HELSEDEPARTEMENTET

Ministry of Social Affairs

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Short version

Prescriptions for a Healthier Norway

A broad policy for public health

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1 Introduction

1.1 The broad approach

Report No. 16 (2002-2003) to the Storting throws the spotlight on health in Norway. It addresses factors that play a part in creating health problems or which help to combat disease. Looking after the health of the population means relating to the factors that affect health. These include the curative, rehabilitative and nursing/caring activities of the health services. This is important work, which naturally receives a great deal of attention, but the health sector alone is not the most decisive factor in the development of health and sickness. Our own choices and the way we jointly organize and adapt society in a number of different areas play a far more important role. It is this broad approach which is the subject of this White Paper.

This White Paper draws up strategies for a healthier Norway. The more disease we can prevent, the less we have to cure. The attention of politicians is often caught by acute illnesses and by the need to help here and now. Giving priority to prevention can also be difficult because this is not dealing with people's illnesses here and now; it is dealing with statistical risks and future illnesses – about what *may* happen, often far into the future. In this sense, public health work is more «invisible». As a society, we should adopt a policy which also takes responsibility for directing future needs and challenges and which tries to reduce future illnesses.

The main focus of this White Paper is on factors that we know effect health, because:

- Each determinant of health often contributes to several different health problems.
- Focusing on factors that affect health helps to bring to light the responsibility of other sectors and policy areas for the health of the population.
- When action is aimed at known determinants, we can measure the results in the form of reduced health risks long before they develop into real disease and death in the population.

Box 1.1 Public health work – more energy to cope with everyday demands

- Public health work means reducing factors that entail a health hazard and strengthening factors that contribute to better health. The negative factors have an adverse effect on health, be it the things we eat and drink or things that are to be found in our social and physical environment. The positive factors include, for example, our relationships with the people closest to us and the networks we become a part of, and the degree to which we feel our lives are meaningful, predictable and manageable. These can be called 'protective' or 'coping' factors and they give individuals and groups sustainability and resistance to wear.
- The World Health Organization defines health as «a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity» and this can suggest that good health equals a good life. This White Paper takes the view that we want good health in order to be able to live a good life, on a par with safe local communities and meaningful work. Health is then an investment factor for a good life.
- Public health work is about promoting physical health by, among other things, influencing living habits and living conditions. But it also about promoting mental health, by helping people to feel that they can cope, giving them self-esteem, human dignity, security, respect and visibility.

1.2 Objectives

There are several reasons why the Government now – ten years after the Storting debate on White Paper No. 37 (1992-1993) *Challenges in health-promoting and preventive work* – wishes to submit a new report containing strategies for the next ten-year period. New trends in society bring new health challenges. Examples of these are globalization, a multi-cultural society, a demanding workplace, and drug and alcohol problems. The World Health Organization has shown that a third of the total burden of disease in industrialized countries is caused by five risk factors: tobacco, alcohol, high blood pressure, cholesterol and overweight. At the same time, the knowledge base needed to develop both policies and practice has improved in a number of areas.

Against this background, the Government wishes to revitalize public health work. Its objective is a healthier Norway through a policy which contributes to:

- More years of healthy life for the population as a whole
- A reduction in health disparities between social classes, ethnic groups and the sexes.

This White Paper aims for a more systematic and comprehensive policy than hitherto. The Government will attach importance to the connection between the community's and the individual's responsibility for and possibility of influencing the health situation and to showing what the individual and the community have to gain from effective preventive healthcare. The Government seeks to strengthen public health work in all social sectors through active partnerships which places responsibility, bind and inspire action. Work must also be done to further develop and reinforce preventive work as a central instrument within the health services. In addition, the focus will be on ensuring that the measures implemented are based on experience and new knowledge acquired, for example, from research and pilot projects. A better understanding of complex causal relations will make for more effective measures.

1.3 Personal responsibility and social responsibility

Every individual has a responsibility for their own health and, in many areas, will have choices and be responsible for these choices. However, the community can and should influence these choices by providing information, dispensing knowledge and shaping attitudes. Knowledge and attitude-shaping campaigns must be accompanied by other measures. These may be measures that make healthy choices easier and more attractive, but they may also be measures that make health-damaging choices more difficult.

Influencing other people, whether individuals or groups, involves major ethical challenges. This work must be based on respect for different choices and have the fundamental support of the community. For that reason, public health work must always be rooted in the democratic institutions in society and build on knowledge and discussions which embrace the largest possible sectors of the population. Ethical assessments carried out by central expert bodies are important, but they must be accompanied by an ongoing debate in the population. If not, there is a danger that measures will be regarded as uncalled for interference.

Individuals and local communities have a responsibility for public health, but the health of a population is just as much the result of trends and political choices beyond the control of the individual. The picture of disease reflects a general social development and the conditions under which we live. Responsibility must therefore be made transparent in all sectors when national policy is being formulated. From the point of view of public health, we must care about what society does to make cycling safe and what it does to encourage healthy eating habits. We must care about how schools deal with bullying and how the workplace can have a beneficial and not an adverse effect on health.

The challenge lies in getting everyone to pull in the same direction. In submitting this White Paper, the Government emphasizes the need to reinforce the place of public health in all social sectors. This can be done by, for example, launching tools which ensure that health is taken into consideration when decisions are being made in different social areas.

1.4 Scope of the White Paper

Although it is the intention of this White Paper to survey public health policy as a whole, certain areas and challenges are deemed to be more important and will be emphasized. Certain aspects must be considered when selecting a special priority area, such as

- Whether it concerns one or more major health problems
- Whether it concerns health problems that are very costly for the country
- Whether knowledge is available about the causal relations
- Whether it can be dealt with by effective and accepted preventive means

As shown above, this White Paper is concerned mainly with health risks and protection – and not with treatment, nursing and care. An exception is made in Chapter 11 on women's health, which also deals with the curative services. The reason for this is a wish for a comprehensive follow-up of NOU 1999:13 *Women's Health in Norway*.

A broader public health perspective might also include instruments which seek to influence the gravity and course of a disease once it has been established and measures to moderate the impact of health problems on, for example, activity, participation and living conditions. These are measures which can involve social welfare work, rehabilitation, medical rehabilitation and measures to improve access to services. However, these measures are either in the grey zone between treatment and rehabilitation or aim to ease the situation of individuals with health and functional problems and are not given a central place in this White Paper.

If we regard public health work and prevention as an attempt to reduce risks in the healthy part of the population, then there are also other subjects and measures which could be included in a White Paper on public health, but which are not considered here.

These include medical interventions in healthy persons who have a known or assumed higher risk of becoming ill. For example, high blood pressure medicine and cholesterol-reducing drugs are used to reduce the probability of illness occurring. However, in this White Paper the focus is mainly on the relationship between such interventions and alternative or supplementary action, such as physical activity, diet and giving up smoking.

This also applies to screening, which aims to identify persons suffering from a disease or in the initial stages of a disease, where an early diagnosis can reduce the risk of deterioration and a fatal outcome. Screenings are discussed in a number of international documents dealing with prevention and public health. In this White Paper, however, this much debated subject is not included because screening must be regarded as part of the treatment chain – i.e. part of early diagnosis activities. Reference is also made to the discussion of mass surveys in White Paper No. 26 (1999-2000) on the basic values for the Norwegian health service.

2 The diagnosis

«Surveys indicate that the level of physical activity
is too low in more than half of the adult population»

Figure 2.1: The diagnosis

2.1 State of health and trends

2.1.1 The health of the population

Positive developments, but greater health inequality

The health of the Norwegian population is generally good and is improving. At the same time, improvements are now slower than in countries it is natural to compare Norway with. In 1970, Norway was placed third in an OECD survey of life expectancy for men, and first for women. Several countries passed Norway by in the mid 1980s and held their lead throughout the 1990s. In 1999 Norway was in eighth place for men and ninth place for women.

Life expectancy has risen steadily over the past twenty years and today a woman can expect to live to the age of 81.4 and a man to the age of 76. Generally speaking, groups with a higher social status have a higher life expectancy than groups with a lower social status. Well-educated women with a good income have the highest life expectancy and people who are married or have a partner have better prospects than single persons. The socio-economic disparities in health have grown in the course of the past thirty years. Most of this increase can be explained by a less favourable health trend in single persons than in other population groups.

Cardiovascular diseases

Cardiovascular disease is the leading cause of death for both men and women. At the same time, the mortality rate for this group has fallen most.

Type II diabetes – increase in incidence

We estimate that there are about 140,000 persons with type II diabetes in Norway, and this figure is increasing. Since diabetics run a considerably higher risk of developing cardiovascular diseases, it is possible that this trend will offset the favourable development in cholesterol, high blood pressure and smoking. We may then see a levelling off or reversal of the decline in cardiovascular diseases.

Cancer – mortality rate stabilized in the 1990s

Cancer is the second most important cause of death and here the mortality rate remained stable in the 1990s. More than 21,000 persons in Norway are diagnosed with cancer each year (about the same number of women and men). In 1955 7,500 cases of cancer were registered. Most of the increase is due to the fact that we have a larger percentage of elderly people in the population. The percentage of people who survive cancer today is far higher than in 1955. We anticipate an increase in the number of cancer cases due to the larger percentage of elderly in the population.

While we have seen a levelling off in the incidence of lung cancer among men since the 1980s, there has been a steep rise in lung cancer among women. The incidence of lung cancer in a population can be seen as a reflection of the smoking habits in the same population twenty years earlier.

Chronic respiratory diseases

The incidence of chronic obstructive lung disease is estimated to be 6% of the population and there has been an increase in both incidence and number of deaths. The mortality rate today is 38.4 per 100,000 and that is almost as high as for lung cancer. The registered incidence of asthma in the Norwegian population has shown an increase, but at the same time the mortality rate has dropped considerably. Diseases of the respiratory organs are the third most important cause of death in Norway.

Accidents and injuries

Accidents and injuries are fourth on the list of causes of death. The number of persons who have lost their lives as the result of injuries has shown a downward trend over the past thirty years. On the other hand, there has been an increase in the number of persons admitted to hospital with accidental injuries.

Mental illness

We estimate that about fifteen per cent of the adult population suffer from mental illness (more women than men) and that about ten per cent of this group are seriously ill. More than twice as many women suffer from depression and anxiety symptoms, while substance misuse is far more common among men.

It is estimated that between ten and twenty per cent of all children have such serious mental problems that this affects the way they function on a day-to-day basis and that between four and seven per cent need treatment. We estimate that about ten per cent of young people in Norway have

mental problems that need professional help. In an average tenth grade (15-16 years old), six pupils have one or more daily health problems. Typical complaints are anxiety, depression, headaches, stomach pains and insomnia.

More people are living with health problems

Four out of five adult Norwegians say that their health is good or very good. At the same time, there are more people living with chronic health problems. One out of three adults say they have illnesses or conditions that affect their everyday lives and one out of eight have problems that seriously affect their lives.

Greater risk of communicable diseases

Communicable diseases are less common in Norway than in most other countries, but this situation may change as a result of the increase in international trade and travel, changes in the properties of pathogens and the threat of the spread of dangerous pathogens.

2.1.2 Risk factors

Physical inactivity

The weight of the Norwegian population has increased gradually in recent decades. The weight of adult men (40-year-olds) has increased by 9.1 kg over the past thirty years. At the same time, people's daily physical activities have been considerably reduced. The number of people who exercise regularly has increased somewhat, but this cannot compensate for the reduction in everyday activity resulting from the diminishing day-to-day demand for physical activity. Surveys indicate that the level of activity is too low for more than half of the population. Physical activity is also linked with social status. Far more people with a high education exercise than people with a low education.

Eating habits

In the course of the past twenty-five years, the Norwegian diet has become far leaner and the consumption of vegetables and fruit has increased. These changes go a long way towards explaining the drop in premature deaths from heart attacks that has been registered over the past twenty years. But the eating habits of a large part of the population still show obvious nutritional weaknesses. They eat too much fat, sugar, salt and alcohol and too few vegetables, fruit, coarse grain products and fish. By way of comparison, the consumption of fruit and vegetables in Italy is three times higher than in Norway.

Thirty per cent smoke every day

In 2001, about 30 per cent of the adult Norwegian population smoked daily (about the same number of men and women). That makes approximately 1.1 million people. In addition, about 400,000 people smoke now and again. The percentage of men who smoke every day has fallen steeply since the 1970s, while the percentage of women has remained relatively constant. Although the percentage of women smokers has not changed in almost thirty years, the underlying picture is more complicated. For example, there are now fewer young and more older women smokers than there were in the 1970s.

Alcohol and drugs

Norwegians have a low alcohol consumption by European standards, but we have seen a slight increase in the last ten years. Norway's drinking culture is still characterized by many incidents of high alcohol intake and a drinking pattern associated with many accidents and violence. The use of narcotics rose from the 1980s to the end of the 1990s and the increase was particularly noticeable in the second half of the decade.

Social lifestyle differences

There are considerable social differences when it comes to health-related behaviour such as eating, smoking and exercise. For example, we know that pupils taking vocational subjects smoke more, exercise less and eat less regularly than pupils taking academic subjects.

2.2 Trends and social features

Some social features represent major public health challenges. These include rapidly changing trends, cultural diversity and globalization. Another challenge is our increasing preoccupation with health issues and with our own health.

2.2.1 Medicalization and focus on risk

Ever-increasing pressure on the use of health services may reflect the fact that we define and handle disease and disorders differently from the way we used to. To some extent, the increasing use of health services is linked with the breakdown of informal and social networks and a resultant need for professional networks and services. Nonetheless, health seems to be taking a more and more important place in people's awareness and a more predominant place in the mass media. The way people react to illness seems to be changing and the threshold for seeking professional help is being lowered. Fear of illness seems to be an increasing problem. Growing old and death are recognized to a lesser degree as a natural part of life itself.

We must beware of the health service becoming a reception centre for an increasing number of life's problems. Nor must unrealistic expectations be created about what the health service can achieve. There is a danger of increasing medicalization, whereby more and more of the trials and tribulations of life are viewed as medical problems. Counteracting this will in itself promote health. An increasing preoccupation with illness, symptoms and avoiding risk will in itself seriously limit development and reduce the population's enjoyment of life. On the other hand, more focus on health can make public health an easier task for the authorities.

Box 2.1 Increase in physical and mental problems

- One in every fifth or sixth young person complains of life problems that affect their ability to function, and every tenth has such serious problems that they need professional help and assistance.
- The past ten years have seen an increase in the use of drugs and alcohol among young people and so far we have not succeeded in reducing the percentage of young people who smoke.
- Available data indicates that the average weight of children and young people is increasing, but we have no reliable information about how many of them are overweight. Surveys also show that children and young people are less active. We know too little about children and young people's intake of energy, but there is reason to believe that a higher consumption of fizzy beverages contributes to weight increase.

2.2.2 Youth culture – «Cool to be grown up»

Children and young people are primarily the responsibility of their parents. It is first and foremost their parents' job to bring them up and act as role models. But society also has a responsibility to provide for and give them the possibility of a healthy childhood and healthy choices.

Health statistics tell us something about the problems, but very little about the reasons behind them. If we want to influence young people's lifestyle – either by structural adaptation or by attitude shaping – we must do so in collaboration and in dialogue with young people.

The young people of today live a different life from the young people of only five or ten years ago. While yesterday's school diaries were full of messages and photos, today's diaries are full of appointments. Children are quicker to adopt an adult world and lifestyle. It is a question of making your own choices and defining who you are by sending clear signals to the people around you. If smoking is one of these signals, it will be difficult to reduce it without offering an alternative. It is thus important to find the positive health-related trends in youth cultures and build on them.

The authorities must base their approach on an understanding of youth culture and on young people's terms. We must be familiar with the trends if we want to play on the same side as the health-promoting trends and fight against the negative trends. Strategies must also be gender-specific.

2.2.3 A multi-cultural Norway

At the beginning of 2002, Norway had an immigrant population of 310,000 persons. Immigrants from western countries are a relatively homogenous group and do not differ very much from the Norwegian population. However, almost two-thirds of the immigrant population stem from Asia, Africa and Latin-America. In 2000, there were about 67,000 children and young people belonging to ethnic minorities in Norway. Seventy

per cent of them originated in Asia, Africa, Central or South America, or Turkey.

On an average, non-western immigrants have a lower education, lower income and poorer standard of living than the average Norwegian. A study carried out in 1996 showed that twenty per cent of non-western immigrants and no less than seventy per cent of refugee families lived in poverty. The equivalent figure for the whole of Norway's population was 4.5 per cent. The high percentage of unemployed among non-western immigrants is one of the reasons for this situation. However, it is important to be aware that there are great disparities in life situation between the different immigrant groups.

One of the intentions of this White Paper is to give more importance to reducing social inequalities in health. This is the reason why the Government wishes to sharpen the focus on the growing immigrant population's special health problems and the need for instruments adapted to their needs. This will apply in particular to groups of non-western immigrants.

Box 2.2 Health in the immigrant population

- There are greater disparities in health between the different immigrant groups than between the individual immigrant groups and the ethnic Norwegian population.
- Stillbirths and deaths in the first week of life are less common in infants born of Vietnamese mothers and more frequent among infants born of mothers from Pakistan than among infants born of ethnic Norwegian mothers and infants born of North-African mothers.
- The percentage of persons who regard their health as good or very good is far lower among immigrants from non-western countries than among ethnic Norwegians.
- Type II diabetes, cardiac infarct and musculo-skeletal pain are reported more frequently by 59-60 year-olds from non-western countries than from other persons in the same age group.
- Only seven per cent of 59-60 year-old women from non-western countries smoke every day, as against twenty-four per cent of ethnic Norwegians.
- Seventy-four per cent of the new cases of tuberculosis registered in 2001 were discovered among immigrants.
- The majority of the persons who are diagnosed with HIV are immigrants who were infected before they came to Norway.
- Refugees report more mental problems than the rest of the Norwegian population. An important reason for this may be that many have been the victims of traumatic experiences such as torture and war action.

2.2.4 Health and globalization

Increasing globalization is a central trend of the twenty-first century. There is no common understanding of what globalization is and views of what the economic and social consequences of these developments will be vary considerably. It is clear however that globalization is a complex process made up of economic, social, cultural, political and technological components and that these impact on factors that have great significance for public health in every part of the world.

The dividing line between national and international health problems is being obliterated

As globalization increases, the dividing line between international and national health problems becomes less and less relevant. At the same time, the interaction of health with other sectors is becoming more important. Intersectoral coordination in order to protect and promote public health is becoming increasingly important at international as well as national level.

Viruses, bacteria and radioactive and chemical pollution are no respecters of national boundaries. The increasing volume and accelerating speed of international travel is also significant for how infection spreads. *The front-line defence* against communicable diseases such as HIV/AIDS and tuberculosis and the development of drug-resistant bacteria lies outside Norway. National measures are therefore becoming more and more dependent on international cooperation and international agreements.

Health and economic developments

Good health is conducive to economic development and helps to reduce poverty through improvement in children's learning abilities, positive

demographic change, higher productivity in the workplace, reduction in sickness-related expenses for households, greater savings and thus greater investment. The WHO Commission for Macroeconomics and Health issued a report in December 2001 which shows that the global economic returns on investments in health are substantial. The gains from health-promotion measures are three times as high as the outlay. Three of the United Nations' development targets for the millennium are health targets. Norway has committed itself, along with other countries and organizations, to work towards attaining these targets. Norway's objective is to improve the state of health and strengthen the health services in poor countries. This will also help to strengthen our defence against communicable diseases and drug-resistant bacteria in Norway. In this way, the effect of political decisions will be intensified in both areas.

2.3 Challenges

2.3.1 Lifestyle as a risk factor

According to the World Health Report 2002, at least one third of all disease burden in industrialized countries is caused by five risk factors: tobacco, alcohol, blood pressure, cholesterol and obesity. Obesity, high blood pressure and cholesterol are closely related to physical inactivity and a diet consisting of too much fat, sugar and salt. These risk factors are increased by smoking and a large intake of alcohol. Both tobacco and alcohol consumption are increasing problems on a world basis. In 2000, it was possible to link tobacco to 4.9 million cases of premature death and alcohol to 1.8 million of such cases.

We are also facing major challenges as regards lifestyle and health in Norway. The level of physical activity has been reduced. Norwegians still smoke too much, and there is plenty of room for improvement in diet.

We estimate that more than half of the adult population engages in less physical activity than is recommended and, combined with too high an intake of energy, this is the most important reason for overweight and type II diabetes. There are reports of an 'overweight' epidemic throughout the western world. In Norway, the percentage of persons who are overweight has increased from the 1960s up until today. Although data is scarce, available information indicates that overweight is also becoming an increasing problem in children. There is a clear connection between overweight and standard of education, and an unhealthy diet combined with too little exercise is more common in groups with a low social status than in groups with a high social status. Developments in the 1990s show that the decline in smoking among young people has bottomed out and that the consumption of alcohol and other intoxicating substances has increased.

If we are to achieve further improvement in the health of the population, we will have to bring about a change towards a healthier lifestyle. Since it is the group with the lowest education and income that has a lifestyle with the highest risk of illness, it is essential that we reach this group.

Box 2.3 Every period has its own challenges

- In the twentieth century we saw an improvement in the health of the Norwegian population that was unparalleled in history. Average life expectancy rose by more than thirty years.
- At the beginning of the twentieth century every tenth child died before it was a year old. The most serious 'diseases' affecting the population were infections, epidemics, hunger and poverty. Every second death was due to an infectious disease or epidemic.
- Prosperity brought with it lifestyle diseases like: cancer, cardiovascular diseases, pulmonary diseases and type II diabetes.
- At the beginning of this millennium, we have seen an increase in disorders caused by overweight, physical passivity and discontent. Depression and chronic pain are gradually becoming just as serious health problems as heart disease in our part of the world.

2.3.2 Mental health

In addition to the challenges linked with lifestyle and physical health, mental problems and disorders are becoming the great new challenge both in Norway and in other western countries.

Mental health was the subject of the World Health Report 2001. The WHO estimates that mental and neurological disorders are responsible for twelve per cent of all lost years of full functional capacity and that these disorders will repre-

sent fifteen per cent of the disease burden by 2020. In Europe, twenty per cent of the total burden of disability and premature death is caused by mental disorders. Suicide is one of the three leading causes of death in the 15-34 age group.

In Norway, with the implementation of the *Escalation Plan for Mental Health* (1999-2006), we have taken important steps to promote mental health as a priority area, both in the health sector and in other social sectors. In addition to the task of ensuring good follow up and treatment, we are facing major challenges in the work of preventing mental problems and disorders. Mental disorders are a result of the complex interaction of biological, psychological and social factors, and there are still several areas where we lack sufficient knowledge about what causes mental illness and about what constitutes effective measures.

2.3.3 Focus on prevention

In *World Health Report 2002*, WHO recommends national authorities to focus more on preventing the risk of disease, which includes focusing more on scientific research and health surveillance. The World Health Organization also emphasizes the importance of giving priority to effective policies to reduce the use of tobacco, unhealthy diets and obesity. The importance of involving NGOs, local communities, the media and other players in this work is underlined. The report also stresses that individuals must be given the chance and encouraged to make healthy lifestyle choices.

Over the past ten years, Norway has done a great deal of successful campaigning to prevent the risk of disease. This has been directed at eating habits and tobacco, among other things. However, we can still do a better job of customizing information for the different target groups. We live in a society where changes are taking place more and more rapidly. Young people are the first to become aware of changes. That is a significant fact we must remember when formulating policies. We have to try to understand the trends in youth culture and to encourage trends that can facilitate public health work. There are also special challenges inherent in the fact that we have a more multi-cultural population. Some of the immigration populations are struggling with special health problems and cultural differences create the need for special measures. Up till now, public health policy has been more concerned with average factors than with reflecting on the diversity in the population. This may have had significance for the effects of implemented measures. In addition to cultural differences, we also have the challenge of gender differences, and not least social differences, to take into consideration when formulating and implementing policies.

We are still facing major challenges as regards the public health knowledge base. Although we now have a better basis on which to initiate measures in several areas, there remains a great deal of work to be done in developing effective preventive measures. In many areas, however, it is not the lack of knowledge, but the lack of action that is the problem.

We already have most of the legislation and regulations we need to ensure that health considerations are also taken into account outside the health service. However, we still have a bit to go before the relevant social sectors have accepted their share of responsibility. At national level, some important structural steps have been taken, through the reorganization of central social and health administration, to strengthen the public health field. A number of smaller agencies in the public health field have now been incorporated into a new Directorate for Health and Social Welfare. The way has thus been paved for better coordination and stronger implementation of public health policies. Furthermore, with the establishment of a Norwegian Institute of Public Health, the responsibility for major mass surveys and most national health registers has been gathered together in one place. This is an important prerequisite for the work of strengthening health surveillance and causal research. However, there is still a tremendous need to strengthen the infrastructure at local level. The involvement of central authorities in local public health work has to a great extent taken the form of time-limited investments in local projects. In the time ahead, there will be a need for measures which ensure that public health work is given a more permanent and systematic character. This was also some of the background for Official Report No.1998:18 *A Use of Everyone. Strengthening public health work at local level*, which forms an important basis for this White Paper.

In recent years, several major reforms have been implemented in the curative health service. The most important of these are the introduction of the regular general practitioner scheme, transfer of responsibility for the specialist health services to the State and the *Escalation Plan for Mental Health*. We also have four new health Acts relating to the specialist health service etc., to

healthcare personnel, to the establishment and implementation of mental healthcare and to patients' rights. The aim of this new legislationis to promote a more effective use of resources and a stronger focus on the patients. Little emphasis has been given so far in public health policy to the role of the health service in disease prevention. There is room for more prevention work in the health service, and it is therefore important to provide the necessary incentives for greater involvement in this field.

3 Four prescriptions for a healthier Norway

This White Paper advocates a broad health policy. It is concerned with the many factors that play a part in creating health problems and which help to protect us from disease. It wishes to draw attention to the connections between the individual's and the community's responsibility for and possibility of influencing the health situation and it wishes to make responsibility visible in a number of sectors and policy areas.

Given the challenges we are facing, the Government will give particular emphasis to the following general strategies for public health:

1. Make it easier for people to take responsibility for their own health
2. Build alliances to promote public health
3. Encourage more prevention and less cure in the health service
4. Build up new knowledge

4 Make it easier for people to take responsibility for their own health

«Success will depend on cooperation between the individual and the authorities – where both parties take responsibility and make an active contribution»

Figure 4.1: Healthy lifestyle choices

This strategy focuses on the relationship between lifestyle and health and on what can be done to reduce the social inequalities in health. Its aim is to make it easier for individuals to take responsibility for their own health. Facilitation and measures must be directed at social conditions and factors in the environment around us which affect our way of living and health. The success of this strategy will depend on cooperation between the individual and the authorities – where both parties take responsibility and make an active contribution. This White Paper also points to ways in which society can help to prevent mental problems by building up individuals' confidence in their own ability to cope with life's problems.

4.1 Healthy lifestyle choices

The way people live is crucial to their health. A correct diet and regular physical activity can reduce the incidence of cardiovascular disease considerably; it can reduce the incidence of cancer by a third, and it can prevent an increase in overweight and type II diabetes. Smoking is the greatest single cause of illness and death in our time. There are strong indications that physical inactivity is on its way to becoming the great health problem of the future.

At the same time, we register social differences when it comes to lifestyle and health-related behaviour. We also see that these risk factors are distributed unevenly in different groups of the population – and that they reinforce each other's adverse effect on health.

People in motion

Physical activity is a source of health and well-being, and it is an important instrument in public health policy. There is less and less demand for physical activity at home, at work and at leisure. And yet we also know that increasing physical activity can only partly – and especially among the most privileged – compensate for a less active daily life.

For people who are physically inactive, even a modest increase in daily activity will give a considerable health gain in the form of less risk of becoming ill, a better quality of life and improved functional capacity in old age. The recommended level of physical activity for adults corresponds to a thirty minutes' brisk walk each day. Less than half of the adult Norwegian population takes that amount of exercise today. The recommended level for children is at least an hour of physical activity each day.

The Government wishes to curb the negative trend in physical activity in the population and thus prevent a further drop from today's overall level of activity. We must pave the way for more physical activity in the least active population groups. It is particularly important to create attractive facilities and activities for children and young people, which can compete with computer games and other sedentary indoor pastimes. We need arenas where they can organize their own activities and social games. The surroundings should invite movement, games and activity. The necessary steps must be taken to make it safe for them to walk and cycle, for example to and from school.

The Government will pave the way for more physical activity through a collective strategy that covers a wider range of more policy and social areas. A collective strategy for physical activity must, in the first place, include initiatives that will change individual attitudes and behaviour. These may be general information, guidance from the health services, low threshold activities and the possibility of organized physical activity or of organizing one's own activity. Secondly, this strategy must include measures to create surroundings which inspire physical activity on an everyday basis.

Healthy food – good nutrition

Food and eating habits are an important part of our culture and what we eat is important from a nutritional point of view and for our social, mental and physical well-being. In Norway, it is primarily the nutritional content of diets that the public health authorities are concerned with. Food safety is generally good, but some cases of disease due to infection in food and water do occur.

The general objectives of the Government's food and nutrition policy remain firm. The nutritional content of the Norwegian diet must be such that it:

- Reduces diet-related illness in the population
- Is safe from a health point of view
- Satisfies consumers' demands
- Is produced in a sustainable and environmentally acceptable way.

The Government's nutrition policy must help to ensure that the population's diet has a composi-

tion that is in keeping with the recommendations of the Directorate for Health and Social Welfare. The most important challenges in this policy area in the years ahead are to reduce the intake of saturated fatty acids and to increase the consumption of vegetables and fruit in all groups of the population. It is also important to encourage people to eat more coarse grain products and fish and to reduce their intake of sugar and salt. These changes in diet will, among other things, reduce the risk of developing heart disease, some types of cancer, obesity, type II diabetes and osteoporosis. Since overweight and heart problems are most prevalent among groups with a low social status, action to promote healthier eating in these groups will help to reduce social health differences.

Hitherto, information has been the most important nutrition policy instrument. The Government will now give more emphasis to structural instruments, such as legislation and availability of healthy food. Policy instruments such as organization, coordination, legal basis, surveillance, research, development programmes and expertise must be seen in relation to one another. A number of ministries administer regulations and agreements that relate to nutrition policy. The work of the different sectors in this field must be coordinated and it is important to continue the cooperation between the authorities, the food industry and the consumer organizations.

Smoke-free zones

Tobacco is a major cause of illness and premature death in the population and probably takes a greater toll on health in Norway than any other single preventable factor. A reduction in tobacco consumption would therefore give a considerable boost to public health.

The Government's target is to halve smoking among young people over a five-year period and its long-range vision is a non-smoking younger generation

Action to prevent the harmful effects of tobacco will be directed at preventing passive smoking, reducing the recruitment of new smokers and reducing the number of daily smokers. To attain these targets, more resources will have to be invested in preventing smoking and a broad range of high-intensity, long-duration measures will have to be introduced.

The Norwegian Storting has recently passed an amendment to the Act relating to prevention of the harmful effects of tobacco to prohibit smoking in restaurants and cafés. The purpose of the amendment is to protect employees in the restaurant business from passive smoking. With a view to reducing the recruitment of new smokers, the Government will consider whether a licensing scheme for tobacco could be an appropriate step. It will also step up its school-based programme, «BE smoke-FREE» and initiate a five-year campaign against smoking in the mass media. The number of smokers will be reduced by giving them help to stop smoking and through local community-based measures.

The Government also wants to make a contribution in the international arena. Women and children in developing countries are exposed to massive advertising by the tobacco industry, enticing them to emulate western ideals. We in our part of the world must make every effort to ensure that the experience of western countries is not repeated in countries where the people are far less favourably placed as regards economy, knowledge about the health hazards and help from the health services.

Fighting substance misuse

Substance misuse represents substantial cost to the country and to individuals. In October 2002, the Government submitted an *Action Plan on Alcohol and Drug-Related Problems*. This action plan lays the foundation for work on alcohol and drug-related issues for the period 2002-2005 and offers a collective strategy for prevention, treatment, rehabilitation and harm reduction.

To reduce alcohol and drug-related problems, the action plan proposes a greater focus on preventive measures. Efforts will be concentrated on measures that we know are effective, and young people will be an important target group. Research shows that general measures targeting the whole population can be very effective, while it is probably possible to identify persons at most risk at an early stage. It is therefore of crucial importance to help the most vulnerable groups as early as possible.

We distinguish between two main groups of measures in the work of preventing alcohol and drug-related problems: those targeting demand and those targeting supply. Prohibition, regulation and control will be the most important instruments to reduce demand. In the case of drugs, measures will seek to prevent the supply of drugs that are not for medical and scientific use, while in the case of alcohol, the aim will be to give sales a

legal form that has as few harmful effects as possible. It will also be important to have effective preventive measures targeting children and young people who run a greater risk of or show signs of abnormal behaviour and targeting groups of young people who have a liberal attitude to alcohol and drugs. The same applies to adult cultures, for example in the workplace and in leisure time, and help for individuals who are in the process of developing an alcohol or drug-related problem.

4.2 Reducing social inequalities in health

Public health policy in Norway has been more concerned with average factors than with diversity in the state of health of the population. This may have helped to conceal significant features in descriptions of status and development and it may have had significance for the effectiveness of the measures implemented. To reach groups of the population who do not meet the average criteria, it is important to be aware of what characterizes their situation and what constitutes 'their' problems. The Government therefore wishes to place a sharper focus on the differences in health problems.

A strategy to improve public health should pay particular attention to improving the health of groups whose health is below average for the population as a whole. This will mean gearing our policy more specifically to the parts of the population where both the challenges and the possibilities (prevention potential) are greatest. At the same time, we must consider the effects the policies of several sectors can have on the living conditions and possibilities of the most disadvantaged.

Although it is important to emphasize the choices and actual responsibility of the individual – particularly when it comes to living habits – social inequalities in health will largely be a political and social matter. When the differences follow clear social patterns, it is not the individuals' conscious choice of lifestyle that is the crux of the matter. The problem is that people with a low social status, few assets and few resources also suffer from most pain, illness, disability and reduced life expectancy. Social inequalities in health are also a serious matter because health is an important prerequisite for social activity and participation in society in a broad sense.

4.3 Mental health

One of the objectives of *the Escalation Plan for Mental Health* (1999-2006) is to prevent mental problems. Special emphasis is given to preventive measures in the case of children.

There is a great need for knowledge and openness about mental health and an information campaign has therefore been initiated in cooperation with a number of consumer organizations. The information strategy has three priority areas: children and young people, the workplace, and users and the public services. The main focus so far has been on children and young people, while work targeting the workplace has only recently begun. A separate sub-strategy has been drawn up for the workplace and mental health in collaboration with the Confederation of Norwegian Business and Industry (NHO), the Norwegian Federation of Trade Unions (LO), the Norwegian Association of Local and Regional Authorities (KS) and Mental Health Norway.

It is extremely important to achieve a collective effort to improve the mental health of children and young people. This applies in particular to preventive work. *A Strategy for Children's and Young People's Mental Health* will be drawn up in 2003. This will help to ensure that surroundings, next-of-kin, schools, the leisure and recreation sector and the support services attach importance to children's and young people's own resources and ability to cope. This is an important prerequisite for preventing children and young people from developing mental problems and disorders. The target is to ensure that children and young people who develop mental problems are given local and personal treatment as soon as possible. As a follow up to the *Escalation Plan*, the preventive health services (child health clinics and school medical services) will be given an additional 800 full-time equivalent posts in the period up to 2006. Moreover, new staff (260 full-time equivalent posts) will be recruited for other psychosocial work at local level.

A *National Plan for Self-Help* will be drawn up in 2003 in order to increase the focus on self-help. This plan will promote self-help as a tool in the prevention of mental problems. The national self-help plan will be used to ensure that previous experience from self-help work is utilized and developed and that more prominence is given to self-help in existing networks and organizations.

4.4 The surrounding environment

Good health depends on a healthy environment. Factors that affect the environment also affect health and can aggravate existing illnesses such as cancer, hereditary disease, respiratory illnesses and allergies. They can also weaken immune systems, reduce fertility and cause damage to a number of different organs. If we are to prevent this, we must be able to assess the health risk of the individual factors. This means 1) identifying the inherent harmful properties of an environmental factor, 2) clarifying how the harmful effects are affected by quantity and concentration, 3) assessing the degree of exposure and 4) calculating how great the risk is of illness or damage to health. These assessments will show whether it is necessary to initiate special measures to limit exposure to any of the various environmental factors. While the health benefits can be substantial, action can also be extremely resource-intensive. Decisions must therefore be taken on a sound, professional basis.

Communicable diseases

Over the past decades, we have been able to keep the communicable diseases that occur in Norway under control. This is due to prolonged, targeted efforts at many levels and in many sectors of society. If we cut back these efforts, communicable diseases will soon return. International travel and trade help to spread these diseases quickly from one part of the world to another and to combat them we need cross-border efforts and international coordination. A striking example is EU's efforts to combat BSE (mad cow disease). For this reason, Norway takes an active part in international control of communicable diseases for some time.

Box 4.1 Important measures – Making it easier for people to take responsibility for their own health

- Continue developing interconnected networks of foot and cycle paths.
- Assess measures to increase and improve the quality of physical activity in schools.
- Initiate systematic pilot projects for cooperation on physical activity in schools, modelled on the Swedish Bunkeflo project.
- Assess whether current measures in the field of sports take the public health perspective into consideration to a sufficient degree.
- Follow up the World Health Organization's global strategy on infant and young child nutrition.
- Encourage schools to ensure that pupils eat good quality food at school.
- Arrange funding of a subscription scheme for fruit and vegetables in primary and lower secondary schools.
- Continue to pave the way for good eating habits at the workplace, in canteens and other large-scale catering establishments.
- Initiate a five-year anti-smoking campaign in the mass media.
- Initiate an amendment in legislation prohibiting smoking in catering establishments.
- Intensify anti-smoking campaigns in schools.
- Establish smoke-free hospitals and offer help to staff and patients to stop smoking.
- Initiate the measures in the *Action Plan on Alcohol and Drug-Related Problems*.
- Implement the Government's plan to reduce poverty.
- Draw up an action plan to reduce social inequality in health.
- Establish and build up a resource centre in the administration for inequality and health.
- Continue the information strategy under the *Escalation Plan for Mental Health*.
- Draw up a strategic plan for children's and young people's mental health in 2003.
- Draw up a plan in the course of 2003 to strengthen the self-help strategies in the field of mental health.
- Revise the *National Environmental and Health Action Plan*.
- Strengthen surveillance of communicable diseases, control of communicable diseases in hospitals and evaluate the need to reorganize emergency preparedness for communicable diseases.
- Draw up a combined plan for future work on food and control of communicable diseases.
- Strengthen food control and evaluate stronger reactions to contraventions of the food regulations.

The main strategies that have been used in the past are still applicable: measures to prevent people coming into contact with infection, measures to strengthen individual resistance to infection, and anti-viral measures when disease occurs. It is particularly important to maintain a high immunisation level in the population, ensure good diagnostic systems to reveal and identify communicable diseases and their causes, monitor the incidence of communicable diseases, and initiate preventive measures which we know are effective.

Safe food

Food safety is generally good in Norway. Long-established regulation and good supervision of foodstuffs have helped to ensure that illness due to contaminated food is not found in the population at large. We also have less illness caused by contaminated food than many other countries. However, we continually find ourselves facing new challenges and it is costing Norway more and more to maintain this favourable situation.

The production and supply of food and drink must take place in such a way as to ensure that the products are safe to consume. Emergency preparedness is important as regards food and drinking water, as action is often required at short notice. Participation in international reporting systems for the outbreak of disease or bans on the sale of foodstuffs is essential in this connection.

5 Building alliances to promote public health

«A broad approach to public health work means mobilizing
(and coordinating) a large number of players in society.»

Figure 5.1: Building alliances to promote public health

If we are going to build up public health work, we will need to mobilize and coordinate a large number of players in society. We will need to strengthen the infrastructure and place more responsibility for public health work at local level, for example by encouraging the development of local and regional partnerships for public health. This White Paper opens the door for a clearer assignment of responsibility and for extensive partnership building both between different public bodies and between these bodies and NGOs. Health concerns will also be given a larger part in all social planning, by making this clearer in legislation and by developing suitable methods and tools.

The Government wishes to promote a municipal approach rather than a sector approach to public health work. It is necessary to clarify the local authorities' total and comprehensive political responsibility for public health work.

5.1 Partnership model in local government

The Government calls for a national public health chain which will also provide a basis for a far more systematic cooperation with voluntary organizations, educational institutions and other bodies.

The regional authorities can play a central part in public health work by virtue of their position in regional planning and regional developments. The regional authorities are responsible for social planning and social development and this gives them a natural gateway to public health work. Public health work is about developing good, inclusive local communities, about making arrangements for physical activity in daily life, about the connection between culture and health, and about schools as arenas for health promotion. Regional authorities also have an obligation to assist and guide local authorities in their planning work.

Partnerships are based on equality, unambiguous agreements and clear, reciprocal expectations and obligations. One of the government's strategies for public health work in the future will be to encourage regional partnerships and network building where the regional authorities undertake tasks of an inter-municipal nature.

The Government will give a helping hand to regions wishing to enter into systematic, long-term public health partnerships. It will also offer its assistance where local political levels are willing to commit themselves. Partnerships with regional networks or chains will entail the following obligations on the part of the Government:

- *Firstly*, incentive funds will be made available to match the use of local resources
- *Secondly*, national funds earmarked (for example through the National Cancer Plan) for local projects will be channelled through the regional partnership
- *Thirdly*, regional public health work will benefit from professional support and advice from central government. The Directorate for Health and Social Welfare and the Norwegian Public Health Institute possess a great deal of expertise, which will be used more to the benefit of local and regional public health work in the future.

Local partnerships will be expected to:

- Undertake local coordinator functions which have their roots in the central administration and are closely linked with the political level
- Have an organization that looks after the intersectoral perspective
- Be politically committed and ensure that their activities have a basis in the local and regional authorities' plans
- Cooperate with other major players.

It is essential that regional partnerships include all the expertise that can help to promote public health. This applies in particular to the NGOs whose help must be enlisted in various forms of cooperation and partnership.

5.2 Public health in social planning

If public health is to be the political and administrative responsibility of the local and regional

authorities, then public health must be included in central planning and decision-making processes. The Planning and Building Act is the most important legislation for coordinated, intersectoral social and land use planning in local districts. It is therefore important to establish that public health is an important consideration to be taken into account in all land use and social planning. This must be clearly stated in the Planning and Building Act and the Government advocates including public health in the object clause of the Act.

The Municipal Health Services Act requires the local authorities to keep track of the state of health in their district along with factors that

impact on it. A number of regional and local authorities have drawn up local health profiles. However, there is a need for a general tool and methodology to ensure that these health profiles can be a useful tool for the local authorities in community planning.

5.3 Impact assessments and health

Since very many of the factors that impact on health are beyond the control of the health sector as such, consideration for health must be rendered transparent and also incorporated in other sectors. For this we need intersectoral tools. Impact assessments are one such tool. They can give a systematic picture of the consequences of different decisions for part or all of the population. An impact assessment does not give the answers, but it helps to provide a better basis on which to make a decision. Impact assessments mean assessing factors that affect health, such as:

- Lifestyle (nutrition, tobacco, alcohol, physical activity, etc.)
- Socio-economic factors (inequality, access to health services, labour market, poverty, social inclusion, etc.)
- Environmental factors (pollution, noise, accidents, social meeting places and other physical, chemical, biological or social factors).

We can also look at the effects of decisions on any specific groups of the population that might be affected (vulnerable groups, certain age groups, gender). An impact assessment can therefore help us to predict whether or not a decision will result in greater health inequality.

To build up the required knowledge and expertise and to ensure continuity, health impact assessments must be included in syllabuses for, for example, social medicine, social psychology, studies in public health science, engineering/ planning studies, environmental health studies, etc. If health impact assessments are to be an effective tool centrally and locally, it will be essential to have the necessary competence at national level to follow up this work in collaboration with the educational institutions

5.4 Environmental health

The responsibility for environmental health lies with the local authorities under the provisions of the Municipal Health Services Act. This responsibility includes most of the factors in the environment which can affect health either directly or indirectly, whether biological, chemical, physical or social factors. The local authorities provide public health protection through *control and supervision* and through *collaboration*. The latter tasks include responsibility for collecting health data and helping to ensure that health issues are taken into consideration by other sectors and in municipal planning and decision-making processes.

It is now nineteen years since a review was made of environmental health in Norway and the legislation relating to it, and we have seen a great deal of change as regards determinants of health, panorama of disease, knowledge base and administrative apparatus. There seems to be a lack of correspondence between the breadth and balance of the tasks stated in the legislation and the actual situation when it comes to resources, expertise and prioritisation. There is reason to consider, among other things, the relationship between supervisory and collaborative tasks and the way they are geared to physical and social environmental factors respectively. This area still bears traces of a sector philosophy, which may be out of step with modern administrative principles. Furthermore, there may be reason to look more closely at how we tackle social or psychosocial determinants of health. In order to achieve more local attention and expertise in this field, it will be necessary to consider how both the regional and the central authorities can assist the local authorities. Changes have also taken place in related administrative areas, which greatly affect environmental health work at local level. Examples are a national control authority for food and drinking water and a possible national control authority for schools. In view of these changes, there is a need for a broad and detailed review of environmental health work.

5.5 Alliances with NGOs

Non-governmental organizations will have two important roles in public health work. The first will be that of initiator and facilitator of action to promote health and quality of life. Member organizations in the field of culture, recreation and lifestyle, consumer organizations and the broad public health organizations are important partners in public health work. They can help to pro-

Box 5.1 Important measures – Alliances to promote public health

- Encourage the establishment of local and regional partnerships in order to strengthen the infrastructure for public health work and give it a local, democratic basis.
- Build up the public health database (*Norgeshelsa*) under the direction of the Norwegian Institute of Public Health to provide a coordinated tool from which local authorities can obtain their own health profiles.
- Make sure that health impact assessments become an important tool in social planning, among other things by building up the necessary competence at national level and working for the inclusion of public health considerations in the *Planning and Building Act*.
- Set up a committee to undertake a broad review of environmental health.
- Develop alliances with NGOs by establishing special forums for discussion and annual meetings – an exchange – where NGOs and other players can present good suggestions for action.

mote and facilitate a healthy and active lifestyle. Their second role will be that of a major contributor to policy-making on behalf of their members and in that way they can serve as a corrective to administrative and political planning in the field of public health.

NGOs will be valuable partners for local and regional authorities in the public health chain. There is also a need for arenas where they can meet with central authorities. The Government will take the initiative in establishing forums for discussions between the central authorities and the non-governmental sector in the area of public health, through the Directorate for Health and Social Welfare. The purpose of these forums will be the reciprocal exchange of information, discussions and transfer of effective measures. Consideration will also be given to establishing a new and different form of arena for dialogue – an annual meeting or 'exchange' where NGOs and other players can present suggestions for public health initiatives.

6 The health services: Prevention is better than cure

«The health service has not fully exploited the potential gains in preventive measures. There are many areas where it is possible to prevent more and cure less.»

Figure 6.1: The health services: Prevention is better than cure

There is room for more prevention and less cure in several areas of the health sector. The Government wishes to see more emphasis on lifestyle action in the work of the health services and a strengthening of preventive health services for children and young people.

6.1 From pills to green prescriptions

We know that physical activity, a change of diet and giving up smoking can be an alternative or supplement to medical treatment in patients who have been diagnosed with high blood pressure, high cholesterol or type II diabetes. Nonetheless, the increase in sales of drugs for high blood pressure and cholesterol indicate that physicians more frequently prescribe medicines for their patients than a change of lifestyle. The challenge therefore lies in directing the focus away from medication as a «first choice» to lifestyle action and effort on the part of the patient.

The physician's choice of treatment in any particular case will be based on his/her professional judgement. However, the increased tendency to prescribe medicines may be due to poor accessibility of up-to-date knowledge about lifestyle action as an alternative or supplement to medical intervention. It may also be due to an aggressive pharmaceutical industry and the fact that patients expect to receive medicines. Physicians have weak financial incentives to give lifestyle guidance. Moreover, writing out a prescription is less time-consuming for the physician and the patient. We need to look more closely at the potential for reducing the use of medicines.

6.2 Better preventive health services for children and young people

The child health clinics and school medical services have an important role to play in preventing mental and physical problems and disorders in expectant mothers, children and young people and in detecting early signs of neglect, unhappiness and abnormal development. It is the job of these services, when necessary, to refer clients for evaluation and treatment, initiate special measures, cooperate in arranging respite facilities and provide information about measures from other bodies.

There has been a steep increase in recruitment to the child health clinics and school medical services over the past ten years. In spite of this increase, supervision and evaluations show that the help available to young people is still not adequate. Moreover, these services cannot offer satisfactory help to the most vulnerable groups, and the level of competence of the staff will have to be raised and adapted to meet current needs.

The Government therefore wishes to build up these services, so that they can:

- Provide help that is more suitable for young people and more appropriate to the new challenges in the field of mental health and living habits. This will require closer cooperation with other services and players, recruitment of staff with more psychosocial knowledge and updating of competence of existing staff.
- Provide satisfactory help for all young people between the ages of 13 and 20. This will mean a considerable strengthening of the services for this age group.
- Integrate measures targeting the whole 0-20 year target group and measures targeting particularly vulnerable groups and helping vulnerable parents, children and young people and give them the possibility of taking care of their own health.

The preventive health services available to expectant mothers and young children up to lower secondary school age (about 13)will primarily be strengthened by raising levels of competence, increasing interdisciplinary recruitment and through closer cooperation with other relevant services.

6.3 A stronger role for healthcare institutions in prevention

The hospitals possess a great deal of knowledge about the risk factors for disease, the factors that reduce the development of disease, and the development of the panorama of disease in the population (epidemiology). The hospitals are important sources of knowledge for primary prevention, but their most important contribution will be in secondary prevention. The hospital staff's widespread contact with people who already have a health problem enables the hospitals to provide information about factors that affect health and development of disease. In light of their own activities, the regional healthcare institutions also have a part to play in the work of monitoring developments in the disease panorama in the

region. Surveillance of epidemiological factors provides an important basis for preventive measures. The regional healthcare institutions should also be able to provide statistics and knowledge about sickliness, mortality, risk factors, which are of great significance for planning in the region. The specialist health service is an important source of data at national level through reports to the Norwegian Patient Register. Furthermore, hospital reports from local quality registers will be an important source of data for existing national registers and any new registers for certain groups of diseases.

If the local authorities are to be able to fulfil their public health responsibilities, the specialist health service must contribute its expertise through information and guidance. On the guidance side, it will be necessary to identify areas where the local authorities can have legitimate expectations of the specialist health service. In addition to epidemiological knowledge, these areas may be control of communicable diseases, cardiovascular disease, psychosocial problems in children and young people, substance misuse, and the prevention of asthma and allergies. With their knowledge of the correlations between risk, prevention and disease, the hospitals should be useful partners in the implementation of primary prevention programmes. It is therefore important to include the specialist health services in local and regional partnerships in public health work.

Box 6.1 Important measures – Health services

- Introduce incentives for physicians to prescribe physical activity and change of diet as part of the treatment of lifestyles diseases, on a par with those for prescribing no smoking.
- Evaluate organizational and financial aspects of the role of the general practitioner in the socio-medical services as part of the evaluation of the regular GP scheme
- Strengthen the child health clinics and school medical service, especially as regards the help they can offer young people.
- Strengthen preventive work under the direction of the specialist health service.

7 Building up new knowledge

«A more systematic build-up of knowledge is needed
if we are to do the right things – in the right way.»

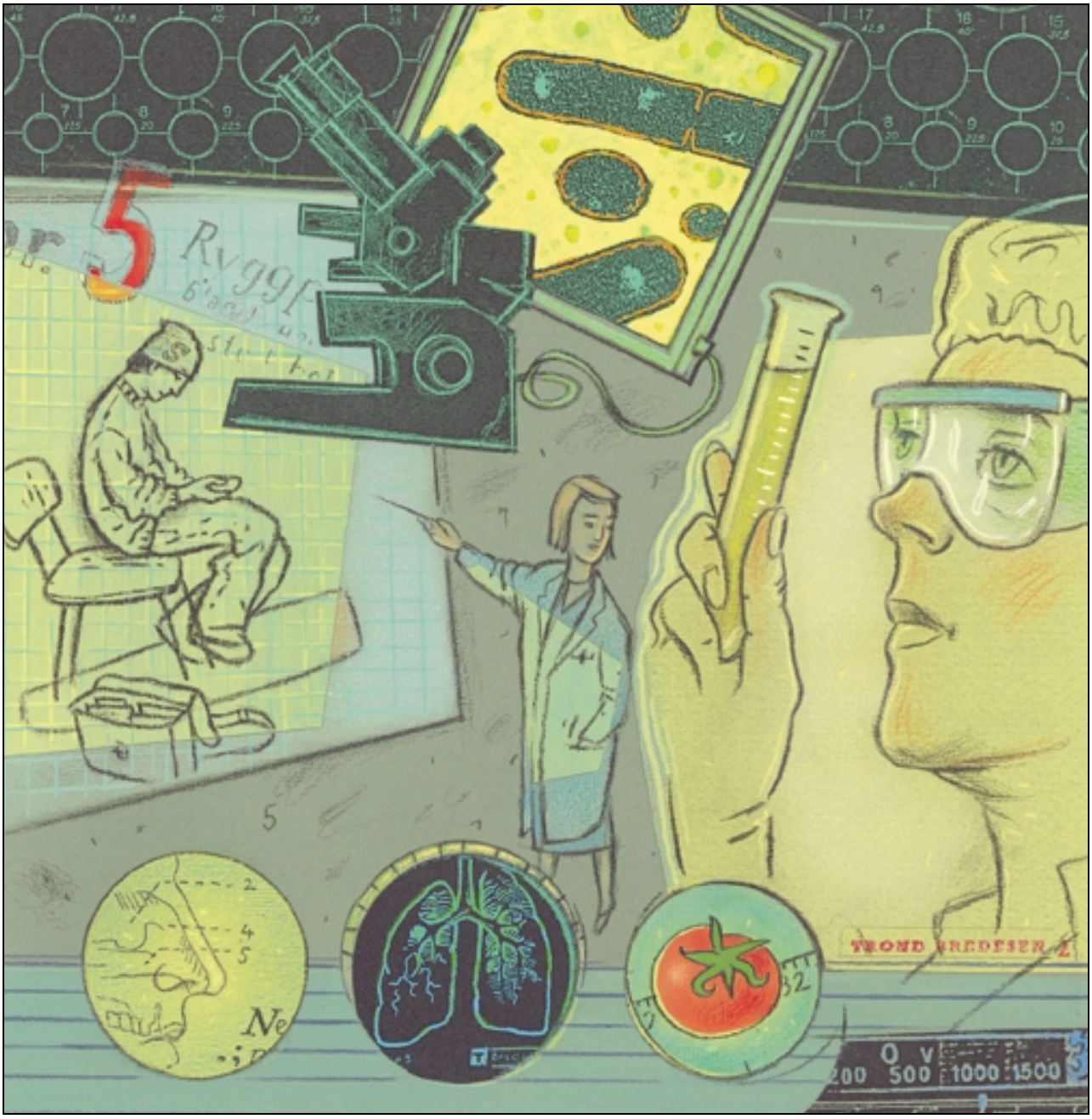

Figure 7.1: Building up new knowledge

Both policy-making and practice in public health work should ideally be based on reliable information. Measures that are planned and implemented must as far as possible be based on knowledge about causes and effects.

The requirement of knowledge is easiest to meet when the causal relationship is clear. In the case of some of the most important public health problems, such as musculo-skeletal disorders, mental problems and asthma/allergies, the causal relationships are complex and to some extent unknown. In order to raise the level of knowledge, we must proceed on several fronts:

- Health surveillance
- Causal research
- Research on actions and intervention
- Systematic evaluation
- Cost-benefit analyses

7.1 Health surveillance and research

Surveillance is an important part of public health policy and it provides a basis for formulating objectives, planning, implementation and evaluation. The aim of surveillance is to support planners and decision-makers. The Government aims for the most complete health surveillance system possible, which will make it possible to monitor developments in the health situation and factors that affect health, and make comparisons between geographical areas and between countries.

Data collection and the administration of health and disease registers are dependent on continuous research to assure the quality of the data. Moreover, data about public health must be used more efficiently in order to build up the public health knowledge base. This data must be regarded as a common property and it is therefore important to make the data sources we have at our disposal available for research in central administration, at hospitals, universities and research institutes. To ensure a more efficient utilization, cooperation between central administration and universities must be strengthened.

Research on actions and intervention is a difficult field which requires special attention. In Norway, the Research Centre for Health Promotion (HEMIL) and the nutritional research group at the University of Bergen have chosen children and young people as the focus of research. It will be important to develop these research communities and ensure a long-term build-up of specialist groups. Closer cooperation will be established between the Directorate for Health and Social Welfare and the Research Council of Norway/ research communities with a view to planning research on actions and intervention in public health.

In the field of public health, there is a need for research input from many subject areas and disciplines – from health subjects, from social subjects and the humanities, and from science and technology. Research cooperation across traditional disciplines and subject areas must be strengthened to ensure the inter-disciplinary knowledge that is needed here. The Government wishes to give priority to eating habits, physical activity, women's health, mental health and social inequality and health.

7.2 Education

In most basic educations in the field of health, the main emphasis is on examination, diagnosis, treatment of illness and injury, rehabilitation and nursing of individual patients. In education geared to public health work, the main emphasis is on preventive work in groups of the population or in the population as a whole. Teaching is interdisciplinary and based on knowledge from many subject areas. Most studies in the field of public health are post-graduate courses and are based on previous basic education and work experience. Public health work touches on many social fields and should therefore also be included to a greater degree in the framework plans for other subjects.

White Paper No. 27 (2000-2001) on a quality reform of higher education in Norway proposes introducing a new degree system which will apply to most higher level educations. The new structure will have a lower degree (bachelor) which will normally take three years and a higher degree (master) which will take a total of five years. In connection with the reorganization of the degree structure, the university colleges have been requested to review the vocational content and direction of their study programmes. It has therefore been suggested that the framework plans for all university college educations should also be reviewed in order to strengthen the public health perspective in the basic educations.

There are many post-graduate courses in health studies today. These last from six months to two years and qualify students for specialized professional posts. Following the reorganization of the degree structure for higher education, the

Box 7.1 Important measures – Building up new knowledge

- Strengthen the Norwegian Institute for Public Health as a national health surveillance body, and stimulate more research on material from the national health registers and from major mass surveys.
- Strengthen research on effective preventive measures by making the field more attractive to research scientists and paving the way for a long-term build up of expert communities.
- Develop strategies for more use of research-based knowledge about public health under the direction of the Directorate for Health and Social Welfare.
- In particular strengthen action-oriented research on eating habits, physical activity, women's health, mental health and social inequality in health.
- Strengthen the public health perspective in basic, continuing and post-graduate education and ensure that post-graduate courses in public health are incorporated in the new degree structure in the university and university college system.

vocational post-graduate courses should be given a place in the new degree structure. One of the tasks of a new accreditation body for higher education to be established on 1 January 2003 will be to evaluate applications from university colleges to offer studies at master level. This body will decide whether and to what degree the present-day post-graduate courses can be included in a master's programme.

Master programmes in International Health and Health Promotion have been established at the Universities of Bergen and Oslo, while the University of Tromsø offers a post-graduate diploma in Public Health. The first two are international in character. The main challenge here is to establish a master's programme in public health work based on the practical challenges in the field. The subject areas span a wide range of lifestyle-related subjects from food, physical activity, tobacco, alcohol and drugs to traditional subjects such as control of communicable diseases, radiation control, environmental health, food hygiene, preventive health services, health surveillance, epidemiology and other methodological knowledge, and social planning. A master's programme like this must be adapted to the needs and demands of several social sectors, be multidisciplinary, be of a higher degree standard and qualify students for further doctoral studies in public health science.

8 A strategy for women's health

«Since women and men are different, the various measures will have different effects.
In some cases it will be necessary to implement different measures for women and men.»

Figure 8.1: A strategy for women's health

The strategy for women's health is a follow up of the proposals in Official Report No. 1999:13 *Women's Health in Norway*. This report revealed a considerable lack of knowledge and poor integration of the gender perspective in health policy and practice. The Report proposes many measures aiming to create structures, routines and tools to ensure that the gender perspective is integrated in research and other forms of knowledge building, policy-making, preventive work, and health services and welfare schemes. Emphasis is given in the Report to the user perspective and to interdisciplinary cooperation, and it makes a point of stressing that gender – as biology, identity, symbol and structure – must be included as a necessary perspective in research, prevention and the health services.

The strategy for women's health aims to boost research and ensure that the gender perspective is given a central place throughout the health service. The Government wishes to follow up the general message in Official Report No. 1999:13, which underlines the importance of employing a comparative gender perspective in research, policy-making, health services and welfare schemes. An important part of the strategy for women's health is to strengthen and continue this work by, for example, highlighting women in the context of mental health, eating disorders, osteoporosis, cancer, diabetes, etc.

8.1 Decision-making processes

Better routines will be established for annual status reports on the work of integrating the gender perspective and gender equality in the Ministry of Health's sector areas, for example in routines for administrative procedures, reports and evaluation. Attention will also be given to quality assessment and integration of the gender perspective in statistics and in indicator and reporting systems. The gender perspective will be an important consideration in health impact assessments.

8.2 Building up and transferring knowledge

In the field of research, measures will be directed in particular at research into gender differences in health, causes of diseases to which women in particular are prone, and research into women's mental health. Special attention will be given to the elderly and to women from minority backgrounds. Knowledge will be built up about the side-effects suffered by women in particular. The Research Council of Norway will contrive to make gender and gender differences in health and illness a theme in all relevant projects. The National Committee for Medical Research Ethics has drawn up guidelines for the inclusion of gender as a variable in all medical research in Norway that relates to humans. The Ministry of Health will consider an evaluation of these guidelines for medicine. It will also consider whether corresponding guidelines should be drawn up and applied to health research in general.

8.3 Health practice

One of the prime objectives of the strategy for women's health is to ensure that the health services treat women in a more equitable way than has been the case up till now.

Two points emerge very clearly from descriptions of how women use the health services. Women have more contact with the health service than men and more often describe their meeting with the health service as problematic, full of conflict and not very constructive. Previous surveys of women's and men's relationship to general practitioners show that women go to the doctor more often, wait longer for an appointment and are more often displeased with the consultation than men.

Box 8.1 Important measures – A strategy for women's health

- Strengthen research on gender differences in risk of disease, development of disease, diagnosis, optimum treatment and prevention.
- Stimulate studies that look at gender differences in relation to the side-effects of medicines.
- Focus more on research-based knowledge and measures targeting health and living conditions and the use of the health and social welfare services by immigrant girls and women.
- Follow up efforts to prevent violence and sexual abuse of women and efforts to ensure that positive help is available to women who have been abused.

8.4 Violence and abuse

The Government's action plan *Violence against Women*, which expires in 2003, will be carried on. This plan includes a number of measures and projects targeting women who have been abused and aiming to increase relevant competence in the services. A committee set up by the Ministry of Justice to look at violence against women will submit its recommendation on 1 September 2003. The committee's terms of reference include a number of components relating to research and surveys of the incidence of different types of violence against women, the way they are treated by the support services and by the police and courts, and coordination of services. The committee will also address prevention, and the needs of especially vulnerable groups such as immigrants, the elderly and the disabled.

Work is underway to establish a national violence and trauma centre to strengthen research, development of human resources and dissemination of knowledge.

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