IN LIFE EXPECTANCY, 2014 - 20

After 2014, inequalities in life expectancy by educational level among those aged 35 continued to widen for women, but at a slower rate than between 1990 and 2013. While women with tertiary education gained 1.9 months of life expectancy per year between 2014-2020 – a similar rate to the previous period – those with compulsory education gained 1.5 months per year in 2014-2020 – a markedly greater rate than in the previous period. For men there was a slight narrowing of inequalities related to educational level between 2014-2020. While men with tertiary education gained 2.8 months per year, the equivalent gain for those with

only compulsory education was 3.0 months per year – a markedly greater rate than in the previous period. For women, inequalities in life expectancy by education were at their widest point in 2020, when a woman aged 35 with tertiary education had a life expectancy of 87.8 years compared to 82.8 years for a woman with only compulsory education – a gap of five years. The comparable figures for men were 85.2 and 78.9, a gap of 6.3 years. In terms of the gender gap among those who had only attended compulsory education, the difference between men and women had narrowed a little bit by 2020 to 3.9 years from 4.3 years in 2013.

The gap in life expectancy between educational groups changes with the reference age group: among those aged 30 in 2020 the gaps for women and men were 5.2 and 6.5 years, respectively (Figure 2.2). By age 65, with fewer remaining years of expected life, the absolute values of the gap had fallen to 3.6 and 3.8 years, respectively, and by age 90, to 0.4 and 0.7 years respectively. However, the relative difference in remaining life years follows a different pattern with age. Among women the ratio of remaining life years of those with tertiary education to those with only compulsory education increases with age from 1.1 at age 30 to 1.19 around age 70. It then decreases marginally with age to 1.16 at age 85 before falling sharply with further increases in age. Among men, this ratio was 1.13 at age 30 in 2020 and increased with age to 1.23 at age 70. In contrast to the pattern for women, the relative difference remained around this level at older ages. This suggests that relative educational inequalities in life expectancy persist into old age among men. Among women, these differences only decline below levels seen at age 30 when they reach 88.

Figure 2.2 Relative and absolute gaps in remaining life expectancy by age and sex, Norway, 2020

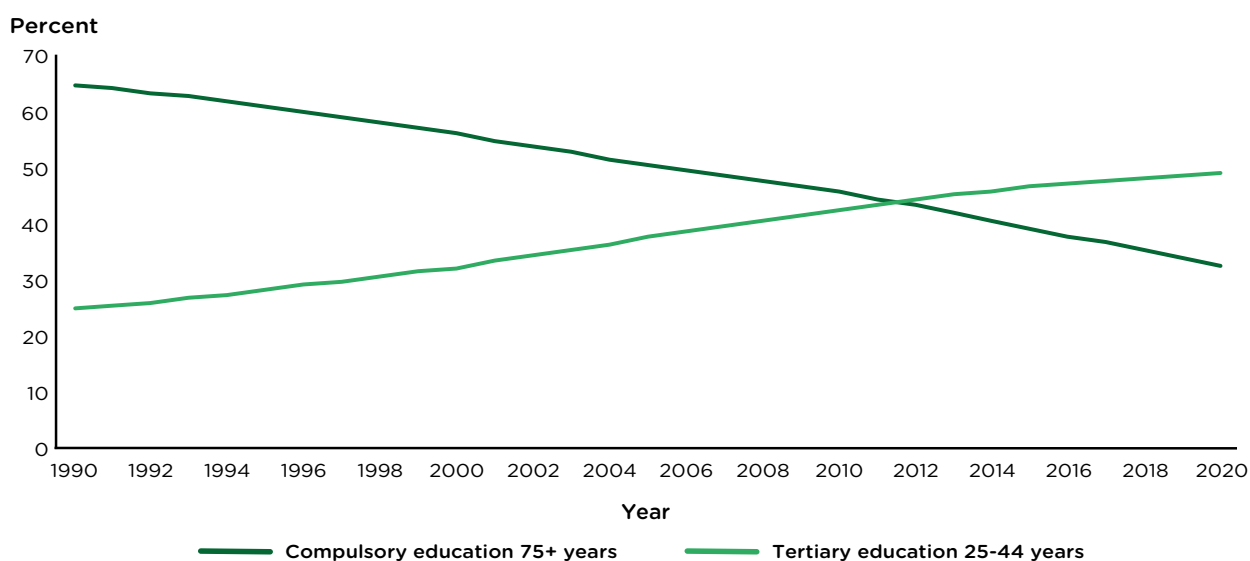


Source: NIPH Database (18)

These trends in life expectancy by educational level need to be seen in the context of the marked changes in the education system in Norway over time, resulting in successive cohorts having different chances of remaining in education and attaining higher educational levels. In summary, these have included the introduction of compulsory education, a universal right to pre-school education and the expansion of tertiary education set out in Section 3B. In particular, the major high school reform introduced in 1994 (Reform 94) introduced several incentives to keep young adults in school, overcoming barriers in the system that was leaving a substantial part of the population without qualifications.

The effect of all the changes on educational levels in successive cohorts can be seen in Figure 2.3. In 1990, 65 percent of those aged 75 and over had only had compulsory education i.e. those born before 1915. By 2020, this figure had fallen to 32 percent as there had been a progressive increase in those staying on beyond compulsory education in cohorts born up to 1945. By contrast, in the age group 25 to 44 in 1990 (those born between 1945 and 1966), 24 percent had tertiary education, and this rose to 49 percent in 2020 (those born between 1975 and 1996).

Figure 2.3 Educational level at ages 25-44 and 75 and over, Norway, 1990-2020



Source: NIPH Database (18)

These dramatic changes in the educational distribution of the Norwegian population must be taken into account when interpreting trends in inequalities in life expectancy by education. The size and age structure of educational groups in 1990 was very different to those in 2020. Furthermore, educational reforms are important to improve the economy of a country and better equip the workforce for a changing and competitive labour market. As educational level is a catalyst to many aspects affecting an individual's life, such as income, working and living conditions, it is closely linked to the improvement of a population's overall life expectancy (19-21).

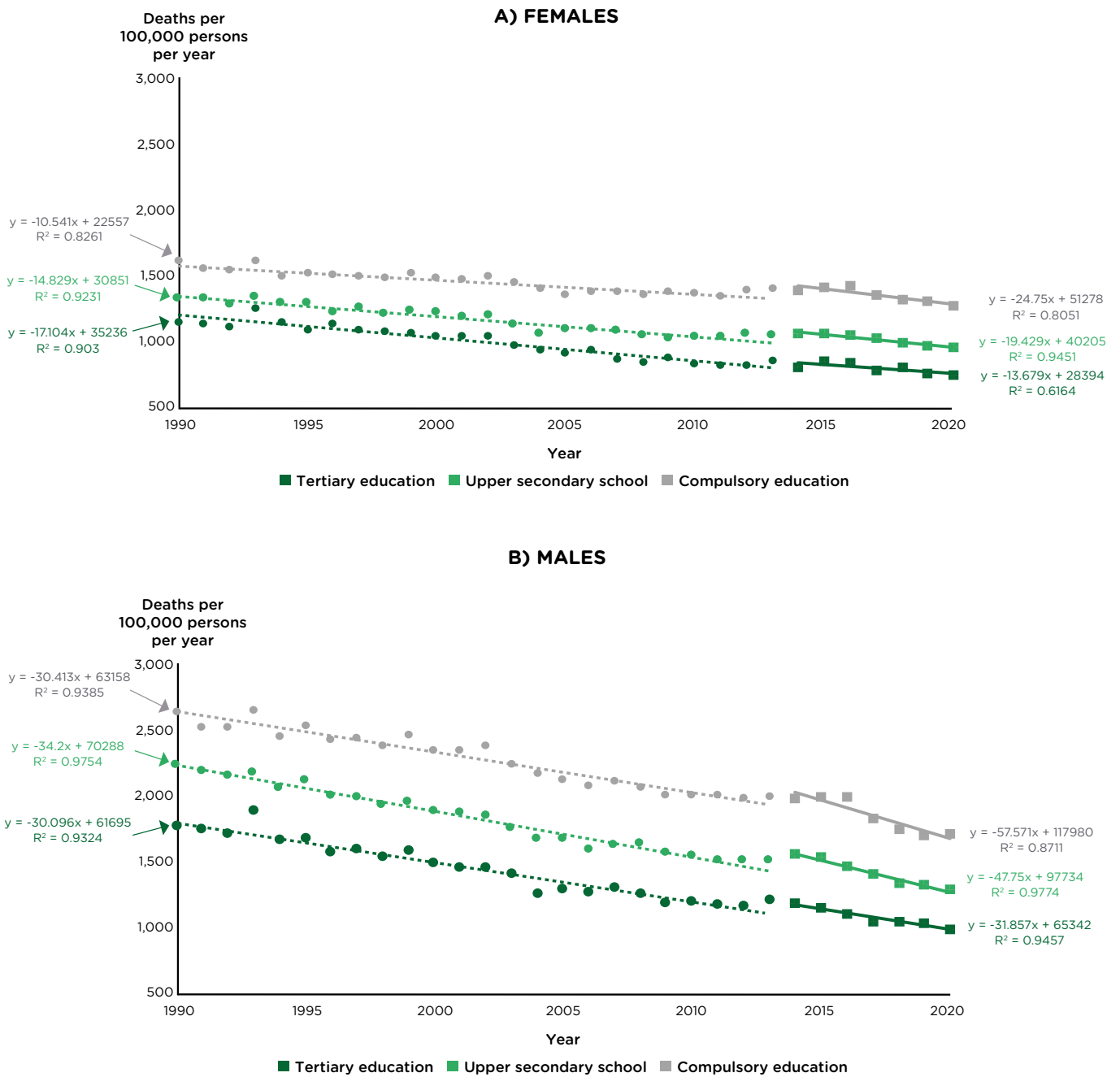
However, it remains hard to quantify whether this impact on life expectancy can be directly related to educational reforms as, while the policies were effective in increasing the proportion of women with high school qualifications, they did not impact the overall enrolment rate in tertiary education. Enroth et al. (21) conclude that educational expansion has contributed to uneven gains in life expectancy between educational groups, something evident across Nordic countries and a symptom of reforms which did not adequately follow through the development of a population that was improving its educational status. They speculate that this poses a risk for the future increase of inequalities in life expectancy (22,23).

DEATH RATES BY EDUCATIONAL LEVEL

In view of these changes in the educational levels attained by successive cohorts, it is important to examine whether trends in life expectancy are reflected in other mortality indicators. One alternative indicator is to use age standardised death rates. These apply a different weighting (the European Standard Population) to each age group and can therefore give slightly different results in terms of trend analysis. Trends for those aged 30 and over since 1990 are shown in Figure 2.4.

Death rates for women have been lower than those for men throughout this period. However, rates for men have been falling faster in each educational group, so that gender differences were considerably smaller in 2020 than previously. This trend was also noted in the life expectancy data discussed earlier. In the years up to 2014, the gap in death rates between the most and least educated was widening in women but staying largely constant in men. However, since 2014 both the gap and gradient in education has narrowed for both men and women.

Figure 2.4 Age standardised death rates of men and women aged 30 and over, Norway, 1990-2020



Source: NIPH Database (18)

Dahl and Elstad (2022) have used mortality data by education and age to estimate years of life lost due to educational inequalities. They show how many years of life would have been gained if people at all levels of education had the same low-risk of premature death as those with the highest level of education. If that were the case, men and women with primary school education would together save around 85,000 life years

in 2020. Those with upper secondary education would gain around 76,000 more life years, and the increase for those with a short university or college education would be 13,000 life years. If the inequalities in risk of death had been 'levelled upwards' to the level among the most highly educated, the Norwegian population would have gained around 174,000 extra years of life, in a single year (2).

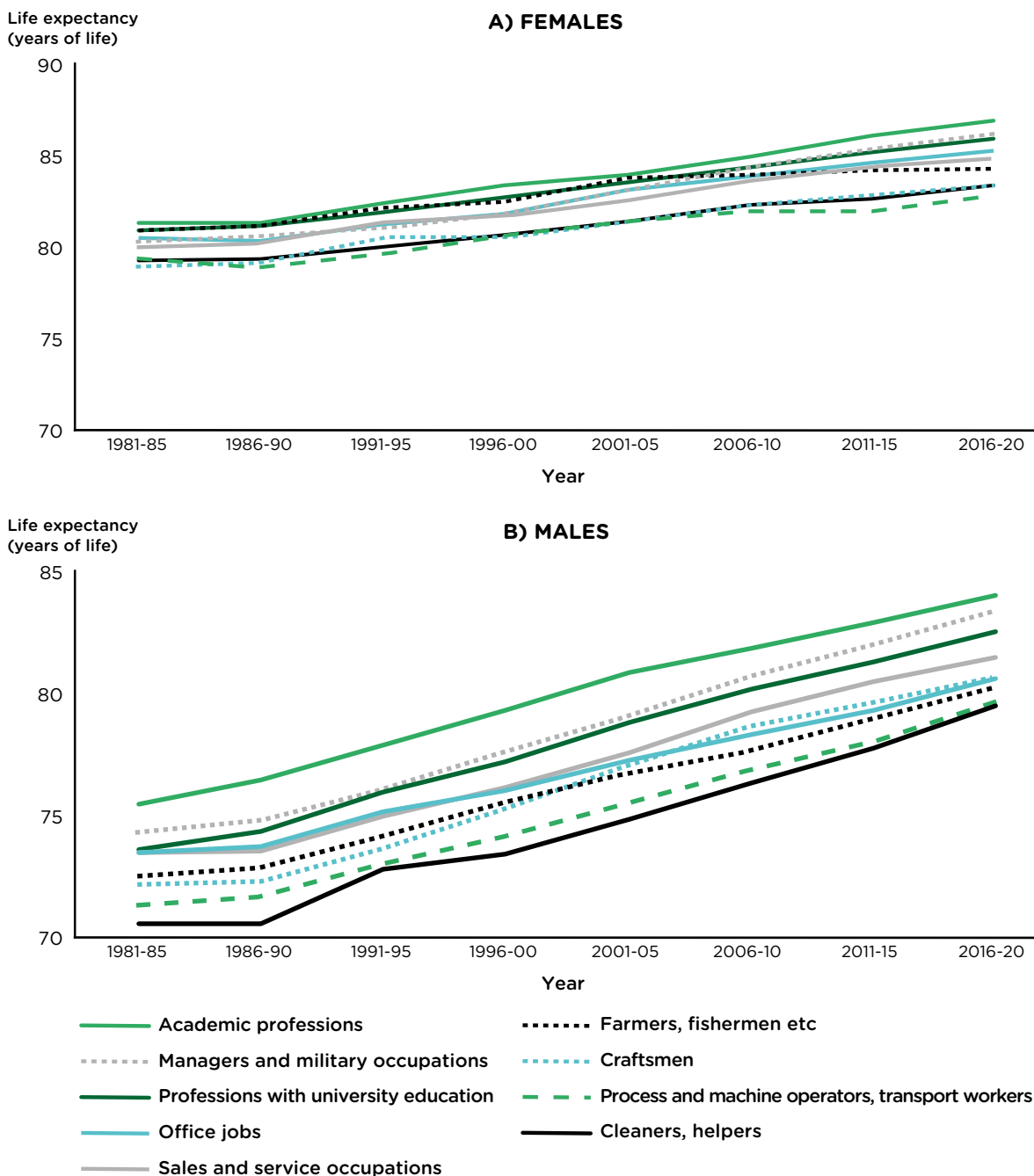
LIFE EXPECTANCY BY BROAD OCCUPATIONAL GROUPS

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 (24). Figure 2.5 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. The main change in the gradient over time was that the life expectancy

of farmers, fishermen, etc increased more slowly than others, so that their ranking fell from third to sixth highest out of nine groups.

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 2 years in 1981-5 to 3.5 in 2016-20. The relative position of females in farming and fishing has also changed, as for males, from 2nd to 6th highest.

Figure 2.5 Life expectancy at birth by sex and broad occupational groups over five-year time periods, 1981-2020



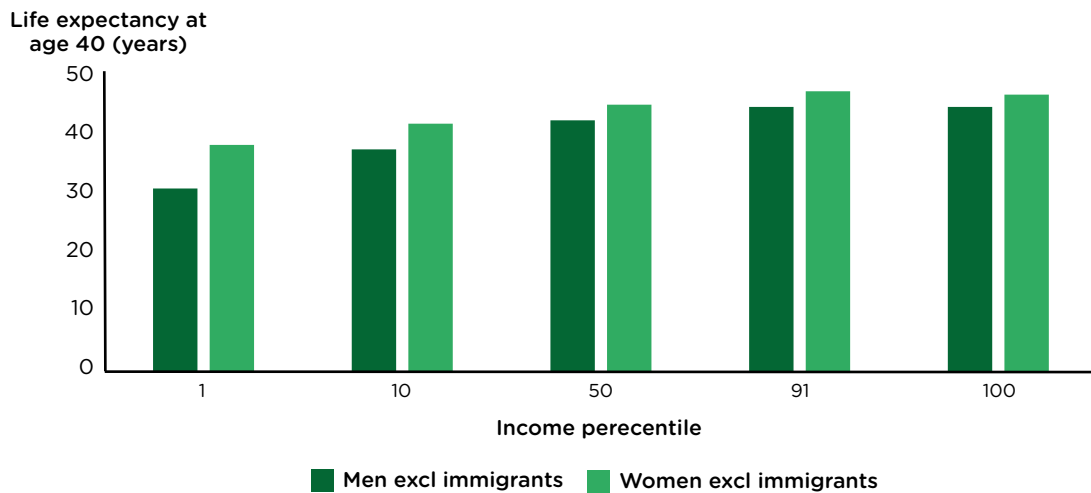
Source: Texmon (2022) (24)

LIFE EXPECTANCY BY INCOME

Kinge et al. (2019) used Norwegian registry-based data linking household income over the previous five years (disaggregated by income percentiles) to mortality data in each of the years 2005 to 2015 for persons aged at least 40 years (25). Figure 2.6 shows remaining 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 1st and 10th percentile was

6.53 years for men and 3.56 for women; between the 10th percentile and the median it was 4.9 and 3.08, respectively; between the median and 91st percentile it was 2.36 and 2.35, respectively; and between the 91st and hundredth percentiles there were non-significant differences for both sexes. These incremental gaps across the gradient result in an overall gap in life expectancy between the top and bottom percentiles of 13.8 years for men and 8.4 years for women at age 40.

Figure 2.6 Life expectancy at age 40 by household income percentile and sex, excluding immigrants, 2011-15



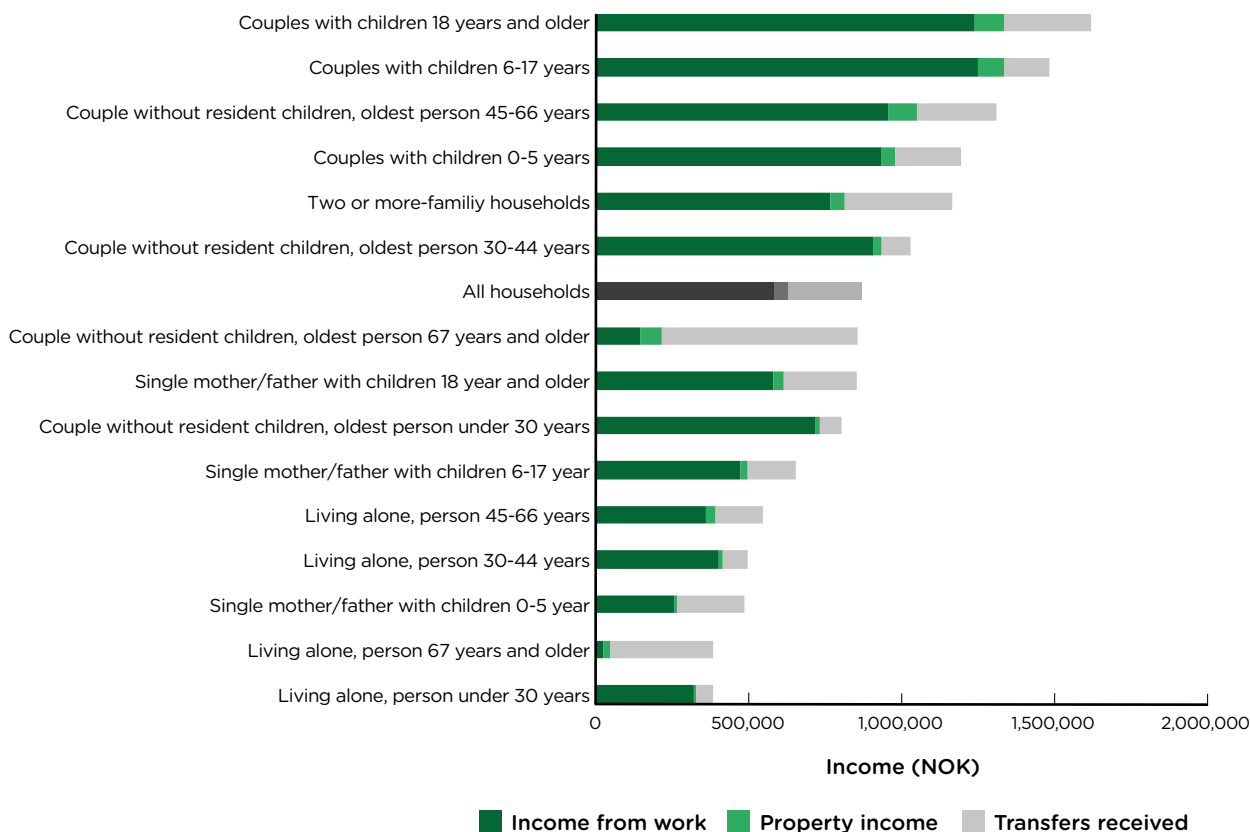
Note: The primary income measure was “equivalized household income,” defined as household income after tax divided by the square root of the number of household members, averaged across the preceding five years.

Source: Kinge et al (2019) (25)

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 to 9.1 percent in the top one percent (25). This has two potential effects on the comparison of life expectancy across percentiles. First, the comparison of income levels is simultaneously a comparison between those living alone and those in larger family households. Second, the income of those living alone is potentially more likely to fall due to failing health in the five years before death than that of a household in which there are multiple earners.

Figure 2.7 shows how household income varied, in total and by source, by household type in 2020. As well as those living alone whose income supports only one person, it is single parents who have below average incomes and receive a higher proportion of their income from social transfers than the average household. This disadvantage is greatest for those with the youngest children (aged 0 to 5) – although many of these parents are likely to be below the age cut-off of 40 years of age used in the analysis by Kinge et al.

Figure 2.7 Income sources of private households, by type of household, 2020



Source: SSB Table 07780 (26)

As well as indicating the distribution of income by household type, Kinge et al. also point to the educational distribution by income – the percent with a university education increases steadily across income percentiles from 18.2 percent in the lowest one percent to 53.9 percent in the top one percent. The income gradient in life expectancy is therefore also affected by the education gradient discussed earlier. Kinge et al. also present data showing the income gradients in life expectancy separately for those with at least upper secondary school education and those who left school earlier. While there are income gradients at both levels of education, the gap between education levels is greatest for those in households with the lowest one percent of income. Therefore, overall life expectancy of this lowest income group reflects both the distribution of education across income groups and the very low life expectancy of those with lower levels of education who are also in the lowest income percentile.

These effects of interactions between income and education at the extreme of the income distribution can be reduced by comparing those on the 10th percentile to those on the 91st percentile. The gaps in residual life expectancy at age 40 are 7.26 and 5.43 years for men and women, respectively. These differences are similar to those described earlier by education and slightly wider than between broad occupational groups.

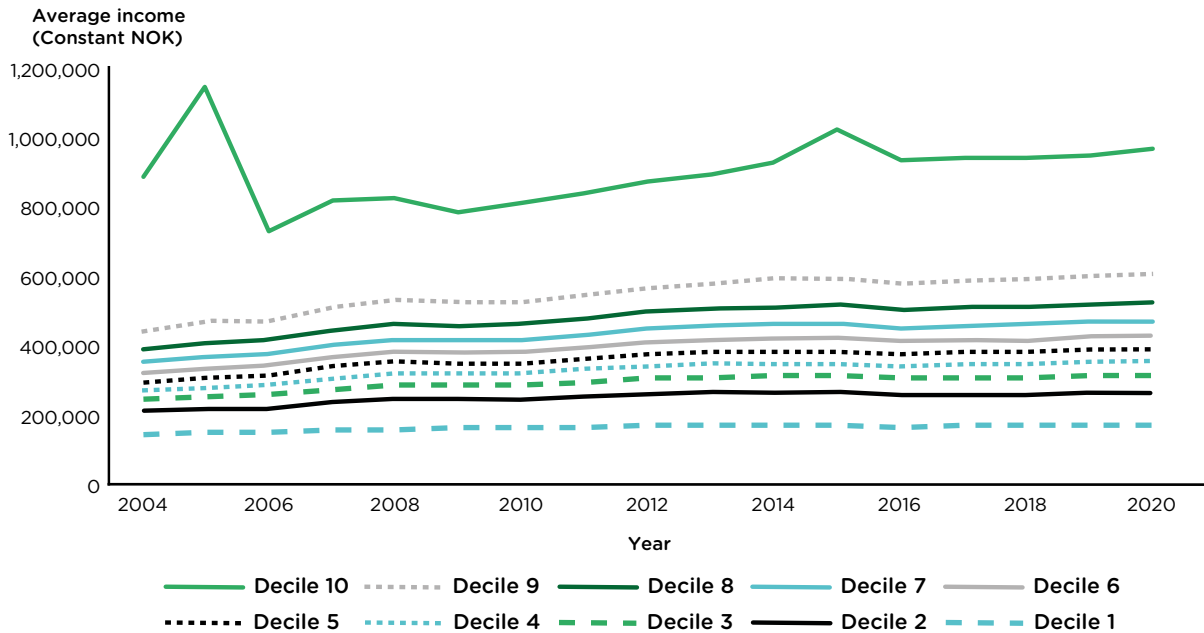
In older age groups, inequalities in premature death rates by income were largely because of cardiovascular disease, cancers, chronic obstructive pulmonary disease, and dementia. In younger age groups, substance misuse and suicides were the most common causes of inequalities in mortality. They show that while cardiovascular death rates fell substantially in the period 2005 to 2015 for both men and women across income quintiles, cancer death rates fell in the highest income quintile but not in the lowest quintile, injury death rates remained largely constant in all quintiles and death rates from other causes increased in the lowest quintile but decreased in the highest quintile. Kinge et al. (2019) conclude that health inequalities in Norway between 2005 and 2015 were comparable to those in the United States (25).

In considering the causes, extent of patterns and trends in inequalities in life expectancy and mortality rates by income level, it is important to look at how these relate to income differentials and how these have changed over time. From Figure 2.8, it can be seen that the average post-tax income of the lowest income decile is around a third lower than that of the second lowest decile. This income gap has widened over time. While the average increase in post-tax income between 2004 and 2020, after accounting for inflation, was 27 percent, the increase in the lowest decile was only 21 percent.

Over this period, progressively larger increases were seen moving up the income distribution up to decile 9, with a 37 percent increase. This graded increase in post-tax income from decile 1 to 9 is thus largely responsible for

widening income inequality. Decile 10 has always been at a markedly higher post-tax income level than every other decile but has also seen markedly greater year-on-year fluctuations than other deciles.

Figure 2.8 Average income after taxes per consumption unit (EU-scale), adjusted for inflation, by income deciles, 2004-20

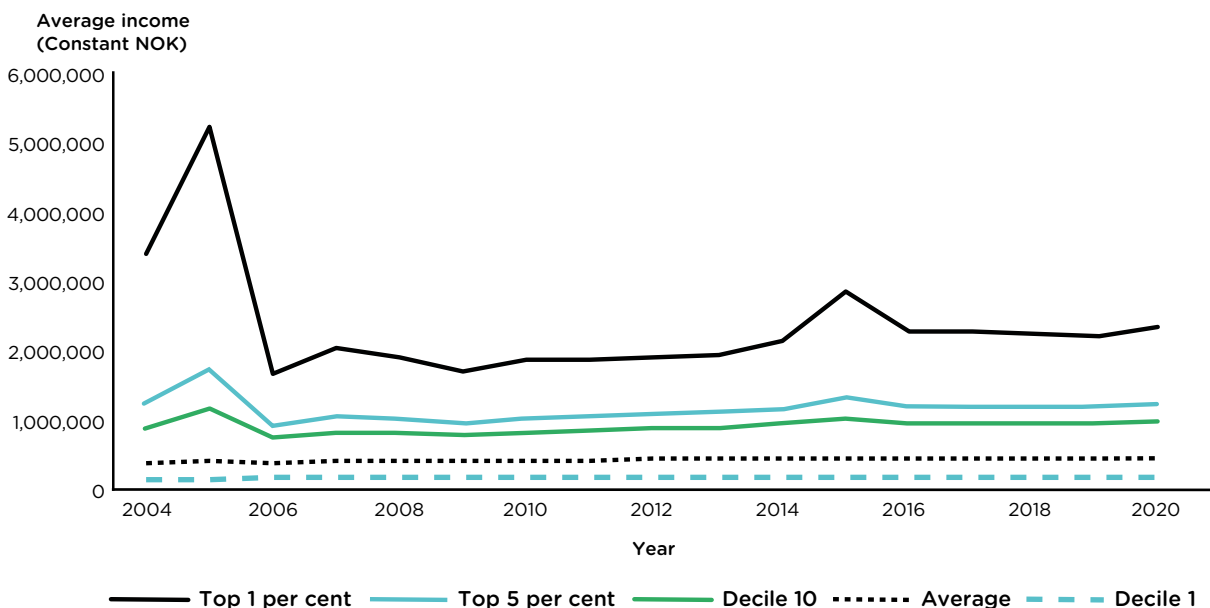


Source: SSB Table 07780 (26)

When income in decile 10 is further disaggregated to look at the top 1 percent and the top 0.1 percent, in Figure 2.9, the broad spread of higher post-tax income

is further highlighted, as is the substantive contribution of the highest incomes to the year-on-year variations in the Gini coefficient.

Figure 2.9 Average income after taxes per consumption unit (EU-scale), adjusted for inflation, by income percentile, 2004-20

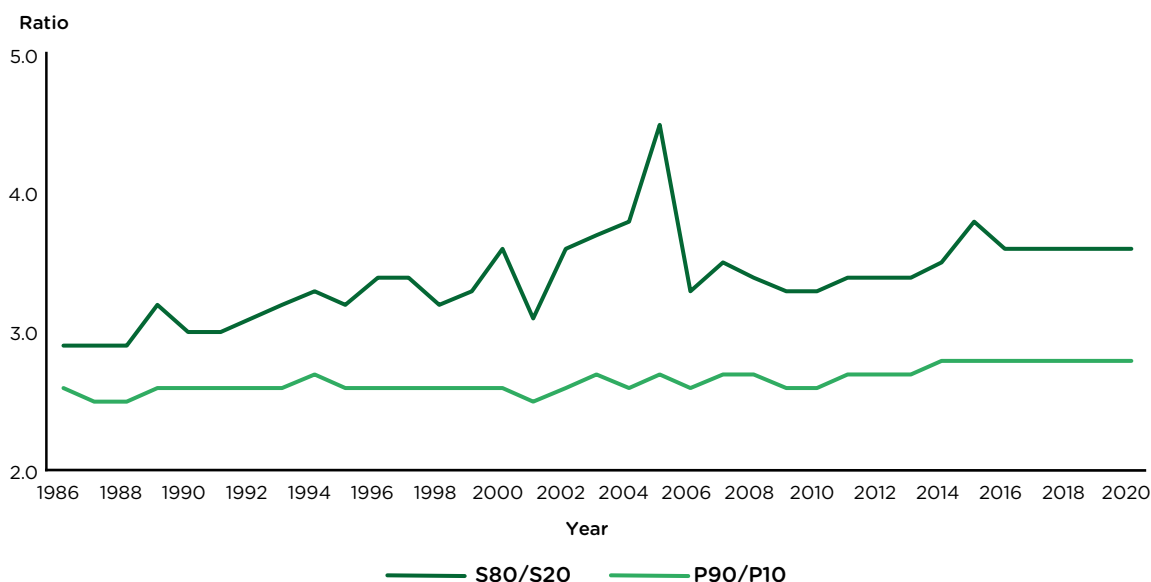


Source: SSB Table 07780 (26)

The steady widening of income inequality is seen in the ratio of income at the top of the 9th decile to that at the top of the 1st decile (P90/P10) in Figure 2.10, from 2.6 in 1986 to 2.8 in 2020. On the other hand, the ratio of the share of income held by the top two deciles to that held by the bottom two deciles (S80/S20)

S20) is more affected by year-on-year variation in decile 10. Nonetheless, the increase in this indicator has been greater – from 2.9 to 3.6 – pointing to the relative weakening of the contribution of those on lowest incomes to this indicator.

Figure 2.10 Ratio of (i) income at the top of the 9th decile to that at the top of the 1st decile (P90/P10) and (ii) the share of income held by the top two deciles to that held by the bottom two deciles (S80/S20), 1986-2020.



Source: SSB Table 07780 (26)

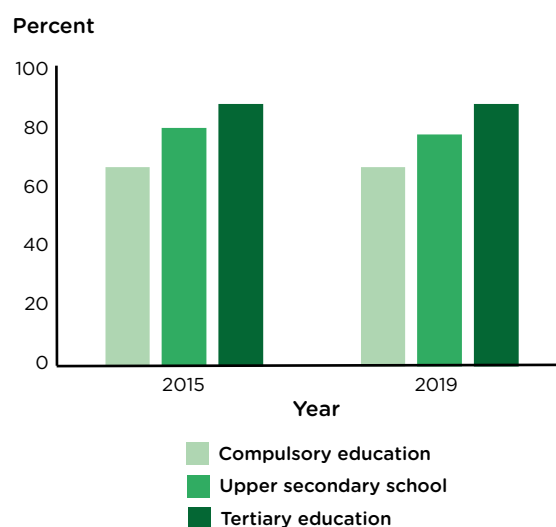
INEQUALITIES IN SELF-REPORTED HEALTH

There are clear inequalities in health related to level of education, indicated by surveys covering self-rated health, chronic illness, and mental health.

1) GOOD HEALTH

Statistics Norway's survey of living conditions includes a question on how respondents rate their health in general. Figure 2.11 shows inequalities in the percent of those rating their health as good or very good by level of education; while the rate was 66 percent among those with only compulsory education, it rose to 87 percent among those with tertiary education in both 2015 and 2019.

Figure 2.11 Age standardised proportion of survey respondents who perceive their health as very good or good, by educational level, Norway, 2015 and 2019

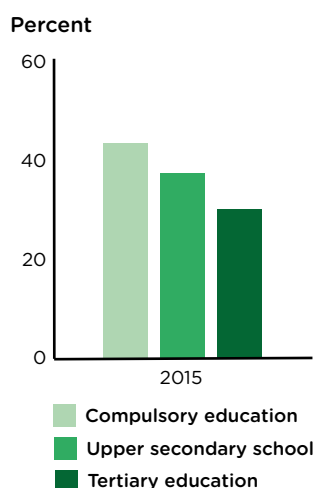


Source: NIPH Database (18)

2) CHRONIC ILLNESS

Statistics Norway’s survey of living conditions includes a question on whether respondents report that they have an illness or condition lasting six months or longer. Figure 2.12 shows that, in 2015, while 43 percent of those with only compulsory education reported a chronic condition, this was the case for only 30 percent of those with tertiary education.

Figure 2.12 Proportion of survey respondents aged 25 to 79 who report that they have an illness or condition lasting six months or longer,* by educational level, Norway, 2015



Note: *Long-term illness or condition is defined as an illness or condition that has lasted for at least 6 months, or a newer illness/condition which is expected to last at least 6 months, in Statistics Norway’s survey on living conditions

Source: NIPH Database (18)

INEQUALITIES IN WELLBEING AND MENTAL HEALTH

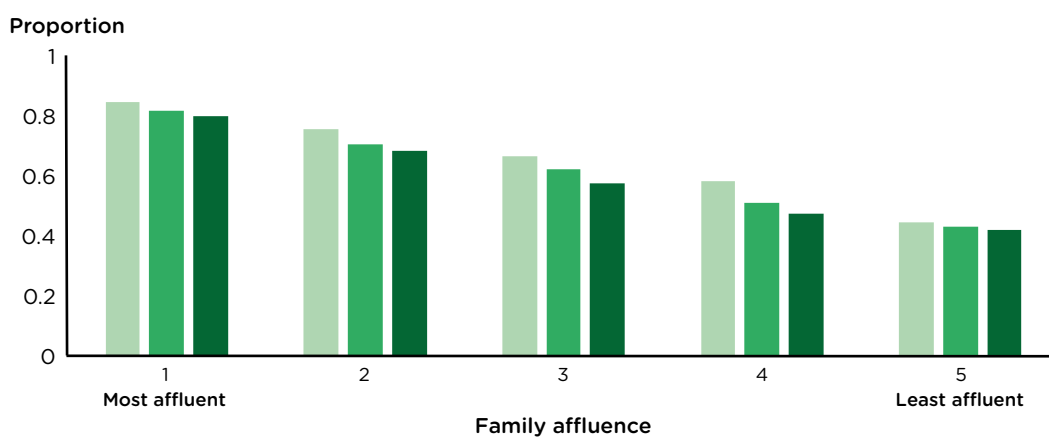
In this section we discuss the level of inequalities in wellbeing and mental health in the Norwegian population. While Norwegians on average enjoy high levels of wellbeing, steep social gradients are identified. In 2022, 22.2 percent of the population reported being highly satisfied with life (answers 9 or 10 on a scale from 0 to 10), while 28.4 percent have low satisfaction with their life (answers between 0 and 5 on the scale). Between those who have a university education (more than four years), 18.6 percent report low life satisfaction, while among those with only compulsory education, 38.6 percent report having low life satisfaction (SSB Tables 13762 and 13763) (26).

People’s economic situation greatly impacts on wellbeing and life satisfaction across all age groups. People who report having a difficult or very difficult financial situation also have a significantly increased risk of being dissatisfied with life compared to those who state that they have an easy/very easy financial situation (27). Of all negative life events, being exposed to humiliation and emotional violence over a long period of time is the factor most strongly associated with mental health problems, followed by having economic difficulties (28).

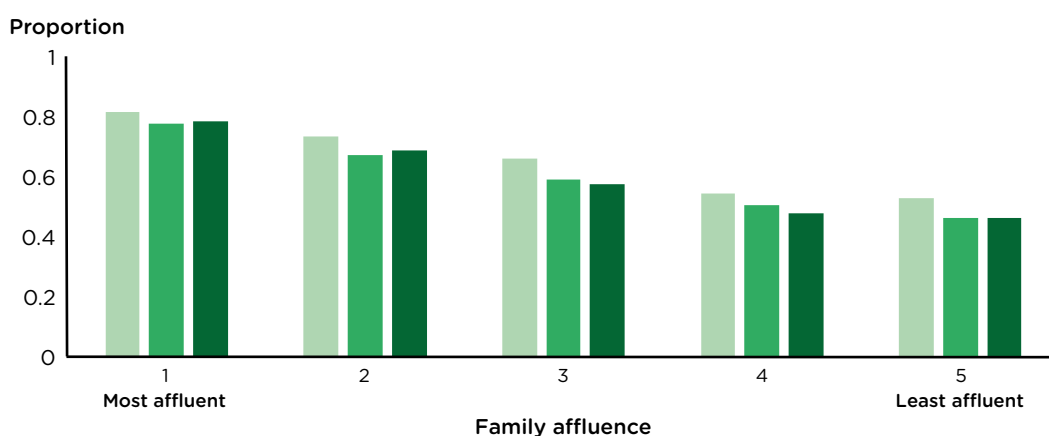
A comprehensive and national study on the health, wellbeing and life circumstances of young people in Norway, the Ungdata (Young Data) study, is an important source of data to reveal patterns of inequities. Young data is a national data collection scheme, designed to conduct youth surveys at the municipal level, where data allows for comparisons between municipalities and regions as well as national trends and socioeconomic patterns (29). Family affluence greatly impacts the wellbeing of adolescents and their expectations for future wellbeing, as shown in Figure 2.13. The proportion of boys and girls currently in lower secondary education who expect to have a good, happy life has declined between 2014-16 to 2021-2022.

Figure 2.13 Proportion of secondary school children who expect to have a good, happy life by sex, lower and upper secondary and family affluence, 2014-16 to 2021-22

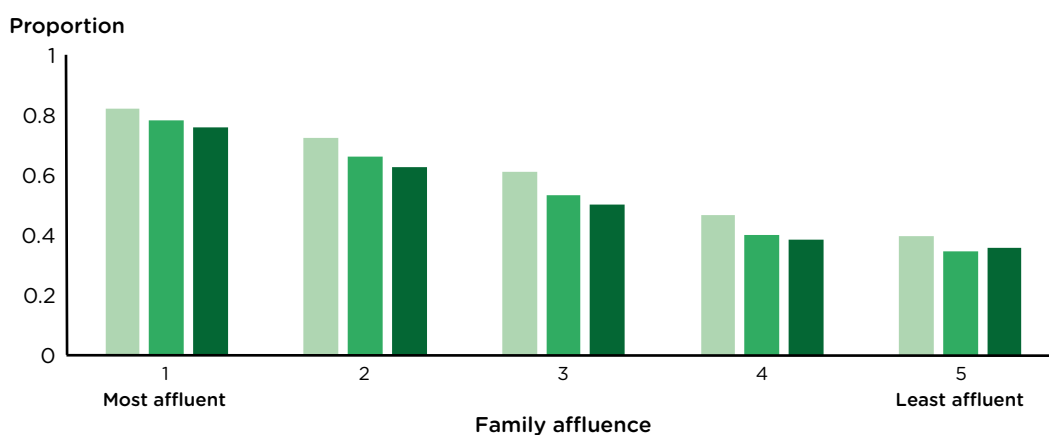
**(A1) BOYS,
LOWER
SECONDARY**



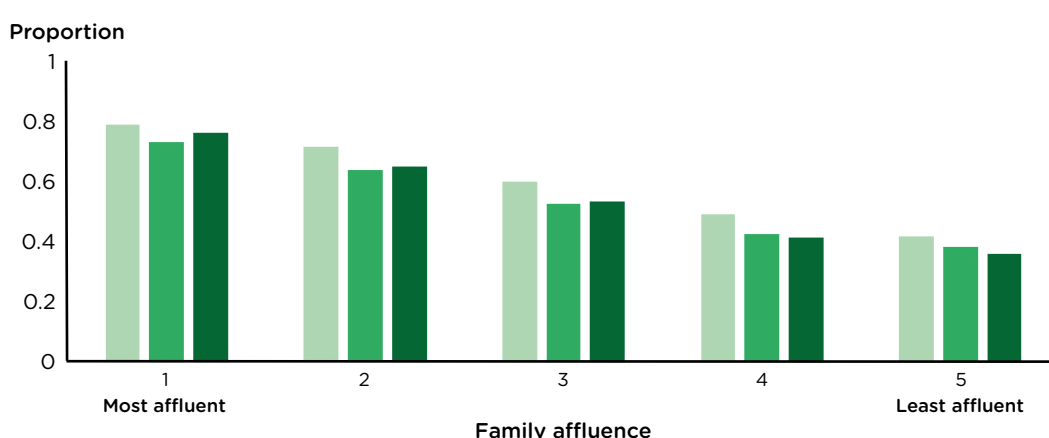
**(A2) BOYS,
UPPER
SECONDARY**



**(B1) GIRLS,
LOWER
SECONDARY**



**(B2) GIRLS,
UPPER
SECONDARY**



2014-2016 2017-2019 2021-2022

Source: Young Data (29)

There are several groups who are significantly worse off on all subjective wellbeing indicators compared to the general population. In general, people that have low income, no or low labour market attachment, low education, physical disabilities, symptoms of mental illness and the LGBTQ+, people in single households (lone parents without partner/boyfriend), and people who are exposed to discrimination or social exclusion are groups who are particularly at risk of having low levels of wellbeing. These groups generally report lower levels of wellbeing both in terms of subjective dimensions, such as experiencing meaning in life and how satisfied people are with their lives, presence of positive emotions and feeling well and functioning well, as well as relational, social and objective wellbeing indicators (30,31). The situation of minorities and groups who are vulnerable to being left behind or discriminated is further set out in Chapter 3F.

Young people are generally less satisfied with life than older people across multiple domains of life satisfaction (30). This trend represents a shift, since it was previously the other way around. The HUNT study is a longitudinal population study in Trøndelag county which did a first round of data collection in the early 1980's, followed by three additional waves of data gathering (HUNT 1-4). These comprehensive decennial surveys have illustrated major shifts in mental health (32). Krokstad et al., (2022) found that, in the HUNT Study, adolescents' and young adults' mental distress increased sharply, especially between 2006-2008 and 2017-2019 (33). However, depressive symptoms

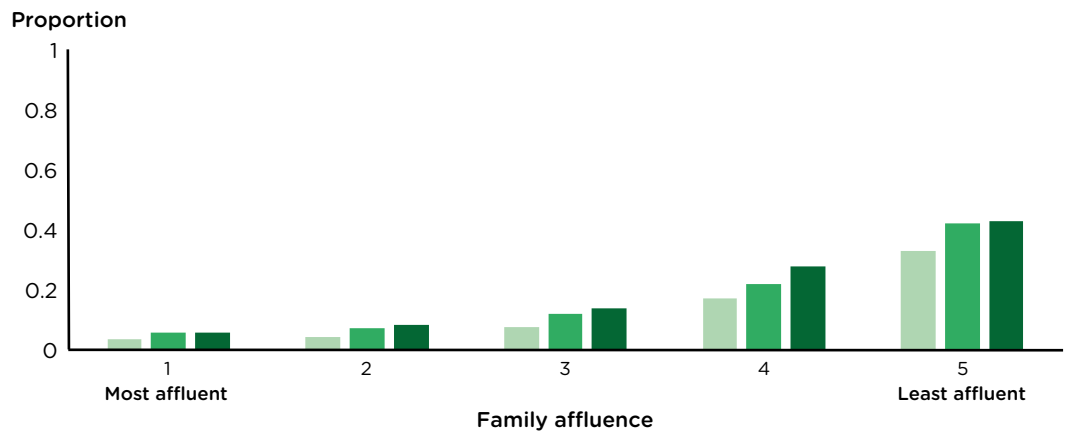
declined among adults aged 60 and over, and anxiety symptoms remained largely unchanged in these groups. They conclude that data trends from the HUNT Study in Norway indicate increasingly poor mental health among adolescents and young adults.

The Young Data study indicates how wellbeing and mental health relate to family affluence for young people in lower and upper secondary schooling. Myhr et al (2020) found that the prevalence of students with moderate-to-high symptoms of psychological distress, in terms of symptoms of depression, anxiety and loneliness increased among girls and boys during 2014-2018, with girls showing higher rates (34). They conclude that rising rates of adolescents' psychological distress, particularly among girls, may have long-term consequences.

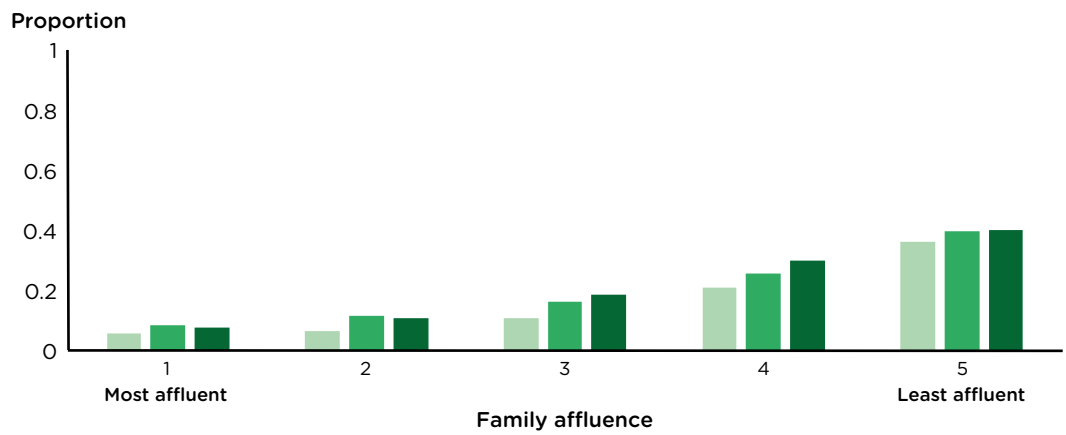
Their analysis also showed distinct, but stable, inequalities in psychological distress of young people between socioeconomic groups, both in absolute and relative terms between 2014-18. As Figure 2.14 demonstrates, there is a strong connection between mental health and financial difficulties. Depressive symptoms follow a sharp social gradient in family affluence. They did not find evidence of any changes in inequalities in adolescents' mental health between socioeconomic groups, suggesting current strategies are not sufficiently addressing mental health inequalities among adolescents and there is an urgent need for greater research and more investment and effort to reduce these inequalities and reverse the deteriorating mental health of young people.

Figure 2.14 Proportion of secondary school children with depressive symptoms by sex, lower and upper secondary and family affluence, 2014-16 to 2021-22

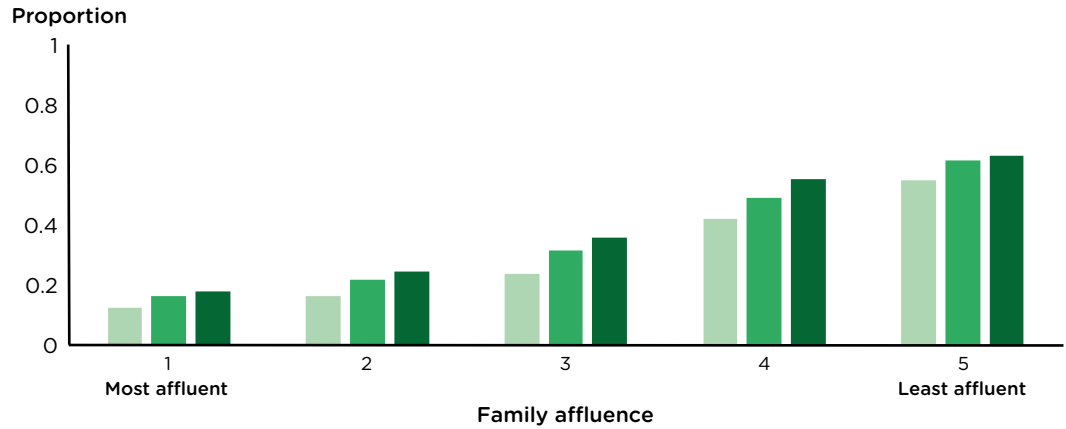
**(A1) BOYS,
LOWER
SECONDARY**



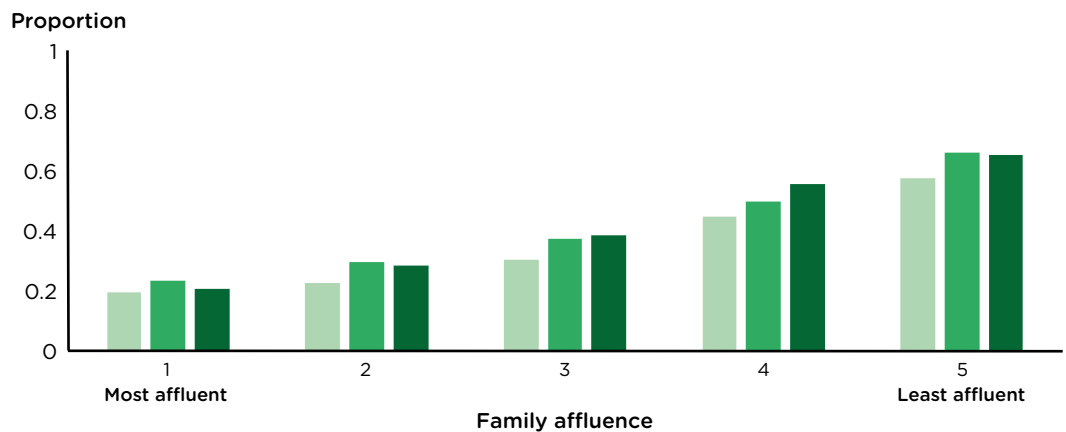
**(A2) BOYS,
UPPER
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**(B1) GIRLS,
LOWER
SECONDARY**



**(B2) GIRLS,
UPPER
SECONDARY**



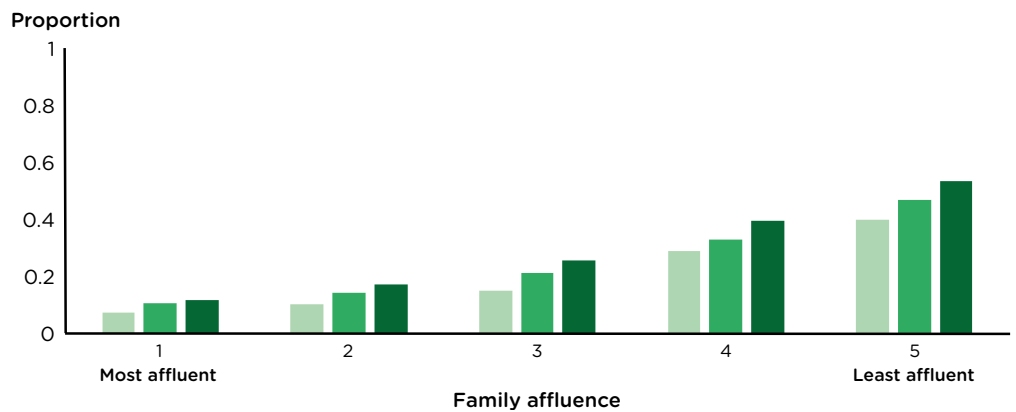
2014-2016 2017-2019 2021-2022

Source: Young Data (29)

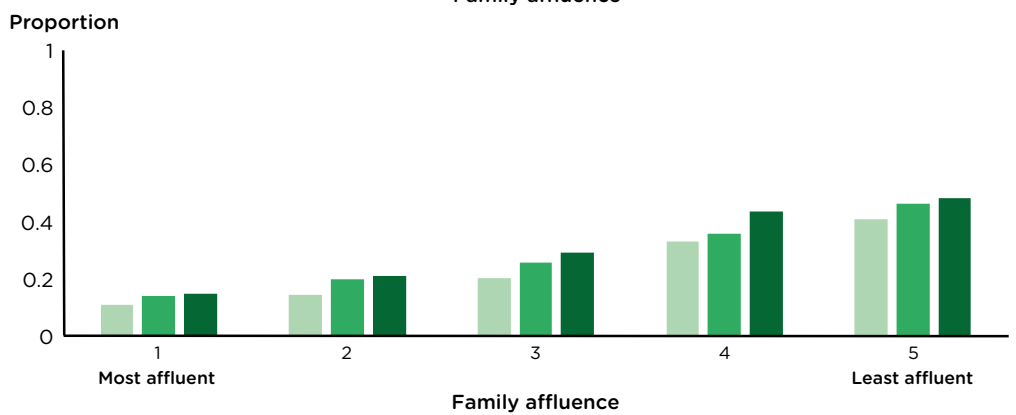
The Young Data Study also shows for young people that feeling lonely, making a contribution and coping with things follow a clear gradient by family affluence from 2014-16 to 2021-22 (Figures 2.15 to 2.17).

Figure 2.15 Proportion of secondary school children who feel lonely by sex, lower and upper secondary and family affluence, 2014-16 to 2021-22

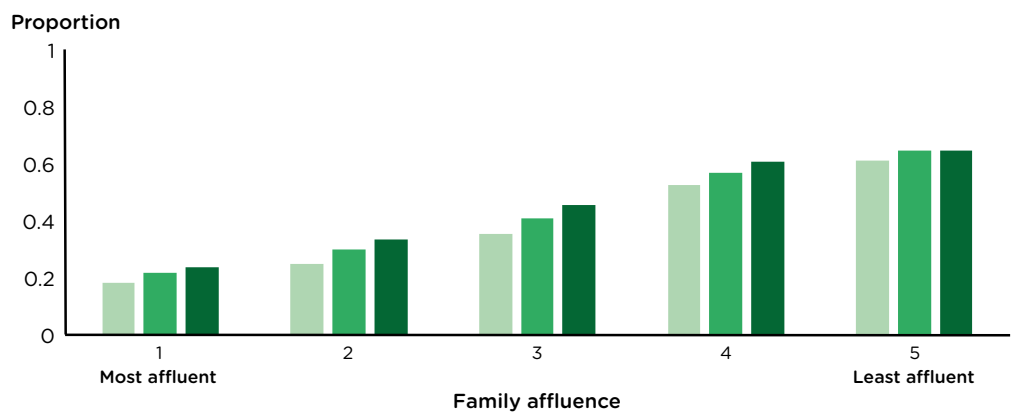
**(A1) BOYS,
LOWER
SECONDARY**



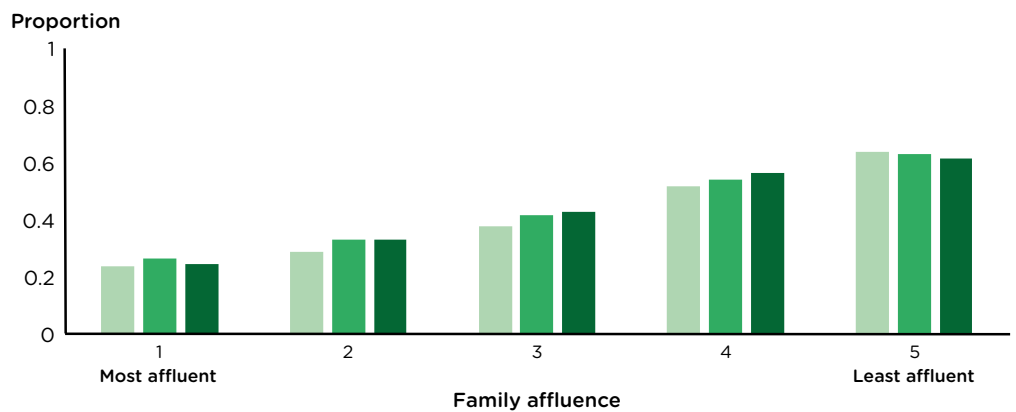
**(A2) BOYS,
UPPER
SECONDARY**



**(B1) GIRLS,
LOWER
SECONDARY**



**(B2) GIRLS,
UPPER
SECONDARY**



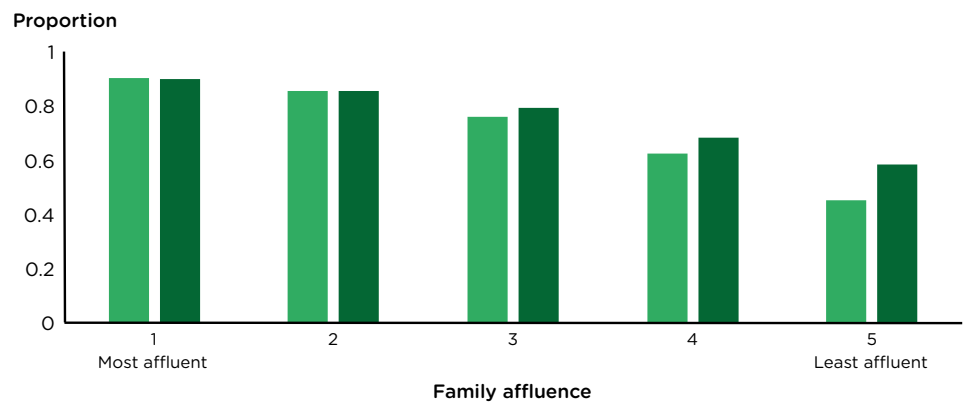
2014-2016 2017-2019 2021-2022

Note: Based on responses "Been affected quite a lot/a great deal"

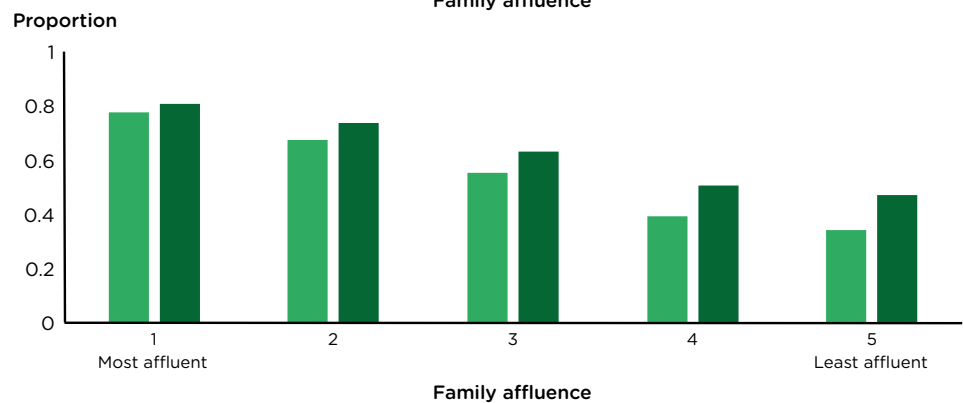
Source: Young Data (29)

Figure 2.16 Proportion of secondary school children who feel they make a contribution by sex, lower and upper secondary and family affluence, 2022

(A) BOYS



(B) GIRLS

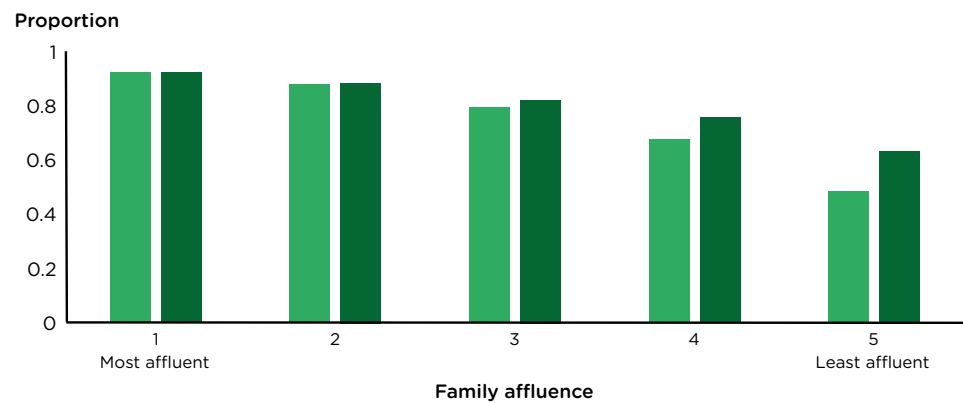


Source: Young Data (29)

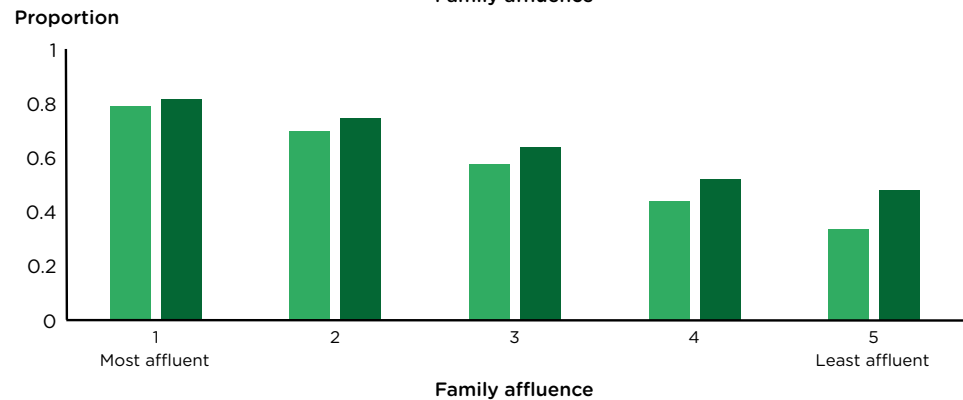
Lower secondary Upper secondary

Figure 2.17 Proportion of secondary school children who feel they are coping by sex, lower and upper secondary and family affluence, 2022

(A) BOYS



(B) GIRLS



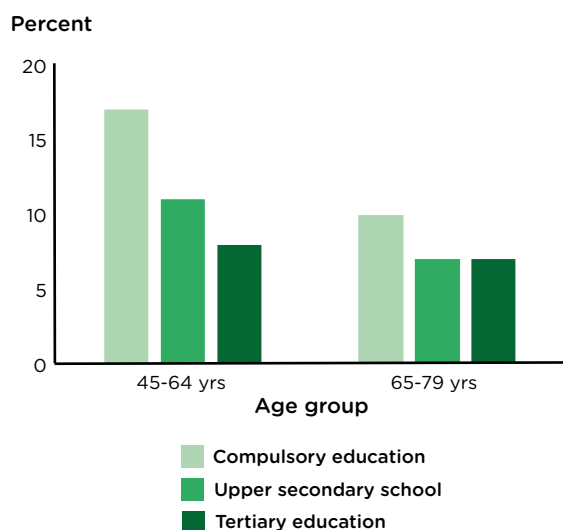
Source: Young Data (29)

Lower secondary Upper secondary

Inequities in mental health persist not only in adolescents, but also among adults. There are wide inequalities in reports of symptoms of psychological distress, related to level of education. Statistics Norway's survey of living conditions includes a sequence of 25 questions on symptoms of mental health problems experienced during 14 days prior to the interview. On a scale from (1) no difficulties to (4) a high number of difficulties, scores for each answer are summed into an index and a mean score is computed. A mean score over 1.75 is defined as an indication of significant symptoms of psychological distress. Figure 2.18 shows the percent of those recorded as having these symptoms at ages 45 to 64 and 65 to 79 in 2015. Among those with only compulsory education at ages 45 to 64, 17 percent were recorded with these symptoms, compared to eight percent among those with tertiary education. At ages 65 to 79, these percentages were lower - 10 and 7 percent, respectively.

Recent reports on Norwegians' wellbeing highlight the social drivers of wellbeing and their effect on inequalities (27,35). Lack of mattering is a particular type of vulnerability that seems to mediate between conditions of inequality and inequality in health outcomes (33,36-39). Mattering, which is defined as experiences of feeling valued and adding value (40) is related to positive outcomes when present, and negative results when absent. When people are treated with dignity and respect, the overall sense of mattering and wellbeing increases. When people perceive that they do not matter, their overall wellbeing suffers greatly. This is the case because all people have a fundamental need to experience social worth (41).

Figure 2.18 Proportion of survey respondents who reported symptoms of psychological distress,* by educational level, ages 45 to 64 and 65 to 79, Norway, 2015



Note: *Based on the Hopkins Symptoms Check List (HSCL-25), which includes anxiety, depression, somatic pain, headache, trembling, faintness or dizziness, feeling nervous, sudden unfounded fear, constant fear/apprehension, heart palpitations, tension, anxiety, restlessness, lethargy, self-blame, crying, suicidal tendencies, loss of appetite, sleep problems, feelings of hopelessness about the future, loneliness, loss of sexual desire, feelings of being taken advantage of, worrying, lack of interest, feeling everything is a burden, feelings of uselessness.

Source: Office for Health Improvement & Disparities (based on Office for National Statistics source data) (54)

CHAPTER 3

INTRODUCTION

This chapter covers the eight policy objectives outlined in the introduction. Successive evidence reviews have shown that these are the key social determinants of health and understanding outcomes and policy activity in these areas is central to understanding health inequalities and how to reduce them. Policy recommendations follow the analysis of the data and the overview of current policies.

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 socio-economic 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 (1).

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. Norway first introduced mandatory early childcare in 1975 and reformed its kindergarten education system in 2006. Since 2009, every one-year-old child in Norway has a legal right to a kindergarten place.

The National Insurance Act of 1997 established the rules for and access to parental leave. It also introduced the Norwegian Child Allowance, a universal, non-means-tested cash payment which parents receive for their children in the first 18 years. While the child allowance is not means-tested, single and disadvantaged parents receive double the amount for each child they have.

Municipalities are required to offer essential health and care services in schools to all children up to 20 years old. Health centres and school health services play a variety of preventative and overall wellbeing roles, ranging from providing basic health services to tackling bullying, mental wellbeing issues, and social environments. Overall, they play a key role in providing proportional, universal wellbeing services for young children and adults, and remain the central point of contact for this part of the population for all of their youth (16,42). These services are accessible to all households regardless of immigration status or socioeconomic level. They are managed at municipal level and are central to the administration and monitoring of the health of children as well as new parents. They also serve as the primary access point for public health reforms and programmes targeted at families (16,42).

The overwhelming majority of families (up to 98 percent) access care for their young children through the Infant Healthcare Programme, a free service for households with children provided by municipalities (43).

A systematic review of the Infant Healthcare Programme found no studies examining usage in terms of intersectional inequalities such as ethnicity, socioeconomic status, disadvantaged mothers and mothers suffering from post-partum complications such as depression (44). The same review found that home visits to families with a lower SES might be successful in preventing childhood injuries, but without any particularly strong results. Recent investigations on understanding the small proportion

of potential users not using these services found no significant socioeconomic gradient.

While it took decades to eradicate the differences in infant mortality between rich and poor families, these inequalities have now been eradicated. 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 (45). However, while inequalities in the chances of surviving the first year have been leveled 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 run.

QUALITY OF MATERNITY CARE

Maternity care services in Norway are widely regarded as being of high quality. Women who live in Norway and are within the National Insurance Scheme have access to maternity services that can be accessed free of charge via a GP or a midwife at Maternity and Child Health Care Centres (46). Maternity care usually consists of eight antenatal visits and one ultrasound scan at 17-19 weeks, and birth preparation classes arranged by maternal and child health centres or hospitals (47). Specialised care is available for women with high-risk pregnancies.

While the quality of maternity care services in Norway is high, reports suggest that maternity care specialists and users consider that there is still room for improvement. The perspective of several Norwegian specialists in obstetrics and gynaecology and community medicine is that the maternity care system needs to be better at learning from events that sometimes occur with adverse outcomes for the mother and/or child (48). A better exchange of information requires an efficient system to rapidly disseminate new learning across the Norwegian maternity care system.

For women receiving maternity care, psychosocial aspects of care are important. An online survey of 8,400 women who have given birth in Norway found that women emphasise sociocultural and psychological aspects of care in childbirth, as well as high quality

physical and clinical care (49). Part of this is infusing care with kindness and part is aiming to understand each woman's values and expectations relating to childbirth. These aspects require that maternity care staff can spend enough time with each woman while ensuring high-quality maternity care for all is maintained.

Several recent studies examine the experiences of maternal care among immigrants living in Norway. 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 (50). There is a legal right in Norway for patients to receive healthcare information in a language they understand, free of charge. Nevertheless, a third of the 401 women in a study of newly arrived immigrant women's experiences of maternity health information reported limited understanding of the information provided to them (50). Factors associated with poor understanding of information provided by maternity staff included low Norwegian language proficiency, refugee status, no completed education, unemployment, and reported interpreter need (50). Women reported insufficient information, in particular in the areas of family planning, infant formula feeding and postpartum mood changes (50).

The strongly held belief in equality in Norway underpins how social and health care services, including maternity care services, are delivered. While equality and universalism are important principles, when applied rigidly to maternity care they allow little space for individual choice (51). Maternity care in Norway is less medicalised than in some countries. Depending on where women have migrated from this may be empowering. For others for whom expectations of maternity care differ from the maternity care available in the Norwegian system, there may be a breakdown in trust in the safety of care offered (51).

Undocumented immigrant women in Norway are excluded from general practitioner care and from benefits (52). They can access antenatal care and give birth in hospital (53). However, gaps in the system have prompted Non-Governmental Organisations (NGOs) to set up health clinics for undocumented immigrants in municipalities. Health care staff provide maternity care on a voluntary basis in the NGO-run facilities and can make referrals to the public system. A study that examined the medical records of a cohort of undocumented women who received maternity care from NGO run clinics reported that they received inadequate antenatal care and there was a high risk of adverse pregnancy outcomes (52). This evidence suggests that further support and care for undocumented immigrant women through their pregnancies is warranted.

INEQUALITIES IN DEVELOPMENT OUTCOMES IN THE EARLY YEARS

ADVERSE CHILDHOOD EXPERIENCES

Stress and problems in early years accelerate disadvantage over the life course. Adverse childhood experiences (ACEs) such as household dysfunction, parental substance use, neglect and abuse are relatively common in Europe and a systematic review and meta-analysis found a pooled prevalence of 23.5 percent of Europeans reporting at least one ACE and 18.7 percent reporting two or more ACEs (54).

A Norwegian study among 28,047 adults from the general population participating in the Norwegian Counties Public Health Survey 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 being in receipt of welfare benefits (55). This pattern among adults could simply reflect the continuation of socioeconomic disadvantages that were already present in childhood (55,56). However, ACEs may also impact later adult incomes, educational attainment and employment (57), and have been found to do so even after controlling for family/childhood socioeconomic variables (58).

Similar findings have been shown within the Nordic context. A Swedish register-based study found that exposure to parental substance use disorder (SUD) before the age of 17 years was associated with increased risk of being not in education, employment or training (NEET) during early adulthood after controlling for household income (59). A Norwegian study found that young females who were NEET had much higher odds of reporting experiences of violent threats, being beaten without visible marks, and being injured due to violence, compared to female peers that attended upper-level secondary school, controlled for parental education (60). Based on analysis of population data from the HUNT study, Rangul et al. (2021) demonstrated that there are consistent correlations between educational levels for both genders and experiences of childhood adversity and lack of adult support, retrospectively reported by adults (61).

The role of ACEs in relation to social inequalities is complex. Chronic stress due to ACEs can interfere with learning and the development of necessary skills in education or the workplace (62). Additionally, ACEs have a detrimental health impact (63–68) and are also associated with an increased risk of health-harming behaviours (69,70). These negative consequences related to ACEs may in turn increase the risk of economic marginalisation. Since ACEs are more common among those with low socioeconomic status and reinforce marginalisation by negatively affecting educational attainment and employment, it is critical to address the potential impact of early adversity to break the intergenerational cycle of poverty and social inequality in health.



EARLY CHILDHOOD EDUCATION AND CARE

Inequalities in capabilities for positive developmental outcomes in the early years not only relate to the caregivers and their living conditions, but are highly impacted by wider systems of support (71). In particular, early childhood education and care (ECEC) is shown to be effective to reduce inequalities in health and wellbeing, where high-quality ECEC may serve a compensatory function for children growing up poor (72,73). Children's right to education, care and play should, according to the UN Convention on the Rights of the Child, enable children to have equal opportunities to develop their potentials and to matter in their own lives and in the wider society.

Norway has a high participation rate in ECEC, with 93 percent of children aged 1-5 and 97 percent of children aged 3-5 attending early childhood education in 2020 (74). ECEC is for the most part administered by local municipalities, allowing adaptation to local needs and an easier administration of services. This is complemented with a strong parental leave scheme, which in 2022 amounted to 49 weeks at 100 percent of earnings, or 59 weeks of leave at 80 percent of earnings with both parents required to take at least 15 weeks of leave after birth.

Norway has systematically worked to reduce barriers to access for all to the national ECEC system, reducing costs and improving communication for stimulating usage of the services among the socioeconomic groups using the services the least and gradually transferring the responsibility of children's care from family to institutions (75,76).

There is good evidence that efforts to improve inequalities in participation in ECEC at national level have been successful, with the Norwegian efforts to scale-up universal coverage by lowering costs and increasing availability improving the outcomes of the most deprived children more rapidly than in other socioeconomic groups (72). The Child Centre Agreement reform of 2003, which required municipalities to provide childcare for all parents of children up to five years old as well as capped the prices for full-time childcare programmes, was successful in improving maternal employment rates and improving the rates of low-income, low-educated women the most (77). This suggests that some form of proportional universalism in ECEC has been successful in narrowing the inequality gap for these services.

Annual costs per child in kindergarten are greater in Norway than in the other Nordic countries (78). Mean annual payment for a full-time place in Norwegian kindergartens (including food and other costs) increased by 3.8 percent between 2021 and 2022. Privately owned kindergartens generally charge more for food and other expenses than publicly owned kindergartens (79). Investments in ECEC have steadily increased, especially since access to kindergartens became a legal right in 2009. In total, Norwegian municipalities spent 52.6 billion NOK on kindergartens in 2021, an increase of six percent from 2020. Local governments finance 85 percent of spending on both public and private kindergartens (74).

Other tools which lowered costs and access for lower SES families were able to improve ECEC usage. There was a 20 percent increase in the use of kindergarten free core-time (a programme targeted at lower SES families with children aged 2-5 to access the main hours of ECEC without costs) between 2015 and 2017, with 61 percent of relevant households using this programme, according to the latest available data (80). There was also a noted increase in the number of households that can afford ECEC costs thanks to the six percent rule, which establishes that no household should pay more than six percent of their income on kindergarten education. In addition to this, kindergarten fees are capped, and in 2021 the maximum fee was NOK 3,230 per month and NOK 35,530 per year (81). However, usage data stratified by income shows that lower income families still do not use completely these mechanisms to access ECEC (82).

The Norwegian Institute of Public Health has argued that kindergartens are one of the most important mental health-promoting and preventive measures available in Norwegian society, with lifelong and intergenerational positive effects. It is specified that this only applies if kindergartens are of high-quality, with a focus on stable, well-educated and caring staff (83-85). The high-quality in kindergarten's health promotion and prevention services is dependent on close collaboration between the staff, the parents/guardians, the maternal and child health centres, the public health nurse, the special educational services, child protection services, and the pedagogical-psychological services when necessary (86).

Good evidence from international studies shows that high-quality early childcare and education provided in centres as well as parenting styles and the home learning environment are all important for child development. But parenting and the home environment for children from low-income families has consistently been shown in cohort studies 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 (87,88). 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 (82,89). Children from families with limited education and low income and with parents from minority backgrounds are also less likely to attend kindergarten than other children (90). This may be due to lack of awareness that the discount is available, lack of skills to navigate the application process, or preference not to send their children to kindergarten. In 2020, procedures were simplified to allow municipalities to access parental income information from tax returns to make a decision on eligibility.

Children in families in which the mother is not in work are less likely to attend kindergarten than children whose mothers work outside the home (90). A survey of kindergarten attendance conducted in 2016 found that 80 percent of parents with children aged 1-5 who do not attend kindergarten say that it is important for the child to stay with the mother (82,90). In addition, 70 percent of parents in receipt of cash for care benefits (discussed below), say that even if the benefit was withdrawn, they still would not apply for a kindergarten place (82,90). These findings may reflect, inter alia, parental cultural beliefs or preferences, lack of trust in institutional care and education, or lack of awareness of the benefits of kindergarten for children's outcomes.

The Norwegian state still offers a child-care allowance, or *Kontantstøtte*, for parents of children aged 13-23 months to choose their preferred form of childcare. The aim of this policy has been to allow one parent to spend more time with the child in exchange for an allowance if this is what parents choose. However, several studies have shown that this measure is likely to reinforce gender inequality since the allowance is disproportionately received by women (91,92). Sweden has abolished it after seeing that nearly all recipients were women, mostly immigrants and mainly working part-time. Also, three-quarters of women recipients in Sweden were originally from non-European countries (91). In 2017, the Norwegian Government limited this benefit to parents who had been part of the National Insurance Scheme for at least five years (93).

This benefit may be keeping children who need it the most out of good quality care in kindergarten, as well as keeping women out of the workforce. Alternatively, values-based arguments take the position that individuals should have the right to choose. A way forward that could potentially satisfy both positions is for reforms to the system to include offering every child a place at kindergarten as a right and making kindergarten free or nearly free, so that parents need to actively opt out to decline their child's place. The child-care allowance could be replaced with cash payments or vouchers to low-income families conditional on parents sending their children to kindergarten.

To date, kindergartens are the only part of the educational system in Norway where access requires payment. From compulsory schooling up to universities, education is free of charge for Norwegian citizens. Given the evidence on the importance of ECEC in levelling up social gradients, this seems paradoxical, particularly given the universal principles underlying the Norwegian welfare system. However, this policy is being modified in two related areas. The Norwegian Government has decided to make kindergartens free of charge for citizens living in the regions of Nord-Troms and Finnmark from August 2023 (94). Moreover, the Sami Government has recently prioritised making all Sami kindergartens in Norway free of charge, a decision anchored in the Beaveálggu-declaration (95). While 665 Sami children attend kindergartens in Nord-Troms and Finnmark, this decision will give an extra 228 Sami children free-of-charge access to kindergartens in other regions (96). Although these political priorities are largely justified by arguments based on promoting the attractiveness of rural areas and protecting social and cultural identities, they do represent a political will to lower thresholds to access in specific circumstances. The evidence suggests that the abovementioned initiatives are likely to have a positive impact on social gradients in health and wellbeing and their determinants as the children benefiting from these changes grow up.

Increasing access and availability to high-quality kindergartens could also benefit parents in ways that would directly or indirectly benefit their children. Providing skills training and support to parents in finding employment would improve their employment opportunities. Kindergartens can also potentially act as facilitators to access other welfare and community support systems. In short, as a non-stigmatizing and universal arena, kindergartens could be a key part of a coherent system of family support in the early years of children's lives (97,98).

CHILD POVERTY

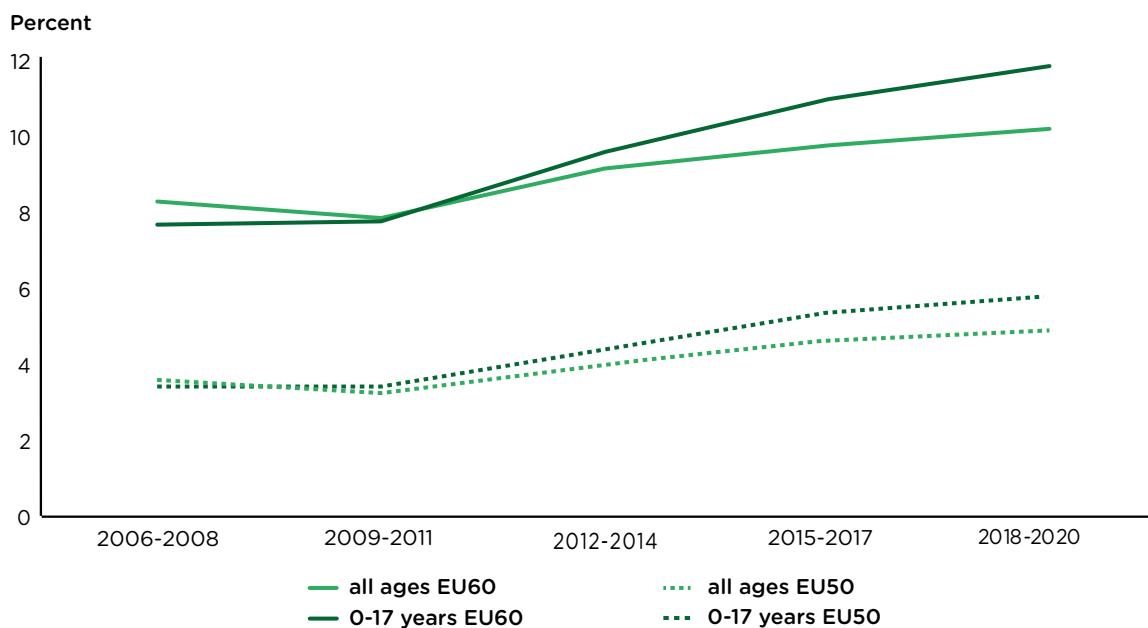
Child poverty damages early development, which in turn affects a range of critical lifelong social determinants of health and health outcomes throughout life. Parenting approaches are often heralded as key to children's development in the early years, but it is important to recognise that parenting is 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. Households in poverty, or at risk of poverty face many difficulties, which often include difficulties around work, work-life balance, schooling, housing, diet and nutrition, family social relationships, and mental health. All of these can affect children's health, educational and social outcomes with far-reaching impacts on their lives as children later into adulthood, and on their own children.

Child poverty has been increasing in Norway. Two standard EU poverty indicators are available from the Norwegian Institute of Public Health (NIPH) website. These show the percent of households with incomes below 50 and 60 percent of median Norwegian income levels. Figure 3.1 shows that poverty has increased since 2009-11, for both all households and those with children aged under 18. In that year, the figures for all households and those with children were similar (3.3 percent below 50 percent of median income and around 7.8 percent below 60 percent of median income). However, by 2018-20, child poverty had risen by more than that for all households. The respective figures for child poverty were 5.8 and 11.9 percent, while for all households they were 4.8 and 10.2 percent in 2018-20. These represent roughly 75 and 50 percent increases, respectively in child poverty, compared to roughly 45 and 30 percent increases for all households.

In 2020, 11.7 percent of children in Norway (115,000 children) lived in a household with persistently low income. This proportion was unchanged since 2019 (99). Child poverty in Norway is associated with low parental levels of education, weak attachment to the labour market, single-parent households and to having an immigrant background (100), with 60 percent of children in persistently low-income households having an immigrant background in 2020 (99). Among children who have immigrated to the country themselves, 48.4 percent lived in a household with persistently low income in 2020, compared to 33.2 percent among Norwegian-born children with immigrant parents and 5.8 percent among those without an immigrant background (99).

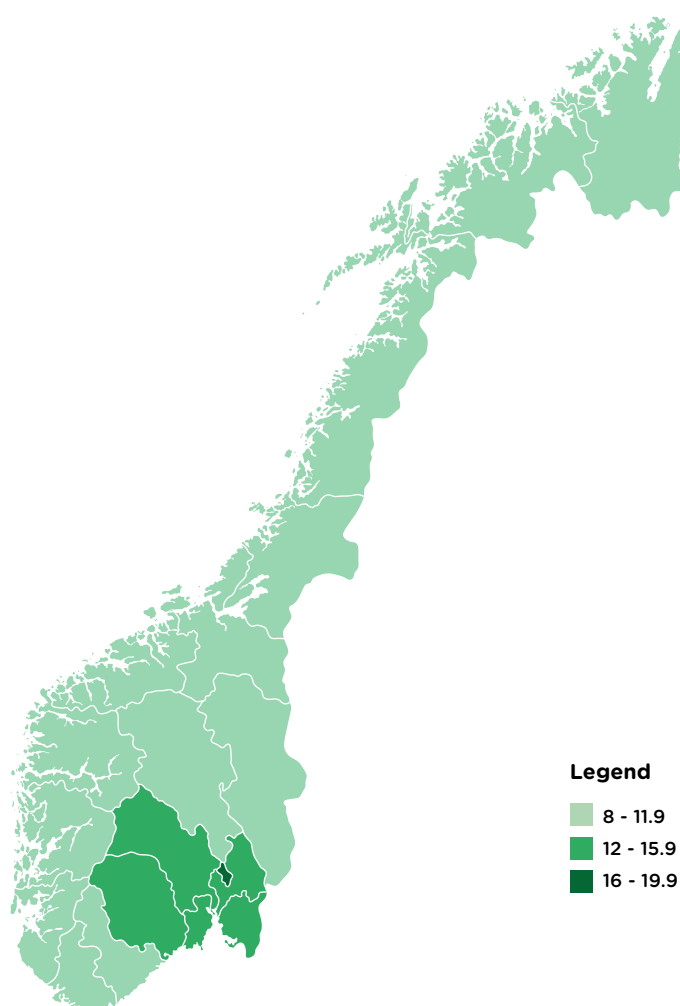
There is a clear geographic pattern to the distribution of child poverty below 60 percent of median income – with levels above the Norwegian average in Oslo (18.6 percent) and the two surrounding counties, Vestfold and Telemark and Viken (Figure 3.2). These are areas with larger than average concentrations of immigrants.

Figure 3.1 Percent of households in poverty levels (EU50 and EU60 indicators), all households and those with children aged 0 to17, Norway, 2006-8 to 2018-2020



Source: NIPH database (18)

Figure 3.2 Map of child poverty, based on households below 60 percent of median income, Norwegian Counties, 2018-20

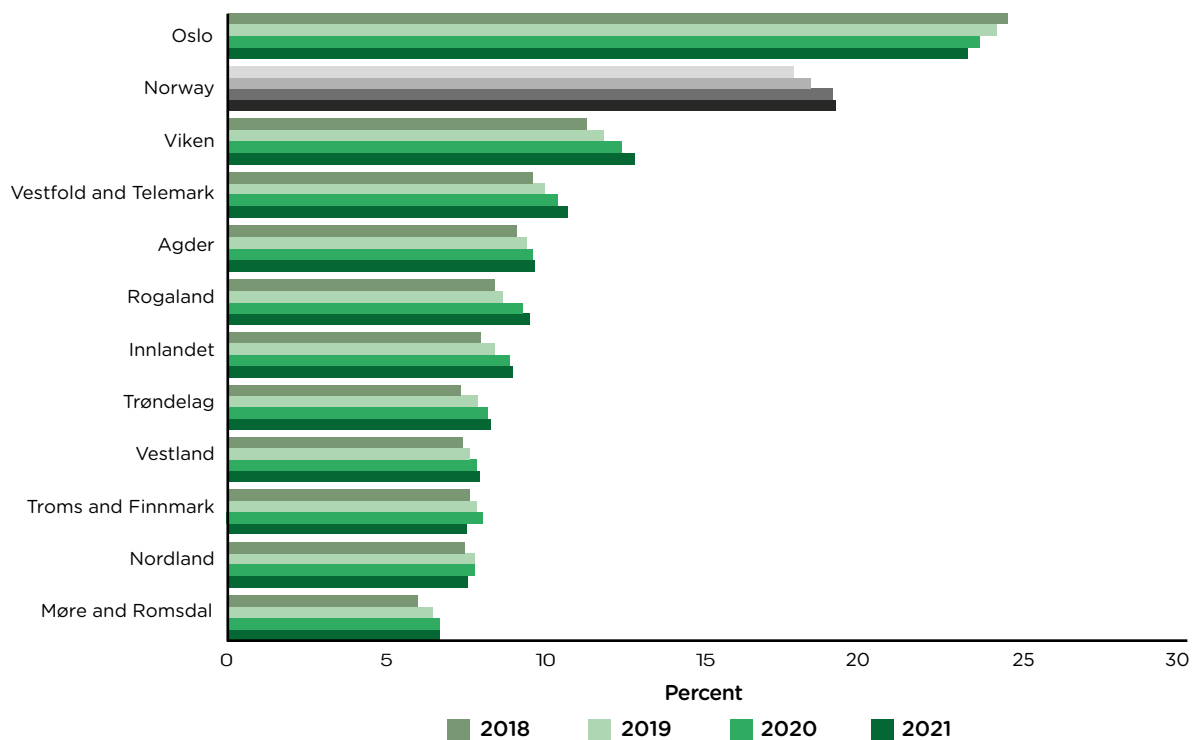


Source: NIPH database (18)

Figure 3.3 shows the counties in which immigrant children from Africa and Asia live. While Oslo has by far the largest percent of immigrant children from these continents, followed by the two surrounding counties,

this figure has decreased slightly in recent years. By contrast in the majority of other counties (and Norway as a whole), the figure has increased – suggesting some dispersion out of the capital.

Figure 3.3 Percent of those aged 0-17 who were immigrants from Africa and Asia*, Norwegian Counties , 2018 to 2021

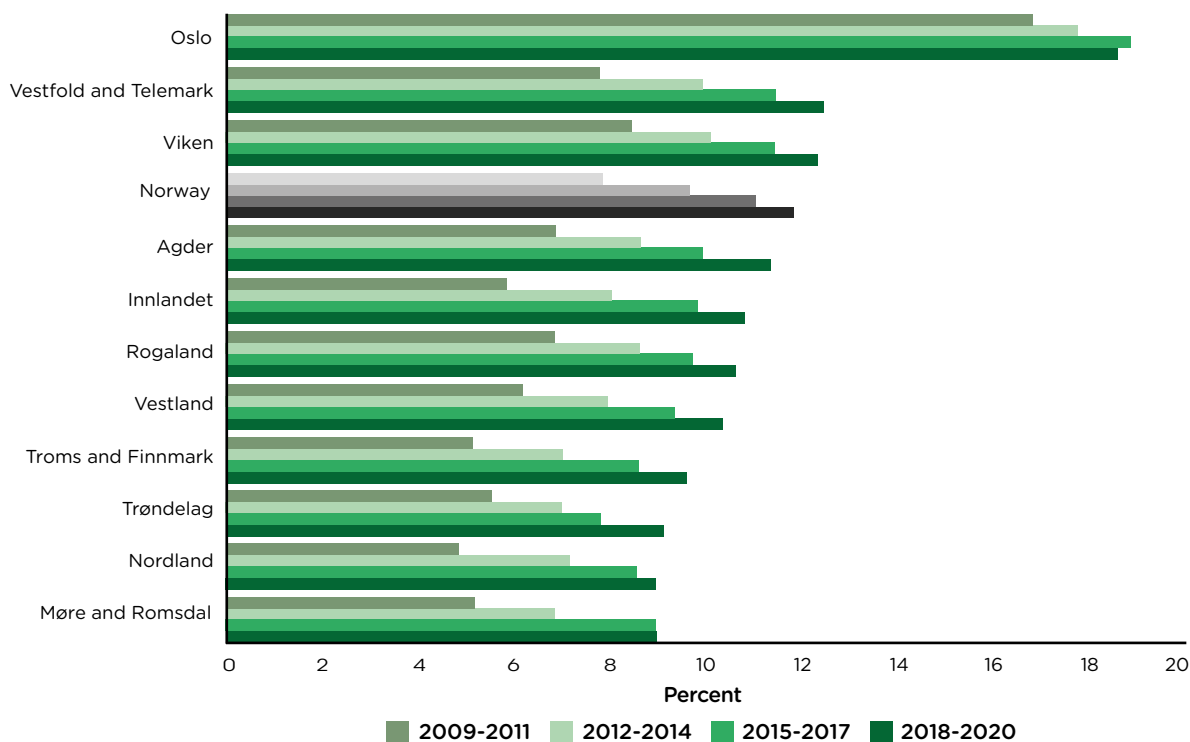


*Note: *Including Turkey*
Source: NIPH database (18)

Similarly, while all counties have seen increases in this measure of child poverty since 2009-11, the smallest percentage increases have been seen in Oslo and the two surrounding counties (11, 60 and 46 percent,

respectively) while the largest have been in Finnmark (88 percent), Innlandet (85 percent) and Nordland (84 percent) – Figure 3.4.

Figure 3.4 Percent of households with children aged 0 to 17 below 60 percent of median income, Norwegian Counties, 2009-11 to 2018-2020

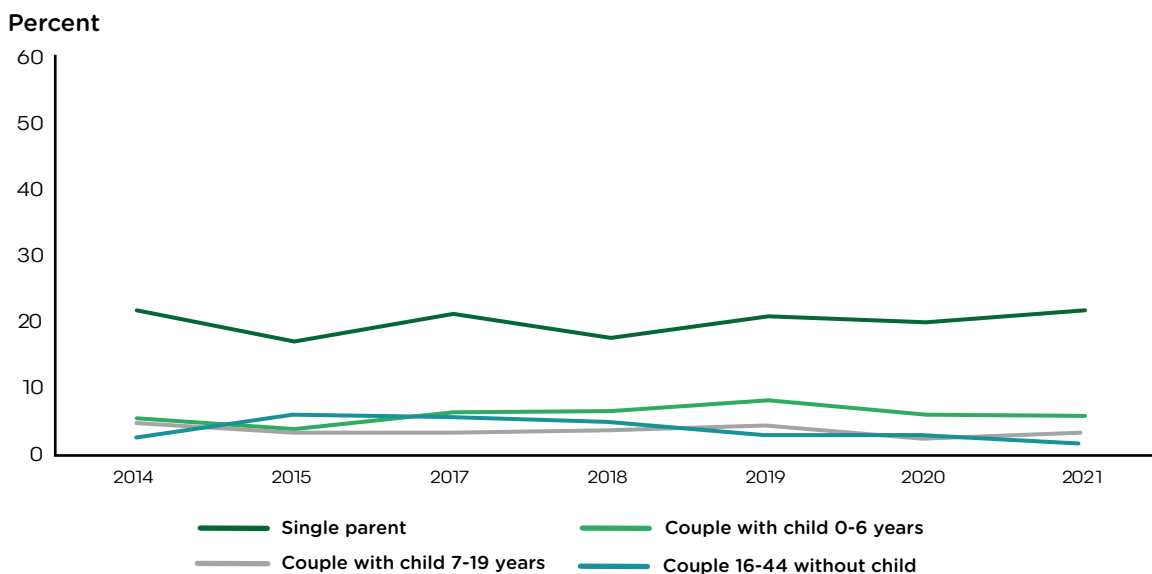


Source: NIPH database (18)

One indicator of the economic difficulties experienced by families with children is the proportions reporting that they have difficulties in making ends meet. Figure 3.5 shows that this problem has been consistently greater among single parents with in excess of 20

percent experiencing these difficulties in most years since 2014. The next highest group at present are couples with children aged under seven - with over six percent experiencing difficulties since 2018.

Figure 3.5 Percent of those aged 16 years and older having difficulty making ends meet by family building stage, 2014-21

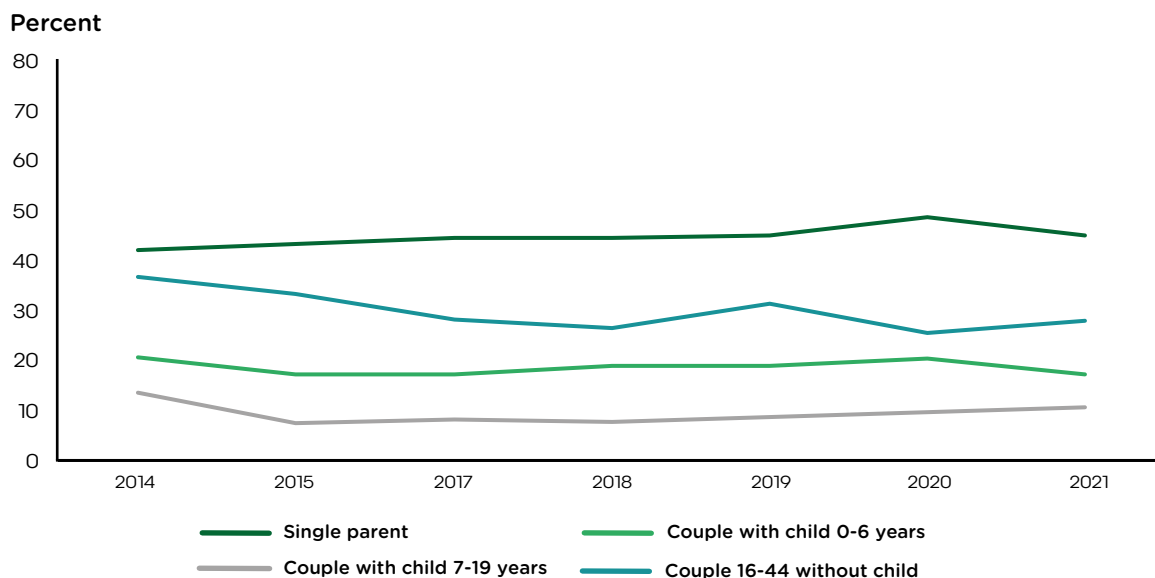


Source: SSB Table 12125 (26)

Housing costs also bear heavily on single parents and lead to shortages of resources for other essentials, increasing debt and other financial problems leading to a higher risk of mental health problems as a result. Figure 3.6 shows that 45 percent of single parents

report that high housing costs are a problem. Couples without children also report high levels of housing cost burdens; this may reflect their age since couples without children are more likely to be younger.

Figure 3.6 Percent of those aged 16 years and older reporting a high housing cost burden by family building stage, 2014-21

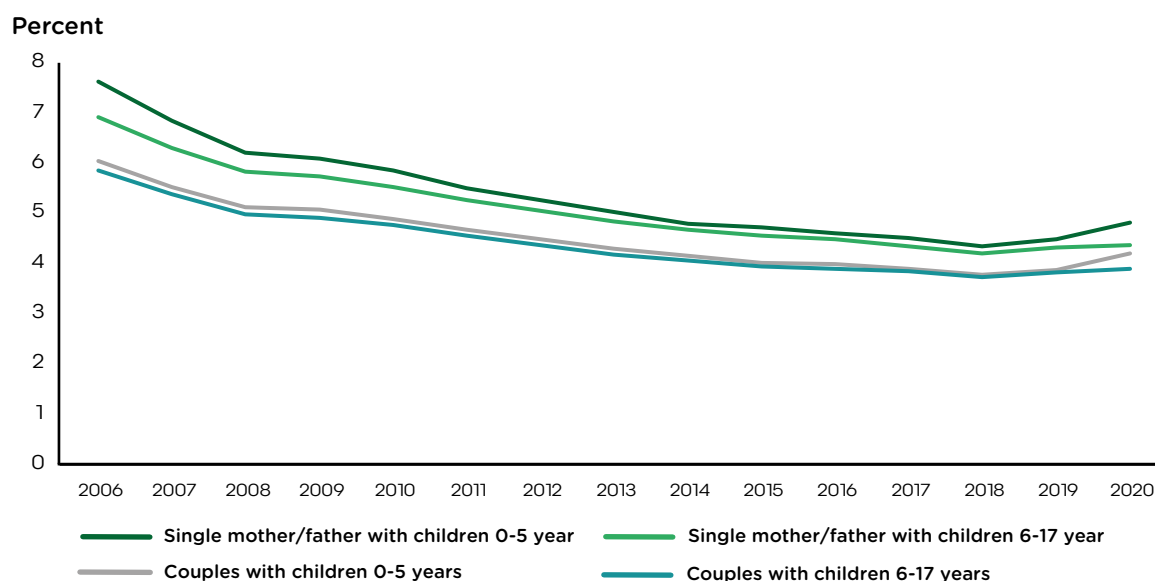


Source: SSB table 12125 (26)

Levels of cash transfers and services affect rates of child poverty (101). In Norway benefits and services are universal, meaning that all citizens have an equal right to receive benefits. However, as shown in Figure 3.7, 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.

Figure 3.7. Family allowances received by households with children as a percentage of income received from work of all households, by family structure and age of children, 2006-2020



Source: SSB table 07780 (26)

While Norway has introduced an array of benefits and services to support families with children, bureaucratic obstacles such as complex eligibility criteria and application procedures can introduce barriers to access for some segments of the population most in need of them (102,103). Parents are entitled to parental benefits only if they have been employed and have received a pensionable income for at least six of the ten months prior to the start of the benefit period. Parents who are out of work can apply for a lump-sum grant, which in 2022 is NOK 90,300 per child (104).

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

There is a labyrinth of different sources of income [for households in poverty.] Some people don't know how much income they'll have from one week to the next. But if they get 100 Krone extra one week, then that money is going to be deducted from payments the next week. So, in addition to having extremely low income, some of these families have an extreme sort of volatility of income. They have no way they can save their money. There's no way they can plan, they can't budget.

Tormod Bøe, University of Bergen, Norway

The following case study is an illustration of a programme offering support to low-income families with children. It is based on family coordinators, whose role in the system is to coordinate services that low-income families receive from different sectors, including education, labour and welfare, health and social services, and volunteer organisations.

CASE STUDY: HOLF - A FOLLOW UP PROGRAMME OF LOW-INCOME FAMILIES

HOLF (*Helhetlig oppfølging av lavinntektsfamilier*, or 'Holistic support for low-income families') is a programme developed by the Norwegian Welfare and Labour Administration (NAV) targeting low-income families with children. The aim of the programme is to reduce the intergenerational transmission of poverty through coordinated and goal-focused support for children and families in low-income households. HOLF aims to facilitate parental employment, improve housing conditions and the economic situation of the families, and to strengthen children's possibilities of participation in various social arenas (105).

The HOLF programme consists of two manuals. First, the HOLF Process Manual which describes the details and tools of the work process. Second, the HOLF Implementation Manual which describes how the programme can be implemented locally in NAV offices. The work processes in HOLF consist of three main parallel phases: meeting with families, coordination of services at the family and system levels and administration.

Each family who participates in HOLF has a family coordinator. Together, the family and the coordinator agree on goals, how to meet them and who is responsible for doing the different tasks and activities to fulfill these goals.

The piloting and implementation of HOLF have been evaluated by a research team from OsloMet who found that the implementation quality of the programme was successful in terms of how it was followed in practice (106). Although it is difficult to draw clear conclusions about the effects of HOLF in terms of the outcomes for families, it was found that having a family coordinator increased the levels of financial support to poor and low-income families in need. Families with a coordinator were more successful in getting a positive result on their applications for social benefits, and these families also showed a slight, but non-significant, increase in parents'/caregivers' participation in employment (106).

While the quality of follow-up of families seemed to increase with the HOLF model – when compared to locally developed projects – analysis of this follow-up demonstrated no significant effects from HOLF compared to traditional interventions. However, recent studies on the model demonstrate that adopting a whole-family approach, where children are actively involved in family interventions, is potentially promising. HOLF seems to have improved children's agency and access to welfare support (107,108). However, the long-term effects of HOLF remain uncertain and the promising practices explored should be evaluated further.

Despite the universal services and cash transfers there are growing proportions of children growing up poor in Norway and since the problem is increasing, it is relevant to ask whether Norwegian policies are adequate to secure children having economic, material and socially decent living conditions and support systems (109).

The rise in child poverty in Norway provides a strong case 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 health. As noted in this section some universal services and benefits are not being accessed by those who would benefit the most, and the levels of benefits are too low to prevent poverty in many cases. To address child poverty, in addition to universal benefits and services there could be an additional element more focussed on people who are at risk of or in poverty, thus maintaining the principle of universality while including an element of proportionality. Such an approach would go some way to reversing the increase in child poverty levels, as well as helping to reduce intergenerational transmission of inequalities.

Services for children and families with poor finances and challenging life situations are rarely integrated and coordinated, and they often focus on individual problems, or on individual family members (110). Trommald (2017) points out that the challenges must be seen as comprehensive, and that coordination and cooperation to find solutions is becoming increasingly important (111). Children do not experience one problem, but several problems at the same time (112). Families have signalled their frustration and powerlessness due to their challenges not being seen in the round (113). An innovative intervention ('New Patterns') developed by researchers and implemented in collaboration with the municipality of Kristiansand aims to provide a holistic approach to enabling families to improve their lives by improving coordination across sectors at the municipal level. New Patterns is currently the subject of a major research study, with 12 participating municipalities in the south of Norway (114).

CASE STUDY: THE NEW PATTERNS STUDY

New Patterns is a new model for coordinating services to families with persistently low incomes in which both the children's needs and the adults' needs are considered together. The model's purpose is to break existing patterns where challenges linked to child poverty are passed on through generations.

Families with children aged 0-17 years with household incomes below 60 percent of the median income and with a long-standing need for welfare benefits are referred to the programme by service sectors within the municipality. These include kindergartens, schools, public health clinics, general practitioners, Norwegian Labour and Welfare Administration (NAV), child protection services and mental health services (114).

The New Patterns programme employs Family Coordinators (FCs), who work with each family to develop a bespoke 'family plan' based on the family members' needs and resources and on what is important to the whole family. In the municipalities' existing services systematic and comprehensive assessments of a family's life situation are rarely undertaken. In this programme, mapping of the family's finances, life situation, health and quality of life, and the family members' resources and challenges is carried out at the start and followed by an annual update. In this way, needs are identified, and adequate help measures can be provided. Each FC works with up to ten families and offers follow up over a period of five years, providing support such as home visits, and accompanying family members to meetings with service providers. In total, 200 families (approximately 250 adults and 550 children) with persistently low income and complex challenges are participating in New Patterns.

The greatest challenge in developing and implementing New Patterns, according to the project leaders, has been to handle the political and administrative expectation of seeing quick results. Working with complex and comprehensive challenges takes time, and specific results from the efforts being made to break patterns between generations cannot be seen until the children are grown up. It has been important to convey the complexity and the need for a long-term perspective, while at the same time continuously providing information about experiences and insights from the research project.

The model has been developed as a research-supported project, with collaboration between the municipality, practice fields, and various research environments. While testing the intervention, it is also being evaluated within the research project, both through quantitative and qualitative methods. The aim is to develop new knowledge which will be useful for the practice field in working with families with persistently low incomes and complex challenges (114).

BARRIERS AND OBSTACLES

Willingness to make changes

Introducing new models in established organisations can be difficult. Institutional logics are challenged, and employees in the organisation may experience uncertainty or feel challenged and thus resist change. An organisation's 'readiness for change' (115) is of great importance for the implementation of new models and has been emphasised in the implementation work in New Patterns. Anchoring leadership, across municipal areas, has been central.

Compassion fatigue

Another challenge – according to the researchers who are evaluating the project, is that it can be very tiring for the family coordinators to work so closely with complex and burdensome cases over time. Measures for preventing compassion fatigue have been important. Such measures cover leadership, guidance, room for action and the workplace community. However, employees also have the opportunity to work in a way that is perceived as meaningful and useful. Managerial support and delegated authority are important prerequisites for the model and the role of the family coordinator.

SUCCESSSES

The model is based on an understanding of coordination as relational collaboration (116). This involves establishing meeting places for dialogue and discussion between the collaborative parties to achieve greater understanding and increased insight into the challenges and how the parties can contribute to this work.

Establishing and evolving relational collaboration into a practical model within welfare services, across professions and sectors, has contributed significantly to the strengthening of collaboration across municipalities, according to the evaluation. After families have joined New Patterns, collaborative partners have reported improved perceptions of their own work, as part of a holistic and coordinated effort.

Replicability/scaling up

New Patterns is based on principles from relational welfare and is an example of how the trust-reform that the Government is pursuing can be realised in practice (117). The model is an alternative to both traditional silo-thinking and the complexity of the welfare system, which is unsuitable when working with the myriad of challenges experienced by families. New Patterns has been tested in ten municipalities in Norway, all diverse in size and organization. The model utilizes existing municipal services and is therefore transferable to all municipalities. It can have transfer value to other groups and contexts where there is a need for coordination of services for several family members.

FAMILY AND CHILD WELFARE

Norway has a long history of providing welfare services for children and families and is said to have introduced the first child protection acts in the world (the Protection Councils of 1896 and The Castbergian Child Laws of 1915). The system and organisation of Family and Child Welfare Services is complex and the overall policy responsibilities are shared across different departments.

As mentioned previously in this chapter, family and child welfare services are provided both through universal and needs-based services. Universal services include health centres (*Helsestasjon*), for example, while the most central needs-based services are the Child Welfare Services and the family support services (*Familievernkontor*). Other services include children's houses (*Barnas Hus*), emergency shelter homes (*Krisesenter*) and those provided by NAV. The Ministry of Children and Families (BLD) has the overall and main responsibility for most of these targeted family and welfare policies. Some of the family and child

services are provided by the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) and the Office for Children, Youth and Family Affairs (Bufetat). Their responsibility relates to state-funded child welfare services, family support services and adoption.

There are some public services in Norway dedicated to supporting the whole family system. The family support centres provide free and low-threshold support and guidance nationwide, and their mandate is to prevent and deal with relational problems in families. According to the White paper NOU 2019:20 - *En styrket familietjeneste – En gjennomgang av familieverntjenesten* (which can be translated as 'A strengthened family service – A review of the family protection service'), the use of services from the family support services varies by sex and age. The elderly, children and young people use the services less than other age groups and women tend to seek guidance more than men.

Municipalities are responsible for the everyday tasks related to the Child Welfare Services. Their mandate is to ensure that children and young people who are living under conditions that might represent a risk to their health and/or development receive timely help. One of the aims of the Child Welfare Act, effective from 1st of January 2023, is to ensure that children are met in a 'safe, loving and understanding' way. The municipality must promote conditions for a good upbringing through measures that can prevent children and young people being exposed to neglect and also coordinate its services to children and families. The cross-sectoral responsibility is also dealt with in the White Paper No. 19 (2018-2019) *Public Health Report – A Good Life in a Safe Society*.

The Child Welfare Services are responsible for providing help, care and protection when necessary due to the child's care situation. This includes early intervention measures to prevent serious neglect. The duty to identify children at risk applies to all services that are working with children and families, for example the midwifery service, the health centre, nurseries, schools and leisure clubs. Norwegian Official Report 2017: 12 *Failure and betrayal – review of cases where children have been subjected to violence, sexual abuse, and mistreatment* proposes a range of measures to develop practices, systems and services that could prevent harm to children related to adverse childhood experiences (ACEs) (118).

Public services generally tend to be divided into focusing on the interests and rights of the child on the one hand, or on the individual needs and rights of adults, on the other (119,120). Another challenge is how the focus on risk assessment after a report-of-concern – a formal notification from someone who is worried about a child to the Child Welfare Services. There can be a lack of holistic thinking, with the consequence that important information can be missed. In some services, it also seems routines and standardised questions limit the overall focus. Thus, efforts must be made to ensure a comprehensive approach to the work of the Child Welfare Services (120).

In 2022, amendments were made to welfare legislation and new national guidelines (121) were launched in September 2022 to support implementation of these amendments. The changes in the 14 welfare acts accompanied by the new national guidelines are especially relevant to the follow-up of disadvantaged children and families as they require intersectoral cooperation at both the individual and system levels. Additionally, children in need of coordinated health and welfare services have the right to a coordinator, and if they are in need of long-term services, they have the right to an individual plan (121). However, it is still a challenge to coordinate holistic support for the whole family (122).

The new national guidelines emphasize a whole systems approach to supporting children, young people, and families, but to date, focus is generally skewed toward coordinating measures around the individual child rather than holistically supporting families and their living conditions. Like several previous studies, Kojan and Storhaug's (2021) findings show that the psychological view is prevalent in child welfare services' work. This overshadows other perspectives related to how social and economic conditions affect the everyday lives of children and parents. Most child welfare workers do not consider financial and living condition-related challenges as their area of responsibility, which may seem to be in line with national guidelines. The absence of a holistic understanding of the child's and family's everyday life also appears to lead to limited cooperation with other agencies – where efforts from several agencies could be appropriate (119).

The following case study illustrates how better coordinated and outreach support to families in their homes and neighbourhoods can help families in complex life situations.

CASE STUDY: LIFE FROGNER

LIFE Frogner was developed by NAV and the Child Welfare Services in Frogner municipality and was inspired by a model for radical help (123,124). The target group for the project were families experiencing multiple life challenges and problems, such as difficult living conditions, health problems, addiction issues, crime and/or concerns for the caring environment of the children. The main aim of the LIFE project is to provide closer and better coordinated support and follow-up to families who receive multiple services from the municipality. This should help to prevent short-term and long-term child welfare placements in and out of home care. Central aspects were relational work, building trust and realising real user participation.

LIFE has three main phases. It starts with an invitation to participate. The families who are part of LIFE first spend some time getting to know the team to be able to gradually open up and establish a sense of security and trust to tackle their challenges. The second phase begins by drawing up a plan for new futures for the family members. The plan is about creating a shared vision of what a good life entails for the individuals as well as the family as a whole. The third phase is about building capabilities and developing resources to achieve better outcomes. This can be about wanting a job, but first having to acquire education and knowledge. The family members themselves must do what is necessary to promote key capabilities, with support from the transdisciplinary project team. Measures concentrate on four main areas: the ability to learn/work; to be fit and healthy; to be part of a local community and to learn to build and maintain equal relationships in their own family as well as in their surroundings.

Moe et al. (2021) evaluated LIFE Frogner in 2021. Their main conclusion is that LIFE Frogner has been successful, showing that it is possible to improve complex situations (124). Many of the families who were included in the project had previously required many services and resources. The outreach practices in the Life project, where support systems were tailored and coordinated around the family in their specific everyday life context, seem to be a promising and effective way to support families at risk of being left behind.

When it comes to the community child welfare services and the education sector, Kojan and Storhaug (2021) highlight the following recommendations: 1) apply a knowledge base that accommodates a comprehensive understanding of the family's living situation. This involves exercising 'socio-economic sensitivity' in meetings with children and parents and clarifying in the reporting and investigation phases the cause of concern; and 2) develop a holistic approach using relief measures for children and families with low SES, where assessments of socio-economic conditions that can have a negative impact on the care environment are carried out using parental guidance measures. In turn, this might impact the appropriateness of the changes in care and the compensatory measures and the extent to which children and young people have real participation both in their own case and in decisions about measures to be taken (119).

INEQUALITIES AND CHILD WELFARE SERVICES

The Norwegian system for protecting children is usually referred to as the Child Welfare Service, reflecting its extensive use of supportive in-home measures (125,126). Although it provides a high level of supportive services, the number of families receiving these interventions has decreased slightly over the last five years (127). There has also been a shift in the kind of services provided, from low-threshold services such as economic support, leisure activities for children or kindergarten, to a

greater use of parental guidance, especially parenting programs (119,128). The total number of children in out-of-home care (both on coercive and voluntary basis) is quite stable (127), but expenditure on child welfare services has increased significantly.

There is a significant social gradient in the Norwegian Child Welfare Services. Although Norway's system of family support has equality as a strong underpinning value, studies using quantitative and qualitative data revealed patterns of a social gradient regarding who is involved with the child welfare system (119,129). There is a clear overrepresentation of low SES groups (119,119,130). The presence in the child welfare system of children with low SES is over four times as high as that of children with medium/high SES (119) and can be linked to social determinants such as education/work, living conditions, health and minority-related conditions. Furthermore, the same study (119) found that the services provided for different SES groups partly followed different patterns. Supportive in-home-measures aimed at low SES groups are seldom targeted at combatting their challenges relating to their socioeconomic situation. Low SES groups receive parental guidance measures more often than medium and high SES parents, despite the fact that the study did not find significant differences in self-reported parenting practices between different SES groups within the child welfare population (128).

RECOMMENDATIONS

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.

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.

Inequalities in development and attainment persist from the early years and, if not disrupted, tend to accumulate during school years, leaving lifelong impacts in terms of income, quality of work and a range of other social and economic outcomes affecting physical and mental health and overall wellbeing across the life course (1).

The provision of high-quality schooling and ensuring that as many pupils as possible complete upper secondary school is of vital importance to leveling up social gradients in health and wellbeing (16). 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 particularly vulnerable situations. There are concerning trends and wide inequalities in young people’s mental health and wellbeing which are vital to address.

TRANSITION FROM EARLY YEARS INTO SCHOOLING

In Norway, children start compulsory schooling at the age of six. Children and young people have a right and an obligation to complete primary and lower secondary education. Adults are also entitled to primary and lower secondary education, lifelong learning representing an important policy priority (131). Education, after the early years in kindergartens, is free of charge and a cornerstone of the welfare state system. In Norway, 90 percent of schools are public. Primary and lower secondary education is managed by local governments, while the upper secondary schools are managed by regional governments (counties).

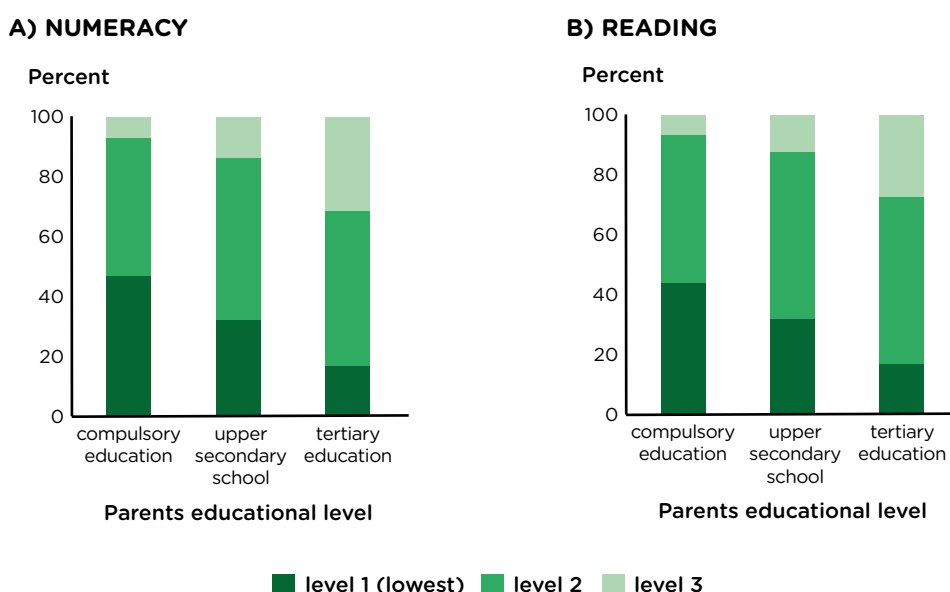
Prior to what is known as the Systemic School Reform, which included reducing the start of schooling from age seven

to six, there was an extensive professional debate about where six-year-olds ‘belonged’ in the educational system – in ECEC or school. Evaluation of the reform indicates that the policy was ineffective in reducing inequalities in learning outcomes. On the contrary, the evidence suggests that learning support for children has not been proportionate to need, and has contributed to widening social gaps (132,133).

In addition, reform 2006 – known as the Knowledge Promotion Reform –, introduced ideals of learning intensity and performance measurements aligned with what is known as the ‘New Public Management’, which led to an increased focus on school performance, measurements and tests, and the academisation of schooling. The role of play was diminished and the promises given regarding six-year-old school starters gradually developed into a school environment with longer hours focused on training and skills, and in particular on literacy and numeracy (134). Recent studies indicate that the reform has failed to achieve its vision to improve children’s learning and skills, for boys in particular, suggesting a more flexible start to schooling based on school readiness should be implemented (135).

The long-term health consequences of differences in educational level were outlined in chapter 2 – educational gradients in mental health in middle age and beyond, self-reported physical health, mortality rates and consequently length of life. There are clear inequalities in attainment related to parental level of education shown in Figure 3.8 for children in the fifth year of primary school in Norway.

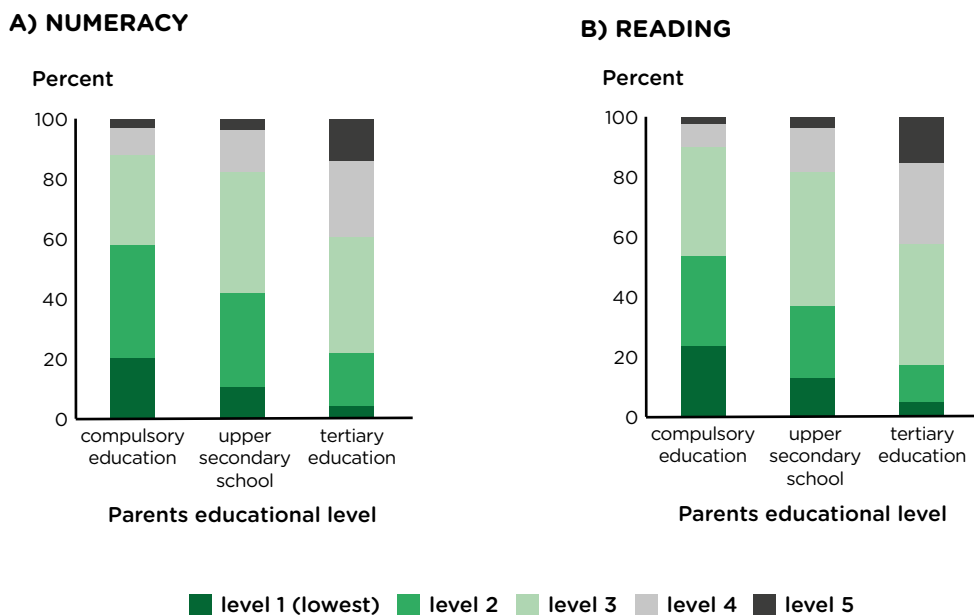
Figure 3.8 Distribution of proficiency in numeracy and reading in the fifth year of primary school by parents’ highest level of education, 2020/21



Source: Frøyland (2017) (136)

These inequalities persist among children three years older, in the first year of lower secondary school – Figure 3.9

Figure 3.9 Distribution of proficiency in numeracy and reading in the first year of lower secondary school by parents' highest level of education, 2020/21



Source: Frøyland (2017) (136)

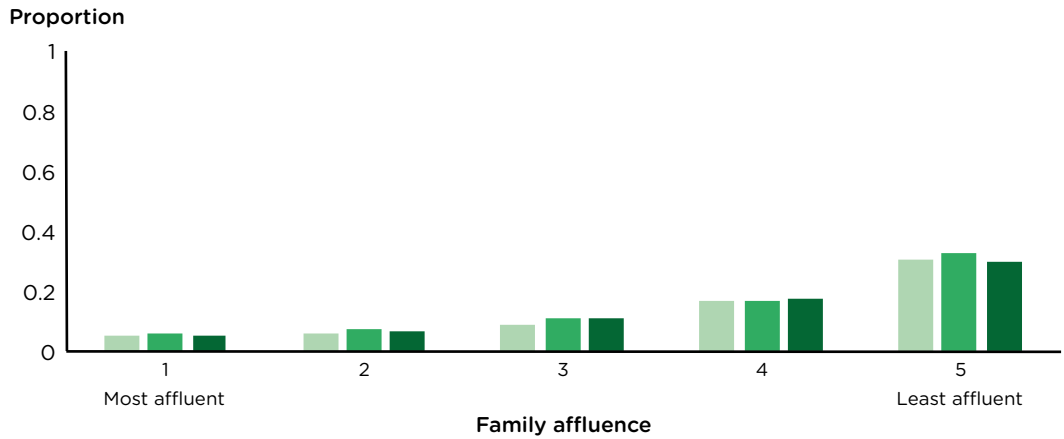
Academic performance and being able to feel that one can cope with life affects self-identity and the development of skills needed to participate in society and in working life. The reviewed evidence suggests that the Norwegian school system does not work well for some pupils and for some children it can be a place associated with underperformance, defeat, discomfort, stigmatisation and marginalisation as a result (133,137). Alterations to the curricula since 2020 through the Renewal and Improvement Reform have not so far helped to reduce inequalities (138). Madsen and von Soest (2021) argue that introducing health and life skills in Norwegian schools may fail to properly address the wider social determinants of increasing psychological distress, because effective measures connected to political and economic systems are not present (139). A cross-disciplinary approach to the school system is

important to address inequalities and to support a whole child, whole of family and whole of community way of working, and to proportionally support pupils and families in need of extra help. Moreover, building strong networks of support is key to addressing psychosocial problems in schools and communities, such as bullying.

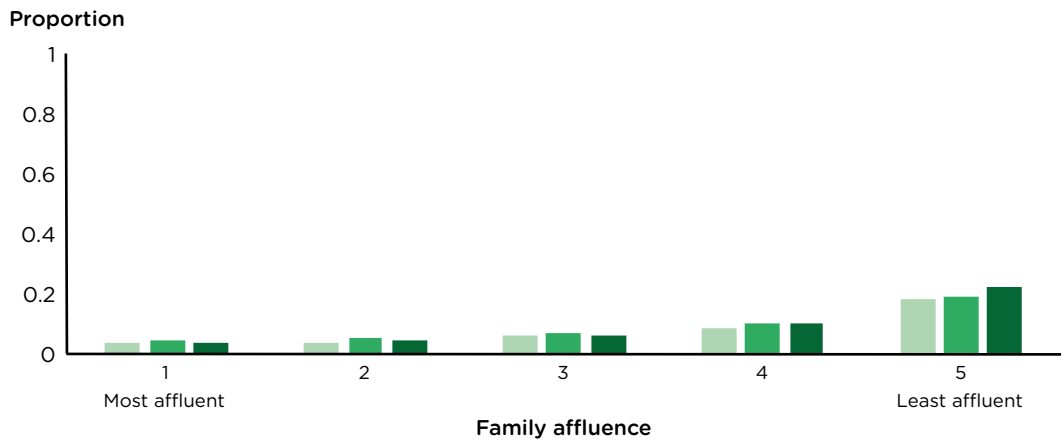
Figure 3.10 illustrates the inequalities that exist in the experience of being bullied at secondary school. In lower secondary schools around 30 percent of both boys and girls from the least affluent families reported bullying at least every fortnight, compared to around five percent from the most affluent families. Bullying was less common in upper secondary schools, but a steep gradient by family affluence persisted. Among boys, the figures were around 20 and four percent, respectively and among girls 16 and three percent, respectively.

Figure 3.10 Proportion of secondary school children being bullied every 14 days or more often, 2014-16 to 2021-22

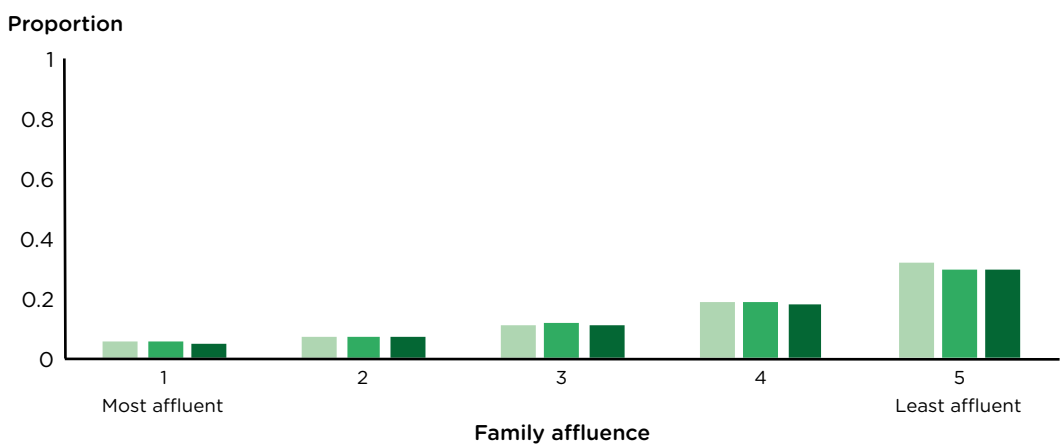
**(A1) BOYS,
LOWER
SECONDARY**



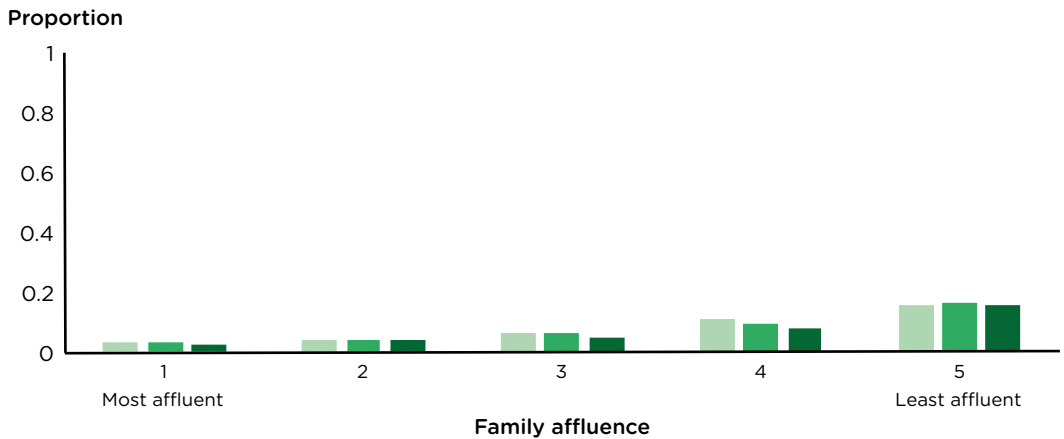
**(A2) BOYS,
UPPER
SECONDARY**



**(B1) GIRLS,
LOWER
SECONDARY**



**(B2) GIRLS,
UPPER
SECONDARY**



2014-2016 2017-2019 2021-2022

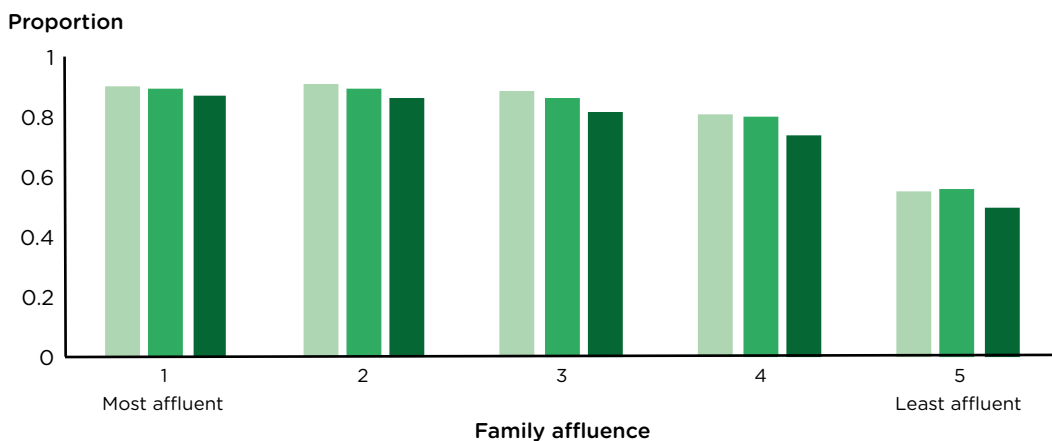
Source: Young data (29)

As we highlight through this report, the experience of mattering – to feel valued and add value – is fundamental to people’s dignity, health, and wellbeing across the life span. For children and young people in particular, experiences of mattering and being cared for are crucial for positive development and self-identity. The social and relational qualities of class and the school system linked to the wider family setting and community create

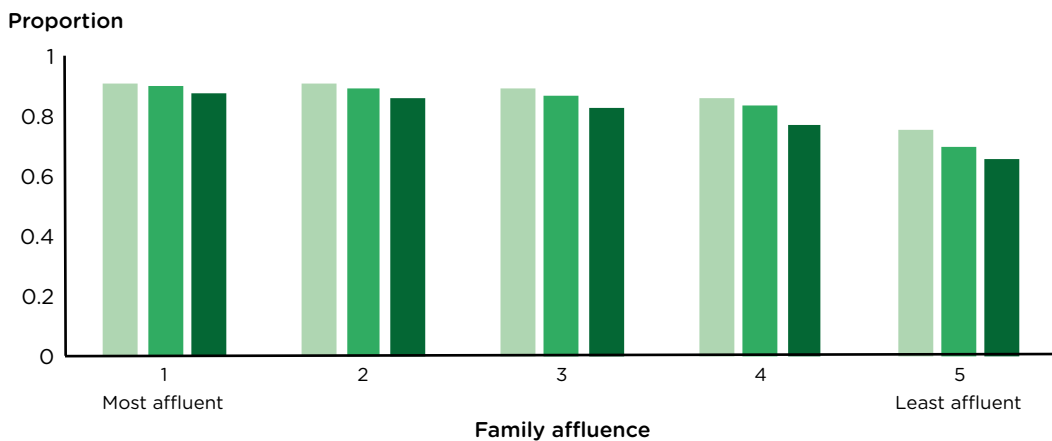
the conditions for the pupils’ development and learning, both socially and academically. One of the most central elements in this social system is the relationship and interaction between teacher and students (140–142). There are clear inequalities in the proportion of children indicating that their teachers care about them, shown in Figure 3.11 and some indications of overall declines in this since 2014-16.

Figure 3.11 Proportion of children indicating that their teachers care about them by family affluence, 2014-16 to 2021-22

**(A1) BOYS,
LOWER
SECONDARY**

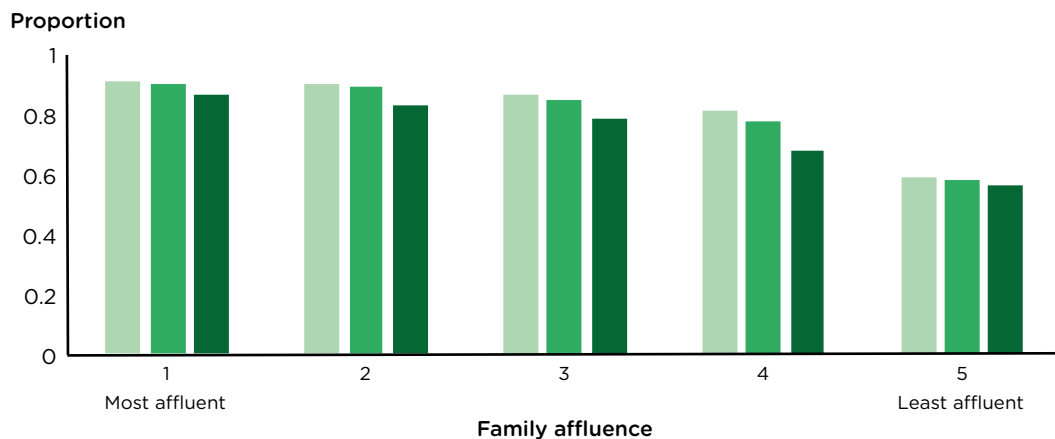


**(A2) BOYS,
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SECONDARY**

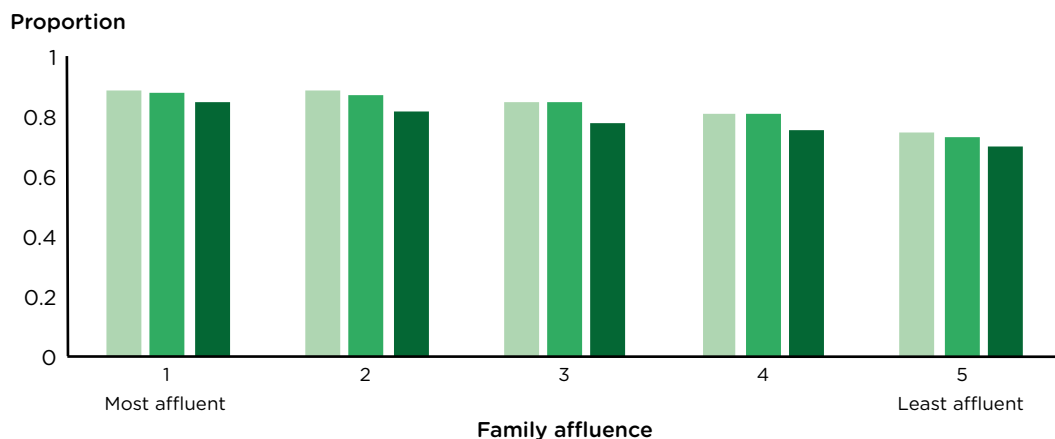


2014-2016 2017-2019 2021-2022

**(B1) GIRLS,
LOWER
SECONDARY**



**(B2) GIRLS,
UPPER
SECONDARY**



2014-2016 2017-2019 2021-2022

Source: Young data (29)

There is a need for improving accountability and competence on the social determinants of health and wellbeing, as well as whole systems responses in Norwegian schools (122,143-145). In a diverse classroom filled with pupils who have different needs,

teachers alone cannot do the follow-up and provide all of the support needed for disadvantaged and at-risk children. The case study below illustrates potentials for transdisciplinary working to proportionately support children and young people in schooling.

CASE STUDY: SOCIAL GUIDANCE IN PRIMARY SCHOOLS

Primary schools have an important role in identifying and providing early intervention for children at risk of negative psychosocial development and mental health issues. The last decade has brought increased attention to the need for more interdisciplinary schools with a wider variety in competences concerning child development and significant roles for school social workers. Given that these professionals have competence and knowledge of preventive psychosocial work, child development, relational competence, bullying prevention, multidisciplinary cooperation, and other relevant interventions, they can contribute to enhanced efforts in this field, as they complement teachers' and other school staff's competences.

However, despite the clearly stated needs for interprofessional competence in school, there is a lack of structured and systematic thinking in the use of these professionals, which reduces the potential positive impact of their work. The project aims to outline a knowledge-based, systematic, and structured job description, and thereby practice, in the use of school social workers in primary schools.

ACTION/PLANS

As frontline professionals, identifying emerging problems and providing early intervention, school social workers can observe and interact with students, in addition to establishing supportive relationships. A structured approach and a work description that clarifies the school social workers' roles and responsibilities will be outlined and investigated in three parts: 1) mapping the knowledge-base by conducting a scoping review (146), several surveys and interviews with school principals, school social workers, and other actual respondents, concerning the need for and use of school social workers today; 2) preparation and implementation of a structured approach in a selected number of schools, including investigation of effects on students, teachers - related to stress and self-efficacy and multidisciplinary cooperation; and 3) construction of a website consisting of knowledge and research on selected topics, teaching material, contact information for other professionals, in addition to offering webinars and discussion platforms for school social workers.

The project has a reference group for quality assessment of all materials, interview guides, and interpretation of data. The reference group consists of seven user participants, two students, a principal, and a school social worker.

PROJECT GROUP

The project group has seven members: a professor, three associate professors, a researcher with a PhD, and two assistant professors. The members work at three different departments at the Norwegian University of Science and Technology, Volda University College, and at the Centre for Child and Adolescent Mental Health, Eastern and Southern Norway.

Children and young people spend a considerable amount of time in the school setting, and their wellbeing is essential to develop the capabilities to live well and flourish in childhood and later life. Time spent in the school setting after school hours also impacts children's health and wellbeing. Children in primary education have opportunities to go to out-of-school-hours care (SFO), and in 2021, 61 percent of children between first and fourth grades were in SFO. After-school care is an important arena and has the potential to function as a socially inclusive tool and an enabling mechanism for coordination regarding children with special needs and those at risk of being left behind (147).

Although schooling in Norway is free of charge, SFO is not. There are substantial geographical differences in parent pay schemes, and recent evidence points to steep social gradients in participation (74,147). However, the current Government has made a decision to give all first graders (who start school the year they turn six) across the country free after-school care for 12 hours each week, effective from August 2022. The Government is also giving 60 municipalities the

opportunity to provide full-time places in after-school education to first-graders who come from families with low incomes (148).

To support improvements to children's outcomes in the social determinants of health, greater alignment and collaboration between sectors which affect these determinants is needed. An important underlying driver of multidisciplinary collaboration both at the national and local levels in recent years has been the implementation of the UN Convention on the Rights of the Child. This has been included in measures such as the *Sjumilssteget*, a programme which is intended to empower municipalities in Norway to adopt the UN Convention on the Rights of the Child in their daily work. The focus is shifted from the individual service or profession to the municipality's overall responsibility for safeguarding the rights of children and young people (149). Among the seven rights highlighted are a child's right to participation, good health, care and education. A strong interdisciplinary collaboration at the municipal level needs to be based on the UN Convention on the Rights of the Child.

INTRODUCTION OF UNIVERSAL SCHOOL MEALS

Establishing healthy dietary habits in children supports good health. School meals provide a means of influencing the quality of children's diets and improving children's nutritional intake as well as mitigating child poverty and its impacts. This is particularly important for children from low-income households who generally consume less healthy diets than their better-off peers and is important for reducing costs for households on low incomes. The extent to which school meals adequately fulfil their potential for enhancing children's dietary intake depends on factors such as the quality and nutritional value of the food provided, the acceptability of the available food choices to children, and the rate of participation of pupils in school meals.

Countries around Europe have different policies concerning school meals. In Europe, only Finland and Sweden currently have universal free school meal policies. The UK provides free school meals to children from low-income homes receiving welfare benefits of various kinds, as well as children from families with no recourse to public funds, subject to maximum income thresholds. Wales and Scotland are gradually rolling out free school meals to all primary school children using phased approaches.

In Norway, a minority of schools offer a school lunch. Children predominantly bring bread-based packed lunches to school. Some schools offer breakfast before school, and some offer soup or a snack during after-school homework sessions. However, there is growing political and public interest and debate about school meals in Norway (150). Evidence that highlights the potential for universal free school meals to contribute to health equity comes from the School Meal Project, conducted in two Norwegian primary schools among ten to 12-year-olds which provided a free school meal every day during the school year. A control group continued eating their packed meals as before throughout the project (151). The free school meals followed Norwegian national dietary guidelines and consisted of whole-grain bread, healthy spread, and fruit and vegetables with milk or water to drink. Children completed a food frequency questionnaire, and the results were assessed using a healthy food score. The study found that providing a free healthy school meal for one year improved the overall diet among children, especially children from households with a low socioeconomic position, assessed by number of years of parental education (151). A qualitative study to understand how children and teachers experienced the project reported that pupils and teachers felt that the free school meals were beneficial for a healthy diet and had other benefits including social equality and social interaction, since pupils sat around tables and ate together (152).

Learning from other countries can provide important insights that are relevant to policy development in Norway. Finland was the first country to introduce free school meals in 1948, and currently all Finnish children enrolled in pre-school and basic education are entitled to free school meals during term time. School meals in Finland are part of the national core curriculum and are seen as an investment in the future (153). Responsibility for managing the practical implementation of school meals, including allocating financial and other resources, is devolved to municipalities and other education providers. Recommendations for a balanced school meal are set out by the Finnish National Nutrition Council. According to the regulations in Finland, school lunches should provide one third of the energy requirements for the day (154). The curriculum describes not only the health and nutrition aspects of school meals but also the social aspects, such as developing good manners and community spirit. Pupils can participate in planning and implementing school meals.

Eating school lunch in Finland is associated with higher consumption of vegetables, fruits, rye bread, milk, sour milk, and cheese whereas skipping school lunch is associated with higher consumption of French fries, potato chips, hamburgers, pizza, meat pies, ice cream, candy and chocolate (155). However, a study found that the choices made by children in their school lunch reflect the overall eating patterns among school-aged children: children who consumed a healthy diet at home were more likely to eat the balanced school lunch provided in school (154).

A further study on this topic explored determinants of regular consumption of a nutritionally balanced school lunch in Finland, especially how choices made by children in their school lunch relate to their sense of coherence – a concept comprising three dimensions: comprehensibility; manageability and meaningfulness – and that regularly choosing to eat a balanced school lunch is associated with a strong sense of coherence (156). From a health equity perspective this suggests that while the free school lunches are universal in Finland, extra targeted measures to encourage healthy choices at school might be needed to encourage take-up among those less likely to consume a healthy diet at home. These include measures to increase parental involvement, and efforts to enable children to maximise their capabilities and have control over their lives.

A nationally representative study in Sweden on the importance of school lunches to the overall dietary intake of children found that lunches provided around half of the daily vegetable intake and two-thirds of daily fish intake (157). Analysis of equity impacts found that the school lunches in part compensated for lower dietary intake in children from households with lower parental education (157).

DEVELOPMENT INTO YOUNG ADULthood

Norwegian culture encourages young adults to be independent and live away from the parental household, supporting them through this transition with welfare policies. In addition to providing free, public education at primary, secondary, and higher education level, all students can receive a basic support loan (*Lånekassen*) if they are enrolled in full-time higher education and do not live with their parents. For low-income students, up to 40 percent of these funds can be converted into a grant (requiring no payback) upon completion of the course of study. Student Welfare Associations (*Studentsamskipnad*) provide support, including kindergarten for student parents, affordable housing, careers advice and some healthcare for all those enrolled in a university, for a minimal fee. The overwhelming majority of students also work part-time. Despite the measures taken to assist young people to live away from their parents, many of those that do so face significant financial burdens due to housing costs (see section on housing). Social economic position and parents' level of education remain strong predictors of poverty and wellbeing in young adults once they become independent, despite the provisions protecting them from the risks of precarity while studying.

Recent surveys on loneliness and health have found the 18-20 and 26-35 age cohorts are the loneliest of all age groups analysed. A notable increase in self-reported health problems or complaints has been noted in younger adult cohorts in recent years (see also section 2), with a particularly worrying rise in mental health problems such as depression and anxiety, particularly affecting women (33,158). Levels of reported loneliness among younger cohorts have also steadily increased over the last decade, and recent large scale longitudinal studies of the Norwegian population have found that perceived loneliness in young adults was a significant risk factor for more of life spent with a disability and for earning lower income later in life. Peak loneliness seems to be particularly experienced by people in their early 20s, putting this age group at particular social and economic risk (159). These are two particularly vulnerable moments in young adults' lives, the beginnings of life outside the family home and economic independence (160).

As noted in section 2, anxiety, distress, and depression among young people follows a clear socioeconomic gradient, with increasing negative psychological symptoms with the decreasing socioeconomic position of young adults aged 16-18. Importantly, family socioeconomic gradient seems to affect mental wellbeing of young adults significantly, with young adults with a lower SES reporting higher levels of anxiety and depressive symptoms (161). Mental health distress and symptoms affect the general health of individuals, as those who report high levels of psychological distress also report using healthcare services twice as much as those experiencing a lower level of symptoms (162). Similarly, students with symptoms of severe mental distress used almost all types of health services more than other students (163).

INEQUALITIES IN EDUCATIONAL ATTAINMENT AMONG YOUNG ADULTS

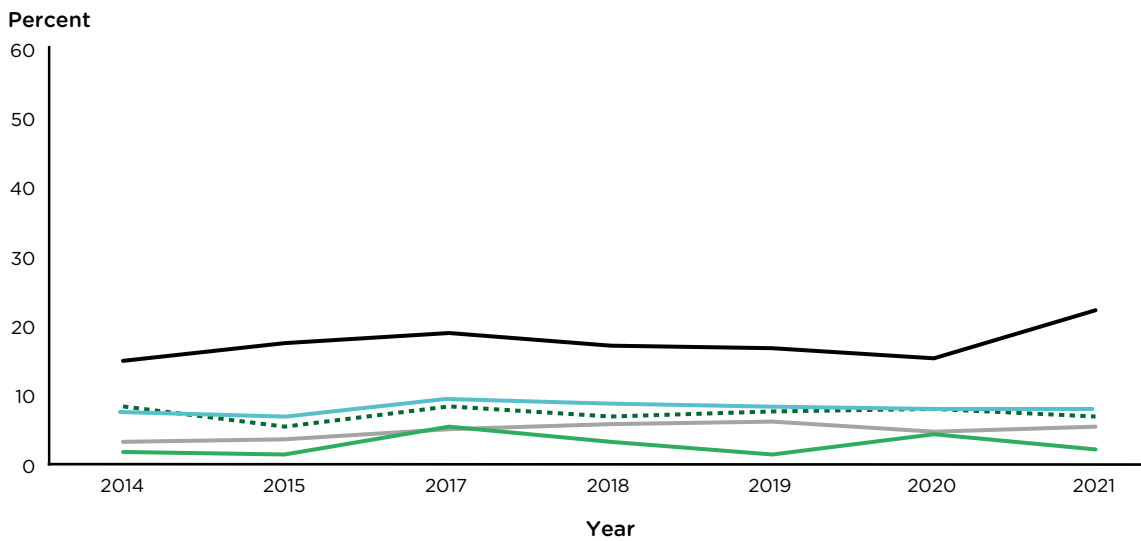
As shown earlier in this chapter for young children the likelihood of achieving a high level of education is strongly influenced by parental socioeconomic status. These inequalities persist during later schooling years and into adulthood. According to the latest available data (2019), the proportion of children aged 15 in the bottom economic quartile achieving at least a level 2 on the PISA Index, the OECD's Program for International Student Assessment, is 19 percentage points lower than that of children from the top income quartile. Clearly family socioeconomic status remains a strong predictor for children's educational attainment and performance (164). According to the Norwegian Directorate of Education and Training, lower secondary grades are the single most important factor to predict if a student will complete upper secondary (82). In addition, children with parents with higher qualifications achieve higher grades in lower secondary than those from parents with lower qualifications (82).

There are particularly clear inequalities in completion of education related to whether a child has been in receipt of child welfare and all other children and these inequalities have lifelong impacts. While 80 percent of the population completes upper secondary education, only 30 percent of those who have received assistance from child protection services have completed upper secondary education. Furthermore, the proportion of this group - who either receive social benefits or health-related benefits is relatively large. Almost 24 percent receive a disability pension and/or work assessment allowance (AAP), and almost 27 percent receive financial social assistance (165).

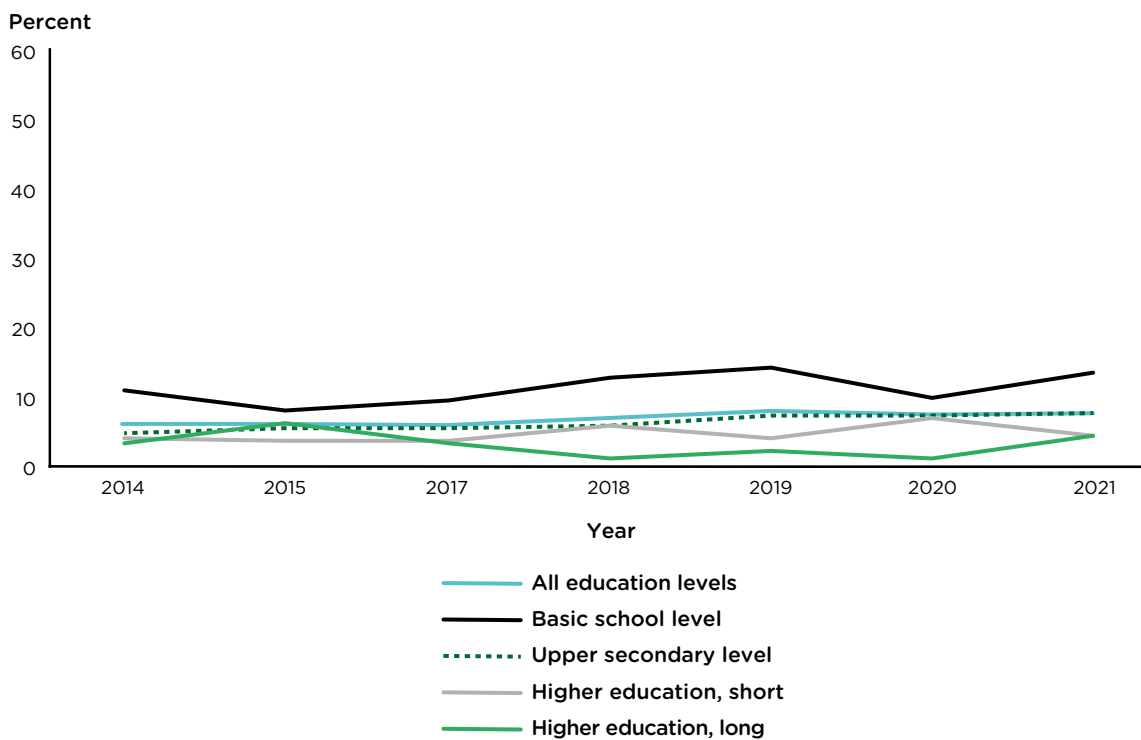
Following schooling, students from lower socioeconomic position are more likely to enter vocational programmes rather than upper-secondary or tertiary education as young adults (164). This, in turn, affects their later life earnings and wellbeing, with 50 percent of adults in working age with the lowest educational level earning an income that is at or below 60 percent of the country's median income (164). This is reflected in the higher proportion of those with only basic education reporting difficulties in making ends meet at working ages 25 and above - Figure 3.12.

Figure 3.12 Percent of those aged 25 to 66 years and older having difficulty making ends meet by educational level and age, 2014-21

(A) AGES 25 TO 44



(B) AGES 45 TO 66



Source: SSB table 12126 (26)

Young adults who come from families which receive social assistance benefits tend to have poor outcomes in the longer term (160) and there is evidence of a lack of opportunities available to these young adults despite the universal access to education in Norway (166-168).



EFFECTS OF REFORMS TO THE SECONDARY EDUCATION SYSTEM ON INEQUALITIES

The secondary education system underwent a significant reform in the early 1990s due to the structural changes to the labour market and the economy of the country (169). Until 1994, there were two parallel and segregated secondary educational systems which allowed students to either follow a vocational preparation programme or a path geared toward pursuing higher education. This was associated with high drop-out rates, and students struggled to complete degrees on time. The vocational system offered few opportunities for apprenticeships and training even if these were central to the programme, and made it difficult to go to college (170). Thus the system was leaving a substantial part of its population without qualifications and created significant occupational inequalities between those completing a vocational training and those going to college prior to 1994 (170).

Reform 94 aimed to simplify the vocational secondary education pathway, offering the opportunity for students to switch between the two choices, as well as to give a more robust and flexible preparation to students (170). The reform introduced several incentives to keep young adults in school as well as prepare them more thoroughly for the job market. Importantly, all 16- to 19-year-olds were given the legal right to three full years of secondary education, with the requirements of regional authorities to follow-up and help those struggling to access it (169).

Reform 94 was implemented in one step, with a birth cohort cut-off established on 1 January 1978, and had an immediate, prolonged impact on the labour market of the country. The vocational high school path was required to include two years of compulsory, statutory standard education which included core subjects, and two years of paid work experience and training for students deciding to pursue a vocational high school path (169,171). This path gave students the opportunity to eventually enter college, as well as remunerated work experience. By delaying early specialisation, it allowed for more fluidity (170). Reform 94 also made vocational education more accessible for students with disabilities. It gave them an extra year to complete their track, as well as priority on their choice of specialisation. At the same time it created a follow-up service to track those who have difficulties in secondary education (in either applying, concluding, or at risk of dropping out), creating an active labour market programme for young adults aimed at either keeping them on track or finding them a valid alternative outside of education from an early stage (169,171). In sum, the reform created a closer cooperation between social services, local authorities, and workers unions by creating a proportional universalist approach to secondary and non-mandatory education.

Reform 94 made secondary education more accessible to all, with a substantial increase in overall enrolment in the years following the introduction of the reform. By making the transition between academic and vocational education much easier, the reform significantly increased both the number of students holding both types of degrees and also the possibility of also attending college. This was especially true for women. The reform significantly improved the situation of women more at risk of dropping out, increasing the share of those finishing high school by six percentage points in the birth cohorts after 1978.

Latest available data also shows that this trend has persisted in the two decades since the introduction of the reforms (170). Male college attendance and completion did not change significantly, but attendance in high school for those considered most at risk of not attending did rise. This suggests that the programme was successful in making vocational learning more accessible overall, but did not increase levels of interest in pursuing an academic career (170). Moreover, for male students considered to be more socioeconomically disadvantaged, a five percent increase in average annual earnings was observed after the introduction of the reform.

However, the same cannot be said for their female counterparts. The policies introduced were not particularly successful in decreasing the gender wage gap, in part also because female attendance was already significantly higher than that of men, so women were more likely to be more qualified within the labour market before Reform 94. The occupational segregation in vocational training remained virtually unchanged and the gender wage gap has increased by an estimated eight percent (170).

Between the introduction of the reform and 2019, cohort studies looking at the overall earnings by SEP show a 20 percent reduction in the gap between the most and least disadvantaged students in terms of salaries attained (172). By 2018, 97 percent of students who complete primary school entered secondary school, a rate which has remained virtually unchanged since 1993, suggesting that the reform did not increase an already very high enrolment rate (171,173).

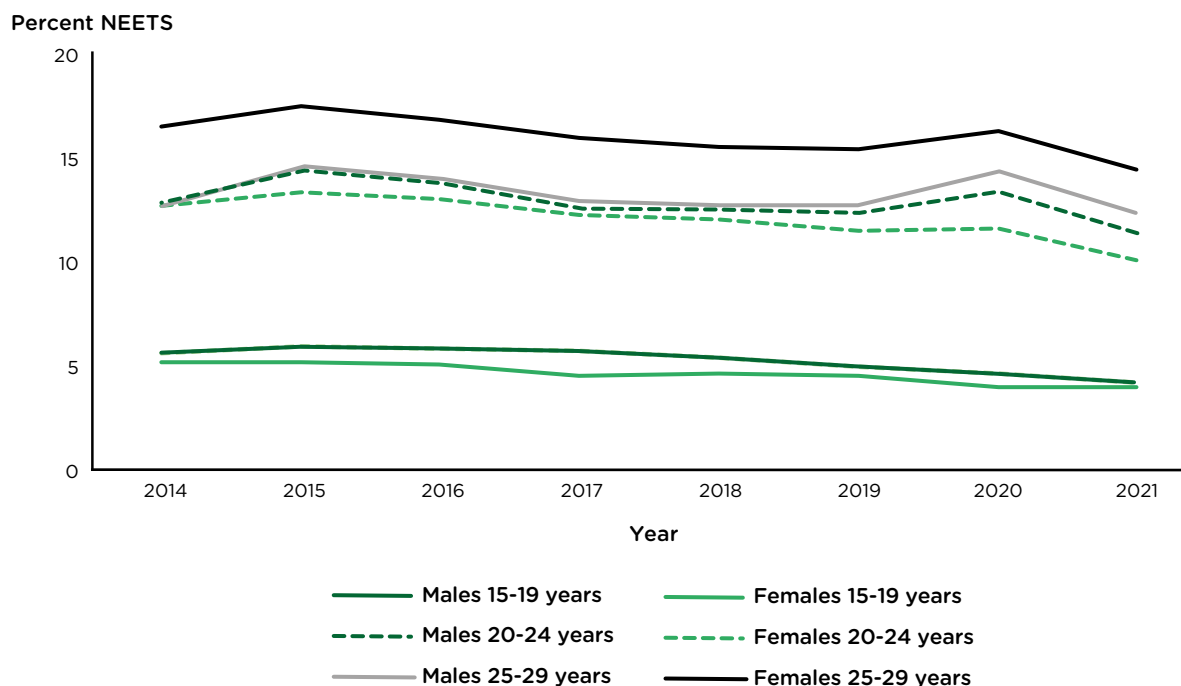
These findings indicate that changes to improve outcomes in social determinants of health cannot happen in isolation and must be undertaken in collaboration with other sectors. Educational reforms need to be supported by both stronger employment schemes and improvements in working conditions for people who do pursue higher education and universal and proportional support to the share of the population that is not directly impacted by the policies implemented.

YOUNG PEOPLE NOT IN EDUCATION, EMPLOYMENT OR TRAINING (NEETS)

In Norway only nine percent of young people are not in education, employment, or training (NEETs), compared to an OECD average of 14 percent. Young adults who lack education or training and are not in employment have difficulty in establishing a subsequent career path and are at risk of social exclusion and having a low income throughout later life. 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. Therefore, the issue of NEETs should be seen as strongly linked to both previous and future phases of life and related to the broader social and economic context.

The proportion of young people who are NEET varies considerably by sex and age. The highest rates among young people are at ages 25 to 29 – above the main ages of tertiary education – with female rates exceeding those of males at this age. At younger ages, when many are still in tertiary education, rates for males are slightly higher than for females – Figure 3.13.

Figure 3.13 Percent not in employment, education or training (NEETS) by sex and age, 2014-2021



Source: SSB table 13556 (26)

Although the proportion of young people who are NEET was only higher than that in Netherlands and Luxemburg among all OECD countries (174), Norwegian NEETs are particularly vulnerable compared to NEETs in the rest of Europe, with a large proportion of Norwegian NEETs receiving health-related benefits, having poorer mental health, and lower levels of education compared with other European NEETs (175). Education is especially important to gain access to the Norwegian labour market, which in turn affects long-term economic prospects.

More than half of all NEETs are young people without an upper-secondary qualification (176), putting them much more at risk of subsequent economic precarity. While access to education is supported through policies which allow most young people to pursue an education even while living far from their parents, poverty and education of the parents remains an acute predictor of the opportunities to which young people have access.

Evidence shows that young people who have been in the care of Child Welfare Services participate less in work and education nine years after completing primary school (166-168). This is to some degree explained by socioeconomic factors, as families with low socio-economic status are overrepresented among users involved with the CWS (177).

Similarly, immigrants are overrepresented among those who are NEET and young NEETs are twice as likely to be born abroad (175). However, there are large variations associated with the age of arrival in Norway, country of origin, and the family's socioeconomic background, such as parents' education, and in particular mothers' educational level (166,178). Some immigrant groups perform better than the ethnic majority.

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. The YouthInvest case study below shows how young people are given opportunities through an appreciative and strength-based approach to schooling and education. This means approaching and appreciating the resources, interests, talents and contributions of pupils instead of focusing on their deficits and learning disabilities. By working with these approaches, YouthInvest AIB has had successful results regarding activate participation and citizenship among young NEETs.

CASE STUDY: YOUTHINVEST AIB

YouthInvest AIB is non-compulsory educational programme organised alongside upper secondary schools for young people aged 16–24, who are NEET and is financed primarily by Viken County Council. The aim is to offer young people in upper secondary school the opportunity to gain qualifications to study and to prepare for a meaningful working life by participating in an enduring and enabling school context rather than participating in a short-term programme. Over 220 students are enrolled each year. There is a continuous intake of students over the entire school year, at five divisions located in different municipalities of the county, to ensure that students facing difficulties or those who are uncertain about their future do not drop out permanently.

YouthInvest AIB offers practical workshops in such areas as handicrafts, mechanics and carpentry, as well as teaching in Norwegian, mathematics, English, IT, and social studies. All teaching is based on the upper secondary education curricula. The target group is young people who, for various reasons, are no longer participating in upper secondary education. It might be because they are uncertain about their educational options or because they need to catch up on fundamental subjects before they are ready to participate in upper secondary school or employment. Many of them have experienced a range of challenges and coping with daily life requires so much time and energy that they have few resources to concentrate on school subjects. There may also be issues with learning difficulties that have not been adequately dealt with and a resulting sense of failure. For some, the experience of not being seen and understood means that they have lost faith in their ability to do anything.

WHAT ARE THE RESULTS?

Yearly follow-up surveys show that within a year after participating in the programme, between 75 and 85 percent of the young participants are in upper secondary education or employed, while more than 90 percent are involved in some form of positive activity that also includes volunteering.

A socioeconomic analysis conducted by the international certification and classification body DNV in the period 2013–2017 found that for each Norwegian Kroner (NOK) that goes into YouthInvest AIB, Norwegian society receives the equivalent of four NOK in terms of what it would cost to support people who drop out of school (179). The analysis also showed a significant development in social and psychological capital among the young people who have participated in YouthInvest AIB, building resources for confronting future life challenges.

Young Invest is increasingly identified as a promising and enabling context for young NEETs and is currently under implementation in several counties, while others are considering its introduction. Today there are seven departments of YouthInvest schools in Norway.

An analysis of the literature indicates that psychosocial problems dominate among NEETS (180,181). Fundamental to this are experiences of lack of belonging and support in important relationships. They describe different variations of broken or missing relationships, which take the form of neglect, problematic family backgrounds, broken contact with parents, bullying at school, feelings of being an outsider and loneliness (182–185). Many also report a negative spiral of low self-esteem and feelings of a lack of mastery (186,187). Furthermore, some of the youth describe feelings of inadequate follow-up by school or the welfare services and that this can contribute to accelerating the process towards dropout and exclusion (180,182).

A scoping literature review by Fyhn et al. (2021) summarises 147 publications of studies on NEETS in Norway (peer-reviewed articles and grey literature) from 1990–2021. According to the authors, the most significant finding in the scoping literature review was the prominence of relational challenges among young

NEETs, and how broken or weak relationships and feelings of lack of belonging appear to play a role in shaping many of the more objectively measured risk factors for being out of school/work such as school grades and criminal convictions. The review found that having relational and emotional support from significant others, including professionals with high levels of relational competences, were identified as key protective factors and vital for successful re-entry to education, training or work (140).

The following case study shows a new tool aimed at helping municipalities prioritise and improve intersectoral work when doing preventative work to support children and youth in vulnerable situations.

CASE STUDY: ACCOUNTING FOR SOCIAL EXCLUSION ('UTENFOR-REGNSKAPET')

The Norwegian Association of Local and Regional Authorities (KS) has developed a measure to account for social exclusion (or *Utenfor-regnskapet* in Norwegian), purposed to show how investing in vulnerable children and youth will pay off in the long run. *Utenfor-regnskapet* is a budget/economic model which shows how costs linked to social exclusion are dispersed across sectors and administrative areas. The tool shows the economic potential of preventive measures and how much an investment can pay off in the long-term.

In the model, consumption of welfare services is linked to public expenditure and income over the life course. People in the target groups are compared to the average population. The calculations show that people in the target groups use more public services and receive more in transfers throughout their lives, compared to the average population. By focusing on investment, the aim is not to identify vulnerable groups in the population, costs, or public expenditures, but to provide children and young people in vulnerable situations the help they need to have a healthy future.

The model leads to strengthening partnerships to provide more seamless and comprehensive services to citizens. Although there have been positive developments, both the state and the municipalities are still characterised by division between sectors, which makes it challenging to build bridges between silos and to collaborate to provide comprehensive services.

The *Utenfor-regnskapet* model makes it possible for the municipalities and counties to prioritise in new ways and to make decisions locally. This makes it easier to develop cross-sector budgets and workforces within the municipal organisation.

However, municipalities' use of *Utenfor-regnskapet* has shown that it can still be challenging to prioritise extra investments in preventive measures. The financial framework is being tightened, and more statutory tasks are being incorporated. A great challenge is the fact that gains from investments almost never return to the department which makes the investment.

Utenfor-regnskapet was launched in the spring of 2019 and is being used by several municipalities, social entrepreneurs, non-profit organisations and government enterprises. KS is now considering the possibilities for extending the model to reach groups between the age of 18 and 29.

RECOMMENDATIONS

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.

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 – is 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 (188). Participation in, or exclusion from, the labour market determines a wide range of life chances.

These are mediated through income from employment and people's social status and social identity (189). 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 (190). 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 (191,192). 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'.

Being unemployed, particularly in the long-term, has long-lasting negative effects on health and wellbeing, increases mortality and is a significant driver of inequalities in physical and mental health (1,193). While unemployment is particularly damaging for health, poor quality and stressful work also undermines health. UCL-IHE outlined the protective health impacts of being in a good quality job and feeling valued in the 2010 *Marmot Review, the 10 Years On report of 2020 and The Business of Health Equity* (1,194,195).

While good quality work is beneficial to the health of employees, its effects are also positive for both employers and the state. It increases productivity and retention while reducing costs associated with work-related sickness and disability, including recruitment and training of substitute staff. Good quality work and a healthier workforce can make significant contributions to better health and wellbeing and to the reduction of health inequalities, as well as producing greater productivity and economic development.

In addition, good quality work affords employees an opportunity to matter, to feel valued, and to add value. Workers feel that they matter when they are recognised for their efforts and when they can make a significant contribution to the team or the products or services they provide (40). In fact, a sense of mattering has been related to improved job satisfaction (196), reduced burnout (197) and overall wellbeing (198). On the other hand, exclusion and lack of fairness in the workplace lead to fatigue, anxiety, tension, devaluation, irritation, and psychological distress (199).

The period covered by employment often covers the years when people are raising families, and as such is

a particularly important period for the transmission of inequities to the next generation. The following aims should be a priority in policies regarding employment (194): improving access to good jobs; reducing long-term unemployment across the social gradient; making it easier for people who are disadvantaged in the labour market to obtain and keep work; and improving the quality of jobs across the social gradient.

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 (200). Key to sustaining these Nordic models has been providing full-time, permanent jobs for a majority of the labour force (201). However, there are inequalities in labour market participation set out below with related impacts on health and health inequalities. Women with low education and those with disabilities are particularly affected.

Robust social dialogue and tripartite cooperation between the state and the social partners across the political spectrum have been two of the main characteristics of the Nordic labour market model (202). This has been possible due to strong trade unions and multi-employers' organisations with minimum facilitation by the state (203). Collective agreements are key in regulating many aspects of the employment relationship, including wage formation. In addition to this, key aspects of working life are regulated by the Working Environment Act, which aims to secure 'a healthy and meaningful working situation, sound conditions of employment and equality of treatment for all workers,' as well as to facilitate a 'satisfactory climate for expression,' 'cooperation between employer and employees' and 'inclusive working conditions'.

However, unionisation rates have declined in Norway over time. As shown by Kjellberg and Nergaard (2022), after reaching 57 percent in 1990, unionisation dropped afterwards, with 51 percent of employees unionised in 2020 (204). The decline in unionisation is significant for working conditions as well as feelings of cohesion and solidarity among workers, all of which affect health.

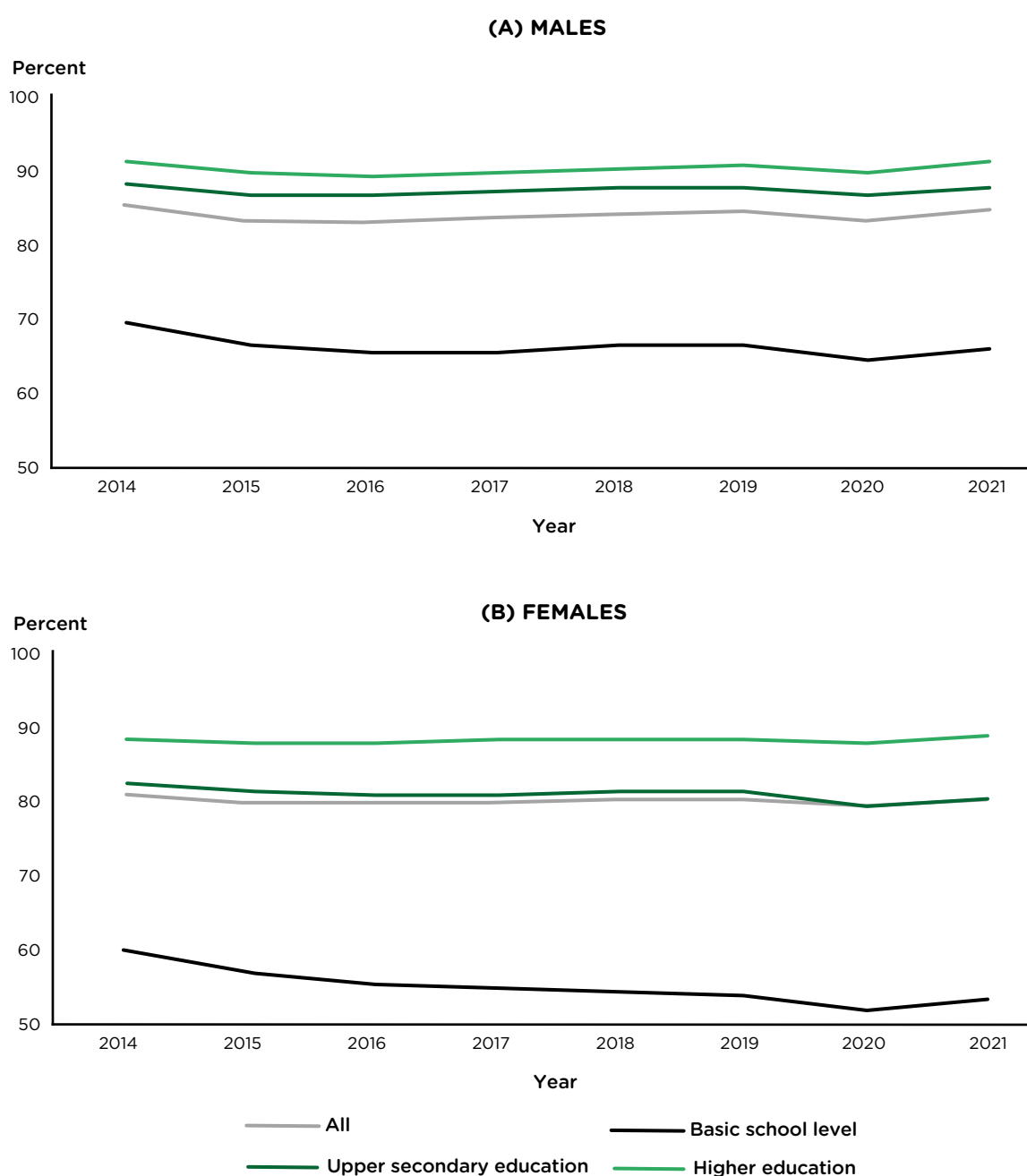
EMPLOYMENT RATES

Reflecting the importance of high levels of employment and labour market participation in the Nordic model, employment rates in Norway are high in comparison with most other OECD countries (205). According to Labour Force Survey data, 78.5 percent of the population between 20-66 years of age were in employment in 2021, with a higher rate for men than women (81 and 75.9 percent, respectively) (SBB Table 08930) (26).

In the period 2008-2017 there was a decline in employment rates among people aged 20-64, although employment started to increase again after that until the impact of the COVID-19 pandemic (206). Part of the development in employment patterns in the last two decades is related to demographic changes, such as the increase in older population and immigration. Historically, these two groups (the elderly and immigrants) have had lower employment rates than the rest (206). The employment rate of people aged 55-64 has risen noticeably (26). According to research by Elstad and Heggebø, the proportion of workers with long-term stable attachment to the labour market also increased between 1993-1999 and 2009-2015, from 51 to 58 percent (207).

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 who have not completed secondary education, lowering their employment rates because of high demand for skills and more competition for jobs (82). This is evident from the trends in employment rates at core working ages (30 to 54). There is a clear gradient in employment rates by educational level that has widened over time - with markedly lower levels for those with basic education, especially among women - Figure 3.14. The reduced employment rates in 2020, shown in this figure, are discussed in the chapter on COVID-19.

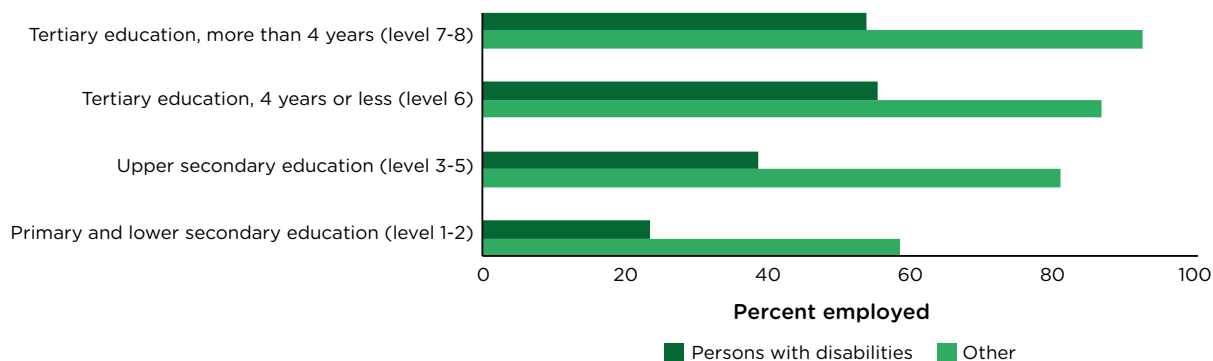
Figure 3.14 Employment rates at ages 30 to 54 by educational level and sex, 2014-2021



Source: SSB table 12425 (26)

Figure 3.15 shows how employment rates of people with disabilities are markedly lower than others at each level of education.

Figure 3.15 Percent aged 15 to 66 employed by education level and whether or not with a disability, 2021



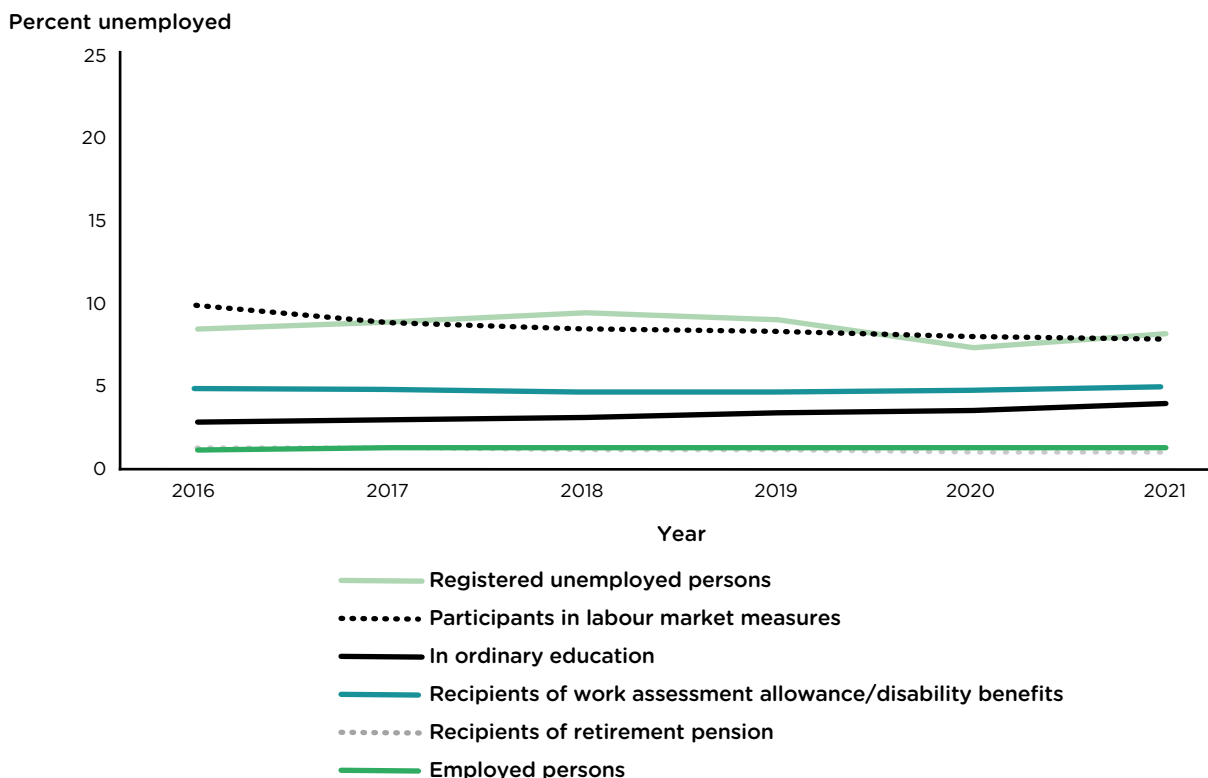
Source: SSB table 13492 (26)

UNEMPLOYMENT

Unemployment – not having a job and actively seeking work – has a negative impact on health. There are several mechanisms by which unemployment can be harmful for health including the direct impacts of loss of social status, stress and lower financial resources as well as impacts on various types of health behaviours, such as smoking, alcohol consumption, poorer diet and reduced physical exercise (194). The financial implications of unemployment are mitigated if the social security system provides a reasonable level of replacement income – and having this safety net is beneficial to those in employment, benefitting the subjective wellbeing particularly of those with more insecure positions as well as the unemployed (208). As indicated earlier, having a job enables people to feel that they matter – unemployment, particularly when it is long-term or persistent, undermines this even if the social protection safety net is adequate.

Unemployment is very low in Norway by international standards and has remained below five percent since 2005 (205). However, persistent unemployment is a particular concern. Figure 3.16 uses data that follows up the subsequent employment status of people in 2012. It shows that among those who were unemployed in 2012, subsequent unemployment rates varied from seven to nine percent between 2016 and 2021. Similarly, among those participating in labour market measures in 2012, unemployment was close to ten percent in 2016 decreasing to just below eight percent by 2021. These levels are well above those of the employed. This indicates that although cross-sectional unemployment rates are low in Norway, unemployment figures include a substantial number of people who experience persistent or long-term unemployment, the consequences of which are described above – financial, adverse health behaviours, poorer health and wellbeing, a lower sense of self-esteem and mattering.

Figure 3.16 Percent of the economically active in 2012 who were unemployed in 2016-21, by economic status in 2012



Source: SSB table 12427 (26)

Most of those who are unemployed will recently have been in employment and therefore, at this early stage, their health would be as good as that of the employed, but is likely to deteriorate over time (209). There are noticeable negative health consequences related to unemployment including deteriorating mental health (210,211), poorer somatic health (212,213), and higher excess mortality among unemployed individuals (209,214,215). Once health problems manifest, some will continue to seek work, but others become economically inactive for two reasons. First, people with poor health have a lower likelihood of gaining employment, due to e.g., hiring discrimination and employer skepticism over issues such as sickness absence and expected productivity level (216-218). Second, people with poor (and/or deteriorating) health status that have gained employment are more likely to lose their job (219,220). This is in part because of last-in-first-out seniority rules that prevail in many labour market segments.

As indicated, the availability of unemployment benefits can counter many of the negative and undesirable consequences of unemployment - if levels of benefits are sufficient (221). Income support provided to unemployed individuals will both limit financial hardship and ease some of the psychosocial and mental stress associated with the uncertain labour market and financial situation. Thus, unemployment benefits can shield unemployed people from (health-damaging)

poverty and ease the transition back into employment. On the other hand, it can be argued that the availability of unemployment benefits could also be a 'welfare trap' in the comparatively generous Norwegian context, leading to high and persisting benefit recipiency. This does, however, not seem to be the case as the unemployment rates have been low in Norway since the turn of the century, at around two to four percent, with the exception of the COVID-19 pandemic, when it rose above these levels for several months (222).

The main eligibility criterion for unemployment benefits is related to previous income earned on the labour market. More specifically, the requirement stipulates that the claimant must have earned more than 1.5 times the Base Amount (BA) during the preceding 12 months. BA is a sum of money used in the Norwegian welfare system, which is adjusted yearly by Parliament to take increasing costs of living into account. As of May 2022, one BA is 111,477 Norwegian Kroner (NOK). The income threshold of 1.5 BA corresponds to roughly half the average wage of a full-time, year-round employee in one of the lowest-paying occupations in Norway. For this reason, the income threshold is low for those who hold full-time employment all year but is too high for many part-time and seasonal employees and they are unlikely to reach the threshold for unemployment benefits. Importantly, it is only work income that counts, whereas business income, which self-employed

and freelancers tend to earn, does not qualify for unemployment benefits. Further discussion on social protection measures is in Section 3d.

The replacement rate for unemployment benefits is 62.4 percent of previous earnings, with an income ceiling of six times the BA amount. Thus, the maximum amount that an unemployed person can receive yearly (if he/she used to earn more than roughly 670,000 NOK) is less than 420,000 NOK. The maximum period for benefit receipt is 24 months. However, for benefit recipients who have earned less than 2 BA yearly, the maximum period is much shorter: one year.

As indicated, by ensuring a high replacement rate, the Norwegian unemployment insurance system is supportive of good health – particularly for mitigating socioeconomic inequalities in health by providing a safety net for the employed at risk of unemployment and, for those who do become unemployed, by limiting poverty and material deprivation and minimising some of the discomfort associated with unemployment. However, many people out of work in Norway are not entitled to unemployment benefits due to the eligibility criteria and this significantly weakens its protective effects on health and health equity

In fact, roughly half of all registered unemployed people in Norway are not entitled to benefits, according to official numbers from the Norwegian Welfare and Labor Administration (223). Furthermore, it is likely that the majority of those who do not register as unemployed at their local employment office are not covered by the unemployment benefit scheme either, although uncertainties remain (some people may e.g., choose to not register as unemployed because they know/expect to get re-hired very soon or, conversely, they leave the labour market due to ill-health). Thus, there are obvious gaps in the existing unemployment insurance system which affect health and the social determinants of health more broadly.

WEAK LABOUR MARKET ATTACHMENT AND INACTIVITY

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.

In 2019, there were approximately 620,000 people aged 18–66 who were out of work or not in education, around 18 percent of the total population in this age group, according to figures from Statistics Norway (206). Recent analysis by Fevang et al indicates that this group is increasingly comprised of people who have either never worked or been out of the labour

market for a long period of time (224). According to the 2019 Labour Force Survey, up to 15 percent of people who are out of the labour force would like to work, but they report being faced with various barriers that make inclusion difficult (206).

In 2019, nearly 44 percent of those who were neither working nor fully registered as unemployed received a health-related benefit (206), with an increase in those with a reduced capacity to work since the 1990s. While the overall proportion has been more stable since 2004, it has continued to increase among the youngest Norwegian-born cohorts (224). As NAV data indicates, the proportion of young people aged 18-29 receiving disability benefits is at a historically high level in Norway, having reached 2.6 percent of young people in June 2022, an increase of 1.3 percentage points since 2013 (226). This growth is largely due to medical advances, which have allowed a greater proportion of people with serious mental disorders and developmental disabilities to reach the age of 18, when they start being entitled to receive disability benefits (227).

In an analysis performed by Statistics Norway with register information, of the group aged 18-54 who were in work, education, or work-oriented measures from NAV in 2015 but ceased participating in these activities in 2016, more than half returned to one of these activities after a further year. Of these, 41 percent obtained employment while the rest entered education or activation measures (228). However, after more than one year of inactivity, the rate of people returning to work, education or work-related measures increased at a much slower pace, highlighting that once someone ceases these activities, it is difficult to return to them the longer the period of inactivity lasts. Additionally, 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 (228).

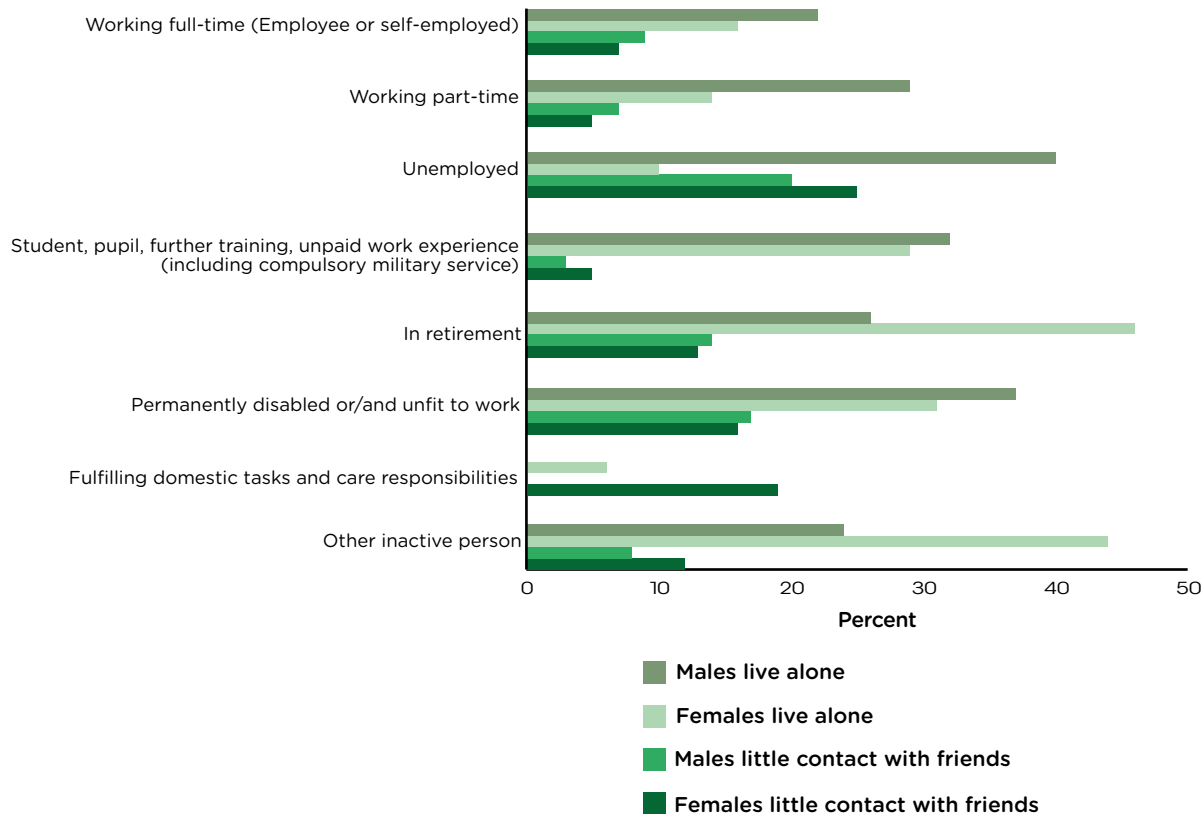
LABOUR MARKET ATTACHMENT

Long-term inactivity and low labour market attachment can have strong impacts financially, increasing the risk of falling into poverty and exacerbating other challenges. In a report analysing the situation of individuals facing major employment difficulties, defined as those being persistently out of work (long-term unemployed or inactive) or having low labour market attachment (having unstable jobs, working restricted hours or having near-zero earnings), the OECD found that, in Norway in 2017 they had on average a 30 percent lower disposable household income and an almost five-times higher risk of poverty or social exclusion than those who do not experience major employment difficulties (229). They identified two main factors acting as employment barriers for people who are persistently out of work or have low labour market attachment in Norway: health limitations and low education (229).

Economic inactivity or weak labour market attachment can also exclude individuals from fully participating in other areas of society. Figure 3.17 shows that two key indicators of lack of social contact – living alone and having little contact with friends – vary markedly by economic status. Among both sexes, those who

are unemployed are least likely to have contact with friends. Among females, living alone is associated with age (a student or retired) but economic inactivity and disability are also important. Among males, unemployment and disability are particularly highly associated with living alone.

Figure 3.17 Percent lacking social contact by type of social contact, economic status and sex, 2019



Source: SSB table 10204 (26)

In the White Paper *No one left out a comprehensive policy to include more people in working life and society* (2020-2021), the Government identified six areas in need of strengthened action to prevent social exclusion and include more people in working life and society. These include: i) work-oriented income security and instruments for easier entry into working life; ii) improved preventative social work, social services and social inclusion; iii) more comprehensive and individually adapted services in the Labour and Welfare Administration (NAV); and iv) more innovation in NAV's services and measures (206). The document relies on the recommendations of the Commission of Employment (*Syssettingsutvalget*), which were disputed in some academic and political circles in Norway. While it discusses the need for better coordination, it is not clear how this would be translated into concrete measures.

A general orientation towards viewing welfare support measures as a disincentive to work can be seen, for example, in the assertion that reducing the level of benefits will lead to some people getting into work more quickly and a reduction in the use of income protection schemes. The Commission on Employment contended that 'a key element in a strategy for higher employment is a more work-oriented social security system in which fewer people are passive benefit recipients (Official Norwegian Report NOU 2019:7 'Work and income security. Measures for increased employment') (230).

This follows the principle of what is known in Norway as *Arbeidslinjen*, or 'work approach', which subordinates welfare schemes to the overarching goal of 'welfare to work' that focuses on providing incentives to work. Although the pre-eminence of work was not new to

Norway's system, the introduction of a 'duty to work' as a condition to receive benefits was introduced in the political discourse in the 1990s and it was developed in a Welfare White Paper in 1995, among others (231). The logical consequence is that benefits should not exceed the lowest paid levels in the labour market so as not to act as a disincentive. Based on this principle, there has been political reluctance to both enhance access to benefits or increase their level.

This has been disputed in the literature and remains a controversial view, with some comparative studies indicating that more generous welfare states produce labour markets which are more inclusive of people with low education and limiting longstanding illness (232) and that there is no evidence that groups with low attachment to the labour market are less motivated to work in more generous welfare states (233). From quite early on, this policy was criticised for re-orienting Norwegian society towards a less inclusive understanding of citizenship (231). In the UK, the principle of 'Fitness to Work' of sickness benefit recipients (234) led to the introduction of Work Capacity assessments. While designed to encourage those who were fit to work, analysis showed significant bias in reaching 'fit for work' assessments among claimants in poorer and less healthy areas (235,236).

HEALTH AND EMPLOYMENT

In 2020, the Norwegian parliament assigned NOK 9 billion to NAV for implementation of labour market measures. However, there is a lack of evidence about which measures and follow-up work best for people with reduced work capacity (237). The main reasons for diagnosis among those receiving work assessment allowance, disability pension or on sick leave are musculoskeletal disorders and mental illness. Since 2000, the proportion of people receiving disability benefits because of mental illness has increased,

while the group with musculoskeletal disorders has become smaller. This, according to the governmental assessments, is related to the fact that many of the younger people entering this scheme have a mental or behavioural disorder, in part due to reasons highlighted earlier related to medical progress, while those older individuals who leave the scheme have musculoskeletal disorders in greater proportions (206)

NAV estimates that 60 percent of the people with reduced work capacity need assistance to get a job or to continue in employment. A large proportion of people will need medical follow-up and rehabilitation before they can be inserted into work or participate in work measures, while others can work or take part in work measures while they receive medical treatment (238).

The principles of supported employment (SE) have been gradually integrated in NAV strategy and documents, since they were first incorporated in the 1990s through the 'work with assistance' scheme (*Arbeid med bistand*) (237). The recent initiative 'extended support' (*Utvidet oppfølging*), in which NAV's specialists provide follow-up to participants is also based on this approach. However, up-to-date Norwegian evidence on the effectiveness of SE is scarce. A Norwegian knowledge summary indicated some positive effect, but many of the studies were carried out in the USA and with small samples (239). A randomised controlled trial on supported employment (SE) for people with disabilities conducted at four NAV offices between 2013 to 2017 found a positive effect on employment rates in the intervention group between 12 and 24 months after starting the trial. However, the difference between the intervention and control groups decreased as the proportion of people in the control group who found employment increased, and three years after the start of the trial differences between both groups had evaporated (237).

THE IA AGREEMENTS

The coordination between Norway's governments and social partners to regulate and promote changes in working life originated in 2001 with the first Agreement for a More Inclusive Working Life (the IA Agreement). The IA Agreement aimed at finding effective responses to the increasing rates of people on sickness absence or disability benefits seen over the 1990s. Its goals were to reduce sickness absence by 20 percent, to increase employment of people with reduced functional ability and to achieve a six-month extension (on average) of active employment after the age of 50 (240). Of course, if goals two and three involved getting more people with pre-existing health problems into work, then this would have made it more difficult to achieve the first goal – as it is likely that these individuals would have required more time off work due to their illnesses.

Companies signing the agreement would have access to resources to prevent sick leave or to promote a faster return to work (241). Companies would also receive support from the National Insurance Administration (NIA) – today part of the NAV- inclusive workplace support centres based in all counties to follow up those who were at risk of long-term sick leave (240). The IA Agreement was renewed for three periods (2006-2009, 2010-2013 and 2014-2018). Of the three aims, only one was met in full: extending the time spent in employment by people over 50. There was no major change in the proportion of people with reduced work ability who were in employment, while sickness levels fell by 12.9 percent from 2001, instead of the intended 20 percent (242).

A new IA agreement was signed in December 2018, focusing only on sick leave, with the aim of reducing sickness levels by 10 percent by the end of 2022 from the baseline of 2018. It also aims to reduce the percentage of people who don't return to work after a period of sick leave (referred to in the agreement as 'withdrawal'). As part of the agreement, the Government commits to not proposing changes in the sick leave benefit scheme during the term of the agreement (until 2024) (243).

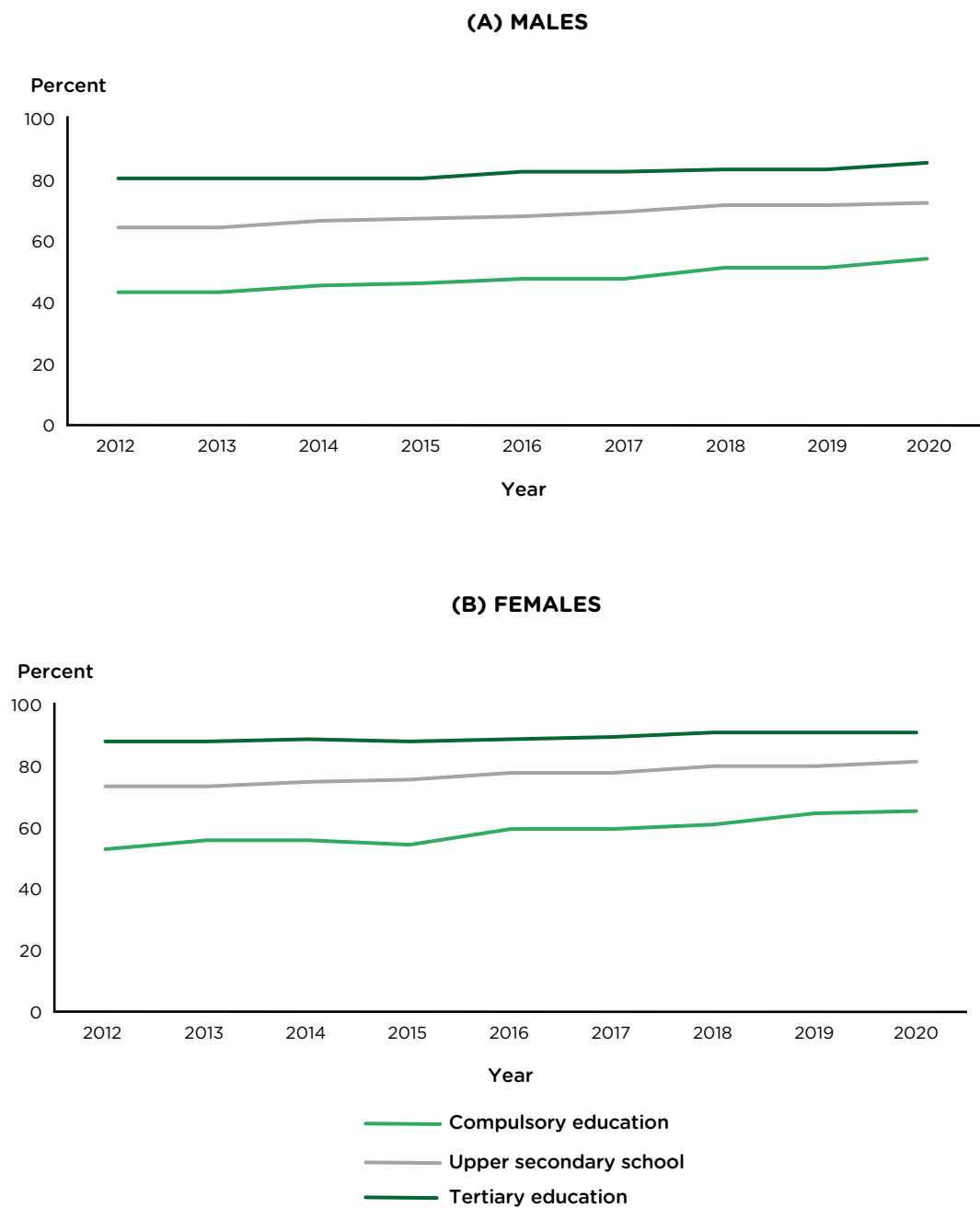
In 2012, the Government launched the 'Job strategy for people with disabilities' targeted at young people under 30 with disabilities and reduced work ability. The strategy's explicit aims were to reduce the permanent labour market exclusion of this group together with their long-term dependency on benefits. Several years later, another Government committed itself to work towards greater equality for persons with disabilities for the period 2020-2030 with a strategy that includes labour market measures, among them facilitating access to assistance and assistive aids to secure participation in employment and making it easier for employers to employ persons with disabilities 'by creating security for both employees and employers.' (238).

In a recent report published by the Fafo research foundation, Strand & Svalund recommended the introduction of a 'youth wage' to provide stable income security for young people and remove the focus on health status required by the current work assessment allowance scheme (244). Having reduced work capacity is currently the key for a young person to be assessed and granted work assessment allowance and this implies that the follow-up work performed by NAV 'is marked by focusing on the health limitations of young unemployed rather than their resources and capabilities.' The other existing programme for activation of young people, the qualification programme, is provided by the municipalities, but the number of beneficiaries is much lower (244).

EDUCATION AND EMPLOYMENT

The importance of education in providing stable employment in Norway has increased in recent years. Several studies indicate the increasingly important role of completing upper secondary education. Statistics Norway showed that in 2016 people with an education level below upper secondary were overrepresented among those who fell outside work, education or labour market activation measures (228). Also, Fevang et al outline that there are rising inequalities between those who have completed upper secondary education and those who have not, reinforcing divisions in the labour market (224). Completion rates in upper secondary education are higher among the employed than among the non-employed and this difference is affecting young men in particular, although the authors warn that compositional effects should be taken into account due to changes over time in the proportion of the population who have completed secondary school (224). Figure 3.18 shows that completion rates in upper secondary school are, to a considerable extent, dependent on the childhood circumstances of those going through the education system. Rates for those with parents who only completed compulsory education are around half of those whose parents attended tertiary education. Completion rates, and therefore subsequent employment and labour market attachment, are intergenerationally transmitted.

Figure 3.18 Completion rates of pupils in upper secondary education by parents' educational level, 2012 to 2020



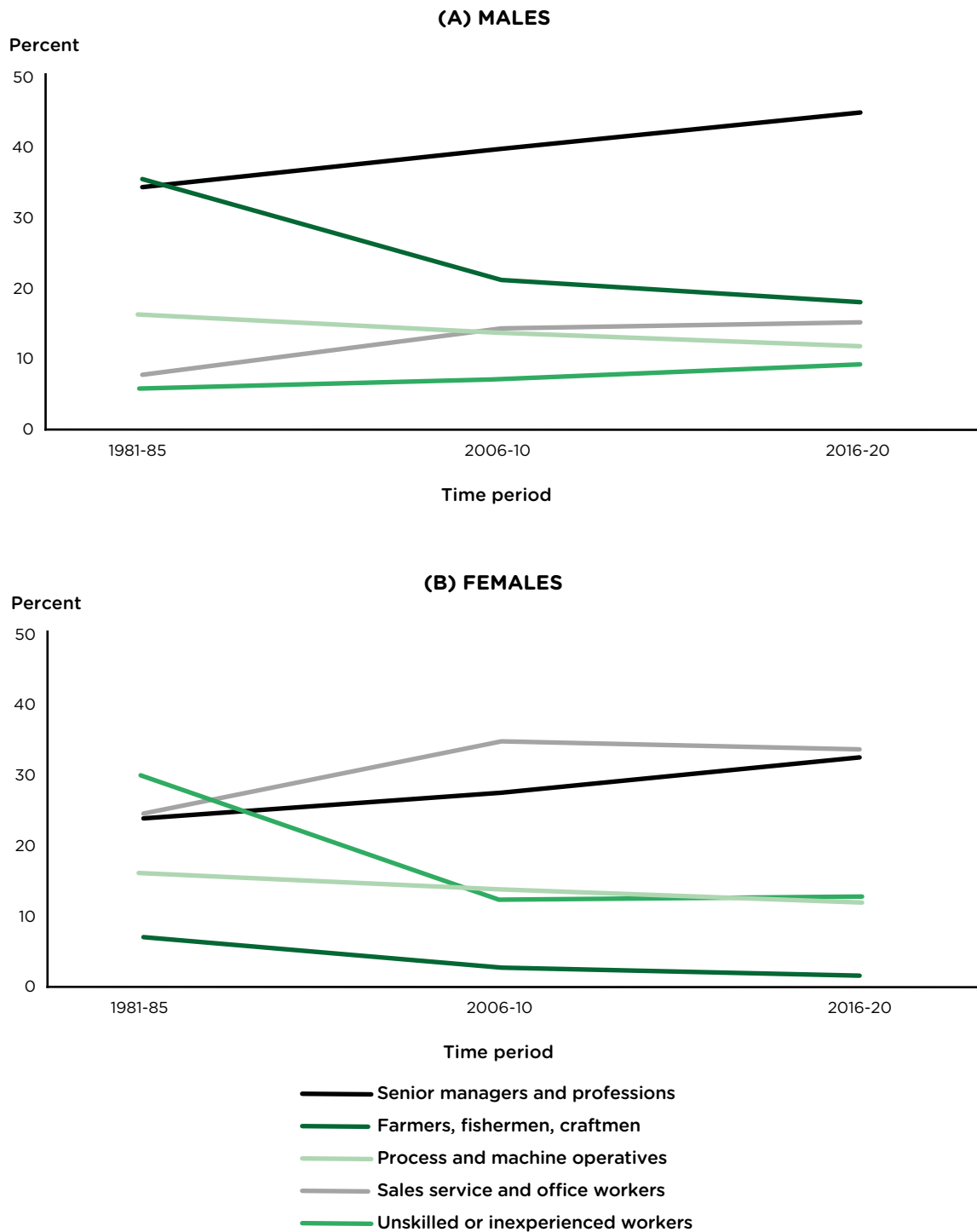
Source: NIPH database (18)

THE CHANGING LABOUR MARKET AND OCCUPATIONAL STRUCTURE

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. There have been a number of studies analysing changes in the occupational structure in Norway (Figure 3.19). The proportion of workers with an occupation who are

senior managers or professionals and those in sales, service and office work have increased since 1981-85, while the proportion involved in farming, fishing and craft occupations, as well as process or machine operatives, has decreased.

Figure 3.19 Percent of those with an occupation who were in each occupational group by sex at ages 30 to 69, 1981-85, 2006-10 and 2016-20



Source: Texmon I. (2022) (24)



Transformations in the occupational structure and changing skills requirements can result in increasing competition in the lowest segments of the labour market. This could in turn result in lower wages and worse working conditions for those in most disadvantaged positions (200). As set out in the comprehensive report *The Future of Work in the Nordic Countries. Opportunities and challenges for the Nordic working life model*, 'large-scale societal efforts to support re-skilling and upskilling appear indispensable to counter the structural pressures towards more unequal, segmented or dualised labour markets' in the Nordic countries (200). This requires policies that deliver a greater scale and intensity of effort than is currently the case in providing 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.

The Norwegian Strategy for Skills Policy 2017-2021 aimed to ensure that individuals and businesses have the necessary skills 'for a competitive business sector, an efficient public sector, and an inclusive labour market'. Education and training were the pillars of the strategy,

which was developed in partnership with the OECD and included the public sector, the social partners and the Norwegian Association for Adult Learning (164). There are no published studies evaluating the impacts of this strategy, which gave the county municipalities (*Fylkeskommune*) an important role in planning and developing the skills policy. Given that many areas which are relevant to this strategy fall outside of their jurisdiction, including educational and labour market institutions, this can limit the extent to which real measures can be implemented. This potential limitation also applies to the Skills reform (Meld St 14.), which is based on the National Strategy for Skills Policy 2017-21 and established the 'skills gap' between business' needs and labour force qualifications as one of the main challenges faced by Norway.

The Future Skills Needs Committee 2021-2027 (*Kompetansebehovsutvalget*) was tasked with providing 'the best possible evidence-based assessment of Norway's future skills needs, as a basis for national and regional planning, and for strategic decision making of both employers and individuals' (245).

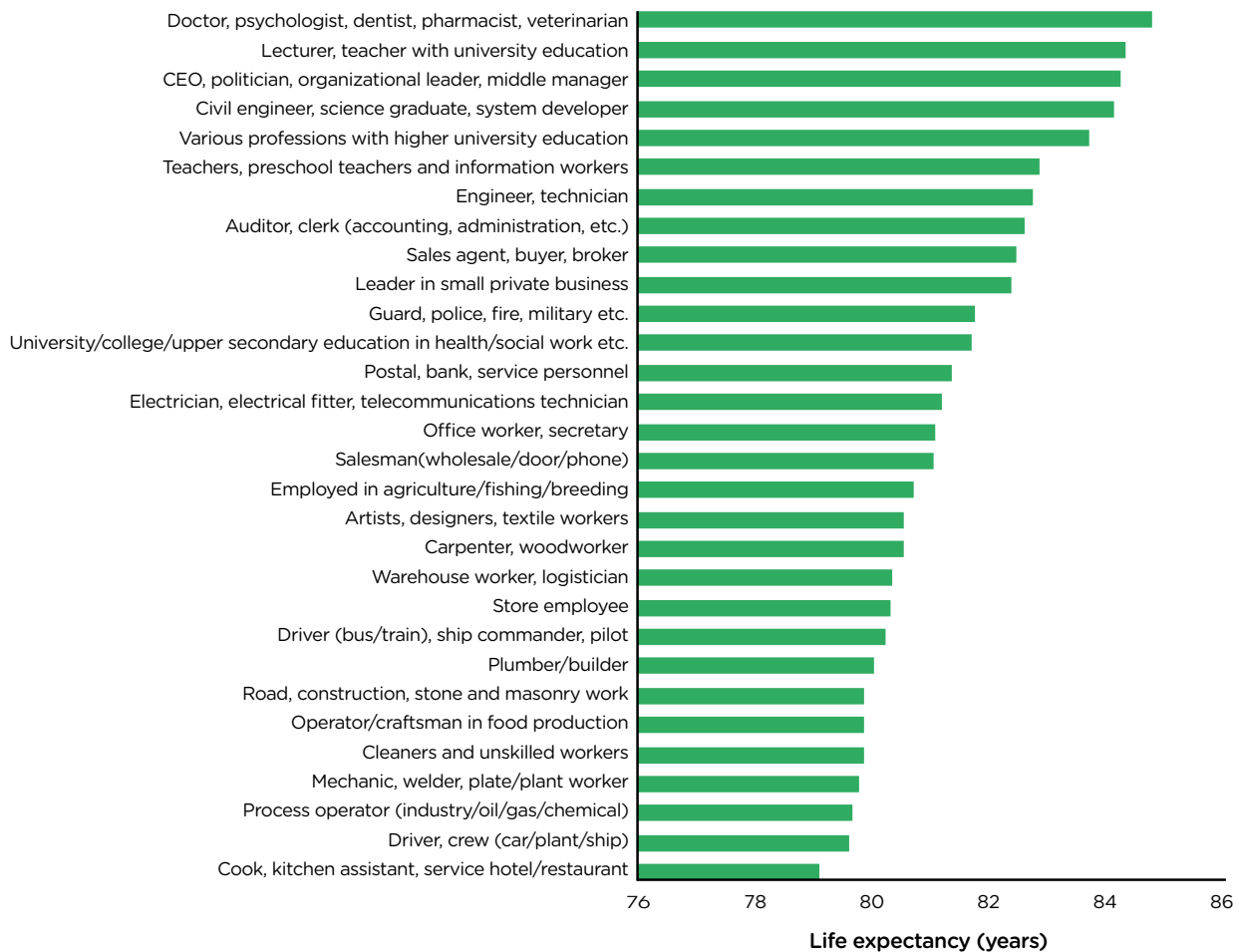
OCCUPATION AND HEALTH

Structural change, most evident in the growth of the service sector, has led to the emergence of new workplace risks. There is increased awareness of the negative impact that psychosocial risks have on workers' health and wellbeing. In Norway, musculoskeletal diagnoses are one of the main reasons behind sickness absence (246). These are often linked to stress arising from the psychosocial work environment as well as the physical and ergonomic characteristics of work.

As indicated in Chapter 2, there have been persistent differences in life expectancy by broad socio-economic groups based on occupation. Figure 3.20 shows how

these differences are evident in 2016-20 for males between the 30 largest detailed occupational groups. The longest life expectancy – 85 years – is seen in the most highly educated medical occupations, followed by academics, senior and middle managers and others mainly in occupations requiring a university education with life expectancy in excess of 83 years. Conversely, the lowest levels of life expectancy (79 years) are seen in hospitality workers such as cooks and kitchen staff. Others with life expectancy below 80 years include drivers, process operators, mechanics, cleaners, food processors and construction workers.

Figure 3.20 Male life expectancy at birth in 30 occupational groups, 2016-2020

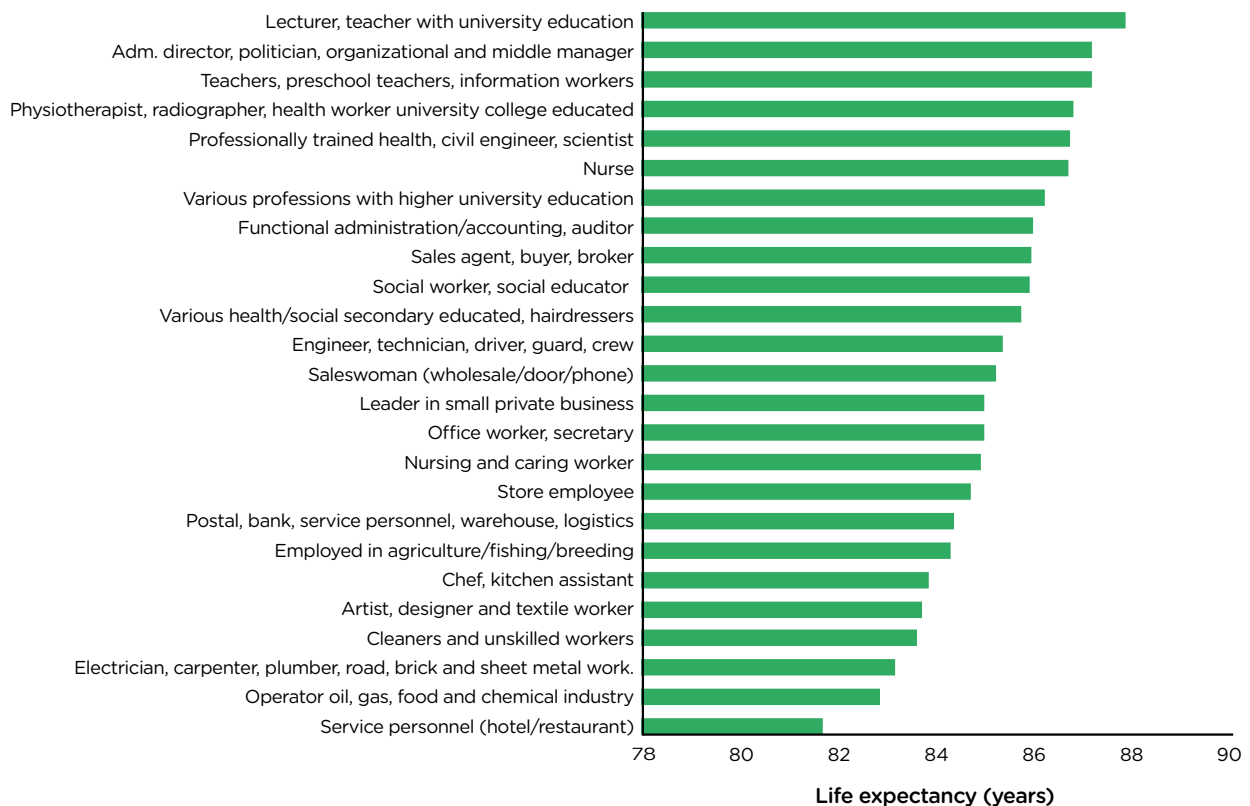


Source: *Texmon I. (2022) (24)*

Among females, 25 of the largest occupations groups are shown in Figure 3.21. The highest life expectancy, of 88 years, corresponds to academics, followed by

senior and middle managers and teachers. The lowest life expectancy is seen among hospitality service personnel at slightly below 82 years.

Figure 3.21 Female life expectancy at birth in 25 occupational groups, 2016-2020



Source: *Texmon I. (2022) (24)*

In a study of 27 countries, Toch et al. (2014) found that physical working conditions had the largest effect on self-assessed health in manual occupations, compared to psychosocial working conditions, accounting for a substantial proportion of occupational inequalities in self-reported health (247). They found that the health of women in manual occupations was generally more affected by physical and psychosocial strain than the health of men in manual occupations. It is important to ensure that best practice guidance is in place to ensure that the physical working conditions of the substantial number of Norwegian men and women involved in manual occupations is protected, for example to reduce the risk of musculoskeletal injury.

There is substantial evidence for the impact of psychosocial working conditions on long term morbidity and subsequent mortality. The most robust evidence for the main health outcomes relates to cardiovascular diseases (248) and poor mental health – mainly depression (249). Overall, risks are at least 50 percent higher for these outcomes amongst those suffering from psychosocial stress at work compared

to those who are free from stress at work. Effects are stronger in men than in women and more pronounced in middle-aged than older working populations (250).

A variety of concepts have been developed in occupational health psychology and sociology, social epidemiology, and organisational sciences that encapsulate adverse psychosocial work environments (250). However, only a few have been tested with convincing study designs such as longitudinal observational investigations of initially healthy employed populations and have addressed the social gradient in work and health. Amongst these, three models have received special attention in international research, the demand-control model, the effort-reward imbalance model and the model of organisational justice.

The *demand-control model* (251) posits that stressful experiences at work result from a distinct job task profile defined by two dimensions: the psychological demands put on the working person and the degree of control available to the person to perform the required tasks. This latter dimension is labelled ‘decision

latitude'. Jobs defined by high demands in combination with low control are stressful because they limit the individual's autonomy and sense of control whilst generating continued pressure, 'high job strain'. A third dimension, social support at work, was added to the original formulation showing the highest level of strain would be expected in jobs that are characterised by high demand, low control, and low social support at work or social isolation ('iso-strain jobs') (191).

A complementary model, *effort-reward imbalance*, is concerned with stressful features of the work contract (192,193). This model builds on the notion of social reciprocity, which lies at the core of the work contract. This defines distinct obligations or tasks to be performed in exchange with adequate rewards. These rewards include money, esteem and career opportunities (promotion, job security). 'High cost-low gain' conditions at work occur frequently if employed people have no alternative choice in the labour market. This is often the case amongst those with low socio-economic position or low level of skills, amongst elderly workers and, more generally, in a highly competitive labour market.

The concept of *organisational justice* has also been linked to health outcomes in epidemiological studies. It distinguishes between three components of justice at the organisational level: distributive (the perceived fairness of the distribution of valued resources), procedural (perceived fairness of processes used to decide on relevant matters) and interactional justice (perceived fairness of being treated in organisations, e.g. from superiors and colleagues) (252,253). The main effects of each of these components on health are postulated, such that higher injustice goes along with higher risk of disease.

Several specific cardiovascular risk factors have been associated with job strain and effort-reward imbalance, in particular metabolic syndrome (254), type II diabetes (255), hypertension (256), elevated fibrinogen (257,258), atherogenic lipids (256), obesity, health-adverse behaviours (193,254,259) and markers of dysregulated autonomic nervous and endocrine system activity (254,260,261,258). Other health outcomes significantly related to job strain, effort-reward imbalance, or organisational injustice are physical and mental functioning (262), musculoskeletal disorders (261,263–266), sickness absence and receipt of disability pension (266,267).

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) has developed a multidimensional concept of job quality that includes seven dimensions 'measured at the level of the job, including observable job features' (268). Several of these capture aspects of the psychosocial and physical work environments and therefore are related to health and wellbeing. The dimensions and the indicators in each dimension are the following:

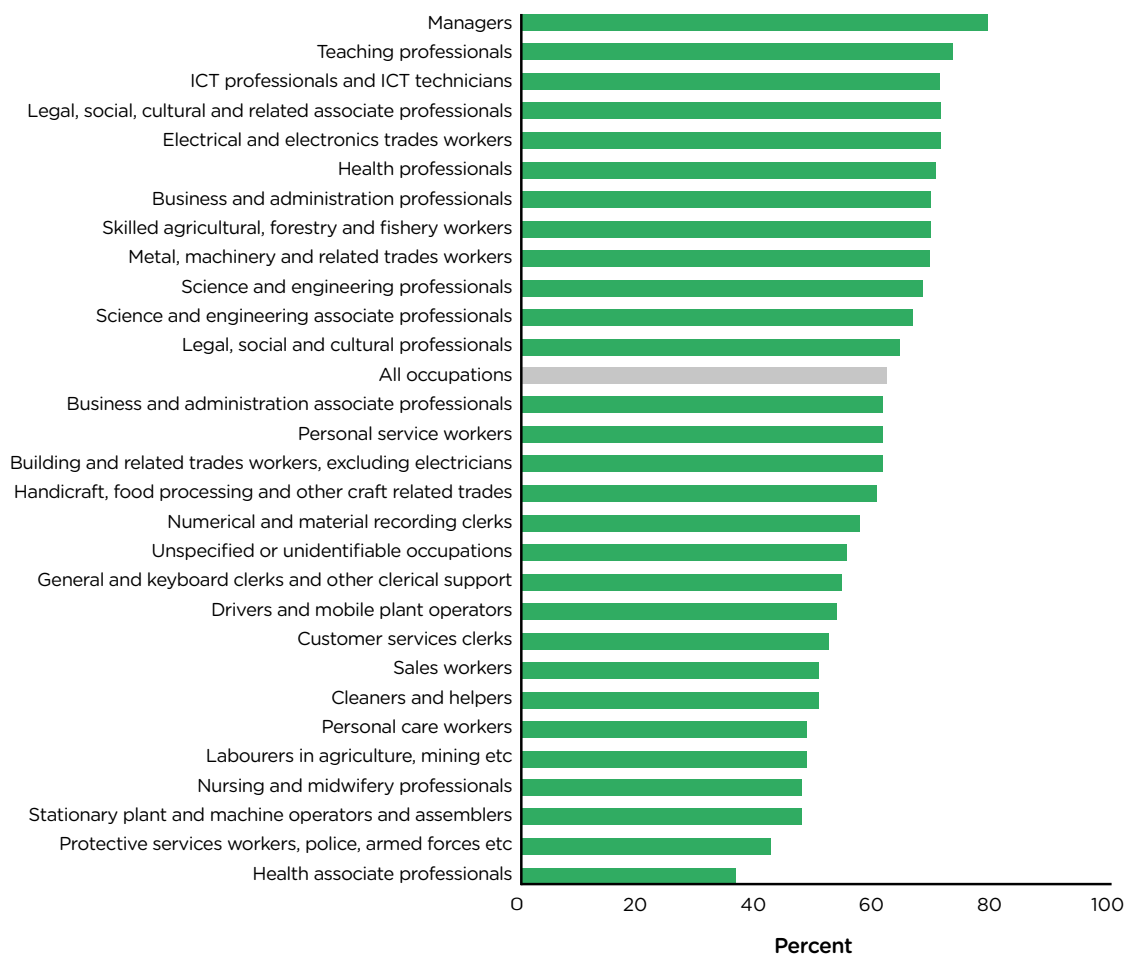
1. Physical environment: posture-related (ergonomic); ambient (vibration, noise, temperature); biological and chemical.
2. Work intensity: quantitative demands; pace determinants and interdependency; emotional demands.
3. Working time quality: duration; atypical working time; working time arrangements; flexibility.
4. Social environment: adverse social behaviour; social support; management quality.
5. Skills and discretion: cognitive dimension; decision latitude; organisational participation; training.
6. Prospects: employment status; career prospects; job security; downsizing
7. Earnings.

Despite the contribution of working conditions to inequalities in mortality between the broad occupational categories (shown in Figures 3.20 and 3.21) and classes (as discussed in Chapter 2), average scores in Norway on Eurofound's indices are generally high in comparison to comparable European countries. Norway ranks first among all the participating countries in Eurofound's skills and discretion index, based on the findings on the sixth European Working Conditions Survey (EWCS): 2015 (269). In particular, the proportion of Norwegian workers asserting that their work involves learning new things is very high (89 percent) and similar to the other Nordic countries. Also, a large proportion of Norwegian workers reported being able to choose or change the order of tasks they perform (82 percent), similar to the percent in Finland (84) and Denmark (85) and higher than in Sweden (77 percent) (270). Norway also ranks high on the prospects index – which measures jobs security as well as the prospect of career advancement, and is among the countries where fewer workers are usually required to work long hours (ten percent), whereas the EU average is 15 percent (269).

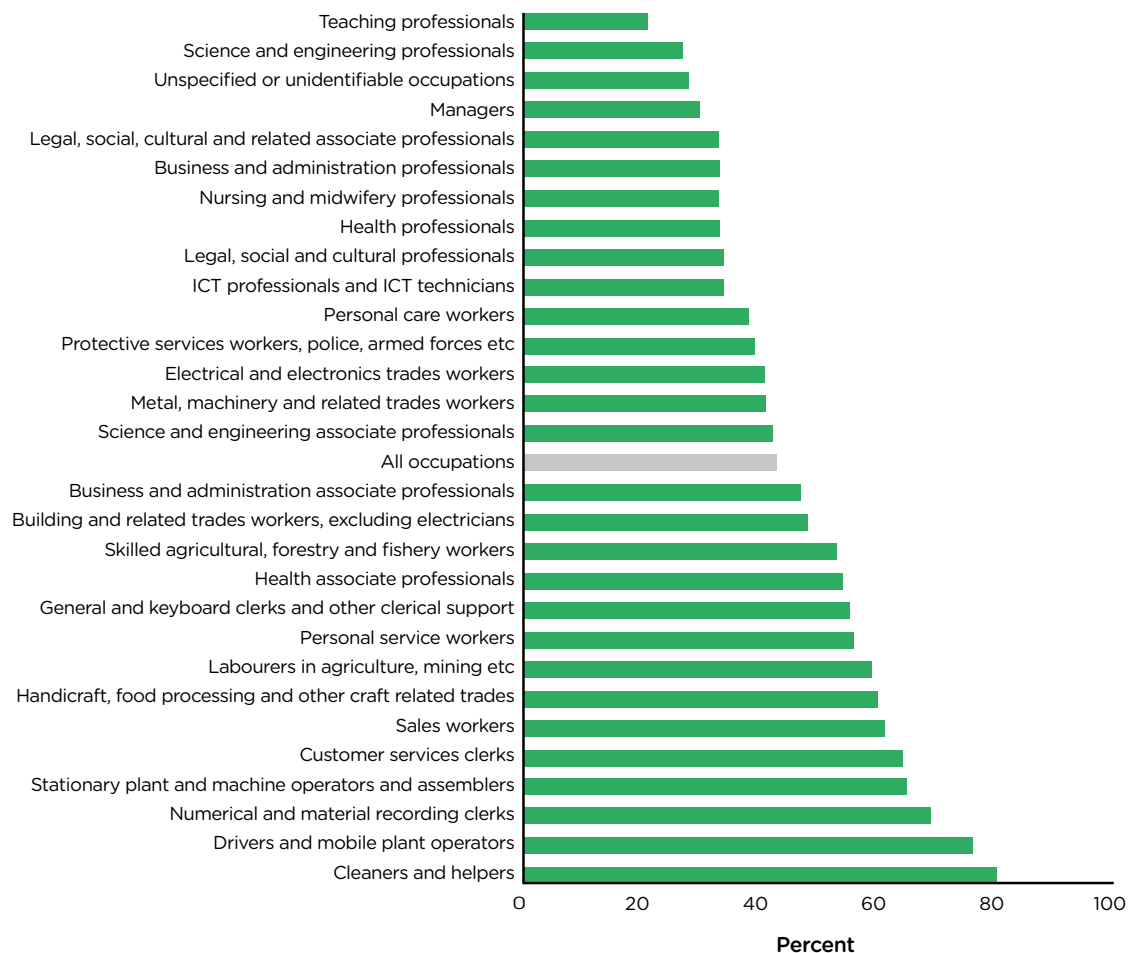
These good results are, however, an average across all occupations in Norway. From 2011, the regular living conditions survey by Statistics Norway includes a survey of working environments that is carried out every three years, in addition to the annual Survey of Living Conditions (EU-SILC). The survey covers physical, ergonomic and psychosocial work environments, as well as work related health problems and absence from work. The latest survey, 2019, shows that, like the other 11 countries in the first wave of SHARE, the nature of work and work conditions vary substantially and systematically between occupational groups. There are two questions in the survey showing a broadly similar gradient by occupation to that seen in the mortality graphs – Figures 3.20 and 3.21. These relate to decisions on how to carry out work tasks and the extent of repetitive work tasks. Both factors contribute to the amount of control a worker has over the demands of the job and therefore stress levels – Figure 3.22.

Figure 3.22: Job demands, control, role conflict and expectations in the job, by occupational group, 2019

(A) PERCENT WHO CAN DECIDE HOW TO CARRY OUT WORK TASKS, TO A GREAT EXTENT



(B) PERCENT REPORTING THAT THEY DO REPETITIVE WORK TASKS MOST OF THE TIME



Source: SSB Table 10481 (26)

The Working Environment Act mandates Norwegian enterprises to have an occupational health service that promotes a healthy working environment. In Norway, data from the 2015 EWCS indicates that 88 percent of workers are covered by a health and safety delegate and committee, which is the highest share among all European participating countries (270).

In many aspects of working life, the Norwegian model has been able to provide many workers with a work environment that provides the conditions for health and wellbeing, particularly in relation to psychosocial factors compared to that in other European countries (271). However, as in other European countries, there are substantial inequalities in work conditions that contribute to work-related stress and hence long-term health consequences.

LOW PAID WORK

The Fafo Research Foundation has produced several in-depth studies on low-paid workers in Norway with important insights on which groups are more affected and which factors can protect workers from being low-paid. Using two alternative definitions of low-pay: 1) pay that is at or below 85 percent of the average annual industrial worker wages (TBU85), or 2) pay that is at or below two thirds of the median hourly wage of all wage earners in the relevant year – and salary data from Statistics Norway, a report found that between 2015-2019 women and those born outside Norway were overrepresented among the permanently low-paid, requiring having been low-paid for at least three of the last five years (272). Having high levels of education was a significant protective factor, with workers with a bachelor's degree or higher being underrepresented among the low-paid, the opposite being true for those with only primary or lower secondary education. The permanently low-paid were also more likely to lose their earnings when the pandemic hit Norway in 2020 (272).

In another report, Jordfald et al found that low-paid workers – at or below TBU85 – amounted to 25 percent of wage earners in 2018. They represented 29.9 percent of all workers in the private sector, while they are only 7.2 percent among state employees. In the public municipal sector they amounted to 21.6 percent of the total (273).

In Norway, some sectors are under generally applicable collective agreements, that is agreements on pay and working conditions that apply to everyone who works in that sector. This was especially important after the EU enlargements to the east in 2004 and 2007, as a way of limiting the effect that more immigrant workers could have in pushing down wages (273). These agreements are in place in the following sectors: construction; maritime construction; agriculture and horticulture; cleaning workers; fish processing; electricians; freight transport by road; passenger transport by tour bus; and hotels, restaurants, and catering. (274). There are no official figures on collective agreement coverage in Norway, but estimates put it at between 63 and 71 percent, depending on whether they do or do not include those covered through the extension mechanism (275).

According to the same study by Jordfald et al, being covered by a collective agreement is key to protecting workers from being low-paid. In 2008, 46 percent of low-paid workers had jobs in a company with a collective agreement, while in 2018 this proportion was 28 percent (273). In private 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. In 2018, 40 percent

of jobs in companies without collective agreement were low-paid, while in those with a collective agreement the proportion was 23 percent.

Collective agreement coverage seems to have been especially protective for those who are vulnerable, such as young workers and immigrant workers (273). Despite this, foreign-born workers are more affected by low-pay. Among immigrants, the highest proportion of low paid workers was found among those from eastern Europe, especially those with a D-number (temporary identification number for people without a Norwegian social security number). In the latter group, 60 percent had wages that were below TBU85 (273).

NON-STANDARD WORK

Non-standard work, also called atypical work, is a broad term which refers to different employment arrangements that deviate from the standard arrangement of continuous, full-time work with indefinite contracts and a direct relation between employer and employee (276). It includes fixed term contracts, temporary agency work, solo self-employment and part-time work (201). Zero-hour contracts are also a form of non-standard employment, but they were banned in Norway in 2019 (271).

Non-standard work is often used as a measure of precarious employment, even though not all non-standard work is precarious (277). Precarious employment usually involves a combination of features, including employment instability, low wages, lack of rights and social protection and low control over working times, incapacity to exercise rights and absence of collective bargaining, among others (278). A temporary experience of low wages or instability when first entering the labour market can be a stepping stone towards more stable work, but if persistent it has been associated with health problems, including 'mental and physical illnesses, occupation-specific afflictions, harmful life-style behaviours and social disadvantage' (279).

TEMPORARY EMPLOYMENT

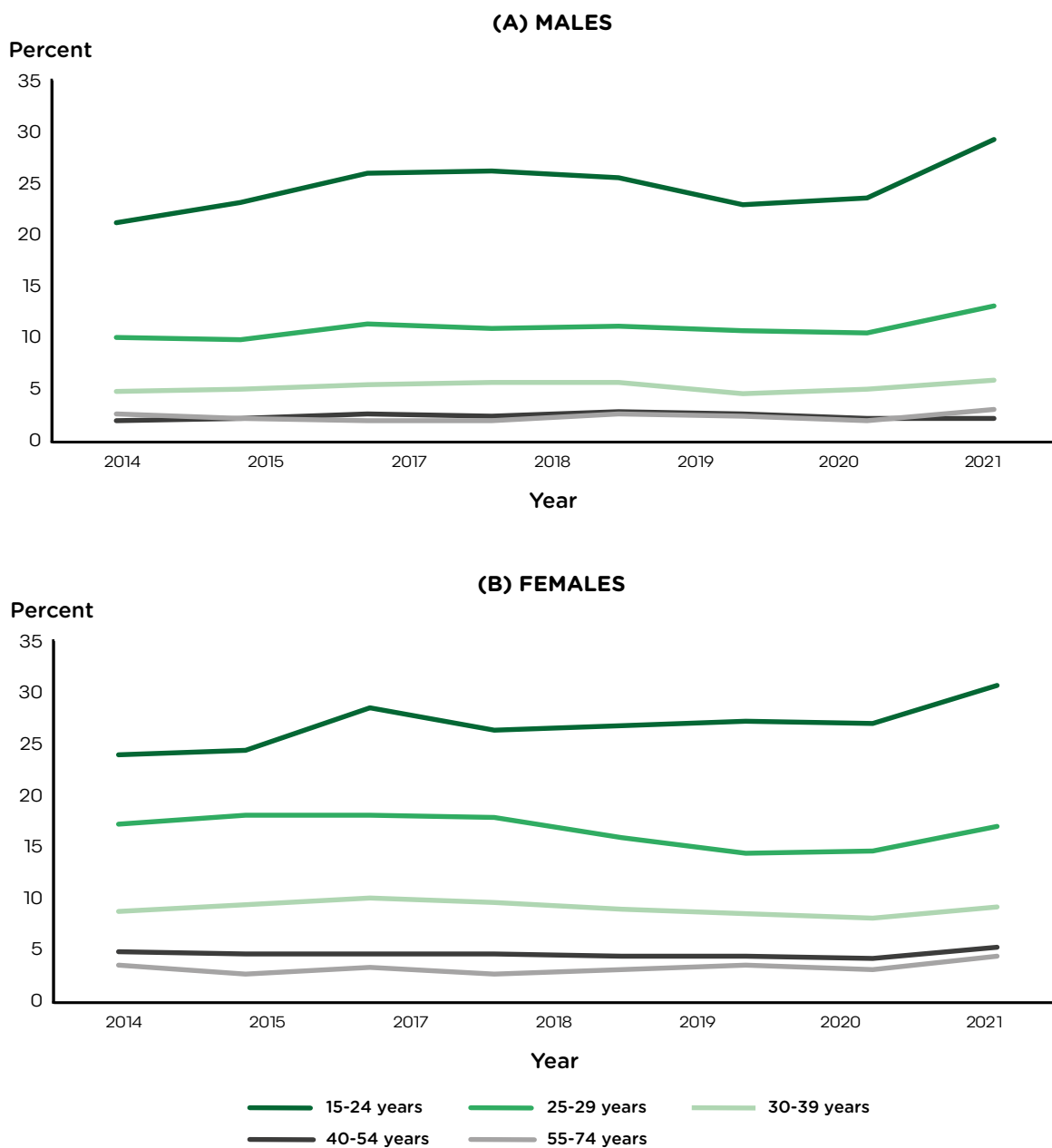
In general, evidence from the 2015 EWCS shows that temporary employees have less favourable working conditions in many areas that are relevant for job quality. They have lower levels of job security and worse prospects for advancing their career, while they are also disadvantaged compared with permanent employees regarding the working time dimension. When controlling for possible confounding factors, being in temporary employment, in particular if it is short-term, is still negatively associated with working time quality, prospects for advancing one's career and the possibility of using skills and discretion at work (280).

In 2015, the Norwegian Government allowed companies to hire workers on fixed-term contracts without restrictions, providing they did so for a maximum period of 12 months and at a level of no more than 15 percent of their workforce (281). This change in the Working Environment Act, which was controversial and raised concerns about its potential to increase low quality employment, seems to have had a modest impact in the use of temporary work overall. While the proportion of temporary employees aged 15-74 as a proportion of all employees increased by 0.8 percentage points

the following year, reaching 8.8 percent in 2016, it then decreased in 2017, in 2019 and again in 2020, when it amounted to 7.7 percent. In 2021, the decreasing trend was reversed, Figure 3.23.

Figure 3.23 illustrates both the growth of temporary jobs in 2021 and the extent to which both the level and rate of increase has varied by age – the younger you are the greater likelihood of temporary work if you are in employment. Regardless of age, women are at a higher risk of having temporary jobs than men.

Figure 3.23 Percent of employees who had temporary jobs, by sex and age, 2014-21



Source: SBB Table 05612 (26)

Even if the effect the 2015 reform had on overall temporary employment figures was not as strong as some feared, a study by Strøm et al. (2018), focusing on trajectories of those who were vulnerable in the labour market, found that the situation for people with temporary employment and those who were looking for work or were outside the workforce, including immigrants, had become less stable after the changes in the Working Environment Act. This was especially for those with low wages, people with reduced working capacity and young people with low levels of education (282). This study also showed that individuals in these vulnerable situations had a higher share of temporary jobs after the reform, while the reform did not seem to induce job creation.

According to Rasmussen et al, using data from the European Union Labour Force Survey (U-LFS) between 2010-15, 15.6 percent of Norwegian fixed-term employees experienced income insecurity, a higher proportion than in Denmark and Finland, but lower than in Sweden. The equivalent for full-time permanent employees (the group with the lesser insecurity) was 3.8 (283).

In 2022, the new Norwegian Government changed the law again to limit the use of temporary employment, eliminating the provision that allowed companies to hire workers on fixed-term contracts without restrictions. Companies can now only use fixed-term contracts when the work is of a temporary nature; to temporarily replace staff; to hire a trainee or as part of an employment program run by the Norwegian state (284).

PART-TIME WORK

Part-time work attracts a variety of people, and it does not need to be detrimental to workers health and wellbeing. It is only when it is associated with low income and insecurity that it can potentially increase inequality in the labour market and create a divide between insiders and outsiders (285).

Analysis of the 2015 EWCS indicates that part-time workers experience lower work intensity and better working time than full-time workers, while on the other hand they are less likely to be able to use their skills and discretion at work and experience a worse social environment, even when controlling for confounding factors such as sex, age, education, income and household type, sector and occupation (280).

Part-time work is the most common form of non-standard work in Norway and it amounted to 22.8 percent of all employment among individuals aged 20-64 in 2019 (286). This type of work is usually divided

into long part-time work (15-29 weekly working hours) and marginal part-time work (less than 15 working hours). Long part-time work decreased from 14 percent in 2000 to 12 percent in 2015, while marginal part-time slightly increased from seven percent in 2000 to eight percent in 2015 (201).

In 2019, involuntary part-time employment in Norway was around a fifth of all part-time employment at ages 20-64 in the five years 2016 to 2020 (287). Data from the 2015 EWCS shows involuntary part-time workers perform worse in six job quality dimensions relevant for health and wellbeing compared with voluntary part-time workers, including the opportunities to exercise autonomy, apply their skills, participate in the organisation and develop professionally; job security and opportunities to progress in their career; working time quality; the degree to which there are physical risks to workers in the workplace; and the quality of the social environment at work (280).

Marginal part-time work has been associated with an accumulation of detrimental characteristics of the work environment and health in countries such as Denmark. Nielsen et al found that workers in this group suffered from a poorer psychosocial work environment and safety, more job insecurity and worse health compared with full-time workers, regardless of age, gender and socioeconomic status (288). Women, unskilled workers and young people represent a large share of marginal part-time work in all the Nordic countries.

In Norway, marginal part-time work has been associated with lower income and job security than full-time work. According to Rasmussen et al., between 2010 and 2015, 20.6 percent of marginal part-time workers experienced income insecurity, compared with 3.7 percent of full-time permanent workers (283). This type of work was significantly less insecure in Norway than in Sweden and Finland, which might be explained by higher rates of people voluntarily choosing this type of work in Norway. The inclusive Norwegian labour market and strict employment protection seem to shield non-standard workers from insecurity to a relatively higher extent than in some of its neighbours (283).

A study analysing longstanding precarious attachment in the Norwegian labour market found a decline in this detrimental form of employment, from 15.5 percent during 1996-2003 to 12.7 percent in 2008-2015 driven by an improvement in the situation of both women and immigrants, although the figures can be underestimated due in part to the exclusion of certain groups in the study, such as young adults and short-stay and undocumented immigrants (289).

NON-STANDARD WORK, RIGHTS AND SOCIAL PROTECTION

Platform work, defined as work that is 'mediated, coordinated, organised and/or controlled by a digital platform', has attracted increasing attention in the Nordic countries and elsewhere (200). While platform work has still low prevalence in Norway and the Nordics, it deserves attention due to its potential to create less insecure employment relationships with less rights and worse working conditions (290).

Some types of non-standard workers have less access to several social protection measures. For example, solo-self-employed workers in Norway did not have access to unemployment benefits or sick leave until the Government implemented pandemic relief measures (290). Self-employed workers also have worse coverage in case of sickness, although they can buy insurance to increase payments. However, those on low incomes might not be able to do this. Few self-employed and freelancers

with low incomes establish pension plans (291). In Norway, self-employment represented 5.7 percent of the employed population aged 15 to 64 in 2019 (292).

In conclusion, for many people in Norway, the Norwegian model has been able to provide good quality work that is supportive of health and wellbeing. However, significant inequalities exist in access to employment, employment contracts, attachment to the labour market, levels of pay and work conditions and types of employment. Some of these inequalities relate to extrinsic factors including educational level and duration, immigrant status, and pre-existing disabilities. However, others relate to intrinsic factors, such as pay differentials and the nature and conditions of the job. These extrinsic and intrinsic factors combine to contribute to gradients in health-related behaviours, wellbeing and, ultimately health outcomes such as mortality.

RECOMMENDATIONS

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

3D. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

KEY FINDINGS:

- While Norway is a prosperous country with high GDP per capita, in 2022 the sixth highest globally, there are increasing rates of poverty and rising income and wealth inequality which are not being addressed through the tax and benefit system.

POVERTY

- Poverty has a cumulative negative effect on health throughout a lifetime and insufficient income is associated with poor long-term physical and mental health and increased mortality at all ages, along with lower-than-average life expectancy.
- In 2021 overall poverty rates were relatively low in Norway with 4.8 percent of the population receiving half the median household income, however poverty rates are rising.
- The risk of poverty in Norway is higher for women than men; 14 percent for women and 11 percent for men in 2020

INCOME AND WEALTH INEQUALITY

- Income inequality has increased since the 1980s.
- 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.

SOCIAL PROTECTION

- 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 Norway, people who cannot earn money through work are entitled to income support from the Norwegian welfare state which is funded by municipalities, but the level of support is low.
- While it is an explicit aim that social assistance should be short-term, over 40 percent were recipients for a minimum of six months and those who receive social assistance for prolonged periods tend to have very poor mental and physical health.
- People with a disability who were in employment were less likely to receive any benefits than those outside the labour market.

DIGITAL EXCLUSION

- 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 and the strongest driver is educational level, but other factors include being retired, older, unemployed and living in areas with few inhabitants.

While Norway is a prosperous country with high GDP per capita, in 2022 the sixth highest globally (293), there are increasing rates of poverty and rising income and wealth inequality which are not being addressed through the tax and benefit system. Although Norway has a generous ‘gold standard’ welfare system, there are issues related to eligibility and access due to the complexity of the system and the level of income provided is too low to be able to live healthily in some cases.

Each of the domains covered in this report show that life is worse for people lower down the socioeconomic hierarchy and having resources to live a healthy life is central to improving health. Poverty and low living standards are powerful determinants of ill health and health inequity. In this section we provide an overview of the impacts of poverty on health and summarise poverty rates in Norway; we then assess how effectively the social benefit system in Norway protects against poverty, unemployment, low income, ill health and disability and other drivers of poverty. The tax system and rising inequality in income and wealth are highlighted. We also include digital exclusion as an important emerging driver of poverty and ill health.

POVERTY

Poverty has a cumulative negative effect on health throughout a lifetime and insufficient income is associated with poor long-term physical and mental health and increased mortality at all ages, along with lower-than-average life expectancy. Poverty negatively affects most of the social determinants of health: reducing the quality of housing and the ability to heat one’s home, the ability to have a healthy diet, and access to employment. Poverty also harms educational attainment, employment prospects and increases levels of debt, which are harmful to health.

Living in poverty implies not only low income but material deprivation – a lack of many of the necessities of life. Both will have impact on physical and mental health. Poverty is stressful, it reduces the ‘mental bandwidth’ available to deal with problems and live a healthy life (1). If you have to worry about whether you have food for dinner, and for the rent on Friday, you have little space to think about anything else (195). Being able to live in society, to ‘take your place in public without shame...is about having agency, a sense of self-worth, and participating in networks of family and friends. Lack of income threatens these fundamental components of living in society and damages mental and physical health.’ (195).

In 2021 overall poverty rates were relatively low in Norway, internationally and compared with other OECD countries. As described in section 3A, using two EU indicators available from the Norwegian Institute of Public Health (NIPH) website, 4.8 percent of households had incomes below 50 of median Norwegian income levels, while 10.2 percent had incomes below 60 percent in the period 2018-20 (18).

However, there are some concerning trends which have negative impacts on health and health equity. In section 3A we also set out rising rates of poverty in Norway since 2009-11 and particularly increases in the proportion of households with children under 17 in poverty (figure 3.1). We also showed rapidly rising rates of child poverty in many counties in Norway. In Section 3F, we describe how some immigrant groups are more likely to have difficulties making ends meet than other immigrant groups and non-immigrants. The risk of poverty in Norway is also higher for women than men; 14 percent for women, 11 percent for men in 2020 with rates for both men and women having increased slightly from 12 and 10 percent, respectively, in 2010 - Eurostat table TESSIO10 (294). In subsequent sections of this chapter we highlight the risks of poverty among immigrants, particularly those from outside the EU. As well as poverty as a result of low labour market attachment, long-term inactivity and high housing costs, we also show the inadequacy of social protection measures in preventing poverty in these groups and suggest that support must be tailored to be tapered. This is to avoid cliff edges and issues with eligibility criteria excluding people who are in poverty or at risk of poverty.

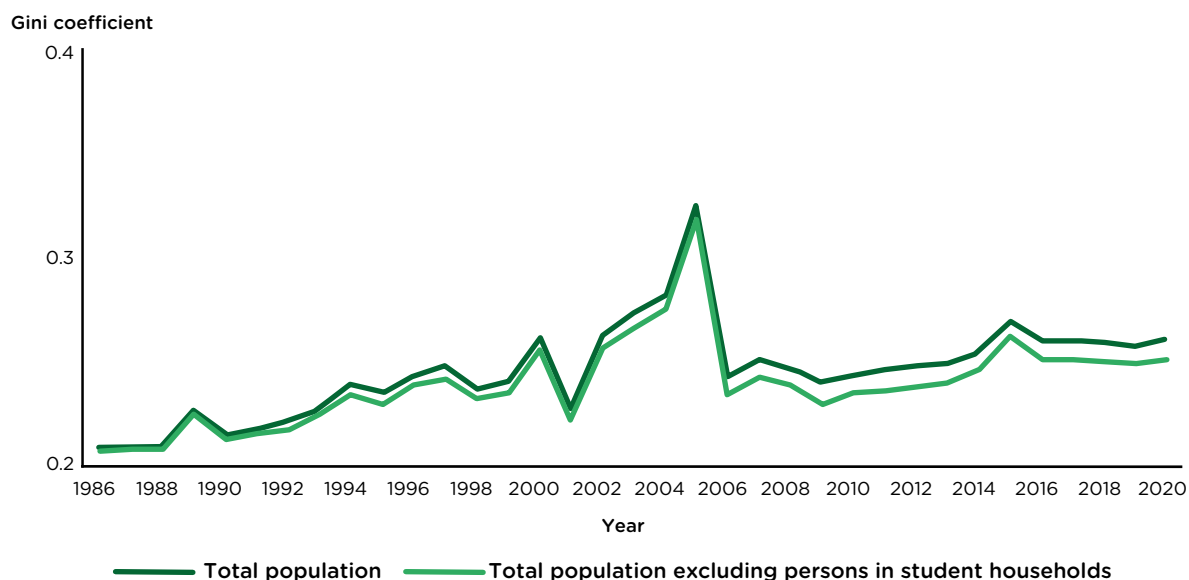
INCOME INEQUALITIES

The income level of an individual or household provides both a single indicator of their capacity to convert opportunities such as education, training and employment into material wellbeing and their capacity to purchase food, heating, adequate housing and the means to live a full social life – in short, to avoid material deprivation.

There are several ways of summarising income inequalities in any country: in Chapter 2 we presented income levels at various percentiles of the distribution and linked these to inequalities in life expectancy. Alternatively, income inequalities can be presented using a single index, such as the Gini coefficient which varies from zero (no inequality) to one (maximum inequality).

Figure 3.24 shows that the overall trend in the Gini coefficient in Norway has been to increase since the 1980s, albeit with substantial year-on-year variation from this trend, from 0.21 in 1986 to 0.256 in 2014. After a sharp rise in 2015, the level fell back to remain stable at around 0.26 from 2016 to 2020. Whereas the inclusion of student households in the calculation made little significant difference in the 1980s, in more recent figures the Gini coefficient has been 0.01 less at around 0.25 when student households are excluded. In subsequent graphs in this section, student households are excluded.

Figure 3.24 Gini coefficient of income, 1986-20



Source: SSB table 07756 (26)

The graded increase in post-tax income from decile one to nine described in Chapter 2 is largely responsible for the increase in the Gini coefficient, i.e. widening income inequality. Similarly, decile 10 was noted to have markedly greater year-on-year fluctuations than other deciles, resulting in the year-on-year variations seen in the Gini coefficient.

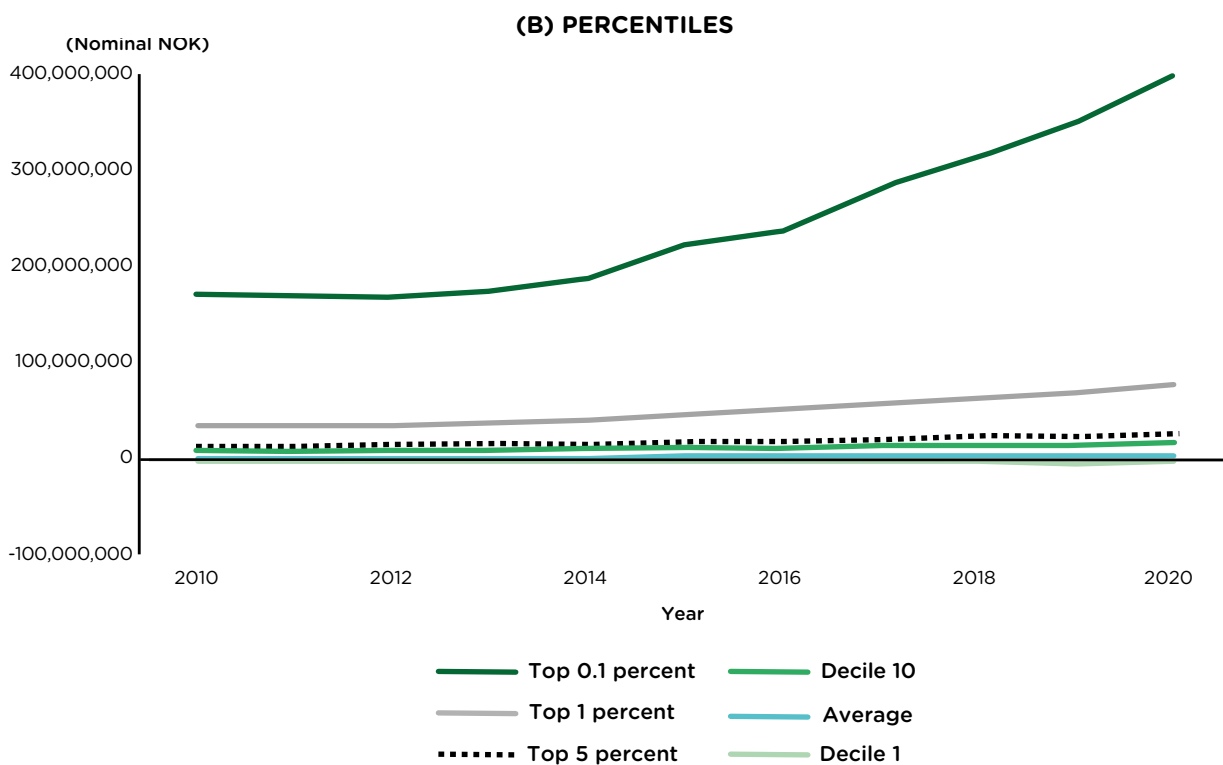
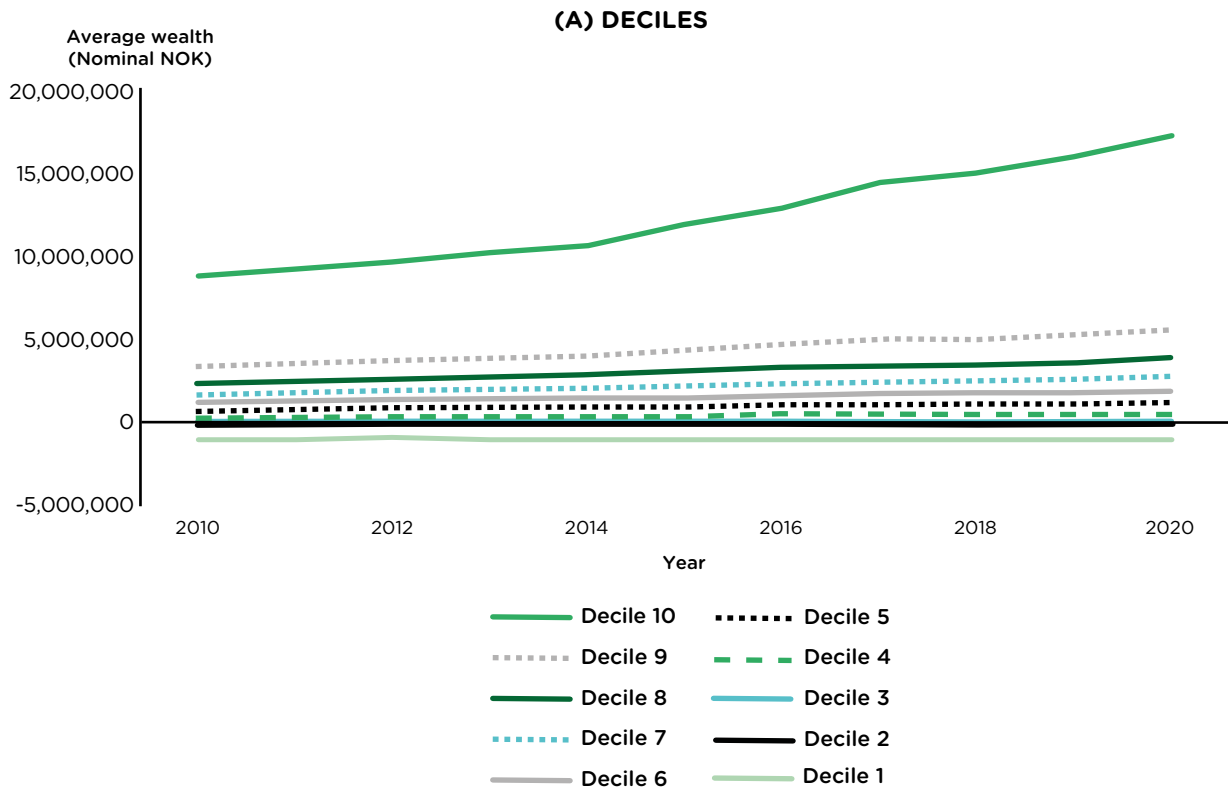
WEALTH INEQUALITIES

As indicated in Chapter 1, what matters most in terms of health inequalities is the accumulation of advantage and disadvantage across the life course and the intergenerational

transfer of advantage/disadvantage. A simple, monetised index of this process is represented by accumulated wealth – although this does not, of course, reflect all the factors that contribute to advantage and disadvantage. Figure 3.25(a) shows that deciles 1 and 2 are, on average, in debt (i.e. have negative wealth), decile 10 is markedly wealthier than others – 170 percent wealthier than decile 9 in 2010 and 210 percent wealthier by 2020. Figure 3.25(b) shows that this increasing concentration of wealth is focused particularly on the top 0.1 percent – almost 1000 percent greater than decile 9 in 2010 and nearly 1300 percent greater in 2020. In short, while the poorest 20 percent have no accumulated wealth, most wealth has increasingly accumulated among the very richest.



Figure 3.25 Average net wealth of households, by (a) decile (b) percentiles 2010-20



Source: SSB table 10318 (26)

THE BENEFIT SYSTEM

A strong benefit system which provides both sufficient income for healthy living at all ages and security against health and economic shocks, has been linked with better health and lower health inequalities. In section 3A benefit entitlements for families with children were set out and in section 3C those available for unemployed people were reviewed. Both have various eligibility criteria and varying degrees of complexity in accessing them which lead to exclusions for people who need financial assistance. In relation to people out of work who are not entitled to unemployment there is only one other income support option: social assistance. This is a meagre and means-tested income maintenance scheme, which is often described as the 'final safety net' in the Norwegian welfare state.

SOCIAL ASSISTANCE

Social assistance is funded by the 356 municipalities in Norway, in contrast to other schemes such as unemployment benefits, sick pay, work assessment allowance and the disability pension, all of which are state-funded. Importantly, it is an explicit aim that social assistance should be short-term economic relief for people who are temporarily unable to earn money through work. Furthermore, the claimant is supposed to take active steps to promote self-sufficiency while receiving social assistance. Thus, this income maintenance scheme is designed to be a transitory income source for people who are in (temporary) need of financial help. Nevertheless, a substantial proportion of individuals do receive social assistance for a prolonged period: out of 129,894 recipients in total during 2019, 42.76 percent (N=55,541) were recipients for minimum of six months (SBB Table O8856) (26).

There are no national guidelines for how much money a recipient can receive and municipalities in Norway therefore have some flexibility and discretion. However, the income support tends to be low: around 10,000 NOK (SBB Table O8856) (26). The means-testing can also be quite harsh – recipients who for example receive money as a birthday gift will often receive reduced income support the following month since all other income support options should be exhausted before social assistance is granted. In a similar vein, people may be forced to sell assets like a car or an apartment before the application for social assistance is accepted.

Previous research on social assistance in Norway has shown that those who receive social assistance for prolonged periods are likely to have poor mental and physical health (295,296). Roughly 50 percent of long-term social assistance recipients included in a linked survey-register dataset report that they struggle with pain, and around 60 percent score higher than 1.85 on the Hopkins Symptom Checklist (HSCL-10), a threshold indicative of anxiety and/or depressive disorders (297).

Substance abuse is also common among long-term social assistance recipients in Norway and people with self-reported drug problems are particularly likely to return to social assistance (298). Neither unemployment benefits nor social assistance are health-related schemes, yet the health status of both unemployed individuals and social assistance recipients tends to be poor on average.

Three other schemes are summarised below, all of which are health-related benefits. This means that a key eligibility criterion is work incapacity due to deteriorated health status, where the diagnosis/condition is verified by a physician or other health professional.

SICK PAY

Sick pay is usually available for people who currently hold employment but are not able to perform their job tasks anymore due to deteriorated health. The medical condition needs to be verified by a physician or other health professional before sick pay is granted. Only medium-to-long-term sickness absence is covered by the sick pay scheme. For short-term sickness absence (i.e., 16 days or less) there is no income support provided by the welfare state and employers must cover the associated costs and pay the employee's salary while they are recovering.

The Norwegian sick pay scheme is generous, at least compared to most, if not all, other European countries and is generous enough to shield recipients from poverty, material deprivation, and psychosocial stress while they are recovering from health problems. The sick pay scheme offers full compensation, that is a 100 percent replacement rate for previous earnings up to the social security ceiling of 6 BA. Thus, the maximum payment, for those with high earnings, corresponds to roughly 668,800 NOK yearly. The maximum period of payment is one year. If the recipients' health status is still too poor for re-entry to the labour market after one year, he/she may be eligible for work assessment allowance or a disability pension, (described in more detail below). High-earning employees will experience an income drop due to the social security ceiling of 6 BA, but the income support provided is nevertheless generous. However, employees in low-paid occupations that struggle to make ends meet while healthy will continue to do so while sick since the income support provided is identical to previous earnings.

The most important eligibility criteria for sick pay are that the claimant must have been employed for a minimum of four weeks, and that they have earned more than 0.5 BA. Thus, sick pay is only available for labour market insiders whereas people who are outside, or on the fringes of, the Norwegian labour market cannot access this benefit. People with weak labour market attachment and poor or deteriorating health status may be eligible for work assessment allowance.

WORK ASSESSMENT ALLOWANCE

Work assessment allowance was established following reform on 1 March 2010 and introduced as a replacement for three other health - and work preparation - related social benefits - *Yrkesrettet attføring*, *rehabiliteringspenger*, and *tidsbegrenset uførestønad*. Work capacity must be reduced by a minimum of 50 percent due to sickness and/or injury to be eligible for work assessment allowance.

The maximum period of benefit receipt used to be four years, but this was lowered to three years after reform in 2018. Recipients with a previous record of labour market participation receive 66 percent of previous income, capped at the social security ceiling of 6 BA. Thus, a person that used to earn a high salary (i.e., more than roughly 670,000 NOK) can receive around 440,000 NOK yearly. For people outside, or on the fringes of, the labour market, there is a minimum benefit available fixed at 2 BA (i.e., roughly 222,000 NOK). However, the minimum benefit is considerably lower, approximately 148,200 NOK (1.33 BA), for young recipients of the work assessment allowance (i.e., those aged 25 years or younger). Thus, for people with no or minimal previous record of employment, the benefit provided is considerably lower than common thresholds for poverty.

There is some previous research on transition rates from work assessment allowance to employment or other benefits (299), but there is a knowledge gap on the health status, childhood disadvantages, and other social surroundings of recipients of work assessment allowance.

The scheme is a temporary health-related benefit, where the overarching goal is to reintroduce the recipient to the labour market as soon as his/her health status is compatible with labour market participation. If the health status of a person is permanently reduced and re-entry to the labour market is considered unrealistic, a disability pension can be a viable option.

DISABILITY BENEFIT

The main eligibility criterion for a disability pension is that work capacity must be reduced permanently by a minimum of 50 percent because of sickness and/or injury. The word 'permanently' is therefore the main difference compared to eligibility criteria for work assessment allowance. The replacement rate for the disability pension is 66 percent of the previous wage up to the 6 BA ceiling, the same as the criteria for work assessment allowance.

For people with low or no employment history, there is a minimum benefit available, which is slightly higher than for work assessment allowance at 2.28-2.48 BA, depending on the family type of the claimant. Thus, people with weak labour market attachment and permanently reduced work capacity can receive between roughly 254,100 NOK and 276,400 NOK in disability pension.

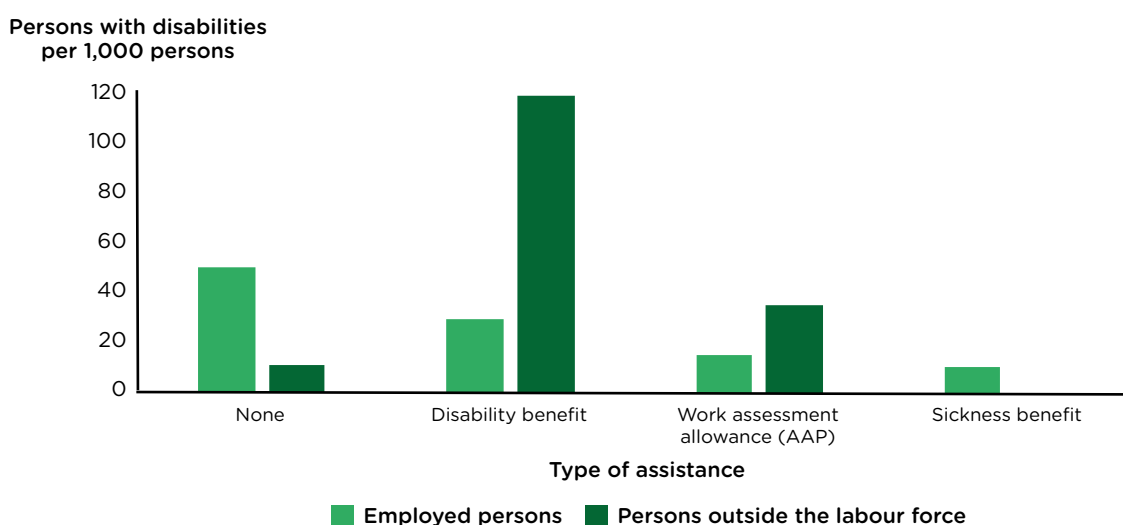
The disability pension is usually granted indefinitely, although the decision may be reconsidered if the recipients' work capacity increases, for example due to improved health or educational attainment/training that opens new job opportunities.

It seems reasonable that the minimum benefit provided is higher for the permanent disability pension compared to the temporary work assessment allowance (2.28-2.48 vs. 1.33-2 BA), where labour market re-entry is the aim. However, the minimum benefit provided for disability pension is still lower than the poverty threshold, according to the EU definition.

Since 1996, the rate of people receiving disability benefits has increased by 2.2 percentage points Norway. At the end of June 2022, there were 362,800 registered recipients of disability allowance, amounting to 10.5 percent of the population aged between 18 and 67 (300). The proportion of women receiving disability benefits was 12.5 percent and 8.5 percent among men (300). Over time, the proportion of people with disability-related benefits has increased more for women than for men. While it has increased among those aged 18 to 54, it has decreased between ages 55 to 67 (300). A study published in a NAV journal linked the decrease in recipients of disability benefits and of work assessment allowance among those aged 62 or above to trends such as 'better health, higher level of education, better physical working environment and more positive attitudes towards seniors and working life'. Also, the pension reform in 2011 allowed more people to withdraw their retirement pension from the age of 62 and this, according to this article may have contributed to the decline. Receipt of disability benefits was more common among those who had low pensionable income (301).

In general, people with a disability who were in employment were less likely to receive any benefits than those outside the labour market and, in particular, were less likely to receive a disability benefit or a work assessment allowance - Figure 3.26.

Figure 3.26 Persons with disabilities by type of welfare assistance and whether employed or outside the labour force, 2021



Source: SSB table 13494 (26)

THE TAX SYSTEM

Individual and corporate taxation is an essential component in supporting good health and achieving a proportionate universal approach to addressing inequalities in the social determinants of health and wellbeing. Tax contributions enable the public sector to provide good quality living and working conditions, support public services and provide adequate support to those experiencing poor health, disability, exclusion and poverty. Corporation tax (and its derivatives) are therefore a vital way in which businesses contribute to health in Norway.

Norway has a small, open, and robust economy with well-regulated spending of high petroleum revenues through fiscal policy (302). Norway had the 20th highest tax wedge among the 38 OECD countries in 2021. The tax on labour income, including the tax paid by both the employee and the employer (tax wedge), for the average single worker in Norway was 36 percent in 2021. The OECD average tax wedge in 2021 was 34.6 percent. Norway had the 11th highest tax wedge in the OECD for an average married worker with two children at 32.6 percent in 2021, which compares with the OECD average of 24.6 percent (303). But, as indicated earlier in this section, there are substantial and widening inequalities in post-tax income and wealth accompanied by significant gaps in the provision of sufficient benefits to those in need to ensure a sufficient income for healthy living. Potential mechanisms for achieving a more equitable distribution through an integrated tax and benefit system that has a greater proportionate element are described in Chapter 5.

DIGITAL EXCLUSION AND INEQUALITY

Digital exclusion occurs when an individual does not have access to the internet or digital technology – or will/cannot access it. Those who are the most in need of support, such as older people and those on the lowest incomes, are the least likely to engage with digital platforms (304).

Digital exclusion is important to health equity as internet access has become an increasingly significant factor in the wider determinants of health. Employment, education and lifelong learning, social participation and community life, housing and the built environment, as well as access to health and healthcare can all be negatively affected by a lack of digital connection (305). The COVID-19 pandemic highlighted the importance of digital platforms – as healthcare, education, and social interaction moved online – as well as revealing persistent inequalities in access to technology (304). Those who are already facing increased levels of deprivation may be pushed into worse deprivation and higher rates of poverty as it becomes more difficult to navigate banking, education, employment, healthcare or social interaction without access to technology and the internet. It is crucial that new barriers are challenged (306). Without attention to digital exclusion, digital solutions can widen health inequalities.

Trappel (2019) points out that while digital inequality was previously about access to digital tools, the economy and gender differences, it is today a more complex matter that has at its core the issues of literacy and competence (307). Research in Norway shows that it is difficult both to map digital competence areas and to pinpoint groups who are particularly vulnerable to digital exclusion.

Norwegian children and young people use digital media extensively compared to other countries (308) and they score highly on digital competence and so-called online wellbeing (308,309). Most families have access to both the internet and a mobile phone on a daily basis (310,311). Digital competence has since 2006 been implemented as one of five basic skills in Norway – oral skills, reading, writing, digital skills and numeracy – throughout primary and secondary education (312). This means that digital literacy is included in all subjects in compulsory education and is also emphasised in higher education. However, ensuring that the population develops digital literacy skills is challenging. Among other reasons, this is because to a large extent, people develop digital skills outside the formal school institution.

International research shows that those who are vulnerable in their everyday lives are also vulnerable in the digital world. A recent report from Statistics Norway argues that low trust in public institutions is a major contributing factor to digital exclusion (313). The factors found to be strongly associated with falling behind digitally are having a low educational level, being retired, being elderly, being unemployed and living in areas with few inhabitants. However, municipalities offering qualitatively good and advanced digital services have fewer residents who fall behind digitally. The report further finds that three population groups stand out in the statistics. The first group is well-integrated immigrants, who have a significantly lower probability of being excluded from digital public services. On the contrary, some groups of young people and so-called poorly integrated immigrant women are less likely to use digital public services and require particular support.

RECOMMENDATIONS

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.

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 fair and healthy places and communities is central to levelling up the social gradient in health and wellbeing. This involves improving physical and social environments in a way which is proportionate and reduces inequities. In this section, we elaborate on the importance of community development as key to address social and relational drivers for health and wellbeing equity. Creating an enabling society that maximises individual and community potential and the conditions for people to take control over their own lives have been key messages in several previous Marmot reviews (1,194). Then we address community empowerment and participation in organisational life, before focussing on housing, drivers of equity such as access to public places and green spaces and transportation.

DEVELOPING COMMUNITIES

The scientific evidence shows that the quality of our social networks influences health and wellbeing (27,30,314). 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 health and wellbeing (315). 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 such as health, financial aid, housekeeping and babysitting (40,316,316). However, the possibilities of benefiting from a large network of social support tend to increase with the available supply of socioeconomic resources (315).

Recent studies on the wellbeing of Norwegians from Statistics Norway and the Norwegian Institute of Public Health (27,30,35,317,318) demonstrate that access to networks of support is unequally distributed in the population. In general, it follows a social gradient whereby people with lower levels of income and education experience lower levels of support than those with higher SEP.

As discussed in Section 3C, those who were not in employment, particularly the unemployed, had less contact with friends than the employed. Access to rewarding social relationships also relates to other capabilities, such as participating in work life. While 23.6 percent of those who were active in the labour market in 2022 reported having low levels of rewarding social relationships, this share was much higher among those who were out of work (40.7 percent) and those who were receiving work-related benefits (43 percent) (SBB Table 13793) (26).

Local communities go beyond the urban construct and the private dwelling: they represent an environment where social networks, political representation, trust in authorities and people intertwine continuously. All these elements influence and interact with one another, shaping the health of individuals, as well as geographical inequalities in wellbeing (319–321). In this

sense, public administrations and local governments inevitably play a central role in the development of fair and healthy communities, in which every person feels safe and valued. Their role is central to weight support and investments proportionally to the needs and means of communities while listening to all who belong to it. In this sense, municipalities are important amplifiers of the needs of their constituents, as well as potential catalysers to policies aimed at addressing both the root causes of inequalities, as well as their direct and indirect consequences, ultimately leading to an improvement to the overall health and wellbeing of individuals (320).

Communities are places where citizenship and legal rights are realised and where citizens can come together to galvanize joint actions on the social determinants of health and wellbeing. In *Fair Society, Health Lives (The Marmot Review)* (2010), it was emphasized that community or social capital is shaped both by the ability of communities to define and organise themselves, and by the extent to which national and local organisations seek to involve and engage with communities (194). It can include community networks, civic engagement, a sense of belonging and equality, cooperation with others and trust in the community. Community capital needs to be built at a local level to ensure that policies are developed and owned by those most affected and are shaped by their experiences.

In Norway, in spite of the importance given to active citizenship to promote wellness and fairness, situating citizens up front in community development has been challenging, particularly in amplifying the voice and presence of citizens in vulnerable situations and in empowering agency for health equity (315). Recently, however, local governments and communities have accelerated progress to empower lower SEP citizens in community development and joint action, linked to public service innovation, formal planning, and governance. The case study from Trondheim described below covers a wide range of people-powered and innovative practices, placing the citizens at the heart of community development and networks of reciprocal social support.

CASE STUDY: THE CITIZENS' MODEL TRONDHEIM

Through the 'Pilot for programfinansiering 0-24' – a programme to improve services for vulnerable children and young people by improving cross-sectoral collaboration, Trondheim municipality is experimenting in developing new practices for helping and supporting low-income families and young people with a project called The Citizens' Model (CM). It consists of several sub-projects with the common mission of promoting capabilities for wellbeing and supporting participatory parity among the target groups.

Strengthening the citizens' own resources, networks, participation, and contributions while coordinating interactions and capacity-building at all levels is central to this project. By nurturing trust and facilitating joint action through radical welfare innovations, it aims to lower thresholds and reduce stigma for citizens who seek to improve their living conditions, while building an organisational culture to take responsibility for citizens who ask for help. In each project, at least three actors – from areas such as health and welfare, education, family and social services, arts and cultural units, NGOs, the business sector and the police, must collaborate and co-create solutions together.

In the period 2021 to 2023, the sub-projects will manage 20 million NOK in total, which is to be spent on what the citizens say they need to achieve independence, better lives, and the feeling of belonging in the community. The money is not to be spent on wages or creating new jobs within the municipal organisation. So far, the money has been spent in three ways: unconditional financial support (basic income guarantees), conditional financial support (gift cards) and collective financial support (participatory budgeting). In total, nine sub-projects are experimenting with new practices, placing the citizens at the heart of all their actions.

The sub-project 'Veien til førerkortet' or 'the road to a driving license', was developed after a group of boys, most of them with a history of crime, social problems and substance abuse, were asked what they needed in order to live well and participate in society. According to these boys, a driving license would be helpful because it would help them with finding jobs and therefore with having a source of income. Another sub-project, 'Tidlig innsats på Brundalen' or 'Early intervention in Brundalen' – an area in Trondheim, aims to support low-income families with young children and adolescents who are in school. It is a collaboration between the kindergarten and school, the health and welfare office, the Norwegian Labour and Welfare Administration, the cultural unit, the police, volunteer centres, housing associations and sports teams. In the project, the kindergarten works as an anchor institution to facilitate co-creation and lower thresholds for families to receive coordinated support from various parts of the welfare system in a safe and familiar space. The learnings from this particular sub-project have sparked a new sub-project in another local area within the municipality, where the 0-24 initiative is being merged with another national programme-financed initiative aiming to empower and improve living conditions in socio-economically deprived areas in the largest cities in Norway.

Concentrating measures around specific missions, in combination with flexible funding seems to galvanise collaboration between sectors and stakeholders. Mutual sharing of knowledge and improved cooperation leads to increased trust between the actors involved. Employees report that working in this way feels motivating and meaningful and creates opportunities to work in line with what they believe in, as opposed to being subjected to procedures and standards they feel reduce their ability to provide helpful support to families and young people.

So far, citizens and families report that their lives are being significantly and positively changed thanks to the project. The police report less juvenile crime, and citizens are starting to give back to the community. Several new organisations (public, private and NGOs) are being identified and involved in collaborations. Kindergartens and schools are being acknowledged as essential anchor institutions and platforms for co-creation in the local communities.

Across the process, the focus on living conditions and social determinants of health and wellbeing has increased, alongside a strengthened focus on approaching and understanding adolescents and families in relation to their surroundings and in their everyday life context. Across the sub-projects, a need to 'clean up' the existing measures and benefit schemes for this target group has been identified, as the current practices are too fragmented and bureaucratic, causing high thresholds for realising legal rights to welfare and benefits. While the preliminary results from the project are promising, some citizens have reported feelings of stigma. This needs to be carefully addressed in the further development of the project.

Through the municipality-university agreement, the WellFare research centre at the Norwegian University of Science and Technology works with Trondheim municipality to inform and co-evaluate the processes and outcomes. The aim of the research is to understand how the welfare innovations explored in the project affect citizens and frontline workers. Moreover, it enquires whether and how actions taken can be scaled up and implemented as a way of working in the municipality, linked to public value governance and to relational, trust based and co-creational public leadership. The practices that are being developed build from existing structures within the municipality and might therefore be transmitted, repeated, and re-tested in other contexts, linked to the municipality's planning and steering system and to enhancing political accountability for outcomes.

The case study from Trondheim illustrates how universal welfare institutions such as kindergartens and schools can serve as anchor institutions at the level of the place to mobilise co-creation and joint action, a finding that was also identified as a promising practice in the municipality of Levanger through adopting a whole-systems approach to kindergartens (37). Without citizen participation and community engagement facilitated by public service organisations and institutions, it will remain difficult to improve efficient

uptake of interventions and to impact on inequalities in health and wellbeing (194).

When addressing the social determinants of health and wellbeing through community development, it is important to note that initiatives by local residents might act as steppingstones to transformative change. The example 'I'm your neighbour' from Sandnes constitutes a promising practice where the starting point was citizen-engagement from the bottom up.



CASE STUDY: I'M YOUR NEIGHBOUR ('EG E NABOEN DIN'): AN ASSET-BASED COMMUNITY DEVELOPMENT INITIATIVE IN SANDNES

The community building project 'I'm your neighbour' is inspired by multicultural residents' stories about what had been important to them to live well and flourish despite experiencing great hardship in life. At the beginning of the project, local residents started having conversations about networks and neighbourhoods, and they became struck by the power of communities and the importance of belonging. Citizens with minority backgrounds longed to have closer contact with their neighbours and talked about experiences of strong communities in their former home towns. Many said that they did not know any Norwegians, and that they did not know how to make contact or find friendship.

Becoming more closely connected to community and neighbours promotes the health and wellbeing of residents. Community connectedness is therefore an important area for action. Hence, the project is focused on building compassionate and socially inclusive communities by uncovering and identifying the resources of those who live in the neighbourhood. It is about mobilising these resources and connecting them to each other, facilitating inclusive collaboration and creating commitment and participation in the local community.

Local initiators and volunteers invited other residents to take part in a project with the aim of creating connections in the neighbourhoods. Follow-up meetings and arrangements had the same goal: to explore what they could do together, what they wanted to do, and how they could uncover all the resources contained within their neighbourhoods. They started by taking pictures of residents who wanted to be good neighbours. Everyone who joined did so on a voluntary basis and was initially recruited from the local mental health department. They took 150 portraits in Sandnes and 300 in Bryne and hosted several exhibitions in both places. They also collected stories. They worked as agenda-setters to inspire building warm and welcoming neighbourhoods from the inside out through social media and brochures. The rationale for working this way is based on recognising the transformative power of stories to inspire and mobilise actions. The project recognised that there is no universal programme that can be rolled out that fits every local context.

'I'm your neighbour' wants to inspire individuals and communities to take local action to improve neighbourhoods. The aim is to show that small actions might have great impact and that everyone matters in building communities of mutual support. Feedback from various actors and stakeholders suggests that the pictures of ordinary people are touching and inspiring, and work as a reminder of what local residents want to achieve: to see the potential that exists in everyone portrayed. The project has also worked to disseminate relevant research in an understandable way. The project initiators claim that much of the research on which they build supports what they have known in their hearts: to facilitate the citizens' belief that they can make a difference and increase people's understanding of how they matter to others.

A key learning from the project is that local change is possible and manageable and something diverse community members want to be involved in. Mobilising local boundary-spanners and community connectors and being as open as possible to those who sign and follow up on initiatives are key elements. According to the project initiators, the most important element for facilitating community empowerment is creating the conditions that enable local people to take the initiative and want to contribute to their neighbourhoods.

SCHOOLS AS ANCHOR ORGANISATIONS

In the Norwegian and Nordic context, strong institutions are important drivers for promoting trust and social cohesion locally (315,322,323). Schools and kindergartens in Norway may act as universal 'public palaces', where children, young people and caregivers meet and greet on a regular basis across social divides (98,324). They represent unique opportunities to nurture connectedness and networks of social support in local communities. However, societal developments in many western countries, including Norway, have gradually moved towards a governance framing since the mid-1980s where citizens and communities are seen as beneficiaries and 'consumers' of public welfare rather than being co-creators in finding solutions for the common good by engaging in joint action (325,326). We will further elaborate on this tendency in chapter 5, when we discuss

democratic governance for health and wellbeing equity. This trend means there is a need to increase attention towards empowering local communities to act on the social determinants of health and wellbeing by taking relational responsibility and 'doing' citizenship in practice (327).

In previous chapters, we have pointed to a need for building networks of support around children and families. In addition to the examples provided above, another promising practice linked to a partnership and a collaborative approach through schools as local anchor institutions is identified in Sarpsborg. The case study below illustrates how adopting a 'whole school approach' can galvanise social participation for equity and wellbeing in a local community.

CASE STUDY: THE SCHOOL AS AN ARENA FOR CO-CREATING PARTICIPATION, EQUITY, AND WELLBEING

Alvimhaugen Primary School, located in Sarpsborg, Norway, has since 2015 gradually developed into a community hub through cooperation between school management and staff, pupils, parents, and the local community. The school is located in an area with socioeconomic challenges related to living conditions and with a high proportion of immigrants. About 70 percent of the pupils have immigrant backgrounds and 19 different languages are spoken. The school has opened its premises for community activities both before and after teaching hours. All activities are free of charge and include school breakfast, a leisure club 'The mirror of the world' with hot meals, different sport activities for different gender and age groups, guitar courses, and a homework café (328).

The school regularly hosts special events for the whole community, such as an international café and national day celebrations. The school premises are also used free for birthday parties and playing sports and the playground is available after school, in the evenings, and at weekends. Winter sport equipment is also available to rent free of charge (328). The use of the school as a community area is the result of a series of initiatives that were initiated from the bottom-up and gradually developing with growing cooperation between the school's management and staff, pupils, parents and the community (329). The school's built and natural environment, the activities happening there and the human resources and organisation facilitated perceptions of safety, inclusion, and cohesion, which in turn contributed to wellbeing (329).

Developing the school as a community hub might be especially important in deprived areas or in multi-ethnic communities. Schools are usually owned by the municipality and therefore available without substantial costs; they have a variety of indoor and outdoor facilities suited for diverse activities and are often placed centrally within communities. Furthermore, schools are regarded as a safe place to send children for activities. Schools have great potential for improving cohesion, reducing social isolation, providing opportunities and co-creating community activities that enhance participation, equity, health and wellbeing by advancing a whole-school approach.

Communities can also foster intergenerational social support. Both the Public Health Report, *White Paper No. 19 (2018-2019) - A Good Life in a Safe Society, and Meld. St. 15 (2017-2018) A full life - all your life - A Quality Reform for Older Persons*, demand more places for different generations to meet. Inter-generational meetings are described as a measure against loneliness and social exclusion, for both younger and older people. The interaction between grandparents and

grandchildren is seen as important for children's safety, growth, and development, but demographic changes have led to children missing out on these encounters, while the degree of inter-generational social support follows a social gradient (330). The case study 'Joy of Life for older people' illustrates how partnerships between an NGO and schools and kindergartens can build bridges for intergenerational relationships and activities between children and senior citizens.

CASE STUDY: JOY OF LIFE FOR OLDER PEOPLE

Most older people find great joy in the company of children and young people, but most Norwegian youngsters do not often meet older people. The Norwegian foundation *Livsglede for Eldre* (LFE, or 'Joy of Life for older people' in English) is a non-profit organisation that has developed national programmes for schools and kindergartens which are available and free, called 'Joy of Life for the elderly in schools and in kindergartens'. In these programmes, children pay regular visits to nursing homes, care homes and day centres, where they engage in activities with older people. This gives both the children and older adults a chance to be an asset to each other, to experience mattering and to enjoy each other's company. To ensure quality, LFE provides the schools and kindergartens with follow-up guidance and counselling. The visits can be rooted in the kindergarten's framework plan and the school's curriculum.

'Joy of Life for the elderly in schools and kindergartens' fits well with several of the UN's sustainable development goals: partnerships for the goals, reduced inequalities, sustainable communities, quality education, and wellbeing. LFE arranges for the schools and kindergartens to run the programs on their own, so they do not have to rely on a third party, showing how this way of working can be sustainable.

The programmes focus on strengthening local communities with shared meeting places for younger and older people, raising familiarity and trust between age groups, and affiliation in local communities through socialising with different groups of people. In this way, the programmes are in line with the idea of social sustainability.

There are some challenges in that participation is often based on personal factors. For example, applications by schools or kindergartens often rely on a teacher finding this important and choosing to engage. The amount of activity in the schools and kindergartens has also varied.

According to LFE, the intergenerational meetings have resulted in shared experiences and knowledge across generations; reduced feelings of isolation and helplessness amongst the elderly; contributions to meaningful everyday lives for the elderly, and creation of settings for them to share their knowledge, experiences, and skills; filling a social void for children who have been missing out on encounters with their grandparents; removing negative age stereotypes and promoting understanding and solidarity through inclusion and diversity; showing the importance of shared spaces and resources which can be of value for all age groups; creating networks of people who provide safety and support, and relationships across generations.

The programmes are constantly evolving and recruiting new schools and kindergartens. Guidance materials and courses have been developed for distribution, and the schools and kindergartens run the programmes on their own. Therefore, there are good scaling-up opportunities.

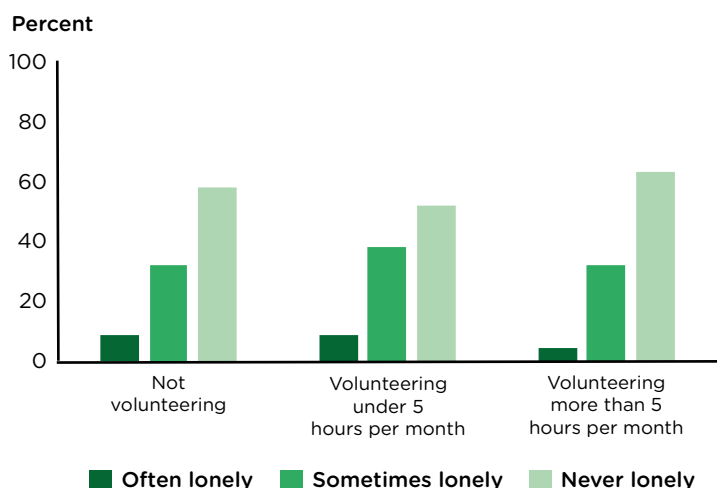
VOLUNTARY AND NON-GOVERNMENTAL ORGANISATIONS

Volunteer and Non-Governmental Organisations (NGOs) play a key role in public health in Norway, which is recognised in Norwegian Public health practice. This is discussed further in Chapter 5. The state facilitates volunteering and NGO efforts through economic support. 2022 has been proclaimed 'the year of voluntarism' by the Government (331), emphasizing the importance of volunteering work for local communities in terms of social inclusion and health equity. While the role of civil society and NGOs will be further addressed in chapter 5, we will outline here the evidence on existing social gradients in participation and volunteering activity.

VOLUNTEERING AND HEALTH

The health effects of participation in leisure and volunteer activities are often described through the social pathways to health. For example, loneliness has received increased attention (especially under the COVID-19 pandemic), affecting 42 percent of the population and even higher proportions of young people. However, people engaged in volunteering report substantially lower levels of loneliness – see Figure 3.27. Participation in volunteering and leisure activities is also linked to higher social capital, which in turn has strong links to health and wellbeing at the individual level (332,333).

Figure 3.27 Distribution of the experience of loneliness by time spent volunteering, 2021



Source: Frivillighetsbarometeret (2021) (334)

Differences in health effects are found across different types of activities, indicating that engaging in organisations linked to culture and leisure activities, as well as social and society-oriented organisations is beneficial for health; while no health effects could be documented for engagement in organisations focusing on housing, religion/spirituality and the economy (332). However, the causal relationship is not clear. Some analyses suggest that health is an important pre-requisite for participating in volunteer and leisure activities. Results also indicate that, outside of working life, people experience the largest positive health effects of engaging in such activities. International findings also suggest a causal relationship between participation in volunteer and leisure activities and good health, especially for people with weak social networks (332).

Engagement in volunteer activities and NGOs is generally high in Norway, with an average of 78 percent of the population being member of at least one, and 48 percent being member of at least two organisations (2020). However, the COVID-19 pandemic had major negative impacts on participation in volunteer and leisure activities. Some four out of 10 people claim that the pandemic prevented them from participating, mostly due to cancelled activities and national and local restrictions. The proportions of people volunteering in any way have decreased from 63 percent in 2019 to 55 percent in 2021 (335). Economic support for volunteering decreased simultaneously (335). This is likely to have contributed to increased inequalities in participation, as the least engaged people are also the most likely to stop participating: for example, trends showed that men engaged less in volunteer work while women were more likely to stop being members of organisations (335). Both these trends can also be observed in younger people, which might indicate future challenges with participation.

Taken together, volunteer work for civil organisations is estimated to be worth 142,000 person-years of work (336). A large proportion of voluntary work (70 percent) is done by approximately 20 percent of the population, who dedicate 10 or more hours to volunteering on a weekly basis (337). Traditionally, people were often closely linked to one organisation, whereas now they tend to work fewer hours for more organisations, indicating a trend towards short-term commitment. This partly corresponds with the cultural concept of *dugnad*, describing short-term, common volunteer work towards an agreed objective – such as cleaning the neighbourhood for spring, or raising funds for children’s activities during a limited time period.

Immigrants are under-represented as members in all kinds of organisations (338). However, research suggests that official statistics do not include all volunteer work that is done in respect to specific ethnic and immigrant organisations. Among immigrants, those who are active tend to invest more time in volunteer work than non-immigrants (337).

PARTICIPATION IN VOLUNTARY ORGANISATION ACTIVITIES

Collaborations with volunteer sport clubs are perceived as a resource in public health work, particularly when the target groups are children and young people (339). However, engagement has declined in recent years: from 2019 to 2021, the Norwegian sports associations lost 156,000 of their members. Health emerges as a major motivation for physical activity (84.5 percent agree); but is also described as a potential barrier by 14.4 percent, while 6.8 percent report economic barriers to participating in sports activities. In 2021, 19 percent of the population participated in a religious/spiritual meeting, a decline from 36 percent in 2016. The

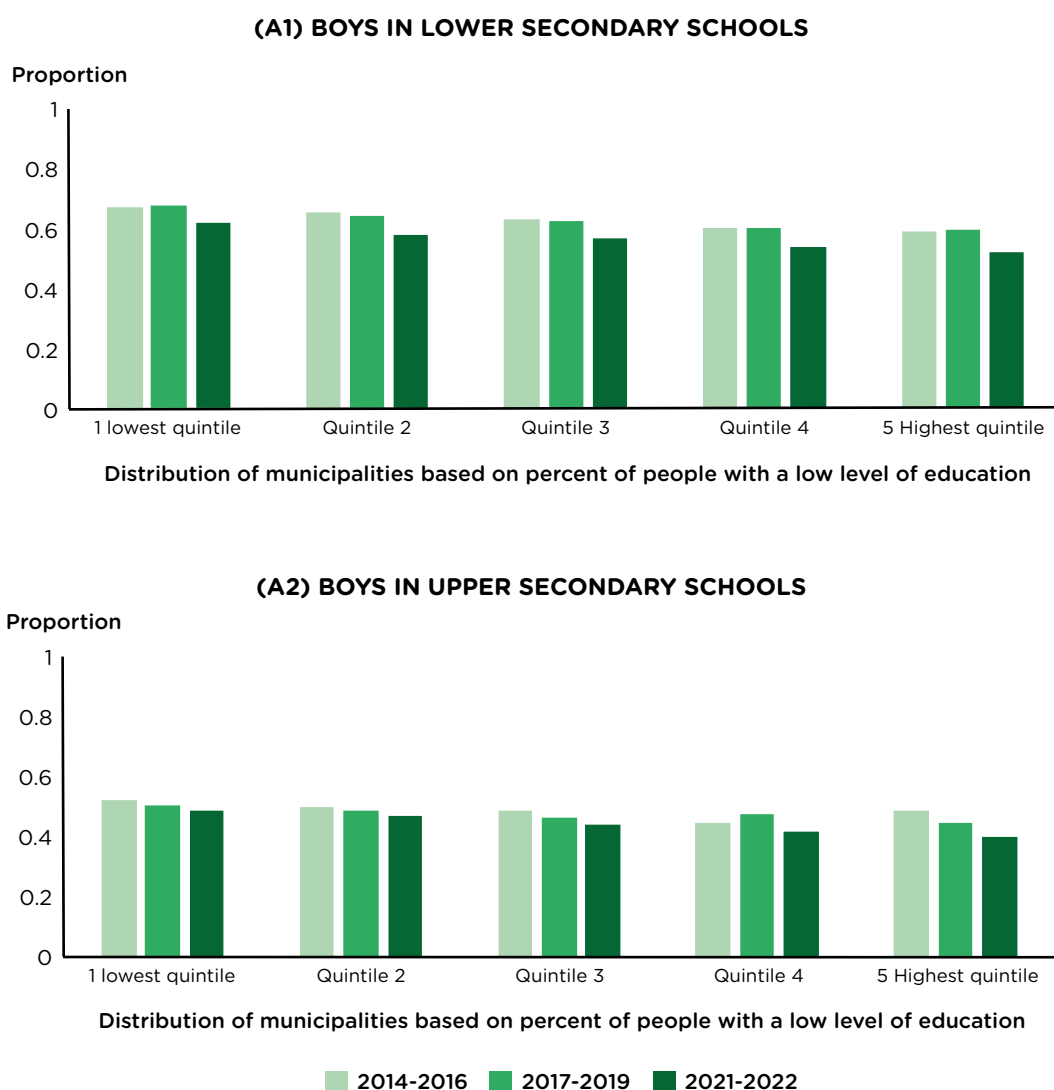
proportion of people who are members of a religious or spiritual community other than the Church of Norway is seven percent. Public libraries emerge as another important resource, being visited by 58 percent of the population in 2021. These proportions are higher in deprived groups, with children of immigrants (between 9-15 years) being among the most frequent users (71 percent had been to a public library at least once) (340).

Socio-economic differences in participation are also pronounced in children in 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

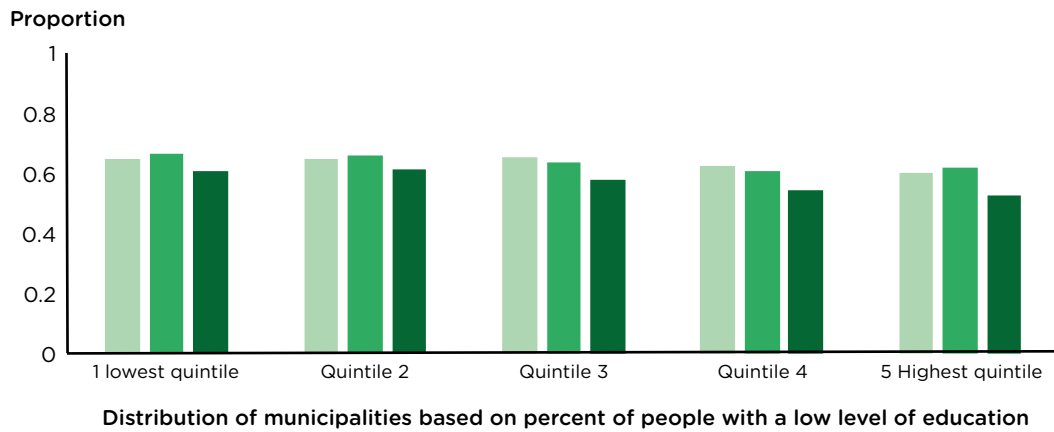
only 38 percent of girls. Differences between types-of-activity are found as well, with children from high SES families participating more in activities like sports, music and other cultural activities and children from lower SES backgrounds being more likely to participate in youth clubs and other kinds of organisations. No differences according to SES are found with respect to participation in religious activities (337).

Figure 3.28 illustrates how participation 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.

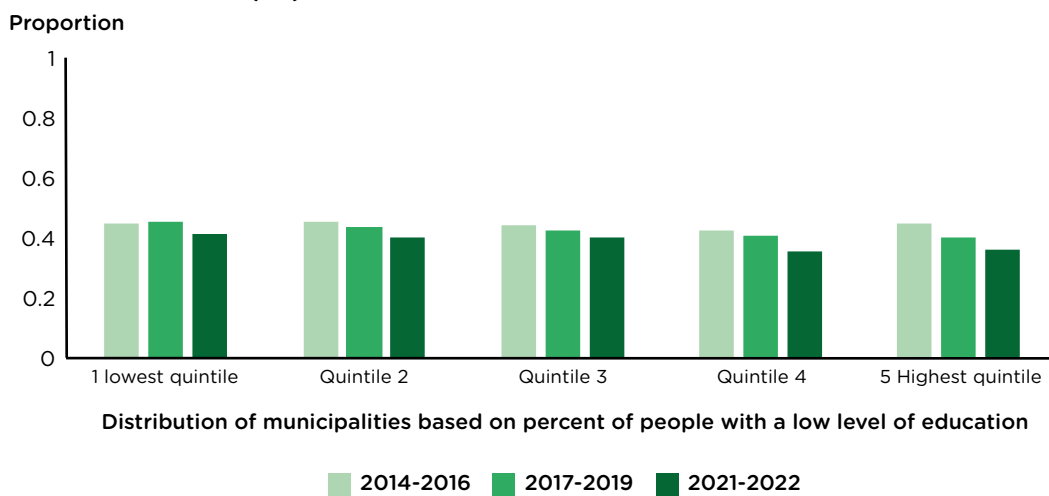
Figure 3.28 Proportion of children indicating that they participate in leisure activities by level of low educational attainment in municipalities, 2014-2016 to 2021-2022



(B1) GIRLS IN LOWER SECONDARY SCHOOLS



(A2) BOYS IN UPPER SECONDARY SCHOOLS



Note: Analysis by M Kozák. Municipality quintiles based on the percentage of adults in the municipality who did not complete any form of tertiary education.

Source: Young data (29).

Differences in participation can partly be explained by economic resources and expenses linked to membership and equipment (341). Another important factor for children's participation is parental engagement, either as members or participants in organised activities themselves, but also as important facilitators of activity for children and adolescents (342,343). This implies that children of parents that cannot get involved can have difficulties participating (337). Additionally, increasing expectations and pressure to perform and compete while growing older might account for some fall-off through decreased motivation or lack of time as adolescents grow older.

Active participation in meaningful leisure activities and volunteering is not only vital for children but supports the development of key capabilities for health and wellbeing across the life course (344). In addition to the political objectives targeting children and young people, the Norwegian Government has also implemented measures to facilitate participation among adults. A specific barrier to participation among people on sick leave or without a job, who were earlier at risk of losing economic support if they engaged in volunteer activity, was removed in 2018 (337). In addition to this, the volunteer sector has created a resource bank to address inclusiveness.

TRANSPORT

The Norwegian Government has recently renewed its transportation plan (NTP) for the next ten years. Within it, there are important and ambitious goals, including a renewed effort to move to a 50 percent reduction in transport sector emissions by 2030 compared to the levels in 2005 (345). The plan sets out several important policies to achieve this, including a 75 percent transition to electric vehicles for both private and commercial mobility by 2030. The government has planned a budget of NOK 1,076 billion over 12 years and estimated the following spending framework:

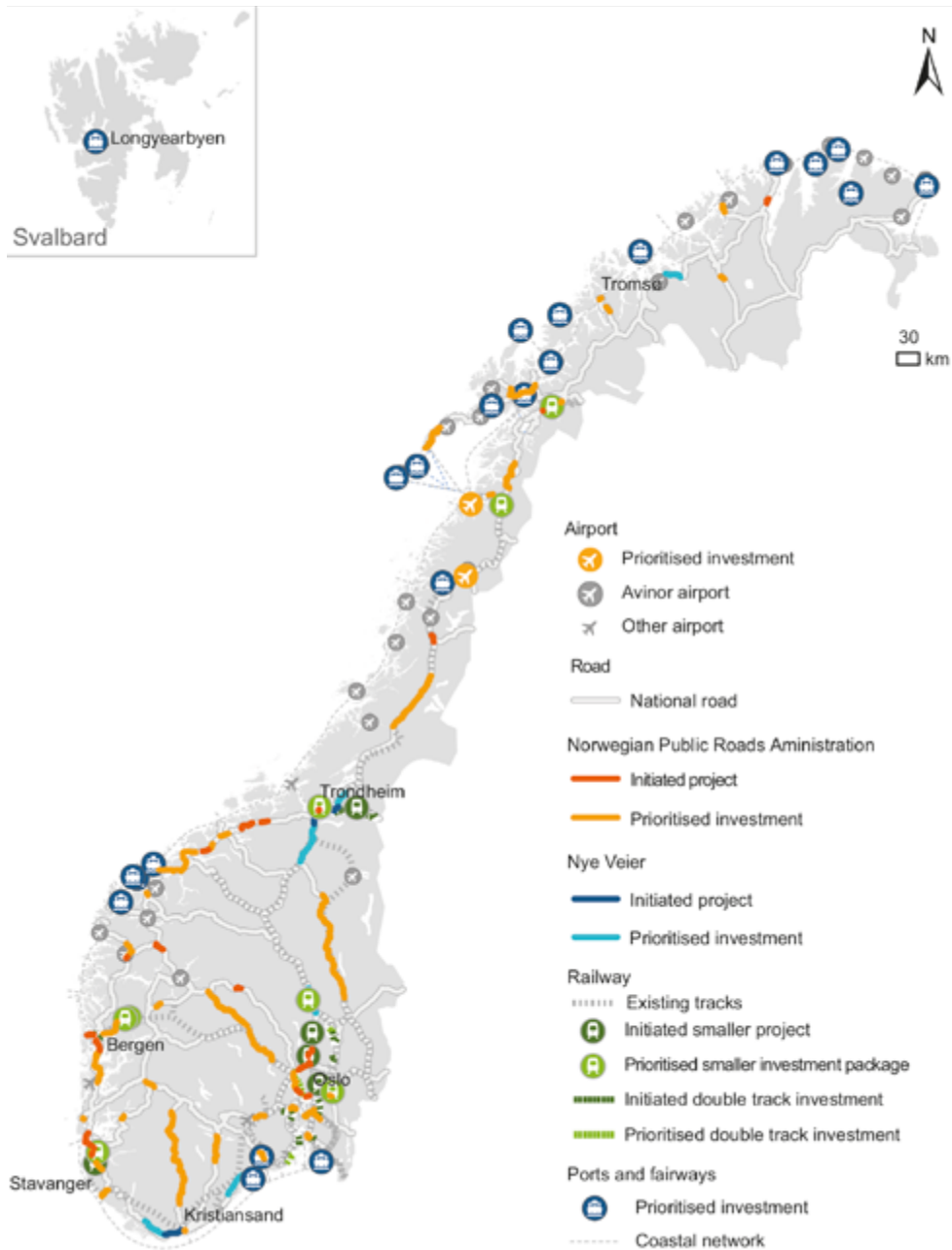
- NOK 510 billion for national roads
- NOK 52 billion in county road grants
- NOK 393 billion for the rail sector
- NOK 33 billion for maritime infrastructure and coastal management
- NOK 80 billion for measures in urban areas
- NOK 5 billion for airports
- and NOK 3 billion for initiatives across transport sectors, such as efficient and environmental-friendly use of new technologies.

Norway has a highly urbanised population, most of which is concentrated in big, urban centres clustered around the biggest cities in the country. Therefore, the long-term transportation development plan is less concerned with increasing accessibility to open, green spaces, which is high, and is more focused toward connecting the population, concentrated in a few hubs,

efficiently in a very vast territory (346). This direction is clearly set out in the plan, however the long-term transportation development envisioned by the Government seems to remain particularly focused on private vehicle transportation. This is also highlighted by the planned NOK 123 billion of its budget which the plan envisions will be provided from road tolls.

The fact that a specific plan to building a sustainable public transportation system aimed at connecting the whole country is missing, means the future development of the Norwegian transportation system is aimed at reducing emissions of private transport, rather than incentivizing use of public transport by enhancing networks between and within cities (346). The plan does not present solutions to connect sustainably and efficiently some of the most remote areas of the country. Figure 3.29 below offers an overview of the planned expansions and where the ten year budget will be spent. Many of the areas across the country still lack connection by railway to the primary urban centres of Bergen, Oslo, and Trondheim (347). While the plan does highlight the strengthening of some of the existing railway connections, a sustainable transition to the future of mobility needs to be focused on building up a public transport system accessible to all and which connects all areas of the country. On top of significantly reducing emissions (348) the stronger development of a more intricate public transport system could help in achieving the goal set out in the NTP in significantly reducing road traffic injuries and fatalities (349) as well as significantly improving the overall public health of the population by reducing emissions more efficiently (350,351).

Figure 3.29 Map of planned public transport development in Norway: 2022-2033



Source: Norwegian Ministry of Transport (347)

With the de-centralisation of the administration of public transport in municipalities from the central government to more local authorities, central government has little power to solve inequalities in local transport

accessibility, which represent a significant barrier to the development of an equitable and fair transport network in the country (345).

CASE STUDY: THE OSLO REGION PUBLIC TRANSPORT INEQUALITIES

A recent paper focused on analysing public transport inequalities in the region of Oslo (352) found a remarkable degree of neighbourhood segregation, with low-income areas of the region having much higher mobility poverty (representing longer, less efficient commutes and a lower number of trips overall) (353) than their high-income counterparts. Areas peripheral to the urban city centre in the region have up to 50 percent less public transport traffic than central areas, making these areas much more reliant on private transportation, which means that these populations will also be more susceptible to an increase in car tolls without the opportunity to choose to switch mode of transportation (352). The NTP provides no indications for the municipalities to address these connection inequalities and the issue of public transport inefficiencies within cities seems to be absent from the presented long-term goals of the Government. However, it is critical to address these issues of public transport reliability to make transportation less dependent on private vehicles and more sustainable. Importantly, the success and improvements of singular municipalities is essential to strengthen the national public transport network.

Both the NTP and the 2019 expectations define the importance of developing strong cycling and walking routes within cities, but no specific plans are listed on how to achieve the planned goal of increasing cycling's share in urban areas to 20 percent and eight percent nationwide. With little more than seven percent of the budget devoted to local urban development and the significant inequalities in the opportunity to further develop the active travel infrastructure, it remains unclear how the NTP envisions to strengthen cycling and walking. However, 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 overall (348,354,355).

In conclusion, the NTP seems to be focused on smart and efficient investments aimed at creating a more interconnected system of industries and businesses but seems less concerned with the central role of transportation planning: the movement of people. While it is important to keep in mind the importance of well and efficiently connected urban areas to industrial ones, transport and mobility should first and foremost be focused on the needs of commuters and movement of the population across the national territory. Major transport corridors should be further developed and strengthened keeping in mind a long-term plan for a reduction in overall private transport, which ensures the most efficient, sustainable solution for the future. Coupled with the ambitious plan of reducing public transport emissions to zero by 2025, Norway has a great opportunity to revolutionise its transportation system by changing the population's transportation habits.

NEIGHBOURHOODS

As well as the social quality of neighbourhoods discussed in earlier sections, the physical qualities of a place are also of importance to health equity. While some factors in the local environment may promote health and reduce inequities, others may harm health and increase inequities, directly or indirectly.

The built environment and conditions that enable opportunities for play, access to green spaces, the infrastructure for walking and cycling, access to local facilities and social infrastructure impact wellbeing across the life span (356–358). On the other hand, the built environment may impair social activity and wellbeing because of traffic, dark alleys, lack of green spaces, space restrictions or noise (356,358). 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 (359,360). If neighbourhoods and communities are stigmatised or characterised by antisocial norms and behaviours (often as responses to social exclusion and/or social deprivation), such features might threaten the wellbeing of all community members and society more broadly (40,361).

In 2021, 85 percent of Norwegian young people reported that they feel safe in their local neighbourhoods, a slight but steady decrease since 2014 when the reported average was 89 percent (362,363). Moreover, in 2020, data from Statistics Norway indicate that 60 percent of Norwegians living in urban areas have safe access to recreational areas within walking distance of their home and 45 percent have correspondingly good access to local hiking areas (364).

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. Most Norwegians own their home, but 23.6 percent of households live in rented accommodation. Housing access influences health and wellbeing in a number of ways. For example, the neighbourhood one lives in and the experiences while growing up influence citizens' access to high quality services, including education (365–367). Housing conditions during childhood are linked to adult mortality, through an increased risk of exposure to pollution, worsening lung health and increased risks of suicide and infection.

Access to owner-occupied housing has become a significant driver of inequality in welfare societies. In Norway, social mobility is today dependent on whether a citizen can afford to own rather than rent. This is because the increase in house prices has completely surpassed income growth (368). As a result, the number of long-term tenants has increased due to the rising costs of living and housing around the major urban areas in the country, with fewer people able to buy a home after a period of tenancy (369).

The Government has laid out its long-term housing strategy through two ambitious plans to reduce the number of tenants as well as assure access to affordable loans to give all citizens the possibility of buying a property. Through the 2014 and 2021 national housing strategies, Norway defined the central role of municipalities as administering social housing, supporting those without a home and supporting the aim of universal access to home ownership. In 2014, several nationally implemented acts were key to action on housing inequalities in Norway. These were the Tenancy Act – which gave more security to those at risk of eviction, the Public Health Act – which required municipalities to have an overview of the health conditions of people living in social housing, the Health and Care Services Act – which laid out the responsibility of municipalities to help residents in precarious or disadvantaged conditions to obtain a house, and the Planning and Building Act – which helped define basic standards of living and adequate conditions of homes.

The national strategy set out to provide safe and stable housing for children and families at risk, which in 2014 were estimated to be about 25 percent of all disadvantaged households, and established a plan for the reduction of homelessness, estimated to affect 6,250 people in 2012. The biggest challenge for municipalities was found to be the lack of funding and space to provide social housing, which according to the national plan should be available to anyone who does not have a safe place to sleep in the coming 24 hours. The Government established a number of tools

in order to ensure the protection of the right to safe housing for every resident. These included:

- The housing allowance grant given to low-income households in order to pay for housing costs.
- Start-up loans, via a means-tested loan scheme financed by the Norwegian State Housing Bank which is in charge of financing housing schemes for municipalities.
- Basic loans used as a universal tool for anyone who needs to buy a house or is in a disadvantaged position in relation to buying a home.
- Grants for first time homeowners, for refurbishing homes and for expanding high-density housing complexes.

The strategy had some successes. The number of people without a home was halved between 2012 and 2016 to 3,900 people and decreased further to 3,325 in 2020 (370). Approximately 50,000 households received start-up loans between 2013 and 2019, with approximately 32,400 going from tenancy to ownership. But the number in rented accommodation remains high. To increase the accessibility of housing allowances and help those struggling with housing costs, an increase in the housing cost ceiling was proposed. Approximately 90,000 households claimed a housing allowance every month in 2021 and around 30 percent of these were families with children (371,372).

The main goal and priority of Government has been a steady increase in home ownership and increasing the budget allocation for start-up loans for the NSHB as part of its continued strategy. However, this marks a significant change in Government housing strategies, moving from the aim of increasing access to social housing toward the goal of increasing the rate of homeownership, shifting the responsibility for housing more toward the individual. This has happened in parallel with continued de-regulation of the housing market over the years which has amplified intergenerational inequalities, as those who have inherited family property have benefitted from the significant increases in house prices (369).

The voluntary and private sectors have been recognised as important partners in the fight for good, affordable housing. However, while the former plays an active role within the strategy as provider of housing and welfare services for those that most need it, the latter seems to be involved in the provision of tenancy contracts for profits (373). While this represents an important example of private-public cooperation at local level, it should be noted that the national strategy does not specify a plan to contain rising living costs (such as rent caps). If housing development is left unchecked, it can become too dependent on the private market, which often tends to raise prices, making access to

good, affordable housing harder for those who need it the most. Addressing this issue is essential in ensuring everyone has access to an affordable dwelling.

While rates of homeownership remain high, rates of low-income ownership have significantly dropped over the last two decades, a sign that the efforts towards making grants and loans more accessible detailed in the two national strategies have not favoured those with the lowest incomes, who have faced the burden of higher rent prices, rising living costs and reduced tenancy protections (374). Finally, means-tested social housing and tenancy, supported and promoted by the latest national strategy, are precise tools for ensuring those who need help the most get it, but also risks keeping those just at the edge of the requirements in a precarious situation: not poor enough to qualify for help, but far from being able to afford a good home and to live comfortably (375). This puts long-term tenants with high living costs, identified as the most vulnerable in this policy area, less likely to own a home and to escape high living costs (376).

Municipal housing accounts for about four percent in Norway. Some of the municipal housing stock requires upgrading. Securing a good housing standard for the most disadvantaged group is a challenge for municipalities, especially those with a tight budget. The combination of old housing stock and rising energy rates has increased the number of people experiencing energy poverty (377).

To understand how to influence policy in a direction that can impact health and wellbeing, it might be useful to look more indirectly at the 'meaningful' dimension of housing, health and wellbeing (378). Taking a 'meaningful' approach makes it possible to also impact health and wellbeing at a service and community level and improve these despite the profit drivers of the housing market. In addition to being a mere shelter, a home can also 'bring ontological security, meaning a sense of security and control and housing can be seen as a component of general wellbeing, ontological security, and the perception of social status, in both individual and community contexts. Conversely, housing debt, poor housing, and deprived areas can be seen as potentially harmful' (379). The meaningful dimension of housing is supported by the finding that even though housing size is used as a determinant of poverty in Nordic countries, people living in smaller homes often report their housing size as 'appropriate'. Meaningful housing is also linked to social capital, community feeling and access to good services (380).

In 2020, 19 percent of children between 0-17 years of age lived in households with cramped living conditions affecting health both in the immediate and longer term. Although there are some variations between regions,

Oslo has by far the highest proportion of all children aged 0-17 living in cramped households (36 percent) (18).

The third housing sector is a housing market model focusing on developing housing where people find meaning and belonging. Within the third housing sector, co-creation experiments are taking place to find out how low-income populations can achieve access to meaningful housing, a socially sustainable community model in which all people have a role to play and matter. In Trondheim, a study has been conducted in which organisational models for the third housing model are co-created with inhabitants in housing. This is administered by a housing association with a mission to offer low-cost housing building self-efficacy, without creating dependency on the social welfare services. In this co-creation project which was a collaboration between NTNU and the Housing Association, the aim was to find ways for people of different backgrounds, social capital and resources to find community-based solutions to good living environments in housing with low rent and rent-to-own models (381). A relational design approach has been proposed as a way forward in which, rather than designing solutions for the individual, the relationships between dwellers is the focus and purpose of the co-creation process (382).

UNIVERSAL DESIGN

Equitable access to public goods and spaces that promote safety, health and wellbeing for all are vital for reducing health inequalities; achieving this depends on creating conditions that enable citizens to participate in social and community life. Universal Design (UD) is a helpful approach; it has no agreed definition, but commonly refers to the outcome and/or the process of designing buildings, products, services or environments with the objective of making them accessible to people, regardless of age, disability or other (383). UD addresses common barriers to participation by designing environments that can be used by the maximum number of people. The focus on design for all separates universal design from design for accessibility for special needs, as UD has a vision of ensuring an environment that does not require special interventions for separate groups. UD designers also believe that if we design for people who are not the 'typical consumers', environments are likely to get better for everyone. For example, if a school environment is designed for a child on the autism spectrum, the result might be an environment that is more enabling, less noisy, and more pleasing to the senses for everyone using it. Furthermore, UD can have unknown benefits, something called the 'kerb-cut effect'. The 'kerb-cut effect' refers to the positive side effects of lowering kerbs on sidewalks, something that was originally designed for people in wheelchairs. The added and unforeseen value was that people on bikes, with baby strollers and skateboards

could more easily use the pedestrian infrastructure. Universal designers look for these 'kerb-cut effects' so that universal design is also design for public value (384). Universal Design has mostly been concerned with architecture and physical infrastructure, yet the move towards UD of services and systems has been accelerated by the influence of increasingly digitised and smart services (385,386).

In Norway, the standards for buildings take into account the technical aspects of universal design, while regulations on universal design guides the digital sphere to ensure accessibility of digital interfaces (387,388) . However, companies or public institutions can bypass the laws if they are too expensive or resource-intensive.

RECOMMENDATIONS

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.

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.

As indicated in Chapter 2, there are several groups who are significantly worse off on all subjective wellbeing indicators compared to the general population. In this section we focus on the intersection between the characteristics that define some of these populations - immigrants, the Sami, LGBTQ+ and prisoners - and the social determinants of health that contribute to their vulnerable situations and frequently lead to worse health and poor levels of wellbeing.

IMMIGRANTS

At the beginning of 2022, there were 819,400 immigrants in Norway, amounting to 15 percent of the population. This represents an increase of 5.5 percentage points compared with 2010, when the proportion was 9.5 percent (SBB Table 09817) (26). The main countries of origin of immigrants in 2022 are Poland, Lithuania, Sweden, Syria and Somalia (SBB Table 09817) (26). The number of Norwegian-born descendants of immigrants was 205,800 people at the beginning of 2022, amounting to 3.8 percent of the total population. The main country of origin of Norwegian-born to immigrant parents is Pakistan, followed by Poland and Somalia (SBB Table 09817) (26). Among those who migrated in 2021, a majority did so for work, family and education reasons (SBB Table 07113) (26).

Although in absolute numbers Oslo is the municipality with the most foreign-born immigrants, the proportion has grown considerably in other areas of the country since 2012. Small municipalities such as Gamvik and Båtsfjord, in Northern Norway, have surpassed Oslo in terms of the total proportion of the population who were foreign-born immigrants in 2019 - 28.8 percent and 27.6 percent, respectively, compared to 25.2 percent in Oslo (389). However, the compositions of the immigrant populations in these three municipalities are very different. In Gamvik and Båtsfjord, 78 and 71 percent of immigrants, respectively, were from the EU and Nordic

countries other than Norway compared to 35 percent in Oslo. Conversely, 53 percent of immigrants in Oslo were from outside Europe, compared to 11 and 19 percent in Gamvik and Båtsfjord, respectively. In January 2022, 30 percent of immigrants, equating to 4.5 percent of the Norwegian population had a refugee background (390).

Official data and studies indicate that immigrants in Norway are doing relatively well when compared to other countries. Their levels of education are relatively high, and so is the employment rate, even compared to other Scandinavian countries. The same can be said of income levels (391). However, there are persistent inequalities between immigrants and the rest of the population in areas which have been shown to have a large impact on health and health inequalities. For example, children with an immigrant background are more likely to live in families with persistently low income, as explained in Section 3A (99).

However, as indicated above, the migrant population in Norway is heterogeneous and there are clear differences in experiences and outcomes which need to be taken into account in policy development. Immigrants from European countries experience fewer social and economic problems than immigrants from Asia and Africa, while refugees generally experience more difficulties than

labour and family migrants (391). When analysing the effectiveness of integration policies, it is crucial to look to the long term. Past studies showed that differences between refugees and family immigrants compared with native Norwegians are reduced in the first decade lived in Norway, but employment rates and earnings differentials widen again after that, often after a period of economic downturn. For instance, as shown by Bratsberg et al, after seven to ten years of being in the country, the labour force participation rate of refugees starts to fall (392).

THE HEALTH OF IMMIGRANTS

Data and research on health and health care use among people with an immigrant background are scarce and inadequate. There is no systematic and regular collection of the immigrant population's health data. Generally, health surveys lack adaptation to immigrants in language and content, are often aimed at selected immigrant groups and have low levels of participation. Health register data needs linkage to country background from Statistics Norway or the National Population Register, requiring permission, financing and time, and it lacks data on undocumented immigrants, asylum seekers and short-stay working immigrants. Statistics Norway has performed living conditions surveys among immigrants at decade intervals, the last one being in 2016 with 4,435 people from 12 countries (393). The National Council for Quality and Prioritisation in the Health and Care Service supported increased availability of data on immigrants' health (394).

Factors such as country background – with more than 200 countries of origin; different reasons for migrating, and different lengths of residence in Norway affect living conditions and health in different ways (395). As happens in other countries, immigrants tend to be younger and healthier than the general population, what is known as 'the healthy migrant effect', but these differences tend to disappear the longer the person has been in the country. According to the Norwegian Institute of Public Health's updated report on immigrants' health (August 2022), there are big differences between people with different immigrant background in terms of living conditions, lifestyle and incidence of disease (395).

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 (396).

As for lifestyle factors, immigrants overall seem to have lower levels of physical activity than the majority. Diet is not well investigated, but vitamin D insufficiency is common among immigrants from Africa and South Asia; smoking is more common in some immigrant

groups, while alcohol intake is in general lower than in the majority population.

With regards to major non-communicable diseases, immigrants from South Asia and some African countries have higher age-specific prevalence rates of diabetes type 2; cardiovascular disease is more common among immigrants from South Asia and less common among immigrants from East Asia, compared to the majority population; and overall, there are fewer cancer cases among immigrants, but more lung cancer, liver cancer and ventricular cancer compared to the majority. COPD prevalence among immigrants is unknown. Fewer immigrant women screen for cervix and breast cancer (395).

INEQUALITIES IN THE SOCIAL DETERMINANTS OF HEALTH OF IMMIGRANTS AND REFUGEES

Inequalities In Education

Early Childhood Education And Care (ECEC)

A study that examined the effects of providing free childcare for four- and five-year old children in some city districts in Oslo found that this had a positive effect on the development of children from immigrant families. In particular, the study found some evidence of improved performance in nationwide tests of children in fifth grade among those from low income families or families with low maternal labour force participation compared with those with similar characteristics living in districts without free childcare (397).

However, as explained in Section 3A, data shows that in 2017 only 61 percent of those entitled to free core time in pre-school received it and that a large proportion of eligible families do not claim the discount. According to The Norwegian Directorate for Education and Training (Udir), an important reason may be the complexity of the application procedure (82). This procedure was somewhat simplified in 2020 by allowing municipalities to retrieve information about parental income from their tax return, which is the basis of the decision on eligibility after parents have applied for the discount.

Asylum seeking families do not have a right to a free childcare place until their application has been accepted and the family has a permanent address. However, children in asylum centres may attend a kindergarten if there are places available in the municipality (81). When their application is granted, children in asylum centres aged two and three are entitled to free core hours (398). Since 2019, one year olds in asylum centres have also been entitled to free core hours (399).

In 2021, 19 percent of children in a kindergarten were minority language children (74). There is significant geographical variation, however. The highest percentage of minority language children can be found

in kindergartens in the areas of Drammen and Oslo, where they represent 35 percent and 30 percent of the enrolled children in 2018-19 (82).

The comprehensive report *Migration and integration 2020-2021* sent by Norway to the OECD – and with contributions from eight ministries, has detailed information on the situation of migrants in Norway in major areas relevant for this report, such as education (81). These data show that there are some inequalities in attendance to kindergartens, although attendance of immigrant children has been increasing in the last few years thanks to efforts made by national and local governments (81). In 2021 among children aged one to five where both the child and parents had a mother tongue other than Norwegian, Sami, Swedish, Danish, or English, 87 percent attended kindergarten. This represented an increase of 6.6 percentage points since 2017, but still lower than attendance among non-minority language children, which stands at 96 percent (74). Inequalities are more apparent in younger children (one and two year olds), while they almost disappear in older children (81).

There are earmarked and non-earmarked Government funds for municipalities with low attendance at kindergartens by minority language children, intended to enhance their efforts to provide information and recruit these children (81). Municipalities also receive a grant to improve the development of minority language children in Norwegian, which is evaluated at child health clinics at the ages of two and four (81). Around 20 percent of minority language children receive strengthened Norwegian language tuition (74). In May 2020, the Government announced an investment of NOK 35 million to recruit more kindergarten teachers in the socioeconomically deprived areas of Oslo, Bergen, Stavanger, Drammen and Trondheim, aiming to reduce social inequalities. The current Government has stated that it will 'strengthen the investment in kindergartens in areas with integration, language and living conditions challenges' (400).

Primary And Lower Secondary Education

According to the *Migration and integration 2020-2021* report, in 2020 around 19 percent of students in primary and lower secondary education were immigrants or children of immigrants, whereas for upper secondary schools the proportion was 20.5 percent (81).

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 (81). The difference between non-immigrant students and those born in Norway from immigrant parents was only two points, indicating that

having foreign-born parents has only a small effect on educational outcomes at this stage (81).

There are important gender differences in achievement by immigrant background. Overall, girls achieved 4.4 more points than boys. However, Norwegian-born girls with immigrant parents achieved more points than boys without an immigrant background, although they did not entirely catch up with girls without an immigrant background (81). These differences in achievement in school between boys and girls can be seen globally and have been dubbed 'The Boy Crisis', but they are very marked in the Nordic countries. This suggests that boys who were born abroad are the group experiencing more difficulties (398). Thus, policies are needed to improve the outcomes in this group.

Upper Secondary Education

According to the Norwegian Directorate of Education and Training, grades at lower secondary level are the most important factor in predicting whether a student will complete upper secondary level (82). In addition, children whose parents have higher qualifications achieve higher grades in lower secondary than those whose parents have lower qualifications (82).

Immigrants are less likely to complete upper secondary education or training than other young people (74). Among immigrants who started upper secondary education (general or vocational) in 2014/15, only 63 percent completed their studies within five years, compared with 82 percent among the population without an immigration background (81). The figure for Norwegian-born students with immigrant parents was 78 percent, quite close to the general average (81).

Research of the 15 cohorts which graduated from compulsory education between 1990 and 2004 in Norway showed that the difference between immigrants and native-born students in completion rates of secondary education disappeared when grade points in compulsory school were accounted for and family background became much less important for explaining differences (401).

As in primary and early secondary education, gender differences are apparent in upper secondary education among immigrants. Among those who enrolled in upper secondary in 2014/15, 69 percent of immigrant girls and 57 percent of immigrant boys completed upper secondary school within five or six years (81). The proportion was 85 percent for girls with immigrant parents, the same as for girls without an immigrant background, while only 72 percent of the boys with immigrant parents did so.

Young immigrants who apply for apprenticeships find it harder to be accepted than other applicants, even when accounting for grades and absenteeism

(82). It is noteworthy that in this case Norwegian-born descendants of immigrant parents also face similar difficulties, especially boys. This means that there is little difference between immigrant boys and Norwegian-born boys with immigrant parents in the chances of obtaining an apprenticeship. Girls are also impacted but to a lesser degree. The fact that both immigrant boys and boys who are descendants of immigrants face disadvantage could indicate that discrimination is having an important role in explaining these differences. This should be better understood so policies can be designed to reduce these inequalities.

Students Over The Age Of 16

Students over 16 who emigrate to Norway near the end of lower secondary school without qualifications which are equivalent to Norwegian compulsory education are in a disadvantageous position (82).

Completion rates in the first year of upper secondary education or training (Level Vg1) are strongly associated with length of stay in Norway, indicating that students who arrive at an older age face greater difficulties than those who have been in the country for longer when they enrol in upper secondary. In 2015, during the migrant crisis, there was a big influx of young asylum seekers and available data shows that for those born in 2000, the proportion of young people who have lived in Norway between 0-2 years who have completed Level Vg1 is only 14 percent, compared with 64 percent for those who have been in Norway for 3 to 4 years. From 5-6 years onwards, the proportion of immigrant children completing Level Vg1 is very high and remains above 90 percent (82).

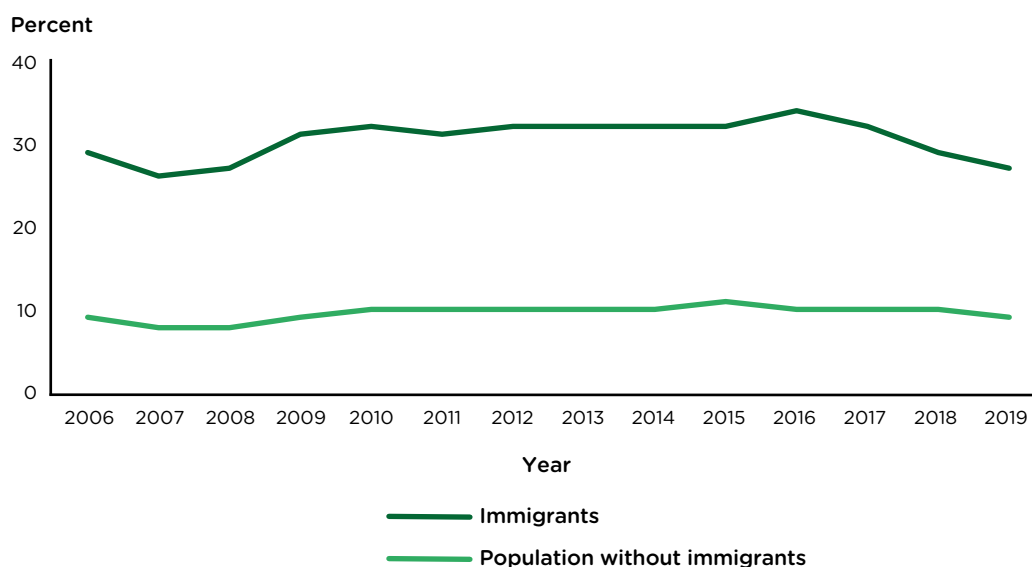
Local authorities are responsible for providing additional lower secondary education for recently arrived young

people who are entitled to upper secondary education or training, so-called combination classes. In 2017-18, 41 upper secondary schools were providing this tailored provision, aiming at enabling more students to complete upper secondary education or training. All counties had combination classes in at least one upper secondary school, but there is no assessment available of the proportion of the target group who receive this provision (402). Due to a lack of clarity on provision and which should be the target group, there is considerable variation across Norway (82). This creates inequalities in the chances of recently arrived immigrant adolescents to integrate and prosper in Norwegian society and, therefore, policies should focus on ensuring that all young people have the same opportunities.

NEETS

A key interim outcome of the education system is the proportion of young people who are either in employment, education, or training. Figure 3.30 shows the proportion of those aged 16 to 25 who are not engaged in any of these activities (NEETS). For those born in Norway, this figure rose to 10 percent in 2010 and remained around this figure through the decade, falling slightly to nine percent in 2019. However, among young immigrants, some of whom will not have been educated in Norway, this figure rose to 32 percent in 2010 and remained around this level until it began to fall in 2017 and by 2019 had declined to 27 percent – around three times the level for those born in Norway. Reducing the numbers of young immigrants who are NEETs should be an important priority in Norway, with greater investment and resources. Programmes to reduce NEETs must be developed in collaboration with young people affected, to ensure they are appropriate and effective.

Figure 3.30 Percent of those aged 16 to 25 not in education, employment or training (NEETS), Norway, 2006-19



Source: NIPH Database (18)

THE INTRODUCTION PROGRAMME

Newly arrived refugees and their families in Norway have the right and, to some extent, duty to participate in the introduction programme according to the 2004 Establishment Act (403). Since 2021, it has been mandatory that an individualised plan is made for each new arrival, according to the person's educational level, work experience and other skills. The programme includes Norwegian language classes and labour market measures, such as training, work experience and subsidised employment, as well as regular education. Refugees and family migrants must take part in this programme if they want to receive a permanent residence permit (404). They also receive a fixed income which is conditional on their participation in programmed activities. The introduction programme is organised by the municipalities. An issue that has been highlighted is the difference in the achievement of goals between municipalities, as well as the variation in the use of the different measures available (405). The percentage of people who enter education or work after completing the programmes varies from 80 percent in some municipalities to 30 percent in others (406).

Between 2010 and 2018, there was an explicit goal that 70 percent of participants in this programme should be employed and/or in education one year after completing it. However, a survey conducted by the National Audit Office (*Riksrevisjonen*) showed that this target was not reached during this period, when approximately 50 percent of participants were in work and 10 percent in education one year after finishing the programme (407). As noted above, the level of NEETs among all young immigrants is much higher than for the rest of the population. The end goal for those who already have at least upper secondary education is for the participant to qualify for higher education or work, whereas for those below 25 years of age who do not have upper secondary education it is to complete this level (408).

Data from Statistics Norway shows that success rates vary greatly by age and gender. In 2019 – before the start of the COVID-19 pandemic, among the age group 20-24 years, 85 percent of men and 76 percent of women who had completed or discontinued the introduction programme one year earlier were in employment and/or education in November. The share of women in employment and/or education, however, decreases abruptly among all the other older age groups. Only 55 percent of women between 25-29 years of age who had completed or discontinued the programme one year earlier were in education and/or employment in 2019 compared to 81 percent of men, while the proportions for those aged 30-34 were 46 and 76 percent respectively; 45 and 69 percent respectively for those aged 35-39; 42 and 63 percent, respectively, for those aged 40-44; 34 and 52 percent, respectively for those aged 45-50 and 13 and 34 percent, respectively for those 51 or older (SBB Table 10809) (26).

Various reasons have been assessed to explain the difficulties in the integration process of refugee women in Europe, such as their lower education levels, a lack of knowledge of the language, family obligations (especially childcare) or health issues (409).

There is not much research on active labour market policies for refugees and family migrants, but Nordic nations are paying more attention to determining how best to organise policies and measures to improve the employment prospects of recent cohorts of refugees and their families. Additionally, according to Calmfors et al. there is debate over whether Nordic nations should prioritise placing immigrants in employment in the hopes that they will develop their language and other abilities on the job, rather than focusing on educational outcomes to improve their skills (404).

INEQUALITIES IN THE LABOUR MARKET

Employment rates among immigrant workers are lower in Norway than those for the native-born. In the fourth quarter of 2021, the employment rate (register based) among immigrants aged 20-66 was 68.9 percent, whereas it was 79.2 among the non-immigrant population (SBB Table 09837) (410). Immigrants from Africa and Asia have lower employment rates, and the same applies to all immigrant women, particularly those from Africa. However, these figures are not adjusted for factors such as age, educational level, country of birth or Norwegian language skills (81).

As with education, it is clear that longer stays are associated with improved outcomes although longer-term some inequalities do persist. In 2018, the highest employment rate in immigrants aged 20-64 was found among those who had been in the country between 8-15 years (74.2 percent) and the lowest was seen among those who had been in Norway between 0-3 years (53.7 percent). However, the rate declines after 15 years in the country (67.4 percent), although the figures were not adjusted for any variation within this broad age group (411).

Analysis from the Directorate of Integration and Diversity (IMDi) – not adjusted by other factors, shows that while high shares of labour migrants are employed, the proportion of refugees or people who arrived in Norway through family reunification who work is markedly lower. Employment rates are higher for labour immigrants regardless of how long they have been in Norway, and close to those of the rest of the population (412).

Employment levels vary by education for immigrants, as they do for the rest of the population. However, at each level of education, immigrants have lower employment levels than non-immigrants and those from outside

the EU27 have the lowest levels. For example, among those with tertiary education, 78 percent of those from outside the EU27 were employed in 2020, compared with 86 percent of those from the EU27 and 90 percent of non-immigrants (413).

For refugees, employment rates are highest at around five years after arrival, but they decline after between seven and ten years in Norway. Gender differences in employment are marked in the case of refugees, with males having higher rates, and have increased in recent years (412).

Previous research has shown that the negative effects of unemployment on future employment and income are greater for immigrants than for people born in Norway (412) and that once they fall outside the labour market or education, immigrants more often find themselves in longer periods of inactivity (414). Immigrants born outside the EU are at a higher risk of being unemployed than native-born Norwegians and those from inside the EU-27 area (415). In 2020, 9.7 percent of immigrants were unemployed, compared with 4.6 in the rest of the population (416).

A larger proportion of immigrants work part-time than the rest of the population, particularly refugees (417). As explained in Section 3C, marginal part-time work has been associated with lower income and job security than full-time work (283). In 2020, 21 percent of all immigrants working part-time wanted to work more hours, while the figure among the rest of the population was 11 percent, according to the Labour Force Survey (417). This is an indication that a large proportion of immigrants are underemployed, and so at a higher risk of suffering from income insecurity. Immigrants from outside the EU/EAA find themselves in temporary positions more often than native-born Norwegians (13 percent compared to seven percent in 2020) (417).

As explained in Section 3C, immigrants are also more affected by low pay than the general population. While 40 percent of those born abroad were paid at or below 85 percent of the average industrial worker's wage (TBU85) in 2008, it had risen to 44 percent in 2018 (273). The highest share of low-paid workers is among immigrants from Eastern Europe. Among those with a D-number (a temporary identification number for people without a Norwegian social security number), 60 percent had low wages. Immigrant workers who are covered by collective agreements are more protected against low pay, and this effect has increased through time (273).

An investigation by the Fafo research foundation reported the existence of grossly exploited migrant workers in Oslo. These workers – whose number is difficult to quantify but whose problems are probably underestimated, are 'in a grey zone between regular labour market on the one hand and a situation that falls under the provisions on human trafficking/forced labour in the General Penal code in the other'. (418). These workers face multiple barriers, such as language problems or the high threshold for obtaining social assistance.

Positively, inequalities in the labour market seemed to be significantly reduced in subsequent generations. According to Government documents, Norwegian-born people with immigrant parents have significantly higher employment rates than first-generation immigrants and experience less gender inequalities. For example, only 26 percent of Pakistani mothers were working in 1993, while 79 percent of their daughters had a connection to working life in 2016 (406). However, the employment rates of descendants are still lower than those from the population without an immigrant background in the same age groups (81).

Although low education and skills among certain groups, together with the high requirements of the Norwegian labour market, can be factors in explaining the disadvantage among certain immigrant groups, different analyses have shown that education and work experience are not sufficient to explain immigrants' position in the labour market, indicating the role played by discrimination (419). As an example, a field experiment found that having a Pakistani name reduced the probability of receiving an offer of a job interview by 25.5 percent (419). Also, immigrants from Asia and Africa with higher education credentials from Norwegian institutions still face higher risks of unemployment and also are worse paid than those without an immigrant background (406).

The Integration Strategy for 2019-2022 made 'stimulating employers to increase awareness of diversity as a resource' one of its two main goals for the. The other goal was to improve and strengthen qualification schemes and labour market measures (406).

UNDOCUMENTED IMMIGRANTS

There are no official figures of how many irregular immigrants currently live in Norway. Undocumented immigrants have very limited rights regarding health and welfare policies (420). For example, they can only access immediate assistance and health care that is ‘absolutely necessary and cannot wait’ and they will be billed for it (421). There is an exception for children and pregnant women, who can access antenatal care and give birth at hospital, but are excluded from having a GP. This is the same access as exists for undocumented children who are not seeking asylum. In section 3A, we set out inequalities in access to antenatal care for undocumented migrant women. People with a D-number can access healthcare but are also excluded from having a GP (421).

Regarding housing, only asylum seekers whose application has been rejected can stay in reception centres and receive a basic allowance, but they are subject to being found by the police and deported (420). For those with no legal residence and no entitlement to stay in reception centres, there are some NGO-managed overnight accommodation services in cities like Oslo and Bergen (420). Irregular immigrants cannot work, but workplace inspections frequently find undocumented workers. They are vulnerable to exploitation by their employers since they cannot report to the authorities. Irregular immigrants who take work without a valid permit risk deportation (420). In a survey among health personnel, half of those who came into contact with undocumented immigrants said they had been concerned that they had been sexually exploited or that they had been exposed to violence in close relationships (420).

INCOME AND POVERTY

In 2022, Statistics Norway published an analysis of the quality of life among immigrants in Norway, based on the Quality of Life Survey from 2020 and 2021 (416). It found that in 2020, immigrants’ average income was 13 percent lower than that of the rest of the population. Half of immigrants cannot afford an unexpected expense of NOK 19,000, compared with 30 percent of the majority population. Also, 27 percent of immigrants cannot afford to go on holiday for a week, compared to 13 percent of the rest of the population.

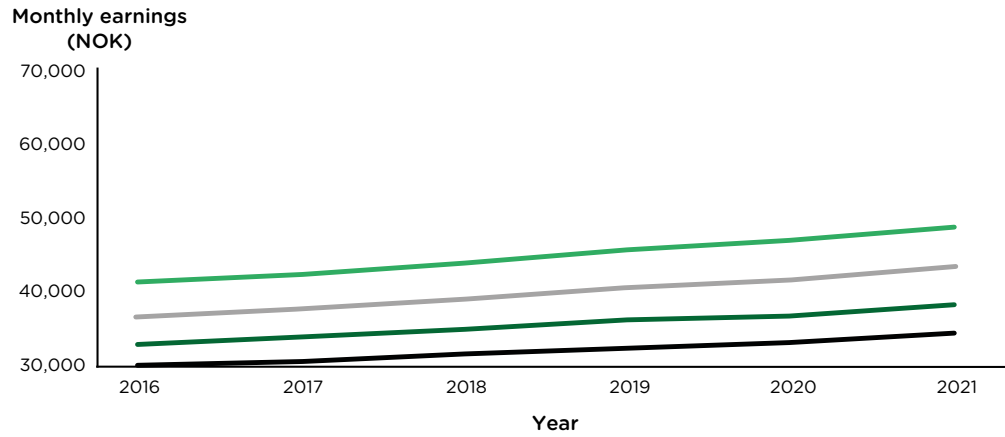
As discussed earlier in this chapter, employment levels are lower for immigrants with comparable levels of education to non-immigrants. Similarly, the earning levels of immigrants are lower than for others in society, with particularly low levels for female immigrants, at every level of education, meaning that low earnings are not a consequence of lower education levels (Figure 3.31). However, earnings for immigrants have increased in line with those for non-immigrants.

Note: Newham data not available.

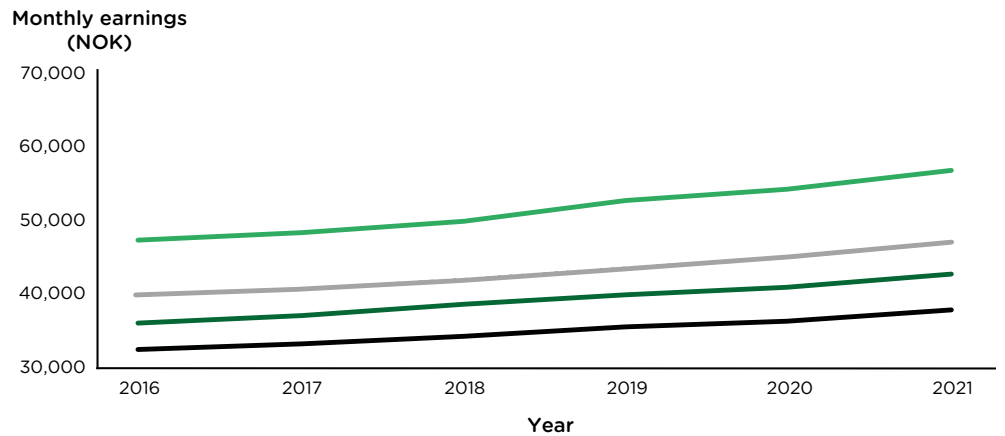
Source: Ministry of Housing, Communities and Local Government (282)

Figure 3.31 Monthly earnings of employees, by immigration category, level of education and sex, 2016-21

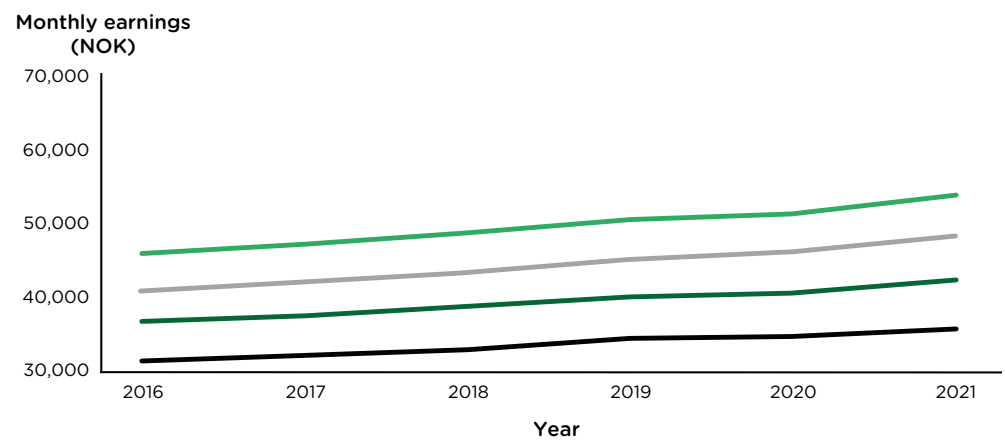
(A) FEMALE IMMIGRANTS



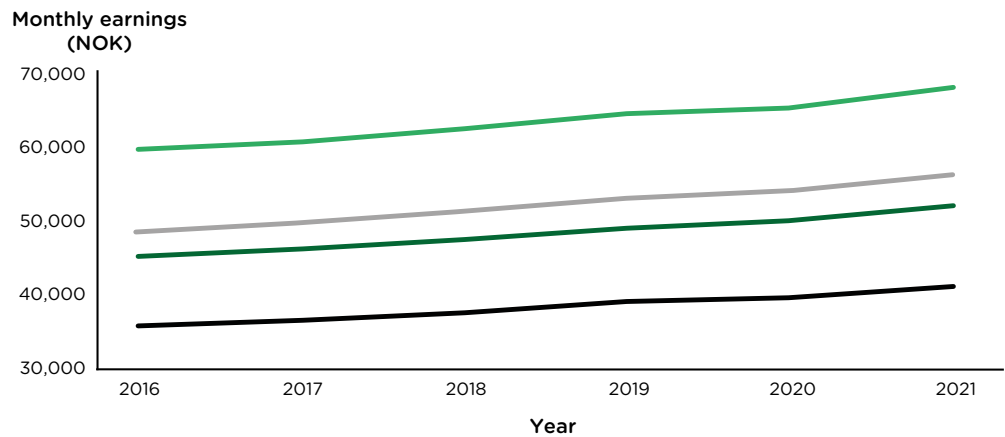
(B) MALE IMMIGRANTS



(C) FEMALES EXCLUDING IMMIGRANTS



(D) MALES EXCLUDING IMMIGRANTS



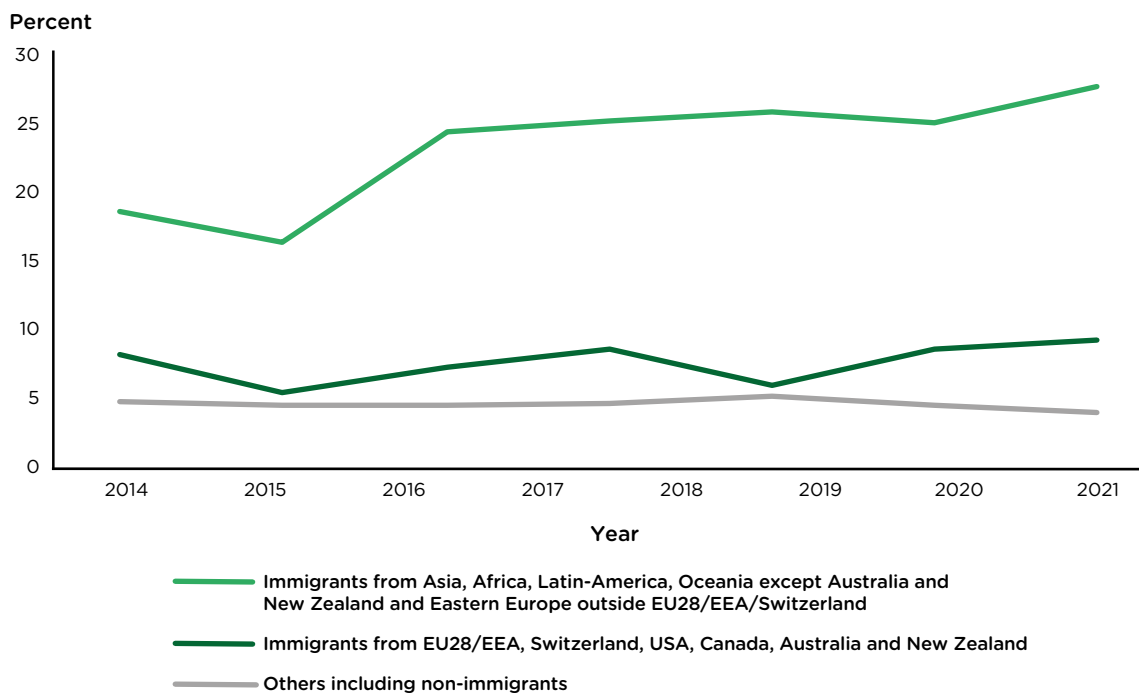
— Higher education — Upper secondary education
— All levels — Basic school level or unknown

Source: SBB Table 12837 (26)

Low earnings are not necessarily a consequence of immigration per se and, as with employment, there are markedly different rates between immigrants within and outside the EU as well as between immigrants and the non-immigrant population. Figure 3.32 shows that

immigrants from outside the EU and a number of other developed economies are markedly more likely to have difficulties making ends meet than immigrants from these countries and non-immigrants.

Figure 3.32 Percent of those aged 16 years and older having difficulty making ends meet by country background, 2014-21



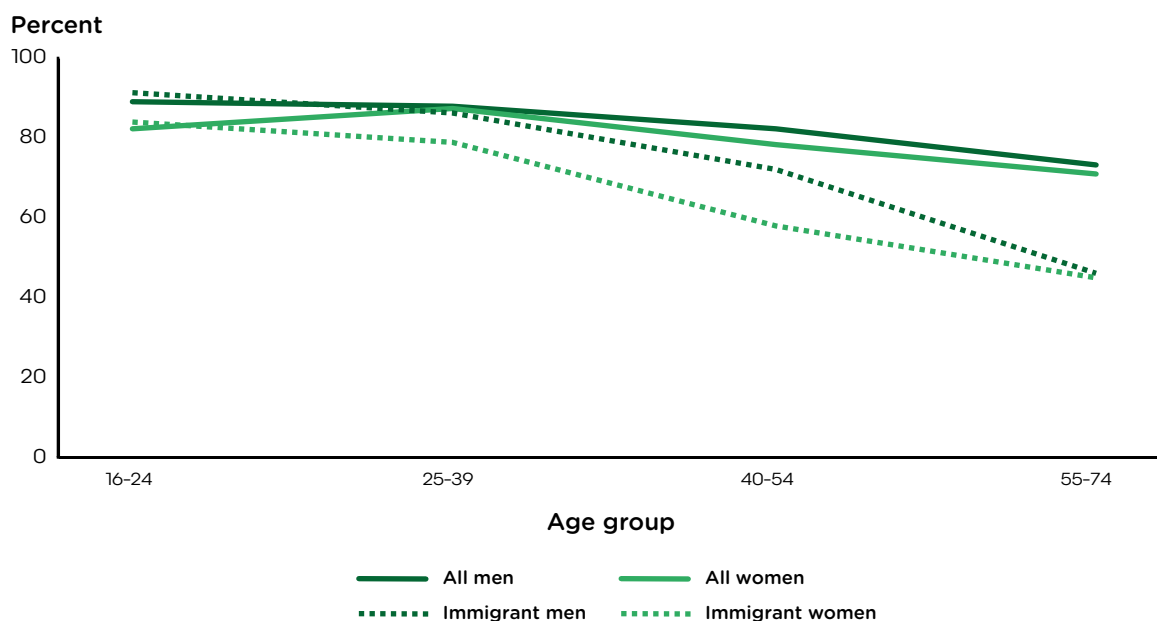
Source: SBB Table 13645 (26)

WELFARE AND QUALITY OF LIFE

On average, immigrants have similar levels of life satisfaction to the Norwegian-born population (416). Younger immigrants, like those with low incomes, the unemployed, those with disabilities, single parents and people living alone, have lower life satisfaction.

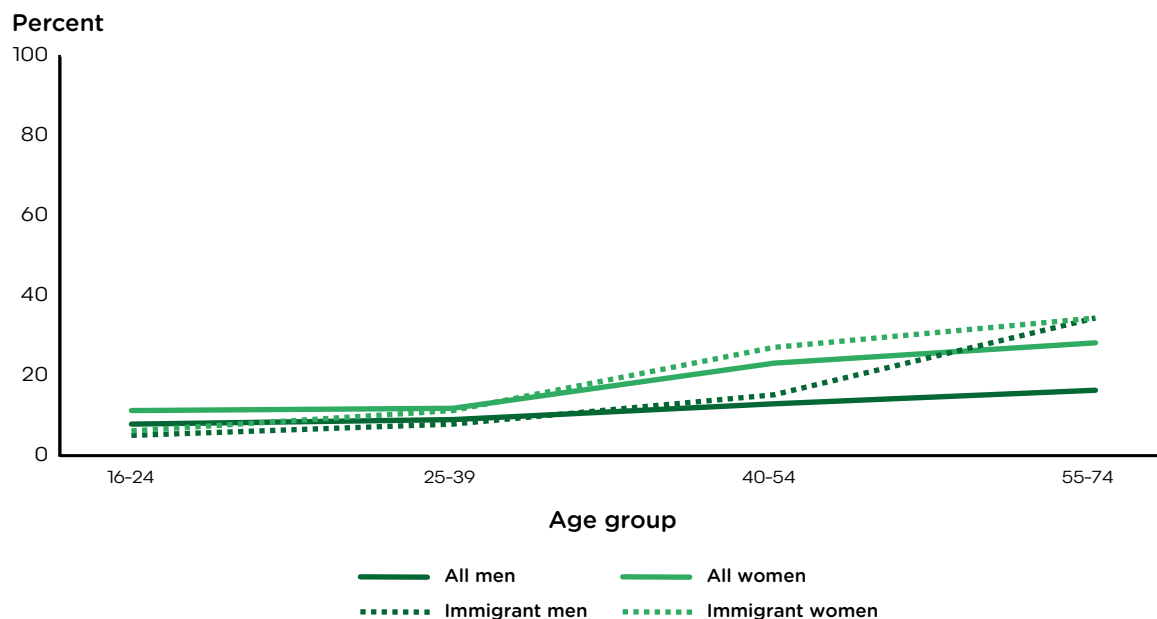
A similar pattern to that of life satisfaction has been found regarding subjective health and daily functioning when comparing young immigrants to native Norwegians. However, the health gap between immigrants and the rest of the population seems to widen in older age – Figure 3.33 – as does impaired functioning – Figure 3.34.

Figure 3.33 Percent of immigrants and the general population who consider their health as good/very good by sex and age, 2016



Source: Hamre (2017) (422)

Figure 3.34 Percent of immigrants and general population with impaired functioning by sex and age, 2016



Source: Hamre (2017) (422)

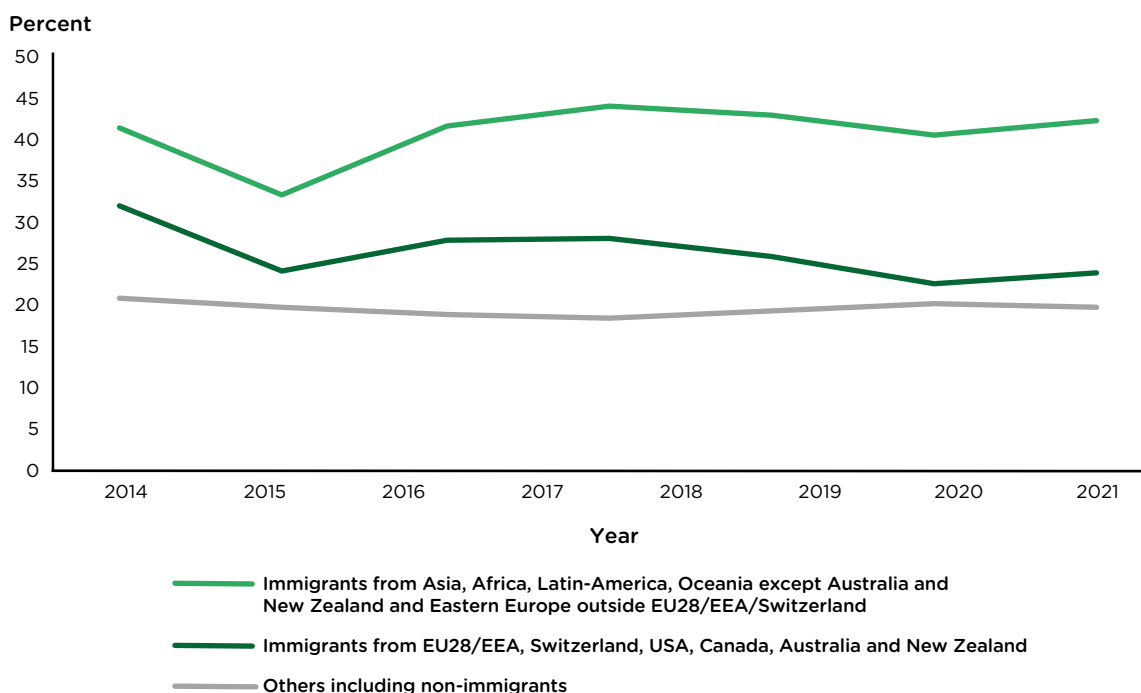
Drawing on a large-scale survey of living conditions among immigrants in Norway conducted by Statistics Norway in 2016, researchers from the Norwegian Institute for Urban and Regional Research set out to identify welfare problems related to work, housing, income, neighbourhood, social isolation, poor health, and mental health among immigrants aged 16-74 from 12 countries, constituting some of the largest immigrant

groups in the country. They also analysed which problems related to living conditions are the most common among immigrants and the accumulation of welfare problems in some groups. The most common welfare problem among immigrants was overcrowding or unsatisfactory housing conditions, followed by low labour market attachment, having no income or very low income from work (391). Social isolation

is the only dimension in which immigrants did not experience more welfare problems than the native-born population. Immigrants reported similarly high levels of life satisfaction as the majority population, scoring 8 on a scale from 0 to 10 (391).

Figure 3.35 shows differences in housing cost burdens for different groups of immigrants.

Figure 3.35 Percent of those aged 16 years and older reporting a high housing cost burden by country background, 2014-21



Source: SBB Table 13645 (26)

Immigrants are more likely to rent their homes than others. While 14.3 percent of the general population rented their home in 2021, 39.1 percent of immigrants from EU/EFTA countries, Great Britain, USA, Canada and New Zealand did so, and the figure rose to 42.9 among those from elsewhere (423).

Everyday integration was one of four main focus areas in the government’s integration strategy for the period 2019/2022. A pilot study found that immigrants had lower levels of trust, both in people around them and in institutions being able to guarantee their rights (424). Some factors are positively associated with experiencing social support and trust in others, including being employed, having higher education, having been in the country for longer and having good Norwegian language skills (424).

THE HEALTH OF THE INDIGENOUS SAMI POPULATION

During centuries, the Sami have been subjected to ethnic discrimination and assimilation policies from the State, what has come to be called the *Norwegianisation*

policy. As part of it, for example, the Sami language was banned in schools. In the last 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. The Sami Act, the Norwegian Constitution and ILO Convention No.169 of Indigenous Rights adopted by Norway also protect the rights of the Sami. However, these parliaments have only limited powers and, as explained by Sjölander (2011), in all three countries, national laws and social structures have still not been properly adapted to meet the rights and needs of the Sami (425).

The Truth and Reconciliation Commission (2017) has been tasked to investigate the *Norwegianisation* policy and its grave consequences for Sami culture, identity and living conditions. It will map the consequences of this policy for the opportunities for the Sami and Kvens/Norwegian Finns to use and practice their own language, culture and traditional trade and what it meant for discrimination and prejudices against the Sami and Kvens/Norwegian Finns among the majority population (426).

Most of the Sami population in Norway has adopted the lifestyle of the majority group. A small group still carries a more traditional lifestyle based on fishing, hunting and reindeer herding (425). There has been considerable migration of the Sami population from the Northern region of Sápmi, where they have lived for centuries, into urban areas in the south of Norway (427).

In contrast to other indigenous peoples in other countries, there are few, small or no differences in living conditions, wellbeing and health compared to the majority population in Norway. However, differences within the Sami population may occur according to traditions, socioeconomic and demographic conditions, gender, age and the cultural context.

As it is forbidden to report Sami ethnicity in registries in the Nordic countries, the Sami population does not have access to knowledge about their own health status, living conditions, welfare etc., which creates a considerable knowledge gap for the Sami community. Statistics are therefore based on either health surveys where ethnicity is reported by the participants themselves or on proxy measures like the place of residence. The Sami Parliament's STN areas, communities receiving financial support from the Sami Parliament based on an assumption of a certain number of Sami inhabitants, are often used in Sami statistics despite its limitation as these areas include Sami as well as non-Sami inhabitants.

The SAMINOR study - The Population-based Study on Health and Living Conditions in Regions with Sami and Norwegian Populations, conducted in 2003-2004 and again in 2012-2014 - is the most important source of knowledge for Sami adults' health and living conditions (428). Findings from this study compared with other indigenous peoples have recently been summarised in an international publication, showing few or small differences in rates and risk factors for mental and physical health from the majority population in the same area (429). For some physical conditions such as obesity, diabetes and ischaemic stroke the Sami people seem to have a higher risk. A higher risk has also been shown for mental health problems in adults, including suicide risk (430) physical, emotional and sexual violence in childhood and adulthood (431) and discrimination (432) but less for substance abuse (433).

Among young children and adolescents, the health status is to a large extent similar to the majority peers. Sami adolescents do experience more discrimination than the non-Sami, but the impact of discrimination on their mental health varies within studies (434). Factors that protect against mental health problems seem to be a supportive cultural context, competence in the Sami language, ethnic identity exploration, cultural activities, and close family ties. On the other hand risk factors are similar with those in the majority population

such as school stress, broken families, low self-efficacy and female gender. (435).

In summary, the health status among Sami based on the limited, available data, shows no marked differences to the majority population. Cultural factors impacting on health have to a great extent been explored in Sami children and adolescents, but less in adults. Several of these factors seem to influence health, which is important to consider in future research and in the facilitation of health services to the Sami population. However, the great challenge of available data must be solved to close the knowledge gap in many fields regarding Sami living conditions, wellbeing, but also health status.

QUALITY OF LIFE AND HEALTH AMONG THE NORWEGIAN LGBTIQ+ POPULATION

Attitudes toward LGBTIQ+ people in the general population over the last decades have become more tolerant and accepting. However, social, economic, and mental health related problems are found more commonly among members of the LGBTIQ+ community and there are persistent issues with discrimination and bullying.

Mental health problems are found more frequently in the non-heterosexual and non-binary segments of the population and non-heterosexuals report ill health more often than heterosexuals in Norway (436,437). One in four non-heterosexuals between the ages of 18 to 24 consider themselves to have ill to very ill health. LGB+ persons are twice as exposed to loneliness and unsatisfactory social relationships than heterosexuals (438). Bisexual women, bisexual men and trans persons are also exposed to loneliness, compared to other groups on the gender and sexual spectrum in Norway (437). LGB+ persons report being more dissatisfied with their own mental health (438). One in three young LGB+ persons (18 to 24 years of age) report dissatisfaction with their mental health status. Bisexual women, bisexual men and transgendered persons, report more symptoms of mental health problems, particularly when compared to heterosexual and cis-persons (437). Feragen and colleagues (2019) have found Norwegian intersex persons to be vulnerable to mental health problems (439).

The prevalence of suicidal ideation is higher among LGBTIQ+ persons than in the majority population. Among the female bisexual participants in Anderssen and colleagues' study (2021), 81 percent reported suicidal ideation during their lifetimes. Also, 32 percent reported having made an attempt on their own lives. Among non-binary and binary transgender persons, suicidal ideation is commonplace, with 76 percent and 69 percent, respectively, reporting such thoughts during their lifetimes. Among them, 34 percent and



30 percent also reported suicidal attempts. Among the other groups in the LGBTIQ+ community, suicidal ideation and suicidal thoughts occur more frequently than in the heterosexual and cis population. A qualitative study with 46 intersex participants showed that while several of them described having good quality of life, others were psychologically vulnerable (439).

LGB+ persons in all age groups suffer from economic deprivation compared to the majority population (438). Almost 50 percent of LGB+ participants report material shortages and 20 percent report a financial situation contributing to difficulties in making ends meet in their daily life. This is related to findings from other studies reporting that non-heterosexual persons are significantly more often unemployed or disabled, and hence, outside the workforce, than heterosexual persons in Norway (436).

LGBTIQ+ people in Norway also experience discrimination, harassment and bullying based on who they are and how they feel. Some are also subjected to interpersonal violence. Bisexual women in particular have been found to be at risk for violence from strangers in the public sphere (440). A study showed that 36 percent of young homosexual males report having been bullied. For heterosexual boys, the number reporting bullying is six percent (441). A

study reporting on the experiences of LGBT people concerning harassment and threats in the workplace shows that LGBT persons are somewhat more exposed to hateful speech and threats from customers, service users or colleagues (442). Many LGBTIQ+ people hide their sexual orientation or gender identity from co-workers, leading to difficulties regarding identity and shame (443).

Non-heterosexuals in Norway experience more problems with housing than the heterosexual majority population (436). Non-heterosexuals report more problems with noise, smell and pollution where they live. They also report more problems with violence, criminality and vandalism and are significantly more worried over violence and threats in the communities than their heterosexual neighbours.

Migrants who are LGBTIQ+ are vulnerable to discrimination on the basis of both their gender or sexual orientation and their migrant background (444). LGBTIQ+ migrants who are also persons of colour report being exposed to discrimination and stereotyping from the predominately white Norwegian LGBTIQ+ community. LGBTIQ+ migrants are also found to be vulnerable to mental health problems, interpersonal violence and threats, sexual violence, suicidal ideation and behaviour.

THE SOCIAL AND HEALTH MARGINALISATION OF THE PRISON POPULATION

Inmates have a higher probability of having grown up in socially deprived neighbourhoods with higher rates of poverty and unemployment than the general population and as adults experience family, educational, employment and health-related disadvantages more often (445–447). Incarceration seems to exacerbate these inequalities through isolation, stress, stigma and by reducing employment prospects, and this in turn impacts on their families and children (448,449).

A large proportion of the prison population has experienced serious difficulties and/or traumatic events during childhood. A large national study showed a quarter grew up in a family with alcohol or drug problems; one in ten grew up in a family where one or more family members suffered from serious psychological problems (445), and one in five had been in foster care as children (450). A national study on living conditions among people in Norwegian prisons found that 40 percent of the participants had experienced abuse in childhood, while 41 percent had experienced the imprisonment of a family member (446).

Women in prison tend to have had a less stable upbringing than men and more psychological problems. More women than men had severe drug use patterns in the six months prior to incarceration. Young people in prison are particularly vulnerable, in terms of traumatic experiences, social problems, mental health and risk of re-imprisonment (446,451).

People in prison often have low education and weak labour force attachment (445,446); just under a tenth have not completed elementary school, while nearly one third have primary school as their highest education, according to the latest figures available from 2013–14 (445). About half were neither in education nor in work during the last six months before imprisonment (445).

There are differences among people in prison according to country of birth: those born in the Nordic countries had more severe substance use in the six months before incarceration and reported more injecting drug use compared to those born in other countries. Inmates of Nordic origin also reported more use of narcotics and medications (not prescribed) during imprisonment (452).

While one in three of the general prison population return to prison within five years (451), findings from the NorMA study showed that people with a high-risk drug use have a four times the risk of returning to prison (450). Besides drug use, being a young person at the time of imprisonment with a low level of education is an important risk factor for returning to prison.

HEALTH AND ACCESS TO HEALTH CARE

A large proportion of people in prison have significant health problems: one in ten has hepatitis C, and a high proportion struggle with severe symptoms of anxiety and depression. One in ten is a patient in opioid maintenance treatment (OMT) while incarcerated (445).

In a national survey, 60 percent rated their current physical health as good or very good, while 16 percent rated it as poor or very poor. Regarding mental health, 54 percent reported it as being good or very good, while 20 percent rated it as poor or very poor. Moreover, almost one third were considered to be greatly affected by symptoms of anxiety and depression, and a higher percentage of women were seriously affected (41 percent) compared to men (28 percent) (445).

In Norway, people in prison are included in universal health coverage and since 2002 the regional health authorities have been responsible for providing all specialised healthcare for people in prison (453). According to Norwegian law, foreign nationals without a residence permit have the right to health care services during their imprisonment, even if they don't have the right to care other than emergency health care outside the prison system. Prisons can therefore, in theory, improve access to health care services for people without a residence permit, who amount to between 20 and 25 percent of people in Norwegian prisons (454). However, in reality the access to specialised health care services for this group, especially those that require Norwegian language skills, is limited (455). The next case study describes an initiative by the health care service in Oslo Prison, provided by the Gamle Oslo district in Oslo municipality.

CASE STUDY: THE USERS' COUNCIL

The health care service in Oslo Prison, provided by the Gamle Oslo district in Oslo municipality, faced many health challenges. A report from the Civil Ombudsman pointed out areas that needed improvement in the health care service, and the need to strengthen and improve it was clear (449).

In addition to this, health care workers expressed that they wanted an opportunity to discuss issues with inmates, and to learn from them. However, a system for feedback and dialogue with the inmates did not exist. As a result, inmates in Oslo Prison were invited to establish the 'users' council' to explore the possibilities for closer collaboration between them and the health care service. The council started in April 2022 and is made up of inmates from the different departments in Oslo Prison and employees from the health care service in the same penitentiary.

The users' council meets every four weeks in the library in Oslo Prison. Only inmates and workers from the health care service attend these council meetings. A written report is provided after each meeting and shared with the inmates. Both employees and inmates can register issues and concerns they want to address for future council meetings.

The users' council has given the inmates a voice to express and explain their needs in a more effective way than before. This makes it easier for the health care service to provide the help the inmates need. At the same time, the users' council helps make clear that there are also inmates who lack access to the health care service. In council meetings, inmates have presented several proposals regarding how health care workers can provide support. They have discussed many issues, for example the fact that inmates who don't speak Norwegian are especially vulnerable.

The health care service has a unique opportunity to contribute to providing health care to people who come from diverse backgrounds. Many inmates have experienced challenges linked to living conditions, trauma, substance abuse and physical and/or mental illnesses. Through the users' council, inmates now have a route to convey their needs and desires. Health care workers have also been given a space for discussion and for conveying health information. Inmates generally have limited access to health information.

Additionally, according to the initiators at the Gamle district and the health services in Oslo Prison, this collaboration has contributed to strengthening the health care service's work to support inmates in dealing with their health situation. Together, they have addressed and worked with important issues such as isolation, sleep, substance abuse, sexual health, nutrition, social health, suicide, release, and relocation. Several of these issues have then been further addressed in discussions with the correctional service and other relevant collaborative parties. In these discussions, the focus has been to explore solutions to the challenges inmates face.

Inmates have begun to initiate issues for discussion, and this has opened up involvement and collective thinking about health in prisons. Some of the proposals from prisoners involve active engagement from several services and stakeholders and are difficult to implement in practice. Such pending issues are forwarded to higher authorities for consideration. Accordingly, the users' council gives prisoners a voice and presence in finding new and co-created solutions to improve the support they need, while also empowering them with the agency to impact decision-making in wider support systems.

Lack of access to mental health care within prisons and insufficient training of prison officers in the complexities of mental health challenges and addiction means that the health of many inmates deteriorates while they are in prison. One important reason for this is that inmates have less access to high quality services, tailored to

their needs (456). As such, incarceration is in itself a contributing cause of health inequalities. Programmes such as that described in the case study below offer opportunities for mitigating the negative impacts of incarceration and reducing the intergenerational consequences of health inequalities.

CASE STUDY: THINK OUT REFLECTION GROUPS (THOR) WITHIN AND OUTSIDE OF PRISONS

Think Out Reflection Groups (THOR) is an innovative and newly accredited programme within the Norwegian Correctional Services. The model brings together a group of five to seven inmates for 90 minutes once a week. The groups are facilitated by two people, one of whom is usually a prison employee and the other is an expert-by-experience or a peer with experience of being incarcerated. The meetings use cards containing images that can produce an emotional reaction from the inmates. The idea is that participation in a safe, supportive space where inmates can talk about their emotions, worries and needs as well as share their vulnerabilities with each other, will contribute to their recovery, increase their motivation, reduce their isolation and increase their sense of wellbeing.

The programme can be offered early on and is open to all inmates, especially for those with complex life challenges including drug addiction and mental health issues. It has been implemented in ten prisons over the past eight years with the support of a number of local NGOs.

A recent evaluation concluded that:

- quality of life among participants improved and their everyday life in prison became easier;
- they experienced less loneliness and isolation;
- the groups initiated a reflection process which seems to contribute to strengthened motivation, increased social competence, improved communication skills and more hope for a life without crime;
- THOR is well-suited as a low-threshold programme for most inmates, including remand prisoners and inmates with short sentences;
- the groups facilitated access to help and played an important role as part of the community reintegration process;
- THOR contributes to cooperation between prisons and voluntary organisations;
- meeting with leaders with lived experience of incarceration is a vital resource. These peer experts-by-experience were perceived as very important in the meetings, and in the time after release. They symbolise that a life after prison without crime is possible, while at the same time they have considerable practical knowledge of how to cooperate with social and welfare services, employment, housing, etc. (457).

People in prison have an extremely high risk of suicide, particularly during the immediate period of incarceration and after release. Convictions for severe violent crime, especially homicide, are associated with increased suicide risk, both in prison and after release (458). People in prison with a high-risk of drug use also have higher risks of adverse health outcomes upon release, including overdoses and suicide and of committing new crimes and returning to prison (450).

Both nationally and internationally, drug use is more widespread in the prison population than in the general community (459,460). Results from the NorMA cohort – a national cohort of inmates in Norwegian prisons and an ongoing project that makes use of this data (461) show that a significant proportion of people in prison have a history of drug problems, both related to illicit drugs, medications (not prescribed) and/or alcohol: 65 percent reported a lifetime history of drug use.

Based on Norwegian registry data from the Norwegian Prison release-study (nPRIS), Bukten et al. (2017) found an elevated risk of death from drug overdose among individuals released from Norwegian prisons, peaking in the immediate days after release (462).

People with substance use disorders (SUDs) may apply to serve their sentence in specialised in-prison treatment facilities where treatment is provided by both the specialist health services (TSB, for *tverrfaglig spesialisert rusbehandling* in Norwegian, which can be translated as ‘cross-disciplinary specialised substance abuse treatment’) and municipal health and care services. In addition to this, Article 12 of the Norwegian Execution of Sentences Act provides an opportunity for people with SUD to serve whole or a part of the prison sentence in an inpatient institution outside of the prison (454). Moreover, people diagnosed with opioid use disorders have the opportunity to both continue and enter opioid maintenance treatment while in prison (453).

However, despite universal rights, SUD-treatment interventions in the criminal justice setting must combine the execution of a penal sanction with treatment goals and there is reason to believe that both access to and treatment delivered in prison differ from that which is provided outside (463). Along with the focus on rehabilitation in Norway, there has been growth in drug control and disciplinary sanctions. In addition to this, prohibitions on prison drug-use may be used to rule out SUD treatment, instead of SUD being a marker of dependence and treatment need.

PERSONS WITH CONCURRENT SUBSTANCE ABUSE AND MENTAL HEALTH DISORDERS

UserPlan (Brukerplan) is a tool for mapping the extent and nature of drug use and mental health problems among service users in the municipal mental health and substance use services. An individual functional assessment is carried out in eight areas: housing; work and meaningful activity; finances; physical health; mental health; substance abuse; social functioning; and social networks. The results from these eight areas constitute a living conditions index (LCI).

Results from 2019 show that approximately 43,700 people in Norway who have mental illnesses and/or substance use disorders also have a low level of functioning in important areas in life, such as poor living conditions, financial and social difficulties and poor integration in the local community. The LCI has gradually deteriorated over a four-year period. Around 30 percent have little or no contact with social networks, are isolated or only have marginal social relations, and around 38 percent are very low social functioning (464).

Userplan is presented in a four-part scale, moving from green (adequate level of functioning) to yellow (limited level of functioning), to red (low in several areas) to blue-light (severely low in all areas). Approximately 5,400 people are in the blue-light part of the scale, all of whom suffer from both severe mental illness and substance use disorders. These persons have a lower score in all areas related to housing, compared to those with a single disorder. 60 percent describe little or no meaningful activities, and 17 percent are homeless. Very few are employed (464).

Most of those who are sentenced to follow treatment are part of the group described as severely mentally ill with a large degree of substance abuse linked to incidents of violence. In many cases, they become severely ill before they are forcibly admitted to treatment. Many have mild-to-moderate cognitive impairment and only encounter support services when the disease is more visible. Due to the divided organisation of health and social services in Norway, providing coordinated and comprehensive care to this group is challenging. In Norway anyone in need of long-term and coordinated health and care services is entitled to have an individual care plan, which is a written description of services, types of support, and activities provided to the individual. According to Userplan, only 17 percent of those with substance use disorders and mental illnesses have an individual plan.

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. However, the excess mortality is linked to common diseases, particularly cardiovascular disorders. There are many affecting factors, such as genetics, allostatic stress caused by neglect and other negative events in childhood, physical inactivity, poor nutrition, high prevalence of smoking (80 percent), and substance use/abuse (465).

Additionally, lack of sufficient medical care in rehab and psychiatric wards as well as barriers in access to general practitioners and other health care services are also explanatory causes of the excess mortality among this group. Stigmatization and discrimination of this group is one barrier, but self-stigmatization can also be seen. This became clear during the COVID-19 pandemic, when many of those struggling with substance abuse and mental illness avoided seeking help (466).

Nevertheless, poverty is the greatest barrier to accessing appropriate services, and user fees to GPs and health care services in general are often an obstacle to seeking help. Not being able to pay user fees can lead to no-shows, which lead to an additional fee. Many find this defeating and feel an additional helplessness when they receive debt collection claims.

Research has identified three main areas which can contribute to recovery for patients with substance use disorders and mental illnesses: (a) a meaningful everyday life; (b) a focus on strengths and future hopes; and (c) the reestablishment of social life and healthy relationships. Experiencing acceptance by society is described as an important factor for recovery. This corresponds with the understanding that patient empowerment is a necessary component of the recovery process, needed to achieve social inclusion and participation in society. Furthermore, the literature points out that psychosocial and rehabilitative measures are important for the social inclusion of people with substance use disorders and mental illnesses (467).

Social participation can be defined as participation in public life, which implies being structurally included in society, and experiencing a feeling of belonging. Initiatives such as that described in the next case study can support the social inclusion of people with mental health and/or substance abuse problems.

CASE STUDY: STREET FOOTBALL AS A MEANS OF SOCIAL INCLUSION AND RECOVERY IN MENTAL HEALTH AND SUBSTANCE USE PROBLEMS

'Street football' is a concept used for football-specific activities and projects to support recovery for people with mental health and/or substance abuse challenges. Street football is organised in partnership with ordinary football clubs, and also in collaboration with mental health and substance abuse programmes, other health and welfare services, and with the volunteer sector (468). In 2011, the first Norwegian street football team was created (468,469), and currently there are 29 street football teams in Norway. The organisation 'The Football Association' organises matches, tournaments and support in a variety of ways and supports the teams with funding and promotion through media and political initiatives. Their goal is to offer a community of support and improve the everyday life of participants. The street football teams are regarded as a low threshold activity, where anyone with a mental health and/or substance abuse problem can participate. No distinction between gender or age is made. Everyone is welcomed. In many of the teams, professionals from various health and welfare services attend training and games regularly. In this way, services become more accessible and available. Breakfast or lunch is organised at trainings and matches to make sure the players get a proper meal (468,470–472).

According to Ellingsen et al. (2022) street football helped 240 players enrol in education and/or participate in work in 2022 and since 2015, 600 players have started education and/or work (470,471). Ogundupe et al. (2022) found that participating in street football highlighted the importance of community and communal efforts through acts of citizenship, in facilitating and promoting social inclusion for persons in challenging life situations (468). They suggest that communities, policy makers and funders need to acknowledge and gain more insight and understanding of the value that street football teams represent.

In Norway, the recovery approach is not systematically practiced and programmes and methods vary between municipalities. Lack of comprehensive, coordinated, integrated and professionally sound health and social services; insufficient implementation of national guidelines and approved procedures; lack of adequate management measures and follow-up, all lead to excessive variation in the quality of treatment services. Unfortunately, many of those suffering from substance use disorders and mental illnesses have negative experiences with the health care they have been offered (473).

The average length of stay in care is too brief to try out treatment and cooperation, especially for the 15 percent of patients who account for 80 percent of the use of resources. More hospital beds would make it possible to admit patients earlier and voluntarily before the condition worsens and forcible admission becomes necessary. However, the most important treatment is provided by the municipalities, such as employment and meaningful activities as well as housing according to the individual user's needs. Peer support workers can contribute by providing hope and optimism (474,475).

There can be high quality evidence-based treatments for this group of patients. Collaboration teams such as ACT (assertive community treatment) and FACT (flexible assertive community treatment) have been shown to improve quality of life by providing good treatment to patients where they live, by using a recovery based IMR approach (illness management and recovery) in which the services are coordinated. In addition, the patients get help to reestablish contact with their family and

friends. Also, IPS (Individual Placement and Support) is often used, with the goal of improving the chances of obtaining regular employment. Housing First is also an important measure, for improving living skills and ensuring that housing is adapted to the individual's needs in various phases of the disease. Housing First is a model for the permanent settlement of homeless people with drug addiction and/or mental health problems. The model is based on the principles that access to housing is a fundamental human right and that the user must have a real say in relation to the choice of housing and the type of follow-up (476).

Nevertheless, many of the patients with substance use disorders and mental illnesses experience a feeling of loneliness and lack of social belonging, and their economic situation is a great barrier to participating in the community. Many receive around 5,000 NOK per month in social assistance, and when a large sum is spent on tobacco and other substances, there is not much left at the end of the month. In addition, many struggle with huge debts, which in most cases makes it impossible to experience financial freedom (477).

Several measures can be used to improve financial circumstances and thereby increase this group's chances of experiencing dignified lives. The simplest would be to provide everyone in this group with exemption cards for public health services so they do not have to pay user fees. Another measure could be to provide free and available dental care, which many of those with substance use disorders and mental illnesses need. Today's legislation is so complicated that even

employers have trouble understanding it. However, the most significant measure 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.

RECOMMENDATIONS

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.

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 per 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.

In this section we examine trends in inequalities in health-related behaviours such as smoking, excess weight, healthy diets and physical activity. We then review the public health policies and plans that have been developed in Norway to address these issues and, finally, assess the role of disease prevention and promotion issues such as increasing health literacy, vaccination and screening programmes.

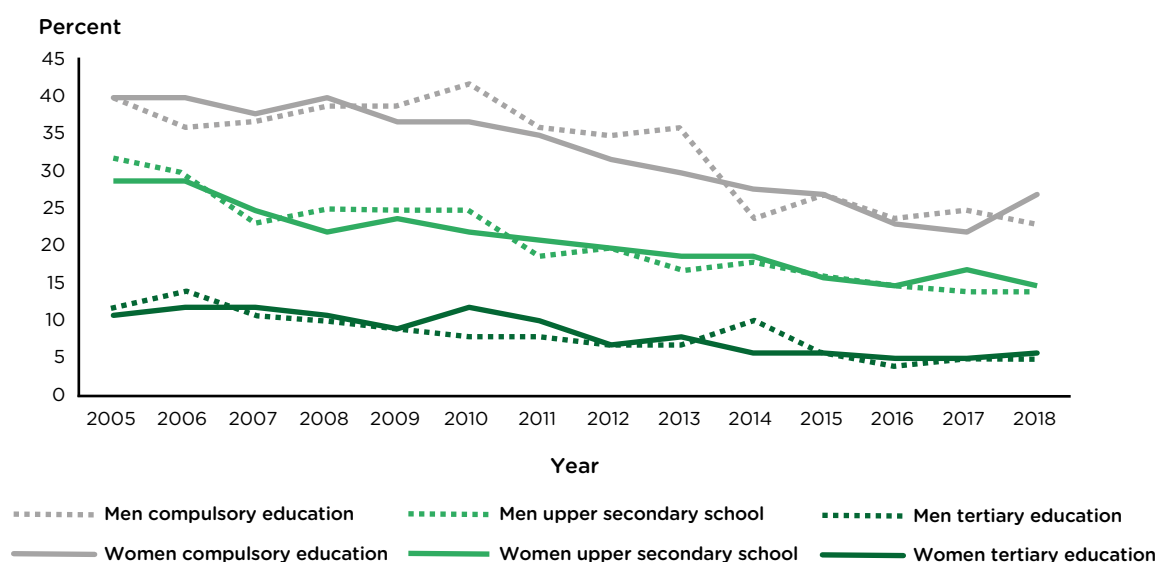
INEQUALITIES IN HEALTH-RELATED BEHAVIOURS

SMOKING

The conditions of daily life, some of which are described above, affect people's behaviours and these then impact on their health and longevity. Figure 3.36 shows smoking trends in Norway by sex and educational level. Within each educational category, the proportion of men and women who smoked daily have been similar throughout the period shown. 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. While there has been considerable fluctuation in the ratio of the odds that someone with only compulsory education smokes compared to someone with tertiary education, in 2018 this ratio was similar for men and women (5.7 and 5.8, respectively).

Figure 3.36 Percent smoking daily by sex and educational level, Norway, 2005-2018



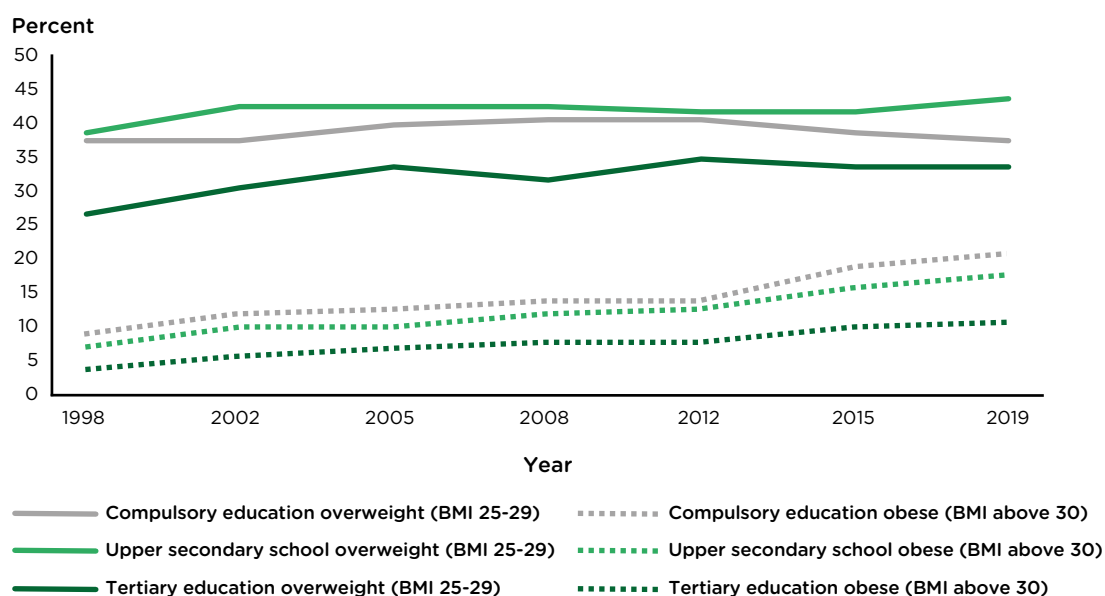
Source: NIPH (18)

EXCESSIVE WEIGHT AND OBESITY

Both diet and exercise contribute to body mass – the likelihood of being either overweight or obese. Figure 3.37 shows the proportion of people in Norway who have been overweight or obese in the period 1998 to 2019. There has been a consistent social gradient related to educational level in both throughout this period. While there has been little change in the proportion who are

overweight since 2005 in each educational category, the proportion who are obese has risen sharply in all categories 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.

Figure 3.37 Percent overweight and obese* by educational level, Norway, 1998-2019



Note: *Overweight is a BMI of 25 to 29, obese is a BMI of 30 and above.

Source: NIPH database (18)

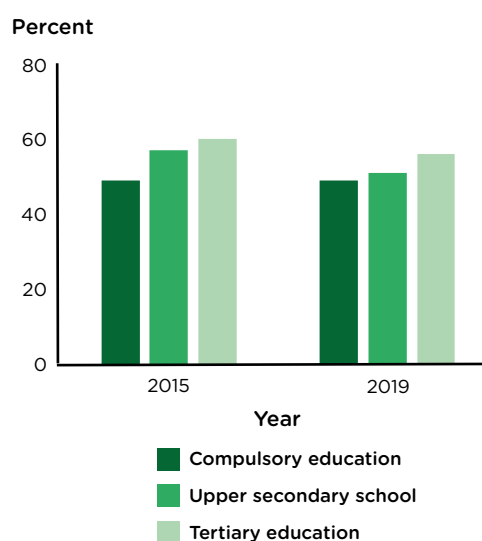
INEQUALITIES IN A HEALTHY DIET

Ensuring a healthy diet for all is fundamental to population health and health equity. Poor nutrition and unhealthy diets are associated with conditions including being overweight, obesity, tooth decay, high blood pressure, type 2 diabetes, some cancers, and cardiovascular diseases. Good nutrition before and during pregnancy and during childhood is crucial for good cognitive, social and emotional and physical development of children and for health across the life course (478).

While there are differences in healthy eating by demographic factors across high income countries, in general a lower socioeconomic position is associated with the consumption of less healthy diets. In common with other high-income countries, dietary patterns in Norway vary by socioeconomic position. The Norwegian Public Health Report 2021 (479) notes that compared to groups with higher socioeconomic position, groups with lower education and occupational position have a higher consumption of sugary drinks and salted food and a lower consumption of fruits, berries, and vegetables (480,481).

Figure 3.38 shows how the gradient in daily fruit consumption changed between 2015 and 2019. In 2015, 60 percent of those with tertiary education consumed fruit daily but in 2019 this figure had fallen to 56 percent. While those with only compulsory education were less likely to do so, the percentage remained constant at 49 percent between the two occasions. As a result, the gradient in consumption narrowed – but by levelling down.

Figure 3.38 Percent consuming fruit daily by educational level, Norway, 2005 and 2019

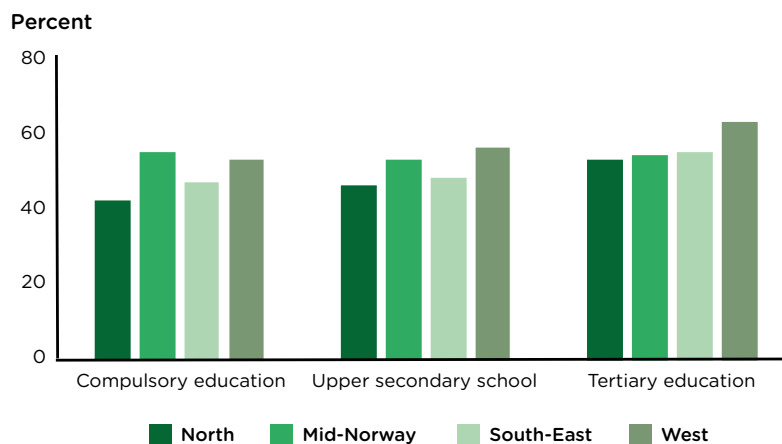


Source: NIPH database (18)

There were also regional variations in daily fruit consumption in 2019. Figure 3.39 shows that, in each educational group daily fruit consumption was lowest in the North region and was generally higher than elsewhere in the West Region. However, the pattern in mid-Norway differed from elsewhere as there was no

educational gradient in consumption with 55 percent of those with only compulsory education consuming fruit daily, marginally higher than those with the same education in the region (54 percent) and marginally higher than those with compulsory education in the West (53 percent).

Figure 3.39 Percent consuming fruit daily by educational level and region, Norway, 2019

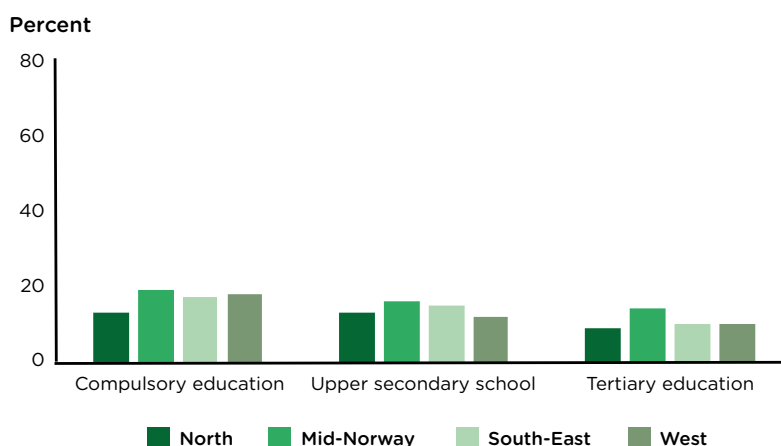


Source: NIPH database (18)

Among pregnant women who took part in the Norwegian Mother, Father and Child survey between 2002 and 2008, those with a higher education and a higher income had a healthier diet, with higher consumption of items including fruits, vegetables, whole grain foods, water for thirst quenching, and less processed meat products, white bread, pizza and tacos (482). Women with a high level of education breastfed exclusively for a longer period than women with a low level of education (483-485).

The consumption of soft drinks or cordials containing sugar is likely to have an adverse health impact. Figure 3.40 shows the proportion of people drinking at least one glass per day in 2015 by region and education. In every region, there was an educational gradient in soft drink consumption – with those having only compulsory education most likely to do so and those with tertiary education least likely to do so. In each educational category, those living in Mid-Norway were most likely to do so while consumption among those in the North tended to be among the least common in each educational group.

Figure 3.40 Percent consuming at least one glass of soft drink or cordial containing sugar per day, by educational level and region, Norway, 2015



Source: NIPH database (18)

Figures 3.39 and 3.40, while largely confirming educational gradients, point to a slightly paradoxical pattern by region – with higher consumption of both fruit and soft drinks among those with only compulsory education in mid-Norway than other regions and, conversely, the lowest figures for both in the North.

Findings from the Norwegian Health Behaviour in School-age Children (HBSC) surveys in 2014 and in 2018 show that children and adolescents in families with a high socioeconomic position had more regular meals, consumed more fruit and vegetables, less candy and soda, and brushed their teeth more frequently than those in families with a low socioeconomic position. There were also fewer young people in families with a high socioeconomic position that had attempted weight loss (486,487).

A regular survey of youth health and wellbeing in Norway covering pupils in secondary and high school (13-19 years) included questions on diet in 2017 (136). Findings show a linear gradient in the proportion of adolescents who eat vegetables and salad at least four times per week, increasing from 42-45 percent in families with the lowest socioeconomic position to 71-72 percent in families with the highest socioeconomic position (488). Socioeconomic position was categorised in quintiles based on parental education, number of computers, cars, books, rooms and having holidays in the young person's family.

A repeated cross-sectional study in Norway of adolescents aged 14-17 years assessed consumption patterns by an online food frequency questionnaire and found a decrease in frequency of consumption of selected healthy and unhealthy foods and beverages between 2016 and 2019 (489). Specifically, the study observed reduced frequency of consumption of vegetables, fruit and berries, whole-grain bread and fish.

The study also observed a reduced frequency of consumption of salty snacks, sweets, sugar-sweetened beverages, and artificially sweetened beverages. The socioeconomic gap in consumption of sweets was no longer apparent, and a greater reduction in consumption of sweets was seen among adolescents with no or only one parent having college/university education than among adolescents with both parents educated at college/university level. The study authors speculate that the 'changing trends in frequency

of consumption of fruit and vegetables amongst Norwegian adolescents during the last decades may be partly because of the implementation and termination of the nationwide free Norwegian School Fruit Scheme (NSFS) which began in 2007 and ended in 2014. Randomised control studies in schools showed that the National Free School Fruit scheme was effective in increasing consumption of fruit and vegetables among school children (490).

A study comparing children in elementary schools that were or were not included in the Fruit and Vegetable scheme found little evidence for beneficial effects on weight gain and no unintended consequences following up to four years of exposure to the free fruit and vegetable policy (491). The study noted that while the Fruit and Vegetable Scheme alone is unlikely to impact on population childhood weight, such schemes are likely to support and promote healthy eating habits.

As a group in a particularly vulnerable situation, asylum seekers in Norway have a high prevalence of food insecurity i.e. 'lack regular access to enough safe and nutritious food for normal growth and development and an active and healthy life' (492) which is otherwise relatively rare in Norway (493).

A study in Norway analysed data on the consumption of fish and vegetables from a survey of 2,000 respondents, categorised into four groups by education and income: low education and low income, low education and high income, high education and low income and high education and high income (494). In this study food knowledge (linked to low cultural capital) and food quality (linked to low economic capital) emerged as significant barriers to consumption of fish and vegetables among those with low education and low income, compared to the other groups (494).

Patterns of dietary consumption in populations change over time through multiple influences at the individual and population level. All too often diet is seen as mainly a matter of personal choice, despite strong evidence that dietary behaviour is set within a complex framework of individual, cultural, social, economic, and environmental conditions and influenced by the food industry and related marketing and advertising activities. The COVID-19 pandemic and the associated restrictions and lock downs impacted on food availability and dietary behaviour as reported below.

IMPACT OF COVID-19 ON HEALTHY EATING

A systematic review of studies on dietary changes during the first lockdown in 2020 found reports in 23 studies of dietary changes that included dietary changes that are pro-health (increase in consumption of fresh produce, decrease in consumption of comfort foods) and also changes that are unfavourable for health (495). No information from this study was available on differential changes in dietary behaviour across socioeconomic groups during lockdowns. However, it is known that food banks, typically providing food for low-income families facing food insecurity, distributed more food in 2020 than in 2019 (496). In Norway, the amount of food distributed by food banks increased from c2.6 million kg in 2019 to c3.4 million kg in 2020 (496).

A population-based study in Norway conducted during the first lockdown in 2020 found that emotional eating, often with an increased intake of food and drink high in sugar, was reported by over half of the population, and was particularly common among those reporting psychological distress, among females, and among those concerned about their financial situation and job security (497). The longer-term effects of the COVID-19 pandemic on healthy eating are yet to be evaluated.

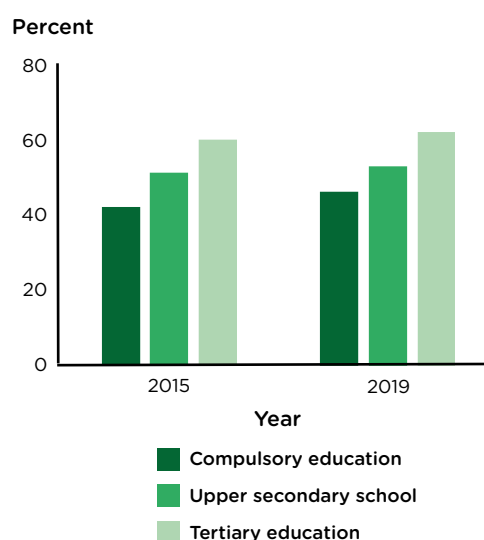
As noted in connection with the COVID-19 pandemic, comfort eating as a response to psychological distress related to changing life experiences and adverse living or working conditions can be a contributory factor in unhealthy eating and its adverse health consequences (498).

Even in high income countries with a wide level of availability and variety across a range of foods, the cost of a healthy diet has been identified as a barrier to good nutrition for the poorest households. Other barriers to a healthy diet identified in the research literature include time, cooking skills, taste, and knowledge (499).

PHYSICAL ACTIVITY

Physical activity is beneficial to physical and mental health. Figure 3.41 shows the percent of survey respondents in Statistics Norway's survey on living conditions in 2015 and 2019 who reported that they were physically active, such that they had increased heart rate and respiration, for more than 2.5 hours per week. This shows a clear educational gradient which slightly narrowed between 2015 and 2019 as levels of physical activity increased. In 2015, 42 percent of those with only compulsory education were physically active compared to 60 percent of those with tertiary education. In 2019, these figures had increased to 46 and 62 percent, respectively.

Figure 3.41 Percent of survey respondents who report that they are physically active*, by educational level, Norway, 2015 and 2019



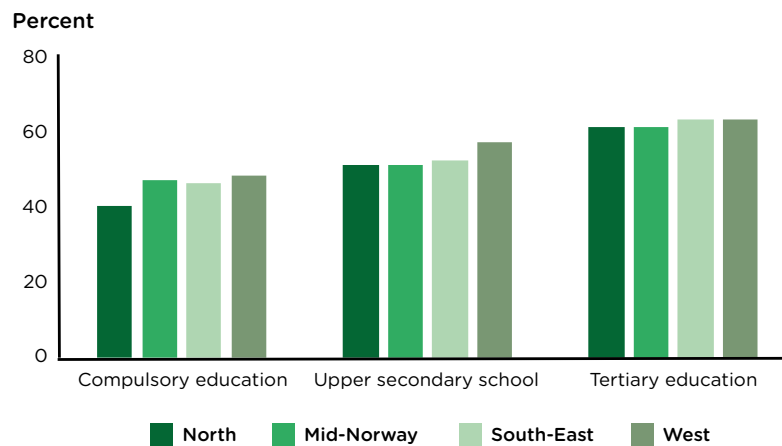
Note: * Respondents reporting that they have increased heart rate and respiration, for more than 2.5 hours per week

Source: NIPH database (18)

Figure 3.42 shows the extent to which physical activity varied by region in each educational group in 2019. In every educational group, more people engaged in

physical activity in the West than other regions and the North had among the lowest levels in each group.

Figure 3.42 Percent of survey respondents who report that they are physically active*, by educational level and region, Norway, 2019



Note: * Respondents reporting that they have increased heart rate and respiration, for more than 2.5 hours per week

Source: NIPH database (18)

The case study reports on an intervention by a voluntary sector organisation to reduce inequalities in physical activity among children and young people.

CASE STUDY: BUA EQUIPMENT LIBRARY - LENDING SPORTING AND LEISURE EQUIPMENT FOR FREE

BUA is a non-profit organisation founded by social entrepreneurs in 2014 with the purpose of improving inclusion in health-promoting activities for children and young people, regardless of the socioeconomic position of their parents. Sporting and outdoor equipment is expensive, and this is a barrier for participation in health-promoting leisure activities. Since the early 1990s, equipment centres have been a way to provide access to sporting equipment to children and young people in poorer families, but they did not work particularly well. The equipment was inaccessible and there is some perceived stigma in using the centres.

In 2014, the organisation received a grant for a pilot project from the Gjensidige Foundation and NAV. Twelve municipalities/equipment centres participated in the pilot project. The result was a set of tools and services to develop the 'equipment library', lending out sporting and leisure equipment for free. Another grant was given to run a pilot for one year and develop a digital service, as well as a social franchise concept - the BUA equipment network, which has become a national brand, with a franchise model that makes it easy to upscale.

Borrowing sporting and outdoor equipment for free contributes to giving everyone equal opportunities to participate in leisure activities and lowers the threshold for trying new activities, such as camping, skateboarding, or cross-country skiing. Also, consumption is reduced. Several municipalities also use BUA as an arena for work training, where people who have fallen out of working life can do internships.

BUA's vision is for all children and young people to be physically active on a regular basis, without increasing consumption.

The BUA network has grown strongly with 30-40 new BUA equipment arrangements per year since 2016. By 2022 there were 216 BUA schemes. More than 1.1 million skis, skates, tents, skateboards, etc., have been lent out and seven percent of the population say that they have made use of BUA in the past year (500).

The BUA equipment arrangements work as a library. Borrowing is completely free of charge, and a digital hub makes it easy to see what you can borrow and from where you can borrow it. The equipment is new and of good quality and can be borrowed for seven days. Good quality equipment has proven to be important to avoid stigmatisation of users.

The establishment and operation of the BUA equipment arrangements is financed with grants from the Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) and from private foundations, such as Sparebankstiftelser (Savings Bank Foundations) and Gjensidigestiftelsen. In addition, the private sector contributes with significant sponsorships. BUA has developed the sponsor concept 'sustainability partner', which refers to the UN's sustainable development goal 17: partnerships for the goals, and the scheme contributes positively to seven out of 17 sustainable development goals.

POLICIES AND PLANS FOR HEALTHY BEHAVIOURS

Norwegian National Plan for a Healthier Diet

The Norwegian Government's National Action Plan for a Healthier Diet 2017 (the Action Plan) (501) aimed to reduce socioeconomic differences in dietary habits and, specifically, increase the consumption of fruit and vegetables, fish and whole grains, and reduce the consumption of added sugar, saturated fat, and salt.

The National Institute of Public Health (NIPH) conducted a mid-term evaluation of this action plan in 2020, recommending that it was extended to 2023 (502). The NIPH evaluation was based on interviews with relevant stakeholders in the public, private and voluntary sectors, including the ministries responsible for the plan, the Norwegian Directorate of Health, municipalities and county administration and grocery organisations. The informants highlighted that most of the Action Plan is based on the previous plan in 2011 and that many action points were already in process, so that the plan was more about continuation and maintaining awareness. There was no specific timeline in the plan, and the stakeholders view this work with a long-term perspective. Most of the action points in the plan had been set into motion to some extent. The report highlights the paradox that seven ministries have signed the plan and all stakeholders express ownership of the plan, but in practice, the Ministry of Health and the Norwegian Directorate of Health do most of the follow-up.

Most stakeholders considered the universal interventions as the main way to reduce social inequalities in health. The evaluation committee pointed out that there is limited knowledge on how well such efforts work for the relevant groups in Norway and recommended that additional targeted interventions are implemented, and that structural/universal changes are continued. For the latter, they recommend healthy tax exchange and free school fruit/vegetables/meals (502) - which were also covered in section 3A.

A report from the Norwegian Government in 2021 on developments in Norwegian diets points out that people with higher education are better acquainted with the dietary recommendations from the Norwegian

Directorate for Health, but awareness has increased since 2013 among those with lower education (479). The same pattern is seen for expressing trust in those recommendations. In addition, the report highlighted that 20 percent of those with low education and 46 percent of those with high education actively searched for the healthier alternatives within a given type of food and the trust in marking of products as healthier with a keyhole sign was highest among the highly educated. There is a risk that dietary recommendations will widen inequalities in healthy eating as they are more likely to be taken up by those with higher education. Additional programmes to support those with a lower socioeconomic position to adopt healthy eating are needed.

Pricing policies for healthier diets

Given the proven impacts of diet and nutrition on child health and development, and on health across the life course, much research and policy interest has focussed on how to promote healthier diets, including through food pricing policies (503). Countries around the world have introduced taxes on certain types of food and beverages that contribute to unhealthy diets and subsidies to promote healthy eating. The impacts of pricing policies have been studied by a variety of methodologies involving modelling and real-world empirical studies.

Food pricing policies include taxes on foods and beverages that contribute to unhealthy diets high in sugar, salt, and saturated fat, and subsidies on fruits and vegetables. The impact on health of price policies on food and beverages depends on consumers' purchasing responses to price changes, known as price elasticity of a product, and on the tendency of consumers to substitute taxed unhealthy foods with other unhealthy food products that are not taxed (504,505). In addition, the impact of pricing policies on health varies across country contexts, depending on factors such as food culture, habits and preferences, and the nature of the food environment (506). The health impact of food pricing at the population level also relates to the population's attributable risk of the taxed product, that is the incidence of a disease that

would be eliminated if exposure to this product were eliminated, for any given health condition in a country (506). Food and beverage pricing policies also have differential effects on consumption across social groups with diverse habits and preferences and different socioeconomic circumstances within a country. Where there are differential effects on consumption patterns across social groups associated with food pricing policies there are also likely to be differential health impacts across social groups within countries and are thus a factor in health inequalities. Pricing policies that successfully promote healthy eating are likely to be pro-equity (505).

There are concerns about the equity consequences of taxes on specific food products. Households with low incomes spend a higher percentage of their household income on food than higher socioeconomic groups and are more price sensitive (504). However, low-income households are more likely to gain in terms of health if the result of the tax is that they purchase and consume less of the unhealthy product being taxed. A systematic review of empirical studies on taxes on health-damaging food products and food components reported that while groups on low incomes are more sensitive to price increases, no evidence was found in the reviewed intervention studies that these taxes were regressive – i.e. that those on low incomes spent proportionally more (507).

There is also the potential for compensatory purchasing behaviour, whereby consumers switch from purchasing an unhealthy food product that is taxed to purchasing other unhealthy or healthy products that are not taxed (506).

Such issues highlight the need for the impacts of food pricing policies to be modelled and evaluated to provide evidence to guide the type and level of food pricing for health equity gains and to limit the likelihood of adverse unintended consequences.

Where revenue from taxes on unhealthy foods is ringfenced for other health promoting measures, there may be additional benefits from those measures and the possibility of gaining public support for the taxes. However, such revenue does not necessarily provide secure funding over the long-term for other health initiatives if the food taxes are successful in reducing purchasing of the higher taxed products (507).

A systematic review of modelling studies on taxes on carbonated soft drinks, taxes on saturated fat, and subsidies on fruits and vegetables ran pooled analyses where three or more papers examined the same pricing strategy and consumption or health outcome (504). The study suggested that a ten percent increase in price could decrease fizzy soft drink consumption by 0.6 percent to 24.3 percent. And a ten percent reduction in the price of fruit and vegetables could increase

consumption by 2.1 percent to 7.7 percent. Regarding saturated fat, a one percent increase in price could decrease energy consumption from saturated fat by 0.02 percent on average. Overall, the evidence from this review suggests that food pricing strategies have the potential to positively improve both population diets and health outcomes. Looking at the socioeconomic impacts of food pricing policies, four of the 11 studies estimated greater impacts of pricing policies on consumption among low socioeconomic groups compared to high socioeconomic groups. This indicates the potential for food pricing policies to reduce diet-related inequalities at the population level (504).

A systematic review of interventions to promote healthy eating, with a focus on differential impacts across socioeconomic groups identified six intervention types classified as ‘price interventions, place interventions, product interventions, prescriptive interventions, promotion interventions and person interventions’ (508). A key finding from this review is that price interventions related to healthy eating were most effective in groups with lower socioeconomic positions. Again, tax and subsidies affecting price of food items are shown have the potential to reduce inequalities in healthy eating. On the other hand, interventions directly targeting individuals’ dietary behaviour (‘person interventions’) increase inequalities in healthy eating (508).

Further research based on systematic review found moderately strong evidence that to be effective, food taxes and food subsidies should be set at a level of at least 10-15 percent and preferably be implemented at the same time (509). Other research finds moderately strong evidence for a higher level of taxation that increases the price of food products by 20 percent (507). Strong evidence supports the implementation of taxes that increase the price of sugar-sweetened beverages by 20 percent or more (507).

A systematic review and meta-analysis of interventional and prospective cohort studies provides further evidence of efficacy for taxes to reduce the consumption of unhealthy foods and drink, and for subsidies to increase consumption of healthy products (510). Overall, the evidence was strong that subsidies are effective in increasing consumption of fruit and vegetables and other healthy foods (such as low-fat products) and moderately strong that taxes decrease the consumption of sugar-sweetened beverages (510). Some of the studies included in this systematic review also looked at health impacts (510). Analysis of evidence from four studies showed that subsidies on fruit and vegetables were associated with a reduction in body mass index of 0.04 kg/m³ per 10 percent decrease in price. A downward trend in body mass index associated with taxes on unhealthy products was not significant (four studies). This review provided no evidence regarding the effects of food pricing on

consumption among different population groups by socioeconomic position.

A systematic review of the impact of taxes on sweetened beverages on different socioeconomic groups concluded that they will 'deliver similar population weight benefits across socio-economic strata or greater benefits for lower SEP groups' (511). Looking further into equity aspects of tax on sweetened beverages, a narrative review reported that they are likely to be moderately effective for health equity, as well as being cost-effective,

supported by the public and health professionals, and opposed by commercial interests (512).

The cases of Mexico and the UK illustrate two different ways of applying tax to soft drinks: excise tax in Mexico and a levy on manufacturers of soft drink calibrated to the amount of sugar by volume of drink in the UK. The effects of both interventions on consumer purchasing behaviour were examined with empirical methodologies.

TAX ON SUGAR SWEETENED BEVERAGE: MEXICO AND UK

Mexico implemented an excise tax on sugar sweetened beverages (SSB) of one peso/litre from 1st January 2014. Researchers examined beverage purchases from stores in Mexico and found an average monthly reduction of six percent during 2014 in their purchase of SSB compared to the expected purchasing level without the tax. The purchasing reduction was greatest among households with the lowest socioeconomic position, averaging a 9.1 percent fall over the year and reaching a decline of 17.4 percent by December 2014 (513).

In the UK, a two-tier Soft Drink Industrial Levy (SDIL) or tax on manufacturers of soft drinks was announced in March 2014 and implemented in April 2018. Drinks with ≥ 8 g sugar/100 mL (high tier) were taxed at a higher level than drinks with ≥ 5 to < 8 g sugar/100 mL (low tier). Drinks with < 5 g sugar/100 mL (no levy) were not taxed. Researchers analysed data on purchases made by a panel of households which reported their weekly purchases between March 2014 – March 2019. A year after implementation of the SDIL, sugar purchased from soft drinks decreased by 30g per household per week while no evidence was found of a statistically significant change in purchased volume compared to before the tax was announced (514). The SDIL provided an incentive for manufacturers to reduce the sugar content of their soft drinks which they did. The study found no evidence that households substituted the reduced level of sugar from soft drinks with purchase of foods high in sugar. The study did not examine differential impacts by socioeconomic group. (514).

Policies to promote healthy diets can provide multiple benefits, including promoting health, health equity and environmental sustainability – a triple win for policy interventions (515). In addition to reducing inequalities in healthy eating it is imperative that food policies encourage and enable sustainable production and consumption patterns. A recent systematic review of taxes on unhealthy foods and SSBs implemented in different countries modelled their potential effects on population health, health system costs and greenhouse gas emissions in a high-income country, namely New Zealand (506). Taxation policies on food products high in sugar or saturated fat (in Denmark) or energy dense foods (in Mexico) and SSB taxation policies in 10 different jurisdictions, including Norway, were selected for modelling. Modelling evidence in this study indicates that taxes on unhealthy foods and SSBs can provide health benefits, cost savings for the health system, are pro-health equity, and also reduce GHG emissions in a high-income country (506).

In Norway, a study described a methodology to estimate optimal taxes and subsidies on a variety of food items that can simultaneously ensure that calorie content remains the same while population consumption patterns change to those that have lower greenhouse gas emissions (516). The study authors conclude that

the methodology 'may be used to estimate optimal climate taxes and subsidies under different emission quantities, taxes, subsidies and health constraints.

In a study of differential impacts of food pricing policies across groups in society, Norwegian researchers examined the effects of adjusting value added taxes (VAT) on purchasing behaviour of healthy and unhealthy food products among low, median, and high-purchasing households (517). Using differential purchasing patterns in Norway, researchers modelled the effect of increasing VAT rates on unhealthy food (including carbonated soft drinks, sweets and ice cream) and reducing VAT rates on healthy foods (including fruits and vegetables). A key finding was that increasing the cost of unhealthy food is more effective in reducing purchases of unhealthy foods among high-purchasing households than decreasing the cost of healthy food is on increasing the purchase of healthy food among low-purchasing households. Increasing the price of unhealthy foods would reduce their purchase, especially among high-purchasing households, and is likely to provide public health benefits that may be pro-equity by reducing purchase of unhealthy foods and thereby improving the quality of diets among high-purchasing households (517).



Sugar Taxes

Norway was a world innovator in sugar taxation, first introducing an excise tax on chocolate and sugar products in 1922, albeit at the time this was mainly as means of raising income for the Government. Excise tax on sugar-sweetened beverages was introduced in 1981. Sugar taxes, along with other measures such as public health messaging about limiting sugar for a healthy diet, restrictions in marketing to children, and a voluntary agreement with manufactures to reformulate products to reduce sugar content provide plausible explanations for the decline in consumption of sugar and sugar products in Norway from 45 kg per person in 1979 to 24 kg person in 2019 (518).

The Norwegian Government increased taxes on sales of confectionary and beverages sweetened with sugar and/or artificial sweetener in January 2018. Studies on the effects of these taxes on sales have produced mixed evidence. A before-and-after analysis of sales of these products reported a 23 percent reduction in chocolate sales and an 11 percent reduction in soda sales (519). In contrast, an analysis using a larger sample from the same data found no consistent estimates of changes in sales (491). This study found the average sales of confectionary may have shown a small decline post

intervention, no similar effect was found for sweetened drinks. However, the researchers pointed out that the statistical evidence was weak, and the results were inconclusive. A possible explanation provided by the researchers is that tax increases were too small to affect overall purchasing behaviour in Norway. Potential differential impacts of the increases in taxes on the purchase of candy and soft drinks among groups by socioeconomic position were not examined.

In a move that ran counter to strong evidence of the harm to public health from high consumption of free sugar in products (520) the Norwegian Government repealed taxes on sugar- sweetened drinks and products made with sugar such as chocolate and confectionary in 2021. In view of the public health harm of consumption of sugar-sweetened beverages and sugary products and the inequities associated with it, a clear recommendation to the Government is to conduct a review to establish a type and level of taxation likely to be most effective in contributing to a further decline in sugar consumption in Norway, to ensure that it has an equity focus and to take the necessary steps for implementation.

DISEASE PREVENTION AND HEALTH PROMOTION

HEALTH LITERACY

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 (521). This involves the abilities to assess the need for healthcare, to recognise how to prevent disease, and to determine which health-promoting actions maintain or improve quality of life throughout the life course. The Norwegian 'Strategy for improving health literacy in the population (2019-2023)' points out that in order to make informed personal health decisions, individuals must be sufficiently health literate (522). In the UK there are clear socioeconomic inequalities in health literacy and also inequalities between immigrants and the rest of the non-immigrant population.

In recent years there has been an increasing interest in health literacy (HL) among Norwegian policy makers. This may be motivated by an escalating awareness of HL as an important and modifiable determinant of health. HL has been linked to greater empowerment, health equity and the achievement of the United Nations Sustainable Development Goals (SDGs), signifying HL as an enabler for developing better health and wellbeing over the life course (Meld. St. 40 (2020-2021)). A social gradient in HL has been documented internationally in all reported national population surveys (523).

The first report on population HL in Norway (HLS19) was released in 2021, commissioned by the Norwegian Ministry of Health and Care Services. It showed that a significant proportion of the population faces a variety of challenges in dealing with health information (524). This has implications for the health of individuals and society's expenditure relating to health.

The report described three empirically defined levels of HL. One third of the Norwegian population scores at or below the lowest level, level 1, meaning that many Norwegians lack the key knowledge and skills necessary to obtain health services and realise the concept of patient-centred health services. As for the measure of general HL used in the study, it was found that women and those with an education above upper secondary school might have slightly better skills (479). Digital HL, as expressed through competence in searching for digital health information, the possession of general digital skills and the readiness to adopt digital health services, was found to be associated with gender, age, level of education and long-term illness (479). General HL was found to be negatively associated with the number of general practitioner (GP) visits and with health-related quality of life. Moreover, the number of health-related days of absence from work appeared to be correlated with the 'healthcare' and 'health promotion' domains of the HLS19 (479).

More than 50 percent of the Norwegian HSL19 population sample scores below level two of navigation HL regarding the ability to recognise how health systems/services work and to make decisions concerning what specific services are needed in due time and situations (479). This domain is characterised by the ability to find information concerning the quality of specific healthcare and to find out what rights they have as a patient and user of healthcare. Considering the Government's goal of providing an equitable health service and realizing the concept of a patient-centred health service, in which the users are to engage actively, the health service must necessarily take into account that many people find interaction with the service challenging.

According to results from the HLS19 study involving five immigrant populations conducted during the Covid-19 pandemic, a larger proportion of immigrants from some countries scored at or below the lowest level of HL compared to the general population. Immigrants seemed to experience more challenges in finding information about the treatment of illnesses. In most immigrant populations, low HL was associated with low education and low socioeconomic status (525). Approximately 30 percent of both male and female immigrants stated that they 'never' searched for health information on the Internet, and digital HL varied with the level of education. The immigrants also reported significantly poorer general digital skills, which vary with age, level of education, economic status and long-term illness (479).

Health literacy can be seen as the sum of competence possessed by the individual and the individual's network, thus it is likely that people with low health literacy and less social support are particularly vulnerable when it comes to health literacy in the population (526). Furthermore, children and adolescents constitute a core target group for health literacy research and practice as adolescence is considered a vulnerable period in life in which fundamental cognitive, physical and emotional development processes take place and health-related behaviours and skills develop (527). However, to date no population surveys have assessed HL in young people.

The Ministry of Health launched in May 2019 a National Strategy to Increase Health Literacy in the Population 2019-2023. Implementation of the strategy is taking place, mainly through the Health Directorate's three goals: 1) mainstreaming HL in all processes; 2) knowledge-based development; and 3) equitable health-literate health and care services. The first goal includes that every process in the Norwegian Directorate of Health has to consider the way in which HL may have an impact on the

intervention, development and/or implementation of the health and public health services. All health service development in the health sector should be aware of and take into consideration the role of HL during the phases of planning, development, implementation and evaluation. Furthermore, the Ministry of Education revised the curriculum for the Norwegian primary and secondary education introducing the cross-curricular theme 'Public health and life skills' aiming at enabling school-aged children to develop competencies that contribute to obtaining and sustaining health and wellbeing through the lifespan (528).

SOCIAL INEQUALITIES IN VACCINATION AND SCREENING

The Norwegian childhood immunisation programme (529) currently includes immunisation against 13 infectious agents. It has been expanded gradually since the start in 1952 and is free of charge. The vaccination is performed by the public health clinics and school health services.

The uptake of vaccination is very high (around 96-97 percent for most vaccines), so there may be little potential for inequalities to arise. However, a survey performed in 2017 and 2018 including 2,169 parents showed that a lower proportion of parents with low educational level or unemployed had confidence in childhood vaccination and this group had more concerns about vaccine safety (530).

Uptake of human papillomavirus (HPV) screening, implemented for 12-year-old girls from 2009 and boys from 2018 has varied over time (531), but was as high as 92 percent among girls in 2021 (532). However, there

is a relationship between (HPV) vaccination uptake and parental education – daughters of highly educated parents have lower uptake but there is a positive association between parental income and vaccine uptake (533,534). There are differences in vaccine uptake according to parents' country of origin, where vaccination rates are higher among girls of Asian and Norwegian origin, and lowest among girls from the rest of Europe, Sub-Saharan Africa, and America and Oceania (531). A delayed catch-up vaccination was offered in 2016 to women born since 1991. In this setting, maternal education was positively associated with vaccine uptake, whereas parental immigration background and low income was associated with low uptake (535).

Among women aged 25-45 years in 2004-2005, those with higher education had a somewhat greater level of attendance in the Norwegian cervical cancer screening programme (536).

Participation in mammography screening is largely independent of educational level (537). However, there are indications that improvements in breast cancer outcomes over time, particularly since 2000, are greater for women with high education, especially among women who are younger than the screening target age (50-69 years) (538,539). Whether this reflects differences in non-programme/opportunistic screening is not known. However, if this was the case, it seems less likely that lead time bias is the main explanation, since these trends are seen for both stage-specific survival (539) and for mortality (538). In mammography screening attendance, there are large differences according to immigration status, where both first- and second-generation immigrants have lower attendance (540). Inequalities in health care usage are further set out in Section 5C.

RECOMMENDATIONS

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.

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.

Environmental sustainability and health equity are inextricably linked because climate change and the related challenges of environmental degradation and the loss of biodiversity all impact on physical and mental health inequalities both directly by increased exposure to extreme weather events, and indirectly through increases in the price of food, water and domestic energy and subsequent increases in poverty and unemployment.

Sustainability, defined as ‘development that meets the needs of the present without compromising the ability of future generations to meet their needs’ (541), requires urgent steps to mitigate and adapt to climate change. The need to act on climate change is widely recognised by national governments and populations. In a significant international treaty (542) participating countries agreed to aim to keep the global temperature rise over this century to well below 2 degrees Celsius and to drive efforts to limit the temperature increase even further to 1.5 degrees Celsius above pre-industrial levels. To do so, countries signed up to the Paris Agreement with the aim of reaching net zero greenhouse gas emissions (GHG) by 2050.

Pursuing environmental sustainability and health equity at the same time is vital to creating a just and sustainable society now and in the future. National

governments have a fundamental role to play in creating policy space to achieve co-benefits for both environmental sustainability and health. 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 (515).

Pursuing a socially just and green societal transition together depends on creating legitimacy for public policy and fiscal priorities, interlinking these agendas to the kind of future that people want to build and engage in creating together.

The following case study is an example of how local residents can work together to develop projects aimed at improving relationships and social networks in their communities and building a sustainable future.

UTOPIA WORKSHOPS FOR SUSTAINABLE SOCIAL DEVELOPMENT

To stimulate creativity, decentralised bottom-up initiatives are vital, and cooperation is more significant than competition. Utopia workshops is a dialogue method developed by Ove Jakobsen and Vivi Storsletten (Nord University) for the sustainable development of local societies based on participation and communicative cooperation. Through the dialogue processes in a utopia workshop, the participants explore and develop local identity which is vitally important for people’s wellbeing. In addition, participation has a mobilising effect on empowering local responsibility. The impacts of utopia workshops are the development and implementation of projects that are stimulating and promote development both for the individual and for the community.

In the first part of a utopia workshop, the focus is on development of shared values. Then, everyone participates in a philosophical reflection that ends with a common understanding of the core values synthesised from all the different stories. By making the values explicit, the participants share a unifying identity. This inspires co-creation of a future characterised by a high quality of life for people within resilient ecosystems. Some examples of values that were repeated in many of the utopia workshops carried out so far include: safety, closeness to nature, belonging to a community, relationships across generations and across cultures. Even if some values remain the same in many communities, whether it is a municipality or a district in a larger city, there are also differences that express the characteristics of local identity. Experience from more than 40 utopia workshops indicates that a good life in a good society is usually relationally-oriented and rarely linked to increased materialistic consumption.

In the second part of a utopia workshop, the participants are encouraged to propose concrete projects that they would like to see implemented in practice. The prerequisite is that the project incorporates one or more of the core values that were developed in the first part of the workshop. Participants choose the project that they want to co-develop. In this way, self-organising groups are established. The group size varies from two to 10 people.

The utopia workshop ends with a plenary dialogue where everyone has the opportunity to comment and give input on the content of the various proposals and on how the projects can be put into practice. The challenge is to find solutions relating to how coordination of the various projects and to identify how they can strengthen each other and who to collaborate with from the municipality, business, voluntary organisations and local supporters.

After a workshop, the projects must be followed up and new members and actors may want to take part in the implementation. Projects can be revised to ensure implementation. A month after the workshop, project collaborators can assess the further development of the project and its connection to other projects.

Utopia workshops are a way of working that enable local residents to shape the future they want. They are often about initiating new activities that strengthen the relationships and networks in the community. It is important to create and develop positive and meaningful good lives where people feel that they belong. When the projects and future images created are based on experiences around what is a good life in a community, both identity and vitality are strengthened.

AREAS FOR ACTION

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 (543):

- 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 CO₂ 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 (section 5B).

Norway's Climate Action Plan 2021 to 2030 (NCAP) outlines the need for Norway to undergo a major transition to 'achieve climate targets and at the same time provide a good framework for more jobs, greater welfare and the sustainable growth of the Norwegian economy by 2030' (544). Health and health equity are naturally allied to this concerted push for green growth and welfare. The link with health is widely acknowledged in the NCAP, which incorporates;

1. Making it easier for people to travel in climate-friendly ways, including policies and interventions that support walking, cycling and taking public transport.
2. Healthy, sustainable, climate-friendly food in every setting, including; through action to reduce food waste towards a goal of a 50 percent reduction by 2030; to encourage people to follow the dietary recommendations from the Directorate of Health that help to reduce GHG emissions; to facilitate a shift to a healthy, sustainable and climate-friendly diet in, among others, day care centres, schools and after-school care through public procurement, and to enable the agricultural sector to prepare for changing consumption patterns.
3. Reduction in 'climate forcers' mainly methane, hydrofluorocarbons and carbon particulates (soot) to reduce pollution and benefit public health.
4. Introduction of zero emission zones in municipalities; Oslo and Bergen are reviewing the introduction of zero emission zones.

However, the link between environmental sustainability, population health and reducing socioeconomic inequalities is not adequately emphasised in the NCAP. The link is explicit in the UN's Sustainable Development Agenda and in the EU Council on the Economy of Wellbeing (545) which fosters a transition towards a healthier, more inclusive and sustainable society. The incorporation of plans for a more inclusive Norway into the country's climate action planning would be transformational, as would incorporating climate adaptation and mitigation into Norway's health and health inequalities strategy.

NORWAY: ACTION TOWARDS NET ZERO - MORE NEEDED

Norway is favoured with energy resources that provide considerable wealth. Norway set up its national wealth fund to manage the revenue from the country's oil and gas (commonly known as the Oil Fund) with the aim of providing benefits for current and future generations (546). The Norwegian Parliament and the Ministry of Finance regulate the management of the fund and delegated responsibility for its management to Norges Bank. The fund currently stands at over 11.97 trillion NOK (1 trillion GBP), making it one of the largest funds globally, owning almost 1.5 percent of all shares in the world's listed companies in 70 countries, in addition to other assets (546). An independent Council on Ethics conducts ethical evaluations of companies and sends recommendations to the Bank's executive board. The Norwegian Government can spend only a small part of the fund each year, but this still amounts to almost 20 percent of the Government budget (546).

In September 2022 Norges Bank, guided by the Norwegian Government, took a significant step towards the Paris Agreement goals by setting a target of net zero emissions by 2050 at the latest for all companies in its portfolio (547).

The Norwegian Government has taken steps to move towards net zero GHG emissions domestically. Norway's electricity comes largely from renewable sources. In 2020, 90 percent of electricity was generated by hydro power plants, 2.6 percent from wind farms, and less than two percent from combustion power plants (548). In addition, Norway is a world leader in the adoption of electric vehicles; by the end of 2020, 16 percent of Norway's car fleet was fully electric battery powered, with a further six percent hybrid electric. New sales of vehicles were predicted to be 100 percent electric or hybrid electric by the end of 2022 (548).

Under the Paris Agreement, Norway committed to reduce greenhouse gas emissions by at least 50 percent and towards 55 percent by 2030 compared to 1990 (544). This is close to the EU's commitment to reduce emissions by at least 55 percent by 2030 (549), but less ambitious than that of the UK's commitment, made in 2020, to cut GHG emissions by 78 percent by 2035 (550). 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 2030 goal (548).

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 (551). These exports will be combusted elsewhere in the world to release GHG and contribute to climate change. Additional support from Norway for emissions reduction and climate change mitigation in developing countries in the form of finance and technical support would enable some progress in those countries.

RECOMMENDATIONS

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.

CHAPTER 4

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

In common with many other countries, Norway has faced the impact of several crises in the last few years. 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.

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.

4A. THE COVID-19 PANDEMIC

The COVID-19 pandemic has amplified existing inequalities in health in many countries around the world, with a very unequal distribution of infection, hospitalisation and mortality rates between different populations groups, which has further amplified inequalities in health. At the same time, it has also aggravated pre-existing inequalities in the social determinants of health through containment measures, including lockdowns and social distancing measures that had an unequal impact. These impacts will likely have generational effects (552).

Analysis by the UCL Institute of Health Equity (IHE) found stark inequalities in the risk of mortality among different groups in England, with older people, males, people living in more deprived areas, in overcrowding housing, in key worker roles with close proximity to others, from ethnic minority groups, and having underlying health conditions being more at risk (553). These differing risks were related to socioeconomic factors and area deprivation, occupational exposures, living conditions, ethnicity, religion and previous health (553).

In Norway, the Coronavirus Commission was launched to assess the Government's response to the pandemic and identify key learnings. In its second report, it established that Norway had one of Europe's lowest mortality rates from the COVID-19 pandemic. However, it also concluded that the immigrant population was overrepresented among those who caught the virus and among those who became seriously ill (554). 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 – (555). 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 (556).

Those who were foreign-born make up around 15 percent of the population, but accounted for around 40 percent of all hospital admissions from COVID-19, from March 2020 to February 2021, and this varied greatly by country of birth (556). As the numbers using ventilators or dying were relatively low, there is uncertainty in the estimates produced from analysis of the data, but immigrants from Africa and Asia stood out as having higher risks (557). Testing rates increased overall after combined door-to-door and mobile testing facility campaigns began in a city district in the capital Oslo with a high proportion of immigrants (558).

Reme et al (2022) show that the health consequences of the COVID 19 pandemic are unequally distributed. In their population based longitudinal study assessing the mental health of more than 100,000 Norwegian adults during a period of more than 20 years, and into the COVID 19 pandemic, they found substantial, and equally high, increases in depressive symptoms across socioeconomic status after the introduction of containment measures in March 2020. In addition, they showed that the increase was particularly strong among women and those with lower levels of depressive symptoms prior to COVID 19 (559).

In a longitudinal population study from Norway, Hvide et al. (2022) used newly-released register data on all general practitioner consultations in Norway through 2020 (about 14 million consultations in total), focusing on COVID-19 and mental health. The results show that during the spring and early summer of 2020, the number of psychological consultations initially increased relative to previous years, but then fell back closer to the level of previous years during the summer of 2020. Norway implemented strict control measures on 12th March 2020, which were relaxed gradually from 20th April, although measures and recommendations restricting social contact and encouraging remote work continued to be in place. From 26th October measures were again tightened. According to this study, in early September 2020, the number of consultations – including for both psychological symptoms and complaints – and diagnoses accelerated. This pattern held up through December 2020, so that the size of the excess in 2020, compared to previous years, increased by the end of that year. The excess was greater for females and for residents in urban areas (560).

However, Knudsen et al (2022), using data from a diagnostic interview survey in a large Norwegian city and from national death registrations, found that there was no increase in any of the common mental disorders in Norway during the first phases of the COVID-19 pandemic. There was a statistically significant reduction in mental disorders during the first outbreak (561).



The COVID-19 pandemic has caused dramatic and unequal social and economic consequences for individuals, families and countries worldwide (552). Norway, like other Nordic countries, experienced smaller decreases in their GDP during 2020-2021 in comparison with the European average, despite comprehensive shut down measures (562).

This has been attributed, in part, to the high degree of digitalisation of Nordic economies, which allowed many employees to work from home (563).

As the Coronavirus Commission highlighted in its report, the pandemic reinforced social inequalities. Control measures had a major impact on children and young people, especially those in more vulnerable situations who experienced an accumulation of disadvantages. As an example, the Commission's second report refers to the situation of children and young people in urban districts in the east of Oslo. In addition to the impacts on their schooling caused by containment measures, many of them had parents who either had insecure jobs or had become unemployed

during the pandemic. While family income was already low in many cases, with fewer household members in work the financial situation became even worse. These families were further hit by the reduction in the availability of public services such as psychological support services, adapted education and integration services and local meeting places. Overcrowding and lack of digital infrastructure were also key barriers to home schooling in these groups (554). There are other areas similar to those in the east of Oslo in other Norwegian cities and the commission recommended further work on improving the living environments for children in these areas, as well restoring the role of schools in lifting the most vulnerable children academically and socially (554).

Services for children were significantly reduced at the early stages of the public health emergency. Most childcare services were closed due to the restrictive measures introduced to stop the spread of the virus, and many of the healthcare workers assigned to school health services were relocated to intensive care and emergency units to help with the surge of

COVID-19 cases (564). While some services were restored after the indication that the most vulnerable families were the ones suffering the most due to delayed care (565), the primary health services for children and families took some time to fully recover (566). A significant decrease in home visits has been recorded in the country since the start of the pandemic, which has affected vulnerable households and children the most (567).

The Covid-19 pandemic affected all members of society, with loss of contact to family and friends, isolation, and of course, the fear of infection and severe health consequences for those infected. However, people in prison faced particularly hard COVID-19 restrictions. To prevent infection from being carried into the prison population, all prisoners were automatically put in isolation for two weeks on entry to prison. This isolation procedure was introduced by the Prison Authorities against the recommendations of the national health authorities. At the same time, visits from family or friends were suspended. To compensate for the loss of physical visits, people were offered more time on the phone and digital solutions were installed.

There are valid reasons to fear a major outbreak of infectious diseases in the prison population. Though people in prisons are relatively young, outside the age groups otherwise considered at risk for COVID-19, the health status of people in prisons make them in many respects vulnerable to infectious diseases. Reasons for this include the high prevalence of substance use disorders, mental illness and very often, a history of marginalised living conditions. It is well known that other infectious diseases, such as tuberculosis, hepatitis C and HIV have higher prevalence in the prison population compared to the general population. An outbreak of COVID-19 among prisoners and prison staff could therefore have severe health consequences for the people infected and be a logistical challenge to the already limited health care provision. However, prisons and the people in prisons were not prioritised by health authorities. Neither prisoners, nor prison staff (other than health providers), were prioritised for vaccines when they became available, nor were they provided with test facilities (407,568). Had they been given priority, this could have reduced the use of isolation and the adverse effect this has potentially had on the health and wellbeing not just of the prisoners themselves, but also their families and children.

One of the most immediate and inequitable impacts of the COVID-19 containment measures in England was in relation to employment and income (553). In Norway there were two major lockdowns; at the beginning of the pandemic in 2020 and during the first months of 2021. In all the Nordic countries, unemployment increased more steeply for those with low levels of education, young people and immigrants born outside the EU (562). Unemployment reached a historic 16 year high in the third quarter of 2020, with 4.9 percent of the labour force affected (413).

Among people who lost their jobs in the first half of 2020, 27 percent were still unemployed five months after registering as jobseekers with NAV. Those with only primary education and people born abroad were more likely to be unemployed, as well as those in older age groups. At eight months after registering with NAV, people without any work experience had a very low probability of being in work (569).

The pandemic deepened some pre-existing patterns of disadvantage, as shown by recent work published by the Ragnar Frisch centre for Economic Research using data for the period from 2017 to October 2021 (570). Among those unemployed before the onset of the pandemic (February 2020) the chances of returning to work in the near future decreased significantly compared with those who were unemployed two years earlier. Although the pandemic did not have an overall effect on the pre-existing future employment rates of unemployed immigrants, Alstadsæter and colleagues found that the rate of return to employment of unemployed labour migrants from Eastern European countries was disproportionately worsened by the crisis (570). While causing a reduction in the NEET rate, the pandemic also reinforced the social gradient in NEET status, whereby those young people with a more advantaged background are more likely to stop being NEETs or less likely to become NEET.

Among those employed, the crisis caused greater loss in pay among immigrants than the native-born, as well as for those employees in prime working ages who were previously at the bottom of the pay distribution compared with those at the top (570). Strict travel restrictions and closed borders affected the Sami people disproportionately, given that many Sami families live and work across national borders. The Coronavirus Commission highlighted that Sami artists, craftsmen and other entrepreneurs suffered job losses as a result of travel restrictions (554).

Surveys from the Norwegian Institute for Consumer Research (SIFO) carried out in April 2020, June 2020 and June 2021 found indications of increasing inequality in Norwegian society. 40 percent of households initially classified as most vulnerable economically experienced a loss of income during the pandemic, compared to 13 percent among the most secure households. In June 2021, 53 percent of the most vulnerable households lacked savings, compared to two percent of households at the highest level of security (554).

The socioeconomic consequences of the pandemic were ameliorated in great part by action taken by the Norwegian Government, which adopted extraordinary measures, including support schemes for individuals, companies and the voluntary sector, as well as public grants.

The first package of measures in response to the pandemic was introduced quite early, in March 2020. The measures were aimed both at individuals, by ensuring income replacement for those affected, and businesses, to avoid mass redundancies and bankruptcies. Several of these early measures were subsequently renewed and additional ones were introduced in later phases of the pandemic. These are some of the most relevant measures taken, some of which were extended until 2022 (571–573);

- A temporary extension of the unemployment insurance system to grant benefits from the first day and an increase of the standard daily allowance.
- A guarantee to furloughed persons of 100 percent wage compensation, with a cap.
- A relaxation of entitlement rules so that more unemployed people could receive benefits, by lowering the requirement of previous income.
- An adjustment of the rules so that more furloughed individuals could receive benefits.
- A scheme to compensate for loss of income of solo self-employed and freelancers.
- A temporary sickness benefit for the self-employed and freelancers.
- A temporary benefit for apprentices who lost their apprenticeships or were made redundant.
- A temporary extension of work assessment allowance to other normally excluded groups.

The Government also introduced a wage support scheme to help companies that experienced a loss in turnover, with part of their wage costs so that they avoided having to make redundancies, initially from 15th March to 31st August 2021, and then also in December 2021 and January 2022 in a renewed form (574). Another important measure was to make it easier to combine education and unemployment benefits, a temporary measure that has become permanent (572). However, as explained in section 3C, around 50 percent of unemployed people in Norway don't qualify for unemployment benefits because of the requirements regarding income earned the year before. Some commentators have suggested that Norwegian Government responses to the pandemic had a strong economic focus and the Government did not focus enough on social policy measures (573). For example, they argue that not enough was done to fill the gaps in school support and other special institutions for vulnerable young people, or to counteract the loss of social contact and networks. Older people suffered from social isolation and a significant number died in nursing homes (573).

Overall, Nordic countries have managed relatively well, despite their relative differences in strategic responses. Robust governance mechanisms have catered for a collaborative response across the whole of society. As argued by Christensen and Lægneid in an article published in May 2020, the relative success of the Norwegian Government as a 'high performer' in tackling the pandemic 'must be understood in the context of competent politicians, a high-trust society with a reliable and professional bureaucracy, a strong state, a good economic situation, a big welfare state and low population density' (575).

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 (575,576). The Government's priorities have not been without friction and conflict of interest. Nonetheless, policy responses to the pandemic provide an example of why the Nordic model of welfare has been promoted as a 'gold standard' as it fosters societal trust, public health and wellbeing. Multi-level governance and local action in places are key to tackling turbulence and health crises (575,577). As stressed by the Pan-European Commission on Health and Sustainable Development, it is important to draw lessons from the COVID-19 pandemic, in order to ensure public trust and legitimacy. As the World Health Organisation advises 'a situation where some groups are left systematically behind can weaken trust in the political system, with consequences for all of society' (578).

4B. THE COST OF LIVING CRISIS

Rises in the consumer price index – which increased by 6.3 percent between June 2020 and 2021 – driven mainly by increases in food prices, fuel and electricity (579) and several increases in interest rates by the Norwegian Central Bank (Norges Bank) since September 2021, have created problems for many households in Norway. According to data from a nationally representative survey of 2,130 respondents, by the Consumer Research Institute SIFO, on how their financial situation evolved between January and June 2022, this increased burden forced 18 percent of households to use their savings to make ends meet, while 25 percent had problems paying bills, interest and loan instalments and 18 per cent reduced time spent with others as a consequence of having less money to spend on social activities (579).

Between January and June 2022, 35 percent of Norwegian households found themselves in a worse or much worse financial situation (579). The most important single reason for the increase in the cost of living was the rise in electricity prices (580).

As a consequence, some Norwegians are making adjustments to their way of living. For example, 17 percent of households have skipped holidays, 44 percent have reduced the temperature in their house and 18 percent are heating only certain parts of their homes. The impact is, however, unequal. While only six percent of households with the best economic trajectories between January and May 2022 have reduced their budgets to buy food, 47 percent of those households who experienced the worst trajectories in this period have done so (579).

Between June 2021 and June 2022, the share of households having constant problems paying their bills, interest and loan instalments has doubled from two percent to four percent, while those who report they have problems from time to time has increased from 16 to 21 percent. Another report by SIFO based on a survey of 2,030 respondents showed that in August 2022, 130,000 households (five percent) were

‘in serious difficulties’, and an additional 280,000 (11 percent) were ‘struggling financially’, both figures having doubled in just over a year (581). 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 (581).

RECOMMENDATIONS

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.

CHAPTER 5

THE HEALTH EQUITY SYSTEM IN NORWAY

As we have set out throughout the report, taking action on inequalities in health and wellbeing and their social determinants is a cross-sector, whole-of-society endeavour. Previous chapters have made recommendations for action across thematic social determinants of health. This chapter begins by outlining recent developments in Norwegian public health policies. The chapter then sets out these principles for ensuring effective action on inequities in health and in the social determinants of health and wellbeing. The key principles 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.

The second part of this chapter sets out how different sectors and organisations can make a significant difference to reducing inequalities in the health and wellbeing of the population. This includes the VCS sector, healthcare system, business and the economic sector, public services and local government. While national Government has much to do, these sectors also have an important bearing on health inequalities and should, together with national Government and based on the principles set out, comprise 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.

5A. NORWEGIAN PUBLIC HEALTH POLICY

Norway has strengthened its approach to public health over recent years and embedded a strong whole- of- Government approach to ensure that reducing social inequalities in health is included in policy development.

The responsibility for reducing social inequalities in health remains with the national Government, but local municipalities have the power to develop their own approaches under national Government stewardship. This has led to different approaches to public health between municipalities, and likely contributed to regional inequalities in health. There is a strong case to strengthen national leadership and governance for reducing health inequalities, including developing the health equity system based on the approach outlined in this report. Permanent structures at the national level are needed to ensure that the issue of health inequalities gains 'whole- of- Government support' (582).

Norway's public health approach is based on intersectoral action for health at different levels of governance. Addressing the social determinants of health has, to some extent, been integrated into the Norwegian political agenda since the early 2000s with the publication of *Prescription for a Healthier Norway. A Broad Policy for Public Health*. Ensuring adequate focus on the social determinants, however, remains a challenge and concrete policies and measures frequently take more individual approaches, often related to lifestyle factors. These are also mostly initiated by the health sector. The recommendations made in this chapter will address some of the inconsistencies in the Norwegian system.

In 2007, the Norwegian strategy to reduce social inequalities in health (Report No.20 2006-2007) was launched by the centre-left coalition Government. The strategy was characterised by 1) a holistic, broad cross-sectoral approach, 2) an explicit focus on the gradient and 3) the principle of 'proportional universalism', i.e., universal policies in combination with more targeted measures (4,7). The National Strategy reiterated commitments to reduce social inequalities by redistribution, creating more equal living conditions and reducing poverty. This strategy was explicit on the need to focus on upstream measures at the national level such as economic redistribution and healthy tax exchange. Applying a cross-sectoral approach implied that the aim of reducing health inequality was integrated in several policy fields and ministries. As such, the strategy targeted selected domains of action to reduce health inequalities, such as: childhood/adolescence and education, work and working conditions, income, health services and health behaviours, as well as social inclusion (7).

Subsequent reforms have shifted the focus of some key elements of the 2007 strategy. These include a reduced focus on the health gradient and to an increasing extent, buffering measures to tackle the health consequences of social inequalities, rather than the drivers of those social inequalities – the social determinants of health approach. This has involved advancing programmes for social

inclusion in leisure activities, bullying prevention and healthy lifestyles. Reorientating towards the community level was also apparent in the Public Health Act introduced in 2012, where the state had relatively weak legal responsibility to improve public health, including reducing social inequalities in health and wellbeing.

THE NORWEGIAN PUBLIC HEALTH ACT

The national Norwegian Public Health Act (2011) came into force on 1st January 2012. The purpose of the Act 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. The Act created the foundations for strengthened and systematic public health approaches in the development of policies (the health-in-all-policies approach) and planning for societal development based on regional and local challenges and needs (8,583). The Act aimed to address health inequalities by structural reforms, for example in education, housing, and employment policies (584). This approach is well aligned with the whole-of-society approach advocated in this report. While the Ministry of Health has overall responsibility for public health, there is an aim that all sectors of society should be responsible for public health policy development.

The Act also included instructing the municipalities to integrate the policy into their own master plan and budgets. Via the county governor, the national authorities can oversee and audit the municipalities' implementation of the Public Health Act (582). The Act provides a broad basis for coordinating public health work within and between authorities at local, regional, and national level. From 2018, local communities/municipalities were given the overall responsibility for welfare provision, including services such as preschools, schools, childcare, care for the elderly, social support and services, primary health care, culture, agriculture, and the development of local areas, which includes the development of industry and employment (582). According to the Act, central Government health authorities have a duty to support the public health work of the municipalities by producing health profiles for all the municipalities to monitor public health and health determinants at local level.

The relevance of the Public Health Act for the social determinants of health agenda – but also some of its limitations – was highlighted in a stakeholder interview:

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.

Subsequent Governments between 2013-2021 shifted the emphasis from societal measures to measures operating at a more individual level, with a focus on child and adolescent mental health, levels of physical activity in the population, and on the municipalities' responsibility for improving the quality of services they provide (584).

KEY WHITE PAPERS ON PUBLIC HEALTH

In 2015, the Government presented a White Paper on public health called *Coping and Opportunities* (Report No.19 (2014-2015) to the Storting. The paper prioritised the following areas: mental health, healthy lifestyle, active elderly, children and young people and cross-sectoral public health work. While these are all important components of public health policies, it was not clearly stated how these areas are related to initiatives to tackle social inequalities in health.

In addition to this, bold equity ambitions to reduce health inequalities were not translated into concrete policies. To the degree that the White Paper addresses policies to tackle inequality, it is not the gradient that attracts attention, but the gap between the top and bottom. As this report emphasises, it is vital to lift and flatten the social class gradient. The White Paper focuses on health-related behaviours rather than the social determinants of health. As a result of all this, while the document's clear intentions were highly regarded, the challenges were still apparent.

The *Coping and Opportunities* White Paper and components of White Paper No.15 (2017-2018) 'A Full Life - All Your Life' were followed up by White Paper No.19 (2018-2019) *A Public Health Report - A Good Life in a Safe Society* with an increased focus on the population's wellbeing to complement the traditional approaches to physical and mental health. A White Paper on social and economic inequalities was developed in 2019 (White Paper No.13, 2019) dealing with social health inequalities. It states that 'more years of good health and reduced social health inequalities in the population are national goals...'. The paper focuses on health behaviours rather than on the social determinants of health as ways to reduce these inequalities. As this report outlines, reducing health inequalities requires reductions in inequalities in key social determinants of health.

The implementation period of the National Strategy to Reduce Social Inequalities in Health (Report No. 20 2006-2007) ended in 2017 and several new initiatives have replaced the strategy. One example is a ten-year commitment (2017-2027) to municipal public health work. The initiative, 'Programme for Public Health Work in Municipalities', aims to contribute to a long-term strengthening of the municipalities' efforts to promote the population's health and quality of life. Children and adolescents' mental health and substance-abuse prevention are key topics. Moreover, the Government rolled out several strategies through 2022, including a youth mental health and wellbeing programme and a mental health programme aimed at adults. However, strong national leadership and prioritisation are once again required to tackle social inequalities in health and to ensure that equity is embedded in all policies.

At the national level, different ministries have worked together to create a common reporting system and indicators where the National Health Institute and Central Bureau of Statistics provide data and health profiles for municipalities to develop their own local plans to address health inequalities. The national public health reports and equity indicators (585) are not directly linked to fiscal priorities or to the treasury.

To date, local municipalities in Norway are the key players in public health and health inequalities as they are responsible for delivering policies. Policy goals and programmes are formulated at national level and local governments decide how to deliver and achieve these goals, supported by the regional level (counties). Municipalities make their own decisions about funding and are the main providers of welfare services, deciding on health promotion and disease prevention (586). Governance structures mostly include soft governance tools, like facilitation and stimulation of certain measures in the municipalities through various programmes and funding mechanisms (582).

However, 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. The key upstream policy tools are found at the national level. There is a concern that national policies, such as tax and transfer reforms, are compromising the approach of universalism that focuses on the socioeconomic gradient in health (582,587).

5B. PRINCIPLES FOR ACTION

Based on the evidence and the policies reviewed in this report reducing health inequalities requires a coherent health equity system aligned to wellbeing. The principles for such a system which are set out in this section relate to the wellbeing economy; the need for governance and innovation in the public sector, democratic governance including participation and empowerment of people and communities through co-creation, strong partnerships between national and local governments and across all of society, the inclusion of health equity impact assessments in policy design, ensuring that policies and resource allocation is proportionate and universal, ensuring that there are robust accountability mechanisms for health equity and that monitoring for health equity is strengthened.

THE WELLBEING ECONOMY

The first principle for action addressed in this chapter is that of wellbeing as an organising concept for the economy and for societal development. This principle is well-aligned with creating greater health equity. Achieving progress on wellbeing requires greater health equity and vice versa.

During the last decade, there has been an increased interest among some countries in making a shift from using economic growth, measured by GDP as the indicator of societal progress to focusing on universal wellbeing in the population. A wellbeing economy pursues human and ecological wellbeing instead of material growth (588). Health is an intrinsic part of both human and ecological wellbeing and greater health equity is essential to a wellbeing economy.

As indicated in the 2010 Marmot Review (194): The health and wellbeing of today's children depend on us having the courage and imagination to rise to the challenge of doing things differently, to put sustainability and wellbeing before economic growth and bring about a more equal and fair society'.

Accordingly, health and health equity are an important measure of how well a society is performing. Social and regional health inequalities and deteriorating health for the most deprived people are markers of a society that is not functioning to meet the needs of its members (1). Measures that only track economic outcomes do not capture, or facilitate, health and wellbeing. The Norwegian Government acknowledges that GDP is an insufficient metric for a good life and that wellbeing should be a supplementary measure of societal development in Norway. They have also stated a need for more knowledge both about wellbeing and the quality of life in the population (194,590).

There is no unifying definition of what constitutes a wellbeing economy and it needs to be tailored to the specific country context. However, while various definitions address the benefits of a wellbeing economy, they mostly do not explicitly address equity. This is a repeated issue with wellbeing approaches, they are supportive of good health, but do not focus sufficiently on equity. Equity must be front and centre of any approach to a wellbeing economy.

The work on the wellbeing economy is a progression of the work of the Monti Commission (591), pointing to a need to heal the economic and social fractures that left societies vulnerable to the negative impacts resulting from the COVID-19 pandemic and the subsequent social crisis. Important institutions are already working to advance transformative social change, including the OECD, the EU and the WHO. Wellbeing economy (WBE) countries, organisations and communities are shaping the development of economies and markets to deliver better results for wellbeing and inclusive growth to leave no one behind as well as accelerating sustainable development to ensure the wellbeing of future generations. The importance of advancing health equity and environmental sustainability together was addressed in Chapter 3H.

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. Rather, a WBE 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 (592).

As demonstrated in this report, the economy is significant for satisfaction in life and for health (360). A study of the EU-SILC 2017 survey carried out by Statistics Norway found that while satisfaction with life increased evenly with increasing income, the correlation with financial wealth was weaker. In analyses controlling for other relevant characteristics, there was a particularly strong correlation between satisfaction with life and difficulties ‘making ends meet’. This finding is in line with earlier research, pointing to economic problems as one of the biggest happiness or ‘satisfaction thieves’ in Norwegian society (593). Focus on working life inclusion, more integrated and coordinated health care and welfare services, and a strengthening of benefits for the most vulnerable were key recommendations in one of the most comprehensive reviews on social inequality in health in Norway (481). In summary, the economy is vital for important elements of life satisfaction in Norway but should be seen as an input into health and wellbeing rather than vice versa.

In Norway there have been important moves to develop a better understanding about Norwegians’ views on their quality of life. Recent surveys have built a comprehensive wellbeing indicator system (359).

This measurement system includes both subjective and objective wellbeing indicators. The surveys are connected to public health surveys in the counties (27) and repeated national surveys by Statistics Norway in 2020, 2021 and 2022 (30,35,318)

The main purpose of these wellbeing surveys is to gain knowledge about wellbeing in the Norwegian population and among different subgroups of the population. These surveys provide valuable data to support further construction of a comprehensive and manageable indicator and accountability system aligned with driving forward a wellbeing economy. In Norway, there is broad political support for the value of such measurements (317) but such indicators are still not embedded in national accountability systems, nor connected to fiscal priorities and the treasury. The methods for deriving suitable indicators are described in the section on monitoring.

So far, Norway is not part of the official collaboration of ‘Wellbeing Economy Governments’ (WEGo), currently comprising national and regional governments in Scotland, New Zealand, Iceland, Wales and Finland (594). New Zealand and Wales have developed a wide range of promising practices illustrated in these case studies.

CASE STUDY: WALES: THE WELLBEING OF FUTURE GENERATIONS ACT, 2015

The Welsh Government has recognised its key role in promoting a more inclusive and empowered society. Through a comprehensive public conversation between the government and the Welsh people – “The Wales We Want” – the most important issues for improving lives of individuals, the lives families and communities were identified. This national conversation was an important contribution towards the new Wellbeing and Future Generations Act, which came into effect in May 2015.

The Wellbeing of Future Generations Act requires public bodies in Wales to consider the long-term impact of their decisions, to work better with people, communities and each other and to prevent persistent problems such as poverty, health inequalities and climate change (595).

The Act defines a healthier Wales as: “A society in which people’s physical and mental wellbeing is maximised and in which choices and behaviours that benefit future health are understood.”

Public bodies at all levels of Government are expected to work towards achieving seven wellbeing goals, illustrated in the diagram below (596).



Source: Future Generations Commissioner for Wales, 2023(595).

To achieve each of the wellbeing goals, each public body is expected to set and publish wellbeing objectives. Also, the Act seeks to change the way public bodies work and recommends five ways of working to achieve the wellbeing goals: taking a long-term approach, integrating an organisation's own objectives with other public bodies, involving people, collaborating and taking a preventative approach (595). The Act is often called the “Common Sense Act”, pointing to the fact that ensuring the wellbeing of future generations is a natural thing to do.

The Act requires each local authority to establish a statutory board, the Public Services Board (PSB). The PSB is a group of public bodies working to improve wellbeing in each local authority. Local Health Boards are statutory members of each PSB, alongside local authorities, fire and rescue services and other partner organisations including Public Health Wales. Each PSB works in partnership to improve the economic, social, environmental and cultural wellbeing, which they assess, publish, and then identify local objectives and plans to meet.

Under the Act, a Future Generations Commissioner for Wales was established in 2016 with a seven-year term. The aim of the Commissioner is to “monitor and assess the extent to which wellbeing objectives set by public bodies are being met,” and to provide advice to Public Bodies and Public Services Boards. The Commissioners’ general duties are to promote the sustainable development principle, to act as a guardian of the ability of future generations to meet their needs and encourage public bodies to take greater account of the long-term impact of the things they do. The Commissioners carry out reviews into how public bodies are taking account of the long-term impact of their decisions and make recommendations following a review, also giving input and advice to the National Budget process to safeguard the interests of future generations (595).

One of the successes of the Future Generations Act is the involvement of non-statutory organisations in adopting the seven goals. For example, Wildlife Trust Wales published a green infrastructure report as part of its contribution to making Wales a happier, healthier, more prosperous place to live. The report gave examples of green infrastructure, demonstrating how it is a cost-effective way to improve health and wellbeing and the quality of life of individuals and communities. Other visible signs of making new and bold priorities are the expanded use of social prescribing (597), aiming to better connect citizens to their community, and the exploration of the feasibility and desirability of implementing basic income in Wales.

Basic income is approached as an investment in people and place and a boost to the Welsh economy, entitling all Welsh residents to a basic standard of financial security while keeping all social protections maintained or enhanced. In the report “A Future Fit For Wales – a Basic Income for All,” a key recommendation is to make basic income taxable, meaning that “while every resident receives the basic income, those most in need see a larger proportion of it, whilst the most well-off gain relatively less in net terms. This makes a basic income fair as well as universal” (598). Basic Income Guarantees are currently being explored in Wales through the Basic Income for Care Leavers pilot. The pilot started in July 2022 and will give 500 young care leavers in Wales financial support in two years following their 18th birthday while also giving extra professional and community support. The pilot will study the young care-leavers transition into adulthood, where the pilot will deliver valuable learning about the effectiveness of implementing a basic income approach, and its impact on societal participation, health and wellbeing (599).

CASE STUDY: NEW ZEALAND'S NATIONAL WELLBEING BUDGET AND STRATEGY

New Zealand announced the world's first 'Wellbeing Budget' in 2019 (600). The Budget shifted New Zealand's economic goal from increasing GDP to improving the wellbeing of New Zealand's citizens. Similar to the seven wellbeing goals found in Wales's Future Generations Act, in New Zealand all new Government spending is expected to work towards six priorities: taking mental health seriously, improving child wellbeing, supporting Maori and Pacific island people, building a productive nation, transforming the economy and investing in New Zealand. Wellbeing is the focus of each priority; for example, the key actions associated with 'transforming the economy' involve investing in domestic infrastructure to achieve national benefits (e.g., train services, agriculture, climate change, scientific research, sustainable land use and water).

In developing the policies and assessments for the wellbeing budget, there was a large-scale, participatory, deliberative and collaborative process where citizens with diverse backgrounds contributed by constructing meaning and purpose for national policies. For example, in the development of the Child and Youth Wellbeing Strategy, the New Zealand Government, with the support of partner agencies, engaged with more than 10,000 New Zealanders, including 6,000 children and young people (601).

The success of the budget is measured by the Treasury's Culture, Wellbeing and the Living Standards Framework. This framework is based on the OECD's 11 wellbeing measures (subjective wellbeing; civic engagement and governance; health; housing; income and consumption; knowledge and skills; safety; social connections; environment; jobs, earnings and time use). The New Zealand Government added cultural identity and another four measures to influence the future wellbeing of its citizens, all of which require long-term investments to build the resilience of the New Zealand people (600). These included:

- Taking mental health seriously
- Improving child wellbeing
- Supporting Maori and Pasifika aspirations
- Building a productive nation
- Transforming the economy
- Investing in New Zealand

The process led to the delivery of new priorities, approaches and services.

Examples of priorities in the New Zealand Wellbeing budget

<p>TACKLING MENTAL HEALTH SERIOUSLY</p>	<p>A new frontline service for mental health with a \$455m programme providing access for 325,000 people by 2023/24</p>	<p>Suicide prevention services get a \$40m boost</p>	<p>Reaching 5,600 extra secondary students with more nurses in schools</p>	<p>Tackling homelessness, with 1,044 new places - Housing First will now reach 2,700 people</p>
<p>IMPROVING CHILD WELLBEING</p>	<p>Specialist services as part of a \$320m package to address family and sexual violence</p>	<p>Breaking the cycle for children in State care, including helping 3,000 young people into independent living</p>	<p>Taking financial pressure off parents by increasing funding to decile 1-7 schools so they don't need to ask for donations</p>	<p>Lifting incomes by indexing main benefits and removing punitive sanctions</p>

In 2021 the Norwegian Government announced that it would develop a new national strategy for wellbeing (590), to provide important opportunities to pursue greater health equity within a framework of universal wellbeing and a wellbeing economy. While Norway has

not formally committed to the WEGo Network so far, initiatives have been launched at local level and Oslo has made important steps in developing a wellbeing economy with a focus on health as an essential component of wellbeing, as indicated in the case study.

CASE STUDY: AIMING FOR UNIVERSAL WELLBEING THROUGH POLICY DEVELOPMENT IN OSLO

The municipality of Oslo has promoted wellbeing as a goal and local political leadership has launched a future wellbeing budget as part of developing a new public health strategy. The case study has been written before the public health strategy – which is under consultation – is approved by the city council of Oslo. It sets out how and why universal wellbeing has reached the political agenda in Oslo.

The political lead for health in the City Government, the vice mayor Robert Steen, has emphasised the significance of the process of developing the public health strategy as much as the strategy document itself. It has been a political ambition to change the current understanding of public health and involve a range of stakeholders in the processes of developing the strategy. Central to the ‘new’ understanding of public health is:

- a holistic approach to health;
- coining public health work as community development;
- placing wellbeing at the heart of public health.

Steps taken by the municipality of Oslo

In the spring of 2021, the administration introduced the science of wellbeing and the wellbeing budgets of New Zealand and Scotland to the vice mayor of health in Oslo. This gave rise to a political interest in initiating a wellbeing budget.

From the autumn of 2021 onwards, leading researchers in Norway disseminated knowledge on wellbeing to the administration. A group consisting of administrative representatives from all the departments of the City Government were trained on key issues in wellbeing and public health. Wellbeing issues were also presented and discussed with the public in the participatory processes for developing the strategy. A meeting on wellbeing and public health was held between representatives for different public councils and all the city vice mayors. An open seminar was chaired by the vice Mayor of Health, addressing lessons learned about citizens’ wellbeing during the COVID-19 pandemic. The political leadership showcased commitment to the issues addressed.

Politicians in the Standing Committee on Health and Social Welfare visited Iceland. The Icelandic Directorate of Health and the Prime Minister’s office shared knowledge on wellbeing and the Icelandic path towards a wellbeing economy.

In the spring of 2021, policy goals to reduce social inequality and increase the population’s wellbeing were defined in the public health strategy. The idea of initiating a future wellbeing budget in Oslo was launched to representatives from the City Council. In the draft strategy, investigating the possibilities of a future wellbeing budget is described as being part of implementing the public health strategy.

Key factors

- Transformational political leadership and commitment to wellbeing has been a vital factor in this process. Pursuing a wellbeing approach has opened an opportunity for revisiting traditional and biomedical approaches to health and pursuing a more holistic approach to health.
- A broad participatory process to co-develop the strategy has also confirmed the importance of pursuing universal wellbeing as a societal goal.
- A well-informed administration on the science of wellbeing and its connection to public health, alongside comprehensive communication and dissemination, are other key factors.
- The endorsement by the lead person for Health in the municipality and his advocacy for the importance of wellbeing has been of great importance.

THE PUBLIC SECTOR: THE NEED FOR GOVERNANCE AND INNOVATION

The Nordic countries provide a gold standard for welfare regimes (577,602). However as outlined throughout this report, 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 Nordic countries have insider/outsider problems, meaning that people on the inside of the welfare systems are very secure, but those who end up on the outside tend to be worse off than those groups left behind in other countries. Fitzpatrick and Stephens (2014) argue, for example, that it is better to be homeless in the UK than in Sweden for this reason (603), although this argument was made before austerity and other recent economic and health challenges in the UK .

The traditional Nordic welfare model is well suited for a cohesive, working public, but it leaves behind marginal groups. Relatively large groups of people with immigrant backgrounds are at risk of becoming outsiders unable to access the economic and social opportunities available to others (604). Some of the issues identified in this report include the eligibility criteria required to access many services and social protections and the complexity of accessing those benefits and services. 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. Continued high levels of investment in the welfare state is a pre-requisite but must be better tailored to need.

The Nordic model has also been shown to be unsustainable in the long run, partly because of demographic changes, particularly an aging population (605,606). There will simply not be enough professional staff in welfare systems to continue as before. There are also new forms of inequity, particularly for recently-arrived migrants, and as a result of new challenges, including the pandemic and the cost of living crisis.

Maintaining, or advancing social and political consensus on the value of high-quality universal welfare and public services is an essential component of ensuring a more equitable, healthier Norway. This requires positive communication from national and local governments and leading NGOs, as well as public services to build national support. The Government has made a “trust reform” one of their key priorities, to rekindle trust between the people, the public sector, politicians and across the whole of society. Similar reforms are currently taking place in Denmark and Sweden. The Trust Reform should restate the value and importance of public services and welfare to health, wellbeing, societal cohesion and economic progress in Norway and stress the interrelations between these components.

In order to help understand and work towards a more cohesive and equitable society the Government has launched a White paper for a *Long-term Strategy for Research and Higher Education*. The aim is to build ‘a democratic and sustainable society with high creation of value, fair distribution, widespread trust in the population and good public services throughout the country. Society must be based on a safe security policy. Participation in education and work is the key to a fairer distribution, less social exclusion, stronger community involvement and personal liberation. Climate and nature must be a framework around all politics. This research and education agenda, if implemented will help support greater health equity in Norway.

The COVID-19 pandemic in many ways boosted public sector innovation and innovation capacity and also showed how a whole-of-government and whole-of-society approach to tackling complex societal problems can work in practice. The pandemic led to co-creation between public sector bodies, NGOs’, businesses and other relevant and affected actors to find new solutions to immediate problems in the crisis but also to the social consequences resulting from the crisis, for example peer support (see case study). The benefits of adopting peer support and some of the challenges associated with its adoption are set out in the case study.

PEER SUPPORT AS A PROMISING PRACTICE

What are peer-workers?

Peer-workers are people with lived experience of various challenges who are employed within services to support people with similar challenges and assist in developing those services in line with the needs and expectations of current and future service users. Partnerships with peer-workers started in mental health and substance-use services, and these are still the areas where they are used the most, although they are becoming more widespread. Peer workers are now employed in various health and welfare services, such as child protection, older people care, prisons, and services for different medical conditions.

Peer workers easily connect with current service users' groups because they share similar experiences, and as employed within the services they learn the organisational language and can bridge and facilitate communication between service users, the service system and the community. This intermediary position is perceived as one of the most significant reasons for their success (607).

Why is this important for reducing social inequality and increasing quality of life?

Peer-workers can act as the representatives of service users or act on behalf of the services (608), increase service users' access to resources within the service system (609) and improve the ability of the service to tackle social needs (609–611). Hence, peer-workers' representation can address service inequalities. When peer-workers help reduce societal problems and have instrumental value for organisations in improving efficiency and effectiveness, they create broader public value (612). Peer-workers, who are often themselves marginalized and excluded, also benefit from regular and rewarding employment.

How is this organised?

Three different types of peer-worker roles exist, mainly, within the services; peer-workers as providers of pre-determined services, peer-workers as providers of 'peer-support', and peer-workers as an add-on service offered along with other service offers in traditional services (613). The approaches differ in how peer-workers' functions and activities reflect core peer-work principles and are based on their lived experiences.

What are the results so far?

Peer-workers are depicted as having the power to drive social change. Yet, research has revealed resistance to the integration of peer-workers (614,615) and that peer-workers' ability to impact service systems and delivery meaningfully is limited (614–616). As such, peer-worker involvement differs substantially across contexts and so does its potential to generate inputs and affect service delivery and development (617).

DEMOCRATIC GOVERNANCE

Democratic participation is important for health and health equity in a number of ways. Firstly, engaging in political processes which are fair is directly beneficial to health and wellbeing, and being involved in community action and political groups supports good health. Secondly, individual and community participation and voice helps in the prioritisation, design and delivery of policies which are relevant and appropriate to the population and important for health. Thirdly, health is a top priority for the population, according to repeated surveys (30,359,618). Accordingly, democratic processes should ensure that health is a top priority for decisions, policies and funding allocations made by governing bodies. In Norway, governance at all levels is committed to realising the Sustainable Development Goals (SDGs), including the mission to level up the social gradient in health and wellbeing (619–621); the SDGs are well aligned with progress on health equity outlined later in this section.

Norway is generally considered a well-functioning democracy, with strong institutions and well-regulated systems for regular elections at local, regional and the national level of government. The national Government and the interconnected regional and local level of governance are accountable to citizens and committed to ensure their participation in democratic governance. Since the late 1980s, public reforms across sectors have been designed to deepen democratic participation and co-creation (325,622). A crucial issue has been to 'put the public back into public governance.' There is still a long way to go to deepen democracy in practice (37,326). However, participation is generally socially skewed towards privilege, where groups who are most at risk of being left behind are those also easiest to ignore, or purposefully exclude within the public sphere.

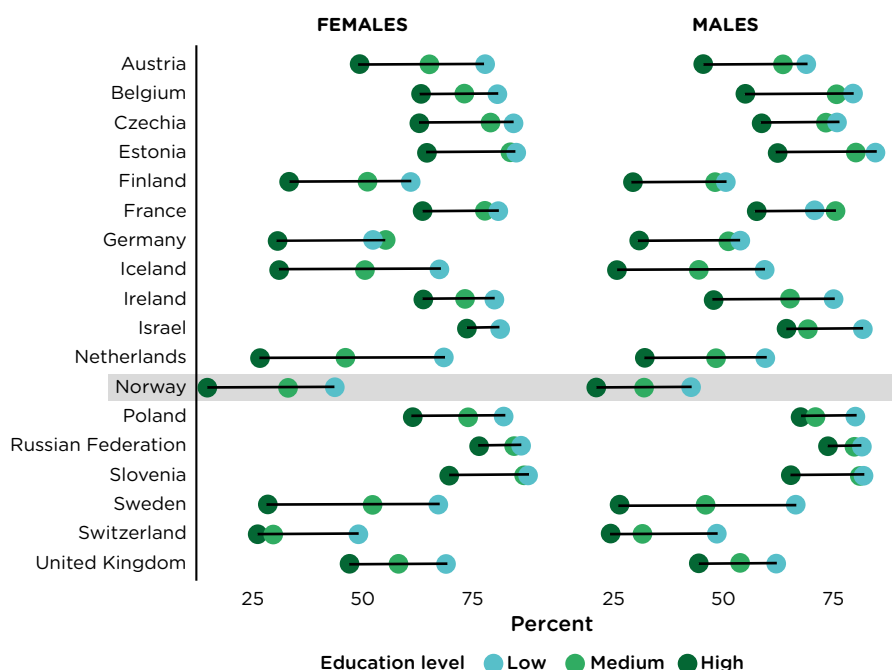
There are differences in democratic engagement by socioeconomic status, age, gender, citizen status and geography (623). Those in employment, with a higher education and higher than average income participate the most in elections. Women tend to participate more than men, and people living in urban areas vote more often than rural residents (315,624). Education seems to have more impact on voting behaviour than income. Additionally, younger and older age-groups participate less in elections than people in mid-life and first-time-voters, (315,624). New migrants to Norway tend to have the lowest voter turnout, however the percentage of immigrants who cast a ballot has slightly increased over the last decade (624). This is largely a result of the integration process and provides a successful example of engaging immigrant voters in democratic processes (625).

Despite the relatively high turnout in elections, only about seven percent of the Norwegian population are members of a political party; and only around two percent report that they are active members of political parties. Generally, older citizens and men are more likely

to be members of political parties than younger and female citizens. In the lowest age group (18-24) women are more likely to be members of a party than men (623). However, even if there is a low proportion of citizens who are organised in political parties, findings indicate that overall, political engagement has slightly increased in the last five years (626). Moreover, political participation in social media, demonstrations and participation in NGOs with political interests, such as animal welfare and climate activism, has increased since 2011. Most of this increase can be seen in individual actions, such as media statements and attempts to lobby politicians or administrative stakeholders. However, even if this kind of political participation is accessible to everyone in theory, people with higher SES, and especially higher education, engage more often in this kind of political activity.

Norway shows the lowest presence among European countries of people who believe they are unable to influence politics. However, there is a greater proportion of people with low-to-medium levels of education who feel unable to influence politics than among those with higher levels of education, figure 5.1.

Figure 5.1 Percent reporting an inability to influence politics by level of education, 2016



Source: WHO (2019) (14)

As well as social differences in the level of perceived ability to influence politics, there are differences in perceived fairness of public institutions by wealth and education - generally the wealthier and higher educated believe that public institutions treat citizens fairly and with respect. It is important to note that those who are likely to rely on public institutions more and

have higher levels of engagement with them are less likely to consider them equitable and fair. In Norway, as well as other liberal and representative democracies, the notion of citizenship has become more passive alongside a development which sees citizens as “users” or “customers” of the public sector alongside a strong tradition of professionalism in the welfare state.

Trust in elected officials remains exceptionally high in Norway, with 77 percent trusting their elected national Government, compared to 47 percent on average in other OECD countries. There is strong trust in public authorities and legal institutions as well, which has gradually increased over the last two decades. This level of trust fluctuated during the peak of the COVID-19 public health emergency between 2020 and 2021, but trust in measures and information given by the Government remained steady throughout the pandemic (627). However, there are differences, and trust in elections and Governmental institutions does follow the same lines as voting behaviour: a higher income and education plus living in urban areas is predictive of higher trust while having lower SES and living in rural areas predicts lower trust in national institutions. Unemployed people experience the least trust (627).

Citizen involvement in local processes and decision-making are explicit means of democratisation and delegating power 'downwards' (628). Strategies for user-involvement and inclusive decision-making have been developed across a wide range of societal arenas, from schools and workplaces to municipal and regional governments. However, little is known about how these strategies work for different population groups or who participates in the results. The same can be said about the degree to which health status, disablement and intersectionality influence political participation (629). Community participation in community groups and in informing and shaping policies and services is covered in Section 3E. There is a need for innovation to deepen socially inclusive democratic participation, ensure better engagement and improve the design and delivery of programmes. The case study Parent-powered Public Planning for Equitable Community Wellbeing illustrates how Levanger municipality has reframed kindergartens as platforms for co-creation, community empowerment and democratic participation.



CASE STUDY: PARENT-POWERED PUBLIC PLANNING FOR EQUITABLE COMMUNITY WELLBEING

In 2012, the Public Health Act (PHA) formalised local government's responsibilities regarding the improvement of public health and wellbeing and the reduction of social inequalities in processes and outcomes. In Levanger municipality, the Act accelerated a data-driven approach to planning, in line with the requirements of the PHA. Data from the Nord Trøndelag Health Survey and analysis of Young Data confirmed steep social gradients in health and wellbeing among young people as well as in the adult population. With support from and consultations with the UCL Marmot review team as part of a European partnership to accelerate action on the social determinants at the local level, Levanger municipality made their municipal master plan (2015-2030) the overarching plan for public health and health equity. The plan was informed by local evidence and research and adopted a proportionate universalist approach as a main strategy. However, the municipality was still struggling to identify effective measures to tackle increasing mental health problems and widening inequities. In addition, the UCL team pointed to a need to accelerate people-powered processes and community empowerment, including a need to deepen democratic participation.

In order to 'do more, and do better,' the municipality initiated a Participatory Action Research Project, PAR; a public sector PhD funded by the municipality and the Research Council of Norway, where they explored how to deepen democratic participation building from a universal welfare institution: kindergartens. They explored co-creation as an approach to health promotion (630) and relational approaches to welfare creation (631) aiming to accelerate socially inclusive community development and equitable community wellbeing.

Kindergartens were approached as meeting places to recognise social inclusion as a common value in early childhood. A mother with lived experience of marginalization and exclusion was employed as a co-researcher to strengthen the voice and role of groups at risk of being left behind. Through the participatory action research process parents, kindergartens employees, community members, policy makers and politicians developed a creative toolbox for inclusive and transformational change towards equitable community wellbeing. Feelings of being valued and adding value to the community were seen as important for social inclusion.

Parents and a wide range of participants and collaborators created meeting places and opportunities to participate in free-of-charge social arenas in their neighbourhoods. For example, they transformed the kindergarten parent meeting from being an arena where information was given from staff to parents, into arenas for co-creation and fostering communities of mutual support. Here, parents engaged in the deliberation of values that were important to them and the upbringing of their children (632). Talking about and practicing social inclusion supported awareness, the sense of feeling valued and empowerment, and parent-powered deliberation of public values on these arenas was included in the process of revising the municipal masterplan.

Throughout the process of revising the municipal masterplan there was a focus on citizens stressing their experiences throughout life. The masterplan was framed through the SDGs and human rights agendas, and the plan broadly echoed visions for co-creating a better and fairer future voiced by parents and stakeholders across the PAR. Parents in politically and socially-marginalised situations expressed that they felt valued in the process and that they had an impact (633). The revised masterplan provided an accountability system with key quantitative and qualitative indicators sensitive to equity dimensions, serving as a feedback loop to the public, staff, administration, politicians and other stakeholders in the municipality. The goals, strategies and accountability system outlined in the plan served as a strategic management tool to mobilise joint action and to keep the conversation going on important public values. The masterplan (2021-2030) was adopted by agreement of the municipal council in May 2021 (634).

The project demonstrates that Norwegian kindergartens, embedded in the national welfare regime, have unique properties for deepening the participation of parents, especially those who are socially marginalized. The PAR process illustrated how using kindergartens as platforms for co-creation and democratic participation can give voice and presence to citizens who tend to be ignored in public policymaking. The process also showed how the kindergarten platform could empower agency for parents without legal citizenship (asylum seekers), and thus give opportunities to impact processes and outcomes beyond voting. By using a universal welfare institution as the platform, the project illustrates how public participation in co-creation and policymaking can be made more socially inclusive and fair.

The project SOSLOKAL places social justice and social sustainability at the heart of democratic community development. The case study on SOSLOKAL illustrates how municipalities and networks can work

in partnership to better understand what social sustainability is about and explore innovative practices and new tools for place-based and socially inclusive community development.

CASE STUDY: SOSLOKAL: SOCIAL SUSTAINABILITY AS A DRIVER IN COMMUNITY DEVELOPMENT

The innovation project SOSLOKAL (Social Sustainability as a Driver in Community Development 2020-2024) has as its main goal to develop social sustainability as a core value and reference point for community development.

SOSLOKAL is driven by a desire to contribute to innovation in four areas:

1. Conceptual innovation: establishing a conceptual starting point for the other innovations by completing two literature studies – one broad and one targeted on the community level.
2. Product innovation: testing of the tool “Place Standard Tool” (PST) which illustrates and communicates social sustainability in an easy-to-understand and geographically relevant way. The innovation tests whether the PST gives a different and deeper insight into the residents’ experience of their own physical and social local environment and whether it contributes to new and more nuanced insight into key aspects of social sustainable local communities.
3. Governance innovation: developing collaborative governance as an instrument to a) provide deeper understanding of crucial aspects of community social sustainability; b) deepen community social sustainability in practice by mobilising local community actors in specific urban development processes.
4. Process innovation: setting social sustainability on the political agenda by creating a new and better link between knowledge of social sustainability and municipal decision-making.
5. Strategic innovation: developing a locally-adapted understanding of social sustainability.

The aim of these innovations is to explore and test out measures that (1) can provide a deeper understanding and operationalisation of social sustainability as a goal for local community development, and (2) can strengthen local communities’ social sustainability by contributing to their voice emerging more clearly in the site development. Ultimately, this will contribute to fill a knowledge gap in both research and practice (635).

SOSLOKAL is being carried out by Kristiansand, Fredrikstad and Stavanger municipalities, Sunne Kommuner (Healthy Cities), WHO’s Norwegian networks, the Norwegian Institute of Urban and Regional Research (NIBR) at OsloMet, and the Norwegian University of Life Sciences (NMBU). The project is developed in dialogue with the municipalities of Levanger and Dundee, the Healthy Cities network in Denmark, and the National Health Service (NHS) Scotland, and the Norwegian Directorate of Health. SOSLOKAL is financed by the Research Council of Norway (636,637).

Findings and experiences

1. SOSLOKAL has completed two systematic literature reviews: one focusing on the understanding of social sustainability as a concept (638), and one which relates to social sustainability in a local community context (635). The findings show that social sustainability is far more actualised within the planning and urban development context than in a more general management context. Also, it is more present in the social justice literature than in the literature that looks more generally at social capital – which is a core concept within democracy research and voluntary research (635). Findings also show that social sustainability should be given meaning and operationalised at all levels in society, from the global, to the national and local. They also show that participation in collective decision-making enables opportunities for people to participate in decisions over how social sustainability must be operationalised, although there is a scarcity of literature specifically on how this should happen. In addition, the reviews show that research that deals with social sustainability in a local community context hardly addresses the strength-based and co-creative approach, or the governance implications of promoting local social sustainability in general. Based on key findings from the literature studies, the subsequent innovations elaborate on two distinct social sustainability dimensions; a) to develop socially robust local communities; and b) to safeguard fair access to benefits and an absence of burdens.

2. SOSLOKAL tests the “Place Standard Tool” (PST), which provides a picture of strengths and weaknesses in the local community as a physical and social system. The PST identifies factors which the population particularly values. Safety, identity, belonging and local bonds of friendship help build robust communities and are important factors in explaining why people thrive. The participants also feel that they have access to benefits which are important to them – nature and hiking opportunities, public transport, as well as good nurseries and schools. However, the population want easier access to health services (medical services, dentist, pharmacy), post offices, banks, shops and informal meeting places like cafes. They lack involvement in, and information about, measures and decisions concerning their own local environment. They want to have greater influence.
3. SOSLOKAL arrange “City labs” that build directly on the findings from the PST. The discussion in these labs showed the importance of social arenas locally and joint platforms between the municipality and the population in order to further develop and maintain the local community’s resilience. Such collective meeting places have both a relational and a physical side. Social relationships are built by meeting physically and doing joint activities in publicly accessible spaces. The social robustness of the local community thus depends on the physical development in the area, in the form of opening new social places, or by making use of existing buildings for meetings. The discussions showed also that a slow pace of implementation of plans and promises negatively affects trust in municipal organisation. Creating better information flows and channels for influence and dialogue between the local community and the municipality needs more than physical investment and is important for democratic development.
4. SOSLOKAL arrange “Policy Labs” concentrated particularly on placing social sustainability higher up on the political agenda. They addressed among others the institutional condition for strengthening social sustainability policies. Particularly the relationship between three main actors in local decision-making; the local community, the political committee at the community level, and the municipal council and its committees. Two key findings emerged from this innovation: Firstly, that the community committee potentially can play a role between the population in the community and the central political bodies of the municipality. Secondly, a more active co-creation practice and culture will require reforms in the governance system. All actors operate in a system with fixed routines and norms where co-creation, at best, is superimposed as something extra. To reach the full potential of co-creation requires increased access to resources such as knowledge and time, and co-creation will need to be placed more firmly at the heart of political and administrative processes. That is, to transform the decision-making process from a reactive to a proactive system of governance.

PARTNERSHIPS: NATIONAL, LOCAL AND ACROSS ALL OF SOCIETY

To reduce health inequalities, it is essential to have systems in place with stakeholders from across social determinants of health sectors working together collaboratively in close partnership. It is important to add that this is not an example of ‘health’ trying to dominate a whole-Government agenda. Actions taken to address health inequalities will create a fairer, more just society, with more social engagement, less crime, higher productivity and employment and a more educated, engaged population. Acting on health inequalities is also crucial to the Sustainable Development Goals. While one Sustainable Development Goal (SDG 3) directly references health – “Ensure healthy lives and promote wellbeing for all at all ages” – at least 11 of the 17 Sustainable Development Goals can be seen as driving the social determinants of health.

Given that most of the drivers of poor health lie outside the usual focus of health care, it is essential that all relevant organisations and sectors, nationally, locally and at community level, are involved in the

endeavour to reduce health inequalities. Involvement and partnerships between many sectors, such as early years, education, work, social protection, environment, housing, social care and community, as well as health care, are required. The role of specific sectors is set out in Section 5C.

Developing the necessary partnerships and collaborations is challenging. Different sectors have different priorities, budgets, workforce cultures, delivery systems and mechanisms, incentives and targets. In Section 5C we recommend a health equity in all policy approach for governments nationally and locally and for all sectors to ensure that supporting greater health equity can be embedded across relevant sectors and to enhance partnerships for health equity. The case study on The public Health Laboratory in Viken focuses on an initiative which aims to promote collaboration between different levels of governance and institutions aimed at reducing health inequalities.

CASE STUDY: 'THE PUBLIC HEALTH LABORATORY' IN VIKEN

In 2022, Viken county took the initiative to create 'The Public Health Laboratory'. This is a public health hub facilitating collaboration between the county, municipalities, and regional universities to ensure the population's health and wellbeing and to reduce inequalities in health within the region (639).

The initiative is based on the idea that the different stakeholders need to get to know one other, learn about each other's language, goals, and methods in order to be able to build trust and mutual understanding. By meeting regularly, it is possible to agree upon common goals, to share and systematise knowledge, and to learn from best practice. The motivation for this initiative is rooted in the fact that to solve complex problems, such as inequity in health, there is a need for interdisciplinary and cross-sectional collaboration. Also, national policies create a 'window of opportunity' for strengthening collaboration between the county, the municipalities, and the regional universities. In regional and local governments there is a political drive towards more evidence-based practice, where universities are prescribed a more active role in societal development and innovation. As the main responsibility for public health is allocated at the regional and local levels, cooperation at this sub-national level is especially viable. As regional academic institutions have local knowledge, they are in a strong position to add value to the collaboration with regional and local professionals and policy makers.

The Public Health Laboratory is conducted twice a year and invites researchers from regional universities, regional and local administrations, policy makers, public health workers, municipal planners and others interested in working together on different topics concerning public health. The topics can be initiated from all stakeholders and can address how to solve specific public health challenges, such as inequity in health. Furthermore, topics cover designing collaborative research projects, discussing implementation of knowledge, communicating recent research knowledge, or sharing best practice and how this can be implemented in different municipal contexts.

In Norway the partnerships between national and local municipalities need to be enhanced. Local municipalities in Norway are responsible for delivering policies. Policy goals and programmes are formulated at the national level and local governments decide how to deliver and achieve these goals. Municipalities make their own decisions about funding and are the main providers of welfare services, deciding on health promotion and disease prevention. As shown in this report, there are considerable differences between local municipalities in Norway in the approach taken to reducing health inequalities, the strength of action and health and social determinants of health outcomes. The role of local municipalities taking action on health inequalities is explored more in Section 5C.

HEALTH EQUITY IMPACT ASSESSMENTS

Impact assessment tools can assist in the development of policies and interventions to reduce social, economic and health inequalities. They can be used during and after the implementation of policies and interventions to assess the processes of implementation and to examine how positive impacts can be enhanced and adverse and inequitable impacts can be prevented or mitigated.

When applying a health equity impact assessment policy tool, it is necessary to consider the intended impacts of the policy, potential unintended or adverse impacts, and the population group/s who will be

affected by the policy. Understanding the potential impacts of a policy or intervention on socioeconomic inequalities should incorporate understanding of the way a policy or intervention will create change through an assessment of relevant evidence gathered from the literature and relevant stakeholder groups including practitioners and groups impacted by inequalities.

Health impact assessments tools have been developed for use at national policy level to monitor policies to promote health equity, such as WHO's Health Equity Policy Tool (640). Countries including England, Scotland, Canada and Australia have developed health equity impact assessment tools to be used by public health leaders and practitioners at a more local level. Health equity impact tools are developed and used with a specific purpose in mind and vary accordingly but share characteristics since the overall intention of health equity impact tools is to inform decisions for developing policies and interventions and/or assessing the impact of policies on health equity.

DEVELOPED FOR NATIONAL GOVERNMENTS IN EUROPEAN COUNTRIES

The World Health Organisation, Regional Office for Europe (WHO Euro) developed a Health Equity Policy Tool intended to support and promote national policies in multiple sectors to reach the most vulnerable and those disproportionately at risk of avoidable poor health (640).

The Health Equity Policy Tool is built on a framework of five multisectoral policy action areas: health services, income security and social protection, living conditions, social and human capital, and employment and working conditions, areas set out in the WHO EURO Health Equity Status Report. Two sets of indicators are included for each policy action area: 1) measures of the implementation of and investment in policies promoting health equity; and 2) measures of the equity impact of policies addressing the determinants of health or their consequences. The equity impact of policies can be measured by indicators of coverage, uptake and effectiveness. A set of evidence-based indicators relevant to each policy area is described, including health indicators and indicators of the conditions required for a healthy life. Many of the indicators map to indicators set out by UN Sustainable Development Goals. To be useful in assessing equity impacts, monitoring data should be disaggregated by stratifiers such as income, years of education and sex, and indicators to enable monitoring of impacts on minorities and other groups protected by human right treaties, including, among others, people with disabilities, migrants and children. It is worth emphasising the need to encourage practitioners to engage groups impacted by inequalities in a meaningful way so that their voices are heard, and their needs are incorporated into action plans.

The usefulness of the WHO Health Equity Tool is that it provides guidance to national governments in the European region to support the monitoring of impacts of policies on health equity using a common framework. Regular monitoring of policies is essential to assess progress or setbacks against policy objectives, to identify what is or is not working and for which population groups, to inform discussions across Government and society on what more can be done, to adjust aspects of implementation, to make further investments, or take further action as necessary.

DEVELOPED FOR USE BY PROFESSIONALS ACROSS WORK PROGRAMMES

The Health Impact Assessment Tool (HEAT) was developed by Public Health England to provide a tool to assess action on health inequalities and to guide further action (641). HEAT is intended to be used by professionals across the health and wider system landscape to assess health inequalities in relation to their work or service. The tool is adaptable and can be adjusted for use by different work programmes. The guidelines encourage users to review their work six to 12 months after the initial evaluation, which is important for incorporating any adjustments or any necessary course corrections identified during the initial period. The tool provides a template to guide users through four stages in the tool; prepare, assess, refine and apply and review.

DEVELOPED TO SUPPORT DECISION MAKING IN A NATIONAL HEALTH SERVICE PROGRAMME

A bespoke health equity impact tool was co-produced by stakeholders in England to support decision-making in the NHS Health Check programme (642). The Health Check Programme is commissioned by local authorities to conduct health checks on people aged 40–74 years with no pre-existing conditions for risk assessment and referral for treatment if needed. A computer interface was developed to allow users to vary key parameters of the programme (invitation, uptake, prescriptions, and referrals) and to compare scenarios. The outcome measures included disease cases and case-years prevented or postponed, incremental cost-effectiveness ratios, net monetary benefit and changes in the slope index of inequality. The tool is intended to be used to optimise cost effectiveness and equity impact of the NHS Health Check programme. A summary of potential benefits of health equity impact assessment tools is below.

WHAT MAKES A HEALTH EQUITY TOOL USEFUL?

- 1) Evaluation for Improvement:** to ensure that the use of a tool results in action and improvement in policies and programmes, specifically, there should be clear benefits to applying a health equity tool such as identifying programme improvements, health equity priorities, or engaging clients in thinking about social factors that may impact health.
- 2) User Friendliness:** a tool should be concise, use plain language, be easy to understand, and be quick to use.
- 3) Explicit Theoretical Background:** it should clearly explain fundamental principles and theoretical foundations, including definitions and explanations of health equity.
- 4) Templates and Tools:** provide clear instructions on how to use the tools and examples of application.
- 5) Equity Competencies:** support understanding of structural causes of health inequities, help build communities of practice.
- 6) Nothing about Me without Me – Client Engaged:** encourage practitioners to engage groups impacted by inequalities in a meaningful way.

A summary of concept mapping study among public health leaders and practitioners was conducted by Pauly et al. (643)

Tools to assess or monitor the positive and adverse impacts of proposed or new policies and interventions on population groups according to a range of characteristics or dimensions, including age, sex, ethnicity, disability, and other characteristics, socioeconomic status, geographic deprivation, or being recognised as vulnerable in some other respect. These tools can apply mathematical modelling 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. This approach can provide powerful information to guide policy.

For example, a study in Copenhagen, Denmark that modelled the impact of reducing the prevalence of overweight and obesity in groups with low and medium education to the same level as that of groups with high education, showed a reduction in future prevalence of cardiometabolic diseases, increased life expectancy, and reduced health inequality (644). In this modelled scenario, the prevalence of diabetes in the group with low education was reduced by 8-15 percent for men and 12-13 percent for women, and life expectancy increased by one year among women with lower education (644). This health equity impact assessment clearly highlights the potential for health and health equity gains.

A study in Germany demonstrated how the overall health impact of modelled scenarios of physical activity interventions varies depending on the intervention and level of education (645). Using health equity impact assessment methods to model intervention impacts across education, income or other groups is important to provide guidance to decision makers about which population groups would be most likely to benefit and the extent to which socioeconomic inequalities would be affected.

PROPORTIONATE UNIVERSALISM

As indicated in Chapters 2 and 3, there is a social gradient both in health outcomes and its social determinants in Norway – as is the case in other countries.

The first National Strategy to Reduce Social Inequalities in Health in Norway (6) included a focus on universal policies in combination with more targeted measures (4,7). However, in recent years this combined approach has not been sufficiently apparent in the implementation of policies in two important respects. First there are significant gaps in the universality of several welfare and other public policies. Secondly, the targeting of need is often inadequate to, for example, lift people out of poverty and too narrowly focused to meet needs that exist across the social gradient.

As indicated in Chapter 3, health centres and school health services in Norway are universal services, accessible to all households regardless of immigration status or socioeconomic level and also serve as the

primary access point for public health reforms and programmes targeted at families (16,42). To this extent they offer a proportionate universal service. But, as the findings in Chapter 3 indicate, there is a need for greater intensity of action, e.g. free childcare, to ensure higher uptake by parents whose children seem to benefit most from attendance.

Any strategy to reduce these inequalities requires the implementation of policies and interventions whose aim is to level up social gradients. It is this that constitutes a fully proportionate, universal approach (194). Simply introducing a universal policy creates two potential risks from an inequality reduction perspective. The take up of a universal offer may be equal across social groups, resulting in an improvement in health that is the same across the social gradient. Thus, overall health is improved but inequalities persist. The additional, potentially larger risk, is that uptake is greater among those who are already benefitting from good health so that the impact of an undifferentiated implementation can be regressive. The reasons for this are often related to the fact that the social conditions which lead to the social gradient are not themselves addressed in an intervention that is focused on behaviours or that the intervention is addressing only a single social factor.

At the other extreme are those interventions or implementations that are targeted only at the most disadvantaged. These also present multiple weaknesses when attempting to reduce the social gradient in inequalities:

- First, improving outcomes in only the most disadvantaged leaves the majority of the population, who also have worse health than the most advantaged, untouched by the action taken.
- Second, the selection of the targeted population creates a cliff edge in terms of eligibility. Whatever criterion is used for targeting will exclude those who either narrowly miss out or miss those whose need is as great and would have been targeted had a different criterion been used.
- Third, the policy will be seen as providing a benefit only for the most disadvantaged and will not therefore be seen as being beneficial to the majority of the population. This will make implementation more difficult to defend in hard times and there will be challenges over the level of investments; where implementation requires the provision of a service, there may not be public support for maintaining its quality – risking the services becoming ‘poor quality services for poor people’.

The aim of proportionate universalism is to address, or mitigate, these risks. It is based on the principle that access to resources should be universal but that the scale and intensity with which the relevant resource is allocated to individuals or places should be

related to their need for the resource (194). The most straightforward example is that of allocating grants from the centre to municipalities. For each area of spending by the municipality, the extent of social need should be assessed and the share of central funding for that activity distributed according to this assessment. The extent to which allocations are graduated by need should be sufficiently great to enable municipalities to meet the identified needs. This method of distribution must, of course, be accompanied by monitoring indicators to hold the municipality to account for spending the additional resources effectively on the intended activity.

One example of this is formula used for allocating funds from the centre to health boards in Scotland. 'Whilst the main driver of a NHS Board's share is the projected size of their resident population, the Formula also takes into consideration other factors that may impact on the need for services such as the age and sex composition of the population, levels of morbidity and the influence of other 'life circumstances' such as levels of deprivation. The Formula also adjusts for the unavoidable excess costs that some NHS Boards may experience in delivering services, for instance in remote and rural areas' (646).

At a meso-level, an example of universal proportionate allocation is the capital funding provided to school districts from the state lottery in North Carolina in the USA. Grants, awarded under the Needs-Based Public School Capital Fund, are aimed at districts in economically-distressed counties to provide for school construction, renovation projects and other capital improvements. The grants are in addition to the state's lottery-supported Public School Building Capital Fund, from which all districts receive an allocation each year (647).

At an individual level, the principle implies that where an intervention is aimed at improving the situation of individuals, all individuals or families who could benefit from the intervention should be entitled to receive it but that the scale and intensity with which it is delivered should be sufficient to make a real change to their situation. This builds on the concept of universal access to welfare in Norway and, more generally extends the concept of a universal basic income (648). But what it adds is the recognition that the needs of every individual and family differ according to their circumstances. This requires a comprehensive view of needs so that support is tapered to level of needs and not to a cliff edge approach to needs. This requires making best use of available finance and other resources in ensuring that every family has the minimum income needed for a healthy life (194), for example based on what the public believe is needed for a minimum standard of living (649).

As indicated in Chapter 3, individual and corporate taxation is an essential component of a proportionate universal approach – tax contributions enable the public sector to provide good quality living and working conditions and provide support to those experiencing

exclusion and poverty. But there are gaps in both who is eligible for particular benefits, the amount that some individuals receive and the duration for which benefits are received while post-tax income and wealth inequalities are increasing. Achieving a balance that is proportionate for the levels of need requires a high level of integration of the tax and benefit systems so that, as taxable income rises, benefits can be tapered off in a way that does not create cliff-edges or, which are in effect, a high marginal rate of tax for those on benefits who try to increase their income through employment. Equally, to address need appropriately, the range of benefits available to an individual must be assessed on the basis of the needs of the family – to ensure that the family has the minimum income required for healthy living (194). The aim of this proportional approach would be twofold, to avoid, as far as possible, both in-work poverty and out-of-work poverty and to ensure that obtaining good quality work provided a greater income than relying on benefits – for instance through minimum wage policies.

As indicated in Chapter 3, the rise in child poverty in Norway and higher rates of poverty for some immigrants provides a strong incentive for increasing spending on benefits and services in line with the cost of living and for adopting a proportionate universal approach to level up the social gradient in health. While this requires national action, some progress can be made at the level of municipalities by coordinating services to families with low income in which the children's needs and the adults' needs are considered holistically and assistance and resources available to them are maximized – see the case study in Chapter 3 – New Patterns, implemented in Kristiansand.

Similarly, as discussed in Chapter 3, in 2017 the Norwegian Directorate of Education and Training financed a project called 'A Support Network for the Pupil: A research-based trial and effect evaluation of measures' (the LOG-model) (650). This cross-disciplinary approach to the school system enables the provision of greater support to all children and families, involving a whole- community way of working, and proportionally giving more support to pupils and families in need for extra help.

In the field of public health interventions, proportionate universalism implies offering interventions to everyone who needs the intervention, but putting greatest effort into those who require most help. For example, in a smoking reduction intervention, it is often the case that all smokers are willing to participate, but it is those in the most difficult situations who find it hardest to succeed and require multiple attempts and additional support, such as debt counselling, to finally achieve success. Reducing inequalities in smoking requires the greatest attention and resources be directed to these individuals. This is in contrast to a programme in which the target is simply to get the greatest number of successes or the greatest number of attempts. Programmes based on

these types of targets are essentially regressive in that they widen gradients in smoking.

In 2019, the Council on Social Inequalities in Health in Norway provided specific advice to reduce social health differences. Their recommendations focus on the entire social gradient rather than just poverty and the socially disadvantaged. By proposing action on the social

determinants of health such as affordable child-care, education, living environments and income structures, they aim to facilitate a possible re-orientation of policy away from redistribution to universalism and a needs-based approach with 29 recommendations to combat social inequality of health that demand cross-sectorial actions (651). There are other important contributions on this matter from Norway (587,652–655).



HEALTH EQUITY MONITORING AND INDICATORS

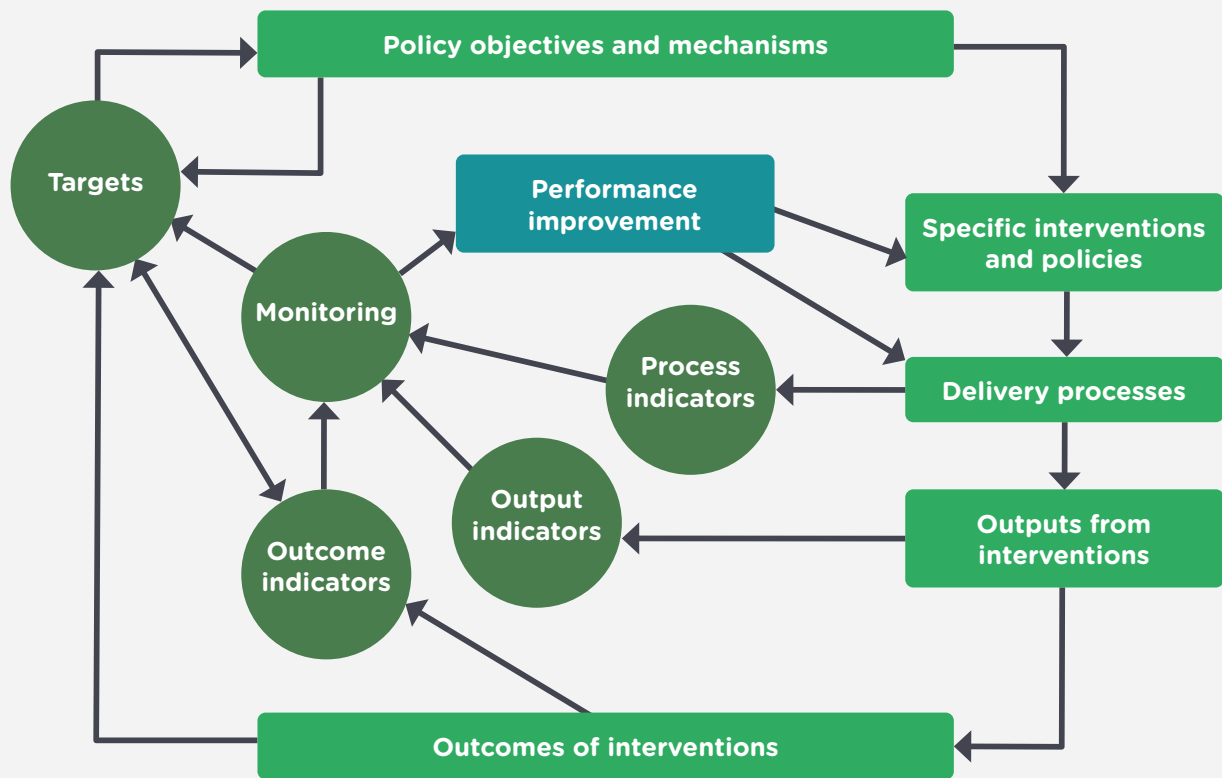
At the municipal level, we don't have the routine statistics to say how the distribution of many of the health determinants is evolving..... Before we can use any impact assessment tools, we need to use better data

Espen Dahl, Oslo Met

On the basis of the conceptual approach, recommendations and actions identified in this report, indicators should be adopted or, where not currently available, developed to monitor the processes, outputs

and equity outcomes for each social determinant of health and wellbeing and the impacts of policies and interventions (see Figure 5.2). Monitoring for health equity is a vital tool to ensure effective accountability for the inequalities that exist locally or nationally. 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 (such as those discussed in Chapter 4), 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.

Figure 5.2 Framework for equity indicators and targets



Source: Marmot (2010) (194)

It is envisaged that these indicators are used to set objectives and hold delivery organisations to account and need to be SMART -- Specific, Measurable, Achievable, Relevant and Time-bound. This has a number of implications. Different indicators may be required to support and measure performance improvement in the short (2023-29), medium (2030-39) and long term (2040 and beyond).

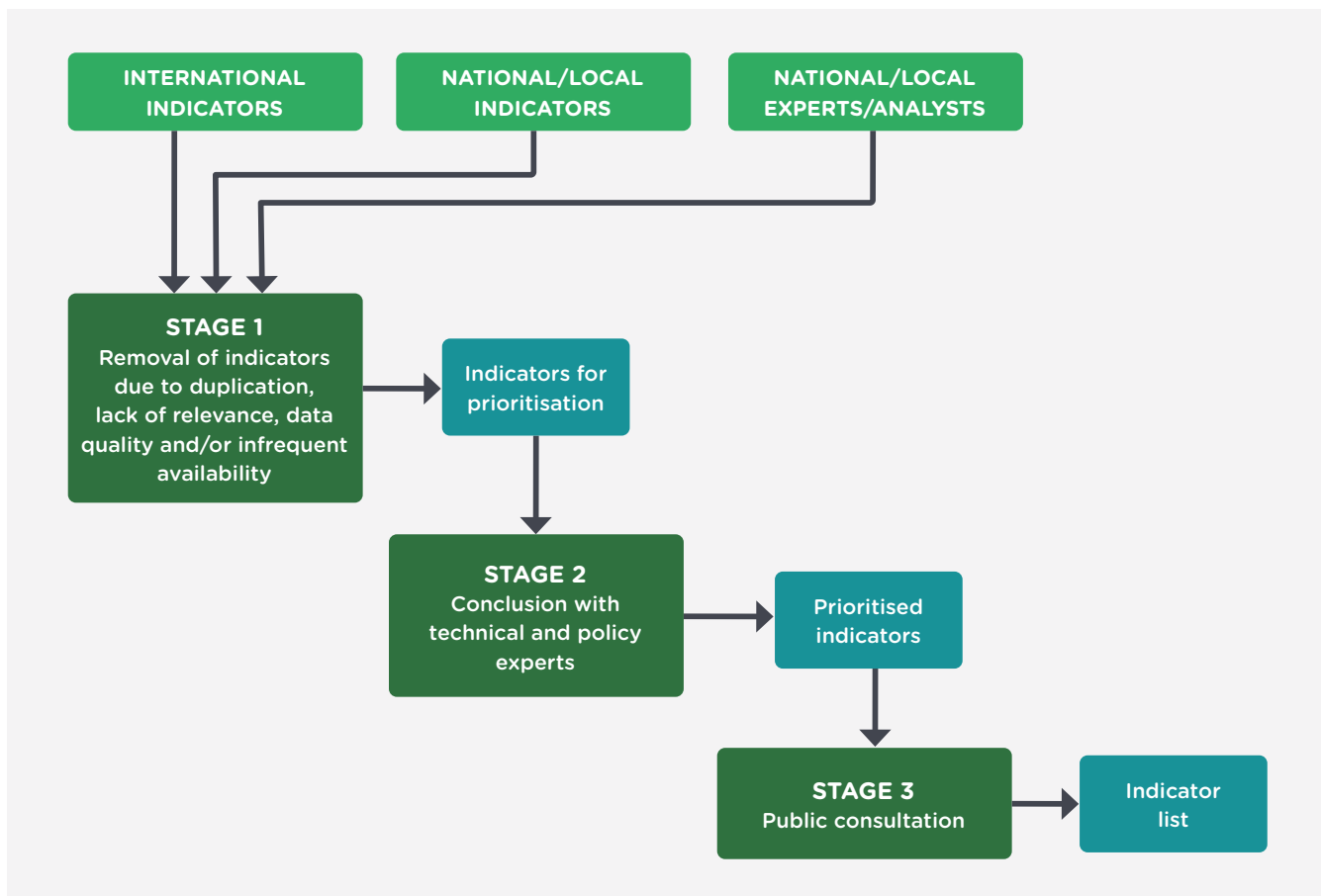
If appropriate indicators are not currently available, there needs to be a realistic prospect that such measurement tools could be put in place to fit with the relevant timescales. Performance indicators need to be defined in such a way that would make it possible for the organisations concerned to achieve the improvements in equity being sought. To ensure relevance and specificity to the equity issues that emerge over time, the detailed indicators proposed at this stage may need to be adapted to changing circumstances - including, but not restricted to, greater data availability.

One approach to drawing attention to, and enhancing, accountability for progress is to set aspirational targets. However, the aspiration needs to be set somewhere between, on the one hand, a forecast of what would have happened without any policy intervention and, on the other, what could realistically be achieved in

the timeframe by the policy intervention. A potential disadvantage of targets is that they can narrow down the focus of action only to those areas for which targets are set - leading to action on other indicators being ignored. This is often referred to as 'hitting the target and missing the goal'. For this reason, where aspirational equity targets are set, this should ideally be done at a national level and supported by a framework of locally measurable indicators, the details of which will vary from municipality to municipality to suit local circumstances. As part of local accountability arrangements for partnerships within municipalities and between municipalities and other local organisations, any targets should be set using this framework to match local needs and provide a basis for equity improvement to be assessed. Implicit in this use of indicators is the need for national comparability across local areas, to ensure that fair and valid assessments of improvements can be made between areas.

In selecting indicators, consideration should be given to both those used or proposed by international organisations (such as UN organisations) and existing national indicators. Figure 5.3 provides an indication of the iterative process that is necessary in proposing and then consulting on a set of indicators - precise steps will depend on local requirements.

Figure 5.3 Indicative indicator development process



One of the main international indicator sets to consider in the process of shortlisting potential indicators are the Sustainable Development Goal (SDG) indicators (656). These are linked to each of the 17 SDGs with the important qualification that: “Sustainable Development Goal indicators should be disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other

characteristics, in accordance with the Fundamental Principles of Official Statistics.” (656).

Figure 5.4 indicates which of the SDGs is in whole or in part related to determinants of equity in health and wellbeing discussed in this report and hence to the report’s individual recommendations.

Figure 5.4 Summary of links between SDH and SDGs





Using individual characteristics, such as those discussed in Chapter 2 based on education, income and occupation, to assess inequalities in outcomes has the advantage of avoiding the problems of drawing inappropriate conclusions from changes at an area level (discussed in Chapter 3). However, for monitoring purposes using an individual's own characteristics relies on routine linkage of health outcomes to these social determinants using register data at an individual level. To enable such data to be used at municipality level for local monitoring requires consideration of the ethical, legal, confidentiality and public perception issues that might be encountered. However, as techniques for anonymisation and pseudonymisation of linked data develop and more examples of 'safe-havens' for storing and granting access to such data expand across the world, this option for monitoring becomes more realistic.

Under this scenario of using linked data, it will be more important than ever to ensure that individual indicators are not developed that lead to misinterpretation of causal pathways. As discussed in Chapter 2, while education is a stable indicator over the middle and later years of life, its interpretation varies between successive cohorts as a result of historic education reforms and is less useful while children and young people have not yet completed their education. Conversely, current household income and occupation can be affected by health status, as discussed in Chapter 2. For this reason it is often better to link current health status (e.g mortality or disease recording) back to occupation five or more years earlier to ensure that the direction of causality between social determinants and health outcomes is clear.

Where reliable individual data are not available at local level, this makes it impossible to analyse or monitor the indicator or target locally and a proxy or synthetic estimate needs to be used. This is particularly an issue for rare events, for example, infant mortality or population groups that form only a small minority of an area, for example, ethnic groups in many areas. This can be avoided if a distributional target is chosen, for example by focusing on the gradient or aspects of the range of variation of the indicator used to derive the target. However, for area-based strategies the constant change in the position of a local area on the distribution of all areas can make it very difficult to set a coherent local strategy and to monitor the effects of interventions. This needs to be reflected in the way in which local targets and indicators are set and relate to those at national level. By setting targets based on a target subgroup within local areas, for example, the most deprived fifth, undue emphasis is given to relatively unstable local indicators of outcome. Where there are few enough outcome events within a whole municipality, limiting local monitoring to changes among a small fraction of the people in the area

makes this issue much worse. By focusing on reducing differences across the social gradient, this can, to some degree, be avoided. To avoid misleading conclusions concerning trends in inequalities and creating perverse incentives, indicators also need to reflect both absolute and relative reductions made to inequalities.

ADDRESSING THE PROBLEMS WITH AREA-BASED MEASURES OF INEQUALITY

As discussed in Chapter 3, by measuring changes only at broad area levels including administrative area level, we cannot tell whether or not any improvements being made are confined to the more affluent living in an otherwise generally deprived area. The introduction of within-area inequalities indicators and targets can address this problem. While these should reflect specific local issues, they should also fall within the overall national framework of indicators. These issues pose less of a problem if small area data were used to define indicators, as long as the numbers being measured in the small areas were sufficient to enable analysis.

EVALUATING THE EQUITY IMPACT OF INTERVENTIONS

The need for evaluation arises from the limitations to the evidence on effectiveness that is available from past interventions. While there is often evidence of the general health or wellbeing effects of interventions, there is a dearth of evidence in respect to their impacts on inequalities in health and wellbeing and of the cost-effectiveness of different methods of reducing these inequalities. Similarly, more research has been conducted on the effects on health inequalities of downstream interventions, than for upstream, social determinants interventions. All too frequently, interventions and policies are implemented without building into their design the capacity to undertake a thorough evaluation of the outcomes. This is inherently difficult in a social context where the link between the intervention and outcomes of interest may be separated by a number of intermediate stages and a long time lag. As in Figure 5.2, this can to some extent be addressed using output indicators as proxies for intermediate outcomes and the tools described in the section on health equity impact assessment.

In assessing whether new policies and interventions are having an impact in bringing about a change in the social gradient in health, evaluations need to take account of the distributional effect across the whole population. This is often difficult when a highly targeted intervention is implemented, as it raises the question of what effect is seen outside the target group e.g., of switching resources to be more focused on the target population. The evaluation design needs to be such that the impact across the social gradient can be measured.

5C. THE HEALTH EQUITY SYSTEM - PARTNERSHIPS AND ORGANISATIONAL ROLES

As we have set out throughout the report, taking action on the social determinants is a cross-sector, whole-society endeavour. The agenda involves national Government and associated organisations, local government, the VCFSE sector, the healthcare system and public services, businesses and the economic sector.

This report is principally oriented around developing proposals for actions for the national government to reduce inequalities and recommendations have been made in section 3 for the 8 broad Marmot principles concerning the social determinants of health and for the development of a health equity system nationally. This section focuses on actions which other sectors, the VCS, businesses and the economic sector, healthcare, public services and municipalities can take; in many cases these actions can be strengthened and supported by national and local government actions – but they also require action on health inequalities outside that context.

THE VOLUNTARY AND COMMUNITY SECTOR

The VCS are vital partners in action to reduce health inequalities and inequalities in the social determinants of health. They tend to have a close relationship with local communities and a better understanding of their experiences. They are also responsible for delivering vital support and services to those who are excluded, marginalised and those who experience poor outcomes in key social determinants of health and poor health. Involving the VCS sector in the design and delivery of public services is important to ensuring that services are appropriate, relevant and bring benefits to local communities.

The voluntary sector makes significant impacts on the social determinants of health, improving health and reducing health inequalities – even those charities whose primary purpose and remit may not be directly health-related (657). Charities are often better situated, both in the services they deliver and proximity and engagement with communities, to work closely with communities, particularly those that have a history of non-engagement with statutory or mainstream services (657).

The indispensable roles of VCS organisations were 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. The following case study illustrates the advocacy role that voluntary sector organisations can have in reducing social inequalities in health.

CASE STUDY: THE NORWEGIAN HEALTH ASSOCIATION

The Norwegian Health Association (Nasjonalforeningen for folkehelsen) is a voluntary, humanitarian organisation with a focus on public health and health inequalities. It also contributes to research on cardiovascular diseases and dementia and acts as an advocacy organisation for people with dementia and their next-of-kin.

As a voluntary organisation, it has an opportunity to be an agenda setter. Through the volunteers in local communities throughout the country, the organisation witnesses the health consequences of inequalities in society and volunteers engage in activities to promote health and wellbeing and seek to reach people across social groups.

In addition to the experiences and narratives that the association collects, it is also concerned with scientific knowledge and makes sure that its advocacy work is evidence-based. It engages in novel partnerships, for example by building strong alliances across voluntary organisations, or through collaboration with different relevant sectors, such as established research communities. It contributes to implementation and awareness of relevant research, and sheds light on the challenges faced by society, to inform the population as well as policy makers and politicians.

At the national level, it has engaged in a partnership with leading researchers Jon Ivar Elstad and Espen Dahl to produce a landmark report on social inequalities in health, 'Sosial ulikhet tar liv – faglige og folkehelsepolitiske vurderinger', translated as 'Social inequality takes lives – professional and public health policy assessments'. The organisation subsequently invited representatives from the Government and Parliament to a seminar to discuss the findings.

In summary, the Association's ability to access local experiences and narratives, combined with its development of scientific knowledge, allows it to be an important actor in setting the political agenda in Norway, as well as in creating windows of opportunity to act on the social determinants of health and to reduce inequalities in health and wellbeing. Reducing social inequalities in health through action on the social determinants is, precisely, one of its goals as established in its programme for action for the period 2022-26. The Norwegian Health Association represents an important example of how voluntary organisations can be important contributors in this field.

In order to fulfil their potential to tackle reductions in health inequalities and the social determinants of health, volunteer organisations require sufficient funding. Volunteering organisations receive on average 27 percent of their income from national and 17 percent from local municipalities. Members and supporters account for approximately 45 percent of their income, while private stakeholders, such as local businesses sponsoring local clubs, etc. contribute 12 percent of average budgets. The overall contribution of the volunteer sector to value creation in Norway is estimated to be about 78 billion NOK (336). Other indirect economic measures to support volunteer organisations include tax exemptions. Close to NOK 270 million were distributed to the voluntary sector to fight poverty through the national funding schemes and an additional NOK 10 million were dedicated to co-operation efforts between municipalities and VCSs that address child poverty (658).

Volunteer organisations benefit from high levels of trust in society, which leads to private funding (334). Some 70 percent of the Norwegian population stated that their household had given money to voluntary organisations during the last 12 months of 2014, increasing from 51 percent in 1998 in line with other rich western countries.

Most monetary gifts go to international aid, followed by religion, health, and social services. Many organisations have professionalised their work and strengthened their efforts to recruit sponsors and regular donors. Games and lotteries are also an important source of income for sports and cultural events (659).

There has been an increase in the number of larger umbrella-organisations from 30 in 1970 to over 300 at present. This is attributed to increasing differentiation and specialisation and a demand for increased co-operation within the volunteer sector; as well as to the need to develop new approaches and ways of funding (660).

The Association of NGOs in Norway and the Norwegian Association of Local and Regional Authorities (KS) have a collaboration agreement where both parties agree that municipalities should develop and adopt local volunteering policies, in dialogue with local voluntary organizations. The intention is increased dialogue and collaboration between the municipalities and the voluntary sector. Approximately 60 percent of the Norwegian population lives in a municipality with a policy for volunteerism. If policies for volunteerism contain measures that lower the threshold for dialogue and collaboration between

the sectors, this opens the possibility for voluntary organisations to contribute on their terms and conditions, as social actors locally, regionally and nationally.

The Association of NGOs has supported its members by providing advice on how to help to break down economic and social barriers for participation in volunteering through activities run by voluntary organisations. The Association has developed tools that are free to use for all organisations that are registered in the Register of Non-Profit Organizations. These tools are known by a large proportion of the population and citizens throughout the country can find a variety of activities.

In addition, employees in the municipalities can help people in vulnerable situations, of all ages, into the social communities that the voluntary organisations represent.

For this review, the Norwegian Health Association convened a roundtable with Norwegian voluntary sector organisations to discuss their role in reducing social and health inequalities. The participants emphasised that the voluntary sector has an important democratic role in the political system both locally, nationally and internationally. The following box lists and summarises the main topics discussed by participants and brings out their perspectives.

HOW VOLUNTARY SECTOR ORGANISATIONS SEE THEIR ROLE IN REDUCING SOCIAL AND HEALTH INEQUALITIES

The voluntary sector as an advocate and democratic watchdog

The voluntary sector has a unique opportunity to work as an agenda setter because it influences public opinion. It can provide evidence of how policies work and play out in real life, for example the importance of proportionate universalism. It offers a voice to groups who are not often heard, including those in situations of vulnerability. It enhances democracy, supporting citizens to participate in the political process. However, to ensure that participation is meaningful, the voluntary sector must be let into the process early on, as well as into the relevant arenas. Some important barriers can be a lack of skills development, limited awareness of the influence of commercial actors and insufficient funding.

The voluntary sector as a co-creator

Municipalities, county municipalities and state authorities can establish a dialogue with voluntary organisations. Some conditions facilitate this interaction, such as the existence of a policy for collaboration between municipalities and the voluntary sector. Also, municipalities that already practise intersectoral action to reduce inequalities are better skilled at involving the voluntary sector. The COVID-19 pandemic also showed that local cooperation agreements can facilitate the work of the voluntary sector. Finally, municipalities must have good financial frameworks that channel funds specifically for co-creation and involvement, and their policy towards the voluntary sector must be linked to other municipal policies.

What are the opportunities and the potential pitfalls?

A renegotiation of the relationship between the public sector and the voluntary sector is needed in Norway. Problems should be defined in collaboration, and solutions must be co-created, with a common understanding of what co-creation means. The voluntary sector should be an equal partner and should be allowed to promote social inclusion through what it does best, instead of being pressured into developing new activities. The state and the municipalities should be facilitators and allow for funding mechanisms that provide long-term and stable frameworks. It is important that structures for learning and skill-transfer between different sectors exist.

The voluntary sector's responsibilities and opportunities

The voluntary sector can also take on responsibility for reducing social inequalities in health. It has a significant role in social inclusion, in developing equal communities of social support (bonding) and in bridging gaps towards working life and education. It can strengthen its work in reducing social inequalities in health by maintaining the elevated level of trust it has in Norwegian society, and by building bridges in cultural understanding and based on knowledge. It needs more awareness of how it can reach out more widely.

The voluntary sector has had an important role in building the Norwegian welfare state, and it has an important role in local democracy. To fulfil this role, it needs to improve language and communication skills, use a language that does not alienate those that it wants to include, as well as to base its work on knowledge. There is little understanding in Norwegian society about the structural causes of social inequalities in health and wellbeing, and the voluntary sector must play its part in explaining this and speaking up. It also needs to become better at recognising who are the groups that are not being reached.

What framework does the voluntary sector need to fulfil its role?

The voluntary sector needs a stable economic framework, productive collaborations, structures and trust.

The voluntary sector needs a long-term perspective, as well as flexibility in its funding arrangements. Too many organisations do not have the economic framework to plan long term and to keep well-functioning long-term projects going. There is too much project-financed support, making it challenging to operate in a sustainable manner and too much focus on initiating new projects, rather than supporting successful activities that have already been initiated. In addition to this, there is a shortage of access to premises and meeting places for volunteers, in larger cities in particular.

List of participating organisations

The following were represented at the roundtable:

- The Norwegian Health Association
- WellFare NTNU
- Church City Mission
- Norwegian Cancer Society
- The Association of NGOs in Norway
- Healthy Cities Norway
- Norwegian Women's Public Health Association
- The Norwegian Red Cross
- The Norwegian Blue Cross
- Oslo Sports Federation (Oslo Idrettskrets)

THE ROLE OF THE HEALTH CARE SYSTEM

In considerations of supporting greater health equity, health care organisations and personnel often focus on reducing inequities in access to services and on inequities in treatment. While both are important for health equity, there is much potential for healthcare organisations and personnel to take action to improve conditions related to the social determinants of health. In addition to the benefits to individuals, families and communities that this would bring, it also leads to reduced burdens on the healthcare system and greater efficiency for the sector. In this section we make the case for healthcare system taking action on the social determinants and set out practical steps to do this. Inequities in access to health care services in Norway and how to reduce them are then set out.

MAKING THE CASE FOR HEALTH CARE SYSTEM ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

The primary reason for taking action to improve population health and reduce health inequalities is that it is the right thing to do. Inequalities in health that are remediable by reasonable means are unfair and unjust and harm individuals, families, communities and economic and social development. However, the costs of treating ill health, largely driven by deprivation and exclusion, fall heavily on the healthcare services; if the healthcare system expanded action on the social determinants of

health it would help reduce costs and demand as well as improving health and reducing inequalities.

According to the Country Health Profile 2021, Norway spent 10.5 percent of its GDP on healthcare in 2019, which is in line with other Scandinavian countries and slightly higher than the EU average (661). Healthcare spending per capita in 2019 was the highest in Europe (EUR 4,661 adjusted for differences in purchasing power), and over 30 percent higher than the EU average per capita spending (EUR 3,521). Public spending on health includes that from tax revenues from national and municipal sources and payroll contributions to the national insurance scheme, shared between employees and employers. Public spending, accounting for 85 percent of total health spending – a higher share than in any EU country – has grown more rapidly than GDP over the past decade. Private expenditure, which in Norway consists mainly of out-of-pocket (OOP) spending by households, makes up the remaining 15 percent of health care spending. In 2019, Norway allocated roughly the same amount of spending on inpatient care, outpatient care and long-term care – just under 30 percent of the total for each category. The proportion spent on long-term care was higher than in any EU country (661).

Containing spending on healthcare in Norway is an important motivation for reducing inequalities in health due to the high costs as a result of unnecessary health inequalities on the healthcare system. A range of levers help to contain costs, including the use of budgeting,

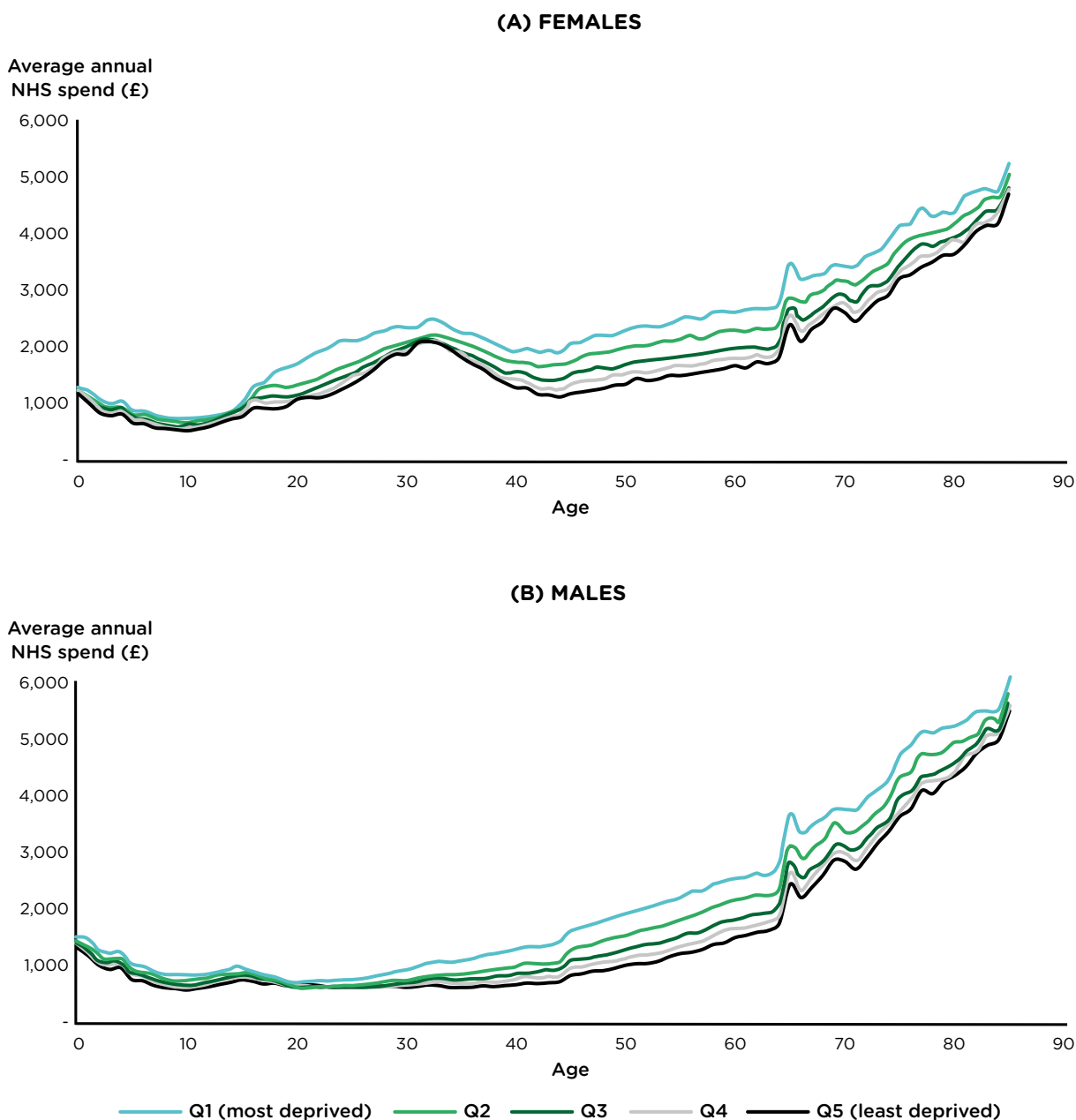
largely salaried healthcare personnel, health technology assessment and price-setting tools but reducing health inequalities and improving health is the most beneficial, effective and socially just way of reducing costs to the healthcare system

The costs of social inequalities to the healthcare system have been calculated in England where researchers at the University of York in 2016 calculated that socioeconomic inequalities cost the NHS acute sector £4.8 billion each year. Asaria also found that in 2019/20 people living in the most deprived 20 percent of neighbourhoods had 72

percent more emergency admissions and 20 percent more planned admissions than those living in the most affluent 20 percent of neighbourhoods in England (662,663).

Figure 5.5 outlines the average additional annual NHS spend in England in each neighbourhood deprivation quintile compared with spend in the least deprived quintile. For both women and men, the NHS spends more in areas of highest deprivation at every age. Whilst this data is from 2011-12, it is indicative of the proportionately increasing costs to the NHS of providing acute care for those in more deprived areas.

Figure 5.5 Average annual NHS spend by age and neighbourhood deprivation quintile group by sex, England, 2011-12



Source: Asaria (2017) (662)

The cost of Accident and Emergency attendances in England in 2019-20 also corresponded closely to level of deprivation (2019-20) with costs rising as levels of deprivation increased (664).

In Norway in both 2015 and 2019, it was found that lower socioeconomic groups use more general practitioner, in-patient hospital services and psychologist services. However, higher socioeconomic groups use more medical specialists, physiotherapy, day treatment in hospitals and dentist services. The social differences in health care utilisation were overall greater among older persons (45-years and up).

Between 2015 and 2019, there was an increase in the use of all healthcare services in Norway (GP, hospitalisation, day treatment in hospital, medical specialists, physiotherapy, and psychologist), except dental services. The use of psychologists has increased most in lower income groups, while for other healthcare services (GP services, hospitalisation, day treatment, medical specialists, and physiotherapy) the increase has been greatest in higher income groups.

HEALTHCARE TAKING ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

THE HEALTHCARE WORKFORCE

There are a number of ways in which the healthcare workforce including clinicians and those who work in the healthcare sector in other roles, can take action on the social determinants. These include as advocates, through establishing partnerships with other sectors and facilitating support for patients' living and working conditions in addition to treating their medical needs.

The healthcare workforce is a powerful advocate for health and is largely trusted by the public and by decision-making organisations. Those working within the healthcare system can advocate for improvements in the social determinants locally and nationally. Locally this can take the form of advocating for good-quality housing, provision of healthy urban and natural environments and forging links with other sectors. Partnerships between the healthcare sector and education, planning, housing, children's services, adult education, the community and voluntary sector and employers will provide a powerful health equity voice within those sectors, all of which shape health and health inequalities. Nationally, the healthcare workforce can be strong advocates for healthy living and working conditions and regulations for products and services. The healthcare sector can hold policy and decision makers to account and contribute to the scrutiny of national Government policies to ensure they support greater health equity.

In relation to working directly with patients, the healthcare workforce has an important and often underdeveloped role in understanding and working to support the living and working conditions of patients. For instance, offering patients with respiratory disease referrals to housing support services and advocating for housing improvements with private and public housing providers. Similarly, support can be offered in relation to improving employment and working conditions, linking more closely with businesses and public sector employers. The primary care workforce can develop strong partnerships with the VCS sector, public services and local authorities and make referrals to other services. In the UK social prescribing is one way to refer patients to support services - see case study on this in Blackpool.

CASE STUDY: SOCIAL PRESCRIBING AND CITIZENS ADVICE IN BLACKPOOL

Citizens Advice Blackpool works closely with GPs and has delivered advice in surgeries since 1997. Prior to the COVID-19 pandemic, weekly advice sessions were taking place in 17 Blackpool general practices. This is being built back currently, with the long-term ambition being to have social welfare advisers in every GP practice in Lancashire.

In addition to its work providing social welfare advisers in general practices, Citizens Advice Blackpool is a provider of social prescribing services. For example, in January 2020, five primary care networks agreed to work in partnership with Citizens Advice Blackpool to deliver a social prescribing model across the Fylde Coast. This led to delivering social prescribing services and also to the creation of a network.

A partnership between the Institute for Voluntary Action Research (IVAR) and the Lancashire and South Cumbria Health and Care Partnership saw that there was a gap between primary care workers and those in the VCFSE sector, who did not often cross paths. A steering group was established, consisting of Lytham St Anne's Primary Care Network, Blackpool, Wyre & Fylde Volunteer Centre and Citizens Advice Blackpool, with the aim of establishing a social prescribing network to share local experiences, listen to voices from the community, and make connections. The social prescribing network enables health providers to connect with social prescribing link workers across the Fylde Coast and to refer individuals to a range of activities provided by the VCFSE sector.

In Norway there have been efforts to provide education and training to the healthcare workforce to ensure the healthcare workforce fully understand the impacts of patients living and working conditions and work to improve them. Social medicine is taught in the basic education for medical training and there are specific learning outcomes with focus on social determinants of health during the mandatory internship in municipalities (665) and for those specialising as GPs (666). In other specialties, learning outcomes include cross-sectoral cooperation and cultural competence (665).

Reforms and guidelines for over a decade have emphasised coordinated holistic care pathways, especially across primary and specialist healthcare. However, on finishing training, and in clinical practice, the use of social medicine skills is largely a personal duty and the ability and capability vary among healthcare workers. In 2021, the Norwegian Medical Association declared a resolution on social inequalities in health, focusing on increased awareness of varying health competence; proportionate efforts needed for health care equity and the removal of financial barriers (667). However, these do not cover work to improve the social determinants of health directly.

A recent textbook on social medicine, welfare and social security points at the clinicians' empathy and ability to build relations as important aspects to reverse health inequities. (668). Barriers to this can be stress and work overload, unconscious bias and prioritisation with higher socioeconomic group patients receiving longer consultations and more lab tests. There is a concern that the use of medical technology may replace dialogue and medical technology tends to increase social health inequalities (669).

The healthcare workforce needs to be equipped with knowledge to understand, detect, and act on social determinants, through education and clinical training and the healthcare system needs to facilitate this. This should include incorporating living and working conditions as risk factors, differentiated treatment and referrals to social and economic support services. In specialist healthcare, living conditions and differentiation should be implemented in patient pathways. In general practice, there should be financial incentives for mapping living conditions and enabling outreach and broad social and economic support services for people with health needs in excluded communities and those experiencing poor living and working conditions.

The 2021, the Norwegian Medical Society resolution stated that medical doctors should use their expertise to raise awareness about health equity and the social determinants of health and promote health literacy among decision makers and stakeholders as well as the general public (667). If this resolution is acted upon and if more health professionals do the same, it could significantly contribute to accelerating the agenda to level up the social gradients on health and wellbeing identified in this report.

HEALTHCARE ORGANISATIONS

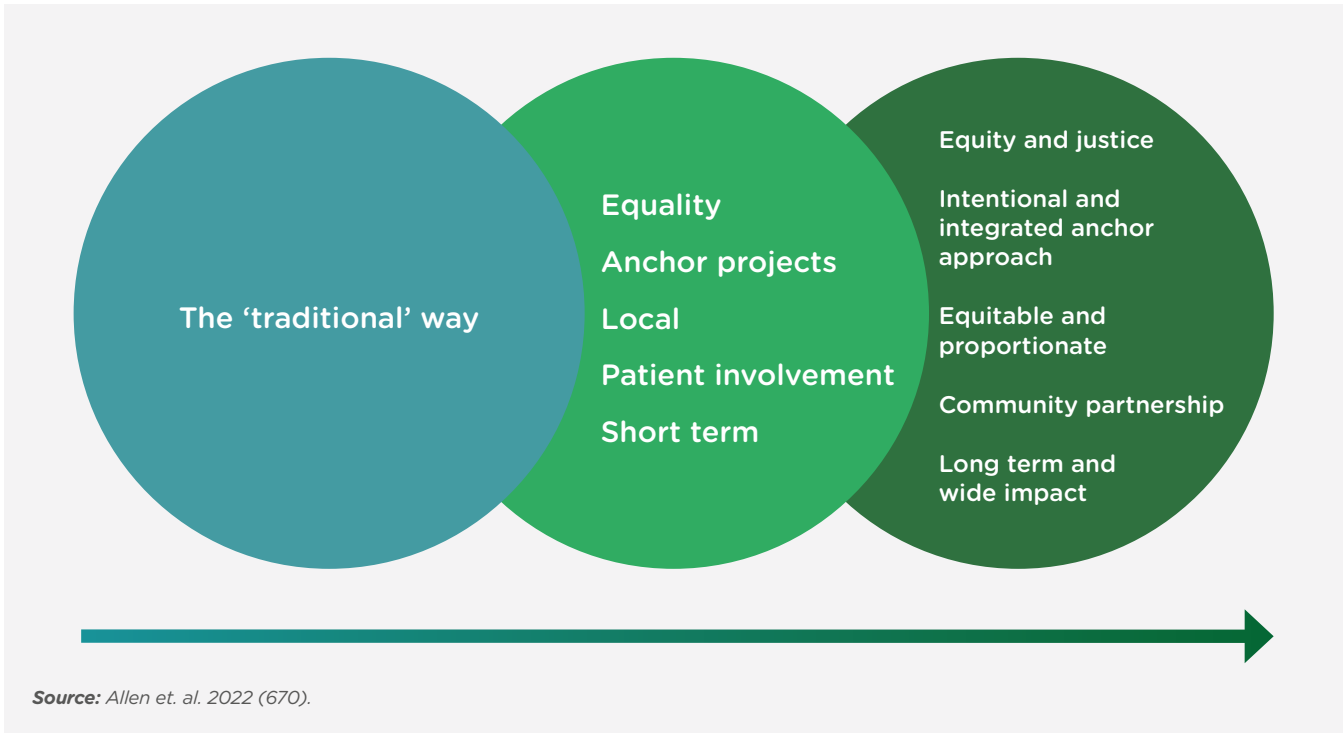
Healthcare organisations can also act to prioritise and strengthen their positive impact on the social determinants of health and the communities they serve. This includes actions affecting their own workforce and through their broad organisational social and economic impacts on local communities.

Healthcare organisations can act on the social determinants of health by developing their role as anchor institutions. Anchor institutions are institutions like hospitals, universities and councils that are physically rooted in communities and can directly and indirectly shape the health and wellbeing of the local population. They leverage their position as employers, purchasers of goods and services, providers of services, owners of local buildings, land and other assets and as leaders in the community to effect change. For example, they can ensure that they are providing good, health-supporting work to the local community, including underrepresented groups and those living in deprived areas, and pay a real living wage that enables a healthy lifestyle. For healthcare organisations in particular, this also represents a form of disease prevention, and an investment in the future of the community that they serve.

Anchor institution work also aligns with similar agendas, including community wealth building, social value, and the role of healthcare organisations in reducing poverty. There is emerging evidence that such approaches help to reduce social, economic and health inequalities and are cost effective. For instance, the affordable housing provided by Bon Secours Hospital in Baltimore, USA, has been shown to produce a significant social return on investment: every dollar spent resulted in estimated benefits of between \$1.30 and \$1.92 across a range of economic, social and environmental impacts. (670).

Figure 5.6 illustrates approaches which can be embedded in moving from a traditional healthcare organisation to an anchor organisation approach and finally developing as an equity-focussed institution and community partner.

Figure 5.6: Five principles for moving anchor institution work towards equity



In relation to the healthcare workforce there are inequalities in employees' health as a result of inequalities in the determinants of health. Healthcare organisations can support their own staff, particularly those in low-paid employment by offering good quality working conditions including sufficient pay, and offering support and referrals to a range of support services – such as advice on financial management, debt advice, support with poor quality and expensive housing and other unhealthy social and economic living and working conditions.

A proportionate universalism approach makes proportionately more available to those lower down the hierarchy: delivering programmes and resources at a scale and intensity proportionate to need; for example, MetroHealth in Cleveland, USA, are taking an anchor approach to their hospital redevelopment, providing a community green space, low to moderate income housing, an economic opportunity centre, education provision, a community kitchen and other community assets. While these will be available to all local people,

they are designed to be proportionate to need, with increasing support for and outreach to those on lower incomes (670).

The East London Foundation Trust, a community and mental health trust, is developing some promising approaches to tackling the social determinants of health (671) described in the case study.

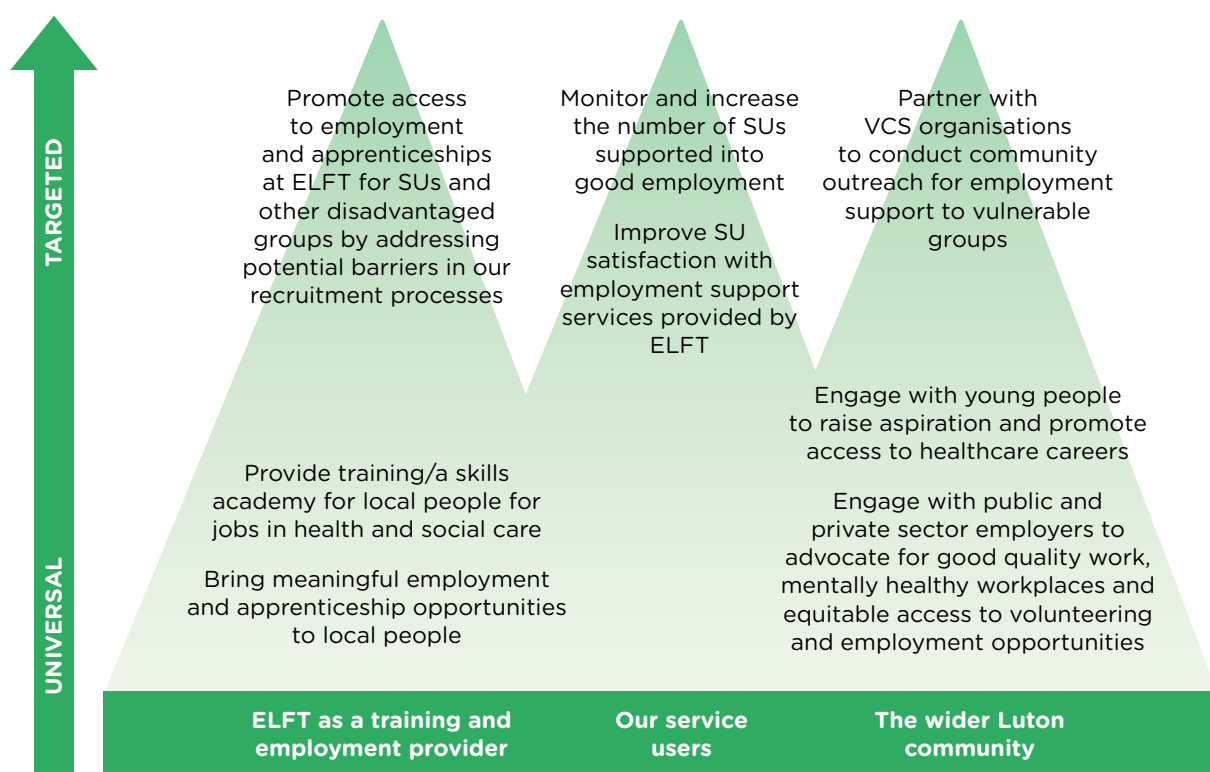
CASE STUDY: ADDRESSING THE SOCIAL DETERMINANTS IN HEALTH IN EAST LONDON FOUNDATION TRUST

The East London Foundation Trust (ELFT) is the first 'Marmot Trust' in England. It is embedding a social determinants of health approach and is developing action that will improve social determinants for its own workforce, its patients and the communities in which it operates. The Trust sees these approaches as preventing ill-health and reducing the demand for its services as well as reflecting its mission to improve health and reduce health inequalities. ELFT serves some of the most deprived boroughs in the country, with high rates of children living in poverty and many overcrowded households as well as small pockets of rural poverty (in Central Bedfordshire). The pandemic highlighted the impact of inequalities and social injustice on ELFT's communities.

Ambition and support came from ELFT senior leadership to extend the health impact of a health organisation to improve the health of communities, not just service users, and not just focused on clinical services. This means thinking more upstream and looking at how to improve the social determinants of health in ELFT's communities

The ELFT is also developing its workforce to take action on the social determinants of health. This includes the development of a population health learning programme to support individuals, teams and the organisation to improve understanding of the impact of social determinants of health and health inequalities in communities, service users and staff; support organisational action to improve population health and identify inequalities in access, experience and outcomes from ELFT's services; and increase the capability and confidence of ELFT's teams and service users to address population health and inequalities.

In the town of Luton, ELFT is working with the local authority, employers, local businesses and the community to strengthen good quality work in the town and develop skills for work for the whole community, their staff and clients. The approach is summarised in the diagram below.



Primary care is particularly well-placed to take action to improve health and reduce health inequalities through action on the social determinants. The Deep End GP approach in England, is an example of a shift from the medical model of health and illness to a more

preventative approach. It has required collaboration with patients to strengthen understanding about the drivers of ill health – see case study. In this model, GPs spend time with patients to discuss alternatives to prescriptions (672).

CASE STUDY: DEEP END GPs

Originally set up in Glasgow in 2009, Deep End GPs is a network of GP practices based in the most deprived areas, aiming to address the social determinants of health through cooperation and the sharing of best practice. Deep End networks have been established across the UK, in Ireland and in Australia, with the goal of tackling health inequalities and championing primary care's role in tackling these inequalities. Populations living in Deep End practice areas have lower life expectancy and spend far more of their lives in poor health than people in more affluent areas.

Deep End practices focus on working collaboratively to create the best outcomes for practices, patients and communities, addressing health inequalities. Deep End practices offer longer than usual consultations, which allows for better opportunity for health screening, health promotion, and assessment of the medical problems of those in more deprived cohorts who might otherwise be missed.

Deep End GPs recognise the additional demands that come with working in practices with high levels of its population living in deprived areas. Deep End GPs aim to support and promote understanding of the health effects of inequalities and to offer positive reasons for GPs to train and work in their practices. They advocate for deprivation to be more meaningfully considered when allocating funding.

Being part of the network gives practitioners a sense of identity and recognition of the additional challenges. Deep End aims to support these practitioners and allow them the time and resources to develop interventions catered to the communities they work in (672).

REDUCING INEQUALITIES IN ACCESS TO HEALTH CARE SERVICES AND MEDICATION

Alongside efforts to strengthen the role of the healthcare system in improving the social determinants of health; there needs to be greater attention to reducing inequities in access to and outcomes from healthcare services. In Norway, both the primary and specialist health care systems are mostly public, and the municipalities provide primary care services and the state provide specialised healthcare. The healthcare system can be recognised as 'universal coverage with controlled access' (673). Hospital inpatient care is free, while consultations in primary and specialist care require out-of-pocket payment. The co-payment is standardised and reimbursed on reaching a fixed threshold (674). Practically all use of specialist care services requires referral from primary care.

Dental treatment is free from 0 to 18 years, 75 percent covered for 19- to 20-year-olds and after age 20, not reimbursed, except for special medical conditions. Since 2001, every citizen has had the right to an assigned regular general practitioner (RGP) in primary care. This right, and access to ordinary primary care, is challenged nationally and more than 175,000 people were without a RGP in August 2022 (675), the number has doubled since August 2020.

Social differences in healthcare use vary with socioeconomic background, type of health service, sex, age, health status, time, and according to different surveys. Between 1984 and 2008, social differences in GP use declined between higher and lower socioeconomic groups (676). In 2015, cancer survival was greater among patients from higher socioeconomic groups (539,677,678) and it has been shown that patients from lower socioeconomic groups receive less intensive cancer treatment, such as surgery (679,680).

Between 2015 and 2019, the proportion of people reporting having unmet health care needs remained fairly stable, going from eight-nine percent. There are variations between different groups, but due to changes in educational and income categories, direct comparison is hindered. In 2019, new categories – impaired mental health and country of birth, were introduced. It is clear, however, that both in 2015 and 2019 the proportions with unmet needs increased with lower income (674,681). Among those reporting unmet needs, people reported long waiting times (26 and 31 percent) and non-affordability (11 and 12 percent), as major barriers in 2015 and 2019.

As in 2015, the group with the lowest reported unmet needs in 2019 were people of pension age – 4 percent, while those with the highest proportions reporting unmet needs were those younger than 45 years, 13 percent; groups with less than good health, 19 percent; people on medical disability benefits, 17 percent; the lowest income group, 14 percent; and unemployed people, 13 percent. Students increasingly reported unmet needs, from 10 percent in 2015 to 13 percent in 2019. People with impaired mental health reported unmet needs more than 4 times as often as people with good health, 29 percent vs 7 percent. Among those who are foreign born, 12 percent reported unmet needs, compared with nine percent of people born in Norway. Unmet dental care needs also differed by age, poor health, medical disability benefits, income and unemployment (674,681).

In 2019 four percent of people reported not collecting prescribed medication because of the cost (681). While the proportion is low there are much higher proportions of people who find the medication unaffordable among low-income groups with longstanding health problems. The proportions of those not collecting their prescribed medication seem to have increased from 2015 to 2019 for those with impaired health, the unemployed and people on disability benefits (681). Out-of-pocket payments must be minimised and more subsidies made available for the lowest income groups and those with longstanding health conditions to enable access to prescribed medication.

While available data points to some inequalities in access to some healthcare services and essential medications, additional data and research on social inequities in healthcare use is needed, including for immigrants.

The role of businesses and privatisation of care services are increasingly important, leading to concerns about rising inequalities in access to services. The current approach to assessing the role of the for-profit sector in health is narrow, and may fail to include the varied activities of the diverse constellation of private companies (682). Additionally, more data is needed on fully private healthcare, which is clearly expanding and currently not covered by health registers. Reforms and alterations need to be implemented in a way that facilitates proper evaluation.

A comparative study of healthcare recommodification in Europe (2010-18) employed indicators to measure a country's degree of healthcare marketisation. The strongest associations were between coverage and satisfaction, with high public healthcare coverage (as in Norway) being associated with higher satisfaction. The findings indicated that people prefer publicly financed and regulated health services, but that it does not matter much to people who offers these services (private or public) (683). Overall, out-of-pocket payments for various medical procedures and devices and products threaten health equity, while free primary and secondary healthcare support health

equity. Performance-based funding (in all healthcare) is an incentive towards maximizing returns, which may harm the treatment of complex patients as they tend to not be cost effective. Patients with lower socioeconomic position tend to have more complex needs and therefore performance-based payments tend to worsen health inequalities.

The COVID-19 pandemic, together with an ongoing GP crisis in Norway, has led to an increased market for private healthcare services. A survey in 2022 shows that more than half (51 percent) of the Norwegian population are positive about buying private health services, representing an increase of 20 percent compared to a similar survey in 2021 (684). A Government-appointed committee (Saglieutvalget) will deliver its report on commercial welfare services in 2024. They will investigate three service models for kindergartens, schools, child welfare, elderly care, specialist care, immigrant and refugee care and labour market measures: 1) public services only, 2) private non-profit actors provide services, or a mix of public and non-profit services, and 3) assess possibilities for the continued involvement of commercial actors based on stricter regulation of their operations (117).

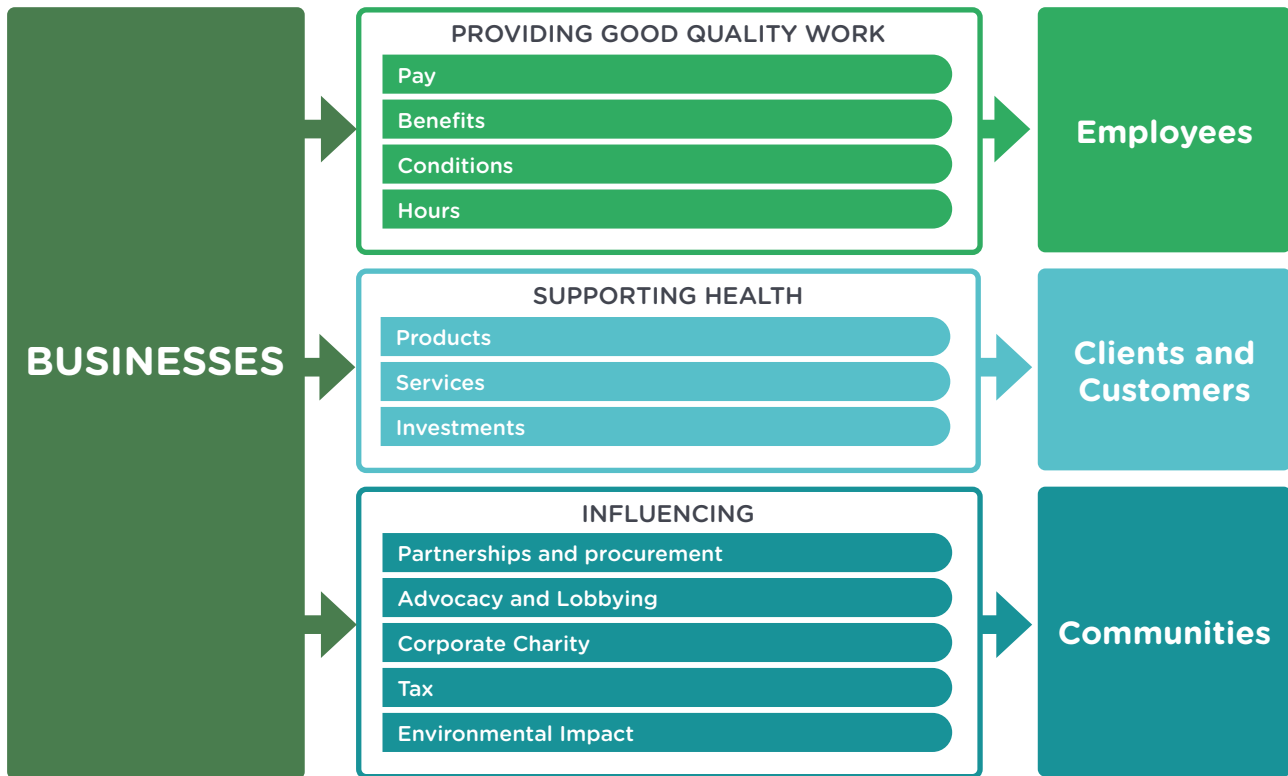
THE ROLE OF BUSINESSES AND THE ECONOMIC SECTOR

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.

The UCL IHE recently published *The Business of Health Equity: The Marmot Review for Industry*, examining the ways in which businesses shape the conditions in which people live and work and, through these, their health (195). While the report was aimed at the UK business landscape, the approach has relevance for Norway.

Businesses affect the health of their employees and suppliers through the pay and benefits they offer, hours worked and job security, and the conditions of work. Businesses affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held. Businesses can also affect the health of 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. The effects on wider society also encompass the environmental impacts of business operations, including both the carbon footprint and air pollution, as well as the taxes paid by businesses to local and national governments, which support policies for health. This framework is shown in Figure 5.7.

Figure 5.7. How businesses shape health: the IHE framework



Source: Marmot et. al. (2022) (195)

The costs of ill-health are well known to businesses, who find that productivity and staff retention are linked to the health of the working age population. The social justice case for reducing health inequalities is clear and is also a motivation for many businesses that want to contribute to achieving better health and reducing inequality. But there is also a strong economic case for businesses to help improve health. The economic costs of poor health are high: it is estimated that poor health costs the UK economy £100 billion per year (685).

The case study on the role of a Norwegian bank as a preventative actor shows how a financial institution has made significant efforts to support its customers in precarious financial positions and helps to support their mental health. The work has increased awareness of the potential of the financial service industry to prevent people from incurring financial problems as a result of crises or mental illness and for preventing mental health problems which often result from debt and financial crises.

CASE STUDY: DEBT, FINANCIAL PROBLEMS, AND MENTAL HEALTH: THE ROLE OF A BANK AS A PREVENTIVE ACTOR

A project between Norwegian Bank2 and the psychological consultancy Reynd AS aims to enhance the bank's expertise in mental health, with the assumption that customers who struggle with mental health are more likely to default on their loans, and that action to prevent this will help customers suffering from high stress related to their financial obligations and reduce the bank's exposure to defaults. The bank is also concerned with not harming customers who are in vulnerable situations.

Bank2 offers loans and restructuring of loans to customers who don't have sufficient equity to obtain a loan from the bank that they use for daily banking. Its customers often struggle with their household finances and are therefore at risk of having or developing mental illnesses. Approximately 11 percent of Bank2's customers default on their loans. Bank2 has had trouble with establishing and maintaining continuous contact with some of its customers.

The programme began in March 2022 and will end its first phase in the spring of 2023. It focuses on training the bank's employees, based on four pillars: mapping the challenges; knowledge and awareness; experienced-based exercises; and guided practice. Halfway through the programme, four work seminars had been conducted with the bank's customer advisors on the following topics:

- mental health problems and their connection with debt and financial problems;
- communication and techniques for communicating with the client;
- avoidance behaviour and how to deal with it.

New templates for written communication have also been produced, as well as a rejection letter for people who have applied for loans but are rejected, containing, among other things, a guide on how to get assistance from the Norwegian Labour and Welfare Administration, information about various support services and a video about the connection between psychological stress and financial problems which hopes to reduce feelings of shame.

KEY LEARNING POINTS AND ACHIEVEMENTS

According to its organisers, the project has been a unique opportunity to further understanding about preventing or dealing with customers' financial and mental health problems. It has also showed the importance of raising awareness and knowledge about finances and mental health in other services. Knowledge about mental health and follow-up of vulnerable customers is almost absent in the financial industry's procedures and strategies.

It is still too soon to reach a conclusion on the effects of this project when it comes to customers' experiences or social benefits. However, feedback from bank employees indicates that there has been a change in both their attitudes and behaviours towards customers who struggle with mental health problems, according to the project's initiators. A goal of this project is that the financial industry's authorisation scheme integrates knowledge about mental health in the training and authorisation of customer advisors.

As set out in Chapter 3, good health requires good quality employment, sufficient pay and reasonable terms and to provide a minimum income for healthy living. Recruitment should benefit local and excluded communities and provide opportunities for progression and on-the-job training, with links to community and voluntary sector organisations, and schools and colleges to support training and skills development.

Businesses have the opportunities to develop as ‘anchor institutions’ similar to approaches in public sector organisations. There are sometimes difficulties making the case to business leaders to act as anchor organisations – partly related to the perceived additional costs of putting pressure on supply chains to improve their terms and conditions and questions around the merits of more regulation. Large business organisations can take the lead in this regard and encourage and support small businesses to take action. Instigating contractual requirements for the supply chain to have good quality working conditions is an important lever to support good health among small businesses. A social value approach supports contracting that builds in social as well as economic value as a criterion for awarding contracts and spending public money (686).

GOODS AND SERVICES: THE COMMERCIAL DETERMINANTS OF HEALTH

Evidence on the social determinants of health has become important to the understanding of noncommunicable diseases, and commercial determinants of health should also be considered in strategies to improve health and reduce risk of ill health (687). In noncommunicable disease prevention, an emphasis is placed on lifestyles and personal responsibility for addressing risk factors. This approach ignores the limited control that many people have over their circumstances and their exposure to the marketing activities of transnational corporations (688). A systematic review on the association between alcohol sports sponsorship and consumption found a positive association between exposure to alcohol marketing and alcohol consumption (689).

The Marketing Act has legal provisions that apply to all advertising activities in Norway. The most important prohibitions are that it is not allowed to advertise weapons, alcohol, tobacco and prescription drugs. Advertising aimed specifically at children is also prohibited (688). In Norway, all alcohol and tobacco (including e-cigarette) marketing is forbidden by law (690,691). Tobacco cannot be openly displayed in shops, and the packaging must be standardised with health, and death-related warnings on labels.

The joint Nordic ‘Keyhole’ has been launched as a labelling scheme that is supposed to make it easy for consumers to make healthy choices. The keyhole symbolises that the nutritional content of the labelled food is in line with the authorities’ recommended nutritional composition of the diet and represents a healthier choice within its food group. At the same time, the labelling scheme is an incentive for food manufacturers to develop products with a good nutritional composition. The labelling of all food is regulated by law in Norway (692).

In January 2021, a new rule on gambling advertising in the Broadcasting Act means that the Norwegian Media Authority can now order Norwegian distributors to intervene and stop the marketing on TV and on-demand services for gambling that does not have a permit in Norway. The new provision is meant to help reduce the number of problem gamblers and the negative consequences of gambling problems (693).

PUBLIC SERVICES

Many of the recommendations made in this report are for public services and the public sector more broadly. Public sector organisations can also develop their positive organisational impact and the anchor institution approach relevant to public services as well as healthcare. Concern for health equity needs to be embedded in the way all public services operate. As with healthcare, a move from crisis management to a prevention-focussed model, acting upstream on the social determinants, has potential to relieve pressure on overburdened services and to reduce inequalities in health and a range of other outcomes. Maximising the opportunity to reduce health inequalities requires all organisations to consider what they can do, in partnership, to improve social conditions, beyond their core operations, including as employers, as contractors of services, and as anchor institutions for their communities.

The ‘Preston Model’ based in Lancashire in the UK has received international recognition for its innovation in using a community wealth approach, which is closely related to social value approaches – see case study. This approach, which was initiated by the City Council can be adopted by local businesses to ensure that local economies in more deprived areas are well-supported.

CASE STUDY: THE PRESTON MODEL

Community wealth-building in Preston, Lancashire, often referred to as ‘the Preston Model’, began in 2011 when Preston City Council began discussions with the Centre for Local Economic Strategies (CLES) about how to tackle inequality in economic development. As a first step, Preston City Council committed to paying all its staff the living wage, becoming the first accredited Living Wage Employer in the North of England, in 2012.

In 2013 the Council engaged CLES to research the proportion of anchor institution procurement that was local to Preston and Lancashire. CLES found there was a collective procurement spend of £750 million by Preston’s anchor institutions and that in 2012-13 only five percent was spent in Preston and 39 percent in the local authority of Lancashire, meaning £450 million was leaving the Lancashire economy. This research was repeated 4 years later to assess the results of community wealth-building, where local economies are reorganised so that wealth is not extracted from an area but recirculated. The results were promising, with locally retained spending increasing from five percent to 18.2 percent in Preston and from 39 percent to 79.2 percent across Lancashire. Further, in 2018 there were 4,000 more employees earning the real living wage than at the beginning of the project.

Community wealth-building has been advanced by Preston through a promotion of five strategies:

- Plural ownership of the economy: a blend of ownership models in an area, small enterprises, community organisation, cooperatives and municipal ownership.
- Making financial power work for local places: increasing local investment as opposed to focusing on attracting national or international investment.
- Fair employment: anchor institutions as larger employers recruiting from lower income areas, committing to paying the living wage, and promoting progression routes for workers.
- Progressive procurement: developing dense local supply chains, SMEs, employee-owned businesses, social enterprises and cooperatives – the types of business that are more likely to support local employment.
- Socially productive use of land and property anchor institutions often hold large amounts of land and property, which represent a base from which local wealth can be accrued.

While the Council leads the way in implementing the community wealth-building approach and the 5 strategies, it is through promoting the concept to other anchor institutions, which often have far greater spending power and assets, that success is to be found.

The National Institute of Health Research has invested £600,000 in investigating the Preston Model and whether it could be used as a national template for ‘building back better’ in the aftermath of COVID-19 (694).

Throughout this report the importance of partnerships between sectors has been emphasised. Nationally and locally these partnerships are vital to reducing health inequalities through action on the social determinants of health. Publicly funded services are essential partners in a health equity system alongside healthcare, businesses and the voluntary sector and local government. The importance of education has been discussed in detail in Section 3B. The education system has a role to play in improving health equity by mitigating the effects of deprivation and supporting families, linking with organisations and sectors that can improve living and working conditions. Educational institutions can further their partnerships with the VCS sector and employers in helping children and young people to achieve their potential, enhance mental wellbeing and gain good, health-supporting work.

Other services which seem quite removed from action on health inequality must also be centrally involved. For

instance, IHE has worked with the West Midlands Fire Service on embedding a social determinants approach into their work (695,696). The service recognised that the social determinants of health are also often the social determinants of fire risk – overcrowded, poor-quality housing, poverty and deprivation. The individuals and families they were visiting often had complex needs and risks in many domains. The service realised they could use the contacts they were making to signpost them to appropriate help and support, for example accessing benefits, advice services and addressing housing needs. The Criminal Justice system is also a vital partner – the social determinants of crime and health are similar – poverty, exclusion, adverse childhood experiences and low educational level. The case study on “Working in partnership to improve wellbeing and health” illustrates a partnership between the police, the local municipality and housing which works to improve health and wellbeing in Blackpool a deprived area in England.

WORKING IN PARTNERSHIP TO IMPROVE WELLBEING AND HEALTH

Jobs Friends and Houses (JFH) is a community-interest company set up in 2014 and is jointly 'owned' by Blackpool Council and Lancashire Police. Since 2017, JFH has been managed by Blackpool Coastal Housing.

JFH's key objective is to help people to heal from substance-misuse and to begin thinking about their future. The company works with individuals often referred to as 'revolving door' clients, who repeatedly access treatment without ever being able to take control of their own recovery. JFH works on the model of long-term support, as evidence shows average recovery time from alcohol addiction is four to five years and from opiates is five to seven years.

A year-long evaluation in 2018 showed reductions in offending and substance misuse and improvements in wellbeing among service users. These outcomes were strongly associated with the length of time spent in the programme. The 48 clients involved in the evaluation had, prior to joining JFH, a total of 1,142 recorded offences over 13 years between them. After joining JFH a total of five offences had been recorded, representing a 94.1 percent reduction in the annual recorded offence rate.

JFH helps people to build a future through support to recovery from addiction to routes into employment, and to finding housing. JFH recognises that meaningful activity is good for an individual's wellbeing and when clients join the service their existing skills are identified, and the team then seeks to raise aspirations of each client. They help clients find work and offer support to both employees and employers.

JFH connects clients who have been socially isolated or had destructive relationships with a positive community that cares about others. The JFH community is an important aspect of the programme, which is made up of those in recovery and the wider community. This includes a network of mentors who have lived experience of addiction but are further along their recovery journey and a psychologist who provides therapeutic support.

JFH's recovery houses have a crucial role in helping individuals heal and rebuild their lives, offering security and stability. When clients are ready to move on, they are supported to find secure and safe accommodation and begin independent living with the support of the recovery community.

JFH's commitment to partnerships is key to the organisation's success. It has a strong business and community representation so that it is viewed as a key part of the Blackpool community. This also means that JFH clients have increased access to a range of community resources (697).

LOCAL GOVERNMENT

Strengthening approaches to health equity, as envisaged in this report, will require a united and collaborative approach within the municipalities and a commitment to take forward a health equity in all policies approach. This approach means that health equity must be a central consideration in the design and delivery of policies and interventions, requiring health equity impact assessments and collaborations with all relevant sectors across the local authority. It is vital that the local authority takes this cross-sectoral approach and that the relationship between national and local government is supportive.

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 (584). The national Government legislates and issues guidance to municipalities concerning delivery and overall standards in these areas and provides a proportion of the funding in the form of grants. Municipalities also generate funding for local services via local taxation. Municipalities are free to prioritise spending

in their areas of responsibilities within the constraints of the total funding available to them.

MUNICIPAL RESPONSIBILITIES

The Norwegian planning system consists of core planning activities devised by the Planning and Building Act (2008), the Local Government Act (2018), and the Public Health Act (2011). Elected politicians are the final decision makers, linked to processing of strategic planning, the financial plan, the annual budget, annual accounts, and annual reports. One of the issues highlighted in the evidence reviewed for this report has been the relationship between national and local municipalities.

The 2012 Public Health Act in Norway ensured that Norwegian municipalities had a central role in levelling up the social gradient in health. However, Norwegian municipalities are mostly responsible for providing services and measures connecting to downstream measures, with few regulatory mechanisms to deal with key social determinants such as taxation or

labour market policies. The PHA establishes that local municipalities are responsible for monitoring and addressing social determinants of health within their territory, however there is little leverage for the central Government to ensure changes are implemented. This system puts local authorities at the centre for socioeconomic policies and actions but without some of the main levers to improve them, while also limiting the role of central Government (698).

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: willingness and action on the social determinants of health remains largely dependent on the political willingness of local leaders, which has the potential to create significant inequalities between different administrations (698).

Approximately 40 percent of local governments' budgets come from local resident taxes, which constitute an important financial asset for investments in public transport, urban development, education, and healthcare, all vital for action on the social determinants of health. The central Government's General Purpose Scheme represents the framework of funds redistribution (through income taxes) and makes up the other 70 percent of municipalities spending power. It helps to ensure a generally equal provision of universal services to the whole national population, but leaves decision of allocation of funds and spending up to the local authorities (699,700).

A substantial part of local budgets comes from local taxes that are proportionate to the wealth of the population: richer municipalities will have access to a larger spending pool potentially widening social, economic and health inequalities. Differing leadership on the social determinants and different spending pools risks weakening the coherence between municipalities and the national aim of curbing social and economic inequalities. There is little available leverage from central Government to act if municipalities are failing to provide the services provided or tackling inequalities as expected (206). Action is dependent on the willingness of local authorities as well as on the funds which are available to them (701). Municipalities can often lack the competence and capacity to address the complex problem of the social determinants of health (701,702). The provision of universal wellbeing as a public good must be reliant on a central authority which clearly administers this good and has a political responsibility toward the fulfilment of set targets.

The current system blurs the direct link of accountability of municipalities for the implementation of national strategies to tackle the social determinants of health, as

well as the responsibility which the central Government has toward the provision and implementation of these programmes at national level (703). This general accountability seems to be missing toward citizens, who do not have a single authority to hold responsible for the lack of implementation.

National institutions must continue to play a key role in developing healthy, equitable, local communities. The responsibilities cannot be subdelegated completely to the role of local governments, as many of the policy instruments (such as national welfare provision programs, educational reforms, and housing guarantees) necessary to concretely impact inequalities remain largely out of the hands of local governments. Moreover, it puts progress in inequalities and in the social determinants of health at the will of prioritisation of local authorities, with the potential to creating even greater geographical divergences: municipalities alone cannot be expected to address the complicated causes of social inequalities (651,698).

STRENGTHENING MUNICIPAL CAPACITY IN PUBLIC HEALTH

Intersecting national policies to local action is a complex challenge, where ongoing knowledge and development work is particularly important to reduce social inequalities in health. Gotaas (2022) explored the promoting and inhibiting factors are important for the systematic public health work towards children and young people including; (1) institutional capacity and organisation of systematic public health work, (2) strategic profile in the form of plan types and planning processes, and (3) knowledge production and project and initiative development. In addition, Gotaas investigated the districts' experiences with regard to the impact of the pandemic on children and young people's situation and the systematic public health work aimed at this group (42).

The results show that public health work is a complex phenomenon that concerns all sectors and areas of society. Several findings in the study illustrate this. Both managers and employees refer to the general and all-encompassing nature of public health work, which concerns almost everyone in the district's service areas. At the same time, there are differences in the extent to which service organisations have knowledge of the district's public health work. Another result of the complexity of systematic public health work is that it is difficult to define and determine concretely which job falls under public health work. The districts are organised differently, and this also applies to their organisational location and arrangement. A key finding was that the extent and orientation of measures towards children and young people largely ties into the district's general institutional capacity including job roles, but also funds for initiative development, knowledge production and project work. Secondly, it

concerns organisational resources to develop roles and leadership in public health work and in the planning work in general. Previous surveys in the municipalities show that having a public health coordinator is associated with greater attention to the public health perspective throughout the organisation (704).

There are strong signs that, since the PHA, municipalities have acted upon the causes of inequalities and of the social determinants of health, in part also because of the reporting system which this and the Planning Act created. Local authorities can help mediate policies, steer how innovation can bring benefits to social welfare, and holistically implement

plans by galvanising the local population (705). The development of strong institutional pacts aimed at curbing social and wellbeing inequalities is reliant on a clear communication pathway, which also states an equal distribution of responsibilities of different levels of public administration.

The case study from Frøya illustrates how the national Government and the county can support local governments to progress innovation and measures to tackle health and wellbeing inequalities locally through national capacity-building programmes, and how the municipality has worked in partnership with academia to inform and evaluate actions.

CASE STUDY: ØYA - IT TAKES AN ENTIRE ISLAND TO RAISE A CHILD

Frøya is an atypical district municipality in Norway with large economic growth and migration related to fisheries and aquaculture. High economic growth and inward migration, particularly from other countries, provide opportunities but also challenges for the community. The overview of population's health shows that Frøya is faced with increasing problems related to increasing social inequities, loneliness, exclusion, substance abuse and mental health.

These problems sparked the local governments application to participate in the national programme financing scheme Programme for local public health work, jumpstarting the ØYA public health initiative. This initiative was scaled up when Frøya applied to participate in the national funding scheme 0-24 pilot for program financing, leading to a more system-oriented development.

ØYA aims to reduce social exclusion. By empowering the community of adults as a key approach to nurturing resilience among children, ØYA anticipates achieving more sustainable welfare systems by collectively supporting children and young people. Strengthening adults' accountability and relational responsibility for the community of children while highlighting participatory approaches to building communities of mutual support are important elements in the initiatives. An asset-based approach to community development by building on the strengths and resources of citizens and public servants is at the heart of the initiative.

ØYA consists of several sub-initiatives, which together provide a system-wide perspective to the identified public health challenges. It is assumed that complex problems require long-term investment and that the people of Frøya build and shape the quality of their communities.

PREVENTING SOCIAL EXCLUSION THROUGH ATTITUDES AND SYSTEMS

Through the Øya initiative, Frøya municipality is implementing measures that are aimed at both universal health promotion and prevention, but also measures aimed particularly at vulnerable children and young people through the 0-24 collaboration. Improving interdisciplinary and preventive efforts, as well as inclusion and facilitation to counteract exclusion. In the process with employees at the executive level and managers in the municipality, efforts are being made to develop the service system in such a way that it will be easy for those who need it to get comprehensive and seamless help. The project leaders of ØYA believe this requires a radical innovation in the system as well as a change in culture and mindset, placing the needs of citizens and users at the forefront of service provision.

SUICIDE PREVENTION TEAM

ØYA has an extensive focus on mental health and suicide prevention and works for greater transparency related to mental health and suicide, as well as preventive efforts to reduce the number of suicides. Through an extensive participation process involving young adults, young people, business, politicians, councils, committees and municipal employees, the ØYA Fund was established. With funds from the ØYA fund, the municipality has established a preventive team. Prevention teams are working to find methods,

arenas and measures that meet young people's and young adults' needs for more accessible, flexible and visible services, as well as a greater focus on mental health promotion. The team collaborates with the researchers to document results and communicate transferable learning from the initiatives, both locally and to society more broadly.

SUCCESS FACTORS

The ØYA initiative has been made possible through:

- Incentives in the form of multi-year national investments (programme financing) to empower local public health work.
- Having the opportunity for free funds from the same initiatives
- Support and commitment from local politicians and administrative management in the municipality

The ØYA project is developed in partnership with academic institutions and researchers and is being evaluated as a part of the national programmes 0-24 and the public health programme.

ASSESSING AND PRORITISING HEALTH INEQUALITIES AT MUNICIPAL LEVEL

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. While the majority of Norwegian municipalities have developed these overviews (approximately 90 per cent), a large proportion of municipalities still do not identify health inequities as a main challenge for them, and their prioritised measures are only, to some extent, directed towards tackling the social determinants of health and wellbeing. In an article from 2016, Hagen et al reported that only 40 percent of municipalities defined living conditions as a main challenge in their local public health promotion, while 48 percent cited it as a main health promotion priority (704).

A recent survey by the Norwegian Directorate of Health and the Norwegian Institute of Public Health from 2021 (response rate 85.4% of Norwegian municipalities)

showed that Norwegian municipalities consider mental health and wellbeing (61.8 percent), an aging population (42.8 percent) and social inequality in health (35.9 percent) to be the major public health challenges they face (706). At the same time, these are also the three areas where the municipalities have implemented the largest proportion of public health measures. Some 28.6 percent of the municipalities report that they have prioritised measures to address health inequities as a key challenge.

However, as demonstrated by this report, inequalities in health and wellbeing in Norway are increasing. Although 35.9 percent of Norwegian municipalities considered health inequalities as a key public health challenge in 2021, based on the evidence reviewed for this report, social inequalities in health and wellbeing must be a key challenge for all municipalities.

RECOMMENDATIONS

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.

CHAPTER 6

RECOMMENDATIONS

THE SOCIAL DETERMINANTS OF HEALTH IN NORWAY

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 problems 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

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ANNEX

RAPID REVIEW OF INEQUALITIES IN HEALTH AND WELLBEING IN NORWAY

SYSTEMATIC SEARCH OF DATABASES

A systematic search process was conducted, based on mapping review techniques, for studies in English, using the following databases: Scopus (Elsevier), Web of science (ISI), Embase (Ovid) and Medline (Ovid). The initial search process was conducted on 13 July 2022, and resulted in a total of 27,877 items after cleaning and removal of duplicates. In addition, a snowballing method was used - reading reference lists in publications, and reached out to experts across disciplines for consultation and advice.

A further search was conducted on 25 August 2022 using words in Norwegian. This resulted in a total of 787 items after cleaning and removal of duplicates. For this search Oria, the library system used by Norwegian university libraries was used.

The research team from WellFare-NTNU and IHE UCL screened titles, abstracts, and full-texts in Rayyaan and in Zotero to include and exclude reports from the searches.

NORWEGIAN GREY LITERATURE

To find relevant policy documents and other “grey” literature for the Norwegian case, one of the NTNU research librarians browsed the Official Norwegian Reports (Norsk Offentlig Utredning, NOU). NOU reports are written by a committee appointed by the government to investigate an area of interest and present possible policy choices. The committee is composed of politically independent experts, and representatives from civil society. These are deposited at (<https://www.regjeringen.no/no/dokument/nou-ar/id1767/>) where they are tagged with relevant keywords (e.g., worklife, human rights, etc.). While these keywords are not standardised, the number of NOU documents in the time period of interest is not large. Every year about 10-20 documents were in the years following 2000. Using keywords, 32 NOU documents were identified.

WELLBEING ECONOMY

A search for policy documents relating to the wellbeing economy in Finland and Iceland was also undertaken. This was based on a search, using the term Wellbeing economy, of the official (government) websites for Iceland and Finland, Web of Science and Oria. Then the references in journal articles identified in these searches were used to identify further relevant documents.

This was not a systematic search but provided a starting point for further work.

SEARCH STRATEGY OVERVIEW

English language search terms

TS=((Norway OR Norwegian OR Nordic OR Scandinavia* OR Denmark OR Danish OR Sweden OR Swedish OR Iceland* OR Finland*) AND (“educational inequalities in life expectancy” OR “Inequalities in Mortality” OR “educational disparities in alcohol-related mortality” OR “equity in health” OR “income and social protection for inequalities in health” OR “socioeconomic position and health” OR “health inequality*” OR “social assistance recipients” OR “social capital” OR “social inequalities in health” OR “living condition” OR disparity OR SES OR status OR power OR demography OR socioeconomic* OR “social background” OR gradient OR income OR “Living standard” OR Educa* OR work OR employment OR poverty OR sociodemographic OR gender OR sexual OR Minorit* OR Ethnicity OR migrant OR LGBT* OR Underprivileged OR Depriv* OR class OR disadvantaged OR fairness OR “Participatory parity” OR justice OR equity OR equality OR inequit* OR marginalized OR inequality OR inequal OR “Social isolation” OR Vulnerable OR “Spatial inequality” OR Geographic OR “Rural isolation” OR “Left behind” OR Migrant OR Refugee OR “asylum seeker” OR “Sami people” OR Indigenous) NEAR/15 (health OR wellbeing OR mattering OR dignity OR disease OR illness OR “Health status” OR “quality of life” OR wellness OR satisfaction OR “public health” OR “Population health” OR Happiness OR “health literacy” OR “life expectancy” OR longevity OR lifespan OR intergenerational OR “Self-perceived” OR subjective OR literacy OR Participation OR Empowerment OR “Social sustainability” OR “Human rights” OR mortality OR death OR disability) AND (influence OR “public health” OR indicator* OR welfare OR service OR “Public sector” OR “Health sector” OR NGO OR “non-governmental” OR “non-profit” OR “Third sector” OR “Private sector” OR “Civil society” OR Community OR Neighbourhood OR “Local government” OR Institution OR Media OR “Capacity building” OR recommendation OR “Health promotion” OR Prevention OR access OR strategy OR approach OR Skill* OR competence OR partnership OR “Co-production” OR “Co-creation” OR Politics OR Polic* OR “Legal act” OR regulation OR determinant* OR “Cross-sectorial” OR multisectoral OR “Whole-of-government” OR “Whole-of-society” OR economy OR redistribution OR “Proportionate universalism” OR “Rights-based” OR “Social rights” OR “Healthy settings”)

Norwegian language search terms

((«sosial ulikhet» OR gradient OR levekår) AND (velferd OR folkehelse OR helse OR livskvalitet))

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