COUNTRY REPORT

NORWAY

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Norway

Country Experts:
Bernadette Kumar, Arild Aambø, Harald Siem and Thor Indseth

General coordination: Prof. David Ingleby

Editing: IOM MHD RO Brussels

Formatting: Jordi Noguera Mons (IOM)

Proofreading: DJ Caso

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International Organization for Migration Regional Office for the European Economic Area (EEA), the EU and NATO
40 Rue Montoyer
1000 Brussels
Belgium
Tel.: +32 (0) 2 287 70 00
Fax: +32 (0) 2 287 70 06

Email: ROBrusselsMHUnit@iom.int
Internet: http://www.eea.iom.int / http://equi-health.eea.iom.int

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2v5qQhc), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	5.107.970	●●○○○
GDP per capita (2014) [EU mean = 100]	179	●●●●●
Accession to the European Union	.	

Geography: Norway is Europe's most northerly country, bordered by the North Sea and the North Atlantic Ocean, as well as by Sweden in the west and both Finland and Russia in the far north. Its coastline is deeply indented by spectacular fjords. The terrain consists mostly of high plateaus and rugged mountains broken by fertile valleys, as well as small, scattered plains: there is arctic tundra in the north. Norway is less densely populated than any other European country except Iceland. Most of the population lives in the south, but population clusters are found all along the coast. The capital city is Oslo (population 630.000 in 2014), followed by Bergen (272.000); 80% of the population live in cities.

Historical background: From about 800 to 1050 the Vikings, a Scandinavian seafaring folk, carried out raids, conducted trade and established communities in many parts of Europe. Norway was unified into one kingdom around 900 and converted to Christianity during the 11th century. From 1397-1523 the kingdom formed the Kalmar Union with Denmark and Sweden. In 1536 it formed a personal union with Denmark. This developed in 1660 into the integrated state Denmark-Norway, in which Norway had a subordinate role. In 1814, inspired by the French and American revolutions, Norway declared its independence: nevertheless, the Swedish monarch reigned over Norway until 1905, although the country kept its own liberal constitution. In 1905 Norway became independent of Sweden and voted to remain a monarchy rather than become a republic; it chose a Danish prince as its King. The country remained neutral in World War I. In World War II, despite its neutrality, it was occupied from 1940-45 by Nazi Germany. In 1949 it became a member of NATO.

Government: Norway is a parliamentary democratic constitutional monarchy with a unicameral parliament (the Storting). The Labour Party was the largest parliamentary party from 1927-2013.[2] The country is divided administratively into 21 counties, each of which has an elected County Mayor and a parliament-appointed County Governor. Counties are further divided into 428 municipalities *(kommuner),* each with their own elected council.

Norway's relationship with the rest of Europe has been complicated. It was a founder member of the European Free Trade Association (EFTA) in 1960, but in a 1972 referendum[3] the electorate rejected membership of the European Community by a margin of 7%. Norway ratified the European Economic Area (EEA) agreement in 1992, but a second referendum in 1994 on membership of the European Union produced a negative result – albeit with a smaller majority (4,4%).[4] In both referenda, similar arguments

[2] https://en.wikipedia.org/wiki/Politics_of_Norway
[3] http://bit.ly/2v2Ykwg
[4] http://bit.ly/2vw1auz

were voiced against membership. As well as concerns about losing Norway's hard-won sovereignty and distinctive national identity, there were fears that communities in the more sparsely populated regions would die out as trade with the EU swelled the population and prosperity of the south. (Support for membership of the EU was indeed strongest in Oslo and surrounding counties).

Another factor in the 1994 referendum was the vast revenue from the oil and gas resources first discovered in 1969, which peaked in 1992[5] and currently accounts for 22% of GDP.[6] In order to enjoy the benefits of the European Single Market, Norway has been prepared to accept more and more of the EU *acquis*: by joining the EEA in 1994, it committed itself to paying substantial contributions and accepting the 'four freedoms' (free movement of goods, persons, services and capital). Since 1954 Norway, Denmark, Sweden and Finland have had their own free-travel area, the Nordic Passport Union, and in 1996 Norway joined the Schengen area. To a large extent, Norway has become almost a *de facto* member of the EU, although without voting rights. About three-quarters of Norway's trade is currently with the EU; it is the Union's main supplier of natural gas and primary aluminium.[7]

Economy: Oil and gas are only the most recent of the natural resources that Norway enjoys: others include hydropower, fish, forests and minerals. Together with services, shipping and manufacturing industry, a skilled labour force and advanced technology, these assets account for the country's extremely high GDP per capita, which peaked at $92.000 in 2007 – seven times the world average.[8] The government's policy is to build up Norway's strongest productive sectors with the help of oil revenues, while relying on the EU for additional goods needed by its population.

The Norwegian government prudently decided in 1972 to save up most oil revenues for the future, rather than massively increasing public spending. The current value of Norway's sovereign wealth fund is $900 billion; the current fiscal rule is that budgets should aim for structural deficits at 3% of the value of the oil fund.[9] Indeed, government spending in 2015 was only 48% of GDP (ranked 10th out of 28 OECD countries) – not an exceptionally high proportion of national wealth. For the individual, however, this translates into a very large figure ($30.263 per person, second only to Luxembourg's $43.010 and 1,6 times the OECD average of $18.608).[10] Although the cost of living is high, the Norwegian state thus treats its inhabitants very generously.

Norway is vulnerable to fluctuations on the world oil market and went briefly into recession in 2009 and 2013: unemployment increased to 4,9% in 2016. Currently (May 2017) it stands at 3,15 – 2,3% for the native population, but 7,1% for migrants.[11] The government has applied fiscal stimuli to aid the current recovery, which is expected to continue until 2018.[12]

[5] https://en.wikipedia.org/wiki/Energy_in_Norway
[6] http://ec.europa.eu/trade/policy/countries-and-regions/countries/norway/
[7] Ibid.
[8] https://tradingeconomics.com/norway/gdp-per-capita
[9] http://www.oecd.org/economy/norway-economic-forecast-summary.htm
[10] https://data.oecd.org/gga/general-government-spending.htm
[11] http://www.ssb.no/en/arbeid-og-lonn/statistikker/innvarbl/kvartal
[12] http://bit.ly/2wr7UHn

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	13,8	●●●●○
Percentage non-EU/EFTA migrants among foreign-born population	53	●●○○○
Foreigners as percentage of total population	9,4	●●●●○
Non-EU/EFTA citizens as percentage of non-national population	34	●●○○○
Inhabitants per asylum applicant (more = lower ranking)	445	●●●●○
Percentage of positive asylum decisions at first instance	64	●●●●○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	n/a	
Average MIPEX score for other strands (MIPEX, 2015)	68	●●●●●

Norway has a long history of emigration – going all the way back to the Vikings, who established settlements in many parts of Europe and even reached the Middle East, North Africa, Russia and North America (present-day Newfoundland).[13] In the 17th century a dozen or so Norwegian sailors emigrated to colonial America along with the Dutch. The first Norwegian settlers emigrated in 1825, and in the following hundred years more than 800.000 Norwegians – one-third of the population – emigrated to the USA and (to a lesser extent) Canada, in a wave of what those left behind called 'America fever'. With the exception of Ireland, no single country contributed a larger percentage of its population to the United States than Norway.[14] The main reason for emigrating was lack of available land. Many Norwegians also emigrated to European countries (for example, the Netherlands in the 17th and 18th century). After World War II, the establishment of the Nordic Passport Union in 1954 facilitated migration to and from Sweden, Denmark and Finland.

Immigration to Norway is also not a new phenomenon (Brochmann & Kjeldstadli 2008). Immigration from Sweden and Denmark has a long history, reaching a peak in the 18th and 19th century; settlers from Finland (the Kvens) came in large numbers from around the 15th century. Skilled labour, especially from Germany, was recruited to the mining industry from around the 16th century.

After World War II migration to Norway revived only slowly at first, most immigrants coming from other Nordic countries (see Fig. 1). The rate of growth increased steadily, becoming – as in Denmark and Sweden – the major source of population increase in the past 25 years, far exceeding that of natural increase.[15] The most marked increase since 1970 has been from Asia and Africa, followed by refugees from former Yugoslavia in the 1990s and labour migrants from Eastern Europe from 2006 onwards. As in most West European and Scandinavian countries, labour migration from non-European countries to

[13] https://en.wikipedia.org/wiki/Viking_expansion
[14] https://www.naha.stolaf.edu/pubs/nas/volume18/vol18_1.htm
[15] http://bit.ly/2hreQ4L

Norway was severely restricted after the global oil crisis of 1973, in response to the resulting recession and unemployment. Except for purposes of family reunion, asylum-seeking or study, only a small number of highly qualified migrants were allowed in. This selective approach dominates Norwegian migration policy, though after Norway joined the EEA in 1994 it had to accept the right of EU/EEA citizens to seek work freely in the country. This did not lead to any great increases until 2006, following the accession of Poland and Lithuania in 2004.

Figure 1. Immigrants and Norwegians with immigrant parents by region of origin (1st January 2017)
(Source: Statistics Norway)

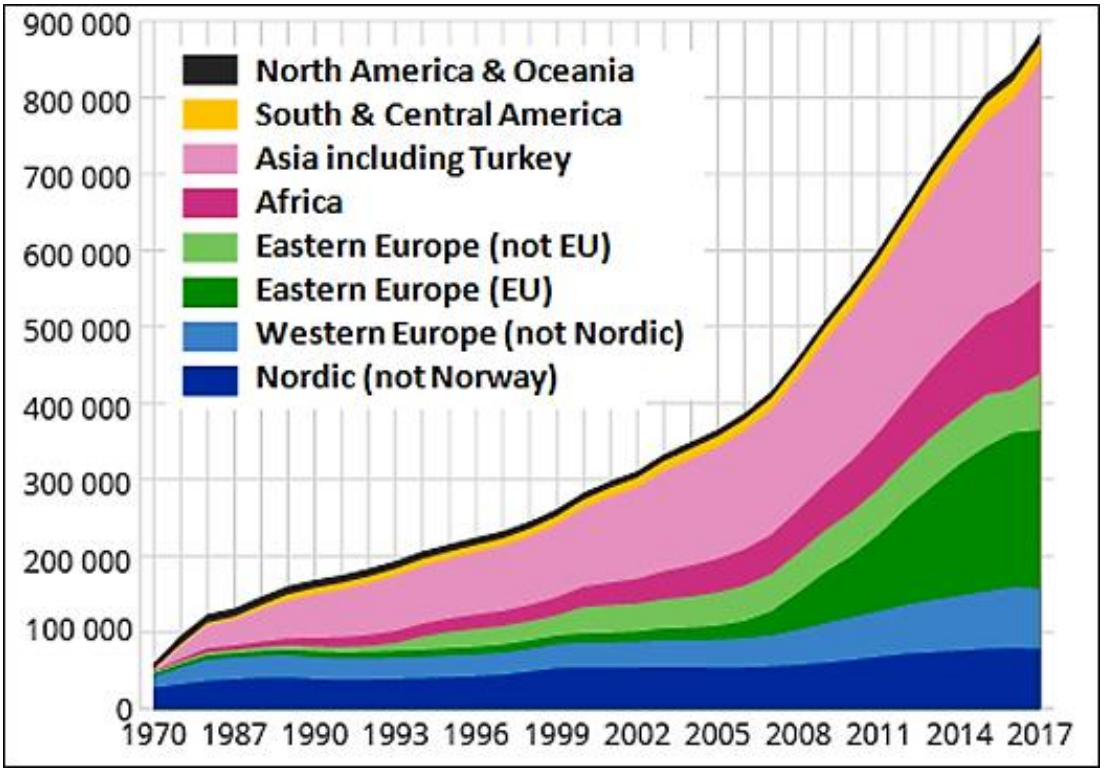
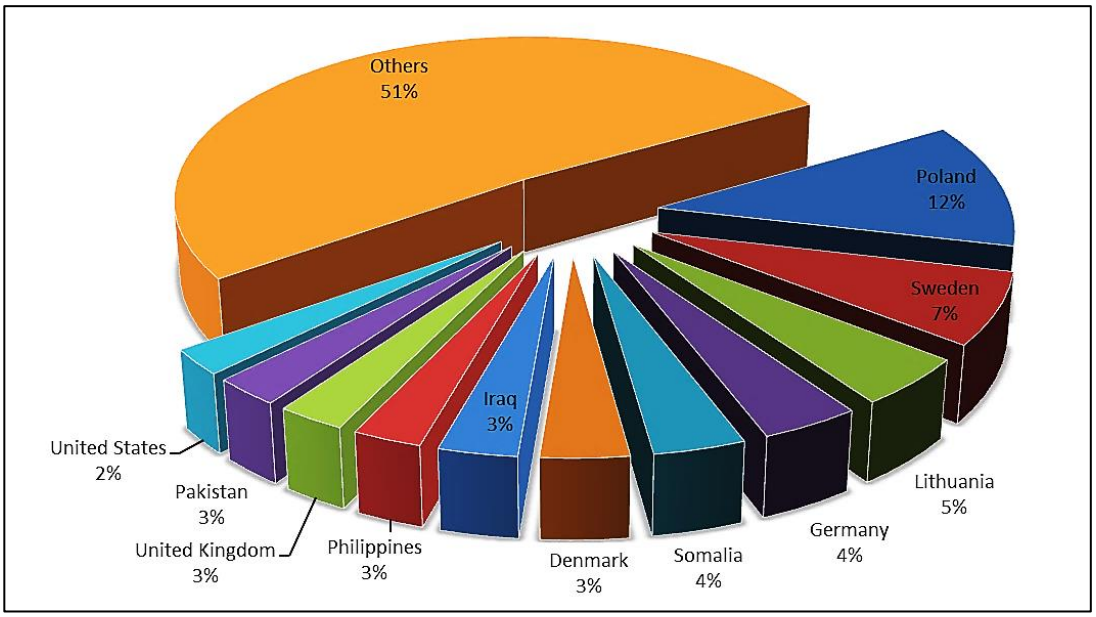


Figure 2. Foreign-born population of Norway in 2014 by country of birth[16]



[16] Source: Eurostat, file migr_pop3ctb.

Figure 2 (above) shows the **countries of birth** of the main foreign-born groups in 2014. The largest group of migrants came from Poland, while the fact that 51% of all migrants fall in the category 'other' shows the wide range of countries represented.

The **geographical distribution** of migrants within Norway is shown in Fig. 3. It is worth noting that high percentages are not confined to the more densely populated south of the country, although there are obvious concentrations in Oslo and Bergen. Health services in many parts of the country can therefore expect to have to deal with patients with very diverse backgrounds.

Figure 3. Immigrants and Norwegian-born to immigrant parents, as percentage of total population in municipality, 1 January 2015.
(Source: Statistics Norway)

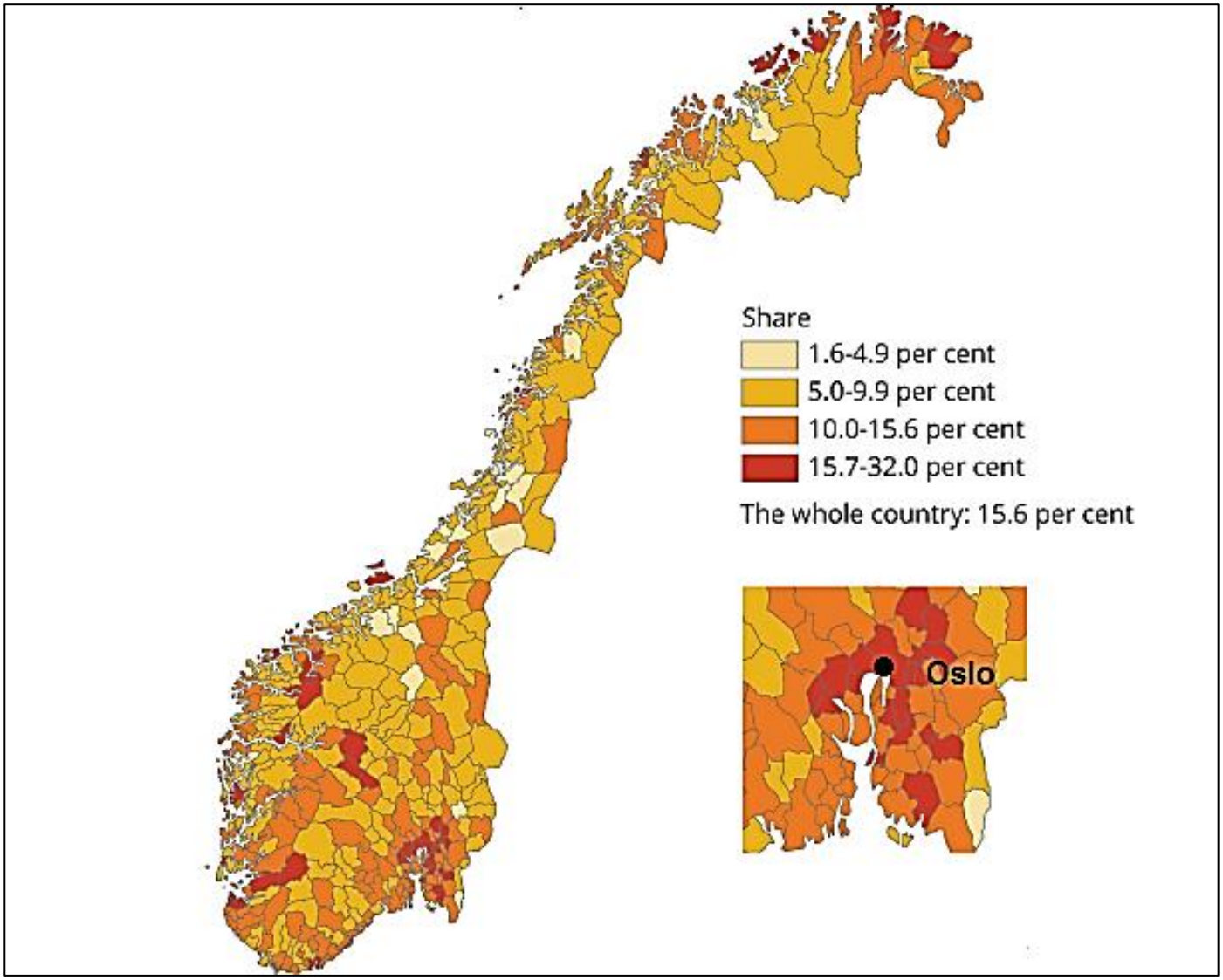
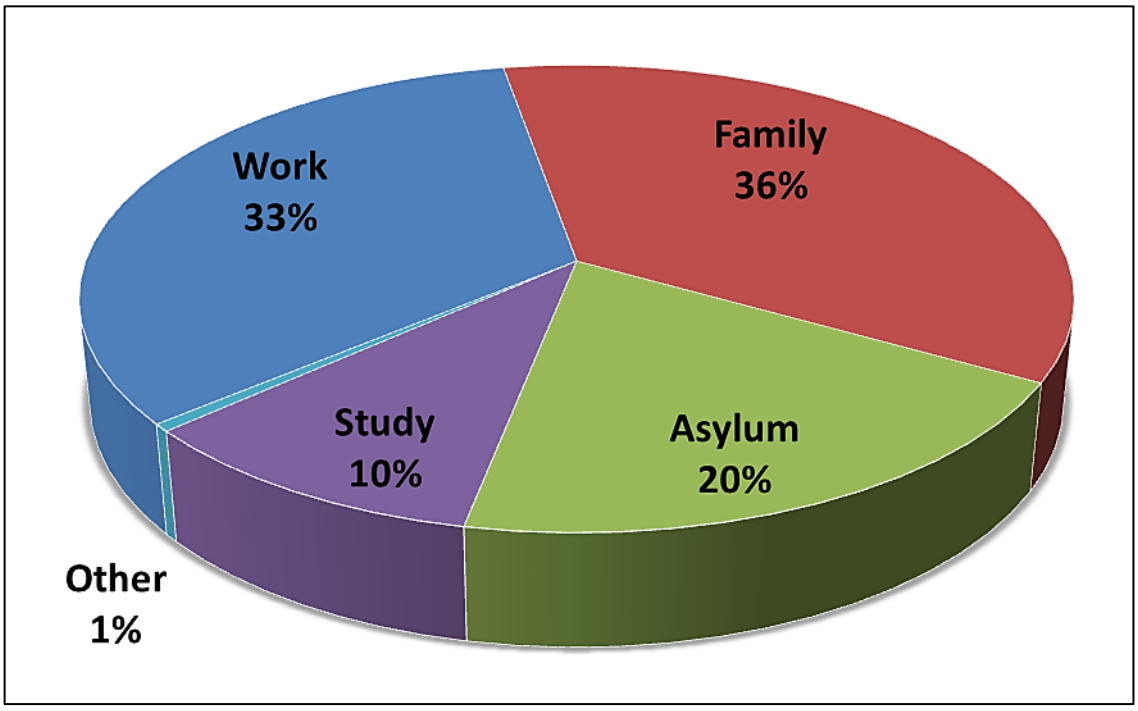


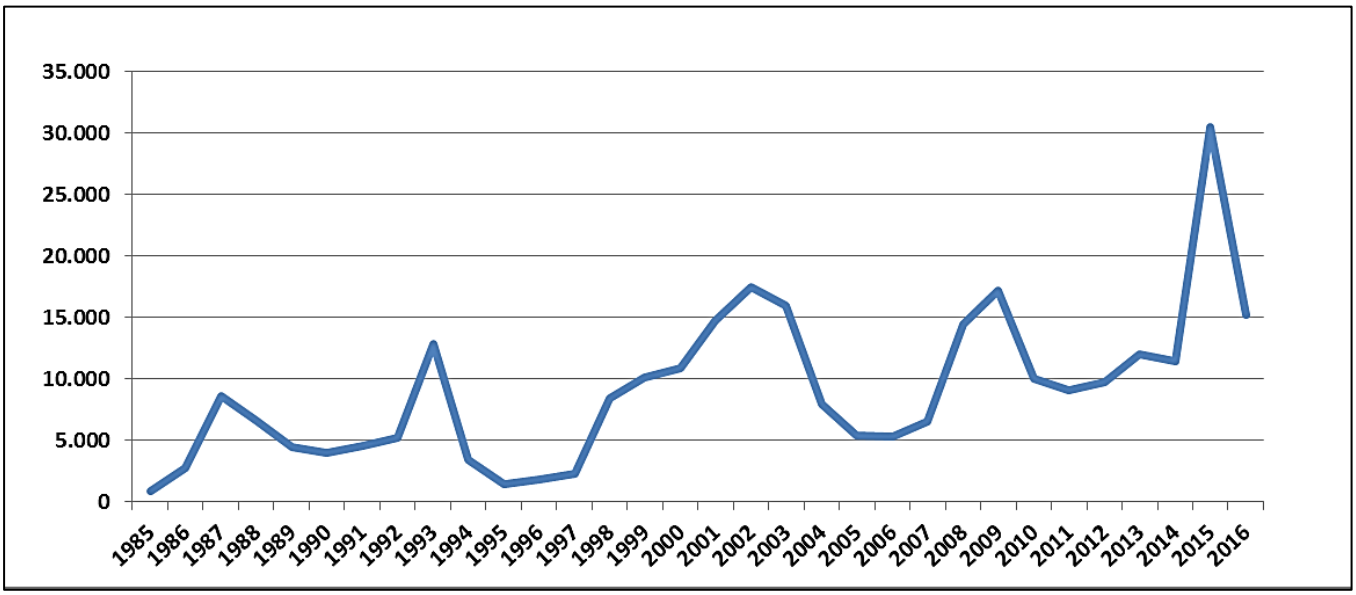
Fig. 4 shows the reasons for migration of all migrants arriving between 2006 and 2016.

Figure 4. Distribution of reasons for migration, 2006-2016
(Source: Statistics Norway)



When the data for 1989-2005 are also included, these percentages change as follows: Work 32%, Family 39%, Asylum 23%, and Study 5%.[17] This implies that before 2006, relatively more migrants were granted asylum but fewer came for study.[18] The following graph shows the rate of asylum applications:

Figure 3. First-time asylum applications in Norway, 1985-2016 (Eurostat)
(Totals for 2007 and 2016 updated from Statistics Norway)



[17] https://www.ssb.no/befolkning/statistikker/innvgrunn
[18] https://www.ssb.no/innvandring-og-innvandrere/nokkeltall

The increases at the beginning and end of the 1990s were due largely to the wars in Bosnia & Herzegovina and Kosovo respectively. The most recent and highest peak was due to the sudden influx of asylum seekers in Europe in 2015, many of them from Syria, when 30.000 sought asylum in Norway.[19] In 2016 legislation was passed implementing a raft of measures to make it harder to enter the country to claim asylum and easier to deport asylum seekers to their country of origin, or one they had travelled through.[20] Similar measures were also introduced by Sweden and Denmark. These measures were roundly criticised by human-rights organisations and the United Nations. It is unclear to what extent they were responsible for the reduced number of applications in these countries in 2016, as opposed to the closing-off of the sea route between Turkey and Greece.

Integration policies and attitudes to migration

On the other strands of MIPEX, Norway's average score places it in fifth position among the 34 countries in the current study (behind Portugal, Sweden, Finland and Belgium). Although the Eurobarometer (containing a question on attitudes to migrants) does not cover Norway, a recent publication (Czaika & Di Lillo 2017) includes the country in a study of attitudes using data from the European Social Survey (ESS). The questionnaire distinguished between attitudes to migrants "of the same race or ethnic group as most nationals" and migrants "of a different race or ethnic group". In all 28 of the EU and EFTA countries studied, attitudes to the former group were more positive than to the latter. On attitudes to migrants of the *same* ethnicity or race, Norway obtained a rank of 6 (after Iceland, Sweden, Switzerland, Denmark and Lithuania); regarding migrants of a *different* ethnicity or race, its score also put it in sixth place (after Sweden, Iceland, Poland, Lithuania and Bulgaria). Regarding the difference between the two scores, Norway was in the middle of the range.

This study also looked at changes in attitudes over time between 2002 and 2014. In relation to the two questions described above, average attitudes in the whole sample became more favourable. However, a third question was also asked, asking for attitudes to "immigrants from the poorer countries outside Europe". Although this question produced answers that were largely similar to the second question, average scores became *less* favourable over time. These general tendencies are however weak; they mask large differences both within and between countries. Norway showed moderate to large improvements in attitudes to all three groups, especially to migrants of different race or ethnicity.

Finally, the study examined local variations in attitudes *within* countries, using the EU's NUTS divisions – in fact, this was its main focus. When it came to immigrants of different race or ethnicity, attitudes in the vicinity of Oslo were more positive than in the rest of the country – though still not as positive as those in nearly every part of Sweden.

Since 2002, Statistics Norway has carried out an annual survey on attitudes towards immigrants and migration, which contains more detailed information. The latest survey,[21] carried out in 2016, showed a drop in positive attitudes to migrants and migration since a year earlier – probably related to the large influx of asylum seekers and other non-European immigrants in that year, which also led to the stricter government policies described above. The percentage of respondents feeling that "most immigrants represent a source of insecurity in society" rose by 6% to 32%, while 7% more (i.e. 51%) felt that "immigrants should endeavour to become as similar to Norwegians as possible".

[19] http://bit.ly/2fcvlkg
[20] http://bit.ly/2tRc3UD
[21] http://bit.ly/2xd90I1

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	4.313	●●●●●
Health expenditure as percentage of GDP	9,4	●●●●○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	85[22]	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	14	●●●●○
Score on Euro Health Consumer Index (ECHI, 2014)	851	●●●●●
Overall score on MIPEX Health strand (2015)	67	●●●●●

Basic features of the health system

The Norwegian health system is a tax-based national health service with two main levels of governance:

- The State is the owner of hospitals (called 'enterprises'), and enters into contracts with private specialists.
- The municipalities are responsible for primary health care, including planning and developing these services to meet the needs of the residents.

The structure of the health system is depicted below in Fig. 4. Within the national framework, the municipalities have a certain amount of freedom in organizing services. There is no direct command and control line from central authorities to the municipalities, but there are regulations and policy frames that strive to secure good coordination and collaboration between the different levels.

The Ministry of Health and Care Services is the secretariat for the Minister, responsible for national policy, legislation and budgets, and is also the owner of health enterprises (hospitals). Seven agencies and boards, including the Directorate of Health, report directly to the Ministry, as the figure shows.

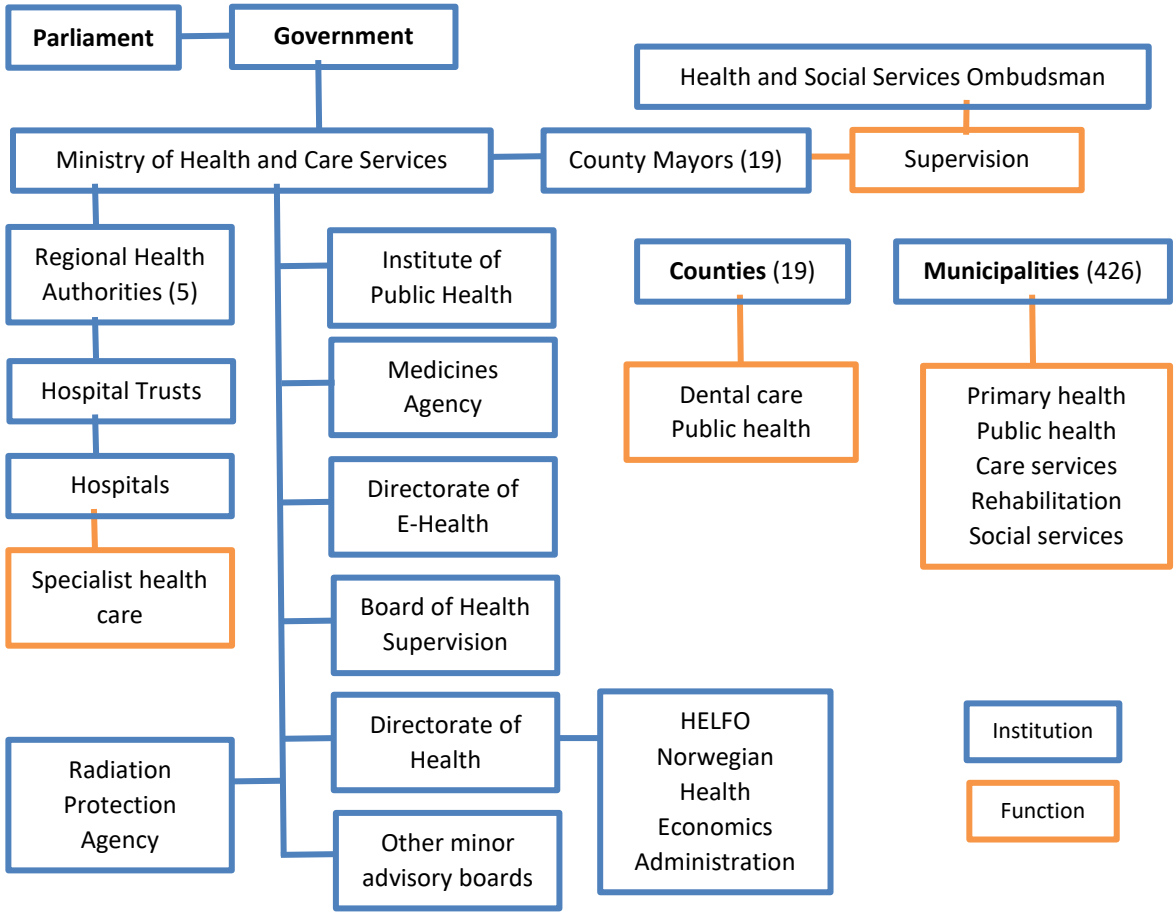
In 2013, 85% of health system financing was provided by government and 14% by out-of-pocket payments. Private voluntary health insurance made a negligible contribution. The annual budgets for specialist services and for municipal health and care each accounted for roughly the same amount of total expenditure, which is among the highest per capita in the EU/EFTA area (second only to Switzerland). Nevertheless, total expenditure as a percentage of GDP amounted to only 9,4%, which is only slightly higher than average. This is explained by Norway's very high level of GDP per capita.

General practitioners (family doctors) are the gatekeepers for the health system. "In 2001, the RGP scheme was introduced and all citizens who are registered in the National Population Register are

[22] Of this amount, 75% came from local or State taxation and 10% from contributions to the National Insurance System.

entitled to a regular GP. Regular GPs must give citizens on their list an appointment as soon as they need one" (Ringard et al. 2012:42).

Figure 4. Simplified model of structural relations in the Norwegian healthcare system



Out-of-pocket payments for consultation and medication

Although the level of out-of-pocket (OOP) payments is relatively low by EU/EFTA standards, it is an important issue in a system that aims at equity. A cash fee for services makes health care regressive – the poorer the patient and the more health care they need, the greater the burden it represents. The issue is particularly important to migrants because they often have lower-than-average-incomes. In Norway, exemptions and ceilings are in place to reduce these inequities.

Inpatient treatment is covered by the National Insurance Scheme and does not require any OOP payments. This applies to nationals, legal migrants and asylum seekers.

A small OOP payment is required for **consultations with a general practitioner or outpatient specialist, ambulatory care, X-rays and laboratory tests.** The Norwegian parliament is responsible for deciding the maximum amount of such payments each year (also known as the ceiling scheme). The ceiling scheme for OOP payments has two categories: scheme 1 and scheme 2 *(frikort egenandel 1* and *frikort egenandel 2),* which in 2014 were NOK 2105 (€227) and NOK 2670 (€288) respectively. All consultations within primary and specialist healthcare services fall under scheme 1, while those for physiotherapy are classified under scheme 2. Any OOP payment over the ceiling level in a particular year will be

reimbursed; at that point, an exemption card will be issued by HELFO (the Norwegian Health Economics Administration). HELFO is subordinate to the Directorate of Health. It is responsible for direct payments to various service providers, as well as individual reimbursement for certain medicines, dental services and health services abroad. It keeps track of all relevant expenditures in a computerized system based on the personal identification number, and issues a card for free treatment for the rest of the year once an individual has reached the ceiling of expenditures.

OOP payments for medication: Medication for inpatients and patients at risk of exposure to certain health problems, e.g. infections mentioned in the Communicable Diseases Control Act, are covered by the National Insurance Scheme and do not require any OOP payments. This applies to nationals, legal migrants and asylum seekers.

A small OOP payment is required for prescriptions for some chronic diseases used over time. This type is known as the blue prescription (*blåresept*). OOP payments for medications in the free prescription category are included in the ceiling scheme each year.

Exceptions for OOP payments that also apply for migrants: There are no OOP fees on consultations and medications for the following groups:

- Children under 16 years regardless of resident status
- Patients with a minimal pension (documentation required)
- Patients with an infectious disease that may put the rest of the population at risk, regardless of their resident status
- Patients suffering from immunodeficiency
- Patients who need palliative care at the terminal phase of their lives.

Most dental care is paid for out-of-pocket. Children and a few other groups are covered by HELFO.

Health policy objectives and frameworks

According to Ringard et al. (2013), Norwegian health care policy has the following characteristic features:

- A combination of central command and control (defining policy goals, monitoring outcomes etc.) and local freedom to choose the most suitable means (the 'tight – loose' principle).
- Policy-making is separated from implementation.
- Significant political commitment is shown regarding the implementation of recent, and earlier, reforms in the health care sector.
- Reducing social inequalities in health is a social priority; however, the effects of policies to reduce them are often not well documented before their implementation and not evaluated afterwards.

The Ministry **of Health and Care Services (HOD)** is responsible for the provision of good and equitable health and care services for the population of Norway according to the political leadership. The Ministry

directs these services by means of comprehensive legislation, annual budgetary allocations and through various governmental institutions.

The Directorate of Health is the executive agency and a professional authority under the Ministry of Health and Care Services. Its commitment is to implement legislation and strengthen the health of the nation through integrated and targeted work across services, sectors and administrative levels.

The County Governor it the state representative at the county level. The governors (whose office includes the *County Medical Officer*, the county representative of the Norwegian Board of Health supervision) are the State's regional representatives. The County Medical Officer is expected to communicate and implement national policy in the field of public health locally and regionally.

Regional Health Enterprises (hospitals) are responsible for specialized health care. During the last three decades Norway has developed enterprises that enjoy an element of freedom similar to that seen in the private sector. Although the state has built-in directing/steering and control mechanisms in the organizations, the day-to-day running of enterprises is the responsibility of the general manager and the executive board. In this way hospital reform implies a decentralized management process.

As mentioned, primary health and care services are the responsibility of the municipalities. The funding system for municipalities was changed in 1986, now giving the municipalities a greater degree of autonomy in spending the global transfer from the state. However, there is an element of third-party payment involved in the health care system. Patients pay an OOP fee for consultations with their GP or other service providers, but are protected by the ceilings discussed above. The providers of consultations are also reimbursed on a fee for service basis by National Health Insurance (HELFO), and receive a capitation fee from the municipality for each person on their list.

Nursing homes and home nursing are run by the municipalities or by contracted private companies.

Steering mechanisms

The Ministry of Government Administration, Reform and Church Affairs issues circulars on the official duties of county governors *(Embetsoppdraget).* Through these documents, all relevant ministries contribute to the governors' task portfolio. In addition, the Ministry of Government Administration, Reform and Church Affairs, in collaboration with other ministries and directorates, prepares a letter of assignment *(Tildelingsbrev Kap 1510, Fylkesmannsembetene)* in which central political principles and priorities are stated, including themes for countrywide supervision of health and care services.

The County Governors prepare an annual report on their activities, challenges and achievements, related to the stated principles and priorities. Each of the funding ministries takes responsibility for following up on their contributions.

Surveillance and complaint mechanisms

The Norwegian Board of Health Supervision is a national public institution organized under the Ministry of Health and Care Services, working independently of political management. It ensures that health and social services are provided in accordance with national acts and regulations, according to standards of service quality and relevant laws such as the Patients' Rights Act. Deviations are reported on and

followed up until the case is closed. Findings of supervision are also supposed to be used in the development and interpretation of national plans *(Strategiplan 2010-2012)*. Moreover, the policy of transparency makes it possible to utilize findings of supervision as a basis for learning and quality improvement.

There are three levels of supervision:

- *Area supervision:* This involves collecting, organizing and interpreting information about health and social services in order to evaluate whether the population's needs are met and whether the quality of services is adequate, that is meet requirements laid down in law. Countrywide supervision is performed in two to four areas each year.
- *Planned supervision of services:* In system audits, conditions and factors not in accordance with acts, regulations, and professional standards are uncovered. Identified nonconformities are then followed up until requirements are met. Seven to nine hundred system audits are performed each year.
- *Incident-related supervision:* This kind of supervision is initiated by reports on incidents where there are possible deficiencies in services. If deficiencies are identified, the Board issues administrative reactions. About two thousand such cases are investigated each year.

Priorities regarding areas of supervision are determined on the basis of information about risk and vulnerability. Countrywide supervision is, as mentioned, determined at governmental level and the themes for such supervision are communicated in letters of assignment to the County Governor.

Patients can also ask the supervising authority to investigate their case. The authority can then check on the quality of the treatment that the patient has received or on the services more generally. This control system contributes to patient safety and raises the quality of health services.

In accordance with the Patients' Rights Act every county must have an *Ombudsman for Patients and End-users*, an independent office which can be contacted free of charge by anybody who is uncertain whether or not they have received the help to which they are entitled. The Ombudsman's purpose is to safeguard patients' interests and legal rights in relation to health care and to improve the quality of the health service. Complete confidentiality is guaranteed and the complainer can, if they choose, remain anonymous.

The *Equality and Antidiscrimination Ombudsman (*LDO) supervises the implementation of the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD). Both conventions are enshrined in national law. Among national acts the Ombudsman oversees are the Gender Equality Act, the Anti-Discrimination Act, and the Anti-Discrimination and Accessibility Act.

The *Ombudsman for Children* is an advocate for children and young people and works to uphold the rights of children, supervising the implementation of the Convention on the Rights of the Child, which is also enshrined in Norwegian law.

Quality improvement efforts

While the Norwegian Board of Health Supervision has authority to instruct health care workers and invalidate decisions, the Ombudsman primarily facilitates dialogue between conflicting parties, his or her legitimacy being a prerequisite. However, both instances will in most cases emphasize quality improvement above other considerations. In addition to these bodies working to uphold law and regulations, several other instances support the development of quality in the health services, like the Institute of Public Health (FHI), the Norwegian Knowledge Centre for the Health Services (NOKC), national and regional expert units such as the Norwegian Centre for Migration and Minority Health (NAKMI), Norwegian Centre for Traumatic Stress Studies (NKVTS), the regional centre for violence, traumatic stress, and suicide prevention (RVTS), the Reporting and Learning System administered by NOCK, departments for research and development at the regional health enterprises, as well as further quality networks like the Norwegian Society for Quality in Health and Social Services and the Norwegian Efficiency Networks (KS). In addition, there are systems for internal control both in municipal and specialist services, and the regional health enterprises perform internal audits. Some of these instances are further described in what follows, as they are considered of special relevance for developing migrant-friendly health care services.

The Norwegian Institute of Public Health (Knowledge Centre) supports the development of quality in the health services by summarizing research, promoting the use of research results, contributing to quality improvement, measuring the quality of health services, and working to improve patient safety. The Institute also receives confidential reports from healthcare staff through a reporting hub. This aims to help ensure that similar events can be avoided in the future.

In the Directorate of Health's national strategy on quality improvement in the health and care services entitled 'And better it shall be!' *(… og bedre skal det bli!*), good quality in service provision is defined as effective, safe, coordinated, cost-effective, accessible and equitably distributed services, also promoting user involvement.

The Norwegian Centre for Migration and Minority Health (NAKMI),[23] established in 2003, is a national research, development and policy centre promoting research-based knowledge about health and care for immigrants and their descendants. NAKMI aims to promote and contribute to equity in health for these groups in Norway. Its main target groups are health policy makers and managers, health professionals, researchers and students.

NAKMI's goal is to be the clearing-house for migrant health matters, through research and development, education, training, capacity-building and dissemination of information. Its approach is multi- and interdisciplinary, as well as wide-ranging, covering both somatic and mental health at local, national and international level. The centre does not carry out clinical activities, but works closely with relevant clinical practitioners. Active user involvement at all levels is the cornerstone of NAKMI's work.

The Norwegian Society for Quality in Health and Social Services (NFKH) is an organization for providers of health and social care working to disseminate knowledge on quality and quality improvement in the health care sector and to stimulate and facilitate quality networks at national and international level.

[23] http://www.nakmi.no/english

The Norwegian Association of Local and Regional Authorities (KS) is the employers' association and interest organization for municipalities, counties and local public enterprises in Norway. KS advocates for the interests of its members towards the Government, the Parliament, labour organizations and other organizations. Its long-term strategy (2012-2016) explicitly supports recruiting immigrants to service provision.

Policies concerning migrant health

A National Strategy on Immigrant Health

In 2013 the government launched a national strategy on immigrant health for 2013-2017 (Ministry of Health and Care Services 2013). The following goals were set:

- Health care providers at all levels shall have knowledge about various immigrant groups, their disease incidence, and cultural challenges that are relevant for ensuring equitable health care services for immigrants.
- Health care providers at all levels shall facilitate communication with patients with different linguistic backgrounds. This requires, among other things, assessment of needs for interpretation and the use of qualified interpreters.
- Health and social services shall have access to up-to-date knowledge of immigrants' health and their use of health services, and use this knowledge to improve services.

To reach these goals, the following measures must be taken:

- The Government will strengthen local health care centres and health services in schools.
- The Ministry of Health and Care Services will strengthen NAKMI in order to increase the capacity of educating and training health care providers.
- The Government will in the follow up on the Parliamentary report no.6 (2012-2013) *A Comprehensive Integration Policy* take the initiative to put more emphasis on migrant health in the education of health care and social service providers.
- Within the period of the plan, the Ministry of Health and Care Services will strengthen the National Institute of Public Health's (FHI), basic grant, so that FHI can make use of existing registry data and publish analyses of the health of the immigrant population and their use of health care services.
- The Ministry of Health and Care Services will strengthen the Norwegian Diabetes Association's work for immigrants.
- NAKMI will be asked to establish a network for researchers in the field of migrant health.
- As part of the follow-up of the cancer strategy, different strategies for disseminating information will be assessed in collaboration with the Norwegian Cancer Society.
- The Ministry of Health and Care Services will investigate possibilities for, and survey the uses of interpretation by telecommunication.

No attention was paid to the situation of undocumented *(papirløse)* migrants, despite the fact that many researchers have documented this group's limited and unclear entitlements to health care in Norway.

Previous health policy documents

In her Masters thesis, *Public health challenges among immigrants in Norway – A content analysis of health policy documents,* Spilker (2012) summarizes what has been written about migrant health policy

in a selection of 10 White Papers and 18 National strategies and action plans found relevant to the field. Under the umbrella of general values for the Norwegian health care system like equity, solidarity, and respect for human dignity and acknowledging a general need for coordinated and integrated services adapted to meet the unique needs of the individual patient, it has during the last decades been an explicit goal for health care authorities to formulate policies that contribute to more life years in good health for the whole population as well as to reduce health inequalities between gender and different social and ethnic groups.

All ten White Papers that were examined have specific sections or paragraphs related to immigrants and the multicultural perspective. Most of the identified texts are descriptive, portraying the immigrant population, their living conditions, health status, cultural perceptions, and language and communication barriers. Challenges for health care services like cultural perceptions of health and illness, poor Norwegian language skills and lack of understanding of the health system are acknowledged, and so are the need for better health surveillance, research programs, and prioritization. Subsequent suggestions for actions are related to improved information and communication, adaptation of services, targeting of health promotion activities, and low threshold and outreach services. Further, it is made clear that the responsibility for being responsive to cultural differences lies with the health personnel and the health services. Concrete measures are, however, few, although the National Health Plan (2007 – 2010) states that "the Ministry will during the period of this plan …… contribute to ensure equitable services and create attention to the user perspective of ethnic minorities".

The overall aim of these plans and strategies is to prevent illness, promote health and improve quality of services. Of the 18 documents studied, 13 mention immigrants explicitly. Eight of these have specific sections on immigrant health: mental health, nutrition, physical activity, prevention of unwanted pregnancy and abortion, and communicable diseases. General challenges like greater risk and vulnerability, being hard to reach, low health literacy as well as the need to adapt services to immigrants' specific needs are acknowledged. However, suggestions for action are of a general nature and, although nine of the 13 documents state specific measures, most of these are vaguely formulated.

Spilker laments the lack of governmental policy formulation towards a comprehensive, systematic and coordinated approach. Identified proposals for measures and actions are general, normative and blurred making it difficult to see which concrete actions should follow. Moreover, in most of the documents there seems to be little concordance between measures proposed and the description of challenges and suggestions. She concludes that there is huge gap between the situation analysis and explicitly formulated measures; a missing link between how the public health challenges are described and concrete actions to improve the health of immigrants.

Government tools of influence

Government tools of influence include guidelines, standards, working plans, manuals, handbooks, training and supervision. Below is a short presentation of selected documents on migrant health policies.

Guidelines: On the home page of the Directorate of Health are over 160 published guidelines concerning health care workers, of which 43 are considered of high relevance for the field of migrant health. Of these, three are entirely devoted to problems related to immigration: one about health care services to asylum seekers, refugees and family reunion, one about communication via interpreter and one

regarding female genital mutilation. Sixteen of the documents have a special paragraph related to migrants or ethnicity, and in six other, migrant related issues are mentioned at least once.

While some of the recommendations have the form of suggestions, others clearly formulates requirements, for example regarding patient-centred services, the use of interpreters, responsibility regarding the provision of linguistically adapted information, the acquisition of knowledge on immigrant related issues and culturally adapted services.

However, in 18 of the 43 'guides' that were found relevant to migrant health, there were no hits for search words like *immigrant, asylum, refugee, culture, ethnicity*, or *interpreter*.

Guidelines on Prioritization: Guidelines on prioritization are tools for specialist health care, and shall ensure that patients receive equal assessment, wherever they live in the country and regardless of to which hospital they are referred. However, although some vulnerable groups are mentioned, neither refugees, nor asylum seekers are to be found. Despite increased vulnerability, in none of the seven guidelines on prioritization examined (blood diseases, treatment of pain conditions, overweight, and the treatment of mental illness), is there a reference to immigrant's health.

National Professional Standards: National professional standards provide norms of good practice and serve as a baseline for improvement. On the Directorate of Health's home page are 58 National Professional Standards. Twenty-six of these are considered relevant to immigrant health. Of these, 15 specifically mention immigrant related issues. Equitable and individually adapted services are highlighted, as well as good communication, a good relationship, patient-cantered care, and user involvement. There is emphasis on individually adapted information, treatment and follow-up regardless of language and cultural background, and when dealing with immigrant patients, assessment of the patient's need for interpreter is obligatory. Likewise, culturally sensitive approaches and strategies are emphasized, as well as knowledge acquisition on social inequality in health and cultural and linguistic matters. Dealing with specific diseases like haemoglobinopathies, infectious diseases (Hepatitis-B and syphilis), vitamin D deficiency, and diabetes, clear recommendations are given and it is specifically mentioned that if there is a need for more time, for interpreter, or for collaboration with the patient's family, this should be provided for. In eleven of the guidelines regarded as relevant for the field of migrant health, immigrant related issues were not mentioned at all.

Implementation: The **annual circulars to the municipalities, county governors, regional health enterprises, and county administrations** mentioned earlier state principles and priorities in the field of health and care. A review of the circulars from 2011 until 2013 shows that there has been increasing attention to immigrants' health in this period. The requests to the municipalities have become more detailed, and in 2013 there was a subchapter on health and care services in a multicultural society, where prioritization of marginalized groups, adequate use of interpreters, and good and adapted communication strategies are emphasized. However, nothing is said about undocumented migrants, which as a group seem not to be included. The county governors are expected to keep overview of the health condition in their population as well as positive and negative factors of influence, with the goal to reduce social inequality in health.

The **letter to county governors on their official duties** *(Embetsoppdraget),* which is mainly the same from year to year, is an overview of the county governors' task portfolio. The governors are supposed to

report annually on, for example, activities taken to prevent female genital mutilation, health care services to prisoners, asylum seekers, refugees, family reunion and health and care services in a multicultural society.

Although there are some variations from year to year, these topics are to a great extent reflected also in the **letters of assignment to governors** *(Tildelingsbrev),* where areas for countrywide supervision are stated. Thus, in 2012 the governors were expected to supervise care centres for unaccompanied minor asylum seekers, in 2013 health care services to children 0-6 years old, including the provision of adapted information and the uses of interpreters.

A review of the County Governors annual reports from 2012 on selected topics like genital mutilation, ceremonies for new citizens, introduction schemes and equality reveals substantial variations between counties regarding activities and practice.

From these documents, it seems that national policy is reflected in guidelines and practice, and in activities at the county level. However, the question remains: To what extent are these policies implemented in service provision? The annual reports from the County Governors give limited insight into this question.

4. USE OF DETENTION

Legislation: Norwegian immigration detention is governed by the Immigration Act of 15 May 2008 and its supplementary secondary legislation.

According to the act, a foreign national can be detained if:

- The person does not cooperate in clarifying his/her own identity
- There are specific grounds to suspect that the person has given a false identity
- There are grounds to think that the person will try to evade a removal order
- The person fails to properly observe rules on entry and stay in the country
- The person is in transit in a Norwegian airport, with a view to removal
- There is a decision that a foreigner is a threat to fundamental national interests.

The list of grounds for subjecting a person to detention was added to in 2012, as the Norwegian government wanted to increase the use of detention to make return policies more effective. The maximum length of detention is four weeks, with the possibility of extension for up to twelve weeks. Generally, foreign nationals under this proviso are detained for 3-4 days before being returned, released, or deported.[24]

Detention facilities: There is only one centre specifically designed to detain migrants, the Trandum Detention Centre *(Trandum Utlendingsinternat),* situated within an hour to the city of Oslo and close to the Oslo airport. The centre, a former military barracks, is a secure facility managed by the Police Foreign Unit and operates since January 2004.[25]

The Centre has been visited and monitored over the years by various institutional and independent observers such as the Norwegian Labour Inspection Authority (NLIA) (2010), the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2006), the Working Group on Arbitrary Detention (2007) and the National Ombudsman (2007). These visits showed up various failings including the overcrowding of the structure, the inadequate use of trained security guards, the use of isolation cells and the frequent security checks of detainees at night. Frequent incidents, such as riots, fires and escape attempts were reported.[26]

The European Migration Network's study (EMN 2014) reported that, in order to avoid overcrowding, the Centre constantly monitors the availability of spaces. In case of lack of space, migrants may be detained in a prison. Detainees are accommodated in single rooms, they have access to a living room, an exercise yard and an activity centre. The Centre is divided into separate sections in order to accommodate separately families, unaccompanied children, single men, single women, detainees in custody and detainees held in high security conditions.[27] Visits of friends, families and legal representatives are allowed. The use of mobile phones is not allowed and e-mail is not yet implemented. Detainees may use

[24] Global Detention Project, *Norway Immigration Detention Profile, 2010*. http://bit.ly/2v2Pfnj
[25] ibid.
[26] Ibid.
[27] According to the NPM's report, at the time of the visit there were no minors detained in the Centre, while in 2014 there were 330 children, largely accompanied minors (NMP, 2015).

a fixed line telephone on a daily basis. Legal assistance and language support is guaranteed and free of charge (EMN 2014).

The National Preventive Mechanism (NPM), a special unit of the Parliamentary Ombudsman's office, visited the Trandum Centre between the 19 and the 21 May 2015.[28] There were no minors detained in the Centre at the time of the visit, though there had been 229 in 2013 and 330 in 2014. Interviews conducted with more than half of the detainees during the unannounced visit revealed some positive aspects related to overall good relationships with the staff working in the centre. Furthermore, the NPM reported considerable efforts made by the Centre in order to adapt the physical surroundings to children's needs. But the NPM also highlighted an excessive attention to control and security through practices that can infringe on the individual's detainee's integrity. The control measures appear to be similar to those in prisons – sometimes even more intrusive.

Access to healthcare: The National Insurance Act regulates the entitlements to healthcare for most forms of legal deprivation of liberty, but deprivation of liberty pursuant to the Immigration Act is not mentioned. As a consequence, migrant detainees have more rights to health if they are detained in a normal prison than if they are staying in an immigration detention centre. This is due to the fact that migrant detainees are supposed to leave the country within a short time, even though a significant proportion of detainees stay longer.[29]

In Trandum Centre healthcare has been provided by a private company (*Legetjenester AS*) since 2004. The agreement between the company and the National Police Immigration Service (NPIS) includes the presence of two general physicians (available for general consultations six hours per week and three nights a week) and two nurses (full-time employed). The interviews conducted by the NPM among detainees highlighted the lack of trust in the health professionals as a result of the contractual relationship between the health professionals and the NPIS.

In May 2015, health assessments for the newly arrived detainees were not routinely conducted. In addition, procedures for following up long-term detainees was lacking.

The limited provision of specialist health services is also a cause of concern. For example, mental health services are not available in the Centre: detainees are only referred to specialist care in the case of acute conditions such as psychosis.[30]

[28] http://bit.ly/2wdAjRW
[29] Ibid.
[30] Ibid.

5. ENTITLEMENT TO HEALTH SERVICES

Score 69 **Ranking** ●●●●○

A. Legal Migrants

Inclusion in health system and services covered

Entitlements for 'legal migrants' described below apply to all foreign citizens who reside legally in Norway other than asylum seekers, who are covered in the following sub-section. Entitlement to health service provisions is conferred by membership of the National Insurance Scheme (NIS), which is a right and an obligation for all national citizens as well as legal migrants. [National Insurance Act *(Folketrygdloven)* Chapter 2 (Membership) § 2-1, §2-2].

Full rights to health care apply only to persons who have legal residence in Norway and who either

a) Have a 'permanent' stay in the Kingdom, i.e. one intended to last or having lasted at least 12 months, with some exemptions (see below). Coverage is granted from the first day in Norway.

b) Are members of the National Insurance Scheme entitled to benefits in health care.

c) Are entitled to health care under reciprocity agreement with another state ('convention patients').

Labour migrants who are employees with a work permit are also obliged to become members of the NIS; they enjoy the same entitlements as Norwegian citizens.

Migrants *seeking* work (with a residence permit for less than 12 months) are not members of NIS: they have to pay for medical services in full, unless they are EU/EEA citizens, or have private insurance, or be insured via their employer. Students with valid student visa for 12 months or more enjoy the same entitlements as Norwegian citizens.

In case of temporary absence from Norway which is not intended to last more than 12 months, the person is still considered as a resident, but not if a person stays abroad for more than six months per year for two or more consecutive years.

To access care residents must have a personal identification number and must be registered in the Register of Residents (Folkeregisteret).

Special exemptions

There are special regulations regarding membership in NIS for people in detention, people serving prison sentences, or who have been referred to compulsory mental health protection or child protection institutions. However, if the person is already a member of NIS, his or her membership is maintained (National Insurance Act § 2-17).

Legal migrants who satisfy the conditions described above may benefit from exemption from co-payments. Exemptions may be motivated by humanitarian considerations (for vulnerable groups) or public-health considerations (for infectious diseases).

Barriers to obtaining entitlement

To access health care, users are required to present a personal identification number, an ID-number or a DUF number which basically provides information on personal details including legal address. The different ID numbers are described as follows:

Personal ID number: An eleven-digit number assigned to everyone registered as being resident in Norway. The personal ID number consists of the person's date of birth plus five digits. Persons assigned an ID number must use this number in all communication with the Norwegian authorities.

D-number: Persons who are not registered as resident, but who intend to work in Norway on a temporary basis, will be assigned a D-number in connection with the issuing of a tax deduction card. The number must be used in communication with the Norwegian authorities. It is issued within two weeks of the receipt of an application by the tax office. Those intending to stay in Norway for more than six months must notify the Norwegian Tax Administration and register as being resident in Norway, where they are assigned a Norwegian personal ID number.

Data System for Immigrant and Refugees (DUF) number: This is a twelve-digit temporary number assigned to all new arrivals from outside the EU/EFTA area who have applied for residence. It is for asylum seekers and other newly-arrived migrants whose application for residency is being processed. The number is issued and administered by the Norwegian Directorate of Immigration (UDI).

Complicated procedures demanding high levels of language proficiency: Migrants with little or no Norwegian language proficiency have the right to professional and licensed interpreters. All patients also have the right to information necessary to gain insight into their health status, the content of health care being provided, and the possible risks and side effects that may follow treatment. The Directorate for Integration and Diversity (IMDI) is a state organ responsible for the necessary measures for providing professional interpreters.

B. Asylum Seekers

Inclusion in health system and services covered

A legally documented asylum seeker is a person who officially seeks safety or protection in Norway and is awaiting a decision on their application for refugee status.

In transit centres a health assessment is performed regarding TB. Treatment for medical conditions that can wait will usually not commence at transit centres.

In ordinary reception centres the local municipality is responsible for medical services.

All legally documented asylum seekers and their family members are entitled to join the NIS and therefore enjoy the same health service coverage as nationals, including access to the General Practitioner scheme.

Entitlement to health services starts from the moment of application until the date that a final decision has been made on their case. Asylum seekers whose applications are rejected are given a final departure date. If they do not leave by this date or make an agreement with the authorities about their return, they become undocumented migrants with severely reduced entitlements (see below).

Sources: Regulations on Welfare Coverage for Asylum Seekers and their Family Members *(Forskrift om trygdedekning for asylsøkere)*, National Insurance Act *(Folketrygdloven*), Patient and user rights act (*Pasient- og brukerrettighetsloven)*

Special exemptions

Entitlements for asylum seekers are the same as for legal migrants and nationals. However, because of their provisional situation, treatment for a few persistent and/or expensive chronic conditions which require long-lasting treatment or recovery may be postponed until their refugee status is decided on.

Barriers to obtaining entitlement

To access care in practice an asylum seeker must present a **Data System for Immigrant and Refugees (DUF) number**. This requirement should, however, not present a barrier.

C. Undocumented Migrants

Inclusion in health system and services covered

All persons residing in the country, including undocumented migrants, are entitled to the following health care assistance:

Immediate assistance (emergency health care).

Necessary healthcare that cannot wait without the danger of imminent death, permanent severely impaired functioning, serious injury or severe pain. If the person is mentally unstable and poses a serious danger to their life or health, they are entitled to mental health care.

Whether the patients' condition satisfies these criteria is left to the responsible medical professional to decide.[31]

[31] https://helsedirektoratet.no/asylsokere-flyktninger-og-innvandrere/rett-til-helse-og-omsorgstjenester-for-personer-uten-lovlig-opphold

Certain municipalities provide both primary and specialist health services that are extended to undocumented migrants free of charge. Non-governmental organizations such as the 'Health Centre for Undocumented Immigrants'[32] in Oslo, run by the Church City Mission (*Kirkens Bymisjon)* and the Red Cross, and 'Health care for the undocumented'[33] *(Helsehjelp til papirløse)* in Bergen, operate health centres for UDMs where health consultations and treatments are offered without charge. Patients requiring acute, emergency or absolutely necessary treatment that cannot be given at the centre are referred to specialists at public hospitals.

Special exemptions

Health care for pregnant women, before, during and after childbirth: All women residing in Norway are entitled to necessary antenatal and postnatal health care regardless of their resident status.

Termination of pregnancy according to the Abortion Act.

Children under 18 years have the same right to all types of health care services. Undocumented children under 18 years also have full coverage, but cannot be registered on a GP's list. (Children also have the right and duty to go to school).

Right to assessment: All persons residing in the country are entitled to a review from the specialist health service.

All residents infected or at risk of infections of public concern, e.g. HIV, TB, Hepatitis, sexually transmitted infections are entitled to information, vaccination, and care free of charge.

People unable to take care of themselves: People who do not have legal residence in the country who are unable to take care of themselves are entitled to the necessary care services until they are obliged to leave the country.

Right to health and treatment information: All persons residing in the country who seek and need health and care services are entitled to the health and treatment information they need to safeguard their rights.

Victims of torture, trauma or human trafficking: Undocumented migrants who after thorough assessment are considered to be victims of torture, trauma or human trafficking, are granted a temporary residence permit on humanitarian grounds and are thereby entitled to primary or specialist health service as long as their resident permits remain valid.

Article 25 of the Universal Declaration of Human Rights, article 12 of the International Covenant of Economic, Social and Cultural Rights, and article 3 of the European Convention on Human Rights, are supposed to have precedence where State law is silent or seems to be restrictive.

[32] http://www.bymisjon.no/Support/English-Site
[33] http://www.helsehjelp-bergen.no/p/english_12.html

Barriers to obtaining entitlement

UDMs cannot usually provide the service provider with any of the numbers that are normally required for admission. A declaration of legal address will usually be required, which may be problematic for some people. In addition, two types of discretionary judgements are involved: whether 'emergency' and/or 'absolutely necessary' care is involved, and whether the patient has the means to pay.

Asking for payment in advance for emergency health care and health care that is necessary and cannot wait is not allowed. Undocumented migrants may receive a bill after the treatment, but if the patient cannot pay, the hospital or service provider must cover the costs. Treatment cannot be refused due to previous unpaid health care bills.

According to the law,[34] "If the patient cannot cover the expenses themselves, they shall be covered by the competent health institution or service provider". However, no criteria are specified regarding ability to pay or the procedure for assessing it. This therefore remains a discretionary area, increasing the UDM's uncertainty about the possible disadvantages of seeking care.

[34] https://lovdata.no/dokument/NL/lov/1999-07-02-61 Chapter 5 § 3.5

6. POLICIES TO FACILITATE ACCESS

Score 60 **Ranking** ●●●●○

Information for service providers about migrants' entitlements

Service providers in Norway are:

1. Regional health enterprises and associated hospitals
2. Municipalities, with their local health service centres and general practitioners
3. Some private health care centres and hospitals
4. NGOs contracted by public services.

Laws and guidelines are made available to the service providers online on www.helsedirektoratet.no. The Norwegian Board of Health Supervision *(Statens helsetilsyn)*[35] is responsible for monitoring and implementation.

Information for migrants concerning entitlements and use of health services

Legal migrants

- Labour migrants are not offered introduction programs in the same way as asylum seekers (see below). Caritas Norway is an NGO offering some information about health rights to labour migrants, but this NGO has neither a mandate, nor financing from the Norwegian government.
- Information on health and some aspects of the Norwegian Health System, including right to be on a GP's scheme, can be found on www.samfunnskunnskap.no and is available in 18 languages (developed by the public organisation VOX).
- Extensive information about the Norwegian health services is also available in English, Polish, Lithuanian and German at www.nyinorge.no.

Although a lot of information is available online, it can be difficult to find if one does not know where to look for it. Accessing it may demand a high level of IT skills and health literacy, as well as knowledge of Norwegian. There is a lack of systematic user involvement in the development of information material and dissemination methods; evaluation of methods, content and languages has not been conducted. It is not known whether the information actually reaches the migrant population as intended.

Another problem is that the information given may not be accurate. For example, the website of a large Norwegian hospital provides information in English on 'Health Care in Norway' containing the following statement: "All persons that are not permanent residents of Norway will be personally responsible to compensate (pay) the hospital for any and all medical attention received". The term 'permanent resident' in the relevant legislation is not explained (in reality it refers to stays intended to last or having lasted for 12 months or more). The statement also ignores the many important exemptions referred to in the previous section. Whether motivated by ignorance or ulterior motives, such misinformation

[35] https://www.helsetilsynet.no/Norwegian-Board-of-Health-Supervision

increases rather than decreases the barriers preventing migrants from accessing health care, and denies them the entitlements that Parliament has agreed to confer on them.

Asylum seekers

- All asylum seekers receive information about rights, including rights to healthcare, from the Norwegian Association for Asylum Seekers (NOAS). NOAS is mandated and funded to carry out this task. Since there is a special information programme for asylum seekers, this presumably implies that both the method of dissemination and the content are adapted to their needs.
- Asylum seekers awaiting the outcome of their application for protection can avail themselves of a 250-hour course, which includes some information about health and healthcare. The municipality where the asylum centre is located is responsible for providing such a course, and can apply for funding from governmental bodies to arrange the course. However, the provision of such a course is not mandatory.
- Information about health and healthcare is a part of Norway's mandatory introductory program for recognized refugees and their families.

Undocumented migrants

Information about basic rights to healthcare for undocumented migrants is available on the Directorate of Health's webpages. The brochure *Information regarding rights and access to healthcare for undocumented migrants in Norway* is available in 20 languages at www.helsenorge.no and http://www.bymisjon.no.

The Red Cross and the Church City Mission, which run clinics for undocumented migrants in Oslo and Bergen, also provide information on rights and access to healthcare on the web, on telephone and face-to-face. In Trondheim a similar clinic is operated by the municipality. 'Refugees Welcome Norway' also provides information on basic rights.

Health education and health promotion for migrants

Systematic health education and promotion for migrants does not exist, but there are some initiatives as listed below. A limited number of brochures with health information are translated; of those translated, most are translated to 10-15 languages. Some topics are thoroughly covered. e.g. diabetes and basic mental healthcare, while other topics are barely covered at all e.g. cancer, heart and coronary disease. No single actor has responsibility to ensure the quality and distribution of information. Consequently, the information can be hard to find and patients and healthcare personnel cannot be sure that the information has been correctly translated. An extensive overview of translated material can be found at www.mighealth.net/no.

Examples of ad hoc initiatives:

- Municipalities are recommended to have a local community health coordinator. Some of these have initiated public health campaigns directly targeted at different migrant groups.
- Workshop of Primary Health Care, an activity of the Church City Mission in Norway, runs various information, support, self-help and activity groups, and provides cultural mediation and training of cultural mediators.

- Caritas Norge provides information on health and access to services. During office hours, migrants can visit and receive counselling on practical matters.
- Patient associations have received funding to translate information material into different languages. *Ammehjelpen* (Breastfeeding association) has translated films on breastfeeding. The Diabetes Association has a hotline, radio campaign and does outreach work, and translates written material into several languages.
- *Mosjon på Romsås* (MORO) is a cooperation project between different public health institutions, the municipality and educational sector.
- SOMAH project: cooperation between researchers at the Oslo and Akershus University College (HiOA) and health institutions in Oslo and Akershus providing counselling on nutrition and food to families with children aged 0-5 in a culturally diverse population.
- STORK Groruddalen is a community project focused on better health for mothers and children in a culturally diverse population.

The majority of campaigns and projects on such topics are carried out by NGOs. Campaigns often have a limited and arbitrary selection of topics and/or geographical coverage; they are limited in time, topics, intervention methods, target groups and areas. There is no systematic prioritization of topics covered, so some topics are widely covered and others not at all.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

In general these are not made available by service providers, but there are few exceptions at local level.

Is there an obligation to report undocumented migrants?

Healthcare professionals are not required to report undocumented migrants to the police or immigration authorities. On the contrary, they are bound by legislation requiring them to protect information relating to people's health (Professional code of conduct for physicians *(Lov om helsepersonell m.v. (helsepersonelloven),* Chapter 5; §4 & 6 s); Professional code of conduct for nurses *(Yrkesetiske retningslinjer for sykepleiere*); Immigration Act *(Lov om utlendingers adgang til riket og deres opphold her (Utlendingsloven),* Chapter 2, § 12).

Are there any sanctions against helping undocumented migrants?

There are no legal or organizational sanctions against healthcare professionals or organizations assisting undocumented migrants.

7. RESPONSIVE HEALTH SERVICES

Score 58 Ranking ●●●●●

Interpretation services

Interpreters are available free of charge. The official web page for the health services in Norway (with translations into 24 languages) states that "it is your right to get information about your condition and treatment options in a language you understand".[36] Official guidelines state that healthcare personnel are obliged to assess the need for qualified interpreter and book one if needed.[37] (It is illegal in the public sector to use children as interpreters (except in life-threatening emergency situations).

Despite these clear-cut policies, it is well documented that there is underuse of interpreters and that contrary to what is prescribed, relatives and children are sometimes used as interpreters, and the use of interpreters without formal qualifications is widespread.[38]

Norway has a national webpage (www.tolkeportalen.no) where interpreters with formal competence are registered, which is administered by the Directorate of Integration (IMDi). It also displays advice and e-learning programs on the use of interpreters in healthcare.[39]

Availability of 'culturally competent' or 'diversity-sensitive' services

The policy framework for the Norwegian healthcare system puts emphasis on equity in health, which includes making individual adjustments to the needs of the patient. However, as in many countries this is defined in very general terms, without specific reference to differences in culture, ethnicity and migrant status, so no national guidelines on 'culturally competent' or 'diversity-sensitive' services exist.

Training and education of health service staff

Policies exist to support training of staff in providing services responsive to the needs of migrants. Training on migrant health is part of basic professional education, but the basic and fundamental module on migration is not obligatory for physicians. Training is also available and optional for all employees in the healthcare sector, but it is small scale and employers are not obliged to facilitate this (Magelssen 2012; Dæhli 2011).

Involvement of migrants

In theory, user involvement is required and systematically applied in the Norwegian health care system. However, no national policies or systematic ways of facilitating recruitment and involvement of users with migrant background in relevant fora have been identified. Nevertheless, despite the lack of an official policy, there are today two nationally mandated bodies (NAKMI/SOHEMI) and several NGOs which are often consulted in matters concerning migration and migration health. Migrants participate in the activities of these bodies.

[36] https://helsenorge.no/rettigheter/rett-til-tolk
[37] https://helsedirektoratet.no/retningslinjer/veileder-om-kommunikasjon-via-tolk-for-ledere-og-personell-i-helse-og-omsorgstjenestene
[38] NOU 2014:8 Tolking i offentlig sektor – et spørsmål om rettssikkerhet og likeverd
[39] https://www.tolkeportalen.no/no/For-tolkebrukere/Kommunikasjon-via-tolk/Kommunikasjon-via-tolk-i-helsetjenesten/

Encouraging diversity in the health service workforce

Diversity in workforce and professional training is encouraged, and guidelines are developed on a national level (Ministry of Children, Equality and Social Inclusion 2013; Bore et al. 2013). These guidelines do not target healthcare services specifically, but target all public services and to some degree the private sector.

- The emphasis on encouraging diversity in advertisements for positions within Regional Health enterprises in Norway varies between regions. Some formulate it explicitly in the vacancy notice, others do not mention it.
- Campaigns at municipal level also exist for Oslo (OXLO)[40] and Bergen (Bergen 2030)[41]. These are aimed at people employed by the municipality in general and not the healthcare sector specifically.
- Campaigns to recruit skilled healthcare workers from other European countries are widespread, though none of these campaigns has a diverse workforce as their primary objective.

Development of capacity and methods

On a limited scale, there have been government-funded projects aiming to develop or improve methods of diagnosis and treatment for a culturally and linguistically diverse population.

- Kale & Jareg (2010) translated the DSM-IV 'Cultural Formulation Interview' for use in psychiatric and psychological assessment.
- A three-year research and development programme on dementia and elderly migrants was administered by NAKMI, in which a new test battery for diagnosing dementia among elderly migrants was developed.
- Some reconstruction measures after female genital mutilation have been developed and are applied in all health regions in Norway.
- Norway has five regional centres on violence, traumatic stress and suicide prevention (RVTS), all of which have projects on mental health and refugees. They also run a website aimed at providing information on refugees and mental health to service providers (flyktning.no).
- A few municipalities have special migrant health expertise units providing advice to clinicians in the municipality. The units in Oslo and Bergen also have a mandate to "develop new knowledge on migration and health".

However, as in other Nordic countries, there is in general little interest in the development of relativistic or multicultural approaches to health care. Socio-economic rather than cultural factors tend to be regarded as the main drivers of inequities; ensuring that everyone has equal access to health care takes priority over adapting the care to the unique needs of different groups.

[40] https://www.oslo.kommune.no/politikk-og-administrasjon/prosjekter/oxlo-oslo-extra-large-en-by-for-alle
[41] https://www.bergen.kommune.no/aktuelt/tema/bergen-2030

8. MEASURES TO ACHIEVE CHANGE

Score 79 Ranking ●●●●●

Data collection

Migrant status and country of origin are not routinely registered in medical databases or clinical records. It is possible to obtain data on health and the use of health services by combining databases on health (Norwegian Health Economics Administration, HELFO) with databases on immigrant status, country of origin, reason for immigration, length of stay in Norway, citizenship, and annual work income (e.g. Statistics Norway). For linking such databases the person's ID-number or D-number (dummy number for foreign nationals staying in Norway for less than six months) is used. As a rule all medical services will register these numbers. However, tourists and persons living illegally in Norway are not registered and thus excluded from this kind of studies.

The National Strategy for Immigrants' Health (2013-2017) (Ministry of Health and Care Services 2013) supports the combination of data from different databases in order to get knowledge about the health of migrants and their use of health care services. Country of birth and nationality are registered at the Norwegian Population Registry (DSF). *Utlendingsdatabasen* (UDB) in the Norwegian Directorate of Immigration (UDI) registers migrant status.

Research

Open calls or earmarked funding for research on migrants' health have only lately appeared in Norway. Migrants are often excluded from studies on population health. However, an increasing amount of research has been carried out in recent years. Much of it has been brought together on the Norwegian website of Mighealth.net (Information network on health and health care for migrants and minorities in Europe),[42] set up with an EC grant and maintained by NAKMI.[43]

The Research Council of Norway has programs in which themes like social inequality and inclusion as well as migration and integration are prioritized areas of research. For example, in their *Research Programme on Health and Care*, several themes of relevance for migrants' health are listed.

Statistics Norway (Statistisk sentralbyrå) produces statistics on immigrants and immigration regarding housing and property, culture and recreation, education, elections, establishments, enterprises and accounts, income and consumption, labour market and earnings, population, social conditions, welfare and crime. The institute also cultivates research fields like: [44]

- *Living conditions and social participation.* "These reports address multiple aspects of living conditions like income, housing, health, employment, social integration, isolation, unpaid housework and care provision. Analyses reveal developmental patterns and distributions in light of government policy and policy reforms. Specific groups are often in focus, i.e.,

[42] http://mighealth.net/no
[43] Since 2015 the site has no longer been maintained.
[44] Quotations from www.ssb.no

parents, children, immigrants, students and lawbreakers. Annual surveys record popular attitudes towards immigration and immigrants".

- *Population trends, migration and mortality. "*Research in this area produces national and regional population projections by sex and age, and immigrant projections also by country background. Demographic trends and patterns are analysed in a regional, national and international perspective. Analyses and projections are produced for specific demographic components, i.e., fertility, mortality, domestic and cross-border migration".

NOVA (*Oslo and Akershus University College of Applied Sciences*, *Centre for Welfare and Labour Research)* carries out research on a wide array of migration-related topics, such as children and youth in multicultural contexts, ethnic minorities and their relations to local and national government services, refugees and asylum seekers, conflict management in intercultural settings, and the national and international regulation of migration. Among their projects is, for example, 'Health Care Utilization among Immigrants in Norway' (funding: Research Council of Norway, period: 01.03.2013 - 28.02.2017). Other Norwegian Universities have produced an increasing amount of publications about health and use of health services among immigrants during the latest years, especially regarding primary health care services.

Norwegian Institute of Public Health performs research in several relevant areas. In 2015 a search for 'immigrants' in publications on their web page yielded 110 hits from 2002 to 2014, 77 on communicable diseases, 33 on non-communicable diseases like adolescents' health, diabetes, cardiovascular disease, physical activity, smoking, chronic pain, suicide prevention, identity, wellbeing and competency.

NAKMI *(Norwegian Centre for Migration and Minority Health)*[45] aims to be "the nexus for migrant health, through research and development, education, networking, training, capacity-building and dissemination of information. NAKMI's approach is multi- and interdisciplinary and wide-ranging; covering both somatic and mental health at the local, national and international level".

IMER Bergen *(Bergen International Migration and Ethnic Relations Research Unit)*, is a multidisciplinary research unit at Uni Rokkansenteret and the University of Bergen. Its aim is to contribute to research-based knowledge about international migration, not least related to European countries, including the consequences of immigration and emigration for societies. Lately, main themes for their research have been 'Politics and mobility' and 'Migration and social inequality'.

NKVTS *(Norwegian Centre for Violence and Traumatic Stress Studies)* has several research projects on refugee health relating to violence and traumatic stress.

'Health in all policies' approach

Policies concerning migrant health were reviewed in Section 3. The 'health in all policies' (HiaP) approach is by definition an 'all-of-government' approach. Norwegian policies on health do not only concern health services, but also include attempts to tackle the social determinants of migrants' health, which involves issues outside the health sector itself. However, although Norwegian health experts – like most of their counterparts in Nordic countries – have a strong focus on social factors, this is not the same as other policy-makers having a strong focus on health.

[45] http://www.nakmi.no

Measures to promote a HiaP approach do not often single out migrants for special attention, but doing so would be particularly relevant in the employment, education, and housing sectors, as well as in immigration policy. Promising signs are:

- The new *Public Health Act* which came into force on 1 January 2012.
- *Meld.St. 6 (2012-2013) A Comprehensive Integration Policy – Diversity and Community.* This White paper has a full chapter on immigrant health and care.
- In a (national) guideline for working with refugees, asylum seekers and immigrants, the Norwegian Directorate of Immigration has included a chapter on health and care services (pp. 196-203) and information on instances where immigrants can ask for help (118-119).
- In the County Governors' office the 'health in all policies' principle is repeatedly reinforced, referring to the regulations cited above.

Whole organisation approach

The 'whole organisation approach' discourages the development of separate care facilities for migrants both within and between organisations, insisting instead on the 'mainstreaming' of measures to combat inequities. Although the Norwegian system of health governance allows some room for regional and municipal variations, there do not seem to be obvious differences in policy between regions. In other respects, mainstreaming seems to be preferred. Guidelines are continually issued and updated, but not enough is known about their impact, especially in relation to migrants and ethnic minorities.

In 2013 a national strategy on migrant health was launched as a first step towards a systematic approach. Clearly, it is too soon to expect all the goals to have been realised. Alongside government measures, patients' organizations like the Norwegian Diabetes Association *(Diabetesforbundet),* the Norwegian Cancer Society *(Kreftforeningen),* Deaf Norway *(Døveforbundet)* and The Norwegian Council for Mental Health *(Rådet for psykisk helse)* have in recent years developed policies for improving immigrant health, as have professional organisations like the Norwegian Medical Association and the Norwegian Psychologists' Association.

Leadership by government

At the end of Section 3 an overview has been given of the numerous government policy measures and other 'tools of influence' encouraging attention to migrant's health.

Involvement of stakeholders

Stakeholders in policy development are involved through structural cooperation. The main advisory body is NAKMI, which is regularly consulted on issues regarding migrants' health. NAKMI has a board with members from all regions in Norway. The Directorate is also advised by SOHEMI (Council for equal health care for the immigrant population), which consists of professionals with immigrant backgrounds and Norwegian experts with particular expertise in health and illness in the migrant population, migrants' use of health services, as well as equality and discrimination. Patients' organisations with migrant health expertise have also been consulted *(Diabetesforbund, Kreftforening, Nasjonalforening),* as well as OMOD (Organization against Public Discrimination).

Migrants' contribution to health policymaking

The contribution of migrants' own organisations to policymaking is not structural but ad hoc. Migrant organizations have been consulted when new laws, regulations or guidelines concerning migrant health are developed. In Oslo, the 'Unit for diversity and integration' EMI *(Enhet for mangfold og integrering)*[46] cooperates in a structured way with the municipality's government on issues affecting health, without being directly involved in the planning of health care services.

[46] https://www.oslo.kommune.no/politikk-og-administrasjon/etater-og-foretak/enhet-for-mangfold-og-integrering

CONCLUSIONS

Norway is a prosperous country with many migrants, a highly developed and strongly regulated welfare state, and – in general – a high regard for human rights. All these factors are associated with good access and quality for migrants in health care. However, the arrival of (non-Nordic) migrants on a large scale is relatively recent, while societies usually take time to adapt to new realities.

Norway's advanced health system is characterised by an elaborate system of governance. There is a proliferation of action plans, guidelines, regulatory agencies and procedures concerning migrant health. Nevertheless, concerns have arisen about implementation. Making systems 'migrant-friendly' is not only a matter of imposing rules, however important that may be, but also "a battle for hearts and minds". Moreover, strong input from migrants themselves is needed to ensure that the measures taken are appropriate. Many matters are well regulated on paper, but doubts are expressed throughout this report about the extent to which measures are actually implemented "on the shop floor".

Policies on UDMs are in stark contrast to the high regard for human rights mentioned earlier (Kvamme & Ytrehus 2015). This discrepancy is not unusual in Scandinavian countries (Jørgensen 2012); irregular status tends to be viewed as an individual choice – despite the fact that many UDMs are rejected asylum seekers, whose choice not to return to their country of origin is often anything but free. In Sweden, exclusionary and punitive measures against UDMs used to be regarded – in particular by the trade unions – as necessary to protect the labour force and the welfare state; only persistent criticism from human-rights bodies and NGOs was finally able to lever a change in health policy in 2013. Norwegian policies on entitlements for UDMs still fail to reach the level required by international human-rights conventions: as in many countries, too much is left to the individual discretion of the service provider.

Reviewing the above report, certain strong and weak points stand out in each section.

A. Entitlements are good for legal migrants and asylum seekers, but not for UDMs.
B. Many measures are taken to improve the accessibility of services, but it is not known whether they reach the intended target group.
C. Regarding responsiveness to migrants' needs, Norway stands out from most other countries because of the provision of free interpretation services. Nevertheless, the 'one size fits all' mentality seems to remain strong in health sector.
D. Norway devotes a lot of effort to achieving change, with good data collection and research and a focusing of efforts (especially through NAKMI) to counteract fragmentation. However, more could be done here, especially regarding systematic registration of immigrant background and evaluation of interventions to promote equity in health, as well as attempts to influence public attitudes and to encourage migrant involvement (a weak point in both sections C and D).

Spilker's conclusion (2012: vi) seems still largely justified: "attempts to meet and incorporate the health needs of migrants and ethnic minorities into the Norwegian Health Care Services are still fragmented and uncoordinated. The measures described are on a small scale but mainstreaming these measures has yet to happen…. Greater attention needs to be paid to research and policy implementation in order to address ethnic inequalities in health. Analysis of health policies needs to be continued to identify gaps both in research and implementation in order to support governments in developing more structured, comprehensive and coordinated policies when it comes to migrant health".

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International Organization for Migration

Regional Office for the European Economic Area (EEA), the EU and NATO

40 Rue Montoyer—1000 Brussels—Belgium—http://www.eea.iom.int

Tel.: +32 (0) 2 287 70 00— ROBrussels@iom.int