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The ambition of Health in All Policies in Norway: The role of political leadership and bureaucratic change

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ABSTRACT

This paper presents and discusses *status, challenges* and *future developments* of Health in All Policies (HiAP) in Norway. Within the frames of the identified challenge of creating coordinated and durable policies and practices in local government, it discusses The Norwegian HiAP policy. More specifically, the paper identifies status and challenges for instituting firmer political and administrative attention to population health and health equity across administrative sectors and levels, and discusses how national authorities may stimulate more coordinated and durable HiAP policies and practices in the future.

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1. Introduction

Health in All Policies (HiAP) is at the core of current understanding of population health and health promotion globally. The approach highlights the importance public policy and practice at all political levels and social sectors play for health:

> Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being [6].

As reflected in the approach to HiAP policy, we are dealing with an all-encompassing concept meant to move the responsibility for population health and health equity from the health sector to government per se—across sectors and scales. The policies developed is founded on health related rights and obligations. Norway is one of the countries that have most clearly embraced HiAP [1]. Here, the HiAP approach is one of five basic principles in the recently adopted Public Health Act (PHA). More specifically, aims and action of population health and health equity is coupled to regional and local government's total breadth of tasks, as well as local plan and decision-making systems [2]. As a forerunner, the specific translation and functioning of Norwegian HiAP policy and practice is of interest to other countries.

From political science literature, we know that aims to enhance intersectoral integration face two basic problems, that of *coordination* and *durability* [3]. That is, respectively, the difficulties of getting relevant organizations to incorporate new goals; and if coordination problems are solved, to make such efforts sustainable over time. Greer and Lillvis [3] argue that political science literature has

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identified techniques capable of solving these obstacles for intersectoral integration. This article highlights two of the most important measures: *Political leadership* and *bureaucratic change*. Political leadership involves "direct action by top policymakers to change agendas, create or redirect networks, and directly make intersectoral policy" ([3]:14). To this end, it is a clearly articulated prioritization of HiAP policies by political leaders aiming to enhance intersectoral integration. Bureaucratic leadership is about developing systemic measures–in reflection of political signals as new routines and procedures ([3]:15). Thus, bureaucratic change can create a durable imprint in an organization by instituting measures directed to enhance intersectoral integration. Understandably, both political leadership and bureaucratic change operates within an institutional framework – regulative, informative and financial instruments – that may hamper or promote coordination and durability at the local level.

This paper will address current HiAP policy and practice in Norway by asking to what extent are political leadership and bureaucratic change employed to strengthen HiAP and what are basic premises to succeed with these measures? As such, this paper identifies status, challenges and future developments of HiAP in Norway within the frames of the identified challenge of creating coordinated and durable policies and practices.

The paper rests on a mixture of quantitative and qualitative empirical data (see Appendix A). In addition, research and evaluations performed by others is consulted, most notably a recent revision by the Office of the Auditor General of Norway [4] and an inspection done by the Norwegian Board of Health Supervision [5]. Together with our empirical data these works provide a solid insight into the status and challenges of Norwegian HiAP work.

2. Background: The idea of Health in All Policies

HiAP rests on the shoulders of ideas and policy goals of numerous statements and charters from global health promotion conferences as well as other United Nations declarations and outcome documents [6,7]. Since the 1980s, international policy development on health promotion has had a focus on developing a healthy public policy where mutual effort to promote and take responsibility for health is highlighted [8]. On the 8th global conference on health promotion, held in Finland in 2013, the HiAP concept was clearly stated as '*a major social goal of governments, and the cornerstone of sustainable development*' [6]. The goal is to better health, health equity and well-being by stimulating positive determinants of health and hamper the negative ones [7]. Such determinants consist of social, physical and economic environments people live and operate in. The effects of these determinants are distributed differently and this imbalance is perceived to be avoidable, unfair and unjust [9]. To reduce health inequities is therefore a global goal, as well as an aim for Norwegian population health policy [8,10–12]. Moreover, HiAP is founded on health-related rights and obligations.

The understanding that health problems and inequities are created outside the health sector makes cross sectoral policies and intersectoral action crucial [13]. This requires maintenance of structures sustaining intersectoral collaboration and mechanisms ensuring a health and equity lens in decision-making processes across the whole of government [14]. However, although there is a strong focus on existing systems and procedures within the approach, to institutionalize HiAP may also involve to develop new structures or processes of government [14] as well as to involve non-governmental actors [13].

HiAP is an ambitious strategy. However, it is underlined that prioritization is needed between various policy goals and measures—to create the best possible strategy within the context of political tensions, will and scarce resources [7]. Moreover, to make the proposed strategy digestable across sectors, the strategy focuses on identifying win–win solutions and synergies between health goals and the aims of various sectors [13]. Integration of health concerns, both in a horizontal and vertical manner, relates to division of roles and responsibilities between public and/or private actors in different sectors and at different levels and scales.

3. HiAP in Norway: Status and challenges

Local government is the primary implementer of population health policies in Norway, as determined in the national HiAP policy [15,16]. As key welfare providers to the citizens, as well as the main planning authorities and responsible for environmental protection and development, the municipalities possess authorities and instruments of great relevance to health promotion. Since 2000, Norwegian population health policy has been revitalized and gradually institutionalized, a fact seen not least through the adoption of the Public Health Act in 2011. The Act states that the basis for good health lay primarily outside the health sector. As such, population health is a responsibility for local government in general, not only for the health sector narrowly defined, as was previously the case [15]. One of the most important tools to secure intersectoral integration of population health in the Act is the so-called "health overview work". Through mapping and data collection, the municipality shall establish an overview over the main population health challenges and resources, and an understanding of the identified condition. The overview shall rest on a mixture of different data sources: (1) information from national and regional authorities. All Norwegian municipalities receives a population health profile annually that includes their score on population health indicators. In the database, there is possible to compare their own scores with other municipalities and the national average. (2) Information from the local health and care services. (3) Knowledge on factors and development patterns in the local environment and society with relevance to population health [17]. The analysis and conclusions made on basis of these data are compiled in a health overview document. This document shall then again lay premises for planning aims and priorities, development of local measures and finally, be evaluated. The chief administrative officer is responsible for the conduction of health overview work, while the actual prioritization of which challenges to follow up in plans and measures is up to local politicians to decide. However, there is reason to believe that who performs the day-to-day overview

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