



Migration and health

Challenges and trends

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Preface

The present report, "Migration and health" is the most recent in a series of reports on challenges and trends in the health sector from the Directorate of Health.

With this series, the Directorate aims to provide new insights into the health and care domain in order thereby to drive improvements and changes where they are needed. Part of our remit is to monitor developments in the Norwegian health service from a general societal perspective. This also enables us to identify challenges and the need for innovation and reform in our own domain and those of other authorities.

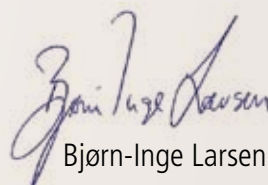
This year's report is devoted to health and migration. Our aim in this report is to present a picture from a field which has not been extensively researched, but which has received increasing interest and significance in recent years. We hope that the report will provide valuable input on the formulation of a health policy that faces major challenges both nationally and internationally.

Norway, like the rest of the world, is affected by global challenges surrounding

factors such as health, climate, inequality and poverty. Migration entails the interaction of people and cultures, differing perceptions of what constitutes the good life, and an understanding of health and disease that is often at odds with the traditional Norwegian mindset. The report directs attention at the diversity that exists in the Norwegian population and the challenges associated with health and interaction with the health service in Norway.

The report is intended primarily for decision-makers, managers and employees in the health service. Other parties such as journalists, researchers and teaching staff will hopefully also find the report of use.

"Migration and health" was compiled through a broad-based process within the Directorate, and with input from a number of external environments. We would like to convey our thanks to everyone who contributed to this report.



Bjørn-Inge Larsen
Director General of Health

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Summary and main message

Migration has been a phenomenon throughout the ages. The reasons for migration across national borders are many and complex: fleeing war, persecution and disasters are among the key reasons, but the vast majority of migrants move in order to find work or obtain education. Many migrants also seek to be reunited with family members who emigrated before them. Migration challenges society, offers new opportunities and contributes to diversity and change. For many, migration brings positive outcomes and opportunities for a better life.



People lead transnational lives. People's identities break away from the single national identity, and many individuals have and seek to form strong ties with several countries and environments. Increasing migration and the adoption of a new sense of Norwegian national identity embodying greater diversity holds new opportunities. This also entails the interaction of cultures and religions with other traditions and perceptions of health and disease.

The migrant group is heterogeneous and made up of a diverse range of people: from unaccompanied asylum-seeking minors to Swedish café workers, the members of Pakistani family reunifications, Turkish grocers, British stockbrokers and Indian IT experts. It follows that there will be great variation between different patient and user groups.

At present there are some 460,000 persons residing in Norway who either immigrated themselves or were born in Norway of immigrant parents. All told, these persons make up 9.7 percent of the population. The five largest groups of immigrants and their descendants come from Poland, Pakistan, Sweden, Iraq and

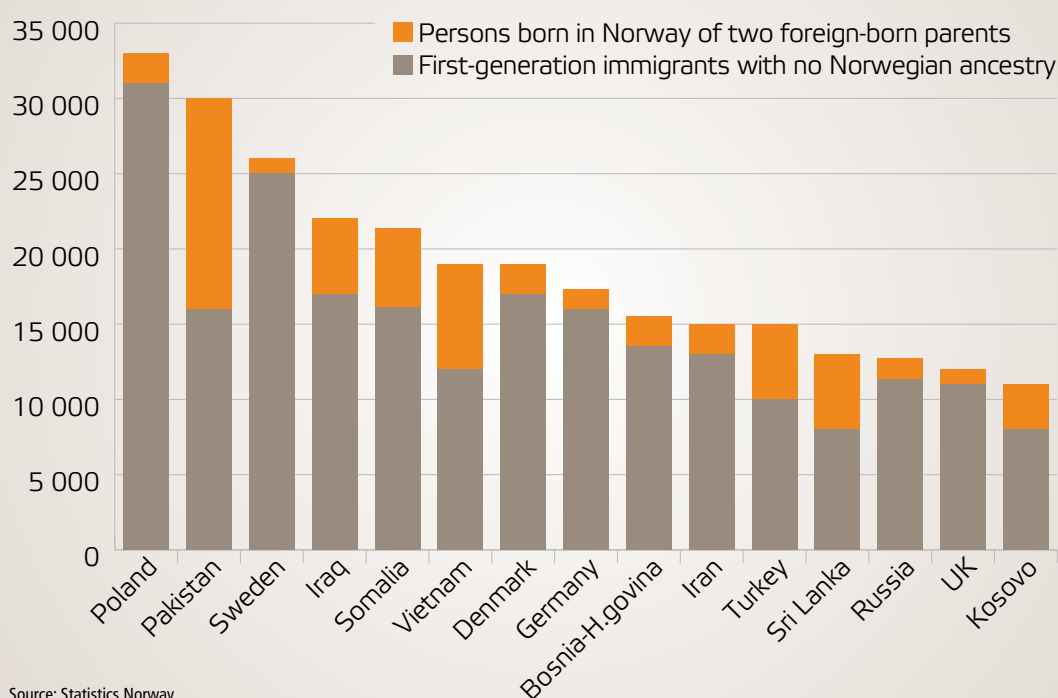
Somalia (see Figure 0.1).

The number of immigrants has increased over the last 50 years. The post-war era brought refugees from Eastern Europe, and they were followed by labour migrants from both Europe and the rest of the world. After a freeze on labour immigration in 1975, the number of refugees from countries in Asia, Africa, Latin America and Europe outside of the EU/EEA has increased. The enlargement of the EU brought a significant increase in immigration from the EU Member States in Eastern Europe.

The degree of heterogeneity will affect the capacity of the health service to offer equitable health care to all patients. A range of instruments must be employed in achieving equitable health care, irrespective of residency status, physical and mental ability and language skills. In addition, the differing expectations of the health care provider and patient will affect consultation and treatment.

In the report, the Directorate of Health focuses on the diversity of the Norwegian population today, and the nature of the health challenges faced by society. These challenges

Figure 0.1 The 15 largest immigrant groups in Norway as at 1 January 2008. Absolute figures.



Source: Statistics Norway

concern both the individual circumstances of the patient and health care provider, and the organisation of the health service.

The Directorate of Health hopes that the report will contribute to ensuring the provision of qualitatively satisfactory and acceptable health and care services for a diversified Norwegian population.

Main theme of the report

Migration and health is a complex of issues and concerns, and the present document is not an exhaustive report on this field. By way of introduction, the report presents a wide backdrop to the issues surrounding migration and health. The chapters that follow deal with a number of special topics of great significance for how the health service can respond to those issues. In Chapter 1: "The big picture", migration is described in terms of a global phenomenon. Here we address the problem of inequitable distribution of welfare and good health globally, and emphasise Norway's means of influencing this state of affairs. Chapter 2 "Health and ethnicity" deals with the issues surrounding health status, risk factors and the use of health services by different immigrant groups. There are great health disparities throughout the Norwegian population, and this is also true with regard to the health of immigrants. Disease patterns vary from one ethnic group to the next. The causes of health disparities are associated just as much with factors such as education, financial and social circumstances as they are with ethnic, genetic, cultural or linguistic determinants.

In Chapter 3 we turn our attention to the challenges associated with interaction with the health services – from the perspective of both the user and the service. The emphasis is on ensuring that the service picks up on and caters for the diversity of the population. Chapter 4 deals with mental health among immigrants, with special emphasis on refugees and asylum seekers. We describe factors affecting health

after fleeing and crises.

Chapter 5 offers input on the debate concerning the rights of paperless immigrants. The report advocates action to clarify the right of paperless immigrants to health care, and the responsibilities of the authorities.

Chapter 6 describes the new wave of labour immigrants. This immigration has provided Norway with much-needed labour, but has also created challenges for the health services, especially as regards the provision of information, organisation and scaling of the services.

There is currently substantial international migration of health personnel. This is the theme of Chapter 7. Here we examine the increasing demand for health and care personnel in rich countries in the years to come. Some countries will resort to recruiting health personnel from other countries which are then drained of the health personnel they themselves need. Solidarity with other nations in long-term planning and distribution of global health personnel resources will be essential.

Chapter 8 sheds light on ethnic Norwegians as a migrants and emigrants, and also as immigrants in another country; Norwegians in Spain. Who are they, what needs do they have for health and welfare services, and what expectations do they have of the Norwegian authorities? How do they relate to the society they live in? This chapter raises issues and challenges.

Main message

• A new international convention on health will ensure basic health care for all

The global distribution of welfare and good health is inequitable. The Directorate of Health is calling for an international convention recognising the right to basic health care for all people.

Health assistance should be based on the principle of the lowest effective level of care

and serve to strengthen primary health care, disease prevention and to reduce socially determined health disparities.

The Directorate of Health is committed to achieving an international convention on health recognising the right to a minimum of basic health care for all people.

- **Equitable health care is an essential investment for the future**

In order to facilitate good health for all segments of the population, we need strong primary health care and prioritised public health work.

The planning and expansion of the health service must take into account the diversity of its users. In terms of health, risk factors and disease, there is great variation in the population. If everyone is to be treated equally, the result may be that some people systematically receive poorer treatment provision and reduced benefit from the services. Given that certain groups of migrants in Norway systematically display a higher incidence of certain health problems, special prioritisation of focus and resources is required in order to achieve equitable services. The aim is therefore not to offer equal services, but rather *equitable* services which take into account the differing pre-determinants and requirements among citizens.

- **A high standard of interpreting services and receptiveness in interaction with patients is a prerequisite for quality in the health service**

Language and good communication are pre-requisites for ensuring equitable health care. Linguistic adaptations in both written and other communication are therefore essential. A high standard of interpreting and active listening are essential in ensuring the quality of Norwegian health services.

- **Early mental health care for refugees and asylum seekers is essential**

There are many causes of migration, but for everyone it involves leaving behind familiar circumstances and networks, which increases the risk of mental distress. As migrants, refugees and asylum seekers are particularly vulnerable, and must be given special attention during the reception phase. Often, it is the conditions they are subjected to post-emigration that affect their mental health. The health service should reach immigrants at an early stage with provisions for mental health care.

- **Establish clearly delineated responsibilities and stronger rights for paperless immigrants**

Everyone is entitled to essential health care in Norway, from both the municipal health service and the specialist health service. The authorities should ensure that clearly delineated responsibilities and rights for paperless immigrants are established. Information concerning rights should be made available to those it concerns.

- **Equitable recruitment of health personnel**

Rich countries such as Norway must not actively recruit qualified health personnel from poor countries where labour is in short supply. National policy should ensure self-sufficiency in health personnel and promote sustainable development internationally.

Terminology

In the field of migration, a number of distinct terms and definitions have tended to be used interchangeably. A few examples would be migrants, immigrants, non-native minority groups and their descendants, hyphenated ethnicity such as Pakistani-Norwegians and first and second generation immigrants.

An inclusive society is predicated on inclusive terminology. Statistics Norway has done away with the collective designation “the immigrant population” formerly in use in favour of the terms “immigrants” and “Norwegian-born persons of immigrant parentage”.

A guide entitled “An inclusive language” published by the Ministry of Labour and Social Inclusion (AID) has taken the same approach and employs the following definitions: The term ‘immigrants’ refers to persons born in another country, who have two foreign-born parents and who reside in Norway. Persons who are born in Norway cannot be referred to as ‘immi-

grants’. If, in a certain context, one wishes to refer to both immigrants and their descendants collectively, ‘persons of immigrant origin’ is an alternative. A descendant is a person born in Norway of two foreign-born parents.

The present report uses various terms, but adheres as far as possible to the Statistics Norway and AID definitions when referring to the Norwegian context. In addition, the term “migrant(s)” is used when the report makes reference to more general or international contexts. Here a migrant is taken to mean a person who moves or has moved across national borders.

1 The big picture

Increasing migration holds new opportunities for people and societies. With the increase in information flows and means of transportation, migration has become more diversified. Migration is linked to the need for labour, economic growth and democratisation, trade, integration, human rights and civil protection. The majority of migrants move in the hope of achieving a better life.



There are currently some 200 million migrants worldwide. UN estimates put the total number of migrants worldwide at 280 million by the year 2050. From 1960 to 2006, the number of migrants worldwide more than tripled from 75 to 200 million (1). This is approximately three percent of the global population (2). In the past, the vast majority of migrants were men; around half are now women. Sixty percent of the world's migrants live in affluent countries, where an average 10 percent of the population are immigrants. In the least developed countries, one in 70 is an immigrant.

Migration is a continuous process and its impacts affect individuals and nation states. The reasons for migration across national borders are many and complex: fleeing war, persecution and disasters are among the key reasons, but the vast majority of migrants move in order to find work or obtain education.

Changes in migration flows

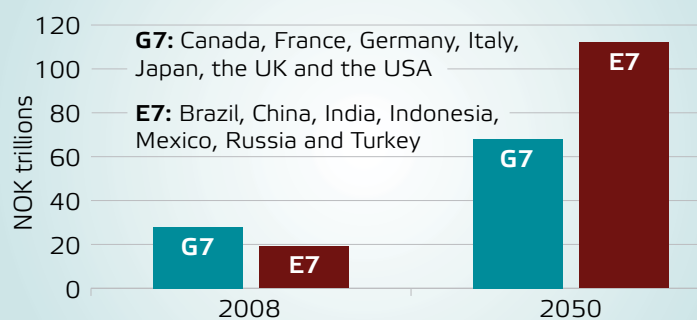
One common perception is that migration essentially has proceeded and will continue to proceed westwards and northwards from the

Global migration

- 200 million migrants globally.
- Around half of the world's migrants are women.
- 16 million refugees, 4.6 million of whom are Palestinian refugees registered with UNWRA.
- An estimated 20–30 million illegal migrants worldwide.
- Money transfers from migrants to their country of origin amount to several hundred billion US dollars. The World Bank estimates that 200–300 billion US dollars are sent back to developing countries annually.
- 1/3 of the world's labour migrants live in Europe.

Source: IOM/UNHCR/UNWRA

Figure 1.1 Projected economic trend in the G7 and E7 countries, 2006–2050.



Source: Hawksworth & Cookson 2008

east and the south. Figures from the World Bank indicate that more than a third of the world's migrants move from the south to the north. Over the next forty years, the migration picture would seem set to change. By 2050, the seven largest growth economies – Brazil, China, India, Indonesia, Mexico, Russia and Turkey - will in all probability be twice the size of all the G7 countries put together. In all likelihood, this will affect population flows (see Figure 1.1).

Opportunities and challenges

Migration holds opportunities and challenges. Migration can be of benefit for migrants, sending countries and receiving countries alike. The challenge lies not in stopping migration flows, but in influencing the processes involved so that the outcomes of migration and migration processes become as beneficial as possible for the maximum number of people. Migration control requires international coordination.

In Norway, the largest migration wave in the past was made up of Norwegians who emigrated to the United States before the late 19th century. The next large wave was immigration to Norway starting in the 1970s. Recent decades have also seen increasing emigration from Norway to countries such as Spain, and a considerable proportion of the emigrants are pensioners.

Society in a state of constant flux

Society is in a state of constant flux, and migration is part of this changeability. In many respects, the main difference between Norway twenty years ago and Norway today is the composition of the Norwegian population – one that calls for redefinition of the Norwegian collective sense of national identity (3). The percentage of Norwegians of immigrant origin in the total population, that is, persons who are themselves immigrants or who have two parents born in another country, increased from 2.3 percent in 1980 to 9.7 percent in 2008. Population projections from Statistics Norway indicate that the steadily increasing migration to Norway currently in progress will be sustained or will increase.

Money transfers, new technology and low-cost travel have produced a new flow of people and ideas. People lead transnational lives. More and more people maintain links – through the Internet, by telephone and international travel, in familial, educational, business and occupational contexts – with multiple countries and communities simultaneously. People's identities break away from the single national identity, and many individuals have and seek to form strong ties with several countries and environments. The question is then for how long the prevailing description of Norwegian society will remain valid. Increasing migration and the adoption of a new sense of Norwegian national identity embodying greater diversity holds new opportunities. The transnational perspective presents quite different horizons from the isolated, national viewpoint.

Global health

International coordination is necessary in order to achieve good health globally. The fight against poverty, and the fight for more equitable distribution of benefits and burdens are necessary in order to achieve good health for all. Greater social justice has the effect of pro-

tecting nation states and individuals against war and need.

Increasing migration is closely linked with globalisation. Globalisation can be defined and understood in many different ways. Similarly, global health is a concept that is variously defined and thus encompasses different aspects. In this context, globalisation denotes the ceding by states of a measure of their national sovereignty in favour of supranational and transnational actors (4). For Norway, an obvious example of this is the EU/EEA cooperation, and especially the Schengen cooperation. Mutually binding agreements of this nature demonstrate how transnational integration of different societies can affect nation states and cooperation between nations. This influences national trends – politically, socially and in terms of health.

The concept of global health comprises the entire population of the globe, and how health is affected by factors across and beyond national borders such as infectious diseases, pollution, food shortages, access to medicine, recruitment of health personnel from poor countries, economic development and the fight against poverty. Factors of this kind will often be the underlying causes of migration.

Poverty and health

Increased prosperity is a prerequisite for better health in poor countries, but the distribution of welfare and benefits in any society is equally important. This is a policy issue which is determinative for health conditions.

In 2008, the World Health Organisation (WHO) published a final report on social determinants of health (5). The report concludes that social justice is a matter of life and death, and that if we change the social conditions people live under, we stand to achieve dramatic improvements in health within a generation.

Differences in living conditions represent

millions of lost life-years (6). Average life expectancy varies globally, nationally and locally. North and South, East and West do not only denote geographical categories, but also social ones. At the same time, it is important to point out that these social categories also comprise great differences in health.

One example of health inequity between the North and the South is the life expectancy of girls born today. A girl born in Norway can expect to live more than 82 years, while girls born in Botswana have a life expectancy of 43 years. Differences in life expectancy between neighbourhoods in Oslo are no less than twelve years (7). These differences arise because of the economic, political and social circumstances in which people live. They are avoidable and can be rectified in our time.

The Norwegian Directorate of Health is committed to influencing conditions of life and factors to even out social health inequities nationally and internationally.

The UN Millennium Development Goals for health

The main UN development goal is to end poverty by 2015 (8). This goal is divided into a number of sub-goals. Norway has made a special commitment to the efforts to reduce child mortality and to reduce the risks to women of pregnancy and childbirth. To achieve these goals, three areas in particular must be addressed (9).

Primary health care for all

Good primary health care is crucial in prevention and treatment of the commonest diseases responsible for high child mortality: infections, diarrhoea and complications during childbirth. Simple measures such as vaccinations, obstetric aid, vitamins and hygiene are of great importance. The 30-year-old Alma Ata Declaration proclaimed the need to focus on primary health care. WHO's World Health

Report for 2008 stresses that the message remains just as valid in both poor and rich countries (10). A health system is of vital importance for the development of good health and welfare in any society.

Nutrition

The second vital area is nutrition. Malnutrition in mothers and children is responsible for 20 percent of maternal mortality worldwide and 35 percent of mortality in children under the age of five. Malnutrition is the cause of 3.5 million deaths each year among mothers and children globally (11). This is preventable.

Climate change affects food production and distribution, and alters access to clean drinking water. Climate change can also result in acute injury, disease and accidents caused by extreme weather, drought and flooding, and also affects the spread of epidemics and vector-borne diseases (12). Responsibility for climate change rests largely with the affluent parts of the world, which also have the expertise and the necessary resources for dealing with emissions that impact on the climate.

Better data

The third area is shortage of data. In order to create a basis for change and to enable the health authorities to plan and implement measures, reliable data are required. In particular, data on morbidity and mortality in women and children have been neglected. Reliable statistical material is necessary in order to implement effective measures.

Norwegian initiative for child and maternal health

The Norwegian Government has taken the initiative for convening heads of state from nine different countries in an international network to strengthen efforts for child and maternal health. Political will at the highest

Principles of the Paris Declaration of 2005:

- Recipient countries take control
- Donor countries align behind the recipient countries' strategic policies
- Donor countries coordinate their efforts and procedures
- All efforts and procedures are to focus on results
- Mutual accountability and transparency

Reference: Paris Declaration of 2005 on Aid Effectiveness (OECD)

level is essential in ensuring that basic health care for all is given priority (13). One means of achieving this is through internationally binding agreements.

A framework convention on global health

The right to health, or health as a human right, is reiterated in the majority of fundamental documents from the UN; the UN Charter, the Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights. However, there is no clear-cut definition of what constitutes basic health care or how such health care can be guaranteed for an entire population. The WHO constitution and the "Health for All" campaign from 1977 are examples of international declarations that define the ideals. But they are not normative and are not binding on the member states. There are only two binding international instruments in the field of health: the International Health Regulations (14), and the Framework Convention on Tobacco Control (15).

One might envisage a framework convention on health ensuring a minimum of health care for all. Arriving at definitions of basic health care and the various elements of the convention will require lengthy international processes and extensive negotiations (16).

There are currently international programme declarations on aid effectiveness – the Paris Declaration on Aid Effectiveness

(OECD) (17), followed by the Accra Agenda for Action (18), but they would appear to have little impact since they are not binding.

Economically, it would be possible to achieve a global convention on basic health care. The funds at least would appear to be in place already. International donor aid for global health for 2006 amounted to just over USD 16 billion. Vital vaccines, clean water, basic sanitary facilities and the treatment of diarrhoea and respiratory infections would, for the poorest billion of the world's population, cost one billion USD annually (19).

The Norwegian Directorate of Health will be working through WHO and other international organisations for a global convention on basic health care.

In April 2009, the Norwegian Directorate of Health, in conjunction with WHO and the Norwegian Ministry of Health and Care services held a meeting entitled 'Health in times of global economic crisis: implications for the WHO European Region'. The final declaration resulting from the meeting stressed the following:

- During times of economic recession, safeguarding the health sector is a priority
- The poor are the most vulnerable in any crisis and development aid must be shielded from cutbacks
- A strong recommendation to invest in health care – for both economic and social reasons
- Think health in all sectors – "every minister is a health minister"
- Invest in the most cost-effective measures, i.e. strengthen primary health care and public health work
- Training of own health personnel must be given priority to avoid draining skills from poorer countries
- Strengthen universal access to social benefit schemes and health services

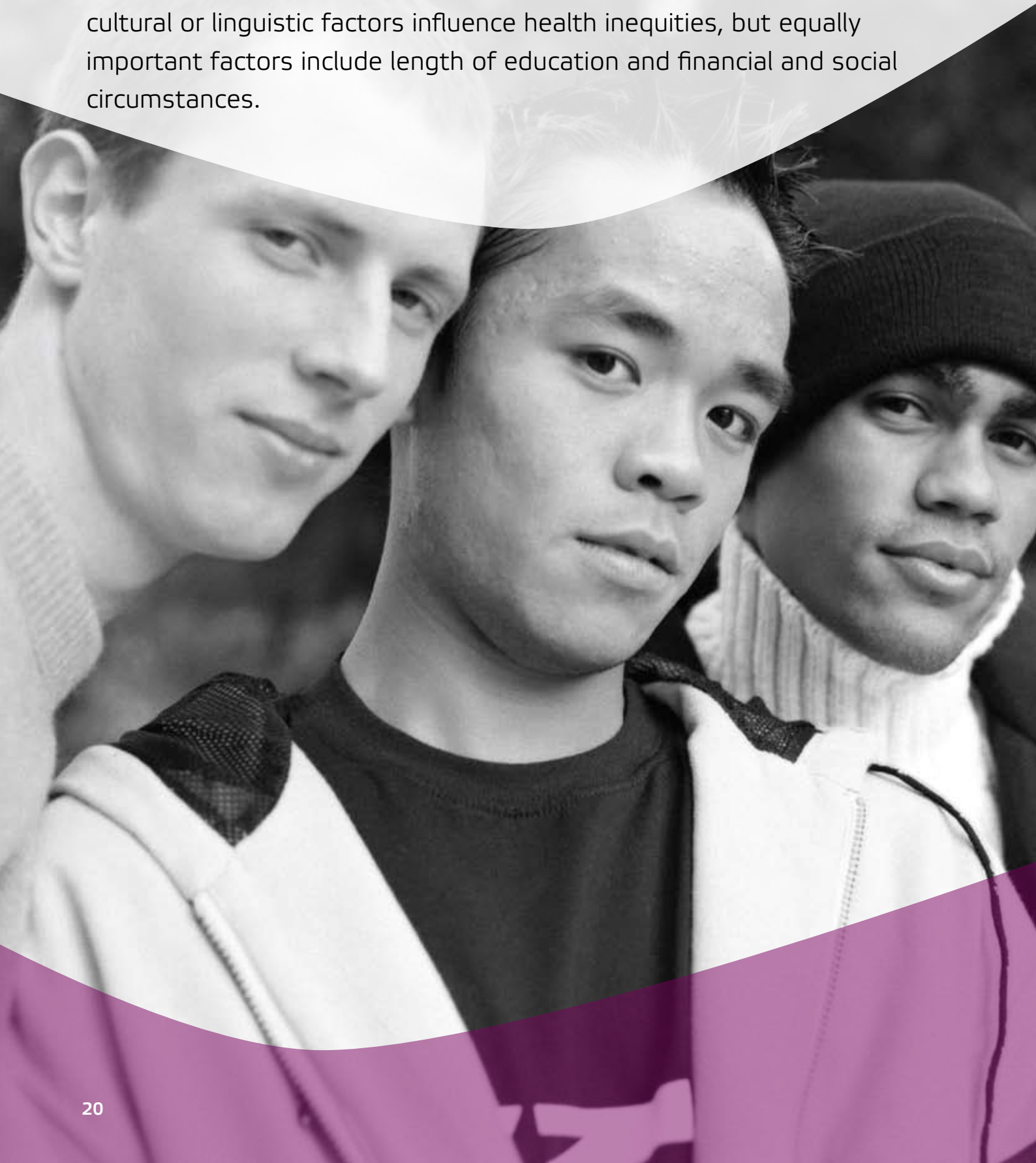
Effective health care is a key factor

Migration processes to and from Norway cannot be understood without looking at the situation in other parts of the world. The differences in general conditions of life between countries and access to paid employment are two of the main causes of more recent migration waves.

The challenge is to achieve greater predictability as regards migration flows and to organise them for the benefit of all parties. Migration and health are closely linked. Health may be one of several factors influencing the exodus of peoples. The health of migrants is often at risk while they are fleeing or relocating. Effective health care is one of several determinants for successful immigration and integration.

2 Health and ethnicity

In the Norwegian population as a whole we find great health disparities. Disease patterns vary individually and between ethnic groups and from one location to the next depending on the time of immigration, reasons for immigration, age, gender or the conditions involved. Ethnic, genetic, cultural or linguistic factors influence health inequities, but equally important factors include length of education and financial and social circumstances.



In this chapter, we present health-related issues associated with ethnicity, life phases and migration. The linkage of concepts such as health and ethnicity is informed by research pointing to great disparities in respect of health status, risk factors and use of health services among persons of immigrant origin.

Ethnicity and life phases from a health perspective

The different segments of the population in Norway are often identified in terms of their ethnicity. An ethnic group is a group of human beings with a presumed or real common heritage where distinctiveness is marked and recognised in interaction with others, both by the group itself and by other ethnic groups. The markers may be cultural, religious, linguistic or behavioural in nature (1).

Ethnicity arises and is constructed in relational processes between groups (2). Ethnicity is generated in a two-sided relationship and is therefore a product of the group’s own actions and ideas and by the majority group’s actions and ideas. The implication is that people of the same ethnic origin may well behave differently in different societies. An example of this would be Somali refugees in the USA, where they are often relatively well integrated in the labour market and society generally. In the Nordic

countries, however, integration of this group has proved more difficult (3).

The different markers that are accentuated or constructed change over time and depending on which groups interact. Depending on the situation, individuals in the group may reinforce or dampen differences between their own group and “the others” .

Different individuals may have different adaptation strategies depending on differences in their time of arrival, origin, expectations and personal abilities and aspirations. In some cases this may lead to conflict within a distinct ethnic group, within families, between generations or an identity conflict in the individual. Great differences exist both within an individual ethnic group and between different ethnic groups. The actions and choices of individuals may have positive but also negative health impacts. Examples of everyday choices that have health impacts relate to nutrition, physical activity, tobacco and alcohol/drugs.

Ethnicity and social factors

The state of health of persons of immigrant origin may often be explained in terms of cultural or genetic factors. This may overshadow other factors that may be more determinative for health.

Besides socio-economic status, the degree of control over their own personal

Table 2.1 Social rights and legal status			
Legal status	Right to residency	Right to employment	Right to welfare benefits
Legal labour immigrants	+++	+++	+++
Refugees	+++	+++	+++
Temporary labour immigrants	+	++	+/-
Asylum seekers	+	+/-	+/-
Paperless immigrants	–	–	–
+++ all rights	+/- no rights in some countries, substantial restrictions in others		
++ some restrictions			
+ substantial restrictions			
	–	no rights in any country	

Source: Bollini & Siem, 1995

situation will affect the individual's state of health. Control involves dimensions such as employment, income, property, gender equality and access to health care and social services in a foreign society (4).

The population in Norway has disparate access to or means of acquiring information as a basis for sound choices and services as and when required.

Minorities from countries similar to Norway generally do well, while minorities from countries that are dissimilar to Norway may have greater difficulty adapting. Meanwhile, great differences exist between non-Western migrant groups in Norway. One group that is very well integrated in the Norwegian labour market is the Tamil population (5).

Many migrants have gained an education or training before coming to Norway; they are keen to use it in Norway and do well. Some come up against barriers, including discrimination, which effectively exclude them from taking up employment. Others are unable to obtain Norwegian accreditation of their qualifications, and end up in jobs they are overqualified for (6). People who become long-term unemployed may end up registered as chronically ill (7).

The practical knowledge of the society that surrounds them, which the majority of ethnic Norwegians take for granted, may be unfamiliar to an immigrant. Norway's complex welfare state model may pose a particular challenge. Encountering so many new and unfamiliar aspects may cause feelings of bewilderment and powerlessness. The health impacts may be wide-ranging: from mild mental distress to more severe complications from disease because the person does not know where to seek help in time.

Education and health

The association between education and health is well documented. People with a low level of

education have higher rates of mental health problems than those with a high level of education (8)¹. This is particularly true of women aged 55 to 67 years. A low level of education is associated with low social support, negative life events and unemployment and low sense of mastery/powerlessness (8). Kumar investigated the extent to which education influences mental health in five different immigrant groups and in the ethnic Norwegian population (9). Taken as a whole, the groups display a health gradient. Those with the highest level of education report the fewest mental health problems. The opposite is seen in the individual groups, especially for the Pakistani group and the Sri Lankan group. Those with the highest level of education tend more often to report mental health problems. It is difficult on the basis of existing studies to draw any cast-iron conclusions about this reverse gradient. Kumar does not offer any explanation for the phenomenon, and there is clearly a need for more research in this area.

Perceived discrimination

By perceived discrimination is meant the immigrants' own subjective sense of whether they have been treated unjustly due to their foreign origin. Studies from Britain indicate that perceived discrimination and racial harassment were significantly associated with acute illness (after discounting other relevant variables) and that experiencing discrimination at work was significant for both acute and chronic illness (10). It is also known that high-level education is an important background variable among immigrants who perceived discrimination. Immigrants with a high level of education have other expectations of employment and of applying acquired skills.

Statistics Norway's Survey of Living Con-

1. Questions which the informants were asked to consider in the Dalgard study were for example: "I am unable to deal with my own problems", "I often feel helpless when dealing with the problems in my life", or "There is little I can do to change the things that matter in my life".

Perceived discrimination

44 % of immigrants perceived discrimination in one or more areas

20 % perceived discrimination on the housing market (42% of Somalis)

18 % perceived discrimination at work (33% of Somalis)

13 % perceived discrimination at school or university

7 % perceived discrimination in the health service

Source: Statistics Norway 2008

ditions 2005-2006 (5) analyses perceived discrimination at work, on the housing market, in education, in the health service and at pubs/clubs. The report indicates that Iranians, who are characterised by having the highest level of education among the groups surveyed, and represent the average in terms of employment, are those who experience the most discrimination. In this area also, we find gender differences. Young women of Pakistani origin perceive the least racial harassment (2 percent), while young Norwegian-Pakistani men as a group report the most racial harassment (16 percent). Norwegian-Pakistani women also experience less discrimination in employment than men. Thus, Norwegian-Pakistani youths perceive themselves as the most discriminated against in employment. When it comes to discrimination in the health services, women with Pakistani parents were among those with the most positive perceptions. In fact seven percent maintained that they were the object of positive discrimination compared with their Norwegian peers (5). Men with Pakistani parents had the most negative perceptions of the health service. Of these, 10 percent perceived negative discrimination within the past twelve months.

The link between discrimination and (mental) health is not investigated in the Statistics Norway report (10). It would also

appear that discrimination cannot be used to explain variation between the sexes as regards mental health, but again, in this area also there is a need for more research.

Although socio-economic status as represented by education and income is important in accounting for health disparities, it is difficult to generalise when it comes to immigrant health. Disease patterns vary individually and between ethnic groups, from one location to the next depending on the time of immigration, reasons for immigration, age, gender or the conditions involved. This is the prevailing picture throughout Europe (11).

Life phases

For children and adolescents, their mental health is the best documented.

Studies indicate that in children of immigrant origin, the incidence of mental illness is not higher than in ethnic Norwegian peers, although more of them indicate that they have emotional and social problems (12). Exceptions are unaccompanied refugee minors (13).

Many boys and girls find themselves caught between two systems of values and norms, for example in terms of behaviour, diet, dress and activities – and variably depending on gender (14). Boys aged 11-13, of immigrant origin achieve a poorer score for several health indicators than girls (12;15).

47 percent of boys of immigrant origin indicate that they have social problems, while the corresponding figure for the girls is 38 percent. For comparison, 24 percent of ethnic Norwegian boys indicate that they have social problems, as against 20 percent of the girls. The girls appear to have more emotional problems than the boys, in spite of the fact that they do better in social aspects.

A study of immigrant youth in five European countries, including Norway, comprised young people aged 13 to 18 years from Vietnam, Turkey, Pakistan, the

Antilles and Angola and also Kurds (16). A special study was made of psychological and sociocultural adaptation, and both aspects reveal distinct gender differences. Boys score lower than girls when it comes to sociocultural adaptation (i.e. behavioural problems), while the girls score lowest when it comes to psychological adaptation (i.e. emotional problems). The study also shows that the parents' occupational status influences sociocultural adaptation, but not psychological adaptation. Those whose parents had the lowest level of education had the fewest behavioural problems.

Adolescents of immigrant origin in the majority of countries studied, including Norway, Sweden and Finland, adapt better socioculturally than their national peers, in spite of lower socioeconomic status ("the immigrant paradox") (16). Adaptation is weaker among descendants (adolescents born in Norway to immigrant parents) than among first generation adolescents. This is due to "normalisation". Norway was distinct in that the descendants actually demonstrated better adaptation than first-generation adolescents. This would indicate great potential for successful integration. Statistics Norway's Survey of Living Conditions 2005–2006 reveals mental health differences for the age group

16–24 years (17). For the whole population, more boys than girls report mental problems in this age group (12 versus 9 percent). Among adolescents of immigrant origin, more girls (22 percent) than boys (13 percent) report mental health problems.

The body of data from Statistics Norway is not large enough to offer any indications concerning disease in relation to gender, age and national group. In order to be able to demonstrate additional determinant health factors in this segment of the population in Norway, more research will be needed.

Adults

For the majority of immigrants, acculturation is a relatively rapid and painfree process, but for others it is lifelong. Immigration has been described by some researchers as a continuous process (18). The extent to which this process poses a "health hazard" depends both on changes in social status, values and identity conflicts entailed by migration, and not least, how the immigrants are received by the wider society.

One study which compared immigrants from mainly Asia and Africa with ethnic Norwegians and immigrants from countries in the West, all resident in Oslo, found that the largest group had a substantially greater

Table 2.2 Percentage with mental health problems. Population and immigrants and descendants, age 16–70, by age and gender. Percent.

	age 16–24	age 25–39	age 40–54	age 55–70
Population 2002				
Both genders	10	9	9	6
Men	12	8	8	7
Women	9	10	10	5
Immigrants and descendants 2005/2006				
Both genders	17	26	35	38
Men	13	24	30	34
Women	22	29	42	42

Source: Blom, Statistics Norway, 2008

incidence of mental health disorders than the ethnic Norwegians, while there was less difference between the ethnic Norwegians and immigrants from countries in the West. Both social and psychosocial factors were contributory in accounting for this difference. Low income and a high rate of unemployment among immigrants from non-Western countries were important explanatory factors, but psychosocial factors such as a lack of social support, lack of integration and low sense of mastery also played a significant role. Once these factors had been discounted, the disparities in mental health between groups vanished (19). Similar findings were demonstrated in a study of Pakistani immigrants in Oslo (20).

Elderly persons

The age gradient in relation to disease is stronger in the immigrant population than in the population as a whole (17). This means that the older a person becomes, the more at risk he or she is of disease. This is particularly the case for women who have immigrated to Norway.

Mental disorders in the population as a whole would appear to diminish the older people get. For the immigrant population however, the tendency is for mental disorders to increase with age. The percentage of women of immigrant origin who have mental health problems almost doubles from the youngest to the oldest age group (see Table 2.2).

The number of elderly immigrants in Norway is currently low, but in the years ahead is set to increase substantially (21). With an increasing number of elderly persons in Norway in the time to come, the number of persons of immigrant origin who develop senile dementia is also likely to increase. If a large number of elderly persons of immigrant origin with dementia come to require health and care services, the Norwegian health

The Oslo Immigrant Health Study (Immigrant-HUBRO), an extension of the Oslo Health Study (HUBRO, 2000–2001), is a collaborative project between the Norwegian Institute of Public Health, the University of Oslo and City of Oslo comprising data from a total of 3,019 persons aged 30 to 60. Although this study, like a number of other studies of marginalised groups, is flawed by a low response rate (39.7 percent), lack of information about those who have not taken part and a lack of validated instruments, the follow-up studies demonstrate that the prevalence projections are still to be regarded as fairly robust. A number of articles and doctoral theses have been published on the basis of this material, and the recent report, *The Oslo Immigrant Health Profile* (9), in which data from the ethnic Norwegian population is compared with data from five different immigrant groups (Pakistan, Turkey, Iran, Vietnam and Sri Lanka) in areas such as sociodemographic factors, self-reported health, risk factors, mental health and use of health services.

The other report is part of Statistics Norway's Survey of Living Conditions 2005–2006: **Immigrant health**. The aim of this survey, which is based largely (62 percent) on visitor interviews, is to elucidate a broad spectrum of the living conditions of a selection (10) of the largest country-groups of migrants and descendants in Norway in the age range 16–70. The questionnaire that was used was available in translation to twelve relevant languages besides Norwegian, and specially trained interviewers of immigrant origin from the respective countries were responsible for most of the interview process. The focus was on topics not covered by registry statistics, and the response rate was 64.3% of a gross sample of 4,752 persons. The report from this survey also compares data from a similar survey conducted in 1996 (22).

service will need to be organised in such a way as to ensure that these individuals also receive qualitatively satisfactory and acceptable health care (see also Chapter 3).

There are more immigrant women who report poor self-diagnosed health than men (17). We cannot exclude the possibility that this is connected with the greater difficulty of coping with illness in a foreign country. It may also be difficult for many to make use of the Norwegian treatment system.

Table 2.3 Incidence of somatic disease and mental problems, by country of origin and gender

Diseases summarised	Immigrants and descendants											
	Entire population	Total	Bosnia-Herzegovina	Serbia-Montenegro	Turkey	Iraq	Iran	Pakistan	Vietnam	Sri Lanka	Somalia	Chile
	2002	2005/2006										
%-age with at least one medical condition	49	48	44	31	51	49	48	52	52	47	36	63
Men	45	43	41	26	44	43	44	46	47	50	29	56
Women	53	53	47	38	61	61	53	59	56	43	46	71
%-age with med mental health problems	9	27	29	24	34	39	42	25	21	16	16	28
Men	9	24	26	20	30	32	40	17	15	18	14	24
Women	9	32	31	30	39	53	45	33	26	13	19	32

Source: Blom, Statistics Norway, 2008

Variation between national groups

A number of large-scale population surveys of immigrant populations in recent years allow us to compare the incidence of disease in different “national groups”. Two such surveys are Statistics Norway’s Survey of Living Conditions 2005-2006 and the Oslo Immigrant Health Study (Immigrant-HUBRO) (see text box, p. 25). It is important to bear in mind that a “national group” may coincide with or be quite independent of any ethnic group (for example, a child born in Norway to Kurdish parents who formerly lived in Iraq). It is also important to take into account where the immigrant came from, age on arrival in Norway and how long the person has been in the country. A comparison, both between immigrant groups and the majority group and between the different groups might well be important for purposes of planning measures and health care provisions.

There is substantial variation between the different national groups both in terms of self-reported health (Table 2.3), risk factors and use of the health service.

Studies indicate that people’s state of health deteriorates after a period in the host country and that the health of immigrants

does not necessarily correspond with their relative socioeconomic status (16;22).

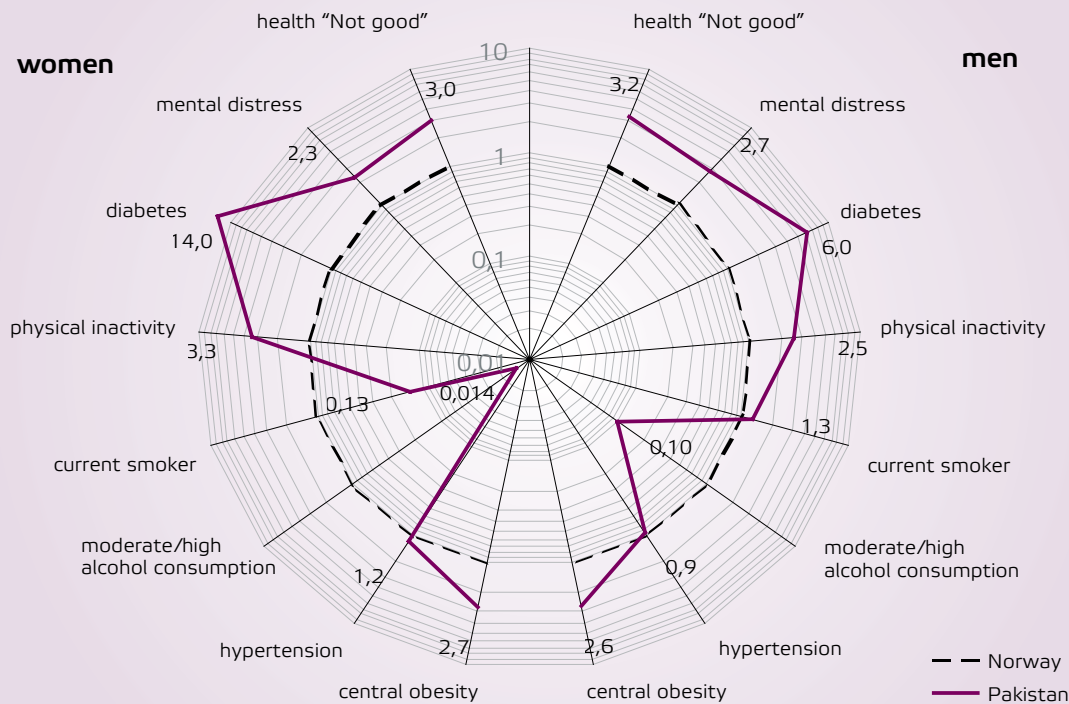
Differing incidence of risk factors

Risk factors vary between different ethnic groups in Norway. This applies to overweight, obesity and the percentage of smokers. Research indicates that 61 percent of men from Serbia-Montenegro are overweight, while the percentage of overweight Vietnamese men is 27 percent. For comparison, the number of overweight men in the Norwegian population as a whole is 50 percent (17). The corresponding figures for women from Serbia-Montenegro and Vietnam are respectively 31 and 9 percent against 28 percent in the population as a whole. When it comes to smoking there are also large differences. While half of all Turkish state that they are habitual smokers, only 15 percent of men from Sri Lanka state the same. There is substantial variation when it comes to risk factors both between ethnic groups and the sexes.

Disparities in disease patterns

If one compares the population of immigrant origin with the majority population, we also find that the disease patterns differ. There are more people of immigrant origin who have

Figure 2.1 The figure shows a number of risk factors and self-reported diseases in immigrants of Pakistani origin and ethnic Norwegians



Source: the Oslo Immigrant Health Profile, Norwegian Institute of Public Health, Report 2008:7

diabetes, angina and rheumatoid arthritis than in the rest of the population. Atypical conditions, hypertension and cancer are however less common than in the rest of the population. There is also substantial variation in the extent to which these health problems affect everyday life (17).

Diseases which are rare among ethnic Norwegians, but which may occur more frequently in certain immigrant groups:

- Genetic disorders: lactose intolerance, alcohol intolerance
- Haemoglobinopathies: sickle cell anaemia, thalassaemia, glucose-6-phosphate dehydrogenase deficiency
- Infectious diseases: tuberculosis, hepatitis, malaria, AIDS, intestinal parasites, resistant microbes from countries with injudicious use of antibiotics.

Gender differences in integration

Men and women react differently to integration. Weak integration accounts for much of the overmorbidity in men, along with poor social support and conflicts in close relationships. Better integration will in all probability prevent mental health problems in men. This is less the case for women, for whom employment and income are more likely to have a positive effect. But this positive effect disappears for women because integration creates problems in other aspects of life. The situation that appears to have the greatest negative effect on women's mental health is to be living without a partner, and unsatisfactory housing (23).

Selected issues of concern

The following offers a brief presentation of individual issues of concern surrounding specific groups of immigrant origin. These issues of concern are relatively new in the Norwegian context and therefore merit special

attention from the different divisions of the Norwegian health service.

Diseases that were formerly rare in Norway

A small number of immigrants have diseases that are rare in Norway. Examples of these are recessive hereditary diseases such as thalassaemia and other haemoglobinopathies.

In Norway, rare diseases of this type pose challenges for the health services, both because they cannot immediately be detected by our diagnostic routines, and because there is little experience in treating the conditions. Denmark has introduced screening of pregnant women of relevant ethnic origin in order to detect haemoglobinopathies (46).

In 2007, the Norwegian Directorate of Health sent a letter out to all general practitioners across the country concerning hereditary conditions within the family. On suspicion of an increased risk of hereditary disease, the GPs are requested to refer patients to medical genetic departments for counselling in accordance with Chapter 5 of the Act relating to the application of biotechnology in medicine.

Norway should consider introducing screening.

Infectious diseases

There has been particular interest in infectious diseases such as HIV/AIDS and tuberculosis, the incidence of which are attributable partly to migration from high endemic areas. The majority of persons infected with HIV are immigrants who were infected abroad prior to their arrival in Norway. In the last five years, the number of new cases among immigrants infected abroad has varied between 99 and 123 per annum.

For tuberculosis too, we find a preponderance of immigrants infected abroad. In 2008, 184 out of a total of 317 persons with active tuberculosis were of immigrant origin.

Although the figures involved are small, the situation is one that causes some alarm, the concern being whether the infection is spreading to the majority population. At the present time this would appear not to be the case. Although a number of immigrants are also infected by HIV in Norway, studies conducted by the Norwegian Institute of Public Health indicate that these persons were in the main infected within the immigrant community in Norway or during a visit to a former home country. The same tendency is seen for tuberculosis. A new survey from the Norwegian Institute of Public Health (24) indicates that immigrants with tuberculosis do not spread infection in the Norwegian population. Similar findings have been made in other countries (25;26).

In 2007, eleven new cases of AIDS were diagnosed. This is a substantial decrease on previous years, and presumably an indication more than anything of the efficacy of the treatment currently available.

Although the above-mentioned infectious diseases do not constitute a significant infection risk in Norway, preventive work and treatment are important. In many communities such diseases may be taboo-ridden and stigmatising, which means that communication concerning them must observe all due care.

Diabetes

Studies indicate that diabetes is considerably more prevalent among persons of South-Asian extraction than in the rest of the population. While the incidence in the Norwegian population as a whole was approx. 4 percent, the incidence was 11 percent in migrants from Sri Lanka and 8 percent in migrants from Pakistan (17).

The incidence of diabetes is higher in women than men. The incidence of diabetes in women of immigrant origin is far higher than in ethnic Norwegian women (9;27). The differences remain substantial even after cor-

rection for physical activity, education, height and fertility (27). The usual explanation for this excess prevalence is that genetic predisposition is significant, in addition to lifestyle factors such as diet.

Type 2 diabetes is associated with the incidence of metabolic syndrome, a condition which according to the WHO definition criteria comprises central obesity, glucose metabolism disorders, dyslipidaemia and hypertension (28). Eighty percent of persons in industrialised nations with type 2 diabetes meet the criteria for metabolic syndrome. In Norway the incidence of symptoms of metabolic syndrome are highest among persons of Sri Lankan and Pakistani origin (9). These persons scored high for risk factors such as hypertension, elevated lipid levels, HDL cholesterol and central obesity. The highest scores were seen in women.

Metabolic syndrome is a so-called lifestyle disease that is preventable and curable through lifestyle changes. The risk of metabolic syndrome may be affected by changes in personal circumstances such as giving birth, establishing a family, death in the family or moving home (29). Other significant lifestyle factors include diet, physical activity and smoking. Lifestyle changes can prevent and curb the syndrome (29). If changes in personal circumstances become too extensive and overwhelming, people may experience a sense of powerlessness and fall ill. Such changes in personal circumstances are often faced by the immigrant population, and again, women immigrants are the most at risk. Several studies demonstrate that it is difficult to draw absolute conclusions as to the association between diabetes, genetic factors, sociocultural factors, acculturation problems, lifestyle factors and socioeconomic factors (32;33). In all probability, a number of such factors are compounded in a complex of interactions, and there is reason to assume that genetic predisposition, lifestyle (including exposure

to the sun), gender role patterns and social norms determining appearance, conduct and participation play an important role. In other words, the issue is not just lifestyle, but "social lifestyle determinants". In the immigrant population, and especially in the South-Asian population, the prevalence of type 2 diabetes is so extreme (more than 50 percent of women over age 50 years are affected and approx. 30 percent of men in the same age group) that comprehensive measures are justified. In order to achieve equitable health care for this population group, screening and active preventive measures should be considered.

Vitamin D deficiency

Recent years have seen increasing awareness of the importance of vitamin D for health. There is a link between vitamin D metabolism and a number of diseases of the skeletal system. Vitamin D deficiency is also a precursor of type 2 diabetes (30).

The average vitamin D value in the Norwegian population reveals variation between groups. In the ethnic Norwegian population, men have the lowest value, whereas for a large percentage of the population of immigrant origin, women have the lowest value². Knowledge of the consequences of a low vitamin D value is at present incomplete. Studies have for example been conducted of women of Pakistani origin and ethnic Norwegian origin, from which it was found that low vitamin D content reduces bone density in ethnic Norwegians, but not in women of Pakistani origin.

Contributory factors in vitamin D deficiency are inadequate sunlight exposure, frequent use of high-factor sun block, dark skin, age, obesity and certain drugs and diseases (31).

While there would appear to be a consistent link between vitamin D deficiency, metabolic syndrome and type 2 diabetes, the findings

2. Countries with a low prevalence of vitamin D are: Pakistan, Iran, Turkey, Sri Lanka and Vietnam.

become somewhat inconsistent when it comes to the significance of vitamin D intake through diet in the development of type 2 diabetes.

Over the course of 2009, the Norwegian Directorate of Health aims to introduce a nationwide programme for local maternal and child health centres to allow them to provide free vitamin D supplements for all infants born to immigrants originating from Asia, Africa or Latin America. The programme will be applicable during the first six months of the infant's life, and specially adapted information materials will also be distributed. This scheme is part of the 2005-2009 strategy plan "A Healthy Diet for Good Health" and will be launched to prevent vitamin D deficiency and cases of rickets in these children.

Consanguineous marriage in Norway

Consanguineous marriage, also referred to loosely as 'cousin marriage', is defined as a union contracted between persons who are second cousins or more closely related. Globally, consanguinity is most prevalent in North Africa, the Middle East and South Asia. Similarly, in Norway we find a high prevalence of consanguinity in groups originating from these world regions. Consanguineous unions occur primarily in families originating from

In 2009, the Norwegian Directorate of Health has published information brochures in different languages on heredity and the increased risk of disease and birth defects when parents are related. The target group is consanguineous couples who are planning to have children, and parents who have children with disabilities. Health professionals are also important target groups. Please refer to the website of the Norwegian Directorate of Health: www.helsedirektoratet.no

Pakistan, Turkey, Iraq, Iran, Sri Lanka, Morocco and Somalia.

Consanguineous marriage is most prevalent among people of Pakistani origin. Among couples where both persons are immigrants born in Pakistan, the percentage of cousin couples is 43.9 percent and total consanguinity amounts to 54.4 percent. In couples where one or both parties were born in Norway, the corresponding figures are 35.1 percent and 46.5 percent. This then represents a fall in consanguineous unions from foreign-born to Norwegian-born persons of Pakistani origin. It would also appear to be a declining trend in that the percentage of consanguineous marriages has fallen substan-

Table 2.4 Number of stillbirths, infant deaths and congenital deformities (1996–2005).

Relationship category	Stillbirth	Infant death	Congenital deformities
Cousins or more closely related	48/3705 (1.3 %)	39/3973 (1.0 %)	159/4108 (3.9 %)
Related but more remotely than cousins	10/1418 (0.7 %)	12/1569 (0.8 %)	53/1591 (3.3 %)
Related but not indicated how	29/4298 (0.7 %)	23/4641 (0.5 %)	129/4756 (2.7 %)
Not related	3029/481097 (0.6 %)	1862/518614 (0.4 %)	13815/525990 (2.6 %)

Calculations based on data from the Medical Birth Registry of Norway and Statistics Norway for children born from 1996 to 1st half of 2005. The total number of individuals in the table varies slightly for the different outcomes. The calculations of stillbirth and infant death discount all cases of unreliable data concerning whether the child was dead or alive on birth. The calculations of stillbirth also discount all cases of unreliable data concerning the length of gestation.

Source: The Medical Birth Registry of Norway and Statistics Norway

tially since the turn of the millennium among both first-generation immigrants and their descendants (34).

In the majority population of ethnic Norwegian origin, consanguinity is rare. The percentage of couples who are cousins is 0.1 percent, and total consanguinity is 1.0 percent.

A study conducted by the Norwegian Institute of Public Health (34) analysed how parental consanguinity affects the risk of stillbirth (defined in Norway as death in utero after 20th week of gestation), infant death (death within the first year of life) and congenital deformities. A survival analysis was also produced, in which the children of consanguineous unions were compared with children of exogamous unions throughout their entire lives up to adulthood, in order to establish any differences in mortality.

The number of stillbirths, infant deaths and congenital deformities in the period 1996–2005 are summarised in Table 2.4 by category of parental relationship. As shown by the table, the incidence of stillbirth, infant death and congenital deformity is higher if the parents are blood relatives and highest when the parents are closely related (cousins or closer).

The risk of death increases over the person's lifetime. A survival study demonstrates that the children of cousin-couples have a 75 percent elevated risk of death at every age stage from age one to adulthood – presumably as an expression of underlying increased morbidity. There is however a

shortage of satisfactory data on child morbidity in those children who do survive.

Although the figures are small, the consequences for families who have children with such conditions will be extensive. Greater knowledge of hereditary diseases is important, among other things through genetic counselling for at-risk groups.

Female genital mutilation

Female genital mutilation is a generic term for all procedures involving partial or total removal of, or other injury to, the external genitalia of women or girls for non-medical reasons. WHO estimates that between 100 and 140 million girls and women worldwide are living with the consequences of genital mutilation.

Female genital mutilation is a practice rooted in cultural values and belief systems concerning marriage, reproduction and purity.

Genital mutilation is harmful and a violation of fundamental human rights. The practice is therefore punishable by law in an increasing number of countries including Norway and also in countries where the practice has been widespread for many generations.

Female genital mutilation was originally documented in 28 countries in Africa and a few countries in the Middle East and Asia, but due to migration, is now practised in specific immigrant communities worldwide (35;36). The age of the girls at the time of circumcision varies from country to country: from newborn to after first childbirth. However, generally the procedure is carried out on the age-group 4-14 years (37). As a result of the legal prohibition being instituted in many countries and campaigns against female genital mutilation, many aspects of this tradition are changing. This applies both to the age/stage in life when the procedure is carried out and the extent of the procedure. Even the least radical procedure represents a health risk and is a grave violation of the rights of girls and women.

Action Plan for Combating Female Genital Mutilation 2008–2011 was presented by the Norwegian Government in February 2008. The plan is part of a long-term effort initiated in 1995 when Norway adopted its own Act prohibiting female genital mutilation. The first action plan for combating genital mutilation was launched in 2000.

Female genital mutilation in Norway

There are currently approximately 10,000 circumcised women in Norway. The majority of these are, or have been infibulated, that is, subjected to the most extensive form of female circumcision. Many of them stand to benefit from corrective surgery to reconstruct the normal genital opening. Provisions for corrective surgery are currently available under all the Norwegian regional health authorities (40).

The number of cases of female genital mutilation reported by public-sector bodies was 15 cases all told in the period 2006 and 2007 (38). The low figure may be due to under-reporting. It is possible that interventions and projects in both the public-sector and voluntary domains have influenced and resulted in a change in attitudes and actions (39).

Male circumcision

Male circumcision is a practice involving the removal of the foreskin from the penis. It is a tradition founded on medical, religious and cultural belief systems. Circumcision is routinely practised in Norway, but has not caused the same alarm and debate as the circumcision of girls. Besides discussing the implications entailed for the individual's sexual life and mental health, responsibilities, rules of consent and competency requirements must be made clear in connection with male circumcision. Recent research suggests that circumcision may reduce HIV infection and other sexually transmitted infections (41;47). Virtually all Jews and Muslims are circumcised. 60 percent of the American population is also circumcised.

A few good examples:

- InnvaDiab is a partnership project between the University of Oslo and the neighbourhood Bydel Søndre Nordstrand to reduce the development of type 2 diabetes in Pakistani women. The InnvaDiab project was very well received among the women, and was awarded City of Oslo's public health award 2008.
- In a neighbourhood in Oslo with a low socioeconomic profile and a high proportion of migrants, Dr. Jenum and staff (45) conducted a large-scale project to mobilise neighbourhood residents to engage in physical activity and demonstrated that this form of mobilisation has positive effects on both physical and mental health.
- The Mosjon på Romsås ("Exercise at Romsås") project demonstrated that using basic assistive devices and regular physical activity it is possible to raise physical activity levels and reduce risk factors for type 2 diabetes and cardiovascular disease (45).
- PMV Centre for Health, Dialogue and Development in inner city Oslo is run by The Church City Mission, where women and young people of immigrant origin can meet in groups to discuss their own situation, where they can obtain information about a range of health issues such as nutrition, coping with pain and infectious diseases such as HIV/AIDS, tuberculosis, etc. The centre also undertakes public information and opinion-forming activities on issues such as genital mutilation, forced marriage and domestic violence. The PMV Centre works closely with several women's organisations on various health-related projects. Similar centres are now being established in other Norwegian urban areas under the aegis of The Church City Mission.
- In recent years, Vinje municipality in Telemark has received a great deal of attention for its wide-ranging programme of activities in refugee reception and integration.

Drugs and adolescents

Adolescents of immigrant origin often start taking drugs later than their Norwegian peers and tend to conceal their drug problems. On the whole, the group takes less drugs than ethnic Norwegians. The picture is however nuanced, and there is much to indicate that it is also changing (42).

Concern has been expressed over increasing drug misuse among immigrant adolescents in recent decades. Unaccompanied refugee minors (boys) are singled out as particularly at risk for drug misuse. In spite of the differences in immigrant youth residency status, refugees/asylum seekers who take and sell controlled substances have many common characteristics (43). They arrived in Norway in their teens or early 20s. While awaiting the processing of their application for asylum, they stayed at asylum reception centres, where life was characterised by passivity, negligible employment, and they have language problems. The sum of this is that they feel poorly equipped to cope in Norwegian society.

Minority youths with drug dependency problems are often more sceptical about the rehabilitation services available, which is a contributory factor in their failure to obtain help to deal with their problem. Use of the Norwegian rehabilitation system by drug misusers of immigrant origin has been very limited. Of those who come under the Norwegian rehabilitation system, many are in treatment for only a short period.

In Norway, khat has been classified as a narcotic drug since 1989 and the use and possession of khat is therefore prohibited by Norwegian law. Khat is used in certain immigrant communities in Norway and may be a contributory cause of weak social inclusion. The report on khat use in Norway, *Bruk av khat i Norge, nytelse og lidelse (Use of khat in Norway; pleasure and suffering)*, (44), indicates that khat among Somalis, especially young Somalis, is

not an extensive problem. For heavy users of khat, there are however great social and financial consequences for the individual and next of kin.

Prevention and public health work

Public health work is the sum total of society's efforts to influence factors that promote and sustain the health of the population. The influence factors exist at all levels of administration and in all sectors of society, and the efforts take place extensively outside of the health service itself, a fact which underlines the significance of wide-ranging and cross-sectoral public health work. It is also important to strengthen the health service's responsibility for cross-sectoral efforts aimed at the causes of health problems.

Public health work is aimed at both living conditions and risk factors such as environment and behaviour. This means fundamental social conditions such as challenges linked to poverty, homelessness, unemployment, truancy and known risk factors for health such as indoor climate in schools, alcohol use, tobacco use, diet, opportunities for physical activity, noise factors, accident risk areas, pollution situations etc.

In order to give different groups coping resources, and in order for everyone to be in a position to make efficient use of the health service, there is a need for public health work that takes into account the different groups and their needs. In recent years, a number of productive projects have been completed to mobilise persons of immigrant origin to engage in public health work. Many of these have been implemented in districts of Oslo where the population of immigrant origin has a strong presence. These projects demonstrate that it is possible to involve people of different origin in health-promotion work, and that many, especially women may perceive such

work as meaningful, and be willing to invest a great deal of time and energy in it. Over time, we find that broad community involvement develops in those who participate in such projects (see text box, p.32).

Summary:

- Substantial health disparities exist in the Norwegian population as a whole. These are essentially attributable to socioeconomic factors such as income, education and social determinants, and not primarily to ethnic origin.
- Different disease patterns are however revealed when the population of immigrant origin is compared with the majority population, with for instance, more people of immigrant origin who have diabetes, angina and rheumatoid arthritis.
- The increased incidence of HIV and tuberculosis in immigrants should be seen in the context of travel to/from high endemic regions, and currently poses little infection risk in Norway.
- The state of health is impaired with increasing age. For elderly persons of immigrant origin, this increase is stronger than in ethnic Norwegian elderly persons. For elderly women of immigrant origin especially, mental state of health is impaired with increasing age.
- Gender differences are extensive when it comes to self-reported state of health in persons of immigrant origin. Women report substantially more ill health than men.
- Girls of immigrant origin appear to be under cross-pressure from different cultural expectations. This can have negative impacts on health.

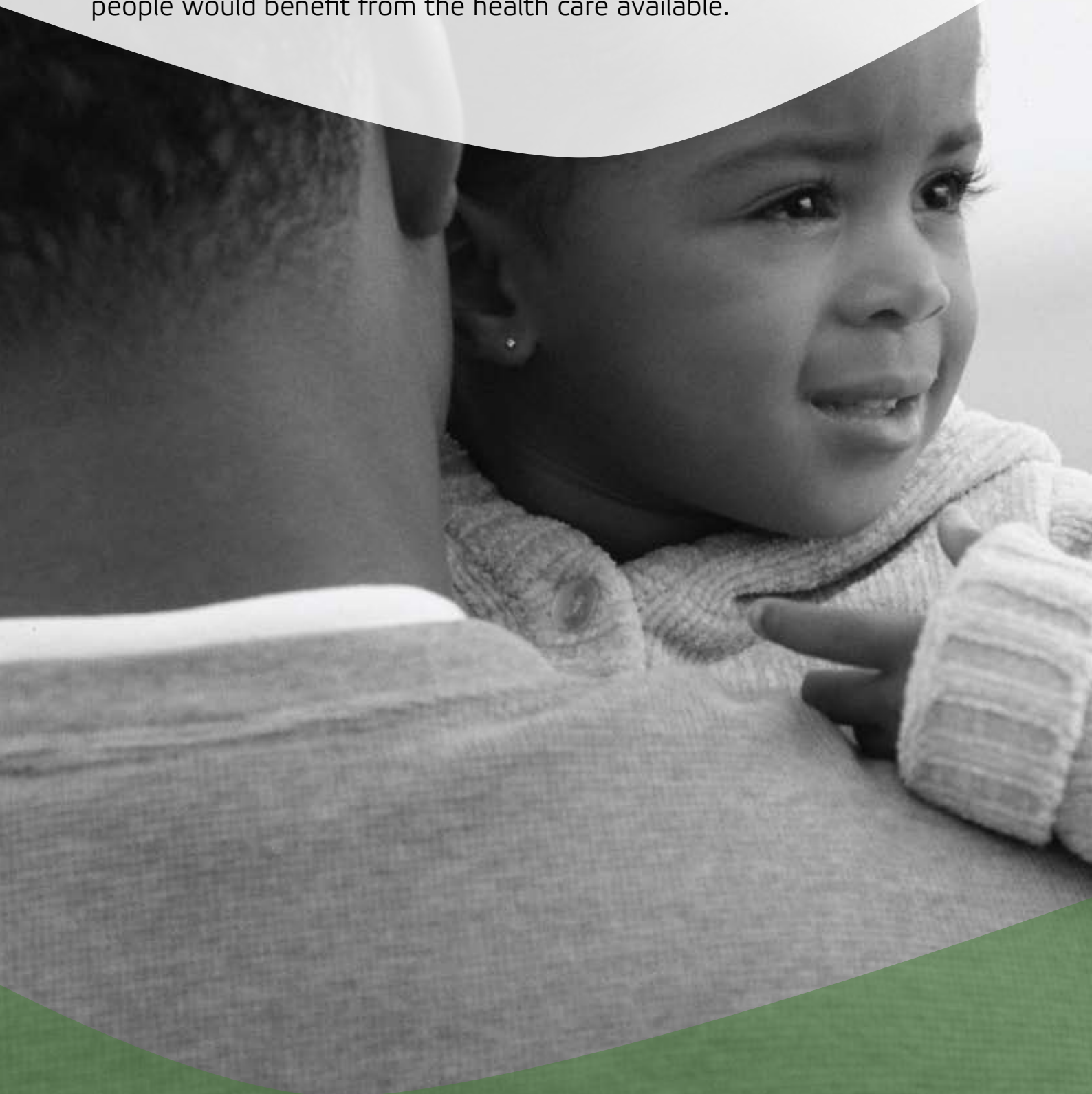
The Norwegian Directorate finds that

- there is a need to monitor trends in the state of health in all segments of the Norwegian population in order to be able to adapt the Norwegian health service and implement preventive measures tailored as far as possible to the needs of the individual. Information and opinion-forming is part of this work.
- positive outcomes from successful projects should be applied to standard services.
- it is important for the entire population to receive the necessary knowledge for preventing harm to health and disease and knowledge of the rights and options embodied by the Norwegian health system.
- there is a need to support initiatives for new research and more comprehensive documentation in the field of migration and health, and to facilitate participation by affected groups in research in key areas.



3 Interaction with the Norwegian health service

All persons resident in Norway are to be offered equitable health services – irrespective of ethnicity, cultural or religious identity, sexual orientation, disability, gender or age. There is reason to believe that services at present are not equally effective for everyone in Norway. If the health services were adapted more extensively to the diversity of the population, more people would benefit from the health care available.



In this chapter we turn our attention to immigrant interaction with the Norwegian health service, and the various challenges this poses, from both a user and service perspective. This chapter discusses different methods and approaches to establishing equitable health services. We then go on to present selected service areas and particular challenges. The emphasis here is on a solution-oriented approach, and we offer examples of successful inclusivity interventions and strategies to serve as instruction and inspiration.

An equitable health service

The composition of the Norwegian population is changing. A larger elderly population and a more international culture make new demands on health service adaptability.

The new multicultural Norway challenges the prevailing ideals of equality in Norwegian society in many ways, including in any interaction with the health service. If everyone is to be treated equally, the result may be that some people systematically receive poorer treatment provision and reduced benefit from the services. The aim is consequently not to offer equal services, but rather equitable services which take into account the differing needs and requirements of citizens (1).

The duty to provide equitable health services is prescribed in Section 1 of the Municipal Health Services Act and Section 1 of the Health Authorities and Health Trusts Act. The Ministry of Health and Care Services' letter of instruction to the Regional Health Authorities for 2009 amplifies on the objects of the legal statutes in its requirements regarding quality, accessibility and user participation for all patients.

The patient group is complex, has differentiated needs and reflects the diversity of society at large. The health service must be alert to and respond to this. Although the principles of treatment are consistent, the need for

time and communications skills will depend on the patient's understanding of his or her own medical condition, and the patient's expectations and knowledge of the health service.

In order to guarantee equitable health care for all, it may be useful to examine the principles of the concept 'migrant friendly health care'.

Migrant Friendly Hospitals

The Norwegian Centre for Minority Health Research (NAKMI) describes migrant friendly health care as follows: It values diversity by accepting that people of different ethnic origin are fundamentally equal members of society. It identifies the needs of people of different ethnic origin and develops services to match those needs. It compensates for any disadvantages

The Norwegian Anti-Discrimination Act

The Norwegian Anti-Discrimination Act prohibits discrimination based on ethnicity, national origin, descent, skin colour, language, religion or belief. The Anti-Discrimination Act applies in all areas of society except for family life and personal relationships. As of 1 January 2009, an activity and reporting obligation was inserted into the Act (Section 3a) requiring public authorities to work actively, purposefully and in adherence to plans to advance the objects of the Act.

Migrant Friendly Hospitals

Through the project Migrant Friendly Hospitals (2002–2005), twelve hospitals in as many countries have collaborated on identifying best practices in the area. Their experiences are summed up in the Amsterdam Declaration towards Migrant Friendly Hospitals in an ethno-culturally diverse Europe, which besides the summary of evidence presents recommendations for how to develop more satisfactory practices in this area. The project, which was funded by the EU, is being continued as a Task Force on Migrant Friendly and Culturally Competent Health Care in the framework of the WHO Network on Health Promoting Hospitals (www.mfh-eu.net). Norway is represented by the Norwegian Centre for Minority Health Research - NAKMI (www.nakmi.no) in this project.

arising from the fact that people are of different origin. The same principles may be applied to patient-friendly health care.

A number of migrant friendly hospital projects have been carried out in a number of countries (please refer to the box – Migrant Friendly Hospitals). These projects have gathered useful experience and have systematised evidence that can be applied in achieving more equitable health services for all.

In Norway, NAKMI is the coordinator of the Norwegian Network of Migrant Friendly Hospitals (NONEMI). In 2008, NONEMI carried out an internal audit of four of the network's hospitals. This revealed that the hospitals have problems securing access to interpreters, and that those they do find, generally possess inadequate medical knowledge and information adapted for the patient concerning hospital routines and treatment provisions. It also emerged that in psychiatric departments especially, no special arrangements or adapted provisions are in place for persons who do not speak Norwegian. One particular challenge for staff generally is that the patients have insufficient knowledge of the Norwegian health service. Coordination and information flows between Norwegian hospitals and municipal health services are perceived as overly demanding.

A number of hospitals have specially adapted information in the form of 'say and point' illustrated board books or demonstration videos for persons who are unable to read. At some hospitals, facilities have been established to permit religious practices on the premises, for example for prayer or rituals for the dead. A number of hospitals provide seminars for staff in cultural studies and the use of interpreters. Hospitals that have incorporated strategies for adapted provisions for the immigrant population in their strategy documents and quality-assurance systems achieve the highest score for 'migrant-friendliness'.

Akershus University Hospital has a special 'credo' room; a room for all creeds and religions, designed to permit patients, relatives and staff to practice their own faith or beliefs.

Project on equitable health care

South-Eastern Norway Regional Health Authority established the project on equitable health care in December 2008, the object of which is to draw up a strategy, by June 2009, to ensure that knowledge concerning minority groups permeates current and future plans and activities. The intention is to guarantee equitable health care by providing recommendations for measures to be implemented throughout the South-Eastern Norway Regional Health Authority.

Source: <http://www.helse-sorost.no/>

Adapted medical care

Adaptation of medical care is also essential for persons of immigrant origin in order to achieve equitable health care provision. Adaptation can be achieved in various ways from adaptations of existing general medical practice to the provision of tailored services. The type of adaptation that will be most appropriate will vary depending on geographical, communicative and other factors.

In Drammen Municipality at the Fjell Medical Centre, the GPs, who have around 70 percent refugees and immigrants on their books, have received financial compensation for this in the form of an increased local authority basic subsidy. This was a necessary measure in order to recruit GPs to the Fjell district.

The municipalities of Tønsberg, Nøtterøy, Andebu and Stokke have set up an intermunicipal health care centre (covering municipal and specialist health care) – Vestfold Migrasjonshelsesenter (Vestfold Migration Health Centre). Asylum seekers staying at reception

centres, resettled refugees and the members of family reunifications have the right to use the Centre for up to 12 months after resettlement in Norway. The Centre has a general practitioner, a clinical psychologist, health visitor (for adults – infection prevention measures) and a secretary/nurse. The psychologist is employed by the specialist health service, but works at Vestfold Migration Health Centre. Patients with complex health problems are given prompt care.

Adaptation of health care which caters for the needs of the migrant population will also serve as a means of achieving more user friendly health care generally.

Language and communication – a special challenge

Studies of minority-language users who receive health care indicate that language and

communication problems constitute a barrier, both to the treatment itself and to the provision of information concerning the disease or disability (2–5).

There is at present no national strategy for information provision to patients or communication with patients. There is currently very little coordinated information for both ethnic Norwegian and minority groups. When information is provided, the overly bureaucratic language used often makes it incomprehensible to the intended readers. Such barriers will be greater for immigrants who have only been in the country for a short period.

Besides the need to translate information materials into a range of languages, both patients of immigrant origin and the health service itself will stand to benefit a great deal from improvements to general information for patients.

Communication problems can give rise to misunderstandings, which in the worst case can have direct consequences for treatment outcomes. They will also impair access to services for groups who, for cultural and linguistic reasons, have difficulty communicating their needs. For groups with extensive need for health care, such as people who are chronically ill and people with disabilities, this is a particularly serious concern (5 p. 93).

Communication problems result in negative outcomes; important information may be misunderstood or be lost on its intended recipient. Both next of kin and representatives of the health care system find that they are missing out on many natural opportunities for consultation and conversation.

Use of interpreters improves communication

The challenges entailed by language and communication generally are often construed as differences in culture and religion (3;4). If we instead focus on the communication chal-

Information materials in several languages

- The hospital Sykehuset Innlandet has produced information binders and DVDs in several languages describing various procedures and tests. These materials will be made available to Norway's paediatric departments.

Source: <http://www.digitalsprakperm.com/>

- Publications by the Directorate of Health include information materials on mental health in 17 languages. The brochures *Mental health care in Norway and BUP – The Children's and Young People's Psychiatric Out-Patient Clinic* explains how mental health care is organised and where to seek help. The Directorate has also produced pamphlets on mental disorders such as anxiety, depression, ADHD, compulsive disorders, eating disorders and psychosis, as well as information about legal rights and involuntary commitment (sectioning).

Source: www.helsedirektoratet.no

lenges rather than define the problem as one of cultural differences, there is then greater likelihood of achieving better interaction between the patient and service provider/practitioner. The use of an interpreter is therefore one of several essential tools.

According to national and international rules, the responsibility for arranging for interpreting services rests with the professional or official. Where interpreting services are

required, they are to be regarded as part of the health care provision.

The challenges posed by the use of interpreters in the Norwegian health service concern the integration of interpreting as part and parcel of the health services; training in the use of interpreters for employees in the health sector; quality; organisation and facilitation of interpreting services within the health sector.

A good interpreter can eliminate language barriers and bridge the language gap in patient-provider interaction. Failure to use an interpreter may result in poorer quality in the health care provided. However, there are also challenges in carrying out interpreter-assisted treatment consultations in terms of both the interpreting situation itself and timely access to an interpreter.

A questionnaire-based survey on the use of interpreters in the health service in Oslo reveals under-use of professional linguistic assistance (6). The report indicates that health professionals tend to settle for the most readily available solutions. They use family and friends as translators or for communicating with the patient, even though these "interpreters" may not be proficient in Norwegian themselves.

Norwegian code of professional conduct for interpreters

- Confidentiality or discretion: interpreters provide their users with a strong guarantee that none of what they interpret will be disclosed to any third party at the end of the interpreting session.
- Impartiality: interpreters guarantee their users that their interpreting will never be more "pro" one party than the other party.
- Not to undertake other tasks: in order for interpreters to remain impartial and perform their work to the highest standard, they must not perform any other task in a session than that of interpreting.
- To translate everything: interpreters shall provide linguistic liaison enabling people who do not comprehend each other's language to interact as if they shared a common language

Source: www.tolkeportalen.no

Use of interpreters in psychiatric treatment and psychological counselling

The Psychosocial Centre for Refugees at the University of Oslo has produced a set of guidelines for what is termed psychosocial interpreting:

- Interpreters should sign a non-disclosure agreement at the site where the interpreting will take place
- Interpreters should provide information concerning the rules of interpreting during the initial conversation
- Interpreters or the interpreting service should advise if they are able to provide interpreting by the same interpreter over time
- Interpreters must translate only what is said
- Interpreters must translate all that is said
- Interpreters must not formulate their own questions, clarify misunderstandings or engage in dialogue on their own behalf
- Translation must be rendered in the first person ("I" form)
- Mobile phones must be switched off
- Any notes taken by interpreters during an interpreting session must be shredded in full view of the client
- Interpreters must be professionals and not "helping hands"
- Interpreters must not collect or drive the patient/client or pass on messages
- It is preferable for interpreters not to have any contact in their spare time with patients/clients
- Interpreters should not make their own agreements with patients/clients

Kilde: Sverre Varvin, Universitetsforlaget, 2003

Interpreting in the health service is subject to special requirements regarding quality. The consequences of any misunderstandings by an interpreter are potentially serious both for the person for whom the interpreting service is provided, and for anyone else involved. It is therefore important to retain the services of professional interpreters, preferably from Norsk tolketjeneste. Family members or friends must not be used as interpreters. Although the website of the Norwegian National Register of Interpreters recommends that telephone interpreting be restricted to brief conversations, the PMV Centre for Health, Dialogue and Development has observed that increased use of telephone interpreting services would be a good supplement to the current arrangements. The reason for this is that, for certain patients, telephone interpreting may be reassuring in that it offers greater anonymity. Telephone interpreting demands a great deal from those who make use of this facility, but still remains a useful alternative.

In a treatment situation, the interpreter will have to be well versed in communicative and interpretative techniques, as well as ethical and interpersonal aspects. At times, the topics may be difficult because they concern taboos in the culture concerned, or the interpreter may come across unfamiliar words for health, body or disease. Some women from minority ethnic groups are only willing to receive assistance from female interpreters.

Service providers/practitioners require interpreting services in order to fulfil their duty to provide information and advice to patients, and will need to have received instruction in interpreter-assisted communication. Even at best, both the patient and care provider may find it alienating and disruptive to have a third party present in the treatment situation.

It may also be difficult for the health service to call in professional interpreters for the various languages at the right time.

Health personnel should use interpreters listed in the national register of interpreters at www.tolkeportalen.no. This provides a list of practising interpreters and their qualifications.

A lack of experience and limited access to interpreters may be among the reasons why practitioners report under-use of professional interpreting services.

The use of an interpreter in various treatment situations is an area in which knowledge is lacking. Although the majority of care providers will eventually encounter patients/users who are not proficient in Norwegian and who have a different cultural background from their own, only a minority have received special instruction or training in interpreter-assisted communication in therapy and treatment.

A survey of the use of interpreters in the Norwegian child welfare services also indicates under-use of professional interpreters (7). The survey reveals a great need for training in interpreter-assisted communication and improved routines for quality assuring interpreting services.

How to achieve equitable health care

There is widespread political consensus that user participation is desirable in the design of the health services (8). Within the health and social services, user participation is a statutory requirement. User participation empowers the user and is instrumental in raising the quality of the services. Public authorities generally, and the individual service provider/practitioner especially, depend on close and productive cooperation with users in order to provide satisfactory services. Through advice and systematic feedback from the users, the authorities will gain a better basis for improving, developing

and offering services in line with prevailing knowledge and expectations. It is important for user surveys to be designed to pick up on the viewpoints of patients of different ethnic origin.

The Health Authorities and Health Trusts Act stipulates that satisfactory schemes must be established for user participation at all levels of the specialist health services. Under the same Act, the regional health authorities are required to ensure that representatives of patients and next of kin are consulted in connection with the preparation of a programme of activities in the coming years.

User organisations for chronically ill people and people with disabilities have for a long time played a key role in developing the health sector and the welfare of individuals. The organisations have gained increased influence as public-sector partners, are represented on a number of public-sector committees and boards, and make regular contributions to health policy design. The established user organisations have few members of immigrant

origin, and participatory processes tend to less well supported by such members.

The organisations aim to reach out to groups and individuals of immigrant origin in order to provide information about rights, diagnoses and activities. Some of them are in the process of doing so – and this supplements the public information activities. The Norwegian Association of the Blind and Partially Sighted – NABP and the Norwegian Diabetes Association are among the organisations that have operated with a diversity strategy for many years. NAAF – Norwegian Asthma and Allergy Association has translated a great deal of information materials into relevant languages. The MHK mental health national resource centre has engaged actively in outreach to communities of immigrant origin. The Norwegian Cancer Society has a dedicated help line.

Centres for learning and mastering (CLM)

The learning model applied at the Norwegian centres for learning and mastering is based on the principle that planning, implementing and evaluation of learning schemes must take place in an equitable partnership between professionals and experienced users.

It is important that the centres are proactive towards immigrants in designing their services.

A centre for learning and mastery (CLM) has four main functions:

- meeting place and partnering workshop
- course provision for users (patients and relatives)
- competency building for health personnel
- information centre

The National Centre for Learning and Mastering at Aker University Hospital has established tailored learning and mastering programmes for speakers of minority lan-

Minorities counsellors

A number of municipalities and neighbourhoods with many immigrants have employed minorities counsellors to assist people with no command of Norwegian to find their way around in the various municipal services.

They provide advice, guidance and information in a number of languages.

www.bydel-stovner.oslo.kommune.no/minoritetsradgivere/article74558-28388.html

Refugee guides – voluntary sector

- The Norwegian Red Cross, in association with a number of municipalities, has established a voluntary refugee guide scheme.
- These are individuals tasked with providing information about Norwegian society, and who liaise with the local community to facilitate the integration process.
- Equally as important as passing on local and everyday knowledge is the company they provide. Going to a football match together may be integration at its best.

www.rodekors.no

guages. The CLM for children at Ullevål University Hospital has systematised experience in developing and establishing learning programmes within various diagnoses for families of ethnic origin. SINTEF Health Services Research evaluated family-oriented learning programmes for minority-language families, and one of its conclusions was that adapted provisions are needed for minority-language families with disabled children (9).

Active participation

Comprehensible information is a fundamental criterion for communication and equality in a coordinatory situation. This is a precondition for active participation, which in turn is a precondition for exerting influence.

In recent years, there has been growing awareness of this type of issue; often referred to as *empowerment* (10;11). In the context of health care, empowerment is the process of changing the power balance between user and service provider, patient and treating physician. The users are to be accorded the right to define and exert 'ownership' of their own problems, and engage actively in finding solutions to them.

Empowerment is thus an approach that breaks with traditional problem-solving in which the "expert" finds the solution to the "client's" problems. This way of thinking and working is particularly important when catering for user groups with a different basis of experience than that prevailing in the host country. Many immigrants have different perceptions of disease and treatment experiences than those that predominate in Western medicine. Listening to the patient does not mean letting the patient control the treatment, but ensuring that information is understood and that communication is based on reciprocity and equality.

Many people are now referring to user participation and empowerment as a civil right. The question is though, whether the precon-

Individual Plan

The Norwegian Directorate of Health's brochure on the *Individual Plan on rights and tools for interaction* is available in Arabic, Turkish, Urdu and Vietnamese.

The brochure, with order number IS-1292, is available to order from the Norwegian Directorate of Health publications office (Trykksakekspedisjonen): e-mail: trykksak@helsedir.no

ditions are in place to honour this right. The report entitled "Fra bruker til borger" (From User to Citizen) discusses this issue in the context of service provision to people with disabilities (12). The report makes the point that large sections of the population come up against barriers to their opportunities for active participation. Just as people with disabilities encounter barriers in society, a proportion of the immigrant population will likewise meet specific barriers. Although the vast majority of people of immigrant origin have a good command of Norwegian, and do not perceive the language as a major barrier, the language still presents an additional hurdle for many.

User participation and coordination in practice

Anyone who needs prolonged, coordinated services is entitled to what is known in Norway as an 'individual plan'. An individual plan is a tool to enable users to engage in their own situation. Based on the needs of the individual, the user and service provider jointly draw up a plan comprising suitable provisions from all relevant parts of the health service. The object is to ensure that the services provided are considered in their mutual contexts and coherently structured.

The user is to have the opportunity for real participation. One of the service pro-

viders must be appointed as the coordinator and has the main responsibility for the user/service recipient, and for ensuring that the person does not “fall between two stools”. The coordinator then oversees the inter-service planning processes. An individual is an example of user participation in practice for the individual. Professional competence and user competence are mutually complementary.

There is reason to believe that an individual plan will be of relevance to the proportion of users/patients who have not grown up in Norway and who require long-term and coordinated services. A coordinator will be able to provide the necessary assistance to identify the right “helpers” in a complex and – for many people – unfamiliar societal structure.

Mutual comprehension

Under the Patients’ Rights Act, everyone is entitled to information about their medical condition in order to allow them to engage personally in the treatment they are to receive. In this context, informed consent is a key concept in that it requires attainment of mutual comprehension between the patient and health professional, as regards both the nature of the disease and the treatment options.

Grounding, which is a well-established term in communication research, is one example of a technique employed in achieving productive dialogue. In this context, grounding refers to a process whereby the parties to a discourse arrive at mutual confirmation that they comprehend each other sufficiently well to be able to resolve/deal with the matter at issue (13;14).

This technique or process requires active listening, which is to say that the person for whom the message is intended, returns a specific response to confirm his or her comprehension or otherwise (nodding, “mmm” or “OK” are not sufficiently specific to guarantee that the recipient has genuinely understood the message). Grounding usually proceeds

smoothly and spontaneously in informal conversations between equals.

In the strongly asymmetrical patient-physician relationship, however, it cannot automatically be assumed that common ground will be found. At times, cultural factors will also come into the picture, such as for example the loss of face experienced in some cultures in displaying failure to comprehend. Health professionals therefore have to learn to assume responsibility not only for their own understanding of the patient’s perspective, but also for ensuring that the patient has genuinely comprehended what has been provided in the way of health information, proposed treatment etc. (13;14).

There is insufficient awareness of the significance of grounding or mutual comprehension in the health service and how to achieve it. Research is needed to demonstrate good practice in this area.

Supervision – an important tool in equitable service provision

Supervisory experience of issues concerning ethnic discrimination is as yet limited, but the supervisory function is an important measure in efforts to achieve equitable service provision.

In 2004, the county departments of the Norwegian Board of Health Supervision conducted a nationwide audit of municipal health services to asylum seekers and refugees. The Board examined whether the municipalities had measures in place to ensure that asylum seekers, refugees and members of family reunifications from countries with a high incidence of tuberculosis were screened for the disease in accordance with the tuberculosis control regulations. Checks were also made of whether all persons in the above-mentioned groups were given information about the Norwegian health service and the health care they required in terms of infectious disease, maternity care and mental health care.

The Board revealed that the tuberculosis screening was duly performed, but that the prescribed deadlines for when it was to be performed were not being met. The municipalities did not have the necessary oversight of newly arrived immigrants, who had settled in the municipality and who had relocated elsewhere.

The Board revealed that a quarter of the municipalities did not have a system to ensure that new arrivals received information about the health service, and that the municipalities were not aware of their responsibility to provide information or that it was unclear as to who in the health service had responsibility for providing the information.

The municipalities did little to address issues concerning infectious diseases other than tuberculosis. Pregnant asylum seekers, refugees and members of family reunifications were systematically offered maternity care. The Board indicated that while interpreters were used, only limited records of this were made in the patients' medical notes.

Pacesetters programme

The British health authorities are working systematically to promote equality and eliminate discrimination in the health service. Inequalities in health service provisions are linked especially to age, disability, race, gender, religion, sexual orientation and gender identity.

The Pacesetters programme addresses how to achieve more equitable treatment of patient groups. The programme focuses on the health service, both as an employer and as a provider of health care to the entire population.

The UK Pacesetter's programme is being evaluated by the Centre for Evidence Based Practice at Bergen University College.

For more information: www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Pacesettersprogramme/index.htm

Follow-up of persons with mental disorders among newly arrived migrants was assumed to have been conducted to the same extent as for the population generally. Following review of the Norwegian Board of Health Supervision's other audit findings over the last five years, just a single written inquiry was received as to whether a set of circumstances could be regarded as discriminatory.

Interaction with the Norwegian health service

Only half of the immigrants who took part in the health survey conducted in Oslo (see fact box p. 25) stated that they had at all times received the health care they had needed. The survey also showed that persons of non-Western origin were less satisfied with their GP than others were. This indicates that the current health services are not functioning equally well for everyone, and that more people would have had greater benefit from health care provisions if the services had been more extensively adapted to the diversity of the population. The problem is not limited to Norway. In the UK, the health authorities have launched a comprehensive Pacesetters programme, the aim of which is to reduce discrimination in the health services (see fact box).

Regular GP scheme

Primary health care is the cornerstone of the Norwegian health service, and for many people the most important point of contact between the individual user and the health service. Responsibility for sound information about disease prevention for patients, regardless of origin, rests largely with the primary health service, regular GPs, the Maternal and Child Health Centres and the Schools Health Service.

The regular GP is a key individual in health care services to the public. Trust, good communication and coordination between the

The Norwegian Medical Association has published a report entitled "Equitable health services?" which points to a number of challenges and initiatives for providing good health care to immigrants. (The Norwegian Medical Association, 2008)

regular GP and the patient are prerequisites for patient/doctor consultations.

All persons registered in the civil register as residing in a Norwegian municipality have the right to be listed with a regular GP. This also applies to asylum seekers. While rights at the regular GP are the same for everyone, certain special challenges exist for asylum seekers and immigrants. The GP may for example have no particular routine in place for booking an interpreter or lack skills in the use of an interpreter, and may underestimate the time it takes to communicate properly with patients who have no command of Norwegian/English, or who are unfamiliar with the Norwegian health service.

Maternal and Child Health Centres and the Schools Health Service

The Maternal and Child Health Centres and the Schools Health Service perform a key function in preventing physical and mental illness in children and adolescents. This combined service is a low-threshold provision designed to guarantee children and adolescents of equitable health services, irrespective of their parents' socioeconomic status and geographical place of residence. The service covers almost 100 percent of its target group, and has a unique opportunity for identifying those who may be in need of treatment. Disease prevention, early intervention and follow-up of children and adolescents are the primary tasks of the service.

The Maternal and Child Health Centres are in early contact with children and adolescents through regular health checks under a

fixed programme that also includes vaccinations. Home visits and regular follow-up of families provides a good basis for extensive registration, review, follow-up and, if needed, referral. The service operates in multidisciplinary teams and is thus instrumental in ensuring a high standard of quality in the treatment of patients with complex or special needs. Relevant partners include preschools, schools, regular GPs, the Educational and Psychological Counselling Service, the Child Welfare Service, refugee services consultants and the specialist health service.

At some Maternal and Child Health Centres, the tasks are distributed on the basis of the child's/adolescent's ethnicity, for example, by having a specific health visitor assigned to all refugees and newly arrived migrants, while others find other solutions for attending to their users.

A report on refugee mothers of infant children reveals that the mothers are, on the whole, satisfied with the services they receive at the Maternal and Child Health Centres; that they have confidence in the health visitor and find the advice she provides useful. Common to all the mothers is the fact that it matters to them that health personnel ask them about the lives they led before arriving in Norway (15).

Midwifery services

The midwife has a special responsibility in maternity care. For many women, their first encounter with the Norwegian health service will be in connection with pregnancy and

The Norwegian Directorate of Health has produced a guide to health service provisions for asylum seekers and refugees. The guide, with order number IS-1022, is available to order from The Norwegian Directorate of Health publications office (Trykksakekspedisjonen), e-mail: trykksak@helsedir.no

the birth of their child. This provides good opportunities for educational and informational activities towards women who have not previously been in direct contact with the health service. Although in principle all pregnant women have the same access to information about pregnancy and birth through books, brochures and the Internet, a midwife (assisted by an interpreter) may in some cases be the sole source of knowledge for individual women of immigrant origin.

Dental health care

The public-sector dental health care service is required to provide regular and pro-active services to selected groups, including children and adolescents. The county authority is also required to ensure that the dental health care service is to a reasonable degree within reach of all persons residing permanently or temporarily in the county.

Studies show that dental health in infants of non-Western background is poorer than for Norwegian peer groups (16–19). Among older children and adolescents, there is slightly less difference in dental health status among individuals of non-Western origin and the remaining section of the population (19). Differences in dental health would thus appear to even out somewhat with increasing age. Parents of non-Western origin in Norway are likely to need adapted information and other strategies for establishing good dietary and oral hygiene habits in their children (20;21).

Socioeconomic differences are in evidence in dental health just as they are in people's general health. Persons of lowest socioeconomic status have the poorest dental health of all groups in the population. Socioeconomic factors constitute a possible underlying cause of dental caries in immigrant children (20). A larger proportion of the non-Western population has lower socioeconomic status, and the barriers that stand in the way of

healthy habits would appear to be greater than in the population generally. In addition, cultural and linguistic obstacles may stand in the way of access to information and opportunities for a change in habits for the better.

Care services for elderly persons of immigrant origin

The population of Norway is aging, and the need for care services is set to increase in future. In 2008, 693,000 persons (14.6 percent) in the Norwegian population were aged over 65 years. Of these, just over 9,000 (3.4 per cent) were immigrants from Asia, Africa and Latin America. This is almost 5,000 more than ten years ago, and represents an increase of 109 percent (22).

Future users of care services will represent a greater cultural diversity, which requires individualised design and adaptation of the care services provided, based on the individual's origin and needs. This future trend must not be met by new forms of specialist, non-standard care services.

Both international and Norwegian research indicates that among immigrants from Asia, Africa and Latin America there is less use of the nursing and care services than among the majority population, and primarily demand for care-giver's pay and domiciliary nursing arrangements. Studies indicate that the local authorities are restrictive in authorising these care-giving arrangements. Many relatives undertake intensive care-giving in the home, and the elderly persons tend to be in very poor condition and in great need of help before the family finally accepts a place in a nursing home. Altered care-giving patterns among persons of ethnic origin mean that it cannot be assumed that care-giving will continue to be undertaken by the next of kin to the same extent. Figures from the latest population and household census indicate that only one in five elderly persons originally from Asia, Africa

or Latin America is living as a member of an extended family. In future, there are therefore likely to be many elderly immigrants without a care-giver in the household.

New and unfamiliar expectations regarding personal care/hygiene, rituals and norms may potentially pose a challenge for public-sector care services for the elderly. Issues surrounding individuals who are seriously ill and dying may also be important to be aware of. So far in Norway there are only few non-Western immigrants in Norwegian nursing homes. In Sweden, however, there are a number of examples of specially adapted residential and day-centre provisions. Care services in the future will need to be properly planned to take account of these changes. It is therefore essential to monitor trends and consider alternative provisions to specialist care based on the differing needs of user groups and in consultation with the immigrants' own organisations.

Services for persons of immigrant origin with dementia

There is reason to expect that elderly persons of immigrant origin who develop dementia in its various forms, represent a group that is set to increase substantially in size in the years to come.

Internationally, only few studies shed light on the circumstances of persons with dementia of minority ethnic origin and their families. Experiences of providing nursing and care services to the Sami population in Norway may, however, to some degree be transferable. In developing dementia, the person may lose his or her second language, and for Sami people and immigrants this may mean loss of the command of Norwegian and resulting communication problems. Experience gained from the Teaching Hospital in Karasjok indicates that the presence of personnel with a command of the language and insights into and understanding of the Sami culture

Resource centres for rare and little-known diagnoses and disabilities

There are 16 multidisciplinary resource centres for rare and little-known diagnoses and disabilities, which provide nationwide programmes for some 300 diagnoses. All the centres are affiliated with regional health authorities and supplement the ordinary cross-sectoral services.

The centres are there to assist in ensuring that people with rare conditions receive the same service and care provisions as other people, in close collaboration with other services. The majority of the centres have minority-language users.

A number of the resource centres have launched a project to develop/adapt provisions tailored to minority-language speakers.

The Norwegian Directorate of Health helpline 800 47 710 refers callers to the appropriate resource centre and provides other relevant information.

is decisive for the quality of service provision. Language and culture are two significant factors in planning and adapting the services.

Studies in Norway and Denmark have revealed that persons with dementia who are of minority ethnic origin are rarely registered (23). This increases the risk that sick elderly persons fail to receive the necessary health assistance or suitable care provision. Different cultural perspectives must be taken into account when dealing with attitudes to dementia. The word dementia does not exist in all languages, and may in itself be perceived as degrading and insulting. This makes diagnosis even more difficult and increases the risk of misinterpretation.

Knowledge and commitment from different cultural and health professions is essential. There is a need to find solutions to how, for

example, the health services can reach the public with information, and sound models for investigating and diagnosing disease. There is also a need for increased knowledge of how the service provisions should be organised.

People with special needs

Generally it can be a challenge for the health service to assist patients with pain that is difficult to localise or investigate. Language difficulties and differing explanatory models for disease and suffering may therefore compound the challenges of interaction between patient and service provider, because it takes time to achieve mutual comprehension/common ground for sound decisions and effective treatment.

People with disabilities

In the Norwegian context little research has been done on the everyday barriers faced by immigrants with disabilities, but the small body of research that is available indicates that immigrants come up against the same barriers as other people with disabilities. Equally, a number of other studies indicate that language and communication problems only add to the barriers in interaction with the public-sector services for people with disabilities. These then are essential factors to bear in mind in designing the services.

The Norwegian Directorate finds that

- the Norwegian health services must be adapted more extensively to cater for diversity and the entire population's right to equitable health care
- the health service must improve its response to the communication challenges that arise throughout the treatment process – for all users, but especially for persons of immigrant origin
- there is a need for more research in migration and health – especially in respect of how the health service is organised and functions in practice
- measures must be implemented to achieve user participation in the planning of service provision and in interactions with individual users

4 Mental health

Factors before, during and after migration are known to affect mental health. Circumstances associated with limitations in the migrant's network, employability and financial means in the new country are determinants of good health and successful integration.



In this chapter we discuss a number of special challenges concerning mental health among immigrants. Following a general introduction, the chapter deals more specifically with mental health among asylum seekers and refugees.

Refugees make up a quarter of the immigrant population in Norway, and as a group are at increased risk of developing health complaints, a fact which must be considered in the context of the circumstances before, during and after fleeing their country of origin (1;2). For other immigrants, Norwegian studies have found a substantially increased incidence of mental health problems in non-Western immigrants, while the increase was smaller for immigrants from countries in the West (3–5). When mental health was measured using a checklist on anxiety and depression (HSCL-10), the distribution of persons afflicted by mental distress was as follows:

Norwegian-born: **10 percent.**
Immigrants from Western countries: **14 percent.**
Immigrants from non-Western countries: **24 percent.**
Refugees: **31 percent.**

Fleeing from one's home country is a gruelling process. The continuity and security of life falls away, family ties and social networks are fragmented and there is the constant uncertainty of what the future will bring. Adaptability is put to the test. Often, before life as a refugee, the person will also have been subjected to traumatic factors that affect his or her state of mental health and ability to cope with life in exile (6). Access to health services while fleeing will in most cases be lacking, and long-term stays in refugee camps are characterised by uncertainty and passivity. A long waiting time in the receiving country in temporary circumstances and uncertainty as to whether one will be permitted to stay there are further risk

factors for developing mental health problems.

A Norwegian study (5) found that while experience of war, imprisonment and torture were contributory factors in the higher incidence of mental health problems among non-Western immigrants (who were generally not refugees), circumstances post-arrival in Norway appeared to be more significant. If we look at immigrants as a single group, we find that circumstances of employment and personal finances appear to be especially important, and the higher incidence of mental distress among the non-Western immigrants as compared with Norwegians should be correlated with the fact they had a greater tendency to be unemployed and living on a low income (5). Other studies (3;4;7;8), however, have shown that psychosocial factors are at least as significant. Poor social support, conflicts in their social network, feelings of powerlessness in relation to their own life situation, a lack of social integration and perceived discrimination are important causal factors in accounting for the increased incidence of mental health problems among non-Western immigrants.

Meeting the many and complex psychosocial and health care needs of people who have migrated, often for reasons linked to poverty, persecution and conflict, represents a significant challenge for the health service and society generally, perhaps especially as regards mental health. Efforts to improve preventive measures at all levels should be a priority area.

Norway as a receiving country – a historical perspective

Norway's history as a receiving country of immigrants/refugees is relatively short in modern times, in terms both of labour migration and receipt of refugees. Around the time of the 1st World War, a small number of immigrants arrived, most of them from Sweden, and during the inter-war years, the number of refugees immigrating from Central

Europe was modest. In 1920, foreigners made up 2.3 per cent of the Norwegian population (9), a level which remained stable until 1985. Up until the 1960s, the still-limited labour immigration came mainly from Central Europe. By the mid-1960s, this trend gave way to increased immigration from Pakistan, Turkey and Morocco. In the mid-1970s, a freeze was placed on the immigration of unskilled labour.

Statistics on refugees and asylum seekers

In 2008, 14,431 asylum seekers arrived in Norway. This is more than twice as many as in 2007 (6,528). The increase was especially marked in the group of unaccompanied asylum-seeking minors: 240 percent. Almost 1,400 of persons seeking asylum stated that they were under 18 years of age, and of these, 80 percent were boys. The majority of unaccompanied asylum-seeking minors came from Afghanistan, Iraq and Somalia (Figure 4.1). Almost 7,000 persons (48 percent) were in the age-group 18-29 years. Men made up 73 percent of the total number of asylum seekers. In 2008, the majority (74 percent) of asylum seekers were from Iraq, Eritrea, Afghanistan and Somalia (Figure 4.2).

As for the number of cases concerning family reunification, the figure was 20,766 in 2008, against 17,921 in the previous year. The largest increase was in the groups of stateless persons (148 percent), Iraq (47 percent) and Poland (33 percent), followed by Somalia (19

percent). It is not currently possible to differentiate between families of refugee origin who are reunited with family members after many years' separation due to imprisonment and acts of war, and other types of family reunification.

Places at reception centres

The Norwegian Directorate of Immigration (UDI) estimates that many asylum seekers will arrive in Norway in 2009. In response to this situation, UDI has therefore announced that 2,000 new places will be made available at the Norwegian reception centres and estimates that the number of places required at reception places will run to approx. 2,000-2,500 within the next few months.

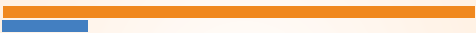





There are currently 106 reception centres in Norway, with a total of 16,315 places distributed across 94 municipalities (see Figure 4.3). 43 of these were established in 2008. At year-end 2008, 13,582 persons were staying at reception centres (4,204 women and 9,378 men).

Mental health

Great variation exists among refugees, asylum seekers and members of family reunifications in terms of level of education, language skills and state of health. Of the some 125,000 persons who originally came to Norway as refugees and who are now resident in the country, many are struggling with the after-effects of war, persecution and fleeing.

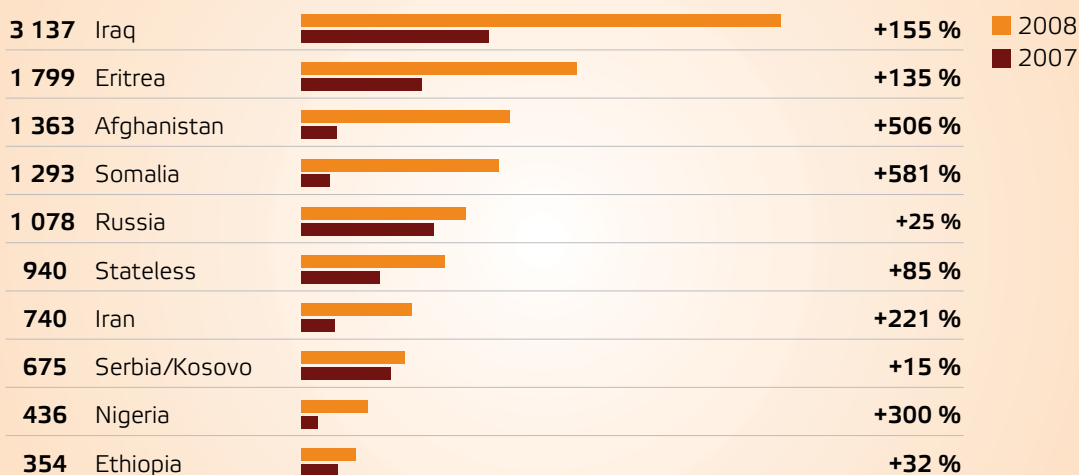
In some groups it is assumed that more than

Figure 4.1 Number of unaccompanied asylum-seeking minors in 2008, including increase over 2007.

475	Afghanistan		+455 %	
314	Iraq		+153 %	
109	Somalia		+276 %	
64	Eritrea		+73 %	
56	Sri Lanka		+65 %	

Source: Norwegian Directorate of Immigration, 2008

Figure 4.2 Number of asylum applications, 2008, including increase over 2007, by nationality



Source: Norwegian Directorate of Immigration, 2008

half of those who apply for residence in Norway, have post-traumatic stress conditions of a nature that normally requires treatment (10). The stressful events they were exposed to prior to gaining asylum in Norway are compounded by the adverse effects of extended stays at reception centres and the difficulties of life in exile. Several studies also identify a number of circumstances of the application process itself as being especially stressful.

In other words, the mental distress and mental disorders seen in asylum seekers and refugees are to a great extent associated with the diverse mental stress factors they were exposed to in their home country (as a result of persecution, war, personal loss and threats), stress factors and assaults while fleeing and the various potential adversities of life in exile (11).

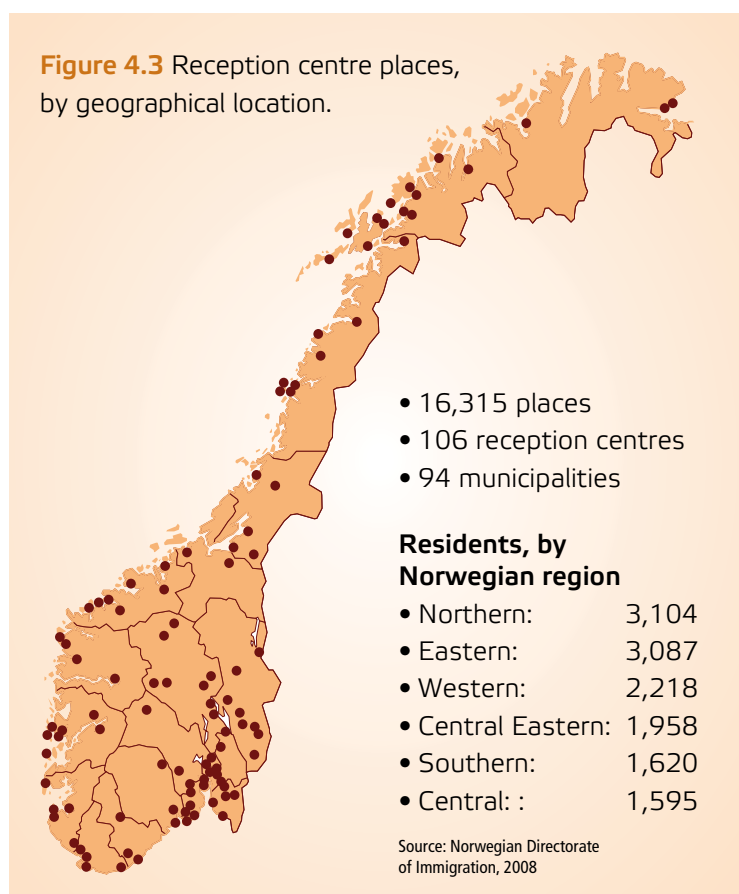
The most frequent diagnoses made in refugees as a distinct group (12) are post traumatic stress disorder (PTSD), depressive disorders, anxiety disorders, somatic disorders, brief reactive psychoses and adjustment disorders (13).


Silove (14) demonstrates in a meta-analysis that the incidence of PTSD among refugees and people from formerly conflict-ridden regions is relatively high, varying between 15 and 47 percent, against an estimated 1.3

and 8 percent in the rest of the population in Australia and the USA.

When individuals are subjected to extreme stress or perceive their life to be at risk, the body reacts with a set of psychological and physiological stress responses. These will usually involve sleep disturbances, hyperactivation, hypervigilance, excessive agitation, that is,

Figure 4.3 Reception centre places, by geographical location.





advantageous reactions in an acute risk situation. If the stresses are short-lived and the person is able to revert to normal circumstances and resume relationships with friends and family, the reactions will often disappear of their own accord. Many refugees, however, have been subjected to repeated traumatising stresses over time in surroundings that were either dangerous or hostile (prison, torture, war) and where many have suffered severe personal losses (loss of loved ones, loss of community, loss of health and more). Such persons will be at risk for complicated sequelae. A significant proportion will continue to be afflicted long after the threat situation has passed and the person is restored to safety. Persistent sleep disturbance, flashbacks, intrusive memories, persistent agitation, depressed mood and increased anxiety, problems controlling aggression and repeated nightmares are among the symptoms that characterise a post traumatic stress disorder (PTSD) (15). PTSD tends to be only part of the picture, however. In addition, many will suffer from chronic depression, severe pain states, dissociative states, changes in personality functioning and the ability to relate to others, and a minority may develop severe personality disorders (post-disaster personality disorder).

Studies have shown that the best outcomes are seen in those who are able to preserve their own cultural background, while possessing the resources for acculturation in their new country of residence (16).

Especially vulnerable groups: child refugees

Children make up a quarter of all asylum seekers, and should be given special consideration. In children, the emotional reaction to traumatic events will often be greater and more intense than the parents can conceive of. Reactions in children include separation anxiety, delayed development and behavioural disorders. Certain neurophysiological changes in response

to traumatic stressors have also been demonstrated. The vulnerability of children increases further if their care-givers have been exposed to stresses that have impaired their care-giving capacity, and as a result of the uncertainty the family lives with during the migration process. Any trauma suffered by the parents themselves will affect their capacity to provide reassurance to their children. Parental care-giving ability is put to the test in a demanding life situation, which often extends over time.

Studies of unaccompanied asylum-seeking minors (UAM group) reveal that depression and behavioural problems are the most commonly occurring mental problems, and around 50 percent of respondents indicate such a high level of symptoms that they can be assumed to affect everyday activities (17). Again, like the self-reported mental problems of the immigrant group generally, gender disparities are also in evidence – the girls report having the highest incidence of depressive symptoms.

Access to and use of health services at reception centres

In a survey from 2004 it emerges that every reception centre in Norway has had residents who received mental health care. At the same time, almost half of the reception centres indicate that they have residents with an unmet need for treatment. The mental health care provisions as a whole are rated as “good” or “middling” by 84 per cent of the reception centres, while 17 percent rate the provisions as “poor” (18).

Competency building in refugee health care has been a priority theme in Norway’s Escalation Plan for Psychiatric Health 1998–2008. New national and regional resource centres for overseeing the area of violence and traumatic stress have been established with direct relevance for health personnel in the municipal and specialist health services and for personnel at reception centres. The national Norwegian Resource

Centre for Violence and Stress Studies (NKVTS) was established in 2004 with the subsequent establishment of five Regional Resource Centres for Violence, Traumatic Stress and Suicide (RVTS). The resource centres have dedicated professional teams for refugee health, and offer instruction of reception centre staff together with thematic competency building for the various municipal bodies and the specialist health service.

Mental health screening in the various phases of the process

The first mental health screening takes place during the transit phase. The Directorate of Health recommends that in this phase the emphasis be placed on assisting people in obvious mental distress and in immediate need of help. Persons who need close follow-up must be guaranteed transfer to a reception centre with such provisions.

In line with their needs and with current regulations, asylum seekers and refugees must be offered maternity care, and the services of the Maternal and Child Health Centres and the Schools Health Service. The state of health of pregnant women, children and adolescents who have lived in poor conditions prior to arrival in Norway must be monitored closely. Contact with the Maternal and Child Health Centres provides an opportunity for ensuring that families with psychosocial problems are offered appropriate support and counselling. In this context, networking activities may be especially useful. Where a coordinated intervention from multiple actors is required, the collaboration should be organised by a single body. The collaboration may include the GP, mental health units, social services, the school, pre-school, Educational and Psychological Counselling Service (PPT) and refugee services adviser.

It is the responsibility of the local authorities to ensure that health data from the transit centre to the local authority are received and acted on by health personnel, and that

systems are established within the local authority for providing information to refugees and asylum seekers, as soon as possible after settlement, about the health services. It is also the responsibility of the local authorities to ensure that asylum seekers with severe mental problems receive essential health care and to ensure the necessary coordination and competency building of health personnel. All employees within the Norwegian health service should be informed of the health rights status of asylum seekers and refugees. There are, however, problems entailed by coordination of the provisions, and many GPs feel under-qualified to deal with the problems of these patients and find it difficult to obtain the assistance of the mental health care services. This then raises issues concerning both the expertise and framework conditions for treatment and rehabilitation (19).

The Norwegian Directorate finds that

- mental health screening should be carried out in different phases of the asylum-seeking process
- every effort must be made to reduce the time taken to process asylum applications in order to reduce the strain on mental health caused by uncertainty concerning residency status. Language training must be provided, together with other meaningful everyday activities.
- local and regional health authorities should allocate specialist health personnel resources specifically to work with asylum seekers and refugees.
- staff at reception centres, together with the police and health service should be guaranteed training in mental health care in order to be able to identify health concerns, including assessment of the risk of potentially violent behaviour
- The individual plan (IP) scheme should be offered to asylum seekers with a need for coordinated and long-term services from several bodies.
- it is vital for unaccompanied asylum-seeking minors and children who live with their parents at reception centres that they are assured of essential assistance in joint interventions between the child welfare services, school and municipal health service and specialist health service as required.
- asylum seekers at reception centres and refugees must receive instruction on their rights and obligations in Norway

5 Paperless immigrants – and human rights

Estimates put the number of undocumented, illegal, irregular or paperless immigrants in Europe at between 5 and 8 million. Norway is thought to have some 18,000 paperless immigrants. These are individuals who are often not visible to the authorities. Because of this, they scarcely receive the help they have a right to in accordance with the human rights the countries have pledged to respect – including the right to health care.



In this chapter we turn our attention to paperless immigrants in Norway and indicate the need to clarify their right to health care. To illustrate the situation faced by paperless immigrants, the chapter contains a report based on interviews with 30-40 such immigrants in Norway.

A paperless immigrant is a person who has no legal right of residence in a country and who is barely visible to the authorities. Consequently, such persons receive less than the minimum help they have a right to in accordance with the human rights the countries have pledged to respect. Many of paperless immigrants suffer, many are exploited, the risk of the spread of communicable diseases increases, and emer-

gency medical care tends to be more costly than early intervention. In Norway, no special measures are in place to look after the health needs of paperless immigrants, and they may not be aware of their rights and have difficulty understanding the Norwegian health service.

Estimates put the number of undocumented, illegal, irregular or paperless immigrants in Europe at between 5 and 8 million (1). The term “paperless immigrants” is the one employed in this report. As a group, paperless immigrants in Norway comprise persons who stay longer than the three months permitted for citizens of EU countries; some perform undeclared work; and may be persons whose application for asylum has been rejected or who are the victims of human trafficking.

About the author of the article on which this chapter is based: Per Kristian Aale is a journalist who works for the newspaper *Aftenposten*. In autumn 2007, in collaboration with his colleagues Olga Stokke and Reidun J. Samuelsen, Aale wrote a large series of newspaper articles on paperless immigrants in Norway. For this series of articles, the three reporters received the Norwegian Government’s human rights award for journalists 2008 and the Brostein Award 2008 from the Church City Mission.

A life lived in constant fear

Av Per Kristian Aale

Illegal immigrants are everywhere. They deliver the paper to your doormat in the morning, clean your house and carry your furniture when you move. Paperless immigrants suffer from poor health and mental distress, but are rarely in contact with the health service.

“Mahmoud” (9 years old) is lying on the worn settee in a small room he and his mother “Leyla” have been given the use of. The curtains are drawn tight. Three years ago, Mahmoud and Leyla finally had their application for asylum rejected. At that point, mother and son from the Middle East go underground, moving from one place to the next in a town in Southern Norway. The mother sleeps on a mattress on the floor, her son on the settee.

Mahmoud cries: “Mummy, I’ve got really bad earache”. Leyla doesn’t know what to do. She feels to blame.

She daren’t take him to a doctor. In her desperation, she phones a friend who knows a doctor. The doctor arranges it so that Leyla can pick up antibiotics from a dispensing chemist. But this means she has to leave the house – a rare event.

Under cover of darkness, Leyla looks around each street corner before venturing out. As soon as the coast is clear, she runs off down the street, but freezes with fear when blaring sirens break the silence. A police car comes rushing towards her. She forces herself to walk normally, but her heart is pounding so loudly she feels that anyone passing might hear it. Her palms are damp; she is shaking all over.

A large series of reports

In autumn 2007, the newspaper *Aftenposten* published a series of reports on the living conditions of paperless immigrants in Norway. The paper interviewed many

researchers, organisations, government agencies, the police and between 30 and 40 paperless immigrants living in different parts of Norway to survey the living conditions of illegal immigrants.

More stringent asylum policy and more effective control measures mean that more such immigrants go into hiding, and the cultural diversity of Norway today makes it easier to hide. Just a decade ago in Norway, any foreigner would have been immediately noticeable in a small village, but today there are people from all over the world living all over the country. Very few paperless immigrants would get by without a network of helpers – the people who hide them. These are often other immigrants, but also Norwegians.

Foreign citizens whose application for asylum is rejected are required to leave the country. Those who do not do so voluntarily are transported out of the country by the police. And yet, there are many thousands of paperless immigrants in Norway. The latest estimates from Statistics Norway put the number at between 10,000 and 30,000, and although the figures are subject to great uncertainty, a realistic figure is probably around 18,000 (2).

Poor mental health

After a course of antibiotics, Mahmoud soon recovers, but his state of mental health is becoming more of a problem.

For almost two years, this young boy is isolated from the outside world, with no schooling or playmates. Leyla tries to get him enrolled at several schools, but is turned away because they have no residence permit.

While other children are at school, he watches TV all day long in the small room. He can't play outside because someone might notice him. Indoors he has to keep quiet so as not to disturb the neighbours. He has crying fits several times a day and is increasingly confrontational.

Inhuman pressure

Researchers and networks of people surrounding paperless immigrants recount that these people are subject to inhuman pressure. They can rarely relax because they are always afraid of getting caught.

Many children live in hiding, which is potentially damaging for them. Some of them are infants, others are of pre-school age. Yet others are of school age, but do not attend school. Often, they have no friends, and rarely play outside.

"The future is on hold. New stress factors aggravate frayed nerves in both adults and children when families move from one place to the next out of fear of being discovered," explains one Norwegian woman who has been helping paperless immigrants for many years.

Children have their own rights through the UN convention on the rights of the child – rights which have been enacted in Norwegian law. Among other things, the Norwegian education act stipulates that all children residing in Norway for more than three months have a right to attend school. Yet many children of school age are kept at home because the families are afraid that their circumstances will be revealed. In other instances, they are rejected, as in the case of Mahmoud. After a couple of years, there is a school that takes him on.

Born into a life in hiding

She feels the warm waters running down her thighs and calves. Beneath the big belly, a puddle is forming on the floor. Her waters have broken. Is the baby coming now, a month early? Pregnant with her first child. After seven years living underground in Norway she now has to come up to the surface to give birth to her longed-for child. Jyoti, a woman in her mid-30s, fled to Norway ten years ago. Her husband, Sures, whom she met at a refugee centre, came a year after her.

Jyoti receives help. Last autumn, a month before the due date, the baby is delivered by professional midwives in the birthing suite of a public hospital somewhere in Norway. The baby receives checkups from the local Maternal and Child Health Clinic. Everyone accepts the explanation that they are asylum seekers awaiting a decision on their application. No-one discovers that the address they have given is borrowed. No-one asks any awkward questions.

The baby girl lights up their lives. But she herself has hardly seen daylight. The baby is born into a

basement life of concealment, suppression, fear and secrecy. The mother's gaze switches from bright happiness to dull defeat. Brick walls, tiled floors with visible heating cables, the musty smell of mothballs.

This basement in a village in Norway is 'home' to the mother, father and infant. Striplighting high on the wall lights up a poky interior containing a kitchen unit at one end of the passage, a bathroom with a shower, a living room with a TV and grey velour settee. Behind a curtain in the living room, the double bed is squashed close to a child's cot wedged against a home altar of religious icons.

Emergency health care

Although paperless immigrants are illegal residents in Norway, they still have the right to emergency health care. Yet only few such immigrants seek help from the Norwegian health service because they are afraid of being reported to the authorities, or because they cannot afford the cost of treatment. Illegal immigrants refrain from seeking help from the health service even when they are in real need of medical care.

"In effect, they have limited rights to medical care," says Arild Aambø, a medical doctor and assistance manager of the Norwegian Centre for Minority Health Research (NAKMI).

The Government does not reimburse any expenses incurred by health personnel in attending to and treating immigrants with no registered name and number. According to the law, this means that the bill has to be footed by the patient, but it is impossible for the majority of illegal immigrants to cover such costs.

"This is a dilemma for the health service. Doctors have the right to provide medical care, but who foots the bill?" Aambø asks.

When people are in real need, or require emergency care there is no discussion: they get what they need. But where is the limit?

The big, black hole

Several of the doctors we talk to who work at major hospitals tell us that they treat paperless immigrants regardless. The bill disappears into "the black hole", as they put it. This is a bigger problem for the general

practitioners, who do not have the vast budgets of the hospitals.

Some paperless immigrants get around the problem by borrowing friends' identities. They pretend to be someone else when they see a doctor. That way, they receive treatment and medication.

In other cases, medical care is arranged by the people who hide them by getting their own dentist or doctor to see them.

Illegal immigrants who have communicable diseases go untreated because they are afraid to seek help from the health service.

Illegal immigrants usually fall outside of the health service, says Sofia Olausson, a Swedish doctor who has worked with paperless immigrants for many years.

"If they have communicable diseases – like tuberculosis – there is a risk to public health if they go untreated," she says.

HIV-infected and in hiding

We are in contact with paperless immigrants who are living in hiding and who are HIV-positive, and the Church City Mission confirms that a number of people with HIV are living underground, including a number of prostitutes who work on the streets. The voluntary and independent organisation set up to help immigrants and refugees, Selvhjelp for innvandrere og flyktninger (SEIF), comes into contact with people who have communicable or chronic diseases, but who are afraid to seek medical help.

The county medical officer of Vest-Agder, Kristian Hagestad, has been involved for many years in dealing with the problem of the health of paperless immigrants.

"In the interests of the individuals themselves and public health at large, it is important that they receive essential health care. The problem is that many of them are afraid, and do not dare to approach the health service even when they ought to for their own sake and that of society generally – especially when it comes to communicable diseases," asserts Hagestad.

Rwanda, April 1994

Shrill whistles hit the air like the lash of a whip. The Hutu militia arrive marching and dancing. Some bear

military uniforms, others are in civvies. Some of them have tied white cloth strips around their heads.

'Come out cockroaches, come out cockroaches', they screech as they ransack a house to find a Tutsi family they are hunting down on the outskirts of Kigali, the capital of Rwanda.

Soon after, they drag out a father, a highly pregnant mother, two brothers of 11 and 9 and a 5-year-old sister. "Moises" (9) is crouched down in the bushes a little way off. The rain is trickling down his face, and he feels the mud soaking into his clothes. But he can't take his eyes away from what is happening. One of the boys is his classmate.

A Norwegian city, autumn 2007

Moises wakes up with a gasp. The duvet is soaked in sweat. The dramatic images from April 1994 are etched in his memory. They come back to him over and over again – at night, at work, while studying for his exams. Often he can't sleep. He freezes up in terror, without realising why. At the sound of whistles he feels sick.

Six years ago, this young Tutsi boy applied for asylum in Norway, but three years ago his application was finally rejected. Since then he has been illegally resident in the country. Moises suffers from anxiety attacks and nightmares since he was an eyewitness to the genocide in Rwanda in 1994 when he was a young boy. Within 100 days, just under a million Tutsis and moderate Hutus were slaughtered.

A number of those living in hiding in Norway are asylum seekers whose application for asylum has been rejected. Many of them come from war-torn countries and have come to Norway burdened by extremely traumatic experiences.

A report from the Norwegian Resource Centre for Violence and Stress Studies (NKVTS) documents that newly arrived asylum seekers are struggling to cope with severe trauma and mental problems (3). 22 per cent are rape victims, 64 percent have experienced famine, 77 percent have been on the point of being killed, and 64 percent have been tortured. 59 percent report symptoms of severe anxiety, 46 percent symptoms of depression, while a third appear to be suffering from post-traumatic stress disorder.

Rwanda, April 1994

We talked to former asylum seekers who are living in hiding after their application for asylum was rejected. They are struggling with mental problems that go unchecked.

"This life situation can only be extremely stressful and puts a strain on human coping mechanisms. Paperless immigrants are in a terribly difficult situation, and that makes our society less stable," says Marianne Jakobsen, a psychiatrist with NKVTS.

Jakobsen and her colleagues have not done any research on people living in hiding, but she comments that their mental state can only be aggravated by going underground.

"We don't know much about them. But the added stress of living in hiding – with no certainties of a permanent home or employment, and the constant fear of police arrest – compounds the symptoms of their conditions. It is alarming to have a 'sub-group' of people like this in our society," says Jakobsen.

Rwanda, april 1994

"Let's see what this Tutsi child in her belly looks like", screams a militia leader, pointing at the belly of the pregnant woman.

Moises catches his breath and swallows hard as he tells his story. Often he falls silent. Words fail him.

"Rwanda is not a country I want to live and raise my children in," he whispers.

Many paperless immigrants we talk to recount traumatic experiences from their homeland. They have applied for asylum and received minimal professional care while their application was processed. After they went underground – after finally being rejected – they receive no psychological follow-up at all.

We talk to people who have lived in hiding in Norway for several years, but who have then been granted residence. Yet these people are still struggling. They are clearly affected by the time they spent living underground. Living in hiding marks them forever.

The right to health care is indisputable

Under the Human Rights Declaration of 1948, the right to health is a human right: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care... (4). But this section of the Declaration is not itemised, not quantified and proves difficult to enforce. The same applies to the rights under the International Covenant on Economic, Social and Cultural Rights, ICESCR, which in 2005 was ratified by virtually all European states (5). This recognises the fundamental right of everyone to the highest attainable standard of physical and mental health (5, Article 12).

The right to health care is indisputable. It also transcends the concept of essential health care, as it is used in the Norwegian Municipal Health Service Act. Many countries in Europe have taken steps to make their health services available to paperless immigrants, but the measures implemented have differed a great deal.

On the one hand, there is Germany, which officially requires health personnel contacted by such patients to report them to the police. On the other hand, there are Switzerland, the Netherlands and Portugal, which provide comprehensive health care to paperless immigrants. Other countries, between these extremes, have different types of provisions through voluntary organisations.

In recent years, a number of intergovernmental organisations have become involved in the problems surrounding migration and health. In autumn 2007, the EU, under the Portuguese Presidency, placed migration and health on the agenda. However, "Health and Migration in the EU: Better health for all in an inclusive society" (6) makes no explicit reference to paperless immigrants. The WHO resolution under the World Health

Assembly in spring 2008 did not address the challenge either. However, the Council of Europe's follow-up to the Portuguese initiative readdressed the problems in Bratislava in November 2007. "On health, human rights and migration" advocates the removal of barriers to health for all persons who are "on the move" including "emergency health care" for irregular migrants (7). The Council of Europe has subsequently appointed a committee of experts to examine mobility, migration and access to health care, with a mandate running until June 2010.

In 2009, the EU Fundamental Rights Agency (FRA) resolved to undertake a comprehensive survey of the rights of paperless immigrants in respect of education, health, housing and employment. The International Federation of Red Cross and Red Crescent

The Netherlands

Paperless patients are to be provided with "responsible and appropriate" medical care. The definition as to what constitutes appropriate medical care rests with the doctor. The patients are required to pay for the cost of treatment. If they are unable to pay, the care provider is entitled to claim an 80% reimbursement from a special fund established by the authorities. If the remaining 20% is substantial, in the case of expensive treatment, the institution absorbs the costs. Paperless immigrants cannot take out insurance. Patients are not reported to the authorities.

Portugal

Everyone has the right to essential health care. Paperless immigrants must pay their own way, with two exceptions, one of which is for communicable diseases. A medical panel determines which communicable diseases are subject to exemption. Both AIDS and resistant tuberculosis fall within the exempted diseases. The other exception is for paperless immigrants who are unable to pay. For such individuals, a commissioner on immigrants will determine whether the public sector is to carry the costs.

Switzerland

In Switzerland, there are between 80,000 and 300,000 paperless immigrants (*sans-papiers*). They have the right to health care in emergencies, and in certain cantons, there is no emergency requirement. The treatment must be covered by medical insurance.

All persons in Switzerland are required to have medical insurance, and the insurance companies are under obligation to insure anyone who applies to them for cover, irrespective of state of health. Immigrants are required to take out insurance within three months of entering the country. Employers are required to insure all their employees, including those who are illegal residents.

However, eighty to ninety percent of paperless immigrants in Switzerland have no insurance cover. They are not aware of their options, are not familiar with the system or are afraid of being reported. However, within the health service, disclosure of personal data is explicitly prohibited.

Paperless immigrants with no medical insurance still receive essential medical care. The costs are either covered by the social services, the employer, the health institution, by the patients themselves or by a system of retroactive insurance, subject to certain provisos.

Societies (IFRC), Médecins du Monde and PICUM (Platform for International Cooperation on Undocumented Migrants) have also become heavily involved. "Health Care in NowHereland" a project under the EU, and the information network site MIGHEALTHNET (8) offer information on the concerns at issue. The last-mentioned network has a Norwegian site providing comprehensive information about migration and health.

In Norway too, interest in paperless immigrants is growing. Doctors and other health professionals often provide voluntary medical care in cases where the patients are unable to pay their own way.

The right to basic health care

In 2008, the Norwegian Medical Association published a report on equitable health care for non-Western immigrants (9) to address health care for paperless immigrants and to

set out the legal and other barriers preventing access to the Norwegian health service. The Norwegian Medical Association asserts that the authorities must ensure that persons without legal residence can have their need for essential health care covered, i.e. over and above emergency medical care.

The Norwegian Official Report 2008:14 on how coherent Norwegian policies can assist development in poor countries deals with migration and calls for a more pro-active position to improve conditions for paperless immigrants in Norway and internationally (10). One of the measures proposed in the report is to grant such persons the right to basic health care over and above emergency treatment.

Costs are prohibitive

All tourists, business persons and paperless immigrants have access to receive Norwegian medical care if they pay for it. But for paperless immigrants, the costs will be prohibitive. There are also other barriers besides lack of money, including attitudes among health personnel, fear of being reported and lack of understanding of how the health service works.

There are those who claim that schemes that provide paperless immigrants with access to health care act as a *pull factor*. In other words, that access to treatment from the Norwegian health service will directly attract migrants from poor countries. However, there is little reason to believe that this is actually the case.

Norway

Anyone resident in Norway, legally or illegally, has the right to essential health care from the municipal health service. Such health care must be provided on condition that it is “urgently necessary”. The question is, however, where the threshold in the right to essential health care within the municipal health service lies. This is especially relevant in cases of comprehensive long-term courses of treatment, rehabilitation, etc. Adults over the age of 18 residing illegally in Norway are generally not entitled to medical care from the specialist health service other than immediate treatment. Under the Convention on the Rights of the Child, pregnant women are entitled to medical care from the specialist health service before and after the birth of the child. Under the same Convention, children under the age of 18 have the same right to health care as anyone else even if they are not legally resident. Persons without legal residence are entitled to be informed of what health care they have a right to, and where they may receive it.

Everyone has the right to preventive treatment against communicable disease in accordance with Section 6-1 of the Act relating to control of

communicable diseases. Medical care to prevent infection from communicable diseases presenting a public health risk is free for all persons residing in Norway even if they are not legally resident. Persons who are not legally resident are not entitled to be registered with a regular GP. The right to receive health care must be kept separate from payment to obtain that health care. The duty of professional secrecy will as a rule prevent any information from being passed on to the police without the patient’s consent.

A bill to amend the Norwegian General Civil Penal Code (Ot.prop.nr. 22 (2008–2009)) recommends that: “a new fifth article in Section 108 is to read: Any individual providing humanitarian assistance to a foreigner residing illegally in the country shall not be punishable by law for aiding and abetting illegal residence unless: a. The individual intended to assist the foreigner in evading a compulsory order to leave the country and b. The assistance rendered has obstructed the authorities’ means of achieving the expulsion of the foreigner.”

Source: www.helsedirektoratet.no

The Norwegian Directorate of Health finds that

- paperless immigrants must also be accorded the explicit right to preventive and curative health care within the primary health service
- for at-risk groups such as children, people with disabilities, pregnant women and elderly people, the provisions must be commensurate with those for the wider population.
- information systems should be established to contribute to ensuring that illegal immigrants are also informed of their rights to health care, and that contact with the health service is comprised by the duty of confidentiality of the health service. Information must not be passed on to the police or other authorities.
- schemes must be devised for financing health care for paperless immigrants who have no financial means.
- a committee should be established of representatives of the immigrant, integration and inclusion authorities, jointly with the health authorities, in order to clarify responsibilities and delineate explicitly the rights and obligations entailed by paperless immigrants’ right to health care.
- the services should comprise both preventive and curative services, within the municipal health service and specialist health service.

6 Labour immigrants

Labour immigration has existed for as long as people have had prospects for work and opportunities for a better life elsewhere. Since the EU expansion eastwards in 2004, labour immigration to Norway has risen strongly. Immigration has provided Norway with the labour it needs, but has also created some challenges for the health service, especially in terms of service information, organisation and upscaling.



This chapter discusses the challenges and consequences that increased labour immigration ensuing from the EU/EEA enlargements in 2004 and 2007 have for the Norwegian health service. By way of introduction, the chapter offers an insight into labour immigration to Norway over time. There then follows a description of current labour immigrants and challenges relating to their needs for health care.

Labour immigration to Norway

1950 – The Nordic Region

Historically, labour immigration to Norway has been economically motivated. The number of labour immigrants has varied in line with differences in economic cycles between Norway and the countries the workers have come from (1). In the 1950s, labour immigration to Norway consisted primarily of Swedes, Danes and Finns, in part as a result of the founding of the Common Nordic Labour Market in 1954, which gave inhabitants the freedom to work and settle within the Nordic Region.

1965 – Asia

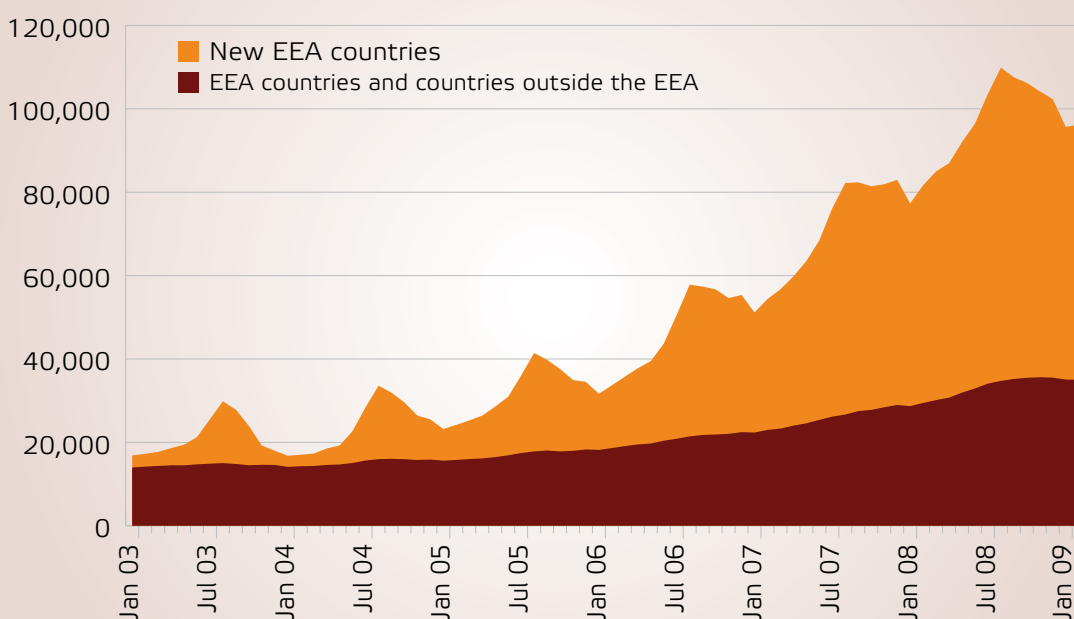
Towards the end of the 1960s, labour immigration from Asia increased, notably from Pakistan and Turkey. This immigration did not arise from deliberate political policies and the authorities had not expected that labour immigrants would settle permanently. In 1975, a freeze on immigration was introduced and labour immigration fell off dramatically. The immigration had however created bridgeheads and it continued, despite the freeze, in the shape of family immigration, from Pakistan and elsewhere.

2004 – Eastern Europe

The opening of the EU eastwards in 2004 and 2007 gave the populations of the new member states the opportunity to travel, seek work and perform services in other countries in the EU/EEA. Norway was an attractive labour market, especially for the citizens of Poland and the Baltic States. Following the EU enlargement, there has been a steady increase in the number of Norwegian work permits granted.

At 1 March 2009, 60,900 people from the

Figure 6.1 The number of valid work permits in Norway.



Source: Norwegian Directorate of Immigration, 2009 (from August 2007, Bulgaria and Romania are included in new EEA countries)

new EU countries had valid Norwegian work permits, an increase of eleven percent over the same time in 2008. However, from February to March 2009, there was a fall in the number of work permits granted (2).

The figure 6.1 shows the number of valid work permits in Norway on the first day of each month from January 2003 to February 2009. Nordic citizens do not need work permits and are not included in the analysis.

There has been a steady increase in work permits for new EU members. The figure also shows distinct seasonal variation in the number of work permits.

Changes in labour immigration

The enlargement eastwards of the EU has led to changes in labour immigration to Norway. Although most labour immigrants continue to come from the other Nordic countries, the increase is strongest from the new EU member states. Labour immigrants from Poland made up the largest group in 2008 (1). Projections made by Statistics Norway for the immigrant population from the EU/EEA/EFTA show an increase from 161,000 individuals today to around 320,000 in 2014. By 2060, this group may number between 480,000 and 930,000 (3).

The new labour immigration

Labour immigration since 2004 has been concentrated on low-paid, unskilled work within specific sectors: mainly construction, cleaning, agriculture and individual industry sectors (4;5). These are sectors which involve hard physical labour and a high risk of accidents and injury.

The great majority of individual labour immigrants are men; only a scant 20 percent of work permits are issued to women (6). A survey conducted by the Fafo Institute for Labour and Social Research among Polish labour immigrants in Oslo, showed that most had a low level of training, or were unskilled. The men worked primarily in the construction sector,

while the women worked as cleaners in private households. The majority of the women were working illegally, without residence permits and without paying tax. Many worked part-time (5).

A lot of work, little social interaction

Studies of labour immigrants from Poland show that they work so much that they have neither time nor the capacity to learn Norwegian, establish social networks or engage in leisure activities (7). Their relationship to Norway can be described as a commercial relationship, in which the stay is primarily about work and earning money. Most labour immigrants from Poland travel to Norway alone (8). Only 20 percent of married couples with children and 10 percent of unmarried couples travelled together. It is often easier to be integrated into society when accompanied by a family, and those that bring their family with them also reduce their likelihood of return migration (1). A number of studies show that good social integration has a positive effect on health, especially mental health (9).

Longer stays

The trend is in the direction of longer stays for labour immigrants. Much labour immigration to the Nordic Region has been short-term in nature, but Norwegian figures in particular are now showing a clear trend towards more lasting stays. There is also pronounced growth in settlement and family reunifications from the new EU member states (10;11).

In the wake of the financial crisis in the autumn of 2008, the labour market has become more constricted. Many labour immigrants have lost their jobs and it was expected that many of them would return home. For the time being, the trend indicates that the great majority will be staying. Although many of the immigrants work in sectors that have been hard-hit by the recession, the situation is probably better in Norway than in other EU

countries. The Norwegian economic situation, combined with high salary levels and good welfare schemes, will tend to make the labour immigrants want to remain in Norway in anticipation of better times (1).

Amended rules create unpredictability

From 1 May 2009, the requirement for a residence permit has been replaced by a system of mandatory reporting. This applies to people from the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia. Experiences from other EU countries show that mandatory reporting is not well adhered to. The abolition of the residence permit requirement is likely to result in a more diffuse situation, making it harder to plan and determine the scale of health service provision required.

Use of the health services

The increase in the number of labour immigrants imposes demands on the health services, in terms of their scale and organisation, but also in terms of provision of information. A study of Polish labour immi-

grants and their health (7) shows that a lack of information, inadequate foreign language skills and economic factors are barriers to their use of health services. The respondents in the survey by the Directorate of Integration and Diversity (IMDi) of labour immigrants (4) rank health as the second most important area they need information about during their first year in Norway. This does not necessarily mean that labour immigrants have an especially great need for health services in their first year of living in Norway, but indicates that information is important in order to know what to do in the event of illness or injury and what rights one has in terms of treatment and follow-up.

The main priority is for labour immigrants to receive information about medical assistance, available health services and how they can get the help they need. Labour immigrants who speak neither Norwegian nor English may have practical problems in gaining access to health services (making an appointment, communicating with doctors). According to IMDi's survey, labour immigrants speak little or no Norwegian even after a number of years in Norway (4). This requires that the health service uses professional interpreters when dealing with labour immigrants who do not speak Norwegian.

IMDi is cooperating with other public bodies, including the Directorate of Health, to produce a "Starter pack for labour immigrants" containing details of health care provisions and other basic information.

Right to emergency medical assistance, but not to a regular GP

Everyone staying in Norway has a right to emergency medical assistance. The paperless immigrants or those who have residence permits of less than 6 months do not however have a right to a regular GP. Very many labour immigrants have only been granted a work permit for less than 6 months (approx. 44

"Helping Polish construction workers to help themselves" is a pilot project which seeks to improve the situation of Polish labour immigrants by providing effective and targeted information about their rights and responsibilities as employees in Norway. 30 Polish construction workers have received instruction on various topics, along with Norwegian language teaching, and they now act as resources within the Polish contingent by disseminating relevant information. The project is a collaboration between the International Organisation for Migration (IOM) and Tømrer og Byggfagforeningen in Oslo (the carpentry and construction union). The programme was launched in the spring of 2008 and will continue in 2009.

Source: <http://www.iom.no/>

percent of applicants in autumn 2008) (11), and accordingly do not have a right to a regular GP. (See also chapter 3, Interaction with the health service.) This can create problems, not only for the individual labour immigrant requiring medical assistance, but also for the health system, and especially for out-of-hours primary care services which receive patients who should have seen a GP.

The out-of-hours primary care service in Oslo reports treating a high number of patients with 'D-numbers' (temporary civil identification numbers). This high-level use of out-of-hours primary care services is probably due to the high incidence of acute medical conditions, as well as the fact that many people have no alternative, or are not familiar enough with the system.

Use of out-of-hours primary care services for conditions other than acute health problems is unfortunate, both because it drains resources and because it results in sub-standard medical care for patients who have illnesses that should be followed up over time. Alternative solutions should be evaluated to provide for the health needs of these people. One alternative would be to require GPs to receive and treat people who are not yet registered with a regular GP. This would require changes to the regulations governing the regular general practitioner scheme.

Unregistered labour immigrants

Many labour immigrants work outside the regulated section of the labour market. The Fafo Institute for Labour and Social Research survey of Polish labour immigrants in Oslo shows for example that a third of the interviewees pay tax neither in Norway nor in Poland (5). This means that many people who come to Norway as labour immigrants sort under the same range of issues as other paperless immigrants in terms of access to health services. Health conditions which

should have been treated at an early stage may develop into acute suffering because of a failure to contact the health service. (See also Chapter 5, Paperless immigrants).

Potential long-term challenges

As mentioned above, many labour immigrants are employed in sectors which involve heavy physical labour and a high risk of accidents and injury. In the long term, individuals may exit the labour market as a result of working in risk-exposed, physically demanding trades. Some labour immigrants may have difficulties getting out of the black economy. They do not accrue national insurance rights.

Like the labour immigrants who came to Norway from Pakistan, India, Turkey and Morocco in the 1970s, today's labour immigration is characterised by a high level of employment. The labour immigrants who arrived in the 1970s, however, largely lost their foothold in employment after ten years (12). They left the labour market on reaching 50 years of age and now live on disability pensions or other types of state benefit. Non-Western labour immigrants who were in Norway for more than 20 years had on average considerably shorter careers than Norwegians of the same age and level of education (12).

This low labour market participation may be due to the immigrants having worked in risk-exposed industries and trades.

This is not necessarily transferable information predictive of future developments, but it may point to a possible trend, and, if true, may stretch the health services beyond what is to be expected from normal population projections. Proper integration of labour immigrants will be important, so that they remain in employment for longer.

The Norwegian Directorate finds that

- public health work and preventive work directed at labour immigrants must be strengthened.
- the out-of-hours primary care service is used as the principal health service contact point by many labour immigrants. Alternative solutions should be evaluated to provide for the health needs of this group.
- it is the health service's responsibility to facilitate equitable provision for the entire population.
- information about rights and service provision should be made available for labour immigrants.

7 Health personnel across borders

Health personnel are mobile and want to work outside their countries of origin. There is presently considerable international migration of health personnel. Rich countries will have a need for more health personnel in the years to come. The training capacity will probably be insufficient to meet this need. Some countries recruit health personnel from other countries which themselves have a great need for health personnel. Ethical recruitment is a requirement.



In this chapter we are looking at the increasing demand for health and nursing personnel in rich countries in the years to come, Norway included. Many countries will opt to recruit health personnel from poor countries, which then lose the health personnel they themselves need. It will be important for long-term planning and distribution of the global human resources for health care to be implemented from a perspective of solidarity.

Most countries have insufficient health personnel resources

Norway has a comprehensive health and social service with medical physician coverage somewhat higher than the European average and the highest nursing coverage among the OECD countries. Physician coverage is reliant on both medical training of Norwegians at foreign universities and qualified doctors of foreign citizenship coming to Norway as labour migrants. Dentist coverage is increasingly reliant on foreign labour, and there is a considerable number of foreign nurses. The proportion of immigration from the other

Nordic countries is on the decline.

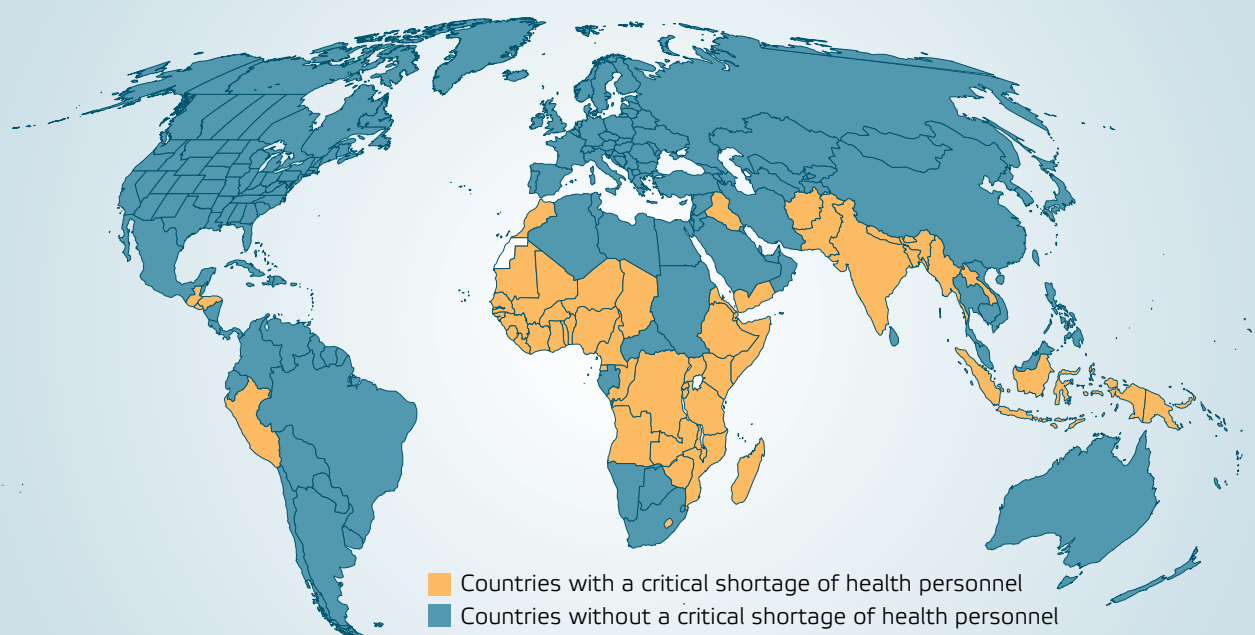
Most countries have insufficient health personnel resources. Planned recruitment from other countries can produce domino effects, where the sending country obtains its health personnel from countries in an even more difficult position.

Norway has taken the initiative to limit damaging effects for poor countries which have a critical shortage of health personnel. At the same time, there are national challenges. There will for example be a major shortage of available labour in the nursing and care service in the future. This is a problem Norway shares with many other parts of the world. The authorities must ensure that the national health personnel policy is sustainable relative to their own resource needs.

Considerable migration of health personnel

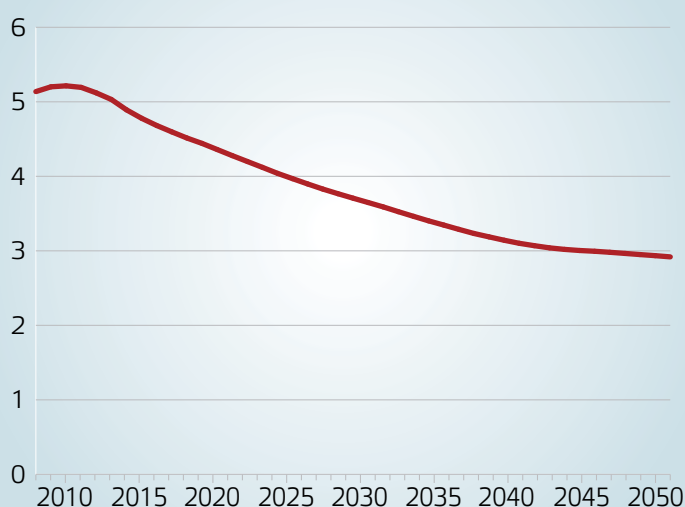
There is presently considerable international migration of health personnel. Rich countries will experience increasing demand for health personnel in the years to come. Training capacity will probably be unable to keep pace with this

Figure 7.1 Countries with a shortage of health personnel, 2006.



Source: WHO, Global Atlas of the Health Workforce (<http://who.int/globalatlas/default.asp>).

Figure 7.2 The potential support ratio (the ratio between the economically active, aged 16–66 years, and pensioners, aged 66 and over) in Norway, 2000–2050.



Source: Report to the Storting no. 25 (2005-2006) Mastering, opportunities and opinions - Future care challenges

increasing demand.

If many countries recruit health personnel from other countries, migration of health personnel from poor countries increases. A number of poor countries already have an acute shortage of health personnel. Poor countries are lacking well-functioning health systems, and the shortage of health personnel is a key cause of this. Poor countries do not have the capacity to train the personnel they themselves need, and much of the health personnel they do train then opt to migrate. The migration of health personnel is thus both cause and effect of deficient health systems.

The global misdistribution of health personnel

In its report "Working together for health", 2006 (1), WHO states that all countries require a minimum of 2.3 health workers per 1,000 inhabitants in order to provide the population with access to basic health services. Estimates indicate that 53 countries are failing to meet this requirement and have a critical shortage of health personnel. Overall, WHO estimated a global shortage of 4.3 million health workers (1).

The shortage is greatest where the needs are most acute. Sub-Saharan Africa and South-East Asia are each short of 2.4 million health workers.

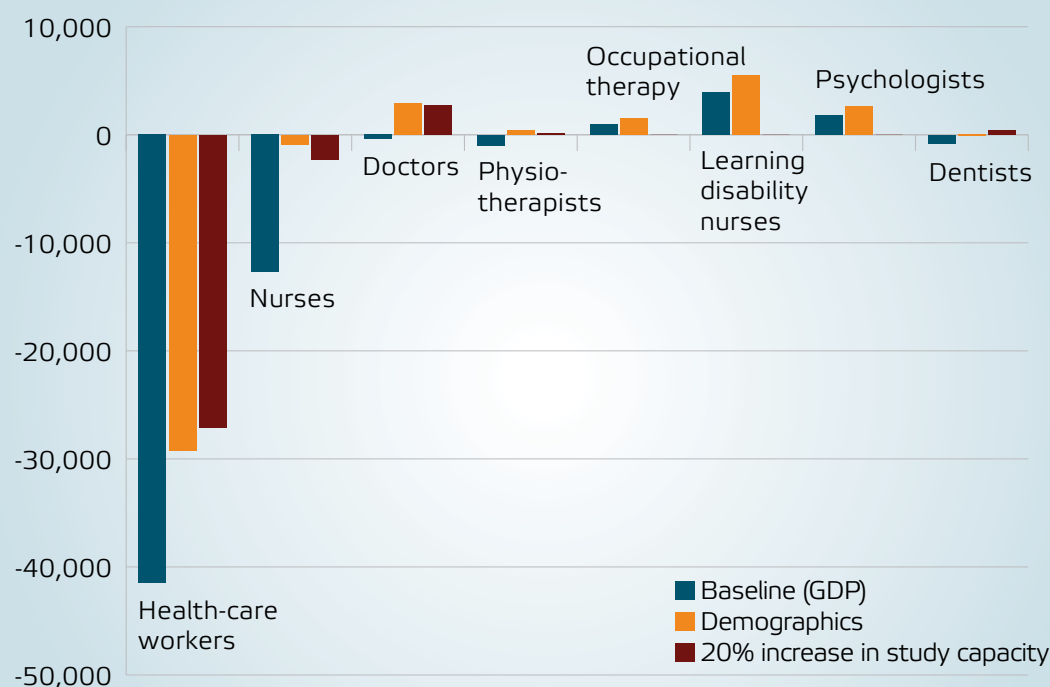
There is a global misdistribution of health personnel. While rich countries suffer from least disease, they also have the most health workers. In 2007, there were some 361,000 people with health and social services training in Norway. This means that there were around 77 people with health and social services training per 1,000 inhabitants. The aging of the population will probably cause this to change. Currently there are five people of working age per pensioner in Norway. In 2050, there will be fewer than 3 people of working age per pensioner. There will accordingly be far fewer people to care for each pensioner in some 40 years' time. Other rich countries are exhibiting the same trend.

One possible consequence of this trend is the increased migration of health personnel. The rich countries' needs will probably be increasingly met through the recruitment of labour from other countries. The OECD countries are currently those which receive the most health-personnel migrants. In 2000, 11 percent of nurses and 18 percent of doctors in the OECD countries were from other countries. This figure is likely to be higher now due to an increase in the international migration of health personnel. Surveys have shown that the net flow of health personnel is to the USA, Canada, Great Britain, Australia and New Zealand (2). Norway is also in the group of net recipients.

The need for more health-care workers and nurses in Norway in 2030

Projections by Statistics Norway indicate that the greatest personnel challenges in the health service in the years leading up to 2030 will be in the nursing and care sector (3). The lack of health-care workers will be especially great, with an expected shortfall of 40,000 in 2030. There will also be a need for more nurses than

Figure 7.3 Projection for the labour market in 2030 for selected health personnel groups. The ratio of estimated supply and estimated demand.



Labour-market projection based on different calculation alternatives. For more information about HELSEMOD, please visit www.helsedirektoratet.no or www.ssb.no.

Source: Helsemod (Helsedir/SSB)

could be met by current capacity. The expected increase in demand is not the sole reason for this. There are already now problems recruiting sufficient people into health work.

High level of physician coverage in Norway

In the short term, there is satisfactory overall access to medical physicians relative to demand. This must be seen in the context of Norway having an existing high level of physician coverage for its population.

Of the some 5,650 Norwegians currently studying medicine, around 2,350 (42 percent) are studying abroad. Since 2006, 4,397 doctors have been licensed, and only 1,246 of them (28 percent) trained at Norwegian institutions. Currently, 13 percent of doctors in employment in Norway have foreign citizenship (4).

The Norwegian health service gains approximately 1,050 newly qualified doctors per annum. Of these, approximately 400 have

studied outside of Norway. The majority of Norwegian medical students are in Poland, Hungary, Denmark, the Czech Republic and Slovakia. The Norwegian Directorate of Health has taken the initiative to ensure that a higher proportion of future doctors are trained in Norway.

The Norwegian authorities are also working to establish a policy to help ensure that Norway is responsible for training the number of health personnel in the different groups that we will need in the decades to come.

The Norwegian health service and foreign citizens

In 2007, 12,642 people with the combination of foreign citizenship and health and social services training were working in the health and social services. This was an increase of 5.4 percent over 2006, according to information from Statistics Norway (5). Figure 7.4 shows the proportion of health personnel with foreign

citizenship in the period 2001-2007.

The graph indicates that there is a considerable amount of foreign labour employed in the health and social services. Increasing permanent residence in Norway of people who retain their original citizenship may have an effect on these figures, and one needs to be cautious in assessing all those with foreign citizenship as "non-Norwegian".

Nurses, midwives and health visitors

Nurses, midwives and health visitors constitute a significant share of the immigration to Norway of health personnel; they are recorded by Statistics Norway as a single group and comprise in excess of 4,500 of the 12,642 foreign health personnel in 2007 (5).

Nurses make up the largest sub-category. In 2001, there were a total of 68,000 nurses in employment. In 2007, this figure had risen to 83,000. Traditionally, the largest share of foreign citizens in this group came from the other Nordic countries, but from 2003 to 2007 there was also a rise in immigration from the rest of Europe (Figure 7.5).

In recent years, an increasing number of nurses from the Philippines have come to Norway. The Philippines are a special case. The

Filipino authorities are involved in dialogue to improve the situation of Filipino emigrants in other countries.

The Philippines have more nurses abroad than any other country. One reason for this may be the financial contributions which the emigrants send back home. However, the country itself has a shortage of in health personnel.

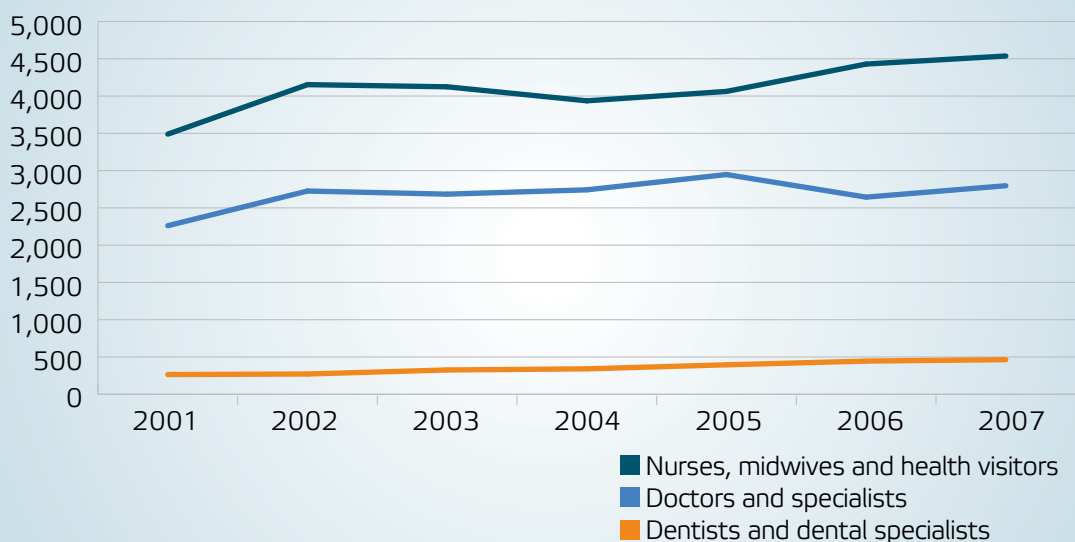
Medical physicians

The proportion of foreign doctors employed in Norway is more or less average for the OECD countries.

Figure 7.6 shows that the number of German doctors has increased since 2003, and in 2007 there were more German doctors than Swedish ones registered in Norway. Since 2006, there has been an 18.3 percent increase in the number of medical specialists from Germany. The number of doctors from Denmark, Sweden and Germany also includes those who are in the country as short-term locum doctors. The number employed may not therefore be interpreted as full-time equivalents.

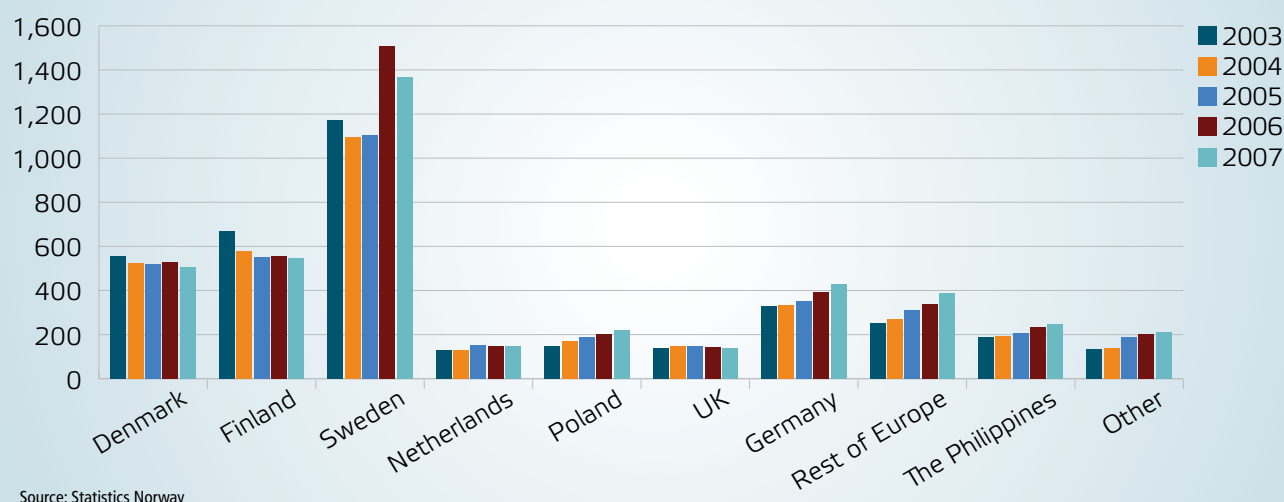
Increasingly more doctors are arriving who need training in Norwegian language and culture. The doctors are also coming from countries which have lower physician coverage than

Figure 7.4 Health personnel with foreign citizenship 2001–2007.



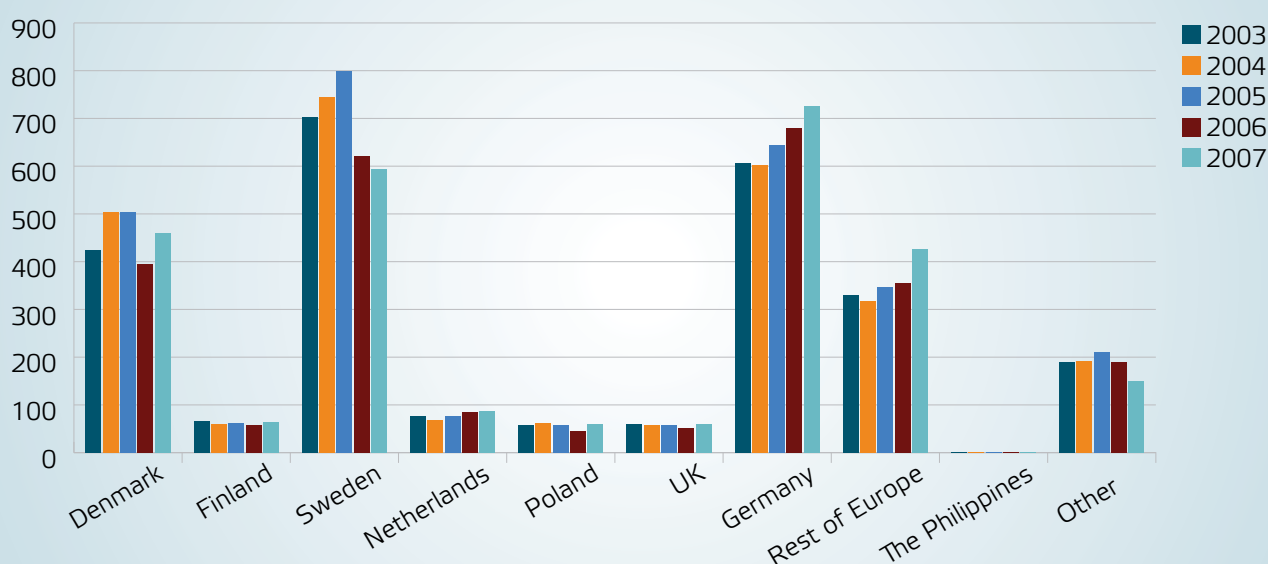
Source: Statistics Norway

Figure 7.5 Number of nurses, midwives and health visitors, employed in Norway, by citizenship.



Source: Statistics Norway

Figure 7.6 Doctors in employment in Norway, by citizenship



Source: Statistics Norway

Norway, but who are attracted by good salaries and working conditions. One example of this is Danish doctors.

4,000 Danish doctors are licensed to practise in Norway and around 400 of them are working in Norway. At the same time, there is a shortfall of doctors in Denmark and Danish hospitals are recruiting doctors from Germany, Austria and India.

Long-term planning is essential

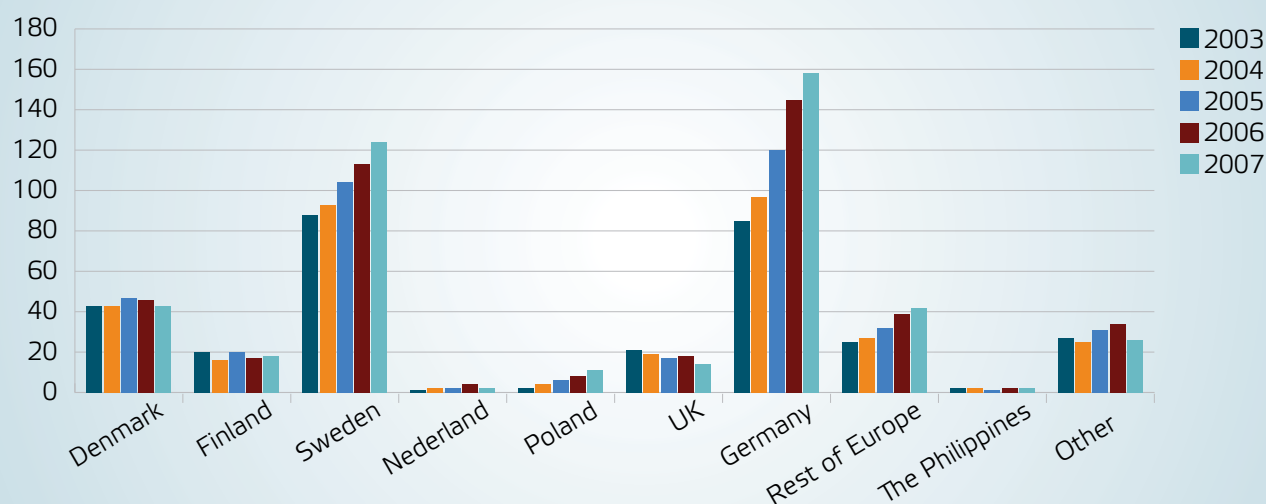
The training of health personnel takes time. Increased access to health personnel is often contingent on very long-range planning. This

is one of the reasons why many countries are trying to meet their shortfalls by recruiting ready-trained health personnel from other countries.

Ethical recruitment

One of the key issues in terms of health personnel recruitment is what account should be taken of other countries' needs when meeting one's own requirements. Labour migration has been and will remain an aspect of individual freedom and national need. However, extensive draining of the resources in one country may lead to that country's authorities being unable

Figure 7.7 Dentists in employment in Norway, by citizenship.



Source: Eurostat

to offer appropriate health services for their own population. The Norwegian Government has therefore determined that Norway will not actively recruit from countries which have a serious shortage of health personnel (6).

The Government has resolved that Norway will take responsibility for promoting a development that distributes global human resources for health from a perspective of solidarity. Norway will conduct a policy that does not drain poor countries of their qualified health workers. On instructions from the Ministry of Health and Social Affairs, in the first half of 2007, the Directorate of Health reported on a potential basis for a Norwegian health personnel policy which accords with these obligations (7).

On the basis of this report, the Government decided to set up two new working groups, led by the Directorate of Health and the Ministry of Foreign Affairs respectively, in order to propose measures relating to the coverage of national health personnel requirements and to Norwegian development policy. These working groups completed their remits in early 2009. The Directorate of Health's report has been published and is available at helsedir.no (4).

Norway has been a driving force for raising the issue of and delineating the health-per-

sonnel crisis internationally, and has helped reinforce international cooperation on the issues of concern. The challenges are now the object of discussion in many international fora, including WHO, the EU and the OECD. Norway's clear position and interministerial approach has attracted considerable international attention. It is expected that Norway will continue to play an active role.

International guidelines can make a difference

The aging trends in the rich countries are highly likely to lead to increased migration of health personnel and contribute to further weakening of those health systems where the needs are greatest.

It is expensive and time-consuming to train health personnel. Recruiting ready-trained personnel from other countries may therefore be an attractive choice for many countries. But it is important to remember that this may result in a loss for the sending country, especially if the training is financed by the public sector.

However, health-personnel migration is not the only cause of deficient health systems in poor countries. Calculations have shown that only 12 percent of the shortfall in African

Report to the Storting no. 25 (2005-2006) Mastering, opportunities and opinions:

The demographic challenges are both national and transnational. Increased aging of the population that will result in greater need for care services can therefore not be solved by importing labour. The Government stresses that targeted recruitment of health and social services personnel from developing countries is not appropriate, and that it will instead focus on adequate domestic training capacity and recruitment.

Proposition to the Storting no. 1 (2006-2007) and National Health for Norway (2007-2010):

One criterion for developing countries' greater success at retaining their own qualified labour within the health sector is for rich countries to conduct a policy that does not drain poor countries of their few qualified health workers. Norway aims to conduct such a policy.

countries is due to migration to OECD countries. The shortfall is due primarily to a lack of long-term investments in the health sector and unsuccessful reforms. There have also been failed financial measures under global aid initiatives (2).

WHO member countries have asked WHO to prepare guidelines for the international recruitment of health personnel. The essence of the guidelines must be to not recruit actively from countries with health personnel shortages and for rich countries to take responsibility for training to at least meet their own requirements in the demographically challenging period up to 2050. The guidelines should facilitate the recruitment of health personnel that is ethically responsible with regard to both migrants and sending countries. Norway has participated actively in drawing up the guidelines. They are expected to be completed for the World Health Summit in 2010.

While recruitment guidelines are important, it is crucial that rich countries help to increase the poor countries' own capacity to train, recruit and retain their own health personnel. Examples of potential instruments include specific measures for retaining health personnel, increasing capacity and recruiting for training, as well as financial support for health institutions. Norway, for example, possesses good preconditions for being able to assist in the development of research and training in poor countries.

International recruitment guidelines must not become a hindrance to individuals who wish to try their luck in another country. The migration issue should also be evaluated against the individual's right to mobility, to leave their own country, and the right to a free choice of occupation. These are laid down in the human rights declarations. In Europe, the free movement of labour is also a key plank of the EEA Agreement and the Common Nordic Labour Market Agreement. The guidelines must therefore be designed so as not to conflict with current legal principles. It is fully possible to achieve this without facilitating systematic recruitment to the rich countries.

The Norwegian Directorate finds that

- Norway must commit to ethical recruitment that does not deprive poor countries of their own human resources for health
- Norway should be able to contribute to the development of research and training in poor countries
- it is necessary for the rich countries to contribute to increasing the poor countries' own capacity for training, recruiting and retaining their own health personnel.

8 Emigrants – Norwegians in Spain

22,000 people emigrated from Norway in 2007. Most emigrants from Norway travelled to other European countries, while others went to Asia, Africa and America. Spain is one of the countries people moved to. According to Spanish population statistics, there were 15,630 Norwegians registered as resident in Spain in January 2007. Many of them need health and care services.



In this chapter we will be examining migration by Norwegians generally, and emigration to Spain in particular. In addition to relevant research, the text is also based on statistics, documentary analysis, field studies and interviews with key actors in the Norwegian environments in Spain. The chapter is based on work undertaken by researcher Brynhild Solvang. She interviewed people in the province of Alicante, home to the oldest and largest contingent of Norwegians in Spain.

To begin with, we will investigate what we know about the many Norwegians resident in the country. We will then focus on what they themselves say about the need for health and welfare services in the Spanish context. We will also look at their perceptions of Norway's responsibilities in circumstances when, for whatever reason, they are unable to take care of themselves. For reasons of space, we will be concentrating on the needs of those late-middle-aged and elderly Norwegians in Spain who, over the years, have been campaigning to make Norway accept more responsibility for them than it has to date.

Figures from Statistics Norway show, for 2007, 62,000 registered immigrants to Norway and 22,000 emigrants from the country. Emigration was largely to other European countries, but also to Asia, Africa and America. Out of the European countries, Sweden and Denmark received the majority of Norwegian emigrants, while emigration to Eastern Europe was also relatively extensive (1).

Over the last two centuries, Norway has experienced what can be seen as two waves of emigration: one to America in the late 19th and early 20th centuries, and the other to Spain in the latter half of the 20th century. This second wave of emigration is still going on, even though, in 2007, only 162 Norwegian citizens registered their relocation to Spain.

Norwegians in multi-cultural Spain

Since charter holidays took off in the late 1960s, tourism has grown into a major industry for Spain. The country has steadily become an attractive holiday destination for people from all over the world, and official figures show that some 60 million foreigners visited Spain in each of the years 2007 and 2008. It is still too early to determine how the global financial crisis will affect this sector, but there are many indications that it has already had a negative impact, with increasing unemployment and the halting of a number of planned real estate development projects.

In 2007, Spain had 45.5 millions registered inhabitants. National population statistics show that around 10 percent, or nearly 4.5 million, of them were foreign citizens. Most come from Europe and the new EU member states such as Bulgaria and Romania, but a high proportion also from America and Africa (2). Spain is also one of a number of Mediterranean countries that make up the so-called Mediterranean Wall for people from the African continent. Even though many arrive as legal immigrants, in recent years we have read in the Spanish, international and Norwegian press countless stories of the thousands of boat refugees who have suffered and died while fleeing from countries in Africa. However, many of them have succeeded in reaching land and the Spanish authorities have huge problems in keeping a check on the numbers of illegal and legal immigrants. The country is a cultural melting pot and a centre for various migration flows due to its strategic location between Africa and the rest of Europe. Between those who, as EU citizens (or in the case of Norwegians, EEA citizens), are on the inside and those on the outside, there is great disparity in individual rights, and there are gaping contrasts between the privileged long-stay tourists from the North and the

less privileged migrants from the South. Both groups are seeking a better life in Spain, but they have unequal starting points on which to base their success.

In many of Spain's coastal municipalities, the proportion of foreign residents is greater than that of 'ethnic Spaniards' – however that is defined. In the Valencia region, for example, 15 percent of the population are foreign citizens. In one of the provinces of the region, Alicante, foreigners make up 21.5 percent of the registered population (2). Here, for instance, is Alfaz del Pi, a relatively small town with some 20,000 registered inhabitants, of which more than half are foreigners, from no less than 80 different countries. Alfaz del Pi promotes itself as an international and multicultural municipality, and is looking forward to even more people wanting to settle there. It is also here that we find the oldest and largest contingent of Norwegians registered as living in Spain, in excess of 2,000. British and Dutch citizens comprise the large groups of foreigners, with Norwegians in third place. But here, as in many other coastal municipalities, it is estimated that the actual number of foreigners is at least double – especially in the colder half of the year, due to all the Northern Europeans spending winter in the favourable Spanish climate.

How many Norwegians live in Spain?

Many Northern Europeans migrate between their home countries and Spain as the seasons change. Such a modern lifestyle evokes that which migratory birds have practised for time immemorial: when autumn arrives in the North, they set course for the mild climate of the South. When spring arrives and the days grow longer and lighter in the North, they head for their summer grounds. In this sense, charter tourism has adopted a new course, inasmuch as increasingly more people are

staying in the country for periods well beyond the usual concept of a holiday stay. Others have taken the major step of leaving their home country officially and applying for permanent residency (*residencia*) in Spain.

It is difficult, if not impossible, to say how many Norwegians are living in Spain at any one time, and different figures are used in different contexts. We are looking at a rather diffuse transnational phenomenon, whereby people move more or less freely across national borders. In 2003, the Norwegian Embassy in Madrid estimated that there might be somewhere between 10,000 and 15,000 Norwegians in the country and that this included employed persons and disability pensioners of all ages, early retirees and old-age pensioners, and families with children (3). In 2005, the Norwegian authorities estimated the number to be between 20,000 and 30,000 (4). According to Spanish population statistics however, the number of Norwegians registered in the country was 15,630 at January 2007 (2).

Norwegian ghettos?

Even though there is a certain concentration of individual nationalities in a number of municipalities in Spain, it cannot be claimed that there are ghettos of Norwegians or other nationalities. Most Norwegians live in four different areas or "contingents", in the municipalities of Alfaz del Pi and Rojales (Torrevieja) on the Costa Blanca, in Fuengirola on the Costa del Sol and in Arguineguin on Gran Canaria. Here there are Norwegian consulates, branches of the Norwegian Church Abroad (Sjømannskirken) and a total of five Norwegian schools. As state-funded organisations, they receive financial support from the Norwegian authorities. Since 2005, Norwegians have also been able to apply for assistance from the National Insurance Administration Office, now NAV, in Spain. Norway was the first foreign country to

establish a national office of this kind on Spanish soil. The office was set up to provide services to the many Norwegian national insurance benefit recipients who live in the country, but also to monitor the system and prevent potential national insurance fraud. NAV has also published dedicated websites with information for people living in, or thinking of moving to, a foreign country.

In Spain, there are also a number of health and rehabilitation institutions founded and run by Norwegian foundations or voluntary organisations. In addition, there are some nursing and care institutions which are owned and operated by Norwegian municipalities. Norwegians in Spain have also to some degree organised themselves and formed social networks, for instance in so-called “Norwegian clubs”. These are associations which are financed by membership fees and which organise various social activities in order to promote members’ well-being. For several years, the Progress Party has had a local association in Spain and, recently, the Labour Party has established itself with two local associations – both on the Costa Blanca.

The fact that many people from the same country live in the same area or the same municipality in Spain has created a foundation for operating various commercial businesses and services aimed at one’s own compatriots: typical Norwegian goods are available to buy, and it is possible to get most services performed in one’s own language – in the same way as, for example, for English, German, Dutch and Danish citizens who have made Spain their second home. To a certain extent, it is possible to see these as parallel groups of different nationalities who exist side-by-side but with rather limited interaction with each other or with the Spanish host society. That said, it is important to emphasise that, within this scenario, there is much variation in the degree of participation and interaction

between the different nationalities in Spain, at both individual and group level.

In recent decades, Spain has opened its borders, facilitated immigration and welcomed foreigners but without an active integration policy vis-à-vis those who have settled in the country. With a high tolerance for cultural variation and lifestyles, Spain has not implemented any policy of assimilation but has rather prioritised living with cultural and international diversity.

Why Spain?

Studies of Norwegians in Spain have mainly focused on old-age pensioners and indicate that their primary motivation is that the good climate provides health benefits and enhanced quality of life (5–8). Studies of other Northern Europeans in Spain broadly concur and conclude that, in general terms, the pensioners’ participation in and integration into Spanish society is weak (9–11). The weak level of integration is explained by language problems and the fact that participation in the wider Spanish society is not the primary objective of this group. Myklebost (7) refers to this migration of pensioners as a kind of ‘amenity-led migration’ while others see these people as a group of privileged early retirees and old-age pensioners who wish to enjoy their leisure in Spain’s agreeable climate (12).

Norwegians in Spain cannot be defined as a homogeneous group, whether by lifestyle or by age composition. In addition to old-age pensioners, there are also younger early retirees, both with and without spouses and children. Workers on flexible rotas, such as North Sea workers, airline staff, Internet workers, health workers and various types of private business people all go towards creating a kind of “Norway in miniature” in Spain. Many people with health complaints have a better life in the Spanish climate, which has a positive effect on various rheumatic com-

plaints, asthma and allergies. As for the young, the number of pupils at the five Norwegian schools has varied between 400 and 600 in each of the last ten years, and an unknown number of Norwegian children are pupils at Spanish state schools and private schools.

Permanent residents and tourists

From a formal point of view, there is a distinction between those who have tourist status and those who have registered a change of residency. This difference in status affects the rights and obligations the person has in both Norway and Spain. As we have seen, there were 15,630 Norwegians registered as living in Spain in 2007. The other Norwegians staying in the country, and whose numbers we do not know, are counted as tourists – even if they live in Spain for several months in winter. The majority of these have registered neither as emigrants from Norway nor as immigrants to Spain, but are Norwegian citizens on extended holidays.

In an open society, not everyone takes the trouble to count the days they move between and sort under two different countries. In practice, it would be difficult and scarcely desirable for the authorities in western democracies to have a complete overview of how long each individual citizen stays in Spain (or in other countries). Those who have registered their departure from Norway and had this approved (which is not the case for everyone), and who have simultaneously acquired legal *residencia* in Spain, are essentially to be considered Spanish citizens – even if they do not acquire full rights of citizenship until a number of years have passed. For these, Norway has decided, as a special arrangement, that they may not stay in Norway for more than 61 days a year, i.e. fewer days than a foreign tourist.

Under Spanish law, foreign citizens may stay in the country for up to 90 days without

any special permit, as is the case for foreign tourists in Norway. For the problems in focus here, the main rule that one must reside in Norway for at least six months of the year in order not to lose membership of the Norwegian national insurance system will be of particular interest.

Migration and mobility across national borders produce many and varied consequences at structural and individual levels. This is also true of such cross-border lifestyles as are under consideration here. In spite of transnational agreements between European countries and separate agreements between Norway and Spain, on for example tax issues, this is a multifaceted and complex landscape for people to find their way around in. Magazines and web pages for Norwegians living in Spain (and other countries) are full of tips, advice and articles on how to deal with what are often perceived as complicated and sometimes confusing regulations. Often, it is a matter of differing regulations relating to temporary or long-term relocation. Rules for taxes and charges and questions of property and inheritance, the need for private health insurance and various social rights are also common topics and issues.

Although Norway is not a member of the EU, the EEA Agreement guarantees Norwegian citizens the right to essential (and unforeseen) medical and health services when in Spain. The Norwegian health insurance card (E 111) guarantees this. Those who have registered and had approved their migration to Spain will receive a Spanish health insurance card (E 121) which provides the right to medical treatment in Spain, and which guarantees a right to emergency treatment when travelling to Norway on holiday.

Tourists, i.e. those who have an address in a Norwegian municipality, who are members of the Norwegian national insurance scheme, who pay their taxes and who sort formally

under Norway, can simply travel back home if they require medical treatment or need services from the Norwegian welfare state. The challenges are, however, somewhat greater for those who have registered as emigrants, who are no longer members of the national insurance scheme and who do not have permanent residency or an address in Norway. What rights do they have in the Spanish health system and the social system, and how does this work? What experiences do they have and what expectations of the Norwegian authorities? These are questions we will now be examining more closely.

Provisions and obstacles relating to the need for health and social services

Within certain limits, Norwegians may take various insurance schemes and pensions out of the country with them, but a number of restrictions have been imposed here in terms of, for example, the child benefit and cash benefit schemes. A survey by the foreign affairs division of the Norwegian Labour and Welfare Administration, NAV Utland, shows that the disbursement of pensions to Norwegians residing abroad is increasing every year. In 2006, approximately three billion Norwegian Kroner were paid to pension recipients in other countries, of which old-age and disability pensions comprised the majority. Spain was the country with the third largest number of Norwegian pension recipients (4,735). Sweden tops the statistics (14,740), and the USA was in second place (6,976) (13).

The figures in the Spanish population statistics show that, in January 2007, there were 15,630 Norwegians registered in the country. 4,735 were Norwegian pension recipients and it can therefore be deduced that these did not depend on work or other income to provide for themselves. The figures also indicate that there were some 11,000 Norwegians in Spain

who were not living on national insurance or pension payments from Norway. The figures in the Spanish population statistics include Norwegians of all ages, but this fact helps to establish that far from all Norwegians in Spain are national insurance or pension recipients.

GP and hospital services

The EEA Agreement ensures the right to acute medical and health services for Norwegian tourists staying in Spain. Permanently resident pensioners with a Spanish health insurance card, for their part, are allocated a regular general practitioner, they receive treatment at Spanish public sector hospitals and they are entitled to free medicine. The GPs interviewed here assert this as a particularly positive aspect of the Spanish health system, which is ranked higher by the WHO than the Norwegian health system.

Even though Norwegians in Spain state that they are very largely satisfied with public health provision in Spain, there are also here – as in Norway – those who have had negative experiences of the medical treatment they have received and of the attitudes of Spanish health personnel. The Spanish health service prioritises purely medical treatment, while nursing and care is largely left to the patient's family and relatives. If a patient has no family or relatives who can assist, the stay in hospital will be something quite different than they are used to from their home country. There are therefore a number of stories of patients who have shared rooms with extended Spanish families visiting the next bed – experiences which not all hospitalised Norwegians are equally enthusiastic about. Nor do the public hospitals offer the same interpreting services for their patients as the private hospitals do. The consulates and the Norwegian Church Abroad have therefore expressed a wish for greater resources for this from the Norwegian public sector. To discover

whether there are Norwegian patients needing help or assistance, the Norwegian Church Abroad has established routines whereby they visit the hospitals in their area each week. In addition to this, the Norwegian Church Abroad or consulate are contacted by the Spanish hospitals as required or in accordance with patients' wishes.

In addition to what has been described as an extensive and well-functioning public health service in Spain, there are also a large number of private practice doctors and private hospitals. Those who wish to, and can afford it, can take out private insurance which guarantees treatment at private clinics. The Norwegian doctors interviewed here stated that they cooperate well with and make use of both the Spanish and Norwegian health services. Patients who do not have health care provision or are unable to use the health care provisions available, are encouraged to travel back home to Norway for treatment and follow-up. The doctors only miss Norwegian specialist services to a small degree because, as they say, "It must be remembered that those who migrate are mentally robust people with relatively few problems." At the same time, it was stressed that there are also people who have come to Spain to get away from things at home, whether the authorities or other circumstances. Many experience Spain as a place of refuge from harassment, stigmatisation or trauma at home. The wishlist for actors in this field therefore includes a psychologist, especially in order to be able to produce expert reports without patients having to travel to Norway to have this done. It is claimed that such a scheme would be better for the person in question but that it would also be a more cost-effective scheme for the Norwegian authorities.

Physiotherapy services

Norway has a special agreement on free physiotherapy for Norwegians abroad, including in Spain. Special rules apply but the scheme covers those who have a right to such treatment in Norway and who have a valid referral from a doctor in Norway. As such, this is a service for those who are on holiday or on a long stay abroad – although only in areas where there are Norwegian physiotherapists with national insurance reimbursement agreements. This scheme was reported as beneficial and useful for the many Norwegian patients who, in this way, are able to receive expert training and quicker rehabilitation than if they were at home in Norway. The scheme does not cover those who have emigrated to Spain who are able to receive such services through their Spanish health insurance card and by using Spanish physiotherapy services. The scheme might appear to be in conflict with the EU's Services Directive and, in the opinion of the Directorate of Health, should be evaluated.

Nursing and care services

"Most things work well for us down here until we reach the fourth age and need care or nursing." This observation from the manager of the Norwegian club in Alfaz del Pi in many ways sums up the actual circumstances in this area. In their study of elderly Norwegians in Spain, Helset et al. (6) conclude that if these people are to enjoy this way of life, they need the ability and will to be sociable, open and active, which requires good physical and mental health. Sørbye et al. (8) conclude that Spanish social services are effectively non-existent for this group.

For Norwegians in Spain, the Norwegian Church Abroad in many ways represents what was once the social security office in Norway. The deacon of the Norwegian Church Abroad said the following when

discussing the relationship between supply and demand in this field:

There are not more social problems down here than at home, maybe fewer in fact, but the problem is that there is less public-sector assistance available here, and people expect more or less that it should be like at home ... One shouldn't glorify what there is at home either, but the problem concerns primarily the elderly, who are over-represented here. Many of them came here 20-30 years ago and it is typically now that they have a greater need for help. They are becoming senile and falling ill here, and they are dying ... For example, when they start suffering from dementia and can't tackle day-to-day living, it is rather by chance whether we come in and manage to help them, which we try to do as best we can ...

When people move from Norway to Spain, they also move from one welfare regime to another. Many of them are scarcely aware of the consequences of this, for example in terms of the provision of social services. In Spain, they will find a society which is traditionally based on the family, social networks and the third sector (i.e. voluntary organisations) providing a safety net for its citizens. In the rudimentary welfare state model found in the Mediterranean countries, social rights are largely linked to and exercised through participation in working life. The subsidiarity principle applies here, with a greater element of means testing and more responsibility for the development of services lodged with the local authorities, without the same degree of national norms as we have in Norway. In the social-democratic welfare state model that dominates in the Nordic countries, the universality principle applies. Here individual social rights are exercised to a greater degree through a person's residence within a national territory, and less on the basis of their labour contribution or ability to pay (14).

Spanish care provision

Even though public-sector social services and care for the elderly and those in need of nursing are gradually being extended in Spain, there are long waiting lists for institutional places for the elderly. Home-based services and domiciliary nursing operate to some extent in many municipalities – and are performed under the direction of both the public and private sectors. When the need for nursing and care services arises, only very few will be able to find a place in a Spanish public-sector institution. Until a few years ago, pensioners were exempt from paying tax in Spain. If a person had then not paid tax or was not a member of the Spanish pension system, they were obliged to use private services. There are many private nursing and care institutions in those areas where many Norwegians live, but, with costs of around Euro 2,000 a month, such provisions will be unattainable for a Norwegian on a minimum pension without financial assistance from Norway.

The Norwegian network members and actors interviewed here say that they are aware of 4-5 elderly Norwegians living in Spanish institutions whom they try to stay in contact with. But language problems, a lack of stimulation and cultural differences mean that these old people 'fade away quickly', as it was put.

Norwegian care provision

There are also a number of Norwegian care institutions which offer 24-hour care for elderly Norwegians in Spain. These can be divided into three categories: Firstly, there are those which are operated on a purely private basis. Here we are talking about costs of around Euro 2,000 per month for a place, in other words the same as it costs for a place in a private Spanish institution. Secondly, there are so-called semi-public institutions, which receive some state funding from Norway and are operated by various interest organisations. These rarely offer long-term residency. Finally

we have institutions operated by Norwegian municipalities. These provide primarily for the municipality's own inhabitants or inhabitants of municipalities which have purchased or leased institutional places within them.

This situation, in which only a few selected elderly people have the key to a Norwegian institutional place in Spain, is perceived as both unreasonable and unfair by those who are excluded and who do not have the opportunity to benefit from any of these provisions.

The elderly who are sick and in need of nursing

In terms of the elderly who are sick and in need of nursing, the difference in attitudes and decisions by the municipalities and NAV offices in Norway are identified as a particular challenge. For some elderly people it will be best for them to return home to Norway; for others not. The experience here is that applications are refused and denied, both when it comes to those wishing to return to Norway and those wanting help to remain in Spain. For those who want to return to Norway and who are fortunate enough to have grown-up children there, the solution will often be to go home to them. They then have an address, so that the municipality is obliged to deal with them. Those who have their Norwegian passport, proof of Norwegian citizenship, also possess a formal key for being able to return and demand to be taken care of in Norway. But for those who have lived in Spain for a long time, Norway will seem almost like a foreign country. Some will have spouses who have died and been buried in Spain, and they will have neither immediate family nor relatives who can support them in daily life in Norway.

Those who deal with this problem in Spain – the Norwegian Church Abroad, the Norwegian clubs, the Norwegian welfare consultants who operate private consultancy services, those who provide private services

for the elderly, and to a degree the Norwegian consulates – refer to the situation as especially difficult for those who emigrated to Spain 20-30 years ago and who are now beginning to have a serious need for nursing. Even though a complete overview is lacking, it is estimated that somewhere between 100 and 200 elderly Norwegians in the province of Alicante on the Costa Blanca need more help than they are presently receiving. Dementia and Alzheimer's are particularly challenging, and they require special services which are available scarcely or not at all.

Where should the line be drawn?

For a number of years, socially and politically active Norwegians in Spain (and in Norway) have been mobilising to influence Norwegian health and social policies and to resolve various aspects of the fact that increasingly more Norwegian citizens are spending parts of their lives in another country. These lobbyists, if we may call them that, claims that much Norwegian legislation is outdated and should be modernised and adapted to present-day circumstances. Although they are not demanding precisely the same services that are provided to those who live and remain at home in Norway, they do demand just, coherent and fair treatment.

As we have seen, it is, in particular, varying attitudes and divergent practices in Norway that are being reacted against. It is stressed that minor measures can make life easier for many Norwegians living in Spain and that both the municipalities and the NAV offices responsible for service provision could be more flexible, accommodating and coordinated than is presently the case. We have also seen that elderly Norwegians living in Spain and who have a need for nursing and care services are in what we may see as a marginal situation. The question is then who has – or more properly who should take – responsibility for them when

they can no longer take care of themselves. Is it Spain, is it Norway, or must each individual take matters on their own head?

These questions also apply, in principle, beyond the province of Alicante in Spain and to groups other than elderly Norwegians in the country. They may also apply to other Norwegian citizens staying or living in other countries.

For most countries, offering services and assistance or guaranteeing the welfare of citizens who are freely living in another country will be a relatively new challenge. The fact is that access to, and the right to, various health and social services for Norwegian citizens is legitimated for those remaining within Norway's territorial borders. This is a consistent policy enacted in health and social legislation. However, the legislation does not define any prohibition against people not only taking their pensions out of the country, but also services.. In the Report to the Storting on the challenges of Norway's future care provision, there is a separate section which refers to old-age pensioners abroad in these terms:

There is nothing to prevent the municipalities from paying for care provision made abroad, in those cases where it is assessed as a sound and professionally justified solution and is in keeping with the user's own wishes. In a number of cases, this may well be a good solution (15).

To some degree, through this statement, Norwegians' desire to be able to spend their old age in Spain is accommodated by the Norwegian authorities. The formal and practical responsibility, however, will be lodged with the municipalities – and this will probably not involve an equitable provision for everyone, as a national responsibility might be more strongly conducive to.

Many Norwegian pensioners who have

moved to Spain see themselves as Norwegian citizens with rights to services from the Norwegian welfare state. Two different local associations of Norwegian political parties have been set up in Spain, and both have an objective that 'the Norwegian authorities should recognise their responsibility for people down here'.

The main argument is that they have paid their taxes and fulfilled their obligations while they were in employment in Norway, and that provision of services in Spain will be more cost-effective for Norwegian authorities than if they were to return home. Seen from the sidelines, it might appear paradoxical that these demands are not directed at the Spanish authorities. We found the explanation for this in the fact that this group, in any case up to the present, has not seen themselves as full citizens, but as guests of Spanish society. And a demanding guest is a rude one – and who wants to be that?

Challenges:

- that there will be increasingly more Norwegians living in Spain, who will have an increasing need for health and care services.
- Norwegians' interaction with health services in Spain presents, for many, the same challenges as for immigrants to Norway: challenges concerning language, communication and cultural understanding.
- Norwegian municipalities and NAV offices implement the regulations somewhat unevenly with respect to services for Norwegians in Spain. There may be a need to develop a common understanding and practice in this area.
- there are potential problems relating to the fact that institutions and services financed by Norway are only for ethnic Norwegians in Spain. This is not in compliance with the principles in the EU's Services Directive.

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1 The big picture

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