

**SENATE**



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**POPULATION HEALTH POLICY:  
INTERNATIONAL PERSPECTIVES**

**First Report of the  
Subcommittee on Population Health of the Standing Senate  
Committee on Social Affairs, Science and Technology**

Chair  
The Honourable Wilbert J. Keon

Deputy Chair  
The Honourable Lucie Pépin

**February 2008**

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## ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Tuesday, November 20, 2007:

The Honourable Senator Keon moved, seconded by the Honourable Senator Watt:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population — known collectively as the social determinants of health — including the effects of these determinants on the disparities and inequities in health outcomes that continue to be experienced by identifiable groups or categories of people within the Canadian population;

That the Committee examine government policies, programs and practices that regulate or influence the impact of the social determinants of health on health outcomes across the different segments of the Canadian population, and that the Committee investigate ways in which governments could better coordinate their activities in order to improve these health outcomes, whether these activities involve the different levels of government or various departments and agencies within a single level of government;

That the Committee be authorized to study international examples of population health initiatives undertaken either by individual countries, or by multilateral international bodies such as (but not limited to) the World Health Organization;

That the papers and evidence received and taken and work accomplished by the Committee on this subject since the beginning of the First Session of the Thirty-Ninth Parliament be referred to the Committee; and

That the Committee submit its final report no later than June 30, 2009, and that the Committee retain all powers necessary to publicize its findings until 180 days after the tabling of the final report.

After debate,

The question being put on the motion, it was adopted.

## **MEMBERSHIP**

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The following Senators have participated in the study on the inquiry on the issue of *Population Health Policy: International Perspectives* of the Subcommittee on Population Health:

The Honourable, Wilbert Joseph Keon, Chair of the Committee  
The Honourable Lucie Pépin, Deputy Chair of the Committee

### **The Honourable Senators:**

Bert Brown  
Catherine S. Callbeck  
Ethel M. Cochrane  
Joan Cook  
Joyce Fairbairn, P.C.

### *Ex-officio members of the Committee:*

The Honourable Senators: Céline Hervieux-Payette, P.C. or (Claudette Tardif) and Marjory LeBreton, P.C. or (Gérald J. Comeau)

### *Other Senators who have participated from time to time on this study:*

The Honourable Senator Jim Munson  
The Honourable Senator Art Eggleton, P.C.

## **EXECUTIVE SUMMARY**

### **INTRODUCTION**

The report presents an analysis of government policies to address population health and reduce health disparities in 6 countries –Australia, England, Finland, New Zealand, Norway and Sweden.

### **AUSTRALIA**

The Commonwealth government in Australia has not yet established a national population health policy. In contrast, four State governments (New South Wales, Victoria, South Australia, and Tasmania) have taken concrete action to improve population health and reduce health disparities.

The Commonwealth government does fund a number of initiatives and programs, however, that aim to improve either the health status of the overall population or that of specific population groups (including, in particular, Aboriginals).

Australia believes there is insufficient evidence of the effectiveness of interventions to improve overall population health and reduce disparities in health; its government is correspondingly cautious. It does not propose inaction, but has a careful program to evaluate experimental interventions.

A defining feature of the Australian federal system is the dynamic tension inherent in intergovernmental relations and the degree of cooperation required between levels of government. Intergovernmental relations involve ongoing negotiations over funding and governments' respective responsibilities. This may have hampered the development and coordination of a truly national population health policy.

### **ENGLAND**

England has a long history of pioneering a national approach to population health. It is the first, if not the only, country with a whole-of-government policy to reducing health disparities and improving overall population health.

A new policy was initiated in response to a 2002 Treasury-led Cross Cutting Review which examined all government programs to identify how public spending could be applied to greatest effect on the reduction of health disparities.

The policy is coordinated by a Cabinet Subcommittee chaired by the Deputy Prime Minister. The Secretary of State for Health and the Minister of Public Health champion the policy within government. The Health Inequalities Unit, based in the Department of Health, fosters and coordinates efforts within central government and works with local authorities and non-governmental organizations. Progress is monitored across government by the Treasury.

Local Areas Agreements have been established: these are three year agreements that provide a framework for the relationship between central and local governments. They set out specific national goals to be accomplished at the local level over the duration of each agreement.

## **FINLAND**

Finland has had an explicit policy aimed at improving population health and reducing health disparities since 1987. There is a sound information base, coupled with a specific government investment into population health research and a legislative requirement to report to Parliament on population health.

Concerned about increasing levels of health inequalities in Finland, the national government is preparing a national action plan to reduce them. It will be interesting to review this action plan which was initially set to be released toward the end of 2007.

Over the last 20 years, population health policy in Finland has emanated from the department of health, despite the recognition that many determinants of health lie under the purview of other government departments. Although the relevant departments are sometimes recognized within policy documents, it is unclear how they collaborate together in Finland to achieve common health goals.

A major challenge to implementation of the population health policy relates to the highly devolved system of government in Finland. While the national government provides national leadership, most programs and services are implemented and delivered by municipalities. Policies developed at the national level cannot be directive but, rather, indicative, guiding and supportive. It is also unclear whether the Finnish municipalities are equipped to respond to the challenges posed by a broad population health approach.

## **NEW ZEALAND**

The New Zealand Health Strategy adopted in 2000 explicitly addresses health disparities and the health of the entire population, but its implementation is limited in its scope to actions taken by the health sector.

Special attention is being paid to Maori populations, with particular strategies and action plans incorporating a population health approach.

Restructuring has placed increased responsibility for the health of the population and the power to identify health priorities on regional bodies – District Health Boards). These boards are required under legislation to report to the Minister of Health on the implementation of the Health Strategy and progress toward health targets.

The Public Health Advisory Committee is actively promoting the pursuit of a population health agenda beyond the health sector, primarily through the use of Health Impact Assessment (HIA).

Amendments to the public health legislation were tabled in Parliament in late 2007 to encourage the use of HIA across government departments and agencies.

## **NORWAY**

Initially, population health initiatives in Norway focussed on quality of life, placing the primary responsibility on individuals to improve their health status. Later a policy shift resulted in more balance between the personal responsibility of the individual for health and the community's role in making health-related choices easier and more attractive. Moreover, it is only recently that disparities in health have been addressed explicitly; previously the focus was on reducing poverty within vulnerable groups.

In 2007, the Norwegian government tabled in Parliament a *National Strategy to Reduce Social Inequalities in Health*, a White Paper considered as the health-related part of a broad governmental effort to promote greater equity in health. Its focus is on education, work and income and the department of health has overall responsibility for its implementation.

The White Paper, along with other policies on *Work, Welfare and Inclusion*, the *Action Plan to Combat Poverty*, and *Early Intervention for Lifelong Learning*, constitute a comprehensive policy framework to improve the health of Norwegians and to reduce disparities. Population health is organized in a three tier system with the municipalities having the greatest role. Interdepartmental/intersectoral collaboration is an integral part of the population health approach in Norway.

## **SWEDEN**

Sweden has a comprehensive, “whole-of-government” approach to population health. Its population health policy is enshrined in legislation – the *Public Health Objectives Act* of 2003.

The Act enumerates 11 objectives for population health and sets specific, measurable targets for each one. Meeting these 11 objectives involve some 50 government departments and agencies.

The Act does not require government to restructure departments and agencies, but rather to achieve better coordination and greater efficiency among them to improve population health and reduce health disparities.

The Minister for Public Health and Social Services heads a special national population health executive established to facilitate intersectoral collaboration.

The Swedish National Institute of Public Health is required to monitor and report every four years on progress made toward the 11 objectives.

It is too early to assess the impact of the Act of 2003, but clearly, it reflects a strong commitment, at the highest political levels, to an equity-oriented, intersectoral approach to population health.

## **COMPARATIVE ANALYSIS**

There have been substantial lags between the initial documentation of health disparities, the formulation of national policies to reduce them, and progress toward their reduction.

There is no single right way to address health determinants and reduce health disparities. Each country's approach depends on the historical development and current alignment of its political, economic, administrative and social structures, all of which affect both the kinds and the scope of actions that can be taken.

Health goals, objectives and targets are essential components of population health policies. Each country differs, however, in the specification and number of goals, objectives and targets used.

A challenge all countries face is the shortage of evidence on the effectiveness of interventions to reduce disparities in health. In recognition, several governments have established national research programs; others require national institutes to monitor and report on population health.

The health sector has a crucial leadership role to play in recruiting and working in partnership with other actors from other sectors responsible for policies and programs with direct or indirect impacts on population health and health disparities. Moreover, the backing of finance departments is of particular importance to ensuring not only that adequate funds are available to support the implementation of strategies, but also in ensuring the compliance of other government departments.

Health Impact Assessment (HIA) practice is well developed in many of the countries covered in this review. In some countries, public health legislation has been employed to embed HIA as an integral component of government processes.

A broadly recognized challenge for the development and implementation of population health policy is the active involvement of all relevant government departments. Intersectoral collaboration is further complicated in systems where different levels of government share closely interdependent but different responsibilities for the health of the population. Another challenge is to mobilize the wide range of actors who have a direct influence on the lives and health of people – those in schools, the primary health care, the voluntary sector, anti-poverty groups, NGO's, employers, etc.

# **POPULATION HEALTH POLICY: INTERNATIONAL PERSPECTIVES REPORT OF THE SENATE SUBCOMMITTEE ON POPULATION HEALTH**

## **INTRODUCTION**

In February 2007, during the 1<sup>st</sup> Session of the 39<sup>th</sup> Parliament, the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology received a mandate from the Senate to examine and report on the impact of the multiple factors and conditions that contribute to the health of Canada's population – known collectively as the determinants of health. The Senate renewed the mandate of the Subcommittee in October 2007, at the beginning of the 2<sup>nd</sup> Session of the 39<sup>th</sup> Parliament. A central element of the study is to identify the actions that must be taken by the federal government to implement population health strategies.

In response to this broad and complex mandate, we divided our study in two phases. The goal of the first phase is to gather evidence on the development and implementation of population health policy in various jurisdictions. The information obtained during this phase is based for the most part on background material prepared by our research team and external consultants, as well as on the testimony received during public hearings. The second phase of our study will be launched with the release of an issues and options paper which will form the basis for public hearings and consultations across the country. The consultation process will run through 2008. We expect to table our final report containing our recommendations in December 2008.

This is the first report to be released during phase one. It presents an analysis of government policies to address population health and reduce health disparities in a number of countries – precisely Australia, England, Finland, New Zealand, Norway and Sweden – selected after consultation with experts in the field. It describes how population health policy in these countries is developed, implemented and evaluated. Information was obtained by searching government websites as well as through extensive literature review and from some of our public hearings. Although the information contained in this report is limited to six countries, it provides a good sample of the wide range of information on population health policy development. We believe that many lessons can be learned from careful review and comparison of policies from these countries.

This report contains seven chapters. Chapter One through Chapter Six describe the main characteristics and particularities of population health policy in each country. These chapters all address the same issues: main findings; government responsibility for population health; development and implementation of population health policy; and monitoring and evaluation. Finally, Chapter Seven provides a comparative review of the international experience we studied.

## CHAPTER 1: Australia

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### 1.1 Main Findings

- Although many policy documents have over the past 20 years recommended the adoption of a population health approach, there is neither a national population health policy in Australia nor an explicit “whole-of-government” approach to reducing health disparities by the Commonwealth (national) government.
- The Commonwealth government does fund a number of initiatives and programs, however, that aim to improve either the health status of the overall population or that of specific population groups (including, in particular, Aboriginals).
- The health sector in Australia is the strongest advocate for action on population health and health disparities.
- In contrast to the Commonwealth government, four State governments (New South Wales, Victoria, South Australia, and Tasmania) have taken concrete action to improve population health and reduce health disparities. These efforts have been taken at both the State government and health department levels.
- Experts have urged the development of an explicit national policy to encourage comprehensive and coordinated action across the country.
- Australia believes there is insufficient evidence of the effectiveness of interventions to improve overall population health and reduce disparities in health; its government is correspondingly cautious. It does not propose inaction, but has a careful program to evaluate experimental interventions. The Commonwealth government is committed to building a strong base of evidence for the development and implementation of effective population health policies through building comprehensive social health databases, collaborative research on health inequalities and an equity-focused health impact assessment framework for policy development.
- A defining feature of the Australian federal system is the dynamic tension inherent in intergovernmental relations and the degree of cooperation required between levels of government. The Commonwealth government collects most taxes while the States and Territories have a predominant role in administering programs and services; fiscal and functional responsibilities are divided. Therefore intergovernmental relations involve ongoing negotiations over funding and governments’ respective responsibilities. This may have hampered the development and coordination of a truly national population health policy.

## 1.2 Government Responsibility<sup>1</sup>

As in Canada, under Australia's federal system of government, population health is a shared responsibility between the Commonwealth and six State and two Territorial governments. There, however, the Commonwealth government has a stronger role in population health than is the case in Canada. While provincial governments in Canada have far greater fiscal leverage over population health than does the federal government, the Australian States and Territories are largely dependent on the Commonwealth government for its funding. As in Canada, local (municipal) governments play a relatively small role:

- The **Commonwealth government** is responsible for public policy making at the national level. It is responsible for national affairs and collects about 80% of all tax revenue. The Commonwealth also has a leadership role in making health policy, particularly in national issues like public health, health care, research and national information management. Commonwealth responsibilities also include the provision of welfare and other assistance payments, marriage, immigration, external trade and commerce, currency, patents, defence, and telecommunications.
- The **State and Territory governments** have primary responsibility for the management and delivery of programs and services in the following areas: epidemiological surveillance, health literacy, education, culture, emergency services, environmental health, justice, transport, employment, agriculture, property and housing, etc.
- **Local (Municipal) governments** are responsible for health-related matters in their respective districts. Their powers and responsibilities vary from State to State/Territory, but broadly they are responsible for health promotion, disease prevention programs (such as immunization), environmental health services (such as sanitation and hygiene), town planning, building approvals, local roads, parking, public libraries, and community facilities.

## 1.3 Development and Implementation of Population Health Policy

The development of population health policy in Australia began in 1981 with publication by the World Health Organization (WHO) of the *Global Strategy for Health for All by the Year 2000*.<sup>2</sup> In 1985, in response to this call for all WHO Member States to develop national policies, strategies and action plans to improve health and to monitor progress against specified targets, the Commonwealth government established the Better Health Commission. The Commission was asked to report on the current health status of the Australian population and to recommend national policies and strategies relating to health promotion, disease prevention and overall population health. In 1986, it published a

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<sup>1</sup> National Public Health Partnership, *Public Health in Australia*, 1998, <http://www.nphp.gov.au/publications/broch/contents.htm>.

<sup>2</sup> World Health Organization, *Global Strategy for Health for All by the Year 2000*, Geneva, 1981.

three volume report, *Looking Forward to Better Health*.<sup>3</sup> Among the Commission's recommendations were that major illness prevention activities should focus on the three areas of cardiovascular disease, nutrition and injury.

In 1987, the Australian Health Ministers Advisory Council (AHMAC)<sup>4</sup> established a Health Targets and Implementation Committee (HTIC) to advise on implementation of the recommendations from the Better Health Commission report. In 1988, the HTIC published *Health for All Australians* which, for the first time in that country, outlined 20 goals and 65 targets, all with detailed cost estimates, in three main areas: population groups (e.g., socio-economically disadvantaged, Aboriginals, children, women, etc.), major causes of premature death (e.g., cancer, heart disease, diabetes, etc.), and major risk factors (e.g., drug and alcohol use, tobacco smoking, nutrition, physical activity, etc.).<sup>5</sup> The report also included five priority health areas for preventive action (improved nutrition, high blood pressure, injury prevention, preventable cancers and seniors' health).

In 1988, the National Better Health Program (NBHP) was established to oversee the implementation of the strategies outlined in the HTIC report. A review four years later found that while progress had been made in some areas, there were limitations in the approaches to the goals and targets in *Health for All Australians*. It revealed that the NBHP program was mainly viewed as an exercise in health promotion. It recommended that the goals and targets be revised with a view to influencing policy decision-making addressing the underlying social and environmental determinants of health.

In 1988, the Health Targets and Implementation Committee published *Health for All Australians* which, for the first time in that country, outlined 20 goals and 65 targets, all with detailed cost estimates, in three main areas: population groups, major causes of premature death and major risk factors.

Following this review, the Commonwealth government commissioned a report by academics in the Department of Public Health at the University of Sydney. The report, entitled *Goals and Targets for Australia's Health in the Year 2000 and Beyond*, was published in 1993.<sup>6</sup> It revised the goals and targets of the *Health for All Australians* into four principal areas: 1) mortality, morbidity and quality of life; 2) healthy lifestyles and risk factors; 3) health literacy and life skills; and 4) healthy environments. It adopted a broader view of health than the previous reports and contained over 100 goals and 600 specific targets. The report also provided guidance on policy implementation including the identification of agencies to lead work on the priorities and the development of a program to monitor progress.

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<sup>3</sup> Better Health Commission, *Looking Forward to Better Health*, Canberra, 1986.

<sup>4</sup> AHMAC membership comprises the head (plus one other senior officer) of each of the Australian Government, State and Territory and New Zealand Health Authorities, and the Australian Government Department of Veterans' Affairs. Its role is to provide effective and efficient support to the Australian Health Ministers' Conference.

<sup>5</sup> Health Targets and Implementation Committee, *Health for All Australians*, Report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference, Canberra, 1988.

<sup>6</sup> D. Nutman, M. Wise, A. Bauman, E. Harris and S. Leeder, *Goals and Targets for Australia's Health in the Year 2000 and Beyond*, Department of Health, Housing and Community Services, 1993.

The Australian Health Ministers endorsed these goals and targets and established a joint working group to pick initial national health focus areas for action. This group, drawn from the AHMAC and the National Health and Medical Research Council (NHMRC), recommended four priority health areas: 1) cardiovascular disease; 2) cancer; 3) injury; and 4) mental health. Implementation groups were established for each area.

*Better Health Outcomes for Australians* was published in 1994, bringing together the work of the four implementation groups. This report provided a number of goals, strategies and indicators for the four priority health areas. Following the release of the report, the AHMAC established a Better Health Outcomes Overseeing Committee (BHOOC). One year later, the BHOOC reviewed the national health goals and targets process and identified a number of issues: a) that the complexity of the goals and targets were problematic, b) the number of indicators (over 140 indicators across four health areas) was too large, and c) there were no national reporting requirements.<sup>7</sup>

After this review, the National Health Priority Areas (NHPA) Initiative was launched by the Australian Health Ministers in 1996. This initiative underlined the need for a national approach to population health. Reflecting concerns that the population health effort in Australia was not well coordinated, the NHPA is a collaborative effort involving the Commonwealth, State and Territory governments charged with overseeing and coordinating population health action. The National Health Priority Action Council is responsible for overseeing this initiative. The diseases and conditions targeted through the NHPA process were chosen because they were thought to be the areas where significant gains in the health of Australia's population can be achieved. Initially, four priority areas were selected: cancer control; cardiovascular health; injury prevention and control; and mental health. In 1997, diabetes was added to the list. Asthma was added in 1999 and arthritis and musculoskeletal conditions in 2002. Taken together, it was estimated that the seven NHPA priority areas accounted for almost 80% of the total burden of disease and injury in Australia.

It should be noted that, to complement its national health priorities, Australia also has a range of topic-based health strategies (e.g., drug, tobacco, HIV/AIDS; alcohol, needle and syringe exchange, etc.).<sup>8</sup>

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<sup>7</sup> Rebecca Mitchell and Rod McClure, "The Development of National Injury Prevention Policy in the Australian Health Sector: and the Unmet Challenges of Participation and Implementation," *Australia and New Zealand Health Policy*, Vol. 3, No. 11, October 2006, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1635714>

<sup>8</sup> K. Crombie, Linda Irvine, Lawrence Elliott and Hilary Wallace, *Closing the Health Inequalities Gap: An International Perspective*, World Health Organization, 2005.

In 1996, the Australian Ministers of Health created the National Public Health Partnership (NPHP) in another attempt to develop a more effective national coordinated approach to public health, disease prevention and population health. In 2006, the NPHP was replaced with two committees which are part of the AHMAC. The Australian Health Protection Committee (AHPC) focuses on public health, health protection and health disaster management, while the Australian Population Health Development Principal Committee (APHDPC) is responsible for the coordination of the national effort leading to an integrated health development strategy to include primary and secondary prevention, primary care, chronic disease and child health and well-being.<sup>9</sup>

In 1996, the National Health Priority Areas (NHPA) Initiative was launched by the Australian Health Ministers. This initiative underlined the need for a national approach to population health. Reflecting concerns that the population health effort in Australia was not well coordinated, the NHPA is a collaborative effort involving the Commonwealth, State and Territory governments charged with overseeing and coordinating population health action.

To sum up, despite the many committees that were formed, policy documents written and reviews undertaken, there has been little progress in implementing national approach to population health over the past 20 years. A recent study suggests, however, that four States (New South Wales, Victoria, South Australia and Tasmania) are explicitly committed to improving population health and reducing health disparities.<sup>10</sup> New South Wales, in particular, has put in place the most comprehensive range of structural supports to encourage health equity as described in its recent *In All Fairness* commitment to action. Because the State Department of Health alone has been given the responsibility of implementing the new health equity policy, it cannot, however, be considered a “whole-of-government” approach to population health; its implementation rests solely on the contribution of the health sector.<sup>11</sup>

#### 1.4 Monitoring and Evaluation

Australia has a strong knowledge base related to population health and health disparities and, since 1990, has been a pioneer in population health databases when its first social health atlas was published. Moreover, in 1998, the Commonwealth government established the national Health

Australia has a strong knowledge base related to population health and health disparities and, since 1990, has been a pioneer in population health databases when its first social health atlas was published. Moreover, in 1998, the Commonwealth government established the national Health Inequalities Research Collaboration to increase knowledge on the causes of, and effective responses to, health inequalities and to promote evidence-based action to reduce health disparities in Australia.

<sup>9</sup> National Public Health Partnership, <http://www.nphp.gov.au>.

<sup>10</sup> Lareen Newman, Fran Braum and Elizabeth Harris, “Federal, State and Territory Government Responses to Health Inequities and the Social Determinants of Health in Australia,” *Health Promotion Journal of Australia*, Vol. 17, No. 3, 2006, pp. 217-225.

<sup>11</sup> Department of Health (New South Wales Government), *In All Fairness: Increasing Equity in Health Across NSW*, 17 May 2004. <http://www.health.nsw.gov.au/pubs/2004/fairness.html>

Inequalities Research Collaboration to increase knowledge on the causes of, and effective responses to, health inequalities and to promote evidence-based action to reduce health disparities in Australia. This research collaboration was disbanded in 2004 and its responsibilities were transferred to the National Health and Medical Research Council (NHMRC). Three research networks have been established under the auspices of the NHMRC: 1) children, youth and families; 2) sustainable communities; and 3) primary health care. Recent data on health inequalities have also been produced by the Australian Institute of Health and Welfare. According to experts, Australia has a sound knowledge base from which to act.<sup>12</sup>

In collaboration with researchers, the Commonwealth government has also developed an equity-focused health impact assessment (EFHIA) framework for policy development. This framework defines a structured approach for the systematic consideration of equity at each step of assessment of the health impact of policy proposals.<sup>13</sup>

In collaboration with researchers, the Commonwealth government has also developed an equity-focused health impact assessment (EFHIA) framework for policy development. This framework defines a structured approach for the systematic consideration of equity at each step of assessment of the health impact of policy proposals.

## CHAPTER 2: England

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### 2.1 Main Findings

- England has a long history of pioneering a national approach to population health. It is the first, if not the only, country with a whole-of-government policy to reducing health disparities and improving overall population health.
- A new policy was initiated in response to a 2002 Treasury-led Cross Cutting Review which examined all government programs to identify how public spending could be applied to greatest effect on the reduction of health disparities.
- The details of the British population health policy were presented in 2003 in *Tackling Health Inequalities: A Programme for Action*, an ambitious agenda spanning all government departments.
- Under that program, England set specific national targets to reduce disparities in infant mortality and life expectancy at birth by 2010. A set of 12 national indicators

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<sup>12</sup> Fran Baum and Sarah Simpson, « Building Healthy and Equitable Societies: What Australia Can Contribute to and Learn from the Commission on Social Determinants of Health », *Health Promotion Journal of Australia*, Vol. 17, No. 3, 2006.

<sup>13</sup> Mary Mahoney, Sarah Tompson, Elizabeth Harris, Rosemary Aldrich and Jenny Stewart Williams, *Equity-Focused Health Impact Assessment Framework, Australasian Collaboration for Health Equity Impact Assessment*, August 2004.

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was developed to support the 2010 targets. These indicators form the basis of regular reporting by government on progress, with short term proxy measures of long term trends in reducing health disparities.

- At the national level, the Program is coordinated by a Cabinet Subcommittee chaired by the Deputy Prime Minister. The Secretary of State for Health and the Minister of Public Health champion the policy within government. The Health Inequalities Unit, based in the Department of Health, fosters and coordinates efforts within central government and works with local authorities and non-governmental organizations. Progress is monitored across government by the Treasury.
- Local Areas Agreements (LAAs) have been established: these are three year agreements that provide a framework for the relationship between central and local governments. They set out specific national goals to be accomplished at the local level over the duration of each agreement.
- To date, there has been little progress toward the national targets to be reached by 2010. It is clearly acknowledged that reversing the trends in health disparities will require a sustained, long-term, commitment both nationally and locally.
- England is also covered by the *United Kingdom National Action Plan on Social Inclusion*. Its goal is to tackle social exclusion and make a decisive impact on poverty. It is unclear how this action plan is coordinated with the current efforts to reduce health disparities.

## 2.2 Government Responsibility

England, together with Scotland, Wales and Northern Ireland, is one of the four countries forming the United Kingdom. All four constituent countries are subject to the legislative authority of the United Kingdom Parliament, although there has been partial devolution of power to Northern Ireland, Scotland and Wales through the re-establishment of legislative assemblies in each country. In contrast, England has no separate governing body for the whole of it other than that of the government of the United Kingdom. The centralized nature of the United Kingdom, a constitutional monarchy and a unitary state, is reflected in the structure of public policy in England:

- The **central (UK) government** is responsible for a wide range of public policy matters and legislation related to population health, including health care, social services, income support, education, agriculture, transport, business, etc.
- The 9 **Government Office Regions (GORs)** of England are regional entities that represent a total of eleven departments of the UK government: Cabinet Office; Local Government; Business, Enterprise and Regulatory Reform; Children, Schools and Families; Culture, Media and Sport; Environment, Food and Rural Affairs; Work and Pensions; Transport; Health; Justice; and the Home Office. They are involved in the provision of services and supports that influence population health,

including, for example: regenerating communities, fighting crime, tackling housing needs, improving public health, raising standards in education and skills, tackling countryside issues, and reducing unemployment.<sup>14</sup>

- **Local authorities, county districts and London boroughs** all have varying degrees of autonomy in selected areas of population health policy.

Efforts to improve population health and reduce health disparities in England span both levels of government, with increasing devolution by the central government to its regional offices and the local authorities.

### 2.3 Development of Population Health Policy

As noted above, England has a long history of pioneering population health and is the first, if not the only, country with a comprehensive stand-alone policy on reducing health disparities and improving overall population health. Its current approach to population health, one that addresses health inequalities specifically, has been developed step by step over the past 30 years.

In 1977, in response to mounting concerns about health disparities, the UK government established the Inequalities in Health Research Working Group, under the direction of Sir Douglas Black, to review the evidence of health disparities and recommend a policy response. The Black Report (1980), as it became known, showed that, despite the advent in 1948 of universal health care through the National Health Service (NHS), significant disparities in health persisted and that they were largely attributed to poverty. In addition, the report made a strong case that “people’s behaviour is constrained by structural and environmental factors over which they have no control”. As a result, it recommended a horizontal approach to improving population health backed by significant financial expenditures across government departments.<sup>15</sup>

The Black Report showed that, despite the advent in 1948 of universal health care through the NHS, significant disparities in health persisted and that they were largely attributed to poverty. In addition, the report made a strong case that “people’s behaviour is constrained by structural and environmental factors over which they have no control”. As a result, it recommended a horizontal approach to improving population health backed by significant financial expenditures across government departments.

The government of the day, however, decided that the recommendations were too expensive to implement. Nonetheless, the long-term policy implications of the Black Report were substantial. It generated public attention directed toward the non-medical determinants of health and health disparities and set the agenda both for research and policy discussions over the next two decades.<sup>16</sup>

<sup>14</sup> Government Offices for the English Regions, *About the Network*, <http://www.gos.gov.uk/aboutusnat/>

<sup>15</sup> *Inequalities in Health: Report of a Research Working Group* (Sir Douglas Black, Chair), United Kingdom Department of Health and Social Security, 1980. <http://www.sochealth.co.uk/history/black.htm>

<sup>16</sup> Michael Marmot, “From Black to Acheson: Two Decades of Concern with Inequalities in Health. A Celebration of the 90<sup>th</sup> Birthday of Professor Jerry Morris”, *International Journal of Epidemiology*, Vol. 30, No. 5, 2001, pp. 1165-1171. <http://ije.oxfordjournals.org/cgi/content/full/30/5/1165#R3>

In 1991, the UK government published a consultation paper which set out its proposals for the development of a population health strategy for England.<sup>17</sup> One year later, *The Health of the Nation* was launched. This population health strategy outlined five key areas for action (coronary heart disease and stroke; cancer; mental illness; HIV/AIDS and sexual health; and, accidents) and identified 25 targets to improve health overall. Interestingly, the strategy rested on a “whole-of-government” approach to population health, involving 11 government departments. A Ministerial Cabinet Committee was established to oversee development, implementation and monitoring of the strategy and to ensure coordination of the central government’s efforts with regional and local authorities. In addition, the government announced its intention to produce a guide to facilitate health impact assessment. Also planned was systematic review of progress towards achievement of targets and periodic reporting.<sup>18</sup>

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Concerns were raised that none of the targets of the new population health strategy addressed health disparities directly but the growing weight of evidence forced acknowledgement of the problem. In 1995, the government initiated another review to obtain advice on what the Department of Health and the NHS could do to tackle ethnic, geographical, socio-economic and gender disparities in health. This review, led by the Chief Medical Officer, culminated in publication of *Variations in Health: What can the Department of Health and the NHS Do?* The report showed that disparities in health were the outcome of socio-economic inequalities in living standards and life chances that took their cumulative toll on health in childhood and throughout the lifespan. It concluded that, without policies to address them, such disparities would be a serious barrier to the achievement of the national health targets. The report also underlined the necessity of partnerships with local authorities, the voluntary sector, and communities and individuals themselves, given that the contributors to health disparities were both many and complex.<sup>19</sup>

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<sup>17</sup> United Kingdom Department of Health, *The Health of the Nation: A Consultative Document for Health in England*, London, 1991.

<sup>18</sup> United Kingdom Department of Health, *The Health of the Nation: A Strategy for Health in England*, London, 1992.

<sup>19</sup> United Kingdom Department of Health, *Variations in Health: What can the Department of Health and the NHS Do?*, London, 1995.

Two years later, the UK government set up an independent inquiry chaired by Sir Donald Acheson, to review and summarize health disparities in England and identify priority areas for the policy development to reduce them. While the Black Report addressed the socio-economic causes of health inequalities, the Acheson Report, released in 1998, identified health inequalities geographically and among population sub-groups as well as at all stages of the life course from pregnancy to old age. It put forward 39 recommendations and identified three crucial priorities: 1) all policies impacting on health should be subject to health impact assessments; 2) high priority should be given to the health of families with children; and 3) further steps should be taken to reduce income inequalities and improve the living standards of poor households.<sup>20</sup>

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While the Acheson Inquiry was ongoing, the UK government released (in February 1998) another consultation document which set out its proposals for concerted action in partnership with local organizations to improve the health and living conditions of the population. These proposals were to meet two goals: 1) to improve the health of the population as a whole by increasing longevity and the number of years free from illness; and 2) to improve the health of the worst off in society and thereby reduce health disparities. It made clear the importance of individual responsibility and partnership with local communities to improve population health.<sup>21</sup>

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<sup>20</sup> *Independent Inquiry into Inequalities in Health Report* (Sir Donald Acheson, Chair), the Stationary Office, London, 1998. <http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm>

<sup>21</sup> United Kingdom Department of Health, *Our Healthier Nation: A Contract for Health*, London, 1998. <http://www.archive.official-documents.co.uk/document/doh/ohnation/title.htm>

In response to the report of the Acheson Inquiry and after public consultations, in 1999 the UK government revised its population health policy and published *Saving Lives: Our Healthier Nation*<sup>22</sup>, along with its companion document *Reducing Health Disparities: An Action Report*.<sup>23</sup> These reports set out the actions the government would take – by its departments and through partnerships between the various regional and local organizations in England – to reduce health disparities. New targets were established for the five priority areas. And again, health impact assessments were to be made “a part of the routine practice of policy-making in government”. The revised policy was considered the most comprehensive program ever proposed to tackle health inequalities in the UK.

To ensure that efforts across government departments were coordinated and that they supported effectively the goal of reducing health disparities, in 2002 the UK government conducted an inter-departmental spending review of health inequalities. The “cross-cutting” spending review, led by the Treasury, assessed government departmental expenditures in education, welfare, criminal justice, environment, transport and local

In 2002 the UK government conducted an inter-departmental spending review of health inequalities. The “cross-cutting” spending review, led by the Treasury, assessed government departmental expenditures in education, welfare, criminal justice, environment, transport and local government in relation to health distribution. In turn, the results from the spending review informed departmental spending plans for the 2003-2006 fiscal years. Further, the results generated mandatory commitments to actions that, in sum, constituted a whole-of-government approach to reduce health disparities.

government in relation to health distribution. In turn, the results from the spending review informed departmental spending plans for the 2003-2006 fiscal years. Further, the results generated mandatory commitments to actions that, in sum, constituted a whole-of-government approach to reduce health disparities. In particular, the emphasis was on:

- Ending the cycle of health disparities by tackling poverty and deprivation, especially a) in families with children, b) by supporting healthy pregnancies and early childhood development and c) through educational interventions to eliminate the attainment gap.
- Addressing the major causes of mortality and injury, in particular the social gradient in modifiable behavioural and physiological risks (smoking, physical activity and nutrition) and in the provision of treatment services.
- Improving access to public services and facilities, in particular in the sectors of primary care and public transport.

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<sup>22</sup> United Kingdom Department of Health, *Saving Lives: Our Healthier Nation*, London, July 1999. <http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm>

<sup>23</sup> United Kingdom Department of Health, *Reducing Health Inequalities: An Action Report*, London, January 1999. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4006054](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006054)

- Strengthening disadvantaged communities through neighbourhood renewal and regeneration, improving housing, making communities safer, and providing more public services to facilitate access to employment and education, and
- Helping particularly susceptible groups through targeting the needs of the fuel poor<sup>24</sup>, those with mental illness, the homeless, and prisoners and their families.<sup>25</sup>

The government provided further details of its whole-of-government approach to health disparities in 2003 with the release of *Tackling Health Inequalities: A Programme for Action*. The program set out an ambitious agenda spanning 12 central government departments/agencies as well as a number of regional and local authorities. It was supported by a national public service agreement (PSA) target along with two more detailed objectives:

- to reduce inequalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth:
  - starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole;
  - starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.<sup>26</sup>

There were, in addition, 76 cross-government commitments to be delivered by 2006. It was made clear, however, that securing results would take many years; the program stressed the intergenerational aspects of many of the contributory factors leading to health disparities.

England is also incorporated under the *United Kingdom National Action Plan on Social Inclusion*,<sup>27</sup> the goal of which is to tackle social exclusion and reduce poverty. It is unclear how this action plan is coordinated with the current efforts to reduce health disparities.

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<sup>24</sup> Fuel poverty occurs when households spends more than 10% of their income on fuel used to heat their homes to an adequate standard of warmth

<sup>25</sup> United Kingdom Department of Health, *Tackling Health Inequalities: 2002 Cross-Cutting Review*, [www.dh.gov.uk/assetRoot/04/06/80/03/04068003.pdf](http://www.dh.gov.uk/assetRoot/04/06/80/03/04068003.pdf)

<sup>26</sup> United Kingdom Department of Health, *Tackling Health Inequalities: A Programme for Action*, 2003. [www.dh.gov.uk/assetRoot/04/01/93/62/04019362.pdf](http://www.dh.gov.uk/assetRoot/04/01/93/62/04019362.pdf).

<sup>27</sup> United Kingdom Department of Work and Pensions, *Working Together: United Kingdom National Action Plan on Social Inclusion, 2006-2008*, 2006. <http://www.dwp.gov.uk/publications/dwp/2006/nap/>

## 2.4 Implementation

Population health/health disparity reduction policy in England is “top-down” guided by a Cabinet Subcommittee chaired by the Deputy Prime Minister that provides overall governance and coordination across government departments. The Secretary of State for Health and the Minister of Public Health are jointly responsible for championing the policy within government. An interdepartmental working group of senior officials monitors departments to ensure that their programs contribute to the achievement of the national target. Within the Department of Health, the Health Inequalities Unit focuses on establishing links among health entities to ensure that a health inequalities perspective applies to their programs and initiatives.

Working in partnership is seen to be the key to the success of the population health/health disparity reduction policy. This involves cooperation and collaboration between the UK government and several regional/local authorities. Accordingly, the Department of Health supported the formulation of Local Area Agreements (LAAs) as important elements in the planning process to give greater prominence to health inequalities and health outcomes in local community planning. LAAs are established with GORs and address particular attention to: children and young people; safer and stronger communities; healthier communities and older people. Together with Regional Assemblies and Regional Development Agencies, the GORs also consider the broader economic determinants of health and strategy on transportation, employment, the environment and community renewal.

Population health/health disparity reduction policy in England is guided by a Cabinet Subcommittee chaired by the Deputy Prime Minister that provides overall governance and coordination across government departments. The UK government also cooperates and collaborates with several regional/local authorities through the use of Local Area Agreements (LAAs).

## 2.5 Monitoring and Evaluation

*A Programme for Action* committed to the development, at the national level, of a high-level cross government set of indicators that would be monitored and published annually to track progress. Locally, each regional entity was encouraged to select and report on indicators relevant to its own needs. The status report on the *Programme for Action* published in 2006 showed no narrowing of health disparities against the PSA targets. The changes reported included:

- a slight reduction in the gap for male life expectancy for 2002-04 compared to 2001-2003;
- a slight increase in the gap for female life expectancy for 2002-04 compared to 2001-2003;
- no change in the infant mortality target between 2001-2003 and 2002-2004;

- in terms of the cross government headline indicators, slight improvements in the trends in terms of road accident casualties for children, educational attainment and housing quality; and
- some signs of a widening of inequalities between 2000 and 2005 in smoking in pregnancy between the routine and manual group and all mothers.<sup>28</sup>

The status report acknowledged once again that reversing the trends in disparities would require sustained commitment at both the national and local levels over time (measured in generations).

In 2004, the UK government stated once again that the impact of “non-health” interventions on population health should be more routinely considered both before implementing policies – through health impact assessments – and afterwards – through evaluation. Accordingly, it announced that it would build health into all future legislation by including health as a component in regulatory impact assessment.<sup>29</sup> This decision, however, has not been enforced either through legislation or policy.<sup>30</sup>

The same year, the Department of Health published a guide on interventions that have shown to be effective in reducing health disparities; this guide was to assist providers and organizations who deliver health care at the local level.<sup>31</sup>

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## CHAPTER 3: Finland

### 3.1 Main Findings

- Finland has had an explicit policy aimed at improving population health and reducing health disparities since 1987. There is a sound information base, coupled with a specific government investment into population health research and a legislative requirement to report to Parliament on population health.
- The current (target year 2015) policy on national population health, however, includes only a few detailed suggestions relating to the kinds of initiatives needed to meet the target. Concerned about increasing levels of health inequalities in Finland, the national government is preparing a national action plan to reduce them. It will

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<sup>28</sup> United Kingdom Department of Health, *Tackling Health Inequalities: Status Report on the Programme for Action – 2006 Update of Headline Indicators*, August 2006. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_062903](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062903)

<sup>29</sup> United Kingdom Department of Health, *Choosing Health: Making Healthy Choices Easier*, 2004. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4094550](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550)

<sup>30</sup> Dr. Fiona Adshead, *Proceedings*, 11 December 2007.

<sup>31</sup> United Kingdom Department of Health, *Tackling Health Inequalities – What Works*, 2005. <http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Healthinequalities/Bestpractice/index.htm>

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be interesting to review this action plan which was set to be released by the Finnish government toward the end of 2007.

- Over the last 20 years, population health policy in Finland has emanated from the department of health, despite the recognition that many determinants of health lie under the purview of other government departments. Although the relevant departments are sometimes recognized within policy documents, it is unclear how they collaborate together in Finland to achieve common health goals.
- Finland has a separate policy on poverty and social exclusion, but there is little information on how its implementation is coordinated with the population health policy.
- A major challenge to implementation of the population health policy relates to the highly devolved system of government in Finland. While the national government provides national leadership, most programs and services are implemented and delivered by municipalities. Policies developed at the national level cannot be directive but, rather, indicative, guiding and supportive. It is also unclear whether the Finnish municipalities are equipped to respond to the challenges posed by a broad population health approach.

### 3.2 Government Responsibility

Finland is a democratic republic with a parliamentary system of government. Its unicameral Parliament, the Eduskunta, has 200 members elected for a four-year term on the basis of proportional representation. The country is divided into 6 provinces and 416 municipalities, the latter with the authority to levy taxes and the responsibility for the delivery of a wide range of programs and services. Democratic decision-making takes place on either the national or municipal level.

- The **national government** is responsible for developing broad national policies, passing legislation, and supervising policy implementation. It has responsibilities in all fields relevant to population health: health care, social affairs, education, labour, environment, justice, etc.<sup>32</sup>
- **Municipalities** also have a broad range of responsibilities. As self-governing entities, they can undertake a variety of functions but also have a number of statutory obligations. National legislation sets out a number of functions that the municipalities may or may not perform but in respect to those they decide to undertake, they must adhere to the relevant national legislation. The most important areas of municipal responsibility include social welfare, health care, education, and culture. They are also responsible for the maintenance of streets and local roads. Moreover, they perform functions in the field of environmental

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<sup>32</sup> Finnish Government, *Facts about the Government*, <http://www.government.fi/tietoa-valtioneuvostosta/perustietoa/en.jsp>.

administration, such as land use planning, building regulation, environmental protection and waste management.<sup>33</sup>

According to one Finnish expert, since 1993 there has been a “radical” shift from centralized state planning and intervention to “extreme” decentralization. In his view, this shift has been both remarkable and rare by international comparison; municipalities now have the main operative public responsibility for health.<sup>34</sup> This highly devolved system of government creates challenges to the development and implementation of population health policy in Finland.<sup>35</sup>

### 3.3 Development of Population Health Policy

Finland was among the first countries to create a national policy on population health; in 1982, it was a pioneer for the World Health Organization in developing the WHO strategy for health for all.<sup>36</sup> At the time, the decision to launch that strategy was both an ambitious attempt to do things differently and also an acknowledgement of the fact that continuing to expand health care would not necessarily improve health outcomes.<sup>37</sup>

Finland was among the first countries to create a national policy on population health; in 1982, it was a pioneer for the World Health Organization in developing the WHO strategy for health for all.

In 1987, the government devised its own population health policy and released *Health for All by 2000 – the Finnish National Strategy*. The strategy incorporated a focus broader than health care and had 34 lines of action directed to four targets: 1) adding years to life (i.e. a decline in premature deaths); 2) adding health to life (i.e. a decline in chronic diseases, accidents and other health problems); 3) adding life to years (i.e. good health and functional capacity for longer in life, with welfare to match); and 4) reducing health disparities between population groups (i.e. reducing health differences between genders, socioeconomic categories and people living in different regions). The government proceeded to implement the steps outlined in the strategy and a special health research program was launched with new government funding to monitor trends in health status and socioeconomic disparities in health.

At the time, the municipalities presented exceptional potential for intersectoral action related to population health based on the fact that in the 1980s all municipalities were required to establish two councils. One was an intersectoral council for health education and promotion, which was intended to bring together health care, schools, youth

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<sup>33</sup> Ministry of the Interior, *Legislation on Local Government in Finland*, Government of Finland, 2007. <http://www.intermin.fi/intermin/home.nsf/pages/15984682D7D068C0C2256B81003A62D4?opendocument>

<sup>34</sup> Simo Kokko, “The Process of Developing Health for all Policy in Finland, 1981-1995,” *Exploring Health Policy Development in Europe*, World Health Organization, Edited by Anna Ritsatakis *et. al.*, 2000, pp. 27-40, [http://www.euro.who.int/InformationSources/Publications/Catalogue/20010911\\_37](http://www.euro.who.int/InformationSources/Publications/Catalogue/20010911_37).

<sup>35</sup> WHO Regional Office for Europe, *Review of National Finnish Health Promotion Policies and Recommendations for the Future*, 2002, <http://www.stm.fi/Resource.phx/eng/subjt/health/hprom/index.htm>.

<sup>36</sup> Simo Kokko (2000), *op.cit.*

<sup>37</sup> *Ibid.*

work and sports. The second, a council for rehabilitation issues, was oriented toward coordinating the work of health, social work and other professionals providing health-related services directly to individuals and families and avoid unnecessary inter-professional referrals. To facilitate intersectoral collaboration, the government transformed its previously earmarked subsidies into block grants so that funds could be used to meet local priorities. The resultant intersectoral action between the health and social sectors intensified in the 1990s as municipalities increasingly consolidated administration of their health and social programs.<sup>38</sup>

In 1993, the WHO conducted an external review of the Finnish population health strategy. The main findings included: 1) development of the strategy had been too confined to the health care sector; involvement of other sectors and wider consultation would have helped subsequently in implementing the strategy; 2) although experts and policy makers were committed to the population health strategy, the principles had not received enough visibility in the mass media or at the grassroots; 3) development and implementation of the strategy had been led by experts and public servants in a top-down manner; municipalities were not brought into the process at the initial stages; 4) the strategy had been used as a means of legitimizing rather than initiating the national process of formulating population health policy; 5) the strategy was not based on sufficiently quantified targets; and 6) the group of public servants within the health care sector that had been given responsibility for implementing and monitoring the strategy was too small; more financial and human resources should have been used.<sup>39</sup>

In 1995, new legislation was adopted requiring the Finnish government to table in Parliament a biannual report on the state and development of the health of the nation. The first report, presented in 1996, provided a broad overview of the health determinants of the Finnish population and highlighted health challenges and trends. A major section of the report was devoted to studying the health impact of policies in fields other than health. Subsequently the contribution of other government departments to health was recognized and their participation in the promotion and protection of health was encouraged.<sup>40</sup> The second report, tabled in 1998, included information on trends in health, illness, social conditions, disparities in health and income, social exclusion, working environments, living conditions of children and youth, etc.; it included information relating to the contributions from all departments. Information was also obtained from umbrella organizations in the social welfare and health sectors. This second report was remarkable for its broader focus on population health and social security than would have been done by any single department.<sup>41</sup>

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<sup>38</sup> *Ibid.*

<sup>39</sup> *Ibid.*

<sup>40</sup> Council of State of Finland, *Public Health Report Finland 1996*, [http://www.pia-phr.nrw.de/abstracts/sf/sf\\_649835.html](http://www.pia-phr.nrw.de/abstracts/sf/sf_649835.html).

<sup>41</sup> Ministry of Social Affairs and Health (Finland), *Social Welfare and Health Report, 2000*, <http://pre20031103.stm.fi/english/eho/publicat/ehocontents13.htm>.

In 2000, the national government released the *Health 2015 Public Health Programme* which revised and updated the national policy on population health.<sup>42</sup> The four general targets (giving people a longer and healthier life and reducing health disparities) were maintained, and eight new targets were added. The first five were aimed at population groups – child health; smoking by young people; accidental and violent death among young men; increasing working and functional capacity of the workforce; and improving functional capacity among people over 75. The last three targets focused on the population as a whole and included: increasing healthy life expectancy by an average of two years; maintaining satisfaction with respect to health care; and reducing health disparities. Some of the targets were quantitative (e.g. to reduce smoking by 16-18 year olds to less than 15%). Others were less specific (e.g. increases in child well-being and health, and appreciable decreases in symptoms and diseases caused by insecurity). According to experts, the 2015 national health policy included only a few detailed suggestions of the kinds of initiatives needed to meet the targets.<sup>43</sup> This policy also stressed the need for multi-sectoral collaboration among the Ministry of Social Affairs and Health and other departments, the municipalities, universities, businesses, communities and individuals. In particular, it acknowledged that local authorities play an increasingly important role as the national government strives to replace top down with bottom up management. Social inclusion was also acknowledged a priority. The *Health 2015 Public Health Programme* will be subject to comprehensive monitoring and external evaluation. Indicators will be devised to assess the attainment of the targets and will feed into population health reports that will be produced every four years.<sup>44</sup>

In 2000, the national government released the Health 2015 Public Health Programme which revised and updated the national policy on population health. The revised policy stressed the need for multi-sectoral collaboration among the Ministry of Social Affairs and Health and other departments, the municipalities, universities, businesses, communities and individuals.

In addition to the health 2015 document, policies, strategies and action plans for specific topics are in place, some with their own targets. Examples of these policies are: the National Aging Policy up to 2001,<sup>45</sup> the Drug Strategy of 1997, the National Action Plan against Poverty and Social Exclusion, and the Development of Health Enhancing Physical Activity. Together, these strategies and initiatives form a comprehensive policy framework to improve overall population health and to reduce health disparities. It is unclear, however, how or whether their implementation is being coordinated.

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<sup>42</sup> Ministry of Social Affairs and Health (Finland), *Government Resolution on the Health 2015 Public Health Programme*, 2001, <http://pre20031103.stm.fi/english/eho/publicat/ehocontents17.htm>.

<sup>43</sup> Caroline Costongs, Ingrid Stegeman, Sara Bensaude De Castro Freire and Simone Weyers, *Closing the Gap – Strategies for Action to Tackle Health Inequalities: Taking Action on Health Equity*, European Commission, May 2007, <http://www.health-inequalities.eu/?uid=2302287e264715c480d6449302b63587&id=Seite872>.

<sup>44</sup> Iain K Crombie, Linda Irvine, Lawrence Elliott and Hilary Wallace, *Understanding Public Health Policy – Learning from International Comparisons*, Public Health Institute of Scotland, September 2003, <http://www.healthscotland.com/documents/992.aspx>.

<sup>45</sup> Ministry of Social Affairs and Health, *A National Policy on Aging Up to 2001*, 1996, <http://pre20031103.stm.fi/english/pao/ageing1.htm>.

In March 2007, the government released the latest step in the implementation of the Finnish population health policy a *National Action Plan to Reduce Health Inequalities*. It was to be completed by the end of 2007 and aims to identify the policy areas and measures required to achieve the national target to reduce socioeconomic disparities in health, set out in the national health 2015 policy.

In March 2007, the government released the latest step in the implementation of the Finnish population health policy a National Action Plan to Reduce Health Inequalities. It was to be completed by the end of 2007 and aims to identify the policy areas and measures required to achieve the national target to reduce socioeconomic disparities in health, set out in the national health 2015 policy.

Preparation of the action plan is the responsibility of the Ministry of Social Affairs and Health and the Advisory Board for Public Health. It will be built around the following seven strands:

- 1) Reinforcing population health policies and integrating the health inequalities into it;
- 2) Strengthening work to reduce health inequalities in municipalities;
- 3) Alcohol and tobacco policies;
- 4) Enhancing the equity in public services;
- 5) Reducing health inequalities in children and young people and preventing social exclusion;
- 6) Reducing health inequalities in people of working age;
- 7) Developing monitoring systems for health inequalities among population groups.<sup>46</sup>

Strands 1 and 2 cover the levels at which actions are implemented and the principles that inform them. Strands 3 and 4 cover major determinants of health disparities, and 5 and 6 the most important targeted populations. Strand 7 addresses the information system necessary for implementation of the appropriate policies and the assessment of the extent to which they are achieving their objectives.<sup>47</sup>

### 3.4 Implementation

Under the national health 2015 policy, many actors have a role in implementing population health policy. The Ministry of Social Affairs and Health is responsible for coordinating the overall policy and the actions that each of the key players should take. It is also given the responsibility of working in close cooperation with municipalities to

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<sup>46</sup> Ministry of Social Affairs and Health (Finland), *Preparation of a National Action Plan to Reduce Health Inequalities – A Roadmap*, 20 March 2007, [http://www.teroka.fi/teroka/uploadfiles/health\\_inequalities\\_action\\_plan\\_2007.pdf](http://www.teroka.fi/teroka/uploadfiles/health_inequalities_action_plan_2007.pdf).

<sup>47</sup> *Ibid.*

improve their potential to achieve the targets. The policy also stresses that municipalities must be supported in their health promotion and monitoring and evaluation activities. Municipalities are also encouraged to cooperate more closely with one another. In addition, the Ministry of Social Affairs and Health must work with other relevant departments to strengthen the health promotion role of the business sector and the industry. Non-governmental organizations must cooperate at the community level in the health promotion efforts and individuals are encouraged to be active in promoting their own health.

A concern was raised that, with the exception of the health sector, the national level has no operational role, and the Ministry of Social Affairs and Health is the only department given explicit responsibilities.<sup>48</sup> It is not yet known how the *National Action Plan to Reduce Health Inequalities* will be developed and which department(s) will have responsibility for its implementation.

### 3.5 Monitoring and Evaluation

Finland has a strong tradition of monitoring health status and the occurrence of illness through various national population surveys and registers. The wide range of data collected has facilitated monitoring of the Finnish population health policy. The population health reports that are presented to Parliament are comprehensive, covering various sectors and levels of government. They are based on legislation requiring all departments to contribute by reporting their health-related activities. It has been argued, however, that the national health 2015 policy contains only a few specific health targets and that their paucity makes monitoring of the policy difficult to achieve.<sup>49</sup>

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In health research, the Academy of Finland currently leads a national research program on health disparities. Another joint research project on health disparities, “TEROKA”, has recently been initiated by three national research institutes (National Public Health Institute, National Research and Development Centre for Welfare and Health, and Finnish Institute of Occupational Health). TEROKA involves researchers with a variety of academic backgrounds including epidemiology, health services research, social policy, medical sociology, medicine, and nutritional science. The goals of the project are to: strengthen research; promote partnerships to reduce health inequalities; develop practical measures of the effects of interventions on population health (e.g. impact

<sup>48</sup> WHO Regional Office for Europe, *Review of National Finnish Health Promotion Policies and Recommendations for the Future*, 2002, <http://www.stm.fi/Resource.phx/eng/subjt/health/hprom/index.htm>.

<sup>49</sup> *Ibid.*

assessment); raise awareness among policymakers; and encourage the development of policies to reduce health inequalities.<sup>50</sup>

Some experts contend that setting ambitious goals and targets and enhancing epidemiological knowledge through research and development of comprehensive databases by themselves do not necessarily lead to government action. It appears, however, that striving for better health for the whole population has been successful in Finland. In contrast, striving to make more equitable the distribution of health has not been successful because of the lack of active commitment on the part of the different players charged with implementing Finnish health and social policy whose systems to promote equality in health need reinforcement.<sup>51</sup>

## **CHAPTER 4: New Zealand**

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### **4.1 Main Findings**

- The New Zealand Health Strategy adopted in 2000 explicitly addresses health disparities and the health of the entire population, but its implementation is limited in its scope to actions taken by the health sector.
- Special attention is being paid to Maori populations, with particular strategies and action plans incorporating a population health approach.
- Restructuring has placed increased responsibility for the health of the population and the power to identify health priorities on regional bodies – District Health Boards (DHBs). DHBs are required under legislation to report to the Minister of Health on the implementation of the Health Strategy and progress toward health targets.
- The Public Health Advisory Committee is actively promoting the pursuit of a population health agenda beyond the health sector, primarily through the use of Health Impact Assessments (HIAs).
- Amendments to the public health legislation were tabled in Parliament in late 2007 to encourage the use of HIA across government departments and agencies.

### **4.2 Government Responsibility**

New Zealand is a constitutional monarchy, a unitary state with a parliamentary system of government. Its single legislative body is the 120 seat House of Representatives, commonly referred to as Parliament. There are two branches of government: national and

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<sup>50</sup> Teroka project, <http://www.teroka.fi/teroka/index.php?option=content&pcontent=1&task=view&id=71&Itemid=102>.

<sup>51</sup> Hannele Palosuo, *Reducing Inequalities in Health in Finland*, Finnish Institute of Occupational Health, 4 June 2007, [http://www.teroka.fi/teroka/uploadfiles/HOPE\\_HP\\_040607.pdf](http://www.teroka.fi/teroka/uploadfiles/HOPE_HP_040607.pdf).

local. Local governments are independent but subordinate to the national government. They act primarily through three types of institutions: regional councils, territorial local authorities, and district health boards, institutions created by the authority of the national government, with powers conferred by Parliament. While local authorities raise much of their own funding, the national government subsidizes some targeted activities (principally health services and road construction and maintenance).

- The **national government** is responsible for legislation, national policies and activities in areas relevant to population health, such as education and training, employment, tax, fiscal and economic policy, and social welfare and services. While national health policy is set by Parliament, much of health service delivery and some flexibility in the means and focus of that delivery have been devolved to District Health Boards.
- New Zealand has sixteen **regional councils** (and one territory), most covering several cities or districts. They have responsibility for issues related to the environment and public transport, including: resource management policy and permits for the use and development of natural and physical resources; land, air and water discharges and water allocation; pest management and policy aspects of biosecurity; flood control; regional emergency management and civil defence; regional land transport planning and coordination; regional hazardous waste disposal; and harbour administration.
- There are 76 **territorial local authorities** with city (mainly urban) or district (rural or combined rural and urban) councils. City and district councils provide a wide range of services related to community well-being and development, notably infrastructure (roads, transport, sewerage, water and storm water); recreational and cultural activities (such as public libraries); and environmental health and safety (including building control, emergency management, civil defence and environmental health matters).<sup>52</sup>
- New Zealand's health care sector was restructured four times between 1989 and 2001, ultimately leading to the creation of twenty-one **District Health Boards** (DHBs). The statutory objectives of DHBs include improving, promoting and protecting the health of communities, promoting the integration of health services, especially primary and secondary care services, and ensuring effective care and support of those sick or disabled. They are responsible for providing directly or funding the provision of health and disability services in their districts.

#### 4.3 Development and Implementation of Population Health Policy

New Zealand has developed its population health policy through a series of steps beginning in 1989 when the national government first established a set of 10 health goals – dealing with risk factors (smoking, alcohol use and hypertension), disease (ischaemic heart

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<sup>52</sup> John Wilson, "Government and Nation," *Te Ara – the Encyclopedia of New Zealand*, updated 26 September 2006, <http://www.TeAra.govt.nz/NewZealandInBrief/GovernmentAndNation/en>

disease, stroke, cervical cancer and melanoma) and unintentional injury – and agreed to report on progress toward meeting set targets on a regular basis.<sup>53</sup>

In 1994, the national government endorsed *A Strategic Direction to Improve and Protect Public Health*, its first policy statement based on a population health approach. This document identified 56 health targets.<sup>54</sup> Three years later the government released another report stressing the importance of continuing the 1994 population health policy by consolidating and building on programs already initiated. This report acknowledged that population health initiatives constitute long term exercises, particularly in terms of changing attitudes and behaviours affecting the underlying determinants of health.<sup>55</sup>

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In 1998, the National Health Committee, an advisory body to the Minister of Health, released a paper that documented health determinants and health disparities in New Zealand and recommended additional government action.<sup>56</sup> The main findings of the paper were that:

- Social, cultural and economic factors are the main determinants of health;
- There are persisting health inequalities that result from different socio-economic conditions; some evidence suggests these disparities may be worsening in New Zealand;
- There are good reasons to intervene to reduce socio-economic disparities in health;
- There is evidence that specific interventions can reduce these inequalities;
- The Minister of Health can play a leadership role in initiating policies to reduce health disparities;
- The Minister of Health can require health impact assessments when changes in macroeconomic and social policies are proposed and made and can

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<sup>53</sup> Iain K. Crombie, Linda Irvine, Lawrence Elliott and Hilary Wallace, *Understanding Public Health Policy – Learning from International Comparisons*, A report to NHS Health Scotland, September 2003. <http://www.healthscotland.com/documents/992.aspx>

<sup>54</sup> New Zealand Public Health Commission, *A Strategic Direction to Improve and Protect Public Health: The Public Health Commission's Advice to the Minister of Health 1993-1994*, 1994.

<sup>55</sup> New Zealand Ministry of Health, *Strengthening Public Health Action: the Strategic Direction to Improve, Promote and Protect Public Health*, Wellington, 1997.

<sup>56</sup> New Zealand National Health Committee (National Advisory Committee on Health and Disability), *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health*, Wellington, June 1998. <http://www.nhc.health.govt.nz/moh.nsf/0/BC21C8CFF2D8D5DFCC2572AC0016BBC7>

collaborate with other ministers in implementing broad population health policy.

In 1999, the Ministry of Health published a comprehensive report on social inequalities in health, with a focus on Maori and Pacific peoples.<sup>57</sup> A year later, Parliament adopted the *New Zealand Public Health and Disability Act*.<sup>58</sup> One of its objectives was particularly relevant to population health, its goal “to achieve the best health and disability support outcomes for New Zealanders and reduce disparities between population groups”. The Act also established the District Health Boards (DHBs) and requires them to adopt a population health focus as they fund or provide services (including prevention, early intervention, treatment and support services) for their geographically defined populations. The Department of Health also developed toolkits of evidence of best practices to guide DHBs.<sup>59</sup> The Act also directed the national government to develop a New Zealand Health Strategy and a New Zealand Disability Strategy and to table an annual report to Parliament on progress on their implementation.

The national government released *The New Zealand Health Strategy* at the end of 2000<sup>60</sup> revising the government’s population health policy and setting 10 new goals and 61 specific objectives related to: 1) a healthy social environment; 2) reducing inequalities in health status; 3) Maori development in health; 4) a healthy physical environment; 5) healthy communities, families and individuals; 6) healthy lifestyles; 7) better mental health; 8) better physical health; 9) injury prevention; and 10) accessible and appropriate health care. Of the 61 objectives, 13 “population health objectives” were chosen for implementation over the short to medium term:

- reducing smoking
- improving nutrition
- reducing obesity
- increasing the level of physical activity
- reducing the rate of suicides and suicide attempts
- minimising harm caused by alcohol and illicit and other drug use to individuals and the community
- reducing the incidence and impact of cancer
- reducing the incidence and impact of cardiovascular disease

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<sup>57</sup> New Zealand Ministry of Health, *Social Inequalities in Health, New Zealand 1999*, Wellington, September 2000. <http://www.moh.govt.nz/moh.nsf/49ba80c00757b8804c256673001d47d0/65b8566b2ac3a9684c2569660079de90?OpenDocument>

<sup>58</sup> New Zealand Ministry of Health, *The New Zealand Public Health and Disability Act 2000*, December 2000. <http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/e65f72c8749e91e74c2569620000b7ce?OpenDocument>

<sup>59</sup> New Zealand Ministry of Health, *New Zealand Health Strategy – DHB Toolkits*, available at <http://www.newhealth.govt.nz/toolkits/Default.htm>

<sup>60</sup> New Zealand Ministry of Health, *The New Zealand Health Strategy*, Wellington, December 2000. <http://www.moh.govt.nz/nzhs.html>

- reducing the incidence and impact of diabetes
- improving oral health
- reducing violence in interpersonal relationships, families, schools and communities
- improving the health status of people with severe mental illness
- ensuring access to appropriate child health care services including well child and family health care and immunization.<sup>61</sup>

The Strategy provided a framework for the health sector to improve the overall health of New Zealanders and to reduce inequalities amongst New Zealanders, with a focus on Maori, Pacific peoples and low-income New Zealanders. In particular, it led to the implementation of the *He Korowai Oranga – Māori Health Strategy* and the *Pacific Health Action Plan*.<sup>62</sup>

Perhaps more importantly, the *New Zealand Public Health and Disability Act* of 2000 also led to the creation of a Public Health Advisory Committee (PHAC). Reporting to the Minister of Health through the National Health Committee, the Committee's role is to provide independent advice on the factors influencing the health of people and communities and on the promotion and monitoring of population health. In the years following its creation, PHAC has become a strong advocate of a whole-of-government approach to population health, with particular emphasis on reducing health inequalities, improving Māori health, and fostering intersectoral collaboration.

In 2001, the national government launched *The New Zealand Disability Strategy*<sup>63</sup> involving inter-departmental action which promotes a more inclusive society. Its framework requires that government departments and agencies give consideration to disability issues in all Cabinet papers and policy development. Key departments and agencies must report annually on their progress in implementing the *New Zealand Disability Strategy*.<sup>64</sup>

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<sup>61</sup> New Zealand Ministry of Health, *The New Zealand Health Strategy*, December 2000. <http://www.moh.govt.nz/nzhs.html>

<sup>62</sup> New Zealand Ministry of Health, *He Korowai Oranga – Māori Health Strategy*, Wellington, November 2002. <http://www.moh.govt.nz/moh.nsf/7004be0c19a98f8a4c25692e007bf833/8221e7d1c52c9d2ccc256a37007467df?OpenDocument>; New Zealand Ministry of Health, *The Pacific Health and Disability Action Plan*, Wellington, February 2002. <http://www.moh.govt.nz/publications/pacificactionplan>

<sup>63</sup> New Zealand Ministry of Disability Issues, *The New Zealand Disability Strategy: Making a World of Difference*, Wellington, April 2001. <http://www.odi.govt.nz/publications/nzds/index.html>

<sup>64</sup> New Zealand Office for Disability Issues, *Work Plan 2007-2008 and Report on Progress 2006-2007*. <http://www.odi.govt.nz/nzds/work-plans/2007/index.html>

A year later, the national government released *Reducing Inequalities in Health*. This report set out a framework and enunciated principles to be used at the national, regional and local levels by policy-makers, as well as by service providers and community groups when taking action to reduce inequalities in health.<sup>65</sup> The report was directed specifically to the health/disability sector; however, it highlighted the importance of factors outside the direct control of that sector in affecting the health of the population. In particular, it noted that the Treasury, social welfare, education, housing and labour market sectors, in addition to local governments, could contribute significantly to the task of reducing inequalities in health. The framework targeted four approaches:

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- **Structural:** initiatives attacking the root causes of health inequalities, that is the social, economic, cultural and historical factors fundamental to the determination of health. These include, for example, equitable access to education, labour markets, housing, and other social services.
- **Intermediary pathways:** targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health. Providing access to material resources, promoting healthy lifestyles, enhancing the physical and social environments are examples of approaches in this category (public housing, healthy cities, workplace interventions, community development programs, transportation policies and health protection).
- **Impact:** minimizing the impact of illness and disability through, for example, income support, disability allowances, accident compensation and antidiscrimination legislation.
- **Equitable access to health and disability services.**

In 2003, the national government released *Achieving Health for all People*, a detailed population health framework for the New Zealand Health Strategy.<sup>66</sup> It described areas for action by the Ministry of Health, other government and national policy-making agencies, DHBs, regional councils, educational institutions, non-governmental organizations, etc., under five broad objectives:

- Strengthen population health leadership at all levels and across all sectors;
- Encourage effective population health through public health services and action across the whole of the health sector;

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<sup>65</sup> New Zealand Ministry of Health, *Reducing Inequalities in Health*, Wellington, September 2002.

<http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/523077dddeed012dce256c550003938b?OpenDocument>

<sup>66</sup> New Zealand Ministry of Health, *Achieving Health for all People : A Framework for Public Health Action for the New Zealand Health Strategy*, Wellington, October 2003. <http://www.moh.govt.nz/moh.nsf/pagesmh/2733?Open>

- Build healthy communities and healthy environments;
- Make better use of research and evaluation in developing population health policy and practice;
- Achieve measurable progress on population health outcomes.

In 2004, the PHAC released *A Way Forward: Public Policy and the Economic Determinants of Health*<sup>67</sup> that presented evidence of wide disparities in health among the people of New Zealand. It noted that policy interventions to address disparities in health are more likely to be successful if they focus on the socio-economic health gradient and employ a range of strategies with a mix of universal and targeted approaches. Moreover, it pointed out that intersectoral collaboration is essential to address the fundamental determinants of ill-health, the effectiveness of which must be assessed routinely through Health Impact Assessments (HIA). Accordingly, it recommended a whole-of-government approach to coordinating and monitoring policy aimed at the reduction in health disparities, beginning with reduction of child poverty.

In 2006, PHAC reported again to the Minister of Health – *Health is Everyone's Business*.<sup>68</sup> It recommended again a whole-of-government approach to improving the health of New Zealanders, stating that central and local government agencies must accept responsibility for the health-related outcomes of their actions. It also recommended the use of HIAs and the development of intersectoral mechanisms to coordinate collaborative action effectively at the national, regional and local levels.

The PHAC also emphasized that HIAs provide a way of systematically embedding consideration of the impacts of public policies on health and health inequalities into the routines of policy development across sectors. It recommended that the HIA process be formally recognized in public health legislation.<sup>69 70</sup> The national government responded favourably to this recommendation in 2007 with the *Public Health Bill* which introduces into the public health legislation provisions relating to the use of health impact

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<sup>67</sup> Public Health Advisory Committee. *The Health of People and Communities – A Way Forward: Public Policy and the Economic Determinants of Health*, Report to the New Zealand Minister of Health, Wellington, October 2004. <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-public-policy-economic-determinants?Open>

<sup>68</sup> Public Health Advisory Committee, *Health is Everyone's Business – Working Together for Health and Wellbeing*, Report to the New Zealand Minister of Health, Wellington, June 2006. <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-health-is-everyones-business?Open>

<sup>69</sup> Public Health Advisory Committee, *Health Impact Assessment – A Report on the Work of the Public Health Advisory Committee*, Report to the New Zealand Minister of Health, Wellington, August 2006. <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-hia-advice-to-minister>

<sup>70</sup> It is interesting to note that PHAC prepared a guide to HIA in 2004 and released a companion document in 2007: *A Guide to Health Impact Assessment: A Policy Tool for New Zealand*, 2<sup>nd</sup> Edition, Wellington, June 2005, <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-guide-hia-2nd>; *An Idea Whose Time Has Come – New Opportunities for Health Impact Assessment in New Zealand Public Policy and Planning*, Wellington, February 2007, <http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-idea-whose-time-has-come>

assessments, provisions that are not mandatory but enabling, encouraging the use of HIA in the development of new policy proposals and/or in decision-making processes.<sup>71</sup>

#### 4.4 Monitoring and Evaluation

Health status indicators and health inequalities are well documented in New Zealand. The Director-General of Health and the Minister report annually to Parliament, the former on the state of the nation's health and the Minister on progress toward implementing the *New Zealand Health Strategy*. These annual reports are based, to some extent, on information provided by DHBs as part of their standard reporting requirements on health targets.<sup>72</sup>

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The Minister for Disability Issues is also required to report annually to Parliament on the implementation of the *New Zealand Disability Strategy*. In 2006-2007, a total of 41 government departments and agencies participated in the reporting process.<sup>73</sup>

In addition, the Minister responsible for Social Development and Employment publishes annually *The Social Report*. This presents a series of indicators of social and economic well-being covering 10 domains relevant to population health: health; knowledge and skills; paid work; economic standard of living; civil and political rights; cultural identity; leisure and recreation; physical environment; safety; and social connectedness.<sup>74</sup>

While some limitations in current data collection methods and the quality of the available data on health and social well-being, are acknowledged, the data clearly demonstrate health inequalities in the following dimensions: socioeconomic position; ethnic identity; geographic place of residence; and gender.<sup>75</sup> On this basis, over the years PHAC has continued to advocate a broad population health approach, one that extends well beyond the role of the health sector to encompass all key government departments and agencies.

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<sup>71</sup> New Zealand Ministry of Health, *Summary of the Public Health Bill*, December 2007. <http://www.moh.govt.nz/moh.nsf/indexmh/summary-public-health-bill>

<sup>72</sup> Since the establishment of the *New Zealand Health Strategy*, the Minister of Health has tabled 6 reports to Parliament. These are available at <http://www.moh.govt.nz/moh.nsf/indexmh/implementing-nz-health-strategy>

<sup>73</sup> The annual reports on implementation progress are prepared by the New Zealand Office of Disability Issues and are available at <http://www.odi.govt.nz/nzds/progress-reports/>.

<sup>74</sup> New Zealand Ministry of Social Development, *The Social Report 2007*, Wellington, 2007. <http://www.socialreport.msd.govt.nz/>

<sup>75</sup> New Zealand Ministry of Health, *Reducing Inequalities in Health*.

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### 5.1 Main Findings

- Norway is a healthy nation with a long standing tradition as a comprehensive welfare state. Its international ranking for life expectancy has slipped, however, in recent years, a decline attributed to insufficient progress made to improve lifestyle choices (e.g. tobacco use, nutrition and physical activity).
- Initially, population health initiatives focussed on quality of life, placing the primary responsibility on individuals to improve their health status. Later a policy shift resulted in more balance between the personal responsibility of the individual for health and the community's role in making health-related choices easier and more attractive. Moreover, it is only recently that disparities in health have been addressed explicitly; previously the focus was on reducing poverty within vulnerable groups.
- In 2007, the Norwegian government tabled in Parliament a *National Strategy to Reduce Social Inequalities in Health*, a White Paper considered as the health-related part of a broad governmental effort to promote greater equity in health. Its focus is on education, work and income and the department of health has overall responsibility for its implementation.
- The White Paper, along with other policies on *Work, Welfare and Inclusion*, the *Action Plan to Combat Poverty*, and *Early Intervention for Lifelong Learning*, constitute a comprehensive policy framework to improve the health of Norwegians and to reduce disparities. Population health is organized in a three tier system with the municipalities having the greatest role. Interdepartmental/intersectoral collaboration is an integral part of the population health approach in Norway.

### 5.2 Government Responsibility

Norway is a constitutional monarchy with a parliamentary form of government. Its Parliament, the Storting, consists of 165 representatives. There are three levels of government – national, the counties (19) and municipalities (434). Responsibility for population health is shared among all three levels. While the role of the national government is to determine broad population health policy, to prepare and oversee relevant legislation and to raise and allocate funds, the main responsibility for the provision of services and programs lies with the counties (regions) and the local municipalities.

- The **national government** is responsible for social insurance, social services and supports, specialized health services, specialized social services (institutions for child welfare and for drug/alcohol abuse), higher education/universities, labour market, refugees and immigrants, national road network, railways, agriculture, environment, justice, armed forces, and foreign policy.

- The **county authorities**' responsibilities include: dental care, secondary education, regional development, energy delivery, county roads and public transport, regional planning, business development, communications, and culture (museums, libraries, sports).
- The **municipalities** are responsible for health promotion, primary health care, care of the elderly, care of people with disabilities (including mental disabilities), nurseries/kindergartens, primary school education, social services (child welfare, social protection, drug/alcohol rehabilitation), water, local culture, local planning (land use) and infrastructure (local roads and harbours).<sup>76</sup>

Municipalities raise most of their revenues from personal and corporate income and property taxes (43%). They can also charge user fees for their services. Counties can collect only income tax (which generates 42% of their revenues). The right of municipalities and counties to levy taxes is limited by maximum rates set annually by the Storting (currently, the rate is 13.2% for municipalities and 2.6% for counties). Both the municipalities and the counties receive general grants and specific grants from the national government. Transfers from the national government account for 34% and 47% of counties' and municipalities' revenues respectively.<sup>77</sup>

### 5.3 Development of Population Health Policy

In 2007, the government tabled in the Storting a White Paper entitled *National Strategy to Reduce Social Inequalities in Health*.<sup>78</sup> This document proposes an innovative ten-year plan to develop a national, cross-sectoral holistic approach to population health, the culmination of a commitment to improve the health of the population initiated some 20 years ago.

In 2007, the government tabled in the Storting a White Paper entitled National Strategy to Reduce Social Inequalities in Health. This document proposes an innovative ten-year plan to develop a national, cross-sectoral holistic approach to population health, the culmination of a commitment to improve the health of the population initiated some 20 years ago.

In 1985, the Norwegian government endorsed the principles of the World Health Organization's Targets for Health for All and in 1987 published Health for All in Norway setting out 38 targets relating to lifestyle, health care and the environment. The same year, the government tabled a White Paper entitled *Health Policy Towards the Year 2000* that highlighted preventative health care as an important emerging field. This was followed in

<sup>76</sup> Ministry of Local Government and Regional Development, *Local Government in Norway*, Information Brochure, March 2007, <http://www.regjeringen.no/en/dep/krd/documents/handbooks/2004/Information-brochure-Local-government-in.html?id=88088>.

<sup>77</sup> *Ibid.*

<sup>78</sup> Norwegian Directorate for Health and Social Affairs, *National Strategy to Reduce Social Inequalities in Health*, Report No. 20 (2006-2007) to the Storting, 9 February 2007, <http://www.regjeringen.no/en/dep/hod/Documents/regpubl/stmeld/2006-2007/Report-No-20-2006-2007-to-the-Storting.html?id=466505&epslanguage=EN-GB>

1991 by *More Good Years for All* which again emphasized the prevention of disease and injury. A White Paper, *Challenges in Health Promotion and Preventive Efforts*, was published subsequently (1993) highlighting the importance of intersectoral action in population health, health promotion and disease prevention. The focus was on psychosocial problems, musculo-skeletal disorders, accidents and injuries, asthma, allergies, and indoor environmental disease.<sup>79</sup> In 1997, *Use for Everyone – On the Strengthening of Municipal Public Health Work* was tabled in the Storting.<sup>80</sup> This report promoted a municipal approach and made clear the responsibility of local authorities for population health.

In 2003, the national government released another White Paper entitled *Prescriptions for a Healthier Norway*.<sup>81</sup> The objective of the proposed policy was twofold: to improve healthy life expectancy for the population as a whole and to reduce health disparities among social classes, ethnic groups and genders. It identified four “prescriptions”: 1) make it easier for people to take responsibility for their own health; 2) build partnerships between the national government, county councils, municipalities, private voluntary organizations, universities, colleges, etc., to promote population health; 3) enhance prevention of disease and injury; and 4) increase new knowledge through research and the conduct of health impact assessments. Five specific areas of focus were highlighted: physical activity, nutrition, smoking, alcohol/drugs, and mental health.

Two years later, the government published its *Plan of Action to Reduce Social Inequalities in Health – The Challenge of the Gradient*.<sup>82</sup> This was the first stage in an effort to prepare the ground for a national, cross-sectoral strategy to reduce disparities in health. It pointed out that improving the health of the population and ensuring that good health is more equitably distributed requires broad-based, population-oriented strategies, stating plainly that it is not sufficient to base efforts on a high risk strategy that only meets the needs of the poorest people.

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<sup>79</sup> Iain K Crombie, Linda Irvine, Lawrence Elliott and Hilary Wallace, *Understanding Public Health Policy – Learning from International Comparisons*, Public Health Institute of Scotland, September 2003, <http://www.healthscotland.com/documents/992.aspx>.

<sup>80</sup> Siri Petrine Hole, *Use for Everyone – On the Strengthening of Municipal Public Health Work*, Short Version of NOU 1998: 18 (I-0949 E), Ministry of Health and Care Services, Norway, May 1997, [http://www.regjeringen.no/en/dep/hod/Documents/rapporter\\_planer/rapporter/2000/Use-for-Everyone/1.html?id=420063](http://www.regjeringen.no/en/dep/hod/Documents/rapporter_planer/rapporter/2000/Use-for-Everyone/1.html?id=420063).

<sup>81</sup> Ministry of Social Affairs, *Prescriptions for a Healthier Norway – A Broad Policy for Public Health*, Norwegian Government, 2003.

<sup>82</sup> Norwegian Directorate for Health and Social Affairs, *The Challenge of the Gradient – Plan of Action to Reduce Social Inequalities in Health*, June 2006, [http://www.shdir.no/publikasjoner/rapporter/the\\_challenge\\_of\\_the\\_gradient\\_19679](http://www.shdir.no/publikasjoner/rapporter/the_challenge_of_the_gradient_19679)

This was followed in 2007 with the *National Strategy to Reduce Social Inequalities in Health*. The current White Paper deals with the health-related component of a broad governmental effort aimed at greater equity in health with a focus on education, occupation and income. Four areas claim priority:

- reduce the social inequalities that contribute to inequalities in health (e.g., early childhood development, fair income distribution and equal opportunities for education and work). The government intends, for example, to monitor trends in income inequality and ensure a fairer distribution of income while maintaining the same aggregate in taxes and duties.
- reduce social inequalities in health behaviour (diet, physical activity, smoking, and other health behaviours) and the use of health services. Examples of initiatives include: health information and awareness campaigns, fresh fruits and vegetables and daily physical activity in schools, regulating advertising of unhealthy foods, ban smoking in bars, cafés and restaurants, restrictive alcohol policies, taxing unhealthy foods (sweet drinks), while de-taxing healthy foods (bottled water and juice), and reduced user charges for health services.
- implement targeted initiatives to promote social inclusion (to eliminate homelessness, enable more people to work, reduce the number of adults who leave school with poor basic skills, etc.).
- develop knowledge and cross-sectoral assessment tools. The government will monitor developments in the four priority areas by means of a new review and reporting system that provides a systematic, regularly updated overview of progress toward the reduction of social inequalities in health.

Other elements of the government's comprehensive strategy were enunciated in a series of reports to the Storting including: *Work, Welfare and Inclusion*,<sup>83</sup> *Action Plan to Combat Poverty*,<sup>84</sup> and *Early Intervention for Lifelong Learning*.

#### **5.4 Implementation and Monitoring**

The Ministry of Health has overall responsibility for the *National Strategy to Reduce Social Inequalities in Health*. Responsibility for monitoring and reporting annually on population health indicators has been given to the Norwegian Institute of Public Health while the Research Council of Norway has the mandate of strengthening research in population health. Many other government departments are involved in this comprehensive approach to population health, including the Ministry of Children and

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<sup>83</sup> Royal Norwegian Ministry of Labour and Social Inclusion, *Work, Welfare and Inclusion*, Report to the Storting No. 9 (2006–2007), November 2006, [http://www.regjeringen.no/Upload/AID/vedlegg/stmeld\\_9\\_2006\\_english.pdf](http://www.regjeringen.no/Upload/AID/vedlegg/stmeld_9_2006_english.pdf)

<sup>84</sup> Ministry of Foreign Affairs, *Norway's Action Plan 2015 for Combating Poverty in the South – Executive Summary*, March 2002.

Family Affairs, the Ministry of Education, Research and Church Affairs, the Ministry of Transport and Communication.

Municipalities and counties, through their delivery of numerous programs and services, are key players under the new policy. The national government awards matching grants to those counties and municipalities that form partnerships to conduct their population health work and that imbed population health firmly in their planning systems.

## **CHAPTER 6: Sweden**

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### **6.1 Main Findings**

- Sweden has a comprehensive, “whole-of-government” approach to population health. Its population health policy is enshrined in legislation – the *Public Health Objectives Act* of 2003 – Sweden’s first formal population health policy statement and one of the world’s first explicit strategies employing a determinants of health approach.
- The Act enumerates 11 objectives for population health and sets specific, measurable targets for each one. Meeting these 11 objectives involve some 50 government departments and agencies.
- The Act does not require government to restructure departments and agencies, but rather to achieve better coordination and greater efficiency among them to improve population health and reduce health disparities.
- The Minister for Public Health and Social Services heads a special national population health executive established to facilitate intersectoral collaboration.
- The Swedish National Institute of Public Health is required to monitor and report every four years on progress made toward the 11 objectives.
- It is too early to assess the impact of the Act of 2003, but clearly, it reflects a strong commitment, at the highest political levels, to an equity-oriented, intersectoral approach to population health.

### **6.2 Government Responsibility**

Sweden is a constitutional monarchy. The chief of state and prime minister is elected by the Riksdag, the Swedish Parliament. Although Sweden has a unitary political system, it also is, in practice, highly decentralized – so much so that it resembles a federal system in many ways. As in Canada, population health in Sweden is a shared responsibility between the national and sub-national governments which, in Sweden, are 21 county councils and 290 municipalities. While the national government provides strong

national leadership and priority setting through legislation and regulations, county councils and municipalities play a strong role in the delivery of programs and services.

- The **national government** is responsible for public policy matters and legislation related to population health, including: health care and social affairs; income support; education; research; culture; agriculture; food and consumer affairs; employment; communications; sustainable development; and justice (including integration and gender equality).<sup>85</sup> In addition, the national government transfers funds to the county councils and municipalities to support population health. Some of these transfers are intended for general use, while others are for purposes specified by the national government.
- The **county councils** have full responsibility, subject to national legislation, for the management and delivery of programs and services to their residents. Key responsibilities include: primary care, hospital care, prescription drugs, dental care; public health, health promotion; disease prevention; public transport (in cooperation with municipalities); regional development; support for industry and commerce; culture; and tourism. County councils generate some 70% of their revenue from taxation applied to their residents; the remaining 30% is obtained through transfer payments from the national government and from fees charged for services and programs. County councils are made up of members elected every four years and constitute the most authoritative regional decision-making bodies; they administer matters that are too costly for the municipalities. The national government scrutinizes and supports the work of county councils through a system of supervisory authorities.<sup>86</sup>
- **Municipalities** are responsible for governing and managing matters at a local level including: pre-schools, elementary and secondary schools; care of the elderly; assistance to disabled individuals; rescue services; water and waste; public libraries; public transport (in cooperation with county councils). They also grant various types of licences, such as planning permission or licences to sell alcohol on premises. In addition, they play an active role in promoting tourism, culture and entrepreneurship. The municipal councils are the highest decision-making body at the municipal level and are made up of politicians elected every four years. Like the county councils, municipalities can levy taxes on their residents that account for around 70% of a municipality's income; the remaining 30% is national government grants or direct fee-for-service charges. As with county councils, the national government scrutinizes and supports the municipalities work through a system of supervisory authorities.<sup>87</sup>

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<sup>85</sup> Government of Sweden, *Facts & Figures – Swedish Government Offices: Yearbook 2006*, 20 June 2007, <http://www.sweden.gov.se/sb/d/2013/a/84433>.

<sup>86</sup> Swedish Administrative Development Agency, *How the Public Sector Works*, 2006, [http://www.sverige.se/sverige/templates/pagelist\\_\\_\\_9954.aspx](http://www.sverige.se/sverige/templates/pagelist___9954.aspx).

<sup>87</sup> *Ibid.*

### 6.3 Development of Population Health Policy

In April 2003, the Riksdag passed a government-sponsored bill, the *Public Health Objectives Act*, which established a national comprehensive policy on population health. This constituted one of the world's first formalized "whole-of-government" approach to address the determinants of health.<sup>88</sup> This approach had been developed step by step over the previous 20 years.

In April 2003, the Swedish Parliament passed a government-sponsored bill, the Public Health Objectives Act, which established a national comprehensive policy on population health. This constituted one of the world's first formalized "whole-of-government" approach to address the determinants of health.

In the early 1980s, increasing political and scientific interest developed related to observed disparities in health status and their causes. The major source of inspiration was the United Kingdom's Black Report<sup>89</sup>, which revealed substantial inequalities in health by occupational class, employment status, gender, area of residence, ethnic origin and housing tenure. These findings led the government of Sweden to study health disparities more systematically and a cross-national comparison showed that, while health inequalities also existed in Sweden, they appeared smaller than in the United Kingdom. Moreover, the explanations behind the British disparities were not convincing in the Swedish context, given its universal welfare system, low level of poverty, high standard of housing and low unemployment rate.<sup>90</sup>

The Swedish government was eager to learn more about the causes of these disparities and in 1987, established an advisory body – the Public Health Group – with the mandate to examine this issue. In 1991 this group devised a comprehensive strategy for population health that did not lead, however, to a political platform for implementation. The Public Health Group's recommendation did lead, however, to establishment of the National Institute of Public Health in 1992, an organization that initiated a number of activities for health promotion and disease prevention at the national, county council, and municipal levels.

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<sup>88</sup> Taylor & Francis Health Sciences, Chapter 2: The Public Health Objective Bill (Govt. Bill 2002/03:35) – Extended Summary, *Scandinavian Journal of Public Health*, 32 (Supplement 64), 2004, pp. 18-59, [http://www.fhi.se/upload/ar2005/rapporter/supplement\\_2objectivebill0502.pdf](http://www.fhi.se/upload/ar2005/rapporter/supplement_2objectivebill0502.pdf).

<sup>89</sup> *Inequalities in Health: Report of a Research Working Group* (Sir Douglas Black, Chair), United Kingdom Department of Health and Social Security, 1980. <http://www.sochealth.co.uk/history/black.htm>

<sup>90</sup> Piroška Östlin and Finn Diderichsen, *Equity-Oriented National Strategy for Public Health in Sweden*, European Centre for Health Policy, World Health Organization, 2001, <http://www.who.int/hia/examples/development/whohia036/en/index.html>.

In 1997, the government appointed a National Public Health Commission with the mandate of defining national objectives on population health and strategies to achieve them. The Commission consisted of representatives of all seven political parties in Parliament and a number of scientific experts and advisers from national authorities, universities, trade unions and nongovernmental organizations.<sup>91</sup> Its final

report, *Health on Equal Terms – National Goals for Public Health*, submitted in October 2000, contained 18 health policy objectives together with specific indicators to measure success in their implementation; the National Institute of Public Health was to be given the role of monitoring progress.

The National Institute of Public Health has the responsibility to monitor and report on progress made under the new population health policy. All the relevant government agencies must participate actively and assist with data collection, analysis, assessment and reporting and also pay their share of the costs.

In response, the government in December, 2002, tabled draft legislation covering 11 general objectives for population health, based to a large extent on those set by the National Public Health Commission. The Riksdag passed the *Public Health Objectives Act* in April 2003. Its goal was twofold: to create

social conditions which ensure good health for the entire population and to reduce the disparities in health among different population groups. This reflected the view of the national government that population health is very important for social development and that efforts to improve it should be an integral part of the work done to achieve sustainable growth, good social welfare and ecological sustainability throughout Sweden.

The goal of the 2003 Public Health Objectives Act was twofold: to create social conditions which ensure good health for the entire population and to reduce the disparities in health among different population groups.

The Act's 11 objectives are: participation and influence in society; economic and social security; secure and favourable conditions during childhood and adolescence; healthier working life; healthy and safe environments and products; health and medical care that more actively promotes good health; effective protection against communicable diseases; safe sexuality and good reproductive health; increased physical activity; good eating habits and safe food; reduced use of tobacco and

alcohol, a society free from illicit drugs and doping, and reduction in the harmful effects of excessive gambling. The first six objectives relate to structural factors, conditions in society and surroundings that can be influenced by moulding public opinion and by taking political decisions on different levels. The last five concern individual lifestyles which can also be influenced by the social environment.<sup>92</sup>

The Public Health Objectives Act did not require government to restructure its departments and agencies, but rather to achieve better coordination and greater efficiency among its several programs designed to improve population health.

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<sup>91</sup> *Ibid.*

<sup>92</sup> Swedish National Institute of Public Health, *Sweden's New Public Health Policy – National Public Health Objectives for Sweden*, 2003, [http://www.fhi.se/upload/PDF/2004/English/roll\\_eng.pdf](http://www.fhi.se/upload/PDF/2004/English/roll_eng.pdf).

Specific, measurable targets were established for each of the 11 objectives which involve some 50 government departments and agencies. The National Institute of Public Health monitors these national objectives and reports every fourth year on the progress toward achieving the 11 goals.

Note that these objectives were not necessarily new. In fact, several objectives well aligned with the goals of *Public Health Objectives Act* already existed in various public policy fields. When the Act was passed, it was the government's intention to adopt supplementary targets as needed. Moreover, the legislation did not require government to restructure its departments and agencies, but rather to achieve better coordination and greater efficiency among its several programs designed to improve population health.

The Public Health Objectives Act requires that, when departments draft proposals, the consequences for population health must be taken into consideration regardless of the policy area involved. Similarly, government departments and agencies must also consider the population health consequences of their every action.

It has been argued that the factors that facilitated the development and enactment of the national population health policy in Sweden included: a history of social democratic government; a strong relationship with the labour movement; a highly developed welfare system; a call from municipalities for national goals; involvement of politicians from across the political spectrum; strong civic literacy; a highly democratic process; a political commitment to equity; a high level oversight body; intersectoral goal setting; a strong evidence base; and, a preference for collective, systemic approaches.<sup>93</sup>

Relative to other comparable countries, Sweden developed the basis for a coherent national population health policy at a relatively early stage. In the longer term, the fact that the international community and other countries are now increasingly reformulating public policies based on the determinants of health will be increasingly significant and will no doubt contribute to the legitimacy of Sweden's approach.

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<sup>93</sup> Public Health Agency of Canada, *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health*, 2007, [http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/index\\_e.html](http://www.phac-aspc.gc.ca/publicat/2007/cro-sec/index_e.html).

## 6.4 Implementation of Population Health Policy

Political responsibility in Sweden for implementing its population health policy has been divided among different sectors in all levels of government, national departments and agencies, county councils and municipalities. The responsibility also extends to non-governmental organizations, trade unions and universities. It has been argued that the breadth of this approach is unique and offers a model for governing intersectoral action for population health.<sup>94</sup>

Political responsibility in Sweden for implementing its population health policy has been divided among different sectors in all levels of government, national departments and agencies, county councils and municipalities. The responsibility also extends to non-governmental organizations, trade unions and universities. It has been argued that the breadth of this approach is unique and offers a model for governing intersectoral action for population health.

As mentioned previously, the *Public Health Objectives Act* does not require change in the distribution of responsibilities among departments and agencies with responsibilities and tasks related to the 11 objectives. It does require, however, that when departments draft proposals, the consequences for population health must be taken into consideration regardless of the policy area involved. Similarly, government departments and agencies must also consider the population health consequences of their every action. The National Institute of Public Health has the special responsibility to coordinate this work and supports the departments and agencies in their efforts.

The Act involves a large number of policy areas and, as a result, political responsibility is divided among different sectors and different levels in society. The Swedish government has acknowledged that some form of intersectoral political control should be exercised over population health policy and, to achieve this, has established a special national population health executive headed by the Minister for Public Health and Social Services. This executive, in which Ministers from other sectors also participate, oversees the ongoing implementation of population health goals that fall outside the health sector.<sup>95</sup>

## 6.5 Monitoring and Evaluation of Legislation

To repeat, the National Institute of Public Health has the responsibility to monitor and report on progress made under the new population health policy. The Institute has worked in collaboration with the involved government departments and agencies, the Swedish Association of Local Authorities (representing municipalities) and the Federation of Swedish County Councils to determine which indicators and what statistics best measure the link between the determinants and their effects on the health of the population. All the relevant government agencies must participate actively and assist with data collection, analysis, assessment and reporting and also pay their share of the costs.

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<sup>94</sup> *Ibid.*, p. 22.

<sup>95</sup> *Ibid.*

The Institute holds meetings with government departments and agencies, while its support to the municipalities and county councils has primarily been in the form of its participation in seminars, local and regional conferences and visits to municipalities as well as in the production of knowledge reviews and reports. This support has been provided with a view to helping these regional and local bodies to develop methods to assess the health consequences of activities within their own areas of activity. The Institute has also compiled what are known as the Basic Public Health Statistics for Local Authorities (BPHS), to help the municipalities plan and monitor their work in population health. The BPHS database contains population health-related data on all municipalities and the districts of the three main Swedish cities.

The National Institute of Public Health released its first evaluation report of the Public Health Objectives Act in 2005<sup>96</sup> indicating that the new policy seems to have a positive impact both on the general health of the population and on health disparities among different social groups. Because it is not yet clear, however, how well the policy addresses the needs of specific groups, the Institute has identified the need for more equity-sensitive indicators on health determinants that will demonstrate the effect of the policies on different subgroups; this will be an important next step in tackling health inequalities. It will take place in collaboration with Statistics Sweden, the National Board of Welfare and Health, and the Stockholm Centre for Health Equity Studies.<sup>97</sup>

## CHAPTER 7: Comparative Analysis

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### 7.1 Introduction

The preceding chapters have described how population health policy has been developed, implemented and evaluated in selected countries. This chapter summarizes the lessons to be learned from reviewing and comparing these countries' policies and incorporating information gathered from the literature.<sup>98</sup>

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<sup>96</sup> Swedish National Institute of Public Health, *The 2005 Public Health Policy Report – Summary*, October 2005, <http://www.fhi.se/upload/ar2005/rapporter/r200544fhprsummary0511.pdf>.

<sup>97</sup> Caroline Costongs, Ingrid Stegeman, Sara Bensaude De Castro Freire and Simone Weyers, *Closing the Gap – Strategies for Action to Tackle Health Inequalities: Taking Action on Health Equity*, European Commission, May 2007, <http://www.health-inequalities.eu/?uid=2302287e264715c480d6449302b63587&id=Seite872>.

<sup>98</sup> More precisely, the literature reviewed include the following documents:

- Caroline Costongs, Sara Bensaude De Castro Freire and Simone Weyers, *Taking Action on Health Equity – Closing the Gap: Strategies for Action to Tackle Health Inequalities*, The European Commission, May 2007, <http://www.health-inequalities.eu/?uid=e786a37d3bb9fffc3aa378b481aaa3a&id=Seite872>
- Ken Judge, Stephen Platt, Caroline Costongs and Kasia Jurczak, *Health Inequalities: a Challenge for Europe*, European Commission, October 2005, [http://www.eurohealthnet.eu/index.php?option=com\\_content&task=blogcategory&id=101&Itemid=137](http://www.eurohealthnet.eu/index.php?option=com_content&task=blogcategory&id=101&Itemid=137)
- Iain K. Crombie, Linda Irvine, Lawrence Elliot and Hilary Wallace, *Policies to Reduce Inequalities in Health in 13 Countries*, Report no. 3: Review Group on International Public Health Policy, Scotland, March 2005. <http://www.healthscotland.com/documents/1094.aspx>

## 7.2 Shift in Public Policy Thinking and Action

Publication of the Black Report (1980) and the WHO Target for Health for All (1981), landmark documents, signalled a shift in the way public policymakers thought about and took action related to health. This shift took the concept of health beyond the treatment of disease to the prevention of illness and ultimately to what we now know as “population health”. Today, it is commonly recognized that health is influenced by a wide range of social, economic and environmental factors and that significant disparities in health are avoidable and as such, are unjust and unacceptable. Recent improvements in health have tended not to be equally distributed throughout the population; countries have identified increases in those disparities and worry that the gap between the most advantaged and the most deprived among their populations may widen even further as trends in the underlying socio-economic determinants of health continue.

Therefore strategies focusing on health disparities have been developed in a number of countries; England, Finland and New Zealand provide examples. But there have been substantial lags between the initial documentation of health disparities, the formulation of national policies to reduce them, and progress toward their reduction. Experts

There have been substantial lags between the initial documentation of health disparities, the formulation of national policies to reduce them, and progress toward their reduction. Experts in the field argue that it is time to move from describing the problem to implementing effective, systematic strategies and interventions to reduce health disparities.

in the field argue that it is time to move from describing the problem to implementing effective, systematic strategies and interventions to reduce health disparities.

Experts agree that there is no single right way to address health determinants and reduce health disparities. Although the governments of all the countries profiled subscribe to the equity principles and values underpinning health and express their intention to foster population health and reduce health disparities within

Recent improvements in health have tended not to be equally distributed throughout the population; countries have identified increases in those disparities and worry that the gap between the most advantaged and the most deprived among their populations may widen even further as trends in the underlying socio-economic determinants of health continue.

their jurisdiction, they differ in their approaches to the problem. Each country’s approach to population health depends on the historical development and current alignment of its political, economic, administrative and social structures, all of which affect both the kind

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- Commission on Social Determinants of Health, *Action on the Social Determinants of Health: Learning From Previous Experiences*, World Health Organization, March 2005. [http://www.who.int/social\\_determinants/resources/latest\\_publications/en/](http://www.who.int/social_determinants/resources/latest_publications/en/)
  - Iain L. Crombie, Linda Irvine, Lawrence Elliott and Hilary Wallace, *Closing the Health Inequalities Gap: An International Perspective*, World Health Organization, 2005. [http://www.who.int/social\\_determinants/resources/en/](http://www.who.int/social_determinants/resources/en/)
  - Iain K. Crombie, Linda Irvine, Lawrence Elliott and Hilary Wallace, *Understanding Public Health Policy – Learning from International Comparisons*, A report to NHS Health Scotland, September 2003. <http://www.healthscotland.com/documents/992.aspx>
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and the scope of actions that can be taken. Therefore, the most effective policies and strategies differ from one jurisdiction to the other.

### **7.3 Goals, Objectives and Targets**

Health goals, objectives and targets are essential components of population health policies. A set of goals, objectives and targets provides a useful framework to determine what data to collect, which indicators to measure, establish benchmarks, identify the areas on which to focus attention, and to monitor progress. Each country will differ, however, in the specification and number of goals, objectives and targets used.

In the countries we have profiled, some goals and targets focus on specific health outcomes dealing with, for example, mortality, morbidity and particular symptoms and/or conditions. The relative availability of relevant data and their obvious association with health make their choice straightforward. Other goals and targets selected deal with healthy behaviours or healthy environments, while a few focus on social supports, all of which require thinking beyond the superficial to understand fully their impact on health, both of individuals and of the population. As for disparities in health status, only few countries, like England and Sweden, have set targets aimed at reducing such disparities in specified geographical locations, or across employment status, gender, or ethnic lines.

The health status of Aboriginal populations tends to be markedly worse than the rest of the population. Australia and New Zealand pay specific attention to the health of Aboriginal peoples. New Zealand's Maori Health Strategy, for example, seeks to reduce health disparities between Maori and non-Maori peoples by taking a comprehensive approach to improving the determinants of health and addressing systemic barriers that discriminate against Aboriginals.

### **7.4 Monitoring, Evaluation and Research**

A challenge all countries face is the shortage of evidence on the effectiveness of interventions to reduce disparities in health. In recognition, several governments have established national research programs; national institutes of public health monitor and report on population health in Norway, Sweden and Finland. Experts agree that it is essential to monitor and evaluate policies and strategies on a continual basis in order to generate evidence relating to the effectiveness of different approaches to reducing health disparities and enhance the health of the population.

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## 7.5 Role of the Health Sector and Others

The health sector has a crucial leadership role to play in recruiting and working in partnership with other actors from other sectors responsible for policies and programs with direct or indirect impacts on population health and health disparities.

The backing of finance departments is of particular importance to ensuring not only that adequate funds are available to support the implementation of strategies, but also in ensuring the compliance of other government departments with any health-based initiatives. When a Health Department seeks changes in other departments' policies or programs in order to improve health outcomes, resistance to "health imperialism" is frequently encountered. But when a central agency like Finance is taking the lead genuine cooperation is more easily forthcoming. In England, the role of the Treasury and its use of a cross-cutting spending review was seen as key to the implementation across government agencies and departments of policies to reduce health disparities.

The backing of finance departments is of particular importance to ensuring not only that adequate funds are available to support the implementation of strategies, but also in ensuring the compliance of other government departments with any health-based initiatives. In England, the role of the Treasury and its use of a cross-cutting spending review was seen as key to the implementation across government agencies and departments of policies to reduce health disparities.

## 7.6 Health Impact Assessment (HIA)

HIA practice is well developed in many of the countries covered in this review. HIAs are performed for a variety of reasons, including for example, addressing both the determinants of and inequalities in health, assessing the role that non-health sector policies have in promoting and protecting good health, and ensuring that health-related considerations are built into government-wide policy making. In some countries, like Sweden and New Zealand, public health legislation has been employed to embed HIA as an integral component of government processes. The UK government has often indicated its support of HIA, but to date there is no statutory requirement to apply HIA in England.

HIAs are performed for a variety of reasons, including for example, addressing both the determinants of and inequalities in health, assessing the role that non-health sector policies have in promoting and protecting good health, and ensuring that health-related considerations are built into government-wide policy making.

Our review suggests that HIA is facilitated when assistance in data collection, analysis and assessment is provided to national departments and agencies, local governments and organizations. The increasing demand for support in carrying out HIAs by other sectors, however, has created a need for skills development within health units to

enable them to respond effectively; lack of capacity and resources is frequently cited as a barrier to undertaking HIAs.

## 7.7 Regionalization

Some jurisdictions, like England, New Zealand and Sweden, have devolved the primary responsibility to reduce health inequalities to regional and local authorities, often putting them in charge of developing and implementing action plans to reduce health disparities. National standards and strategies are needed, however, to complement planning and program implementation at the regional and local levels and to provide authorities and stakeholders at all levels with the support needed to develop their capacities to address health inequalities in an effective and sustained manner.

## 7.8 Intersectoral Approach

A broadly recognized challenge for the development and implementation of population health policy is the active involvement of all relevant government departments. Ideally, a broad inter-departmental approach should be made simultaneously in a coordinated fashion to ensure that policy

A broadly recognized challenge for the development and implementation of population health policy is the active involvement of all relevant government departments. Ideally, a broad inter-departmental approach should be made simultaneously in a coordinated fashion to ensure that policy initiatives are implemented concurrently and act synergistically where and whenever possible.

initiatives are implemented concurrently and act synergistically where and whenever possible. This may sound self-evident and simple to do, but practically it is logistically difficult. With the notable exceptions of England (Cabinet Subcommittee) and Sweden (National Executive for Public Health) very few successful mechanisms to achieve interdepartmental coordination have been invented.

Intersectoral collaboration is further complicated in federal systems such as those in Australia and Canada, where different levels of government share closely interdependent but different responsibilities for the health of the population. Devolving responsibilities to regional or local authorities, as in Finland, where municipalities deliver social welfare, health care, education and cultural programming, compounds the challenge. Mechanisms for the effective coordination of intersectoral action at the local authority and community level have yet to be developed.

Another challenge for population health policy is to mobilize, in addition to government departments, the wide range of actors who have a direct influence on the lives and health of people in their widely differing circumstances – those in schools, the primary health care, the voluntary sector, anti-poverty groups, NGO's, employers, etc.; it is a long list. An inclusive policy development process helped ensure that opposition parties, the public and other stakeholders took ownership of Sweden's new approach through its research, consultation and implementation stages.

## 7.9 Government Intervention

Three different approaches have been taken by governments when tackling health disparities. The first is a comprehensive or “whole-of-government” policy as adopted in England. This addresses both the upstream determinants of health (e.g., income, education and employment) and those downstream (e.g. nutrition, exercise and smoking), while also targeting specific groups (defined by age, gender, income level and ethnicity). A high-level Cabinet committee oversees the implementation of population health policy and ministerial funding allocation formulas determine the allocation of resources among the various programs that focus on reducing health disparities.

In the second approach, population health policy emanates from the health department as in Finland, New Zealand, Norway and Sweden, where there are also separate policies on poverty, social inclusion and social justice, all of which relate directly to underlying causes of poor health (low income and unemployment, housing and homelessness, and social exclusion). Experts acknowledge that there is a need to integrate policies in all these areas. Unfortunately, the link between population health policy and poverty and social inclusion/justice policy is not as widely recognized as it should be.

In the third government approach, various interventions are implemented independently to reduce improve population health and reduce health disparities; there is no over-arching action plan. In this case, as in Australia, population health strategies, addressing disparities in health for specific topics (such as smoking and nutrition) or specific groups in society (such as the most disadvantaged), are implemented in many departments but with little or no coordination.

Although experts acknowledge that there is no single right way to reduce health disparities, they all agree that the more focused and integrated a pan-government strategy for action, the greater the probability that health outcomes will change in the desired direction. They also believe that policies to reduce health disparities and their implementation are likely to be more successful when coordinated strategically – in accordance with a clear action plan focused on specific targets within realistic timeframes – which can be implemented and monitored

## 7.10 Concluding Remarks

As shown with this review, population health policy in several countries to which Canada is often compared is in an active stage of development. Potentially, this offers us very valuable evidence-based information on public policy. It also suggests that there is momentum upon which to build to develop and implement made-in-Canada approaches to population health. A number of barriers and challenges must, however, be overcome.

There is momentum upon which to build to develop and implement made-in-Canada approaches to population health.

A major difficulty affecting the implementation of population health policy is that responsibility for health is divided among governments, in our case between the federal government, the provincial and territorial governments, and municipal governments, as well as a myriad of private stakeholders, all of whom carry different levels of responsibility for some of the many and varied determinants of health. This requires the establishment of effective interdepartmental, intergovernmental and intersectoral mechanisms that to date have eluded discovery in Canada.

Political and societal commitment to tackling health disparities is essential. The broad public must perceive health disparities as a serious, even desperate problem and finding solutions to it must become imperative to politicians. It is important to use clear, easily understandable language to raise awareness and understanding in the public and to convince all relevant stakeholders of the need to address health disparities as the first significant step on the road to optimizing the health of the population.

Another challenge lies in the fact that interventions over the long-term are needed before changes in many of the fundamental determinants – education, early childhood education, income supports, public housing, etc. – before measurable improvements in health and reduction in health disparities take place. The timelines

Different approaches have been taken by governments when tackling health disparities. There is however no single right way to reduce health disparities, and experts agree that the more focused and integrated a pan-government strategy for action, the greater the probability that health outcomes will change in the desired direction.

extend well beyond the political horizons of even the most far-sighted of governments. It is difficult to reorganize or reformulate population health policy in successive governments. Political consensus is crucial to the development of long-term policies and strategies for health.

Finally, once developed there must be sufficient financial and person-power capacity in place to implement population health policy at all targeted levels. Long-term interventions require sustained investment. Some realistic experts contend that it may not be feasible to develop and implement a coordinated set of policies affecting the health of the population simultaneously and argue that a step-by-step approach may be the best we can do.

## APPENDIX 1 – WITNESS LIST

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
<b>39<sup>th</sup> Parliament 1<sup>st</sup> Session</b>			
World Health Organization Commission on the Social Determinants of Health	The Honourable Monique Bégin, P.C., Commissioner	22-02-2007	1
Institute of Population Health	Ronald Labonté, Canada Research Chair in Globalization and Health Equity	28-02-2007	1
Provincial Health Services Authority, B.C.	Dr. John Millar, Executive Director, Population Health Surveillance and Disease Control	28-02-2007	1
School of Health Policy and Management - York University	Dennis Raphael, Professor	28-02-2007	1
Public Health Agency of Canada	Jim Ball, Director, Development and Partnerships Division, Strategic Policy Directorate, Strategic Policy, Communications and Corporate Services Branch	21-03-2007	2
Kunin-Lunenfield Applied Research Centre	Sholom Glouberman, Associate Scientist	21-03-2007	2
Public Health Agency of Canada	Maura Ricketts, Acting Director General, Office of Public Health Practice, Public Health Practice and Regional Operations Branch	21-03-2007	2
Public Health Agency of Canada	Dr. Sylvie Stachenko, Deputy Chief Public Officer, Health Promotion and Chronic Disease Prevention	21-03-2007	2
Statistics Canada	Michael Wolfson, Assistant Chief Statistician, Analysis and Development	21-03-2007	2

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
Institute of Population and Public Health	Dr. John Frank, Scientific Director of the Canadian Institutes of Health Research	28-03-2007	2
Global Health and Social Policy	Dr. Jody Heymann, Canada Research Chair in Global Health and Social Policy	28-03-2007	2
McGill University	Dr. John Lynch, Canada Research Chair in Population Health	28-03-2007	2
Public Health Agency of Canada	Jim Ball, Director, Development and Partnership Division, Strategic Policy Directorate	25-04-2007	3
Indian and Northern Affairs Canada	Marc Brooks, Director General, Community Development Branch, Socio-economic Policy and Regional Operations sector	25-04-2007	3
Centre for Aboriginal Health Research, University of Manitoba	John O'Neil, Professor and Director	25-04-2007	3
Health Canada	Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch	25-04-2007	3
Institute of Aboriginal People's Health (IAPH) for the Canadian Institutes of Health Research (CIHR)	Dr Jeff Reading, directeur scientifique	25-04-2007	3
Research Faculty/Saskatchewan Population Health and Evaluation Research Unit	Sylvia Abonyi, Canada Research Chair in Aboriginal Health	02-05-2007	3
National Aboriginal Health Organization (NAHO)	Mark Buell, Manager, Policy and Communication Unit	02-05-2007	3

<b>ORGANIZATION</b>	<b>NAME, TITLE</b>	<b>DATE OF APPEARANCE</b>	<b>ISSUE NO.</b>
University of British Columbia - Department of Psychology	Dr. Michael J. Chandler, University of British Columbia Professor and Distinguished Canadian Institutes for Health Research (CIHR) and Michael Smith Foundation for Health Research (MSFHR) Investigator	02-05-2007	3
National Aboriginal Health Organization (NAHO)	Carole L. Lafontaine, Acting Chief Executive Officer	02-05-2007	3
Toronto University	Dr. Kue Young, Professor, Department of Public Health Services	02-05-2007	3
Observatory on Ageing and Society (OAS)	Dr. André Davignon, Founder	16-05-2007	4
Nova Scotia Department of Health	Valerie J. White, directrice exécutive, secrétariat des aînés	16-05-2007	4
Public Health Agency of Canada - Division of Ageing and Seniors	Margaret Gillis, Director	16-05-2007	4
Canadian Association on Gerontology	Mark Rosenberg, Professor Queen's Université	16-05-2007	4
The CHILD Project	Dr. Hillel Goelman, Director, Senior Scholar, Human Early Learning Partnership (HELP)	30-05-2007	4
Canadian Institutes of Health Research	Dr. Michael Kramer, Scientific Director, Institute of Human Development, Child and Youth Health	30-05-2007	4
Council of Early Child Development	Stuart Shankar, Professor, President	30-05-2007	4
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba	31-05-2007	4

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Métis National Council	Rosemarie McPherson, National Spokesperson for Women of the Métis Nation	31-05-2007	4
BC Ministry of Health	Dr. Evan Adams Aboriginal Health Physician Advisor, Office of the Provincial Health Officer	01-06-2007	5
Manitoba Métis Foundation	Dr. Judy Bartlett, Director of Health and Wellness Department and Associate Professor, Department of Community Health Science, Faculty of Medicine, University of Manitoba	01-06-2007	5
Institute of Aboriginal Peoples' Health	Laura Commanda, Assistant Director, Partnerships, Knowledge Translation and International Relations	01-06-2007	5
Pauktuutit Inuit Women of Canada	Jennifer Dickson, Executive Director	01-06-2007	5
Native Women's Association of Canada	Claudette Dumont-Smith, Senior Health Advisor	01-06-2007	5
Indigenous People's Health Research Centre	Willie Ermine, Professor, Writer - Ethicist	01-06-2007	5
Inuit Tapiriit Kanatami	Anna Fowler, Project Coordinator, Department of Health	01-06-2007	5
National Association of Friendship Centres	Alfred J. Guay, Policy Analyst	01-06-2007	5
Assembly of First Nations	Valerie Gideon, Director of Health and Social Development	01-06-2007	5

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Toronto University	Chandrakant P. Shah, professeur émérite	01-06-2007	5
Congress of Aboriginal Peoples	Erin Wolski, coordonnatrice des programmes de politique sanitaire	01-06-2007	5
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Ministry of Health and Social Affairs	Irene Nilsson-Carlsson, Deputy Director General, Public Health Division	22-11-2007	1
Swedish National Institute of Public Health	Dr. Gunnar Agren, Director General	22-11-2007	1
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Ontario Ministry of Health Promotion	Pegeen Walsh, Director, Chronic Disease Prevention	06-02-2008	3
Toronto Cental Local Health Integration Network	Laura Pisko-Bezruchko, Senior Director, Planning	06-02-2008	3
University of Ottawa Heart Institute	Dr. Andrew Pipe, Medical Director, Prevention and Rehabilitation Centre	06-02-2008	3
Canadian Institute for Health Information	Glenda Yeates, President and Chief Executive Officer	13-02-2008	3
Canadian Institute for Health Information	Keith Denny, Acting Manager	13-02-2008	3
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