NORWEGIAN MINISTRY
OF HEALTH AND CARE SERVICES

Meld. St. 34 (2012–2013) Report to the Storting (White paper) Summary

Public Health Report

Good health – a common responsibility

Translation from the Norwegian. For information only.

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A call for collective actions

A hundred years ago, collective actions within public health work helped to curb the spread of infectious diseases. New collective actions are now required in order to curb the development of lifestyle-related illnesses.

Norway has experienced significant improvements in health and life expectancy. A century ago, voluntary organisations became involved in work with infection control, public baths, and health centres for mothers and children. Clean water and better housing were among the most important demands of the labour movement. Public health work over the past hundred years has been crucial in the fight against infectious diseases. Current public health work is crucial in the fight against non-infectious lifestyle-related illnesses.

Today, many people become ill as a result of an unhealthy diet, inactivity, and the use of tobacco and alcohol. More people are being placed on sick leave as a result of mental disorders. More people get diabetes, cardiovascular diseases, cancer and chronic obstructive pulmonary disease (COPD). These are not challenges that can be solved in hospitals or doctor's offices, but are rather challenges that must be tackled through all sectors of society.

Now, health is not only the responsibility of municipal health care officers, but is the responsibility of all sectors, in line with effective public health strategies. Planning at municipal level must take public

health into account when deciding how to use the municipality's areas. If a hundred square metres of woodland close to a residential area which is home to many young children is allocated for industrial purposes, there will obviously be fewer trees for the children to climb and fewer caves for them to hide in. Transport and communications officers are not only responsible for motorists – they are also responsible for cyclists. Our most important arenas for public health work are not operating rooms and outpatient clinics – they are kindergartens and schools in which all children are recognised and given opportunities.

Work must be undertaken in all sectors of society, and actors that are extremely important to public health outcomes are found in both the voluntary and private sectors. Labour market actors serve both their organisations and their employees if they facilitate physical activity and a healthy diet in connection with work. Football teams can ensure that hungry young players receive smoothies and sandwiches instead of soft drinks and brownies during their tournaments. Retailers can offer healthy alternatives and make the approach to store checkouts something other than a narrow corridor of crisps and chocolate.

A hundred years ago, it was the poorest people in society who suffered most from various illnesses, and this is still true today. Public health work is therefore not only work to improve the health of the entire population – it is also work to reduce society's inequalities. This is no small task, but we can accomplish much if we work together.

Welcome to our collective action!

Jonas Gahr Støre
Minister of Health and Care Services

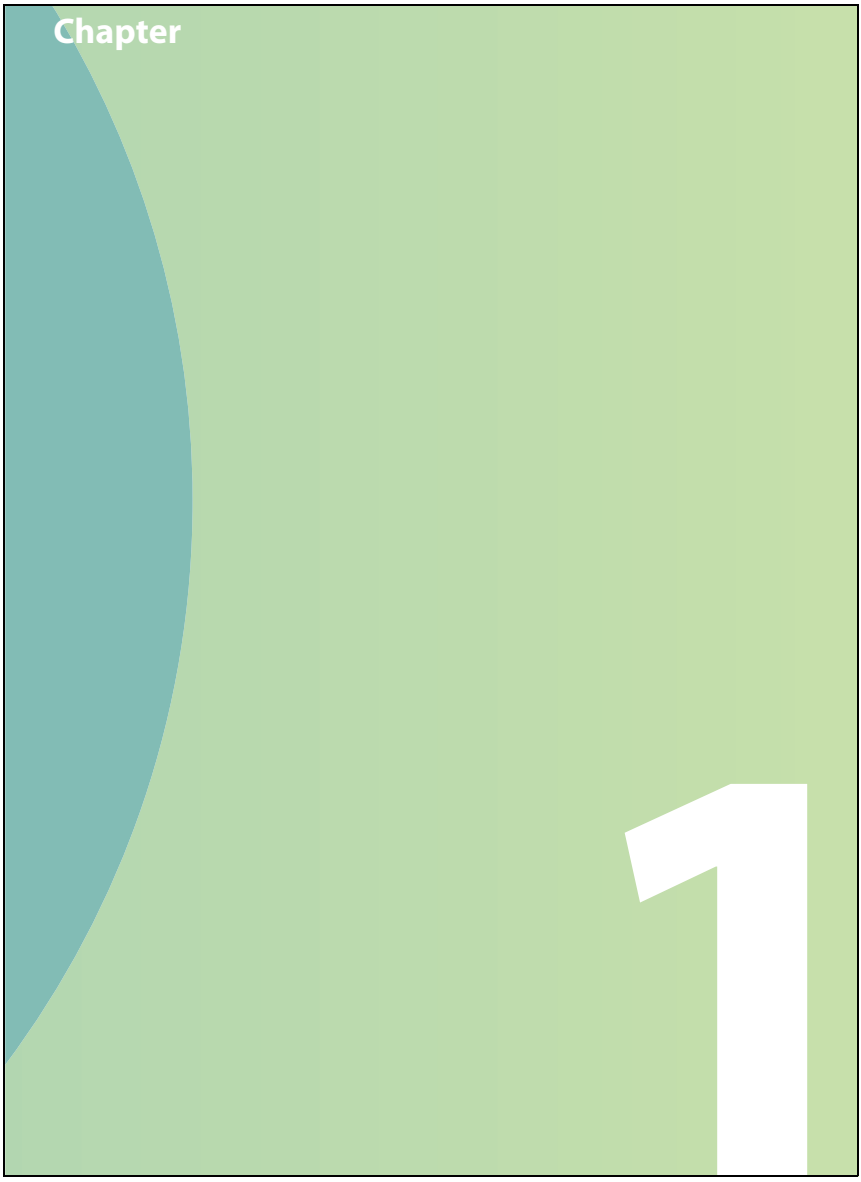

Figure 1.1

1 A public health policy for our time

The population of Norway is in good health. Over the last century, we have experienced a significant improvement in the health and life expectancy of the entire population. Work to improve the nation's health runs like a red thread through the development of the Norwegian welfare state. Developments in legislation and regulations, public hygiene, knowledge and public education have had a significant impact. Step by step, measures and reforms within many sectors of society have contributed to these developments, through the establishment of universal welfare programmes, comprehensive schooling accessible to all children and young people, improved housing, water and sanitation conditions, vaccinations, a high quality public health service, and the development of a labour market which safeguards the rights and health, safety and environment of its workers.

High quality health services are important if good health is to be achieved throughout the population. Historically, however, the development in sectors other than health and improvements in welfare have been of much greater significance. Improvements in the standard of living have been necessary in order to improve the population's health, while a healthy population that is able to work has simultaneously been a prerequisite for economic growth.

This positive development shows that we have solved many health problems, but we must now prepare ourselves to face new challenges. Norway, along with the rest of the world, is facing a global trend of illnesses which, in many cases, are related to our lifestyles, to what we eat and drink, and to too little physical activity.

Increased life expectancies and ageing populations, combined with improved treatments and lifestyle changes, have resulted in more people living with chronic conditions. Medicinal and technological advances result in increased expectations of the specialist health service, and prioritisation becomes increasingly demanding. At the same

time, there is still broad social inequality relating to health. In order to meet these challenges, the government will develop a public health policy for our time. This policy draws upon historical experience, builds on new knowledge, and is rooted in the values of equity and fair distribution.

1.1 Health is related to how we organise society

The population's health and social inequality in terms of health is influenced by welfare developments and differences in living conditions. Developments in health are closely related to the circumstances in which we grow up and the conditions under which we live. This is a question of facilitating societal development which provides optimal conditions for good health. We have a particular responsibility towards children and young people, and the government believes that this is where the majority of efforts should be directed. If we succeed in developing a healthier society, we will also create a foundation for inclusive workplaces, creativity and innovation, and contribute to social development in a range of other areas. Good health and improved living conditions within the population are therefore objectives of all public policy.

Good health involves having enough energy to meet life's everyday demands. This energy provides individuals with freedom of choice and the opportunity to live an independent life. Individuals have considerable responsibility for their own health, and authority and influence over their own lives. However, such responsibility cannot be limited to the individual alone. The prerequisites for being able to exercise freedom of choice are limited by societal inequalities in resources. We almost never make choices outside of a specific context or situation that affects our decision, and which we as individuals often have limited control over. Social conditions influence these choices, and from a government perspective, we must be aware of the possibility to facilitate healthy choices. Society has a responsibility to facilitate self-expression and create equal opportunities. This is about developing a society which distributes resources fairly, and which provides individuals with the opportunity to use their own resources and

exercise true freedom of choice. The objective of public health work is not to limit freedom of action – but to create opportunities.

The government takes a broad approach to the development of a healthier society. This includes everything from kindergartens and schools, communities and recreational opportunities such as sports and culture, to workplaces and transport, urban planning and commerce and industry. This goes to the very heart of the policy – the importance of fair distribution and the willingness to redistribute. Since Norway also has clear social inequalities in terms of health, we need a policy of fair distribution, with access to kindergartens and leisure activities that do not cost more than families can afford, a taxation policy which distributes the burden fairly, schools and universities free from tuition fees, and health and care services that are accessible to everyone. The public health policy must also attend to the needs of the indigenous population, national minorities and immigrants, for example in terms of cultural understanding and language barriers. Emphasis will be placed on the significance that the knowledge and attitudes of ethnic groups have upon health and the development of public health measures. In combination, this constitutes an effective public health policy.

Norway has achieved good results from tobacco control through advertising bans, smoking bans in workplaces, public places and restaurants, taxation and other measures. We have a vision of a tobacco-free society. We have had the courage to challenge the tobacco industry. International tobacco control measures have been of great significance in the development of the Norwegian policy, and international collaboration on effective public health measures will become no less important going forward. New international trends in consumption patterns that influence the health of the Norwegian population create the need for national initiatives and global strategies.

We must have the courage and willingness to challenge other industry sectors. New challenges can provide an opportunity and incentive for the development of new forms ways of collaboration and the sharing of responsibilities. We can utilise this opportunity to develop a stronger culture of social responsibility and participation.

The food industry can be encouraged to produce foods which contain less salt, sugar, and unhealthy fats. We can challenge those who produce and sell alcohol to take a greater social responsibility. This is a more complex and demanding agenda, and the opposing forces are strong. There is a need for more knowledge and improved facilitation. Provided that the conditions are appropriate, the public and private sector can collaborate to shift the development in a healthier direction. In other cases, we have a responsibility to use the democratic right to adopt regulations, and this applies to our responsibility to safeguard the health of children and young people in particular. When evidence shows that something is harmful to health, the population is entitled to be protected.

1.2 Increased collective efforts for public health

The government will reinvigorate the public health policies. We can improve public health, but this requires that preventive and health-promoting measures become a part of increased collective efforts. In Norway, we have a unique opportunity to meet the new public health challenges. Our society is characterised by social safety and trust, economic sustainability, and a welfare state that makes us well-equipped to face new health challenges. If, collectively, we are to give public health the boost it needs, all of society must contribute. This is a positive agenda motivated by opportunities.

We need a new approach which more firmly creates and anchors ownership of the public health objectives throughout the majority of the population. We shall carry existing policies forward. But facing lifestyle-related illnesses requires an approach which more strongly motivates and inspires each and every one of us. It is not enough for political authorities to own the objectives – they must be anchored throughout society. This applies to voluntary organisations, trade unions, industry and employers in both public and private sectors. The nation's health is a shared responsibility. Everyone is responsible for developing a society which promotes good health, and every individual is responsible for his or her own health.

For example, industry can take responsibility by producing healthier products, contributing to projects which adopt a public health approach, and by making it easier for consumers to make healthy choices. In terms of diet, there are several good examples of collaboration between the health authorities and the food industry. This collaboration can be developed further, and be made obligatory. Industry can and should take greater responsibility as an employer, for example in terms of attitudes towards and the consumption of alcohol in social contexts, facilitating physical activity and a healthy diet, and measures to create more inclusive and healthier workplaces.

Workplace organisations – both employee and employer organisations – are both challenged and invited to assume their share of the responsibility. Effective public health work will prevent the exclusion of large groups from education and employment. In the same way, public health work is about creating a safe and secure working environment, which is also profitable for the company, and not least, can help to level out social inequalities in health. The workplace is also well-suited for initiating health-promoting measures and preventive work.

There is a long tradition of collaboration between public authorities and voluntary organisations in public health work. This applies to organisations that have public health as a specified work area, sport and outdoor recreation organisations, humanitarian and non-profit organisations, cultural sector organisations, patient and end-user organisations, and a range of other organisations. This is about the organisations' intrinsic value as a social meeting place, the activities offered by those organisations, the development of health-promoting arenas such as through the creation of alcohol and smoke free areas, outdoor recreation and exercise facilities, and offering healthier foods at events. This collaboration should be developed further, not least within local communities, where the municipalities shall facilitate collaboration with voluntary organisations. The government will initiate a dialogue regarding how voluntary organisations can become even more important collaborative partners in public health work, about the organisation of public sector initiatives, and about the need for improved coordination across sectors.

Local authorities play an important role. One of the objectives of the Coordination Reform is to contribute to promotion of health and the implementation of more effective preventive measures, and to take responsibility at an early stage, in the context of where we live and work. General Practitioners, who form the backbone of municipal health services, can contribute by becoming more involved in health-promoting measures and preventive work. Through the new Public Health Act, local authorities now have greater responsibility for prevention within the health service, as well as public health work across sectors. Local authorities are responsible for maintaining an overview of local public health challenges and opportunities, but choose their own objectives and measures in order to promote the health of their municipality's inhabitants. Most municipalities feature cultural and linguistic diversity, and linguistic and cultural competence is therefore important. In accordance with the Planning and Building Act, municipalities must take the Sami community into account in their planning. The involvement of local authorities provides opportunities for public health initiatives comprising all sectors. This requires effective management, political engagement, and well-founded plans and the power to implement them. Many local authorities have already taken up the challenge with great enthusiasm, and public health work is now more highly prioritised on municipal planning agendas.

1.3 National objectives

The government's objectives for the public health work are as follows:

- Norway shall be among the top three countries with the highest life expectancy in the world
- The population shall experience more years of good health and well-being, with reduced social inequalities in health
- We shall create a society that promotes good health throughout the entire population

The objectives build on the government's strategy for reducing social inequalities in health as laid down in White Paper no. 20 (2006–2007) Nasjonal strategi for å utjevne sosiale helseforskjeller (National Strat-

egy for the Reduction of Social Inequalities in Health), and in the national healthcare plan presented in White Paper no. 16 (2010–2011). The preamble of the Public Health Act states that the Act shall contribute to social development which promotes public health and the reduction of social inequalities in health, while also promoting good social and environmental conditions.

The basis of the public health policy is that health not only involves the absence of disease, but also includes high energy levels, satisfaction, and well-being. Good health is something that we can have more or less of – it is not simply a case of being either healthy or ill.

1.3.1 Among the three countries in the world with the highest life expectancy

One of the government's objectives is that Norway shall be among the top three countries in the world with the highest life expectancy. This objective will be achieved by reducing premature death and reducing social inequalities in mortality. Norway is committed to the World Health Organization's objective to reduce premature deaths as a result of lifestyle-related illnesses by 25 per cent by 2025.

The objective that Norway shall be among the three countries in the world with the highest life expectancy is new to public health policy, but simultaneously builds on the existing objectives to improve health and life expectancy. A good position in international rankings is not an objective in itself, but life expectancy is a good measure of the health situation of a population. We are well-equipped to achieve this objective. We have a high standard of living, relatively low social inequality, good welfare schemes and a high quality healthcare service. The Nordic welfare model represents a society characterised by security and a high level of social confidence, along with economic and demographic sustainability. In the 1950s, life expectancy in Norway was the highest in the world, and in the 1960s and 1970s we were among the three countries in the world with the highest life expectancy. Although we have seen a sharp increase in life expectancy, we are currently only among the ten or eleven countries in the world with the highest life expectancy. There is no reason that we should not be

among the countries with the highest life expectancy in the years to come. This objective must be seen in the context of the other objectives, and efforts to increase life expectancy must be targeted towards strengthening the prerequisites for a long life with good health.

1.3.2 More years of good health and well-being, with reduced social inequalities in health

One objective is that the public health policy shall contribute to individuals experiencing more years with good health and well-being, and reduced inequalities in health.

There is a clear correlation between socio-economic resources and health. If we group the population by income and level of education, we see that the higher a person's income or level of education, the better their health status. The relationship between social position and health is gradual and continuous, and therefore affects all levels of society. We find many of the same social inequalities within the indigenous population, national minorities and immigrant groups. At the same time, however, education and income do not necessarily reflect social inequalities in the indigenous population in the same way as within the Norwegian population in general.

The results of the global burden of disease project suggest that when life expectancy increases, a larger number of those years will be with reduced health. High quality data shall be developed both in order to monitor whether the objective is achieved, and to be able to better assess future needs. Disability and assistance needs are related to factors other than purely medical ones. For example, it appears that although the incidence of diseases is increasing, the number of elderly people with assistance needs and impaired mobility in the Norwegian population has reduced in recent years.

1.3.3 Create a society that promotes good health throughout the entire population

The government will create a society which promotes health and reduces social inequalities in health without a decline in the health of

any group. The objective is based on the fact that there are a range of social factors that affect health and the distribution of health throughout the population. For example, this applies to factors such as the drop-out rate from high school, environmental impacts, income inequality and social differences in lifestyle. By setting objectives for factors that affect health, it also becomes possible to see results in the form of reduced risk long before they result in illness and death. In addition, this helps to highlight the responsibility of sectors and participants with responsibility for the measures.

Social inequalities in health are primarily caused by differences in material, psycho-social and behavioural risk factors. This means that the work to reduce social inequalities in health is also about promoting social cohesion through the reduction in inequalities in income and education. Ethnic discrimination is another factor which can result in health problems. A society which promotes health and shall reduce social inequalities in health must take social, economic, cultural, and environmental conditions into account.

In order for national objectives to function as an effective tool in the work to follow-up and develop the public health policy, it is necessary to render the objectives concrete through the use of performance targets and indicators.

1.4 National tools and measures

This White Paper presents a comprehensive government strategy to develop a public health policy for our time and strengthen the preventive work in the healthcare service. The White Paper represents the national authorities' follow-up of the guidelines presented in the Public Health Act.

Through the Public Health Act, the government is assigned responsibility for the public health work at a national level. Firstly, this involves a national responsibility to identify public health challenges and possibilities by monitoring developments in the state of the nation's health and factors which affect this. Secondly, it means that the description of the public health challenges shall form the basis for the planning and design of national measures. Thirdly, national

authorities are responsible for assisting the municipal sector and facilitating systematic and knowledge-based public health work.

An overall assessment of the public health challenges forms the basis for the tools and measures that are described in this White Paper. The White Paper is based on recognition of the fact that public health challenges cannot be solved within the health sector alone, but are a shared task to be undertaken by society as a whole. The most important thing we can do to strengthen the public health work is to ensure that the nation's health is taken into account across the various sectors. The Public Health Act has established the legal framework, and in this White Paper, the government sets out the overall guidelines for its implementation.

Recognition that public health work is a cross-sectoral responsibility, and one which covers all sectors of society, is nothing new. However, in this White Paper, the government will go one step further and establish an improved system in order to ensure more effective implementation of the public health policy. The White Paper will also help to highlight how policies in all areas of society affect the population's health – the principle of «health in all policies.»

Public health work is not the responsibility of the public sector alone – the whole of society must contribute. The government therefore invites the collaboration of participants outside the public sector and shared responsibility for the nation's health. This applies to industry, labour market partners, voluntary organisations and other participants that can help to improve the health of the population.

This White Paper is also a follow-up of the guidelines in the Coordination Reform. The Coordination Reform assumes a shift in resources towards preventive work and early intervention in the municipal health care service. Through the introduction of municipal co-financing and payment for patients ready for discharge, the government has given local authorities incentives to take responsibility for more patient care and to focus on prevention and early intervention. Local municipalities have also been allocated funds through block grants in order to establish the necessary competence.

1.5 Values and principles

Public health work shall contribute to good health and improved living conditions throughout the population. This does not apply to the health and care sectors in isolation, but is an objective of all public policies. Good health is a value in itself, and increases opportunities for individual self-expression. Good health is a resource and prerequisite for other objectives, such as a productive working life, efficient learning, and the excess energy to contribute to voluntary work. High levels of ill-health and low levels of functional ability place strains on and result in costs for both the individual and society in general in the form of health care services, sickness absences, and social security.

1.5.1 The responsibilities of society and the individual

The population's health is affected by political decisions and the choices of private sector participants that lie beyond the reach of individuals. Since health is affected by social development and the conditions under which we live, the public health policy is about enabling individuals and local communities to take control of conditions that affect their health. This includes, for example, factors such as financial security, participation and the ability to cope, a sense of meaning and inclusion in education and employment.

There must be a balance between society's responsibility for public health and the personal responsibility an individual has for his or her own health. Individuals have considerable responsibility for their own health, and autonomy and influence over their own lives. At the same time, however, the individual's freedom of action in many areas is limited by circumstances beyond the individual's control. Even smoking, physical activity and diet are influenced by the economic and social background factors which the individual has not consciously chosen. The use of tobacco affects not only users but also their families, surroundings and others due to passive smoking, passive drinking and behaviour resulting from intoxication. As long as systematic inequalities in health are due to inequalities in the way

society distributes resources, then it is society's responsibility to take steps to make this distribution fairer.

Influencing choices that affect health through the provision of information, contribution of knowledge, and influencing of attitudes is a social responsibility. This may involve making it easier and more attractive for people to make healthy choices, and more difficult to make unhealthy choices. The influencing of others also represents an associated ethical challenge. Such influence must be based on a solid foundation of knowledge, and be well-reasoned and discussed. Policy instruments must therefore be based on respect for differences in values and be fundamentally accepted within society. The public health policy should be subject to public discussion and debate which covers as many parts of the population as possible. This is particularly important since immigration has resulted in Norway's population becoming more linguistically, culturally, and religiously diverse.

1.5.2 The prioritisation dilemma and the prevention paradox

An objective of the health policy is that it should enable the entire population to experience the best possible standard of health. Both the Public Health Act and the Health Care Act stipulate that services and activities shall be organised in a manner which prevents individuals losing years of good health. This means that available resources shall be used in a way which ensures that they contribute to social equality and the best possible health and quality of life.

In practice, it is often difficult to prioritise prevention over treatment, even if this will provide greater improvements in health in the long term in return for the resources used. Unfulfilled treatment and care needs will always exist. In addition, strong economic interests, the media, and interests of professional organisations direct attention and resources towards specialist treatment. Since no images or stories exist about the ill individuals of the future, ensuring the prioritisation of prevention will always be a political challenge.

If we assume that the resources allocated to health are of a given size, prevention may theoretically be seen as taking resources from those who are currently ill and transferring these resources to healthy

individuals. Such an approach may lead to the conclusion that it is more reasonable to undertake preventive work once all pressing problems have been resolved. However, such an approach will never allow for the implementation of preventive work. Even if we utilise resources effectively, we must always assume that the demand for treatment will be greater than what is available. The paradox of this approach is that, over time, it will result in a greater loss of years in good health for society's individuals. In addition, it is problematic that the approach does not take into account the interests of individuals who will become ill in the future, because no focus is placed on preventive work today. The problem has a clear parallel to environmental challenges, such as the question of what sort of climate or which natural resources we will pass on to future generations. As a society, we must also take responsibility for planning for future needs. Both the Coordination Reform and the Public Health Act are based upon the principle of sustainability, and greater emphasis must therefore be placed on documenting the relationship between the effect on health and the use of resources for preventive measures in order to enable a more direct comparison with medical treatment.

We face a similar prioritisation challenge in terms of prioritising between targeted preventive measures for high-risk groups and broad preventive measures targeted towards the entire population. The trade-off between targeted measures and population-based measures is often referred to as the prevention paradox. This paradox means that measures targeted towards low-risk groups can be just as effective as measures targeted towards groups that are at risk. This is explained by the fact that the low-risk group is large, and the measures will therefore be effective for many. Central to the paradox is the fact that measures that have a seemingly modest effect, but which are directed towards many, can have a far greater public health impact than measures that have a large and measurable effect at the individual level for few.

General welfare schemes are also effective for vulnerable groups. Welfare schemes that are universal and accessible to everyone improve public health, do not stigmatise minority groups, and help to prevent individuals from ending up in vulnerable situations. The

World Health Organization and the World Bank recommend universal schemes as an important approach in the context of the follow-up of the development agenda after 2015. The right to kindergarten places for children is a good example. Today, virtually all Norwegian children attend kindergarten, with most enrolling when they are between one and two years old. Through this daily contact with children and parents, employees have the opportunity to identify and provide help to vulnerable children at an early stage. This applies to all kinds of vulnerabilities, from children who require additional language stimulation or follow-up for minor developmental abnormalities, to children exposed to violence, abuse, and neglect.

1.5.3 Five principles for public health work

The Public Health Act is based on five principles for public health work: equity, health in all policies, sustainable development, precaution and participation.

Equity

Good health is unevenly distributed between social groups within the population and there are many factors which contribute to creating and maintaining such inequalities. The relationships are complex, but that it is primarily social conditions that influence health, rather than vice versa. Although in many cases serious health problems may lead to a loss of income and employment, as well as problems in completing education, social position still affects health to a greater extent than health affects social position.

There is a gradual and continuous relationship between education, income and health which runs throughout all social groups. With the exception of some particularly vulnerable groups, there is no education and income threshold above which health is significantly improved. This means that social inequalities in health are a challenge that affects society in its entirety, even if the problem is greatest for those groups that have the lowest levels of education and income. As long as systematic inequalities in health are due to inequalities in the

way society distributes resources, then it is the community's responsibility to take steps to make this distribution fairer.

The purpose of the Public Health Act is to promote public health and reduce social inequalities in health. The principle of equity has implications for the formulation of policy at all levels. This means that efforts should be targeted towards the underlying factors that affect health and social inequalities in health, as well as towards giving everyone the opportunity to make good choices. A combination of universal schemes and initiatives targeted towards particularly vulnerable groups is necessary.

Health in all policies

The realisation of «health in all policies» is at the core of the public health work. The principle shall ensure that public health is addressed across all sectors. This means, for example, that the education sector, the transport and communication sector and the cultural sector have a responsibility to assess potential consequences of policy changes for the population's health.

The principle of «health in all policies» has also been established as a principle in international processes, and is based on an increasing understanding of how conditions in most areas of society affect public health.

In the Public Health Act, the principle of «health in all policies» is expressed through the fact that responsibility for public health is not ascribed to the health service, but to the municipality itself. The Act is also based upon the premise that local authorities, county administrations and state authorities shall promote public health and assess the impact of their activities on the health of the population. Preventive measures shall be implemented in the sector using the policy instruments that are most effective.

Sustainable development

Sustainable development involves satisfying current needs without this being at the expense of the needs of future generations. The

Brundtland Commission of 1987 defined sustainable development as «... development that meets the needs of the current generation without compromising the ability of future generations to meet their needs.» Sustainable development is about facilitating societal development that ensures basic needs are met over time.

A health sector that consumes too many of society's overall resources, including labour capacity, is not sustainable and may threaten the welfare state's existence. The objective of the Coordination Reform is to develop a sustainable health service by strengthening the preventive work.

A population in good health is an objective in itself, and is one of society's most important resources. A focus on public health work is a foundational investment for better lives and a sustainable society. Preventive work is sustainable because it helps to place greater emphasis on the needs of future generations – which results in greater equality between generations. Good health is of great significance both in terms of an individual's quality of life and in terms of ensuring that society has a healthy and productive population which can contribute to economic growth and prosperity.

The precautionary principle

The precautionary principle shall be applied when establishing norms and standards for effective public health work. This applies to both risk-reducing and health-promoting measures. In many cases there will be uncertainty regarding the relationship between exposure and health benefits, or about the relationship between initiatives and health benefits. When determining norms, it is sufficient that it is probable that an exposure or may pose a health risk. Scientific certainty is not necessary.

The precautionary principle places the burden of proof on the entity responsible for the initiative or exposure, and must be seen in the context of the «health in all policies» principle. Consideration for the population's health is not only a responsibility for the health service, but for all sectors and organisations engaged in activities that may have an impact on health.

The precautionary principle does not assume that the risk should be non-existent, but that it should be acceptable. The principle provides guidelines regarding how to handle uncertainty. An assessment of what constitutes an acceptable level of risk may also include proportionality assessments. From a sustainability perspective, the precautionary principle not only involves assessing what is needed to prevent health problems and emergency situations, but also what is required in order to promote and maintain the nation's health. The precautionary principle is also legally established through the chapter of the Public Health Act regarding environmental health, which provides the authority to intervene before any damage to health is caused.

Participation

Through the right to freedom of expression, the right to participation is laid down in Article 19 of the Declaration of Human Rights and Section 100 of the Constitution. A child's right to be heard is laid down in Article 12 of the Convention on the Rights of the Child. In addition, participation in planning is regulated by Section 5–1 of the Planning and Building Act. The Sami Parliament has the right to object in municipal planning processes that are of significance for Sami culture and commercial activities in accordance with Section 5.4 of the Planning and Building Act. The Planning and Building Act shall help to ensure a natural basis for Sami culture, commercial activities and social life, see Section 3–1 point c. In accordance with Section 3 of the Regulations regarding public health overviews, local authorities shall consider public health challenges specific to the Sami population where there is reason to believe these exist. In this context, it may be appropriate to obtain experience and knowledge of the Sami population both as a basis for clarification and in order to assess the challenges.

The term «empowerment» is often used in health-promoting work in reference to individuals' and local communities' power to influence decisions. Synonyms for the term include authorisation, providing legal capacity, and the strengthening or mobilisation of own

resources. The core of this concept is the opposite of powerlessness or oppression – it is about how individuals and local communities can take control by mobilising and strengthening their own forces. The possibility to mobilise resources relates to the conditions under which people live. This means that participation can be stimulated by strengthening social resources and improving material living conditions.

The Public Health Act links the public health work of local authorities to the provisions regarding participating in the Planning and Building Act, thereby contributing to the legalisation of the right to participate. The involvement of voluntary organisations is central to ensuring participation in the public health work, and local authorities are obliged to facilitate collaboration with the voluntary sector through the Public Health Act.

See also White Paper no. 10 (2012–2013) Good quality – secure services in which the government emphasises the development of a more patient and user-oriented health care service.

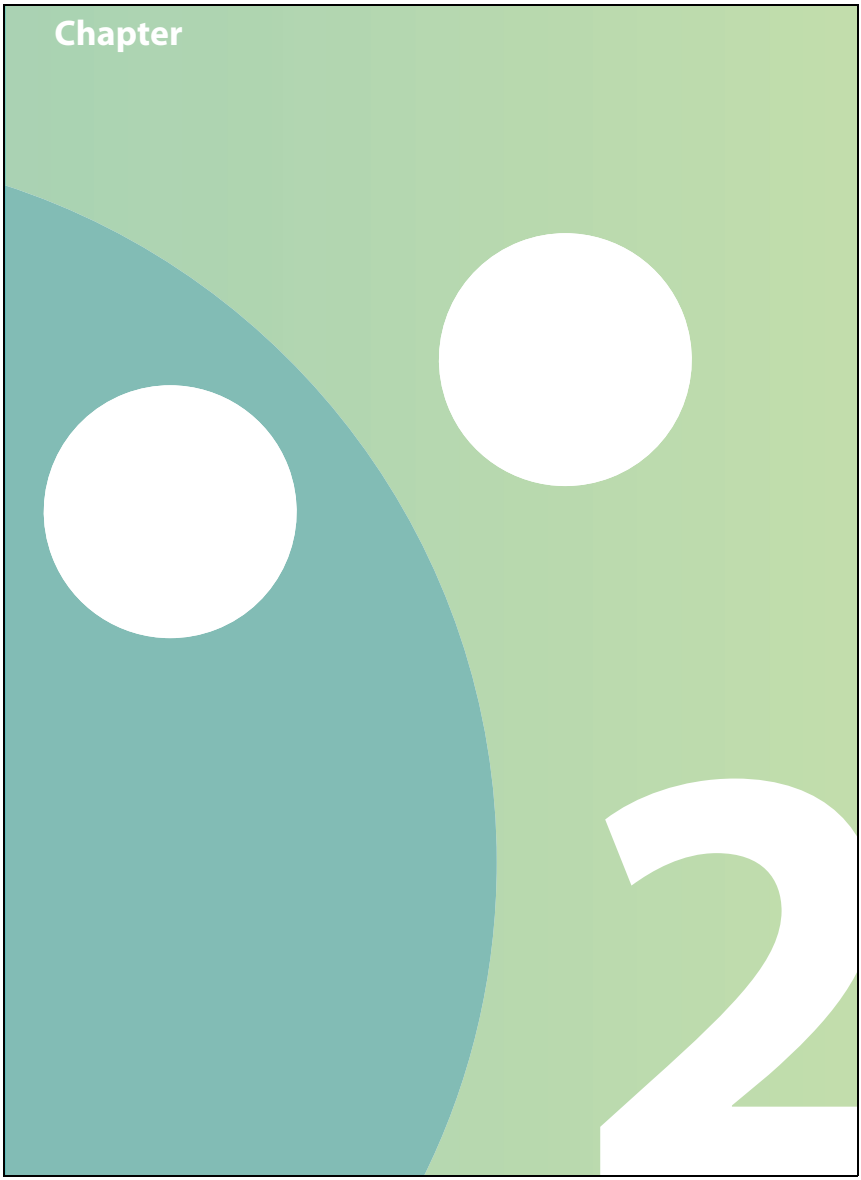

Figure 2.1

2 Health challenges in the 21st century

2.1 State of health

In the 1950s, Norway had the highest life expectancy in the world, while today there are several other countries with better life expectancies. Japan, Australia, Switzerland, Italy, Iceland, Sweden, Singapore and Israel all have higher life expectancies than Norway for both men and women. In addition, French and Spanish women live longer than Norwegian women.

A key feature of this global development is decreased mortality among young people, increased mortality in older age groups, fewer deaths due to infectious diseases and more deaths due to cardiovascular diseases, cancers and other diseases that are not caused by infection. In 1990, infectious diseases caused over half of all deaths. Twenty years later, two in three people died of illnesses other than infectious diseases. In 2010, the five main causes of death worldwide were coronary heart disease, stroke, COPD, lower respiratory tract infections and lung cancer. These diseases are also among the six most important causes of mortality in Western Europe.

The situation in Norway is in line with global trends. A distinctive feature is reduced mortality among the young and increased mortality in older age groups. Another distinctive feature is fewer deaths due to infectious diseases and more deaths due to cardiovascular diseases, cancers and other diseases that are not caused by infection. A third distinctive feature is that the risk factors are the same for most countries. These include smoking, high levels of alcohol consumption, an unfavourable diet and physical inactivity. Even though the new global trends have not reversed the favourable development of increased life expectancy in recent decades, there is much evidence to suggest that trends in unhealthy diets, a lack of physical activity and increasing obesity will slow progress. Increasing life expectancies and ageing

populations have resulted in more people living with chronic illnesses. Despite an increase in the incidence of disease, the proportion of elderly people with a need for medical and other assistance has declined over the last 20 to 30 years.

Even though the health of all groups within the population has improved, social inequalities in health remain a challenge. Groups with higher education and high incomes have experienced the greatest increase in life expectancy. Cardiovascular diseases create the greatest social inequalities in terms of premature mortality.

Almost a quarter of the adult Norwegian population suffer from a mental disorder, and between a third and a half of the population will be affected once or more in their lifetime. Around 10 per cent of the

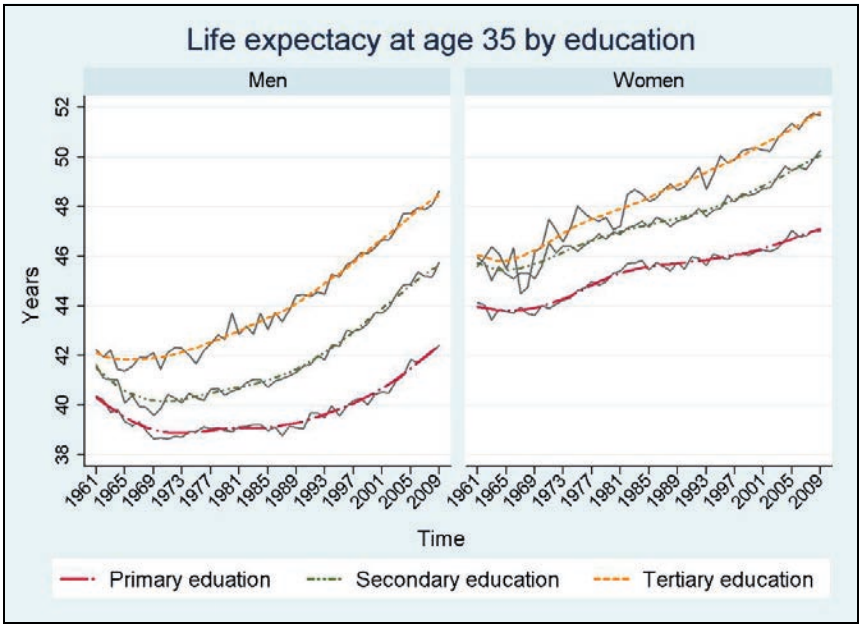

Figure 2.2 Life expectancy at age 35 by education

Source: Steingrímsdóttir and colleagues (Eur J Epidemiol 2012; 27: 63–71). Published with the permission of Springer Science & Business Media B.

adult population report having sought treatment for mental health problems at some point during their lifetime. However, the actual need is probably somewhat higher. The most common conditions include anxiety, depression, and alcohol and drug-related disorders.

2.2 Conditions that affect health and life expectancy

Physical and mental health is the result of an interaction between individual characteristics and factors that may be protective or involve risk. Examples of protective factors include social support, positive life events and physical activity, while unemployment, drug abuse, insufficient social support, an unhealthy diet and obesity are examples of risk factors. These factors are interrelated and form part of a much larger overall picture. For example, changes in diet and physical activity do not usually occur in isolation but as a part of changes in families, working environments, local communities, or society in general.

Conditions within wider society, the local community, and the individual's social network may have an impact on health. A society characterised by mutual trust, social support and solidarity promotes health, while a local society with little sense of community and little social interaction provides an increased risk of health problems. A declining industrial base, extensive inward and outward migration and/or rapid social change can all have an adverse effect on health. Social support in the form of empathy, emotional support, practical assistance and social control has a direct positive effect on health, and can act as a buffer when the individual is exposed to stress or negative life events.

Health and illness are influenced by both present factors and factors dating almost all the way back to when the individual was conceived. A number of vulnerable periods exist throughout an individual's lifetime. Many chronic illnesses are influenced by biological, psychological and social factors that culminate in and contribute to increased risk throughout an individual's life. In many cases, it takes several years before a determinant results in illness. An example of this is smoking as a cause of lung cancer and COPD, in which the ill-

ness and symptoms first become apparent after 20 to 50 years of smoking. In the case of acute coronary thrombosis, however, the risk is already significantly reduced in the first year after quitting.

Figure 3.1

3 A more health-promoting society

The government will base the new public health policy on the premise that public health will be taken into consideration in all policies, and that good conditions for promoting health and well-being will be created. The principle of health in all policies involves more than the health policy alone – it also involves the development of health-promoting policies in all sectors.

Determinants of health can be presented in a causal chain, which extends from general social conditions to individual characteristics. This is illustrated in Figure 3.2. At the start of the causal chain are general social conditions such as economic development, environmental conditions, and political governance. Next in the chain are living and working conditions and social conditions such as social capital, as well as networks and relationships. Towards the front of the chain are individual lifestyles and health-related behaviours that have a more immediate impact upon health, but which are also shaped by conditions within society and the environment.

The overall health situation of a local municipality, county, or country is not simply the sum of individual choices and genetic factors. There are broad geographical and social inequalities in health. Societal conditions create these inequalities – inequalities which we can influence through planning, management, and initiatives. The population's health and social inequalities are closely related to welfare developments and differences in living conditions and income. Norway has a well-functioning civil society with high levels of participation in voluntary work, a diverse culture and generally high level of well-being. Norwegian society is characterised by a high level of trust between the country's citizens, authorities, and democratic institutions.

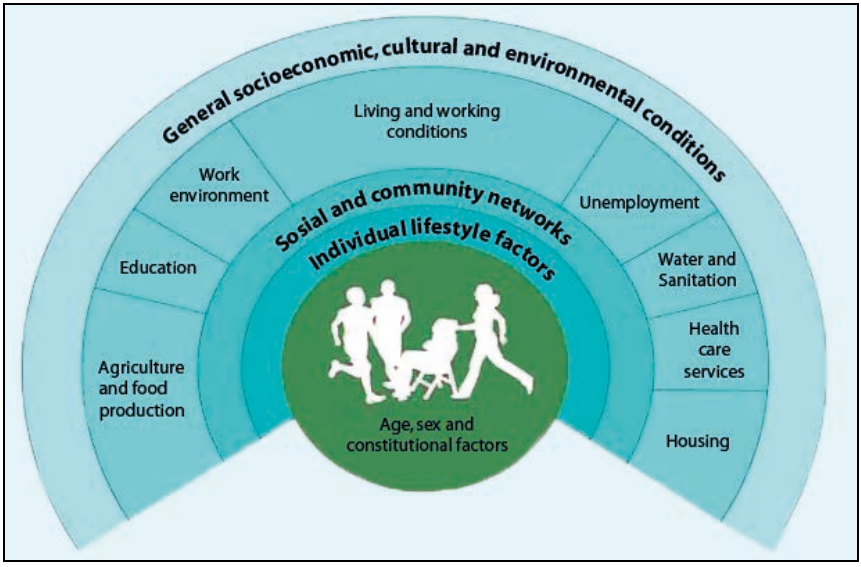

Figure 3.2 Determinants of health[1]

[1] Dahlgren, G., Whitehead, M. (1991). Policies and strategies to promote social equity in health. Stockholm: Institute of Futures Studies

The government's policy for the further development of the universal welfare is one of the main ways in which a sense of social community and inclusion can be strengthened. This is also recommended in a report on social exclusion published by the World Health Organization. The Norwegian welfare model makes a considerable contribution to ensuring that there is a high level of labour force participation. There is good access to free education, unemployment is low, social security is good and cultural activities are accessible to most people. Policies to promote equality and combat discrimination also help to promote inclusion. The public health policy shall build upon the Norwegian welfare model with universal schemes for kindergartens, education and health services, employment initiatives, an accessible cultural policy, and active collaboration with and support for the voluntary sector. In addition, consideration for public health shall take greater precedence in municipal and regional development, industrial

policy, local community efforts, and transport and communication policy. The health of the population and how well health is distributed shall be given greater attention in the planning of a more health-promoting society. In order to prevent lifestyle diseases, it will be strategically important to make healthy choices more readily available and limit the accessibility of unhealthy products. Initiatives targeted towards children and young people shall be prioritised.

Box 3.1 A more health-promoting society

The government will:

- Continue its policy towards an equitable society and prevent children from living under poor living conditions and low incomes
- Submit a White Paper to Parliament on the living conditions of individuals with disabilities
- Submit a White Paper to Parliament on gender equality from a life course, ethnicity, and class perspective
- Help to raise awareness and increase knowledge of the relationship between social support, social capital, and health
- Help to make sure that public health considerations are given greater precedence in the development of local environments and communities
- Present a strategy for active outdoor lifestyles that will facilitate outdoor activities for everyone and outdoor activities in the local community. Help to ensure that outdoor recreation areas across the country are mapped and valued
- Continue and further develop measures to protect and develop particularly important outdoor recreation areas by prioritising this in the local community
- Place more emphasis on preserving important green areas for recreation and outdoor activities near residential areas
- Work to provide more environmentally friendly and healthier transport and transport solutions through the National Transport Plan Follow-up the consultation with proposals for national targets for water in order to implement the World Health Organization and UNECE's Protocol on Water and Health
- Work to introduce a 'smiley programme' in the hospitality industry
- Implement EU's new food information programme with more stringent requirements for the labelling of nutritional content and country of origin
- Invite the hospitality industry to collaborate on the possible introduction of the labelling of the energy and nutritional content in foods and drinks

Box 3.1 continues

- Aim to create a national centre for nutrition, physical activity and health in kindergartens and schools in order to contribute to increased well-being and concentration, and to strengthen students' ability to learn
- Create a cross-sectoral group of experts in order to summarise knowledge of antibiotics and antibiotic resistance
- Develop better management data for the operation and maintenance of public buildings
- Review environmental health regulations and further develop environmental health management in line with the Public Health Act
- Maintain a long-term ambition to expand the programme for free fruit and vegetables to all students in primary and secondary schools
- Consider how the school day can be organised so that students get at least one hour of physical exercise every day
- Implement a physical activity campaign to increase the population's understanding of the importance of physical activity and the health consequences of physical inactivity, as well as increase awareness of what is necessary in order to achieve health benefits for the individual
- In future budgets, evaluate whether it is possible to reorient health-related excise duties in a manner that contributes to improved public health
- Further develop and follow-up tobacco prevention work through a National strategy to combat harm caused by the consumption of tobacco 2013–2016
- Further develop and follow-up an alcohol policy based on pricing initiatives and regulations to restrict availability, cf. White Paper no. 30 (2011–2012)
- Collaborate with the food industry and retail companies with the aim of entering into a binding agreement for the regulation of marketing of unhealthy foods and beverages to children and young people, and if this is not possible, introduce legislation against such marketing

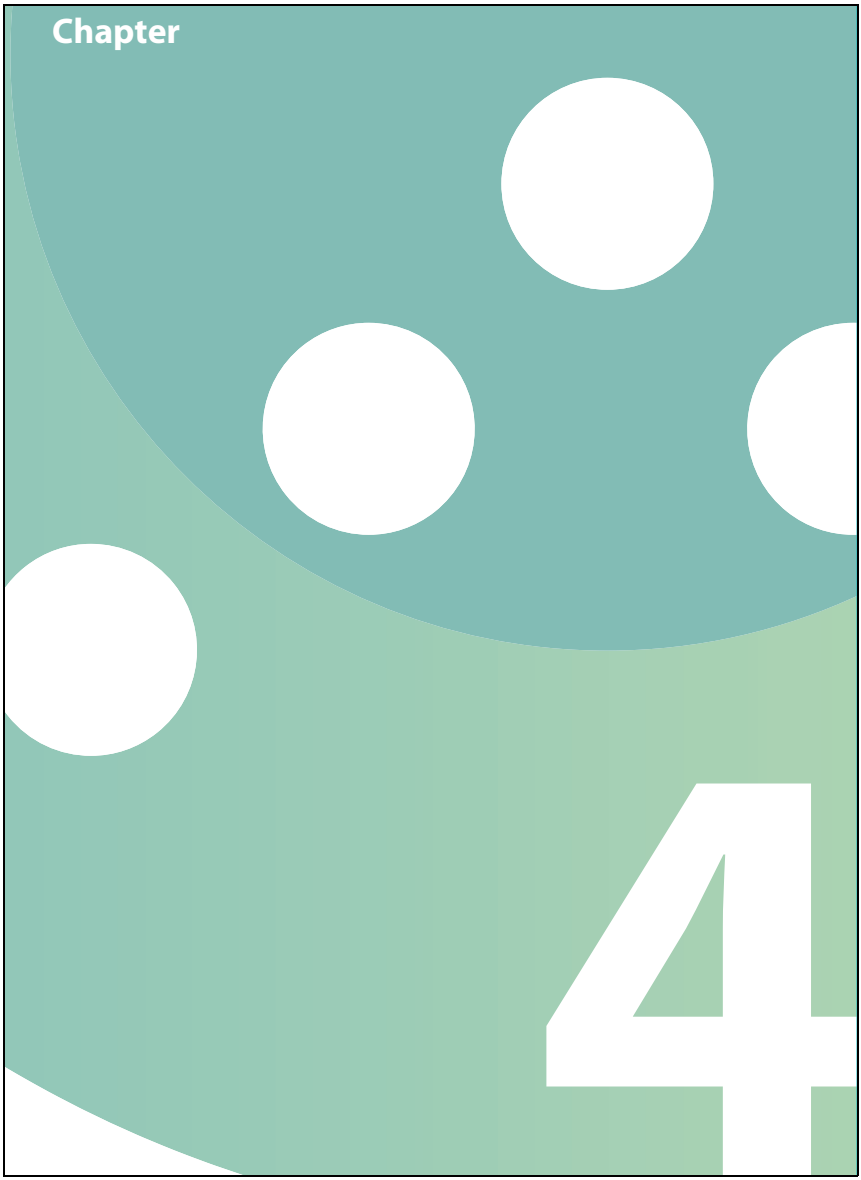

Figure 4.1

4 Health throughout the lifecourse

The government's objective is to develop a policy that contributes to better health throughout the individual's life and to good transitions between life's various stages. All children and young people shall be ensured a good start in life, an inclusive working life and safe, health-promoting workplaces, and the possibility of safer and more active ageing. Efforts shall be directed towards making services and arenas in life's various stages more health-promoting and tailored to the individual's needs, regardless of gender, age, ethnicity, functional ability, sexual orientation, gender identity or gender expression.

The conditions under which children and young people grow up shall be improved by enhancing the quality of kindergartens and schools, further developing and strengthening health clinics and school health services, further developing child welfare services, helping parents to cope and implementing initiatives to prevent problems in the transition between life's various stages. This is primarily about improving and further developing the range of services offered and improving coordination between these services.

More individuals of working age shall have the opportunity to work, and initiatives to prevent sickness absences and exclusion from the labour market will be strengthened. Emphasis shall be placed on improving the working environment in industries with considerable stress on the working environment. In addition, the government will challenge the labour market organisations to assume greater responsibility for lifestyle-related initiatives at the workplace.

Active and secure ageing is not just about health services and care for the elderly – it is also about participation in physical, social and cultural activities. When an individual's health deteriorates, it is important to facilitate housing and accessible surroundings, as well as adapted nursing and care services and the provision of training and rehabilitation programmes. Not least, this is about maintaining the

individual's independence, freedom, and influence over his or her own life, regardless of illness or decreased functional ability.

The objective that all citizens shall have equal access to public services runs throughout government policy. If services do not take into account the fact that users are different, this can lead to systematic disparities in outcomes for users. For example, knowledge of the Sami language and culture is essential in the public health work and in ensuring that the Sami people receive health and social services equal to those received by other groups. The rights of Sami children to practice their own language and culture shall be taken into account. Education in the Sami language and Sami culture in kindergartens and schools helps to build identity and security.

Box 4.1 Health throughout the lifecourse

The government will:

- Further develop the quality of kindergartens by following up White Paper no. 24 (2012–2013) Framtidens barnehage (The kindergarten of the future)
- Lay the foundation for better learning throughout the entire education system, with an emphasis on preventing students dropping out of high school, by following up White Paper no. 20 (2012–2013) På rett vei. Kvalitet og mangfold i fellesskolen (On the right path – quality and diversity in public schools).
- Ensure high quality child welfare services through changes in the Child Welfare Act, the development of knowledge and skills and good coordination between the various levels of the administration and with other services
- Expand the capacity and improve the quality of health clinics and school health services
- Evaluate the possibility of harmonising legislation related to services for children and young people
- Evaluate whether it is possible to develop common national targets across sectors and services for children and young people
- Challenge labour market partners to take greater responsibility for prevention and health promotion in the workplace
- Emphasise the importance of good working conditions and effective health, safety and environment work as an important contribution to public health
- Further develop efforts to prevent young people from being excluded from education and employment
- Pursue policies that enable older workers to remain in work longer, enable active participation in all areas of society, and a range of services that promote involvement and participation

Figure 5.1

5 Increased emphasis on prevention in the health and care services

The government will further develop health and care services in line with the objectives of the Coordination Reform and new challenges associated with lifestyle-related illnesses, an ageing population, more people living with chronic conditions, and challenges relating to mental health and substance abuse. This means that preventive measures will have a more clearly defined role in the health and care services. Health clinics and school health services shall be further developed and strengthened. It is necessary to strengthen the entire health care service's work with lifestyle changes, learning and coping, to strengthen the work with quality and patient safety, to evaluate the use of screening, and to strengthen the health care service's advisory role towards other sectors in order to support cross-sectoral public health work.

The health and care services' role in the preventive work is central to the Coordination Reform. The aim is that initiatives shall be implemented earlier, either in the form of preventive measures or early treatment. The health and care services' responsibility for preventive efforts is emphasised in the Health Care Act, the Specialist Health Services Act, and the Public Health Act. The service has three main roles relating to the preventive work:

- Prevention as an integrated part of the health care service
- Health checks, health education and lifestyle changes, and information, advice and guidance to prevent social problems
- Provide support to cross-sectoral work through overviews and knowledge of health challenges, causal relationships and initiatives

The specialist health service also has a responsibility to develop knowledge and competence in collaboration with local authorities and other partners.

Box 5.1 Increased emphasis on prevention in the health and care services

The government will:

- Further develop the municipal health and care services into a more interdisciplinary and integrated service in line with the intentions of the Coordination Reform
- Further develop and strengthen health clinics and school health services
- Continue to focus on healthy lifestyle initiatives and offer learning and support services within local authorities
- Establish more low-threshold services for pregnant women, mothers and parents who struggle with drug addiction and mental disorders
- Consider clearer requirements for the quality assurance and evaluation of national screening programmes
- Ensure that health enterprises give attention to the preventive work within the specialist health service
- Collaborate with The Norwegian Association of Lokal and Regional Authorities and the municipal sector regarding how the preventive work can be strengthened in the municipal health and care service
- Prepare an action plan for the prevention of suicide and self-harm

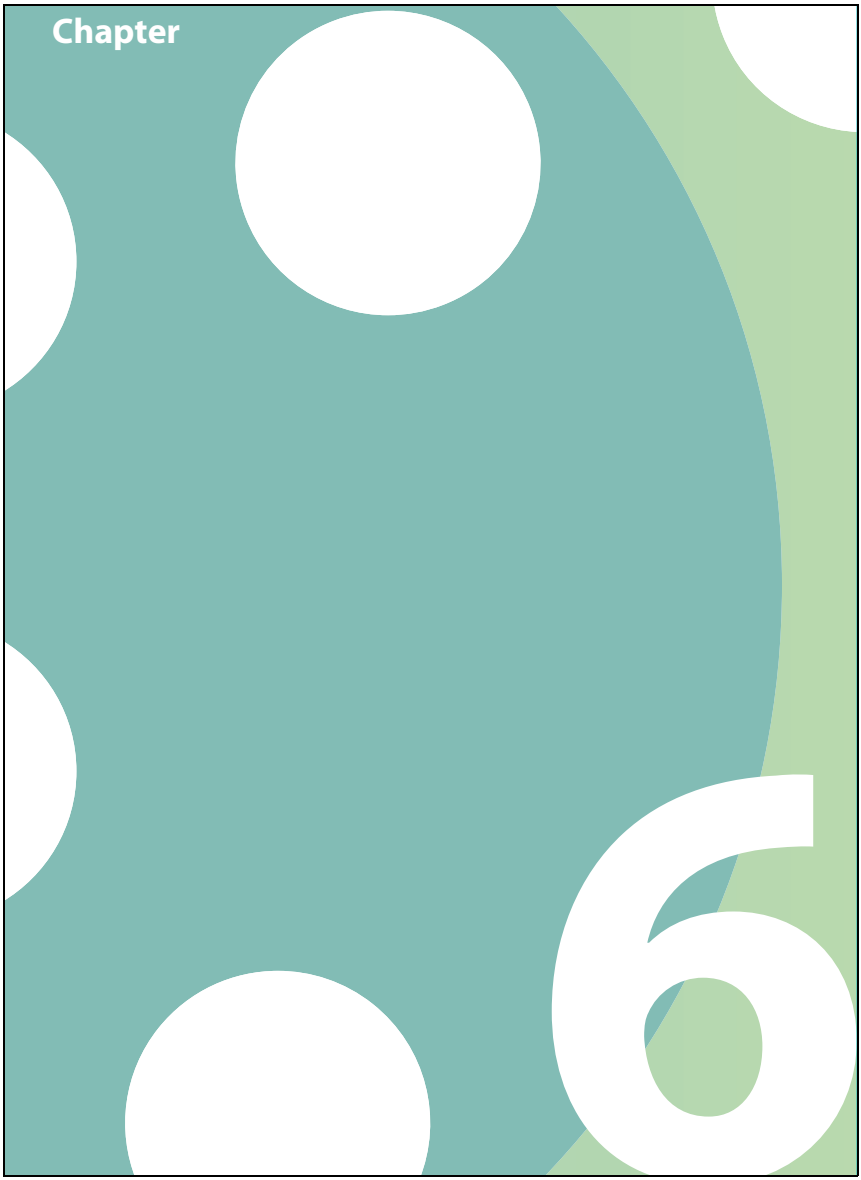

Figure 6.1

6 Knowledge-based public health work

Sustainable public health work must be based on a scientific foundation, and the government therefore aims to make public health work more evidence-based. A stronger professional foundation for public health work will contribute to improved outcomes and the more efficient use of resources.

One objective is to obtain a better overview of the determinants of health. Evidence for effective public health measures shall be strengthened through research-based evaluations. In addition, the government will strengthen the public health perspective in relevant training programmes, help to strengthen public health competence at municipal and county levels, and develop more effective instruments for taking public health into account across sectors.

The establishment of public health profiles for municipalities and counties from 2012 is a major step forward in the strengthening of the knowledge base for the public health work at county and municipal level. These will be developed further. There is still considerable potential to utilise existing data through better coordination and communication.

Box 6.1 Knowledge-based public health work

The government will:

- Further develop health registers in line with the Strategy for the modernisation and coordination of central health registries and medical quality registries
- Consider supporting a new population survey in the county of Nord-Trøndelag, Hunt 4
- Develop a national burden of disease project at the Norwegian Institute of Public Health
- Transfer certain health monitoring tasks relating to nutrition and physical activity from the Norwegian Directorate of Health to the Norwegian Institute of Public Health
- Review regulations relating to access to information in order to ensure that the Norwegian Institute of Public Health can design anonymous, quality-assured health profiles in areas with a low population base
- Develop a competence centre at the Norwegian Institute of Public Health in order to evaluate initiatives based on health registries and other public health analyses
- Enable public health to be given greater precedence in the work of the Norwegian Knowledge Centre for the Health Services
- Consider measures to build capacity on public health interventions in the municipal sector
- Give the Norwegian Directorate of Health the task of developing tools and guidelines for public health impact assessments
- Consider how economic evaluations of public health initiatives can be facilitated
- Provide guidance to local authorities regarding the generation and use of local data

Figure 7.1

7 Stronger policy instruments for public health

Through an improved legal framework and better utilisation of economic instruments, we will contribute to more targeted, systematic and long-term work to promote the health of the population. New public health challenges require that we mobilise a broader set of social resources. We shall build on the opportunities that exist in the various sectors, such as the education sector and the labour market, in order to promote public health.

The government will invite non-governmental organisations, labour market organisations, industry and other sectors of society to become more involved and take greater responsibility.

It is not only national conditions that have an effect on the health of the Norwegian population. We live in an increasingly globalised world, which is having an ever greater impact on national developments. The government will therefore place greater emphasis on international collaboration as a policy instrument for public health, through work within the UN system, the World Health Organization, and international knowledge and research collaborations.

Box 7.1 Stronger policy instruments for public health

The government will:

- Contribute to the implementation of the Public Health Act at municipal, county, and national levels
- Through the provision of advice and guidance to the municipal sector, ensure that health considerations are taken into account in municipal and regional planning
- Facilitate a more systematic use of public health economics
- Further develop the collaboration with voluntary organisations in order to place participation and social inclusion on the agenda for local public health work
- Continue to focus on outdoor activities and recreation programmes under the auspices of the relevant organisations
- Collaborate with the municipal sector to strengthen non-governmental organisations as participants in local public health work
- Initiate dialogue and mutually binding collaboration with labour market organisations regarding public health work in the workplace
- Consider options to more effectively take health considerations into account in procurement processes where this is relevant
- Assess how global and national public health challenges can be addressed through dialogue with the food and beverage industry
- Follow Denmark's lead and propose a ban on industrially produced trans fats
- Strengthen international collaboration in the field of public health and promote the right to implement national initiatives to strengthen public health within the framework of international trade agreements

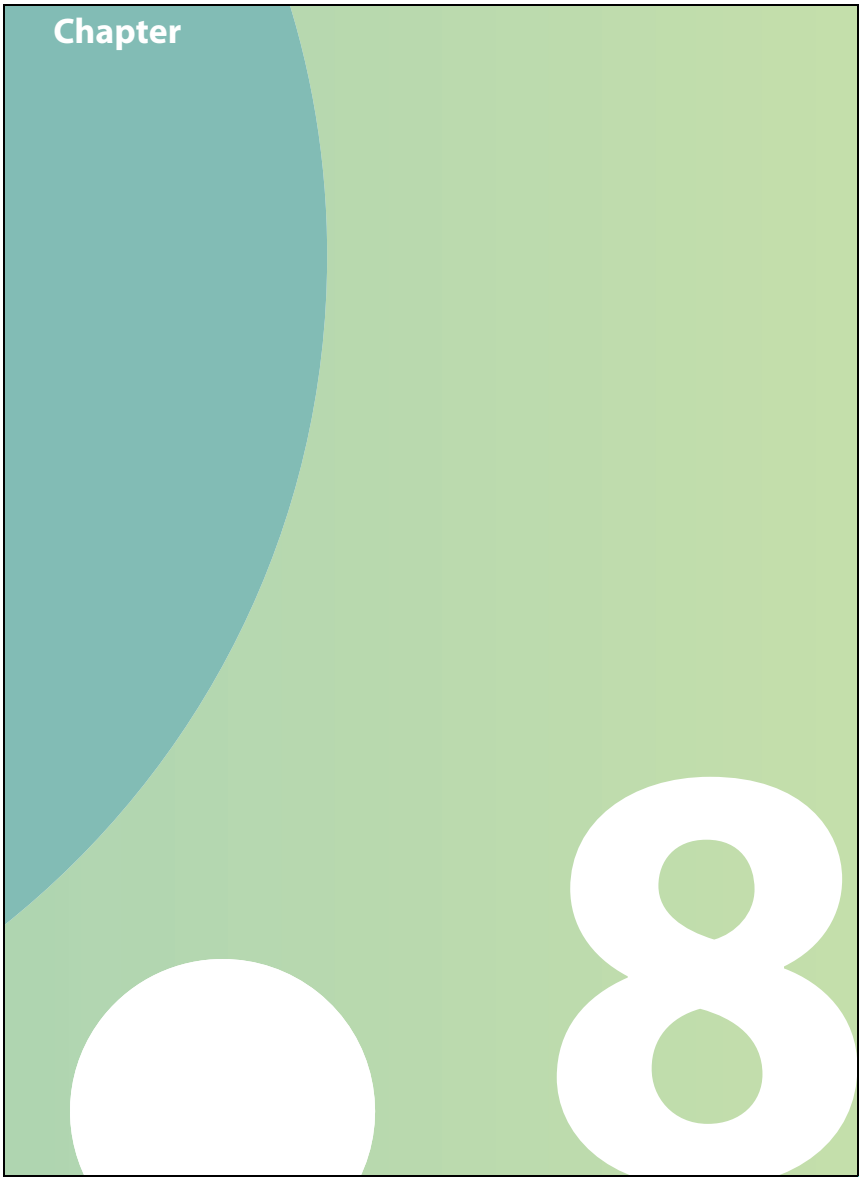

Figure 8.1

8 A national system for the follow-up of public health policies

A long term perspective and sustained political and administrative awareness are necessary if we are to achieve success through the public health work. It is difficult to prioritise prevention. The expectations and demands placed on the services provided, the media and interests of professional organisations direct attention and resources towards the specialist health service. In addition, the cross-sectoral nature of public health work creates additional challenges relating to the coordination of policies.

In this White Paper, the government establishes a framework for the long-term follow-up of the public health work, which will contribute to increased political awareness and improve national coordination. A central initiative is that a White Paper on public health shall be produced every four years. These White Papers must also report on the challenges within the Sami population. In addition, the coherence of policy advice regarding public health at national level must be improved. Collaboration with the municipal sector, universities and colleges, and industry will be strengthened, and dialogue meetings with the voluntary sector and other stakeholders will be held.

The public health policy must be subject to continuous development. This requires robust and predictable management processes and regular political discussion of the challenges.

The Public Health Act gives both state and municipal authorities the responsibility for ensuring that systematic and long-term public health work is carried out. During the hearing on the Public Health Act, there was broad support for the fact that the Act shall apply to all levels of the administration and all sectors. A number of consultative bodies pointed out that state authorities should also be obligated to promote public health in accordance with the «health in all policies» principle in the same way as local authorities and county administra-

tions. The act now also includes state authorities in general. During Parliament's consideration of the Public Health Act, cf. Report 423 L (2010–2011), a unified health care committee stated that:

> «The committee wishes to further emphasise that it assumes the government will adopt an equivalent working method to that which is now being required of the local authorities.»

The act sets requirements for systematic and long-term public health work. For similar reasons, Parliament should assess the national public health work as a whole, and not simply consider individual cases. Parliament has not had an established routine of carrying out general assessments of the national public health work. Individual issues, such as tobacco control measures, infection control and nutrition, are addressed on an individual basis without being included as a part of a larger coherent policy to promote public health. This government has however taken measures to rectify this, firstly through White Paper no. 20 (2006–2007) on social inequalities in health, which highlighted public health policy as a cross-sectoral issue.

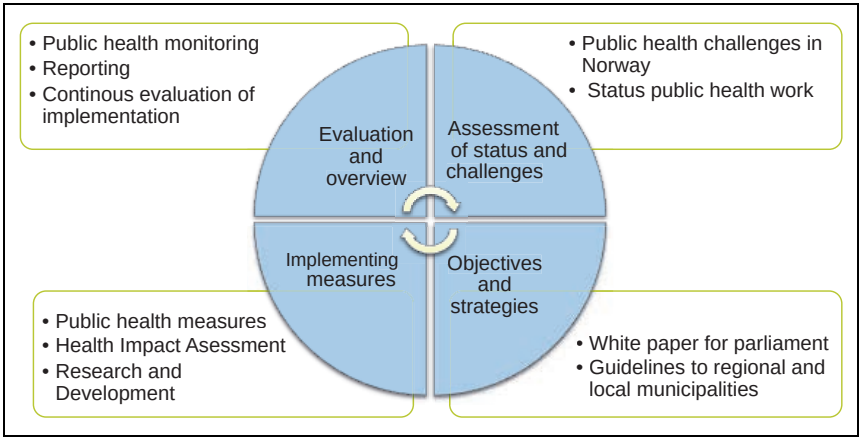

Figure 8.2 Four year cycle in national Public Health Policy.

Box 8.1 A national system for the follow-up of public health policies

The government will:

- Further develop performance targets and indicators in order to follow up the objectives of the public health policy
- Present a White Paper to Parliament on public health every four years
- Consider establishing a public health policy advisory council
- Place public health work on the agenda in consultations and agreements with the municipal sector
- Stimulate the establishment of municipal public health networks in local authorities
- Establish a more systematic collaboration on public health work across ministries and directorates
- Ensure that public health impact assessments are carried out where relevant

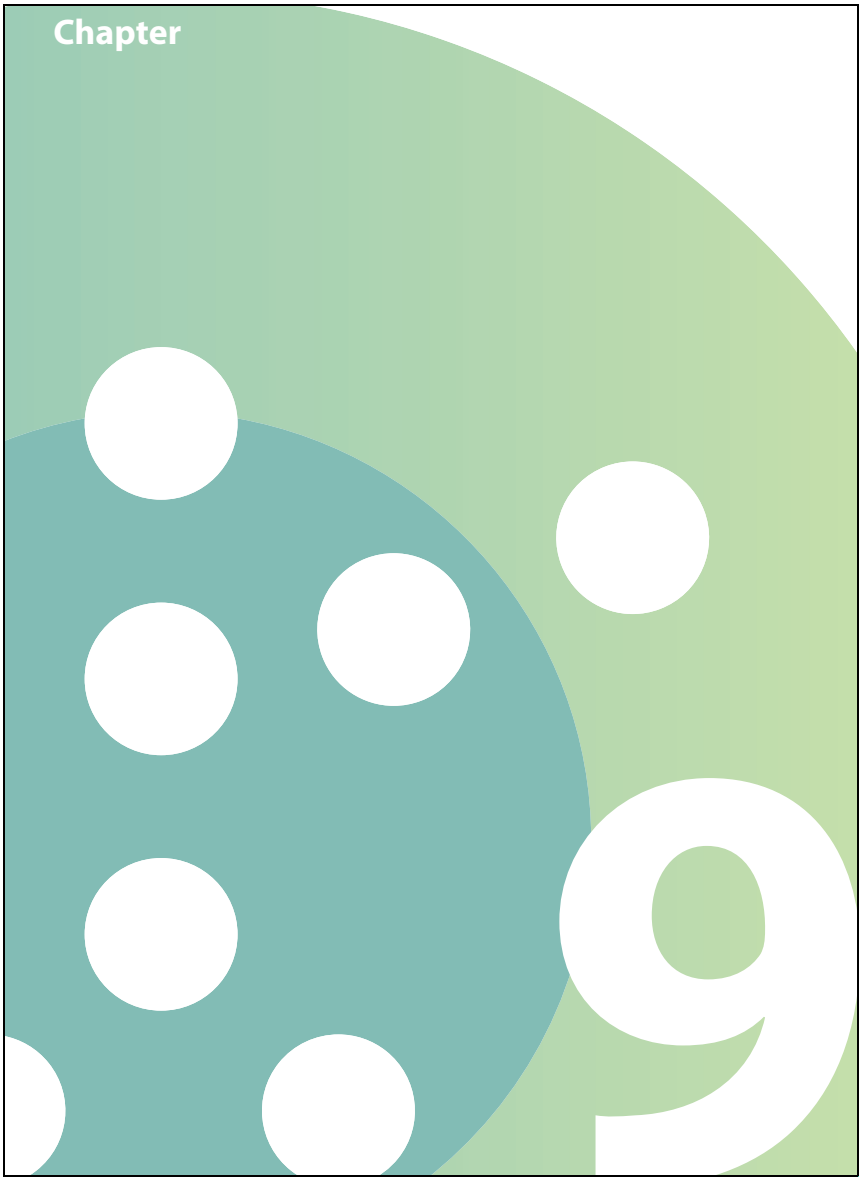

Figure 9.1

9 Economic and administrative consequences

The most important action in achieving public health objectives is to facilitate cross-sectoral policy development. However, effective follow-up of the Public Health Act in municipalities will require the public health work to be strengthened. For other desirable changes to be implemented in the longer term, and which have consequences for the allocation of funds, further implementation will depend upon the general economic situation. The government will make proposals in future regular budgets to be submitted to Parliament. There is also a need to further develop public health work at a national level. In some areas it may also be necessary to reallocate resources.

Furthermore, there is a need to direct efforts away from treatment and towards prevention. According to the OECD, Norway spends a significantly smaller proportion of its health care budget on preventive measures and public health work than many other countries. The Coordination Reform assumes a shift in resources towards preventive work and early follow-up and treatment in the municipal health care service. The introduction of municipal co-financing and payment for patients ready for discharge will help to ensure that more patient treatment is provided within the municipalities, and that local authorities are given incentives to focus on prevention and early intervention. Municipalities have also been allocated funds through block grants in order to establish the necessary competence. However, the funding system still provides limited incentives to prioritise prevention. How economic instruments can be used more effectively to achieve a long-term strengthening of public health work should be assessed.

In future budgets, the government will evaluate whether it is possible to reorient health-related excise duties in a manner that contributes to improved public health. There is a long tradition of using taxation measures in public health work, particularly with regard to alco-

hol and tobacco. In recent years, this instrument has also been used to encourage healthier consumption patterns through changes in excise duty for non-alcoholic beverages.

10 Further reading

More information about public health policy and the full White Paper. no. 34 (2012–2013) *Public Health Report. Good health – a shared responsibility* can be found at *http://www.regjeringen.no*

Other useful links include:
http://www.helsedirektoratet.no
http://www.fhi.no/
http://www.sirus.no/
http://www.mattilsynet.no
http://www.nrpa.no
http://www.who.int/social_determinants/en/
http://ec.europa.eu/health/index_en.htm

Appendix 1

The Norwegian Public Health Act

ACT 2011-06-24 no. 29 - Public Health Act

Act entered into force on 1 January 2012, cf. Section 34.

For an international audience. Not an official legal document.

Chapter 1 Introductory provisions

§ 1 *Purpose*

The purpose of this Act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries.

This Act shall ensure that municipalities, county authorities and central government health authorities implement measures and coordinate their activities in the area of public health in a proper and sufficient manner. The Act shall facilitate long-term, systematic public health work.

§ 2 *Scope*

This Act applies to municipalities, county authorities and central government authorities. What has been stipulated for county authorities in this Act also applies to the City of Oslo.

Chapter 3 of this Act also applies to public and private entities and property when there are aspects that directly or indirectly influence health.

The King may issue regulations on the application of this Act on Svalbard and Jan Mayen and stipulate special rules in consideration of local conditions. The King may determine whether and to what extent

the provisions stipulated in this Act should apply to Norwegian ships in foreign trade, Norwegian civil aircraft in international traffic and installations and vessels employed on the Norwegian continental shelf.

This Act applies to health personnel, public servants and private actors if so stipulated pursuant to Sections 28 and 29.

§ 3 *Definitions*

The following definitions apply in this Act:

a) public health: the state and distribution of health in a population
b) public health work: society's efforts to influence factors that directly or indirectly promote the health and well-being of the population; prevent mental and somatic illnesses, disorders or injuries; or that protect against health threats; as well as efforts seeking a more equal distribution of factors that directly or indirectly affect health.

Chapter 2 Municipality's responsibility

§ 4 *Municipality's responsibility for public health*

The municipality shall promote the population's health and well-being, and good social and environmental conditions; contribute to the prevention of mental and somatic illnesses, disorders or injuries; contribute to reducing social inequalities in health and contribute to the protection of the population against factors that may have a negative impact on health.

The municipality shall promote health within the duties and means that are assigned to the municipality, including local development and planning, administration and the provision of services.

The municipality shall contribute to ensuring that health considerations are safeguarded by other authorities and entities. This contribution shall be made, for example, through advice, statements, cooperation and participation in planning. The municipality shall facilitate cooperation with the voluntary sector.

§ 5 *Overview of public health and health determinants in the municipality*

The municipality shall have sufficient overview of the population's health and the positive and negative factors that may influence this. This overview shall be based i.a. on:

a) information that the central government health authorities and county authorities make available in accordance with Sections 20 and 25,
b) knowledge from the municipal health and care services, cf. Health and Care Services Act Section 3-3 and
c) knowledge of factors and development trends in the environment and local community that may influence the health of the population.

This overview shall be in writing and identify the public health challenges in the municipality, including an assessment of the impact and the causal factors. The municipality shall in particular pay attention to development trends that may create or maintain social or health-related problems, or social inequalities in health.

The Ministry may prescribe, by regulations, detailed provisions relating to the requirements for the municipality's overview.

§ 6 *Goals and planning*

The overview in accordance with Section 5, second paragraph shall be included as a basis for work on the municipality's planning strategy. A discussion of the municipality's public health challenges should be included in the strategy, cf. Section 10-1 of the Planning and Building Act.

In its work on the municipal master plan pursuant to Chapter 11 of the Planning and Building Act, the municipality shall define the overall goals and strategies for public health that are appropriate for meeting the challenges facing the municipality based on the overview in accordance with Section 5, second paragraph.

§ 7 *Public health measures*

The municipality shall implement the measures that are necessary for meeting the municipality's public health challenges, cf. Section 5. This may, for example, encompass measures relating to childhood environments and living condition factors, such as housing, education, employment and income, physical and social environments, physical activity, nutrition, injuries and accidents, tobacco use, alcohol use and use of other psychoactive substances.

The municipality provides information, advice and guidance on what individuals themselves and the population can do to promote health and prevent illness.

Chapter 3 Environmental health

§ 8 *Scope and regulations*

Environmental health encompasses the factors in the environment that directly or indirectly influence health at any given time. This encompasses, for example, biological, chemical, physical and social environmental factors.

Within the purposes stated in Section 1, the Ministry may prescribe, by regulations, provisions relating to environmental health, including provisions for indoor climate, air quality, water and the supply of water, noise, environmental hygiene, prevention of accidents and injuries, etc. Regulations may also be prescribed relating to the establishment of internal control systems and maintaining internal control to ensure that requirements prescribed in or pursuant to this chapter are observed.

§ 9 *Municipality's duties and delegation of authority*

The municipality shall supervise the factors and conditions in the environment that can directly or indirectly influence health at any given time, cf. Section 8. Responsibilities and duties within environmental health that are assigned to the municipality in this Act may

also be delegated in accordance with the provisions of the Local Government Act to an intermunicipal entity.

The municipality's authority can be exercised by the municipal medical officer when necessary in an emergency situation in order to ensure that it will be possible to fulfil the municipality's duties in accordance with this chapter.

§ 10 *Notification duty and approval*

Within environmental health, the Ministry may prescribe detailed provisions relating to the notification duty to, or duty to obtain approval from, the municipality before or at the initiation of activities that may have an impact on health. The same applies to changes to such activities. When granting approval the municipality may stipulate conditions to safeguard public health, cf. Sections 1 and 8. Detailed provisions relating to approval, including administrative rules to complement the Services Act, may be prescribed by regulations. Exceptions to Section 11, second paragraph of the Services Act may only be made when they are justified by compelling public interests.

For entities that are subject to a notification duty or approval requirement it may be required in regulations pursuant to the first paragraph that an assessment by an accredited inspection body be presented. Obtaining such an assessment may be required at specific time intervals. The entity must defray the cost of the assessment by an accredited inspection body.

If approval is not granted, the municipality may demand suspension of the entity. Suspension may only be demanded if the inconvenience caused by suspension is in a reasonable proportion to the health risk that is avoided. If necessary, the suspension may be carried out with assistance from the police.

It may be prescribed by regulations that the county governor shall have approval authority if the activities affect more than one municipality. If the entity affects more than one county, it may be prescribed that the Ministry shall have the approval authority. For water and the supply of water, it may be prescribed by regulations that a public authority other than the county governor shall have the approval

authority. Special provisions may also be prescribed for the appeals scheme in cases where the county governor, Ministry or other public authority has granted approval.

§ 11 *Health impact assessment*

The municipality may order whoever is planning or engaging in activities, or whoever is responsible for the situation at a property, to assess the possible health impact of the measure or situation at his own expense. Such an assessment may only be demanded if the inconvenience caused by the assessment is in a reasonable proportion to the possible health impact indicating that the situation should be studied.

The appellate authority has a corresponding right to demand a health impact assessment when hearing appeals.

§ 12 *Duty of disclosure*

The municipality may impose a duty on whoever is planning or engaging in activities that may have a possible health impact, notwithstanding the duty of confidentiality, to disclose the information that is required to the municipality so that it can perform its duties in accordance with this chapter. When there are special grounds, the municipality may demand that information be disclosed by anyone who performs work for the party who is subject to the duty of disclosure in accordance with the first sentence. The information mentioned in the first sentence may also be demanded from other public authorities, notwithstanding the duty of confidentiality.

Whoever is responsible for the property or activities mentioned in the first paragraph shall disclose information to the municipality on their own initiative concerning the situation at the property or activities that can clearly have a negative health impact.

In addition, the municipality can impose a duty on whoever is responsible for the property or activities, as mentioned in the first paragraph, to disclose information on the situation at the property or

activities that may have an impact on health, to the general public, customers or others.

§ 13 *Investigation*

In order to fulfil its duties in accordance with this chapter, the municipality may determine that an investigation of the property or activities shall be conducted. The investigation may be conducted by whoever has been delegated such authority in accordance with Section 9 or by the municipal medical officer in emergency situations. If necessary, the investigation may be carried out with assistance from the police.

Whoever conducts the investigation shall have unimpeded access to inspect the property and activities and to take the necessary tests without compensation. The submission of documents and materials may be required, as well as inspections that may be of significance to the municipality's duties in accordance with this chapter. The cost of expenses associated with the investigation shall be defrayed by whoever is responsible for the property or activities.

The county governor has a corresponding right to conduct an investigation in connection with appeals.

When activities or property are investigated, whoever conducts an investigation shall contact representatives for the management of the entity first.

§ 14 *Rectification*

The municipality may order that aspects of a property or activities in the municipality be rectified if the situation has a direct or indirect negative impact on health or is in violation of the provisions prescribed pursuant to this chapter. Rectification may only be demanded if the inconvenience caused by rectification is in a reasonable proportion to the health considerations indicating that the situation should be rectified.

The order shall be made in writing and contain a deadline for its fulfilment. It shall be addressed to whoever is responsible for the situ-

ation or the entity as such. The costs of fulfilling the order shall be defrayed by whoever is responsible for the situation, or the entity as such.

§ 15 *Coercive fines*

If the deadline for fulfilment of an order to rectify a situation is not met, then the municipality may impose coercive fines on the addressee of the order in the form of a one-time or daily fine. The coercive fines must be stipulated at the same time as the order or in connection with the stipulation of a new deadline for fulfilment of the order. The size of the coercive fine will be determined based on how important it is that the order be fulfilled and what costs it is assumed to entail. The coercive fines fall to the public purse.

Coercive fines may be recovered by execution proceedings.

The Ministry may prescribe, by regulations, detailed provisions relating to the stipulation and calculation of coercive fines.

§ 16 *Suspension*

If a situation arises with respect to activities or a property that entail an imminent health hazard, the municipality shall suspend all or portions of the entity or activities until the situation has been rectified or there is no longer a hazard. If necessary, the suspension may be carried out with assistance from the police.

§ 17 *Violation fines*

The Ministry may prescribe, by regulations, that the municipality may impose violation fines on anyone who wilfully or through negligence has violated provisions in Sections 10 to 14 and Section 16. The same applies to the violation of regulations pursuant to Sections 8 and 10 when it has been stipulated in the regulations that violation will entail such a sanction.

In regulations pursuant to the first paragraph, the Ministry may prescribe detailed provisions concerning what violations mentioned in

the first paragraph may entail violation fines. In addition, the regulations shall prescribe detailed provisions concerning the determination and payment of the fines, and rules may be prescribed concerning interest and supplemental fines if the violation fine is not paid when due. The fines fall to the public purse.

Final violation fine decisions may be recovered by execution proceedings.

Violation fines can be imposed on enterprises in accordance with the first and third paragraphs when the violation has been committed by an individual that has acted on behalf of the enterprise. This applies even if the violation fines cannot be imposed on any individual.

§ 18 *Punishment*

Anyone who wilfully or through negligence violates instructions or regulations prescribed pursuant to this chapter shall be punished by fines or imprisonment not exceeding 3 months, or both. Aiding and abetting is punished correspondingly.

If the violation has not entailed any health injury, or just an insignificant risk of health injury, the violation will not be publicly prosecuted without a petition from the local council itself.

§ 19 *Appeals*

The county governor decides on appeals against decisions made by the municipality or municipal medical officer in accordance with this chapter.

Chapter 4 County authority's responsibility

§ 20 *County authority's responsibility for public health*

The county authority shall promote public health within the duties and means that are assigned to the county authority. This shall take place through regional development and planning, administration and the provision of services, and measures that can meet the county's public health challenges, cf. Section 21, second paragraph.

The county authority shall support public health work in the municipalities, through, for example, making information available in accordance with Section 21, cf. Section 5, first paragraph, letter a. The county authority shall promote and coordinate public health work in the county through, for example, partnerships for health promotion.

§ 21 *Overview of public health and health determinants in the county*

The county authority shall have sufficient overview of the population's health in the county and the positive and negative factors that may influence this. This overview shall be based i.a. on:

a) information that the central government health authorities make available in accordance with Section 25,
b) relevant knowledge from the municipalities, dental services and other portions of the county authority's activities that are of significance to public health.

This overview shall be in writing and identify the public health challenges in the county, including an assessment of the impact and the causal factors. The county authority shall in particular pay attention to development trends that may create or maintain social or health-related problems or social inequalities in health.

The overview of the county authority's public health challenges in accordance with the second paragraph shall be included as a basis for work on the regional planning strategy. A discussion of these challenges should be included in the strategy, cf. Section 7-1 of the Planning and Building Act.

The Ministry may prescribe, by regulations, detailed provisions relating to the requirements for the county authority's overview, including the duty to conduct population surveys, as well as the content of and conducting such surveys in the county.

Chapter 5 Central government authorities' responsibility

§ 22 *Central government authorities' responsibility*

Central government authorities shall assess the impact on the population's health as part of their activities whenever relevant.

§ 23 *County governor's responsibility*

The county governor shall contribute to implementing national policy in the public health area and promote knowledge-based public health at the local and regional levels, through, for example, providing advice and guidance to municipalities and county authorities.

§ 24 *Directorate of Health's responsibility*

The Directorate of Health shall monitor factors that have an impact on public health, contribute to the implementation of national policy in the public health area and promote knowledge-based public health, through, for example, the development of national standards and norms for good public health practice.

The Directorate of Health shall provide information, advice and guidance on strategies and measures in public health to the municipalities, county authorities, county governors and other public institutions, health personnel and the population. The Directorate shall also cooperate with the Norwegian Institute of Public Health on making information available on the public health and health determinants in accordance with Section 25.

§ 25 *Norwegian Institute of Public Health's responsibility*

The Norwegian Institute of Public Health shall monitor the development of public health, prepare an overview of the population's level of health and health determinants, in addition to engaging in research in the public health area.

The Norwegian Institute of Public Health shall make information available as a basis for the municipalities' and county authorities' over-

views in accordance with Sections 5 and 21. The information shall be based on statistics from central health registers, as well as other relevant statistics. The Norwegian Institute of Public Health shall provide assistance, advice, guidance and information in this connection.

The Ministry may prescribe, by regulations, detailed provisions relating to the information that is to be made available to the municipality and county authorities.

In connection with exposure to hazardous environmental factors, the Norwegian Institute of Public Health shall assist municipalities, county authorities, county governors and other public institutions, health personnel and the population to ensure protection of the population's health.

Chapter 6 Cooperation, emergency preparedness, internal control, supervision, etc.

§ 26 *Cooperation between municipalities*

The Ministry may instruct municipalities to cooperate when it is considered necessary in order to establish an adequate solution for public health work in the municipalities, including the prescription of provisions relating to what duties they should cooperate on and the distribution of expenses.

If the conditions so indicate, the municipality shall provide assistance to other municipalities in the event of an accident or other acute situation. A request for assistance is made by the municipality requiring assistance. The municipality that receives assistance shall compensate the municipality providing assistance for any expenses that are incurred, unless otherwise agreed on or determined pursuant to the first paragraph.

§ 27 *Community medicine expertise*

The municipality shall have the necessary community medicine expertise in order to fulfil its duties pursuant to this Act. One or more municipal medical officers shall be employed as the municipality's medical advisor in order to provide and safeguard, for example:

a) community medicine advice for the municipality's public health work, cf. Sections 4 to 7, including epidemiological analyses, cf. Section 5, second paragraph,
b) urgent expertise on behalf of the municipality in matters concerning environmental health, infectious disease control and emergency health preparedness, and
c) other duties delegated by the local council.

Municipalities may cooperate with other municipalities with regard to the employment of municipal medical officers.

§ 28 *Emergency preparedness*

The municipality, county authority, county governor, Directorate of Health and Norwegian Institute of Public Health are responsible for the necessary emergency preparedness preparations and measures in emergency situations, cf. Section 2-1 of the Health Preparedness Act.

The municipality is required to prepare an emergency preparedness plan for its duties pursuant to Chapter 3 of this Act, in accordance with the Health Preparedness Act. The health preparedness plan shall be coordinated with the municipality's other emergency preparedness plans.

The Ministry may prescribe, by regulations, detailed provisions relating to the municipality's emergency preparedness in the area of environmental health, and a notification duty for municipalities, health trusts and health personnel to the Norwegian Institute of Public Health concerning environmental incidents or suspicion of the outbreak of a disease related to exposure to hazardous environmental factors. Detailed provisions may also be prescribed, by regulations, relating to the duties of and division of responsibility between the municipalities, county authorities and central government health authorities in order to ensure protection of the population's health.

§ 29 *Implementation of agreements with foreign states and international organisations*

The King in Council may prescribe, by regulations, provisions relating to the implementation of agreements in the public health area with foreign states and international organisations.

Regulations pursuant to the first paragraph may prescribe provisions concerning the implementation of the World Health Organisation's International Health Regulations (IHR), including the establishment of IHR registers. IHR registers may include health information in an anonymised or person-identifiable form, without the consent of the registered individuals. Provisions may be prescribed relating to a duty for health personnel, public servants and private individuals to report health information to or notify the IHR registers. The subsequent processing of information in the IHR registers shall be in compliance with the provisions of the Health Register Act.

Regulations pursuant to the first paragraph may prescribe provisions concerning the implementation of temporary and standing measures from the World Health Organisation.

§ 30 *Internal control*

The municipality and county authority shall establish an internal control system to ensure that the requirements stipulated in or pursuant to this Act are observed.

The municipalities' supervision of activities and property in accordance with Section 9 shall be documented in particular, including equal treatment and the independence of the supervision.

§ 31 *Supervisory authority for the Public Health Act*

The county governor shall supervise the legality of the municipality's and county authority's fulfilment of the duties imposed in or pursuant to Sections 4 to 9, 20, 21, and 27 to 30 of this Act.

The rules in Chapter 10 A of the Local Government Act apply to the supervisory activities in accordance with the first paragraph.

§ 32 *General supervision*

The Norwegian Board of Health Supervision is responsible for the general supervision of this Act in accordance with Section 31 and shall exercise authority in accordance with what has been stipulated in laws and regulations.

§ 33 *Maintenance of regulations*

Regulations issued or maintained pursuant to Chapter 4a and Sections 7-9 of Act no. 66 of 19 November 1982 on municipal health services also apply after this Act has entered into force.

§ 34 *Entry into force*

This Act enters into force on a date determined by the King. The King may enforce the individual provisions at different points in time.

§ 35 *Amendments to other Acts*

The following amendments to other Acts become effective as of the entry into force of this Act: (…)

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