The health-promotion perspective in public-health plans in a Swedish region over three decades

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SUMMARY
The trend away from a health and medical care-based policy to a healthy public policy has taken place in Sweden rather later than in other West European countries. One of the first county councils to establish health-promotion plans was Västernorrland. The aims of this study are to describe the contents of and analyze the changes over time in the five public-health plans in the county. The object of study for the policy analysis consists in these plans between 1978 and 2004. A deductive thematic content analysis was performed for each plan on the basis of the central determinants of health promotion. The positioning of the plans was determined using a theoretical framework (Beattie’s modified model) founded in the dimensions of power (individual and collective) and governance (local, i.e. the municipalities, and central, i.e. the county council). The results show that the value attributed to good health was consistently high, but the means for attaining this goal have varied over time. The policy focus of the measures in the plans have taken a cyclical path—from individual empowerment to empowerment from a societal perspective, and back prioritizing of actions at an individual level. On the governance dimension, there has been a corresponding positional change over time—from regional to local and then back to regional. Promoting the health of a population requires mutual interaction between the regional and local levels, in which both societal and individually oriented actions are prioritized.

Key words: health-promoting policies; health policy processes; health policy; health politics

INTRODUCTION
World Health Organization’s Global Strategy for Health for All by the Year 2000 (WHO, 1981) entailed that member states acquired responsibility for the health of the entire population, rather than just for the health care system (Kickbusch, 2003). The Ottawa Charter (The Ottawa Charter, 1986), during which the concept of supportive environments for health was coined, and which was adopted at the World Health Assembly of that year, has been of great importance for the development of the content of global health promotion. In the discouse on the implementation of health promotion, the concept of empowerment has been central, but prominence has also been given to responsibilities at different societal and political levels (WHO, 2009).

In Europe efforts to improve public health have always had a close connection with social reform and the setting-up of a welfare society (Sundin and Willner, 2007). International comparisons, above all with Germany and the USA, show that Sweden is deviant with regard to lifestyles and value systems, both in Europe and in

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the rest of the world; Sweden comes top in the report by Inglehart and Welzel (Inglehart and Welzel, 2005) in terms of citizens’ acceptance of secularization, personal independence in relation to family formation and divorce, women’s and men’s equal responsibilities and sexual preferences. The comparisons have shown that Sweden has been able to balance individual sovereignty and collective mutuality to meet social needs. Further, Sweden is characterized by what is usually described as the Nordic Welfare Model, which entails broad public responsibility and legislated collective polices to meet welfare development and equity goals (Lundberg et al., 2008).

The transition from a focus on health and medical care to a broader public health policy came somewhat later in Sweden than in other West European countries (Pettersson, 2007). The development of modern health promotion started first at county/regional level during the 1970s. One possible reason was that the county councils, which constitute one of three administrative levels in Sweden with self-governance and the right independently to raise taxes, has had the principal task of taking responsibility for health care. The trend towards a public-health orientation came to be supported by a new Health and Medical Service Act in 1983 (Svensk författningssamling, 1983). The Act tasked the health care authorities not only to provide care but also to take responsibility for the population’s health. The goal of the health care system would be ‘to create good health and care on equal terms for the entire population’ (Swedish National Committee for Public Health, 2000). Thereby, the new Act imposed on the county councils a statutory duty to pursue health promotion and prevention at individual, group and community levels, although this was a duty restricted to medically based prevention. The development was given further momentum by the national government’s decision to allocate funding to the county councils for preventive activities (Landstingsförbundet, 1981). This financial support contributed to and enabled the establishment of competencies in health promotion in the county councils/regions.

The development of a national public-health policy started at the beginning of the 1980s. Sweden adopted WHO’s Health for All strategy, and several public inquiries were initiated to shed detailed light on and develop health-promotion issues (Pettersson, 2007). First in 2003, the Swedish Parliament decided on a nationwide public-health policy, with one overall objective and 11 objective domains (Proposition, 2002).

One county council, among the first to give priority to public-health issues (in a ‘broader’ perspective) and to develop health promotion plans, was Västernorrland (The National Board of Health and Welfare, 1995). Priorities were set according to politically determined public-health plans. Västernorrland County Council, one of the 21 counties/regions in Sweden, and situated in the central part of Sweden, embraces seven municipalities with just over 240,000 inhabitants. Alongside Västernorrland’s largest municipality, the city of Sundsvall, the county council was the local arranger of WHO’s and UNEP’s International Conference on Health Promotion, where the Sundsvall Statement on Supportive Environments for Health was issued in 1991 (Sundsvall Statement, 1991). The aims of this paper are to describe the contents of and analyze the changes over time in the public-health plans that, over three decades, were established to provide a foundation for health promotion in Västernorrland.

METHOD

The object of study consists in the health-promotion plans determined by politicians in Västernorrland County Council from 1978 to 2004. Each plan is the outcome of a policy process, and is a superordinate and binding policy document containing goals and priorities for health promotion in the county. During the period five such plans were laid down.

According to Hill (Hill, 2005), there are several different ways of scrutinizing a policy. In this study, the focus is on policy content from a public-health perspective and its change over time. Buse et al. (Buse et al., 2005) have defined content in terms of substance, the constituent parts of which are then listed in detail in any particular policy document. The five plans identified covered a total of 314 pages, and ranged in length between 4 and 150 pages (Landstinget Västernorrland, 1978, Landstinget Västernorrland, 1985, 1993, 1999, 2004). The plans were given different names during the period, but they are all essentially the same kind of document.
Two different approaches to the analysis of public-health plans have been adopted. The first is to perform a deductive thematic content analysis (Patton, 2002) of each plan on the basis of six central factors of relevance to health promotion: policy prioritizing, role of the county council, governance, power (individual/community), settings and target groups. The second approach, or part of the analysis, involves positioning, which is based on the findings of the previously conducted thematic analysis of each plan.

In this study, the contents of the five plans are positioned on the basis of a theoretical framework founded in Beattie’s (Beattie, 1991) model of conflicting political philosophies in health promotion, which has been modified in this analysis to include power and health (Buse et al., 2005), and empowerment and health (Lawerack, 2007). The theories are reflected in a four-field model based on two dimensions: power (individual and collective) and governance (local and central). Here, by local is meant municipal and related settings for health promotion, and by central is meant regional, i.e. the county council and its organizational structure. The two upper fields of the model reflect social determinants of health, i.e. aspects of lifestyle and behavior such as smoking, exercise and eating habits, and structural determinants, such as the presence of collaborating groups in the community. The two lower fields concern empowerment, at individual and community levels.

RESULTS

On the basis of the two analytic approaches, we first present the findings of the thematic content analysis of the five public-health plans, and thereafter report on the changes over time with regard to power and governance.

Contents of the five plans

Table 1 provides an overall picture of the findings of the thematic analysis of the plans (1978–2004), while more detailed descriptions of results for each plan are given in the text below.

Health and wellness in Västernorrland, 1978

In their plan from 1978, county-council politicians expressed a will for ill-health to be prevented rather than for there to be a one-dimensional focus on curing and/or mitigating the effects of existing diseases. It was recommended that a council-owned health farm be set up to provide practical training, theoretical dietary knowledge, fasting therapy and exercise. Also, there was a proposal to establish fitness centers in collaboration with the municipalities. It was stated further that medical base data from within the health care system should be followed up and used for preventive purposes. And there were to be health checks for various target groups.

One consequence of the plan was that economic resources were allocated to enable an infrastructure for health promotion to be set up in the form of a central department for social medicine within the county council. The primary efforts of the department concerned support for the voluntary sector and local associations in the dissemination of information (educational, temperance and sports associations and trade unions). With long-term funding, these organizations came to work with Health and Wellness in Västernorrland. Of the healthcare budget, 0.15% was to be allocated to prevention.

Health above all, 1986

Review of the earlier plan was based on new contemporary currents in health policy. One such current was embodied in Sweden’s new Health and Medical Service Act of 1983. From examination of the former plan, it emerged that the earlier perspective, with its focus on traditional, individual-oriented health information was restricted by its failure to take account of social context. In the new Act, the responsibilities of health care were extended to go beyond medical care per se to include shared responsibility for population health. Rather than on health information and fitness, there was now an emphasis on health promotion. Further, there was the launch of the concept of public-health intervention, which entailed community activities in collaboration with other stakeholders. Also, there was a clearer division of tasks according to their orientation towards society, groups or individuals. There was an emphasis on organizational theories and system thinking.

Epidemiological diagnoses, so-called community profiles, had been developed for all municipalities in the county. From these, it emerged
<table>
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<th>Plans (year, no. of pages)</th>
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<th>Power</th>
<th>Settings</th>
<th>Target groups</th>
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<td>Health and Wellness in Västernorrland (1978, 150)</td>
<td>Health information (diet and exercise) Health checks Health surveillance</td>
<td>Information Financial stimulation of voluntary activity Build up fitness centers/hotels</td>
<td>Central Administrative Committee/Health care board</td>
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<td>The individual</td>
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<td>Health above all (1986, 124)</td>
<td>Health promotion Disease prevention ‘Public-health work’</td>
<td>Collaborate with other community organizations Eradicate environmental health hazards Influence living habits</td>
<td>Central Social medicine Local Primary care chiefly responsible Health planning community diagnoses</td>
<td>Society Fitness factors Promotion perspective S-network formation</td>
<td>Environment/community Council’s own organization</td>
<td>The population</td>
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<td>Public health Västernorrland (1993, 4)</td>
<td>Equality in health and prioritized groups Supportive environments for health Specific health problems (allergies, mental ill-health, alcohol, injuries, etc.)</td>
<td>Support the regional and local health promotion performed in county organs Knowledge base</td>
<td>Central Epidemiology, etc. Local From a settings perspective (health planner)</td>
<td>Society Health equality Supportive environments for health Participation Empowerment (at a community level)</td>
<td>Work/workplaces Schools/preschools Residential areas Outdoor environment</td>
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<td>The Public health program 1999–2002 (1999, 14)</td>
<td>Equality in health and prioritized groups</td>
<td>Continued support for the development of municipal commitment County council responsible for knowledge development, epidemiology and collaboration</td>
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that there was a high prevalence of cardiovascular disease in the county. Such knowledge enabled goals within the plan to be directed at risk factors like smoking, high blood pressure, high blood fats, high alcohol consumption and disadvantageous psychosocial circumstances. A countywide, population-oriented cardiovascular project, Invest in the Heart, was introduced with the support of the plan.

Health Above All encompassed environmental as well as health targets. The decision on a Non-Smoking County Council, reached in 1988, which was the first of its kind in Sweden, provides an example of goal implementation within the council’s own organization. The plan introduced the health-settings perspective, and there was an emphasis on collaboration with other societal organs. Further, the plan expressed the ambition that the council should work for and set up collaborating groups. According to the plan, the local population’s health should be placed at the center, by intersectoral collaboration. Implementation of the plan included a proposal for a special health-planning organization within the county council, with special areas of responsibility allocated to each of the county’s seven municipalities.

Public health Västernorrland, 1993

The Third International Conference on Health Promotion, held in Sundsvall in 1991, supplied the region with new knowledge, and its intentions, as expressed in the Sundsvall Statement on Supportive Environments for Health, came to influence the county council’s third plan, which was adopted in 1993. As in the earlier plans, there was an emphasis on the mutual dependence of health and life environment. Gender equality and being attentive to exposed citizens were specified as significant determinants of public health.

Part of the county council’s health policy was based on the creation of favorable and supportive environments for health, where the efforts of the municipalities and other local stakeholders were decisive. The policy also encompassed an ambition to reduce the risks of ill-health at individual and group levels using the county council’s own organization. With its knowledge base on the population’s health, the county council intended to support the regional and local health promotion pursued by county organs, municipalities, working-life and voluntary organizations and other actors. By investing council funds in the prevention of ill-health in other sectors, it was expected that gains would be made in the form of costs avoided for health and medical care.

In Public Health Västernorrland, the epidemiological, centrally controlled countywide interventions of the earlier plan obtained lesser importance. Instead, prominence was given to a clearly expressed health-settings approach. The following settings were prioritized: work and workplaces, schools and preschools, residential areas and the outdoor environment. Further, there was an emphasis on intersectoral collaboration, especially between administrations within the municipalities and the county council. The key concepts were participation and empowerment.

The public health program, 1999–2002

The fourth plan, the Public Health Program 1999–2002, was based on the idea of a long-term sustainable society. The concept ‘Environment for Life’ was coined as a description of all components of public health. Here, goals and actions for the council’s own organization were set in relation to working with individuals and groups from a visionary perspective on how collaboration with other organizations/stakeholders might be achieved. Also, there was clarification of the roles to be played by different actors. At a community level, the priority was given to collaboration with the municipalities in the county, which resulted in a series of projects based on the concept of health-promoting settings.

A more health-promoting health care, 2004

The health-policy plan, A More Health-Promoting Health care, was adopted in November 2004, and still applied in 2011. This plan is based on Sweden’s national goals for public health from 2003. The influence of the national policy was primarily on interventions in Objective Domain 6, More Health-Promoting Health care, which the council’s plan came to encompass. The focus shifted to the council’s own organization. According to the plan, both a health-promoting and injury-preventing perspective should permeate the entire healthcare system, and should be a self-evident component of all care and treatment. The plan covers patients (individuals and groups), the population
and the county’s own personnel, plus strategies for follow-up and development.

There was a renewed focus on the individual and lifestyle. A return to an emphasis not only on risk factors but also on personal determinants of health, such as fitness, can be detected. The need for informational activities returns to the center, although now more in the form of interaction and dialog than the dissemination of information in traditional form. For example, health counseling and motivational interviewing are advocated as methods. Physical welfare (fitness) and self-care became topical concepts, as they were in the Health and Wellness Plan of 1978. The county’s fitness centers, set up in the 1980s and closed during the 1990s, returned (supported by the plan) with new names like Lifestyle Unit and Physiotech.

There is still an emphasis on local collaboration, but one that has been toned down in comparison with the earlier plans. The value of epidemiological data (morbidity/risk factors) is highlighted, with regard to both creating commitment to action and as an instrument for the follow-up and quality assurance of interventions. More than before, there is a stress on the necessity of working in an evidence-based manner.

The time perspective and the plans‘ relations to the dimensions of power and governance

Public-health policy in Västernorrland County Council, as reflected in >30 years of documentation, and examined on the basis of the documents’ contents and health-promotion principles, has not been a static process. Rather, it can be described as a movement, with changed perspectives and contents, as illustrated in the fields of our valuation chart in Figure 1. There is movement on the following dimensions: power (at an individual/collective level) and governance (at a central/local level). There are also positional changes in the following fields: social determinants (lifestyle and structural) and empowerment (at both individual and community levels).

The individual perspective and lifestyle issues were central not only to the first plan from 1978 but also to the latest plan from 2004. In the 1986 plan, a community perspective on change and structural factors was emphasized.

With regard to empowerment, there is also clear change in the plans over time. In the 1993 plan, empowerment was advocated primarily at the community level, but in the following plans there was a clear shift towards the individual

Fig. 1: Changes in position with regard to power and governance in the public-health plans of Västernorrland County Council, 1978–2004.
level. On the governance dimension, there were clearly conflicting priorities between two of the plans (1993 and 2004). In the 1993 plan there was a clearly expressed intention that health promotion should take place locally in the county’s municipalities and their health-promoting settings, and that there should be collaboration with the municipalities. In the latest plan (from 2004), there is a clearly expressed intention that interventions should be made primarily within the county council’s own health care organization.

DISCUSSION

Methodological aspects
The approach in this retrospective study is both descriptive and interpretive.

A methodological weakness may be that the documents on which our analysis was based varied in length between 4 and 155 pages. The first two plans were both >100 pages long, and it was politicians who instructed the council administration to make future plans more focused and brief. Their argument was that the plans should be easy to read and directly utilizable by the potential stakeholders and collaborating partners involved in implementation. However, the fact that length varied so much may have affected the findings in which the contents of the plans were assessed on the basis of the texts as they stood.

Another methodological aspect is that interpretation of the findings may have been influenced by four of the authors (B.F., H.R.M., R.A. and E.S.) having occupied leading positions in Västernorrland County Council’s public-health organization. Buse et al. (Buse et al., 2005) have maintained that interpreting results concerning a policy within an organization where one is employed may be ethically questionable. But having insider perspectives may also be a strength of the study in which they enable clarification of content and understanding of positional changes over time. Further, the fifth member of the research team (P.T.) was entirely outside the policy process, and had no link to the county council. This may have contributed to a more nuanced interpretation of underlying processes and their contents.

Political and societal developments
Policy formation and its content are affected by both internal and external factors. It is important to take account of when policy documents are scrutinized, especially when they cover a lengthy period of time. This study encompasses five plans over a period of just over 30 years. To understand a policy, it is also important, according to Buse et al. (Buse et al., 2005), to understand its context, as shaped by systemic political, economic and social factors.

During the period covered by the plans, Sweden underwent political changes that may have affected work on policy in the county councils. Three of the nine general elections held during the period saw a shift in power, between a social-democratic minority government and a right-wing coalition. However, there was a social-democratic majority on Västernorrland County Council throughout the period. According to Vallgårda (Vallgårda, 2011) the party-political stance of local government in Sweden has a role to play in public health policies. Also, stable party-political leaderships have been shown to succeed better in implementing structural and intersectoral community-wide policies for coordinated local health promotion (Jansson et al., 2011).

A country’s economy is significant for the population’s health and welfare. Sweden’s economy, like those in many other countries, was affected by the global structural crisis of the 1970s. At the beginning of the 1990s, there was a national economic crisis, primarily linked to high inflation. During the decade, there was a rapid increase in unemployment among both men and women (Gonäis, 1998). In Västernorrland the unemployment rate was around 5% higher than in Sweden as a whole. Also, the country has experienced constant population growth for almost 50 years, and passed 9 million inhabitants in 2004. Population growth took place primarily in the major-city areas, and was close to 11% between 1970 and 2002. Also, to an increasing extent, Sweden has become a multicultural country; the proportion of the national population with a foreign background had increased to 15.8% in 2004, while the proportion in Västernorrland was 6.6%. It has been a new challenge for health promotion to manage the complex contextual issues this has entailed (Pettersson, 2007). In Västernorrland, however, the population has declined, by just over 10% (Statistics Sweden, 2011). This has entailed an increase in the number of elderly people in the population, which impacts on local-government finances, in the form of reduced tax revenue, which is
significant for the financing of regional and local welfare.

In Sweden, there has also been a restructuring of the welfare system through market-oriented reforms, which have affected not only the county councils’ health care organizations, primarily regarding primary care, but also the municipalities’ social-welfare and school activities (Blomquist and Rothstein, 2005). In the National Social Report (The National Board of Health and Welfare, 2006) the main conclusion is that in many respects there has been a polarization of general welfare in which the majority of the population has seen an improvement, but around 6–7% have experienced no improvement at all. In Västernorrland, the so-called sickness rate, which indicates the number of payments of sickness benefits in cash to people aged 16–64 years was, from the 1990s to the final public-health plan of 2004, around 5% higher than in the country as a whole (Swedish Social Insurance Agency, 2011).

There have also been several changes to organizational structure that have affected the direction and control of public-health policy, at national, regional, and local levels. One example is the setting up in 1982 of a nationwide institute for public health, reconstituted in 2001 as the government’s National Institute of Public Health, with the tasks of promoting health and preventing diseases and injuries. Before 1982, these tasks were the responsibility of the National Board of Health and Welfare. At the level of the county councils, there were a string of reforms during the period, where primary care was steadily given increased responsibility for health promotion and injury prevention. Today, the principal focus is on lifestyle. The greatest change has taken place at a municipal level. Up until the 1980s, the public-health activities of the municipalities primarily concerned issues related to hygiene and the environment (Eklundh and Pettersson, 1987). There were also early alcohol- and drug-prevention interventions, primarily aimed at children and youth. Also, the municipalities have acquired responsibility for national legislation concerning tobacco, alcohol and the living and working environments (Jansson and Tillgren, 2010).

**Power and governance**

Beattie’s (Beattie, 1991) model of conflicting political philosophies in health promotion was used as an analytic tool at the second step in the content analysis. The modified model contained two extra dimensions: individual/collective power, and local/central governance. Dahl (Dahl, 1957) maintains that power involves a relationship between political actors, in this case those who determine whether the plans are capable of enhancing population health either individually or by individuals collectively. Here, governance, which constitutes the vertical dimension in our model (see Figure 1), reflects the relation between the political levels locally, the seven municipalities in the county and the central county council. In this regard, the role of the county council has been to support and stimulate the municipalities.

In the plans, the county council acted as the principal for the health care system through the provision of incentives, and strove, using its knowledge base, to mobilize the municipalities towards local health promotion. The strategy entailed the building-up of organizational structures, including public-health committees, to achieve intersectoral collaboration in the municipalities. Local public-health plans were produced and confirmed, and services—like the provision of health-promotion officers in the municipalities—were introduced, in part as a consequence of the political intentions expressed in the county council’s plans. The municipalities of Västernorrland were, relative to Swedish municipalities in general, quick to develop organizational structures for health promotion. But, in a study by Lundgren (Lundgren, 2009), it was found that the kinds of sustainable structures that had existed in several Västernorrland municipalities since the mid-1980s had disappeared. In 1985 a public-health planning organization was set up within Västernorrland County Council, which has had significance for the development of the structure of health promotion. The organization remains in year 2011.

In the five plans, there has been a positional change in terms of whether there should be a focus on the individual or the collective level. Laverack (Lawerack, 2007) described empowerment on a continuum running from the individual to the community, which—in the process—contributes to collective community action. At the beginning of the 1990s, this was reflected in the work for change pursued in socioeconomic-ally weak residential areas of Västernorrland, such as Nacksta and Ljustadalen (Rooth Möller, 1993; Lundgren, 1996; Andersson, 2004). That
the latest plan, from 2004, focused primarily on individual and lifestyle factors may be linked to the national public-health policy adopted by the Swedish Parliament in 2003, in which health care as a health-promoting setting was given prominence in one of its objective domains; in Sweden the county councils have primary responsibility for health care.

Another explanation may be that Sweden has also been influenced by the world-encompassing wave of neo-liberal ideology, which in principle has entailed administrative reforms based on the principles of New Public Management (Hertting and Vedung, 2009). Within several sectors in Sweden, this has entailed major changes, with direction-and-control solutions shifting from the collectively to the individually oriented action.

Politics and policy

Vallgård (Vallgård 2001, 2007) has examined national public-health policies that have grown up in the Scandinavian countries in the new millennium. One of her conclusions is that there is no specific Scandinavian model for health issues within the politics of the welfare state. The increase in social inequality in the population’s health is more apparent in Sweden than in the two other Scandinavian countries (Vallgård, 2001). In the Västernorrland public-health plans of 1993 and 1999, there was an emphasis on the necessity of evening-out social inequalities in health. Vallgård (Vallgård, 2007) goes on to affirm that nor is there any specific Scandinavian policy for health promotion, and that the Swedish model is related to the social–democratic ideal. During the entire period encompassed by the five plans, Västernorrland County Council has had a partisan social–democratic majority. Despite, or even thanks to the durable party-political majority, it can be stated that the plans diverge significantly regarding health priorities.

The dissimilarities between the imprints of the plans over time have several explanations. Some of these lie in environmental or contextual changes, such as health care reforms, ideologies expressed in international strategies, national public-health goals, knowledge of local conditions, power structures and economic preconditions. Dissimilarities may also be explained against the background of differences in plan-developing and rooting processes, and also in manners of implementation. That the plans partly were the products of the work of individual officers may also be of significance. Divergences in budgeting and access to resources, over the period as a whole, were certainly important.

In political science, there are many theories of why policies and organizations change over time. One posits that organizations can choose solely to ‘adjust the facade’ to demonstrate that an organization has been modernized, although in practice routines and activities have not changed (Røvik, 1992). Another speaks of policies changing due to conflicts between participating actors. Then, the policy reflects the current distribution of power between participants in the decision and implementation processes. The theory proposes that the process of developing a public policy can be regarded as an ‘everlasting game’ between diverse players and institutions, and also assumes that the players represent divergent interests (Bishop, 1981). A third asserts that policies change because the surrounding environment is permanently changing. As a consequence, there is an ongoing learning process, in which goals and means are adapted to each other. Here, changes over time are explained in terms of a continuing developmental process rather than stepwise development (Majone and Wildavsky, 1984).

Fosse and Røiseland (Fosse and Røiseland, 1999) take a similar point of departure to those illuminated by the three sets of theories described above. The authors adopt three perspectives on reform—in terms of symbol, conflict and learning—and maintain that these perspectives constitute the most common categories of explanations for policy changes over time. These three basic forms of explanation may help us to understand the changes that occurred over time in Västernorrland’s public-health plans.

Changes over time in the plans of Västernorrland can be explained as an ensemble, reflecting interplay between several influencing factors. Symbol, conflict and faith/spirit perspectives are all relevant. Simply adjusting the facade by changing the text of a plan, without achieving proper changes in the actions entailed by the plan has, of course, occurred. Conflicts, usually due to divergent views on health promotion, have also arisen. Learning over time has clearly taken place, in response to the influences of international and national
visions, such as those expressed in the Ottawa Charter, Sundsvall Statement and other international and national public-health objectives. In the opposite direction, the national level been influenced by the local, e.g. in national tobacco legislation, which might be traced back to the Smokefree County Council initiative in Västernorrland of 1988. Learning from follow ups and local experience of what, at any particular time, is possible, after the taking of either successful or unsuccessful action, is essential. For example, implementation in practice has influenced the wide-ranging Capacity Building Strategies program for personnel and politicians, in collaboration with universities, which took place in the 1990s (Forslin and Sohlberg, 1999). In our view, learning of this kind provides the greatest explanation for what we regard as developments over time in Västernorrland.

The plans’ contents in relation to the phases of modern health promotion

The development and contents of the five public-health plans can be linked to the four developmental phases of health promotion from the 1970s onwards, as described by Catford (Catford, 2004). The 1970s were characterized by the prevention of diseases and risk behaviors, which first took place in Västernorrland in 1986, when the plan focused on countywide interventions in relation to the risk factors associated with cardiovascular disease.

During the 1980s, there was an emphasis on the importance of complementary efforts, based on the five action domains for health promotion in the Ottawa Declaration (WHO, 1986). In Västernorrland this phase was reflected in the plan of 1993, where health and the environment became central, and which was based on supportive environments for health. Supportive environment for health was also focused upon in the statement by the International Conference on Health Promotion in Sundsvall 1991. As a concept, it was implemented in socioeconomically weak areas/arenas in Västernorrland.

The 1990s, according to Catford, were characterized by a developmental phase in which people were to be reached where they lived and encountered from the perspective of settings for health promotion. The health-promoting settings approach was already apparent in Västernorrland in its second plan, from 1986. In the fourth plan, from 1999, this perspective was developed further, and a number of projects came to be initiated, all of which were based on the creation and development of health-promoting settings.

During the final phase, around the start of the new millennium, there were global challenges to health, welfare and the environment, which saw the development of new concepts, approaches and theories. This orientation cannot be found in the Västernorrland plan of the early 21st century, but there is a link to one of the Ottawa Charter’s (Ottawa Charter, 1986) prioritized areas—that of renewing health care in a health-promoting direction. Such a focus has a link to the decision of the Swedish Parliament in 2003 to establish a first national public-health policy. Of the 11 objective domains (no. 6), one specifically touches on the role of the health care system in national health promotion (Proposition, 2002). Lundgren (Lundgren, 2009), who has monitored the new Swedish public-health policy, found that a majority of the 21 county councils investigated focused on this domain in their health plans. One reason is that county councils in Sweden hold the primary responsibility for health and medical care.

CONCLUSION

Analysis of five public-health plans in Västernorrland County Council over nearly 30 years shows that valuation of good health in the population has been consistently high in the policy documents, but that means for achieving this objective have varied over time. Interaction focusing on the individual citizen and community institutions has been adapted to prevailing sociopolitical currents. Changing political focus has, over time, reflected itself in a cyclical movement, where the individual perspective is now being given priority. The significance of societal interventions has been toned down, and the individual’s living habits are now being attributed great importance for public health. International and national visions, such as those expressed in Ottawa Charter from 1986, the Sundsvall Statement from 1991 and Sweden’s national goals for public health from 2003, have been reflected in the plans. Learning from practical experience and insights into what is possible at any particular time have been of crucial importance. Theories and new evidence-based methods have also had a huge impact. They
include learning from successful health promotion in local practice, and knowledge obtained from academic development programs for local-government officials and politicians. Promoting the health of a population requires mutual interaction between the regional and local levels, in which both community and individually oriented actions have equal status. Interaction between individual and community empowerment is a precondition for giving individuals an opportunity to take power into their own hands to change their living habits and life situations. To achieve this, the principles of supportive environments for health must be central to the policy-formulation process and to successful health promotion at regional and local levels. For deepened analysis of the plans, continued studies are needed.

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