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Original article

Are equity aspects communicated in Nordic public health documents?

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Abstract

Aims: To explore if the term equity was applied and how measures for addressing social inequalities in health and reducing inequity were communicated in selected Nordic documents concerning public health.

Methods: Documents from Denmark, Finland, Norway and Sweden were collected and analysed by Nordic authors. Data included material from websites of ministries and authorities responsible for public health issues, with primary focus on steering documents, action programmes and reports from 2001 until spring 2013.

Results: Most strategies applied in Danish, Finnish and Swedish documents focused on the population in general but paid special attention to vulnerable groups. The latest Danish and Finnish documents communicate a clearer commitment to address social inequalities in health. They emphasise the social gradient and the need to address the social determinants in order to improve the position of disadvantaged groups. Norwegian authorities have paid increasing attention to inequity/social inequalities in health and initiated a new law in 2012 which aims to address the social gradient in a more clear way than seen elsewhere in the Nordic countries.

Conclusions: In the Nordic countries, re-distribution by means of universal welfare policies is historically viewed as a vital mechanism to improve the situation of vulnerable groups and level the social gradient. To establish the concept of equity as a strong concern and a core value within health promotion, it is important to be aware how policies can contribute to enable reduction of social health differences.

Keywords: Equity, fairness, justice, social inequality in health, social gradient, public health policy, Nordic countries, document analysis

Introduction

'Equity in health' was identified as one of the key principles of the Ottawa Charter for Health Promotion [1,2]. It is consistent with the WHO call for social justice, 'Health for All', aiming at equality in health between countries as well as between and within populations [3,4]. Inequity in health is considered a consequence of unequal access to health services, education and adequate food and housing, for example [3]. According to Whitehead the concept of inequity has a "moral and ethical dimension and refers to differences which are unnecessary and avoidable, and are also considered unfair and unjust" [5, p.219].

Inequity in health concerns systematic differences in health status between different socioeconomic groups. Within any country, differences in health can be observed across the population. Social inequalities in health include, but are not confined to, worse health among the poor. There is a social gradient, indicating that morbidity and mortality increase with declining social position [6]. According to Dahlgren and Whitehead [7], three distinguishing features, when combined, turn mere variations or differences in health into inequity in health: They are systematic, i.e. not distributed randomly but show a consistent pattern across social groups; socially produced (and therefore modifiable); and unfair. This could imply that the term "social inequalities in health" carries the connotation of health differences being unfair and unjust.

To address the social gradient it is important to take the social distribution of poor health into account [6] and to consider the social dimension of general policies [7]. Furthermore, equity aspects need to be explicitly communicated and emphasised in overall steering documents to ensure that this aspect is focused and addressed by public health planners in the communities [8]. Graham [9] emphasises that focusing on vulnerable groups is not the same as addressing the social gradient. To promote equity, policies must address the unequal distribution of health determinants between advantaged and disadvantaged groups, as well as the differing

consequences of these policies for different parts of the population. Frohlich and Potvin [10] further argue that health-promoting initiatives aiming at the population in general are less likely to reach vulnerable groups. Instead, initiatives should address barriers to optimum health such as resource distribution and exclusion mechanisms.

Despite a long tradition of social welfare policies in the Nordic countries, an increasing gradient between social groups, also reflected in the health of populations, has been identified [11,12]. Vallgårda [13] found clear variations in national public health policies and programmes in the Nordic Countries and argued that differences exist in the way politicians and governments, as a result of their political ideologies, perceive themselves as having a responsibility for the population's health.

The present study aimed to explore if the term equity was applied, and how measures for addressing social inequalities in health and reducing inequity were communicated in selected Nordic documents concerning public health.

Methods

Data collection

Documents from Denmark, Finland, Norway and Sweden concerning public health were collected and analysed by the authors who have Danish (LP), Finnish (LEK), Norwegian (EF) and Swedish (SR & GS) as their native language. Data included material accessed from websites of ministries and authorities responsible for public health issues, with primary focus on steering documents, action programmes and reports published from 2001 until spring 2013. Data thus included official governmental policy documents as well as reports produced by civil servants or commissioned (and subsequently published) by authorities, but composed by researchers or commissions.

Data analysis

Document analysis may be used in combination with other methods but can also be used as a method in its own right [14-16]. When using documents as a data source, it is important to study them in their context and to understand their purpose. It is likewise important to critically assess the authenticity, credibility and representativity of the documents [16]**.** The analysis applied the concepts as presented in Table 1.

[Insert Table 1 here]

The selected websites and documents were read several times, before words or (parts of) sentences were identified for answering the following questions formulated in accordance with the aims:

- Is the term equity applied and communicated at the websites and in selected documents?
- Do the measures suggested for addressing social inequalities in health communicate a clear focus on promoting equity and/or on addressing the social gradient?

The selection process and the contents of the documents were continuously discussed among the authors whose backgrounds are: PhD student in public health (SR); PhD in journalism and mass communication (GS); PhDs in public health (LEK & LP) and PhD in political science (EF). In addition, all authors are members of the Nordic Health Promotion Research Network.

Results

The results are presented separately for each country and include an overview of the selected documents and information about the authorities overall responsible for public health issues, before answers to the questions focused in the analysis are provided.

Denmark

The selected material included two policy documents published by Ministry of Health 2002 and 2009 [a,b], one report commissioned by the Ministry 2009 [c], and three reports published 2008-2013 by the Ministry and the Health and Medicines Authority [d,e,f].

At the websites stating the visions and values of the Ministry and the Authority, no wordings corresponding to equity were identified when accessed in March 2013. In the national goals for public health 2002-2010, social equality in health was described as an overarching objective [a]. The Authority supported a number of projects aiming to develop methods for promoting equality in health among 'socially vulnerable citizens' [d]. A report commissioned by the Ministry 2009 emphasised that health and illness could not just be seen as results of self-imposed lifestyle but that structural conditions also had a significant influence [c]. The latest reports from 2011 and 2013 include words such as 'solidarity' [e] and 'reasonableness' [f] which, not least the latter, correspond to the concept of equity (Table 1).

National goals for public health 2002-2010 [a] focused on better health for all Danes, but vulnerable individuals should be provided special assistance [a]. Documents published 2009 [b,c] similarly suggested measures for enabling a healthy lifestyle among vulnerable citizens, but also stated that communities, in order to reduce social inequality, should integrate health in all policies. Since the publication of the WHO report on social determinants of health in 2008 [17], two significant reports have emerged. One published 2011 identified determinants

for social inequality in health and actions for addressing them, including both upstream and downstream measures [e]. Another published 2013 declares the government's intention to reduce inequality in health and address the social gradient because "inequality in health is harmful for the entire society" [f, p.4]. Applying the concept of 'inequality', however, has the consequence that the fairness aspect included in the concept of inequity (Table 1) becomes indistinct.

Finland

The selected material included seven policy documents published 2001-2013 by Ministry of Social Affairs and Health [g-m] and one policy programme by the Government 2007 [n].

When accessed in June 2013 the ministry's website included the term 'equity', while the dominant terms applied in public health documents were 'health inequalities' [g], 'socioeconomic health inequalities' and 'social inequalities' [h-n]. National Action Plan 2008-2013 [h] described socioeconomic health inequalities as systematic differences in health within the population. The plan stated the need to promote equity and ensure need-based availability of public services. The KASTE programme 2012 [k] demanded equity in healthcare. Including health in all policies was seen as a tool to improve population health and promote equity [m]. Action Plan for Gender Equality [j] emphasized equality as a prerequisite for a fair and just society.

The starting point of the programme 'Health 2015' [g] was to promote health and welfare in all areas of society. It aimed at improving the relative position of the most disadvantaged groups and proposed prevention of social exclusion by ensuring equal access to healthcare for all. A number of action plans published 2008-2013 [h,i,j] aimed to narrow the health gap in

the population by means of detailed upstream and downstream measures. In 2010 the vision for social and health policies [k] was described as a society in which people were treated equally, were able to participate, and everyone's health and functional capacity supported. The KASTE programme from 2012 [l] aimed to reduce inequalities in health. It focused on social well-being across the population and paid special attention to improve opportunities for the most vulnerable groups.

Norway

The selected material included three government reports published by Ministry of Health and Care Services 2003, 2007 and 2013 [o,p,q], a report by the Directorate of Health 2010 [r], and the Public Health Act from 2012 [s].

In the English translations of the government papers, the term 'equity'/'inequity' was either used explicitly or it was underlined that social inequalities are unfair and that it is the responsibility of the government to address them. The concept of 'equality' is part of the Ministry's statement about its responsibilities: "Ministry of Health and Care Services is responsible for providing good and equal health and care services for the population of Norway".

Over the last years, reduction of social inequalities in health has been a priority and this has influenced tasks and priorities for all institutions responsible for public health. The Ministry of Health and Care Services has published three government white papers in which health inequalities are in focus. In order to increase equity in health, upstream measures are described as the most important, but in combination with downstream measures [o,p,r]. Report no.20 [q] has a ten year perspective for developing policies and strategies to reduce

health inequities. In this paper the concept of 'equity' is used and the main point communicated is that "equity is good public health policy". A new Public Health Act [s] with main focus on health determinants was implemented in 2012. Reducing inequities in health is the main issue of this act, and health is considered the responsibility of all sectors of society. Both the Norwegian terms for 'equality', 'equity' and 'equitable distribution' are used throughout the document. In 2013 a government white paper was launched [q] which maintains focus on reducing social inequities in the Norwegian population.

Sweden

The selected documents included five documents by the Government 2005-2010 [t-x] and three reports from National Institute of Public Health 2010 and 2013 [y,z,aa].

The term equity was only used to a small extent [x,y] while in others hardly used at all [t,v,w,aa]. The predominant terminologies applied were 'equal opportunities' and 'equal terms'.

The suggested measures for promoting good health on equal conditions for the population included creating equal conditions for good health for all citizens [y] by providing equitable care and investments in neglected areas [u,v]. The overall objectives basically remained the same 2001-2013 [u,v,x], but in 2008 downstream measures such as individual change and responsibility was highlighted [x]. Although not explicitly pronounced, the concept of equality therefore appears to be understood as a mean to reach equity by providing equal possibilities for everyone [x]. During recent years positive health effects are described both for downstream approaches and for upstream policies [z], but initiatives to support and improve the health of vulnerable groups are also stressed [t,w]. In the latest public health

report from 2013 [aa], the social determinants for health and the social gradient related to educational level was described, but so far the government has not communicated a clear commitment to address equity aspects.

Discussion

This study aimed to explore if the term equity was applied and how measures for addressing social inequalities in health and reducing inequity were communicated in selected Nordic public health documents. The Nordic countries are known to have less income inequalities compared to most other countries [18]. Wilkinson and Pickett [19, p.81] argue that more egalitarian countries tend to be healthier; what matters in determining health in a society is how evenly wealth is distributed. During recent years however, increasing social differences and inequalities in health have been identified in the Nordic countries [11,12]. The present study shows that concerns about social inequalities in health were communicated in Nordic public health documents 2001-2013. It was quite different however, if this concern resulted in concrete actions and to which extent equity aspects were emphasised and addressed.

Most strategies applied in Danish, Finnish and Swedish documents focused on the population in general but paid special attention to vulnerable and marginalised groups, even though the measures proposed were little concrete. The latest Danish and Finnish documents communicate a clearer commitment to address social inequalities in health. They emphasise the social gradient and the need to address the social determinants in order to improve the position of disadvantaged groups. Norwegian authorities have paid increasing attention to inequity/social inequalities and their implication for health, and initiated a new law in 2012 which includes both upstream and downstream measures and aims to address the social gradient in a more clear way than seen elsewhere in the Nordic countries.

Even though it is recognized that equity is a normative concept demanding political action, this has not always been explicitly stated or problematized. By focusing on "the fundamental structures of social hierarchy and the socially determined conditions these create" [20, p.1153], however, the WHO Commission on Social Determinants of Health [17] strongly emphasised the political aspects of health. Graham [9,21] differs between policies and strategies aimed at the whole population and those targeted at the poorest groups. Policies aimed at the poorest may lead to improvements of the social condition and health situation of these groups, but the social gradient in health will remain unchanged. In other words, there are differences between policies aiming to improve the living conditions and health of the poorest, and policies aimed at reducing the social gradient. The latter requires comprehensive intersectoral action, affecting all socio-economic groups. Reducing the social gradient is therefore likely to be more controversial than developing interventions aimed at disadvantaged groups, since it will require a certain re-distribution among social groups in areas such as taxation and labor market policies [17].

Among the Nordic countries, only Norway has so far implemented concrete policies to address and level the social gradient in order to promote equity in health. Denmark and Finland, however, appear to have started moving in the same direction. Re-distribution among social groups by means of universal welfare policies is a vital implicit mechanism in social democratic welfare states which may improve the situation of vulnerable groups as well as level the social gradient. In order to establish the concept of 'equity in health' as a strong concern and a core value within health promotion, it is important to be aware how policies can contribute to enable a reduction of social health differences.

Study validity and limitations

Public health documents including both official governmental policy documents and reports commissioned and published by these authorities but composed by researchers and commissions for example, were the data sources of the present study. Being expressions of formulated intentions and policies or published as part of or foundation to these, such documents may be said to meet the criteria of authenticity and credibility [14].
Representativity is linked to the question whether the documents are typical or atypical. In all four countries we had access to several documents produced at that moment. The issue of meaning was essential in the analysis. This concerned both the explicit and implicit values of the policies presented and was closely linked to the analytical questions asked.
There are limitations, however, in using political documents as sole source of data, since they may provide a very specific approach to a political process. By stating what a government or health authority intends to do, they may be accused of presenting wishes and vague plans rather than solid results. Still, policy documents serve as valuable data sources as they are produced or commissioned by governments and health authorities and thereby have credibility and authority. Last, they serve as guiding principles and tools for action and will thus reflect ideology and intentions regarding the choice of policy instruments [14].The fact that the five authors collected and analysed texts and documents from their native country may be seen as a potential bias, but also as strength. All authors have been members of a Nordic health promotion network for a number of years and the results were continuously discussed among themselves as well as with colleagues.

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Table 1. Clarification of the concepts included in the analysis.

Concept	English[1]	Danish[2]	Finnish[3]	Norwegian[4]	Swedish[5]
Equity	The quality of being fair and impartial	Retfærdighed, rimelighed	Kohtuuden-, oikeudenmu-kaisuus	Rettferdighet	Rättfärdighet, rättvisa, fördelning
Inequity	Lack of fairness and justice	Uretfærdighed, urimelighed	Epäoikeuden-mukaisuus, kohtuutto-muus	Urettfærdighet	Orättfärdighet, orättvisa
Equality	Being the same in quantity, size, degree, value or status; being evenly and fairly balanced	Lighed, ligestilling, jævnbyrdighed	Yhdenvertai-suus, tasa-arvoisuus, yhdenmukai-suus	Likhet	Jämställdhet, jämlikhet, likställighet, likställdhet, likformighet, jämnhet
Inequality	Lack of equality	Ulighed	Erilaisuus, eriarvoisuus	Ulikhet, forskjell	Olikhet, skillnad, ojämlikhet

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