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Window of opportunity for intersectoral health policy in Sweden—open, half-open or half-shut?

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SUMMARY

'Health in All Policies' (HiAP) is defined as a 'horizontal, complementary policy-related strategy with a high potential for contributing to population health'. To ensure that health impacts are highlighted across sectors, the support of actors in different sectors, not just the health sector, is needed. Public health, here defined as a universally important but a low prioritized politics area, needs to involve high politics areas to fulfil the HiAP strategy. This study aimed to analyse the agenda setting, formulation, initiation and implementation of the intersectoral public health policy and one tool of HiAP, health impact assessment (HIA), at the national and local level (exemplified by Stockholm County) in Sweden. A literature search was carried out of scientific and grey literature on intersectoral health policy and HIA in Sweden. The study was a policy analysis, using a content analysis method, and the theoretical framework of Kingdon where the results were examined through problem identification (why a window of opportunity opens for an intersectoral health policy and HIA), the factors and impact of politics (support for the formulation and implementation of policy) and policy (how best to solve the problem). The results showed that actors perceived the problems (the rationale) differently depending on their agenda and interest. Politicians and experts had a high impact on the formulation of the policy, agreeing on the policy goals. However, there was little focus on implementation plans implying that the political actors were not in agreement, and the experts sometimes showing conflicting evidence-based opinions on how to best ensure the policy. Without this in place, it is difficult to involve high politics areas, and vice versa, without the involvement of high politics, it is difficult to achieve the policy. However, this is a long-term process, where small steps need to be taken, leaving the policy window half-shut.

Key words: health politics; health impact assessment; policy and implementation analysis

INTRODUCTION

Health in All Policies (HiAP) is a '*horizontal, complementary policy-related strategy with a high potential for contributing to population health*' (Ståhl *et al.*, 2006). HiAP is a developing concept and a continuation of intersectoral action for health promoted in WHO's HFA-policy (WHO, 1985, 1999) and in the EU Commission's treaties and strategies (European Commission, 1997, 2000). It has also been supported by the UN under sustainable development. Health impact assessment (HIA) has been mentioned as a promising tool to realize HiAP and to ensure that health is not overlooked in other policy areas. HIA is a prospective tool that predicts the health consequences of policy-making. It aims to increase the awareness of health effects outside the health sector, especially to inform decision-makers (Kemm *et al.*, 2004). There are many national and local initiatives on HiAP and HIA (Kemm *et al.*, 2004; Ståhl *et al.*, 2006). However,

there is some scepticism regarding the use and effectiveness of HiAP and HIA which requires collaboration and co-operation between actors in different policy sectors and political support for 'joint-up' policies. HIA differs significantly between countries in regard to administrative and political structure, human and financial resources, and political will, support and commitment (Ståhl *et al.*, 2006). The problem seems to be that public health is not prioritized high enough on the political agenda. In this study, we use and define the concept of 'high politics' as politically prioritized issues, which is identified as among the main concerns for all areas across sectors, and are in the focus of policy coordination and budgeting by actors such as the Prime Minister or the Minister of Treasury. In contrast, 'low politics' are issues given relatively low political weight in the overall coordination of politics. Although health appears to be a universally important area for the public (Kingdon, 1995), public health as an issue extending over the health care sector rarely appears among the issues of high politics.

How can a window of opportunity be opened for an intersectoral public health policy in spite of the seemingly low political priority given to the issue? The aim of this study was to analyse the national intersectoral public health policy and one tool of HiAP, HIA, at the national and local level (exemplified by Stockholm County) in Sweden by answering the following questions:

(1) What were the underlying problems (the rationale) that led to an approval of a white paper on a national intersectoral public health policy (a policy window)?
(2) How did the involved actors, the politicians and administrative/technical/experts differ in regard to the initiation, formulation and implementation of the intersectoral policy and its tool HIA?
(3) Were there differences in the initiation, formulation and implementation between the national and the local level?

THEORETICAL FRAMEWORK

There are rather few studies on the politics of health policy even though there is currently a growing body of evidence in this area (Signal, 1998; McGinnis *et al.*, 2002; Baggot, 2000; Bambra *et al.*, 2005; Mannheimer *et al.*, 2006; Oliver, 2006). Navarro, *et al.*, (Navarro and Shi, 2001; Navarro *et al.*, 2006) found that political ideologies of governing parties affect some indicators of population health and that political parties with egalitarian ideologies appear to implement redistributive policies. Signal (Signal, 1998) states that politics and ideologies are underpinning all health promotion issues and should be more explicit. Bambra, *et al.* (Bambra *et al.*, 2005) promote 'health politics' since health determinants are amendable to political interventions.

This study used the conceptual model of Buse *et al.* (2005) to guide the analysis of the core content of relevant documents and background papers on the Swedish HIAP/HIA policy. This model focuses on the content, actors, processes and context of policy-making as well as on the phases of agenda setting, policy initiation, policy formulation and implementation. The core content is then re-analysed and re-interpreted on the basis of Kingdon's (1995) theory. This framework helps to emphasize the political dimension in HiAP and HIA (Mannheimer *et al.*, 2006). According to Kingdon (1995), policy changes occur in three 'streams': at the levels of problem identification, making policy choices and in political action and climate. The three streams operate in a constant 'flow' with no clear beginnings or ends. For a change in policy to occur (policy window), a window of opportunity should occur in all three streams simultaneously. The strength of Kingdon's framework is that a policy is analysed in relation to the underlying problems, that is, why a policy appears at a particular moment and how. This relates to the politics element which stresses the activities of different political actors and takes into account the political and ideological views. The policy stream focuses on the technical and administrative elements of problem solving by different actors.

METHODS

The data consisted of scientific articles and grey literature, including a number of policy documents and background papers. A search on Pubmed on the topic 'HIA in Sweden' resulted in a retrieval of 3 out of 148 hits (Nilunger *et al.*, 2004; Finer *et al.*, 2005; Forsberg, 2005). 'Intersectoral health policy and Sweden' resulted in one hit (Eklundh and Pettersson, 1987) which led us to other articles in relation to the new

public health policy (Hogstedt *et al.*, 2004). The grey literature includes the governmental website (www.regeringen.se) where data were found on development of the white paper Public Health Goals (Ministry of Health, 1999, 2000, 2002) and Strategic challenges for sustainable development (Ministry of Sustainable Development, 2005). Because the Ministry of Health assigned the Swedish National Institute of Public Health (NIPH) to monitor the development of the public health policy, a search at NIPH resulted in one report on public health politics (Swedish National Institute of Public Health, 2005a), another concerning the development of indicators to realize the public health policy (Swedish National Institute of Public Health, 2005b) and five reports on the HIA development (Swedish National Institute of Public Health, 2001, 2004, 2003, 2005c, 2005d). There was also one case-study report on the public health policy development conducted for the WHO EURO (Östlin and Diderichsen, 2001) and a conference report on HIA (Nordic School of Public Health, 2000).

At the local level, we found one scientific article via Pubmed (Finer *et al.*, 2005). Most of the HIA documents were found at the Swedish Federation of Local Authorities and Regions (www.skl.se). Moreover, the Public Health Guide (www.folkhalsoguiden.se) provided data on the public health policy in Stockholm. Personal contacts were made with staff at the Stockholm County to receive more information on the current situation regarding HIA and the public health policy.

The analysis was made in two stages. The first stage was a descriptive analysis to extract the core content of data on aspects that Buse *et al.* (2005) find as essential in retrospective and descriptive policy analysis. First, all the data were read through carefully. We then highlighted and extracted the content that was related to the HIAP/HIA policy, the actors named with regard to this policy, the policy and political processes and contextual factors. Finally, the highlighted sections of the data were categorized and organized from the perspectives of agenda setting, and policy initiation, formulation and implementation. The analysis followed the methodology of theory driven qualitative content analysis focusing on factual statements expressed in the data (Silverman, 2000; Alasuutari, 1993).

The second stage applied the theoretical model of analysing the opportunities for policy change by Kingdon (1995). The results of the first stage of the analysis were recategorized and reinterpreted to fit Kingdon's stream model and to enable making conclusions about the data on the basis of this theoretical framework. A good example of carrying out this part of the analysis was an earlier study on US Health Care Reforms by Rushefsky and Patel (1998).

RESULTS

Table 1 provides a summary background of the public health policy and HIA development at the national and local (Stockholm) level in Sweden as well as country facts such as population and area size etc. (Statistics Sweden, January 2007).

Agenda setting

The rationale for creating a public health policy varied depending on different actors' perspectives. From the politicians' angle, the main concern was the absence of a comprehensive national public health policy including national targets and strategies in Sweden (Ministry of Health and Social Affairs, 2000; 2002). The rationale was to create a *'pro-active, multisectoral public health approach . . . at all levels'* (Ministry of Health and Social Affairs, 2000, 2002). It was also stated that sectors outside the health sector had an impact on health development. However, co-ordination and collaboration between different sectors were absent (Ministry of Health and Social Affairs, 2000, 2002). It was seen desirable to involve all relevant sectors and actors at different levels, such as experts, the civil society, trade unions and the general public, in the development of the public health policy (Ministry of Health and Social Affairs, 2000, 2002).

From the angle of the public health experts, the new statistics showing stagnating or even increasing health inequalities between different population groups in Sweden, despite steadily increasing life expectancy, was raised as a major problem (Ministry of Health and Social Affairs, 2000, 2002, National Board of Health and Welfare 1994, 1997, 2001). It was also argued that the harder social and economic climate in the country would make the financial and health situation worse for some groups such as for young parents and particularly single mothers (Ministry of Health and Social Affairs, 2000, 2002). Studies indicated that more and more people had to face constraints in terms of their financial situation,

Table 1: Background information of contextual factors and the creation of the intersectoral policies and HIA at the national and local level in Sweden

	National level	Local level
Location	Sweden	Stockholm
Population	9 117 712	1 918 104
Size	449 964	6 519
Policy	Health on equal terms—national goals for public health	Public Health Policy Stockholm County Council
Targets	11 broad goal areas based on the determinants of health, non-specific in time or reduction of risk factors	5 targets specific for Stockholm country, a broad perspective based on determinants of health
Year	Developed in 1995–2002; published in 2002; adoped by government in 2003	Published and adopted by the government in 2005
Initiated by	The government (The Social Democratic Party)	The local government followed the national policy (The Social Democratic Party)
Actors	The national public health committee: members of the Swedish parliament, experts and advisors from public and local authorities, and organizations,	Local committee: members of the Stockholm County Assembly and civil servants
HIA	From 2000	From 1994
Main actors	The Ministry of Health, The Ministry of Sustainability, The National Institute of Public Health	The local government, the Federation of Country councils and Local Authorities, Stockholm counties
Status	HIA was mentioned in the policy as a potential tool to ensure intersectoral policy. The national institute of Public health was assigned to develop HIA further, especially HIA methods	HIA was not mentioned in the policy. Strong focus and development of HIA from the mid 90's by both politicians and civil servants. Currently, little attention around HIA

which was in turn associated with increased long-term sickness rates, and there were indications of increasing mental ill-health among children and young adults (Ministry of Health and Social Affairs, 2000, 2002).

The rationale for using HIA was to raise awareness and put public health higher on the political agenda and to systematically analyse health impacts of political proposals (National Institute of Public Health, www.fhi.se). This was also highlighted in another policy proposal in Sweden for sustainable development where analysis of social, economic and environmental impacts on development (including health) was emphasized (Ministry of Sustainable development, 2005). The development of HIA was also promoted internationally, for example by the WHO Health 21 policy, the Amsterdam treaty of the EU Commission (Nordic School of Public Health, 1999; Sweden National Institute of Public Health, 2001), the Lisbon strategy of the EU Commission, the UN Johannesburg policy and the Ottawa Charter (Sweden National Institute of Public Health, 2005d). These policies and strategies are emphasizing the need for HIA and analysis of health and social impacts in regard to sustainable development.

At the local level, in Stockholm, the rationale for using HIA and the creation of an intersectoral public health policy was identified in a similar way. However, the development and testing of HIA started a decade before an intersectoral overall public health policy was adopted in Stockholm. The relatively early development of HIA took place because 'human health was highly valued' and there was a need for a systematic approach to analysing health impacts (The Federation of County Councils and Local Authorities, 1998). The intersectoral policy in Stockholm, created in 2005 and focusing on the local priorities and problems (five targets), was adapted on the basis of the national public health policy.

Policy initiation and formulation

At the time of the development of the national public health policy, Sweden was governed by the social democratic party with support from the left-wing party and the environmental party. To develop the public health policy, a parliamentary commission was set up. It consisted of politicians representing all seven political parties, including the opposition parties, and a number of experts from academia, trade unions,

authorities and civil society organizations (Ministry of Health and Social Affairs, 2000, 2002). Although the consensus behind the policy and its focus on 'health on equal terms' were strong, some political parties made written reservations about components of the policy. The final policy proposal included four appendices with reservation made by three political parties. The conservative party made reservations against the overall formulation of the policy. The liberal party and advisors from the Swedish Association of Local Authorities objected to the idea of a public health law, which would require municipalities and county councils to draw up health plans. The left-wing party objected to the fact that the proposal failed to sufficiently address the increasing inequality in health between different groups (Ministry of Health and Social Affairs, 2000, 2002). It should be noted that the seven politicians were not just general politicians, but five of them were health or environmental experts. This may not affect the final document directly, but it could have had an impact on the preparatory processes, i.e. the working papers (Ministry of Health and Social Affairs, 1999, 2000) had a much stronger and specific focus on targets related to social determinants of health than the final version. The commission formulated the aim and scope of the policy, health on equal terms, which was kept in the final version but with less emphasis and focus on such targets.

There were many different actors influencing the policy. In addition to the politicians, there were five appointed health advisors and 11 public health experts working closely on the proposal. The working reports were sent to more than 500 actors for consultation (Ministry of Health and Social Affairs, 2000; Östlin and Diderichsen, 2001). Comments were provided by more than 200 stakeholders, representing authorities, universities, municipalities, counties, trade unions and civil society organizations, such as labour and housing organizations, alcohol/drugs groups, children's organizations, the disabled and the women's movement. Many of these actors expressed their support for the policy proposal. Some wished for more visibility of their own organization in the policy and also for clearer direction regarding their responsibility in regard to the policy (Ministry of Health and Social Affairs, 2000).

HIA was mentioned in the policy as '*a potential tool to ensure intersectoral health policy*' (Ministry of Health and Social Affairs, 2000, 2002). The NIPH was assigned by the government in 2000 to develop HIA further, in specific models and methods of HIA.

At the local level, the public health policy was conducted by a parliamentary committee consisting of all the political parties, nine politicians and civil servants (Stockholm County, 2005). The local policy adapted the national policy for its local needs. As a strategy, intersectoral work was stressed, but HIA was not explicitly mentioned in the local public health policy. The Federation of County Councils together with the Federation of Local Authorities decided to develop intersectoral tools, specifically HIA, in 1994. Three different tools were developed: the health questions, the health matrix and the HIA (The Federation of County Councils, 1998). This was carried out by politicians together with civil servants and the general public and implemented in some of the counties.

Policy implementation

According to the WHO (e.g. Health21), it was recommended that a national, high-level policy group should ensure and be accountable for the implementation of the policy. To this end, a national advisory group on public health issues was established in 2003, chaired by the Minister of Public Health. The group includes several members from the local, regional and national health authorities, representatives from the educational, employment and integration sectors, the police authority as well as representatives from all the major ministries. The group has no legal basis, but it is mandated to provide advice on priorities, lead the discussion regarding the policy and co-ordinate various actors and information. No evaluation of the effectiveness of the group has yet been completed.

The MoH assigned the NIPH to be responsible for the coordination of the public health policy activities in all sectors. Since then, the NIPH has developed indicators for the municipalities to monitor the policy implementation (Swedish National Institute of Public Health, 2005b). Moreover, the NIPH has been instructed by the government to conduct a public health policy report every forth year to present the activities and priorities for the 11 public health targets/health determinants (Swedish National Institute of Public Health, 2005a). All counties have developed an overall public health plan and 9 out of

the 18 counties had developed together with other actors, mainly with municipalities, an intersectoral plan (Swedish National Institute of Public Health, 2005a). Regarding HIA, three authorities have during 2005 started to carry out their own policy appraisals. In addition, the NIPH has produced several HIA reports focusing on the methods of HIA, but also on the relationship between politics, policy and research (Swedish National Institute of Public Health, 2001, 2005c, 2005d), such as health impacts of the Common Agriculture Policy (CAP) (Swedish National Institute of Public Health, 2003).

At the local level, there has been little information regarding the implementation or progress of the policy, only guidelines on how to implement it (Stockholm county, 2006). Each unit should develop its own targets. In Stockholm County, especially in the southwest area of Stockholm, the HIA process was initiated, implemented and evaluated. It was clear that HIA was successful because of the clear political will and the successful working methods among politicians and civil servants.

The use of HIA at the local level has decreased since 2001 in counties and municipalities with the explanation that it still needs to be developed. There has not been a political decision regarding HIA at the local level in Stockholm County. However, there have been explicit political inquiries from the opposition parties in 2003 whether or not HIA should be institutionalized, having a legal basis. In Stockholm county, it is discussed whether responsibility of HIA should move from the public health department to the Office of Regional Planning and Urban Transportation with the purpose of including HIA into the sustainable development area (personal communication). However, no activities were undertaken by the local governmental party (the social democratic party) towards that direction. HIA does not seem to be an active tool anymore.

FURTHER ANALYSIS BASED ON KINGDON'S POLICY ANALYSIS FRAMEWORK

1. *The problem stream: the rationale (problem) for creating a public health policy and using the HIA tool was multifaceted leaving the policy window fully open for the problem stream.*

The problems seemed to derive from many directions: (i) lack of an intersectoral public health policy including national targets and strategies; (ii) lack of awareness of how other sectors affect the health development of the population; (iii) a lack of collaboration and coordination between the health and other sectors; and (iv) widening health gaps between different population groups. Simultaneously, international organizations such as the EU Commission (1997) and WHO (1985, 1997) pushed the agenda on intersectorality in health and health impacts of political proposals (HIA). In addition, during the 1990s, the economical climate hardened in Sweden, with for example higher unemployment rates, especially for already vulnerable groups such as single mothers. Consequently, more people were on long-term sick-leaves or received early retirement pensions. This seemed to raise the awareness also among the public regarding the correlation between population health, the labour market and social security. The lack of health equality made a strong case among social democrats for developing an equity oriented public health policy. All these problems led to a policy window, fully opened, for a policy formulation of intersectoral health policy.

2. *The politics and policy streams: the politicians and experts (and other actors) agreed on the initiation and formulation of the policy, but there were different views regarding the implementation and action plans, such as HIA, leaving the policy window half-open for the politics and policy streams.*

Compared to some other policy areas, public health is still regarded as low politics. When the national public health policy was launched, it emphasized the need for intersectoral action for implementation around which there was a relatively strong consensus between politicians, bureaucrats, experts and other groups. Thus, there seemed to be sufficient political support and scientific evidence to realize the policy. However, it has been claimed that a formulation was achieved because the targets were quite vague (Lager *et al.*, 2006). The results of this study indicate that the guidelines for translating the policy into implementation and action plans were insufficient. There were some reservations about the policy, which suggested that not only the politicians but also experts had difficulty agreeing on action plans, such as HIA. There seem to be conflicting views in the scientific literature regarding the effectiveness of HIA.

Since the policy is not accompanied with clear action plans and accountability mechanisms, there is ambiguity about the role and responsibilities of the political and administrative actors in regard to the policy and its implementation. The policy proposed a public health law, based on the national goals. However, the policy (white paper) has not turned into a public health law.

There are no effective incentives to support the HIA development in a more bottom–up manner. To date civil society linkages to ensure the effectiveness of policy implementation and accountability seem not to be in place. Consequently, it may be assumed that actors from neither high or low politics areas are not yet fully involved in the realization of the public health policy in order to achieve its aim, leaving the policy window half-opened.

3. *The local level (Stockholm) appeared to have fewer boundaries between sectors and actors than the national level, leaving the policy window open for intersectoral health policy but half-shut for HIA.*

The working methods differ from the local to the national level. At the local level, the politicians and civil servants work more closely with one another. This means that proposals for a change can be discussed more readily and quickly. The local level also appears to favour a more informal approach to working with other parties, such as the local universities and organizations. This is not surprising since the local level is smaller and relatively autonomous. It operates more 'smoothly', with less strict boundaries between sectors. Moreover, the public health policy developed at the local level consisted of five explicit targets, whereas the policy at the national level had 11 non-specific goals. The development of the local HIA tool started already in the mid-1990s with politicians, bureaucrats and experts working together to initiate, formulate and implement it. This was evaluated with good results (Finer *et al.* 2005). However, there is still no legal basis for HIA and there does not seem to be a clear answer as to why there have been difficulties in implementing HIA in the Stockholm County. There have been several political changes during the last few years which have probably affected the process. Another reason could also be that the local government awaited national support for HIA, which in fact is not in place, and the window of opportunity for HIA fades away.

CONCLUSIONS

The main findings of this study show that (i) the Swedish development correlated with the international progress and promotion of intersectoral health policy and HIA; (ii) the process of policy change was more expert-based at the national level and more politician-based at the local level; and (iii) the interest of HIA mainly took place from the mid-1990s and at least up to the approval of the national policy in 2003. In Sweden, public health is perceived as a universally important subject, but it rarely reaches the highest national policy level. However, if the HiAP strategy would be put into practice properly, having enough political support for implementation activities, it should place intersectoral health policy higher on the political agenda. To realize HiAP requires support and engagement from all relevant sectors, not just from the health sector. The formulated targets (*why*), at both national and local levels, were limited in regard to suggestions for action and plans for implementation (*how*). The policy did not manage to open the way to involve actors in other policy sectors and was not clear about their responsibility in relation to the new policy. This is a long-term process, where steps have already been taken, i.e. creation of ministerial intersectoral health working groups both at the international and national levels, leaving the policy window, all in all, half-open.

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