The Norwegian Directorate of Health's annual report on measures to reduce social inequalities in health.

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Foreword by the Director General of Health

Background

2007 saw the publication of Report no. 20 to the Storting (2006–2007) *National strategy to reduce social inequalities in health.* This white paper emphasised that the prime objective of national health policy is to achieve more equitable social distribution of health – and health determinants. It is the case that health and the distribution of health are attributable not only to areas traditionally covered by the health sector. Daily living conditions and the circumstances in which people are born, grow, live, work and age are the ultimate determinants of health in each individual. In order to tackle social inequalities in health we therefore have to direct our attention at the underlying causes – the social determinants of health.

The social determinants of health that produce and distribute health have also come under increased global scrutiny. In autumn 2009, the Directorate of Health published a Norwegian translation of the Marmot Commission's report, "Closing the Gap in a Generation – Health Equity through Action on the Social Determinants of Health" (2008). The Marmot Commission, set up by WHO, examined the causes of and measures for redressing health inequities. One of the main recommendations of the Commission was to establish systems for monitoring health inequities and social determinants of health. One of the main measures in the white paper, Report no. 20 to the Storting (hereinafter referred to as the 'white paper'), was to establish a reporting system to provide a systematic overview of progress on the efforts to reduce inequalities in health. This was to be achieved by monitoring trends using a set of indicators for the intervention areas of income, childhood conditions/education, work and working environment, health behaviour, health services and social inclusion.

The present report is the first output from this reporting system.

Individual and society

The use of structural instruments such as price, availability and regulation have, in the field of public health as in other policy areas, been perceived as restrictions on the individual's freedom of choice and self-determination. In some instances, such criticism may be justified: when official bodies impose restrictions and policies on the individual's scope of action *for the sole reason* that they claim to know what is best for the individual, there is the risk that we end up as a 'nanny state'. Such restrictions and policies are however justified when they serve to safeguard the *freedom of other individuals*. In any society, the individual's freedom of scope may potentially encroach on the freedom of others and this will often – in the absence of rules, policies and restrictions – affect those most disadvantaged in society. Norway's

relatively strict regulation of the price and availability of alcohol was thus not introduced primarily in order to persuade individuals to lead healthier lives, but because alcohol misuse almost always affects the misuser's family and friends. Similarly, the anti-smoking act was not introduced primarily to get smokers to quit smoking, but to ensure that everyone has the right to a smoke-free workplace. Low speed limits and speed humps in the road in residential neighbourhoods restrict the freedom of the individual to drive as fast as he or she might like, but provide children and others with a safer neighbourhood. Measures to curb the freedom of the individual are thus justified when they serve to protect the freedom of others.

Genuine individual freedom of choice also requires insight into the alternatives that may exist and their potential consequences. It is often the case that our material, social, cultural and psychosocial surroundings are powerful determinants of what we perceive as alternatives and what we believe their outcome may be. If healthy food is more expensive than unhealthy food, many people will take the unhealthy option. If the distance to the nearest recreational area is long and awkward, more people will tend to stay at home. And if the facts about the health risks of using oral tobacco are not widely known, then more Norwegians will choose to use oral tobacco than might otherwise have been the case. Society has a responsibility for putting measures in place that make the healthy choices the easy choices.

In the main, social inequalities in health do not arise because some people *choose* to lead healthy lives, while others *choose* to lead unhealthy lives. They arise because of the social constructs that guide individual freedom of choice. A child born to a financially and socially resourceful family patently has other and far better opportunities than a child from a family struggling to make ends meet. Social inequalities in health arise because freedom of choice in itself is inequitably distributed in society. This inequity of opportunity is due to social constructs, and structural instruments are the most effective and most just – and perhaps also the only – way of changing them. Which means that structural instruments, when justified, result above all in greater freedom of choice – for more people.

The cross-sectoral approach

Since health is produced and distributed across many other arenas than in the health sector, many of the most important instruments also lie outside of the Directorate's own sector. The efforts to reduce inequalities in health thus call for a cross-sectoral approach. The health authorities must to a greater extent be the driving forces in lodging a share of the responsibility for public health with other sectors and in taking the initiative for extensive cooperation between national authorities. We must be instrumental in developing cross-sectoral solutions that are conducive to sound conditions in which to grow and live, and an inclusive and healthy working life. Only in this way

can we promote healthier lifestyles, stability and participation.

The reporting system and the present report are based on a formalised cooperation between several centralised directorates, ministries and professional environments. Interministerial meetings are held to appraise the progress of the work on the reporting system. This is described in more detail later in the report. The point is that we cannot improve public health and how health is distributed without involving, and lodging responsibility with, other sectors in society.

Whether the health sector itself is to play a leading role in these cross-sectoral efforts depends on the problem at issue, This must be assessed with respect to at least two factors: 1) knowledge of causes and effective measures and 2) whether the health sector itself exercises control over the measures to be implemented. It may be helpful to think in terms of three different roles for the health sector:

First, there are the situations in which the health sector itself should and must lead the way. This would include situations where the sector itself has established best practices concerning effective measures and where the sector also exerts control over those measures. One example of this would be group-based preventive work run by the municipal preventive health services, such as the maternal and child health centres and the school health service.

Secondly, we have situations in which the health sector is familiar with effective measures, but in which it does not exercise control over those measures. Examples of this would be the introduction of the school fruit and vegetable scheme or increased physical activity in schools. In such circumstances, the health sector should assume the role of primus motor and negotiator.

Thirdly, we have situations in which the health sector has some insight, and is able to point to adverse health consequences of measures in other sectors, but where the health sector itself does not exercise control over those measures or know precisely how such measures should be designed. Examples of this would include social inclusion in schools or in working life.

Challenges for public health policy

This report is divided up according to the following intervention areas: income, childhood conditions, work and working environment, health behaviour, health services and social inclusion. These are key determinants of health and the distribution of health. In the following, from the perspective of public health policy, we will be indicating a number of trends we regard as being matters of serious concern. We will also be addressing a number of trends within our own field of expertise – health behaviour – and outlining measures which we regard as appropriate for enabling the Norwegian public to make sound health choices.

In Norway, we are seeing distinct social inequalities in **schooling** and particularly in attainment of upper secondary level education and training.

The report shows for example that among pupils taking a vocational training, around half of those whose parents completed only lower secondary (compulsory) education will drop out of their training programme. Among those whose parents completed upper secondary level education, the drop-out rate is around 30%.Even among students whose parents completed long-cycle (university/ college) education, the drop-out rate is 20%. From a long-term perspective, preventing pupils from dropping out of school may be one of the greatest public-health challenges we face.

A **school health service** with sufficient capacity is an important measure in reducing social inequality in health. However, this particular branch of the health service lacks capacity, and this report reveals that our statistics are not adequate for monitoring trends in this area. One measure in the white paper on inequality in health is to strengthen this service. Realising the white paper's ambitions and building up the service in terms of content and capacity will be a challenge in the coming years.

For the majority of health services, any lack of capacity soon becomes apparent in the waiting lists of priority patients. When it comes to **preventive health care and health promotion** services, the situation is quite different. These services target everyone, including individuals at risk, with the aim of preventing health problems from arising in the first place and from worsening. Understaffing is thus not immediately manifest from queues of people with differing health complaints. The Directorate of Health therefore believes that the time has come to consider whether nominal personnel levels should be set for the maternal and child health centres and the school health service. If this is not accomplished, preventive services aimed at children and young people might easily be deprioritised in the face of the limited resources available.

Labour market exclusion puts the health of the individual at risk. From the perspective of public health policy, it is vital that we succeed in maintaining a high rate of employment in the face of global economic trends. Of particular concern is the fact that around one third of persons registered as unemployed with the Norwegian Labour and Welfare Administration (NAV) are young people in the age group 20-29 years. In spring 2010, the Directorate of Health will be publishing a report on the correlation between employment, health and social inequality. This report will seek to shed light on both the immediate and the long-term health impacts of being excluded from the labour market, and how these impacts affect different social layers in the population.

In 2008, a **'qualification programme'** was introduced within NAV as a means of assisting individuals, who are already, or are at risk of becoming, long-term recipients of financial social assistance, to gain employment. This scheme will be operational nationwide from 1 January 2010. Participants in the qualification programme are offered close individual follow-up and individu-

alised schemes. The qualification programme is regarded as one of the main measures in eliminating poverty, and one which also holds great health potential. If we succeed in eliminating poverty and social exclusion through participation, employment and activity, more individuals will enjoy improved health, which will have the effect of reducing social inequalities in health.

In certain **areas of health behaviour**, the trend is moving in the right direction, but we still need to maintain a clear focus on these areas, and not least on how health behaviour is distributed within different groups in the population. The trends that come to light in these areas must be taken as crucial premises for future measures and strategies.

When it comes to **tobacco use**, the number of young smokers has halved over the last five years. However, among 10th graders (age 16), those with the lowest socioeconomic status are around four times more likely to smoke than those with the highest socioeconomic status. In the adult population, those whose education ended with lower secondary school are around three times more likely to smoke than those who completed higher (university or college) education. Smoking is therefore the health behavioural factor for which the correlation with socioeconomic status is strongest, and for which the health risk is also very well documented. Over the last decade, the number of smokers in Norway has gone down considerably – by a third. The decrease is seen in all social layers in the population, yet substantial disparities persist. In order to achieve better public health, adult smokers will need to quit and young people must be persuaded not to start. If not, we will not see any improvements in public health for several decades.

Effective structural instruments are crucial in reducing inequalities in health, and high prices are a precondition. In order to reduce inequalities still further, accessibility must be reduced, both in terms of access to tobacco products and to locations where smoking is permitted:

- Supervisory programme to ensure compliance with the age-limit applicable to sales of tobacco products. It is far too easy for under-eighteens to get hold of tobacco products.
- Amendments to national regulations to make workplaces entirely smoke-free by revoking the exception in the Act relating to prevention of the harmful effects of tobacco, which sanctions smoking in separate rooms and designated smoking areas. A smoking ban in public places has great significance for the quality of life of a great many people.
- Consistent regulations to prevent the use of tobacco in kindergartens and schools.

Dietary indicators reveal major social inequalities in intake of fruit, vegetables and sugary drinks among both young people and adults. The number of infants who are exclusively breastfed for the first 4 months of life increases with increasing level of

maternal education. The number of pupils in junior schools (ages 6-13) registered for the school fruit and vegetable scheme increased from 15% to 27% in the period 2005-2008. But as such, we know that far from all school children are benefiting from this scheme. The special duty on non-alcoholic beverages (including sugary drinks) increased from NOK 1.52 to NOK 1.68 per litre in the period 2002-2008 and to NOK 2.71 per litre from 2008 to 2009.

Within the last few decades, total consumption of fruit and vegetables has increased. This is encouraging, but the improvement is slow and we are far from having reached the targeted levels. Sales of sugary drinks were initially decreasing for a number of years but in recent years have begun to increase again. Annual sales of confectionery increased from approx. 13 to 15 kg per capita over the last decade. In order to accelerate changes in diet and to reduce social inequalities in diet, it is now vital to intensify the measures relating to food prices and school meals:

- VAT exemption on foods labelled as healthy options under the 'keyhole' healthy foods scheme should be considered.
- Marketing of unhealthy foods and beverages aimed at children and young people should be prohibited.
- A free daily fruit and vegetable snack scheme for all children and young people from kindergarten through upper secondary school should be guaranteed and ultimately extended to provide a comprehensive all-day school meals service.

The indicators for **physical activity** reveal substantial differences in physical activity level correlated with educational attainment, but less obviously correlated with income. Among children and adolescents, the trend is less consistent. Equally, the report shows that the general level of physical activity in the Norwegian adult population is alarmingly low compared with the recommended level. Only one in five adult Norwegians is physically active for 30 minutes a day, and we know that only half of 15-year-olds meet the recommendations of at least 60 minutes' daily physical activity for children and adolescents. This is low, since spells of activity lasting as short as 10 minutes count in the recommendations.

The report also reveals an alarming trend in the increase of overweight and obesity with the ensuing health complications such as metabolic syndrome and type 2 diabetes. This trend cannot be reversed without incisive intervention in aspects of health behaviour. Interventions will necessarily include normative, educational, structural and economic policy instruments applied over time. Reversing this trend will require structured efforts for at least a decade.

To increase the level of physical activity in the population, measures will have to be stepped up intensively in a number of areas. The following are especially important:

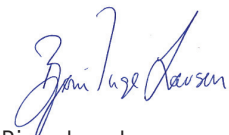
- Daily physical activity at school
- Further extension of pedestrian zones and cycle tracks
- A wide range of effective, low-threshold physical exercise amenities in local neighbourhoods which all residents can make use of. Key arenas are school, workplace, neighbourhood and leisure/recreation. State interaction with the private and voluntary sectors will be an obvious course of action.

In addition, it is important to strengthen education in health and lifestyle in secondary, higher and further education among health professionals, school and kindergarten staff and other relevant educations (e.g. degree programmes in architecture and engineering).

Finally

The white paper on inequality in health proposes an ambitious programme to report on trends concerning the distribution of determinants of public health. This kind of progress monitoring is important for future implementation of measures and identification of new measures to reduce social inequalities in health. This will require cross-sectoral approaches and cooperation. No fewer than 9 ministries and their agencies followed, and provided input for, compilation of this report. This has been a constructive and useful process and is commendable as an important achievement in itself.

This is also the first-ever attempt to compile a full overview of the trends from a public health perspective. Striking the balance between simplification and precision is demanding, especially where access to data is limited. This report is also a first attempt to show the trend in and distribution of key health determinants – and it is by no means exhaustive; the reporting has to be continually improved. the reporting has to be continually improved.



Bjørn-Inge Larsen
Director General of Health

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Introduction

The public health policy report will produce an annual, systematic overview of efforts at national level to reduce social inequalities in health. Combined with the established cross-sectoral working groups that have provided their input for the report, this constitutes what will be referred to as 'Reporting System – Social Inequalities in Health'.

The reporting system ensues from Report No. 20 (2006–2007) to the Storting. *National strategy to reduce social inequalities in health.* This white paper establishes that, while the health of the nation is good, the average figures mask large and systematic disparities between different income, education and occupational groups. The overall goal of the white paper is to reduce social inequalities in health without detriment to the health of any groups.

The white paper makes two strategic choices. Firstly, as stated, it establishes that the prime objective for national public health policy is to achieve a more equitable social distribution of health without detriment to the health of any groups. Secondly, it attaches importance to taking a health determinants perspective. Sound health is not achieved solely in those areas of society which have traditionally been covered by the health sector, such as health services and health behaviour; other factors influencing living conditions such as personal finances, employment, childhood conditions are probably equally important determinants of public health.

The reporting system constitutes an instrument and a mechanism to make it possible to track trends in the structural determinants that are administered by the health sector and other sectors. The reporting system draws on the white paper's objectives and sub-objectives and provides a systematic overview of the progress made in reducing inequalities in health. As such, the reporting system will provide a basis for guiding measures towards the goals that have been set. The white paper sets out the following objectives for the reporting system:

- The Directorate of Health is to publish an annual report throughout the strategy period up to 2017, compiled in close cooperation with relevant specialist directorates and professional environments
- The annual reports are to 1) present a précis of centralised measures and strategies at national level to be seen in the context of the objectives of reducing inequalities in health and 2) comment on trends revealed by the selected indicators
- The reports are to provide a systematic and regularly updated overview of progress made in the efforts to reduce social inequalities in health based on the objectives and sub-objectives described in the individual chapters in the white paper
- For each of the declared objectives, one or more indicators are to be developed to permit trends to be monitored over time
- The Directorate of Health is to be given responsibility for coordinating development of the indicators, in close cooperation with relevant specialist directorates and professional environments
- The indicators are to be selected on the basis of joint assessments of the nature of data available and the types of indicators that will be best suited to reflecting trends in social inequalities in health
- The indicators must in the main be based on existing sources of data
- The indicators of social position used for the different target areas must be viewed in relation to each other

The efforts to establish a reporting system are organised with the Directorate of Health as the project manager and secretariat together with six working groups. These working groups correspond to the six main areas of the strategy: income, childhood conditions, work and working environment, health behaviour, health services and social inclusion. The Directorate of Health is coordinating and heading the work performed in the working groups and facilitating progress and effective work processes.

Report structure

The individual chapters in the report describe correlations between health and the different determinants of health: income, childhood conditions, work and working environment, health behaviour, health services and social inclusion. This is followed by presentation of a set of indicators to show trends for these determinants. For certain factors it was not possible to devise indicators based on existing data sources.

An *appendix* presents reports on strategies and measures from those sectors that are responsible for following up on strategies and measures within the relevant target areas. The appendix section follows the same structure as the report, to make it easy to browse back and forth between indicator reporting (in the report) and measures reporting (in the appendix). The appendix is based on reports from Norwegian ministries and directorates.

Report content

The report is split into chapters covering the six main topics of the Government white paper on inequality in health. Each chapter contains a brief description of the connection between the social determinants of health and health. It then presents a selection of indicators showing how the various determinants are distributed in the population and the progress made over time in reducing

The composition of the working groups was as follows:

Intervention area	Composition
Income	Ministry of Finance Statistics Norway Ministry of Labour and Social Inclusion Norwegian Directorate of Health
Childhood conditions	Ministry of Education and Research Norwegian Ministry of Children, Equality and Social Inclusion Norwegian Ministry of Culture Norwegian Directorate for Education and Training Norwegian Directorate of Health
Work and working environment	Norwegian Labour and Welfare Administration Directorate of the Norwegian Labour Inspection Authority Norwegian National Institute of Occupational Health (STAMI) Norwegian Directorate of Health
Health behaviour	Norwegian Directorate of Health
Health services	Statistics Norway Norwegian Directorate of Health
Social inclusion	Norwegian Ministry of Justice and the Police/Norwegian Correctional Services Department Norwegian Directorate for Education and Training Norwegian Labour and Welfare Administration Norwegian Directorate of Integration and Diversity (IMDi) Norwegian State Housing Bank Vox – Norwegian Agency for Lifelong Learning Norwegian Directorate of Health

social inequalities in health. Sectoral delimitations and priorities have been applied depending on the topics given most emphasis in the different chapters in the white paper, while the declared objectives informed the structure of the report.

The chapter on income discusses the correlation between income and health, presenting different explanatory models for this determinant. The chapter then presents and offers a commentary on indicators of income distribution and low income. No indicators have been developed for sub-objective 3 *Ensure fundamental economic security for everyone*, but a discussion of measures and strategies for this aspect is presented in part 2 of the report.

The *chapter on childhood conditions* addresses conditions during childhood and adolescence as determinants of health. This chapter deals with the target areas of kindergarten, school, school health service and follow-up of children at risk. Indicators for social inequality are presented in terms of schooling and completion of higher education. This chapter introduces an additional sub-objective to the six set out in the white paper; of *Reducing social inequality in children's and adolescents' organisational and cultural participation*. The reason for this is that organisational and cultural participation are the object of discussion and measures on a par with the other objectives laid down in the white paper.

The *chapter on work and working environment* describes the correlation between employment and health in terms of two dimensions: one concerns the significance for health of differing degrees of inclusion in working life. The other dimension concerns the correlation between the working environment and various exposure factors and health. The white paper's discussion of this intervention area attaches importance to prevention and measures to prevent labour market exclusion. The selection of indicators was largely informed by the white paper, in which measures to reduce sickness absences in Norway are key. As a key indicator under sub-objective 2 *Healthier working environments*, data at the National Institute of Occupational Health (STAMI)/National Surveillance System for Work Environment and Occupational Health (NOA) will form the basis for further development of indicators.

The *chapter on health behaviour* describes the correlation between different types of health behaviour and health. This chapter concerns diet, physical activity, the use of tobacco and substance abuse. The indicators for health behaviour cover priority goals for public health and are based on data from Survey of Living Conditions (Statistics Norway); Trends in health and lifestyle in children and adolescents in Norway, Sweden, Hungary and Wales. Results from nationwide surveys in Health Behaviour in School-aged Children, a WHO Cross-National Study (HBSC); and figures from the Norwegian Institute for Alcohol and Drug Research (SIRUS). In many instances it was logical to present separate figures for adolescents and adults.

The *chapter on the health* service is distinct from the other chapters in that the overriding objective is to acquire greater insight into and awareness of social inequalities present in use of health services; and in that it concerns factors that compound social inequalities in the use of the health services and factors that counteract such distortions. This chapter is based on two recent studies: Sosiale ulikheter i bruk av helsetjenester En analyse av data fra Statistisk sentralbyrås levekårsundersøkelse om helse, omsorg og sosial kontakt (Jensen, 2009) and Likt for alle? Sosiale skilnader i bruk av helsetenester (Finnvold, 2009), both of which analyse social inequalities in the use of Norwegian health services.

The *chapter on social inclusion* describes the correlation between living conditions and health. This chapter focuses on the most disadvantaged groups in the population. Indicators have been established to show the effect of measures to improve living conditions among disadvantaged groups with the emphasis on education and training, reinclusion in the labour market, improving housing conditions and improving access to health services. Sub-objective 4 *Improve the accessibility of health and social services for disadvantaged groups*, combines a sub-objective in the chapter on social inclusion and a sub-objective in the chapter on health services in the white paper. These goals are combined because both of them are focused on disadvantaged groups and because they are essentially quite similar.

For sub-objective 5 *Reduce inequalities in living conditions between different geographical areas*, a provisional delimitation has been made according to where central government measures have been implemented to reduce geographically-determined inequalities in living conditions, as seen in the interventions in the deprived districts of Groruddalen and Oslo Sør in Oslo. The programme for these districts extends until 2016, which will permit progress here to be monitored throughout the reporting period.

Appendix

The appendix contains sectoral reports on strategies and measures in pursuit of the white paper's target areas, and follows the structure of the main report. In this section, the various sectors describe both general and fundamental political policies, together with current measures and instruments.

Challenges

One of the greatest challenges in the efforts to establish viable indicators for the various intervention areas is the lack of relevant data and statistics. This is a particular problem for the area of health services. Even where useful data exists, links have not been made between the registers that contain them, making it impossible to draw any conclusions concerning socioeconomic distribution. One example of this is found in the intervention area of work and working environment, for which we need to be able to link sickness absence statistics with Statistics Norway's educational statistics, but where this will require modifications to how data are compiled and new routines for data extraction. Another example is in the area of health services, where there is now the prospect of being able to establish useful distribution indicators following the removal, from April 2009, of the anonymity of data on citizens in the Norwegian Patient Register, which means that individual medical records/case notes and use of health services are recorded and accessible for research purposes. Challenges of this nature are discussed in the report in terms of development needs, and represent an area in which we hope to see improvements over the next few years.

Yet another challenge concerns the timing of when different statistics are released by various information systems. Figures from KOSTRA, the national information system for municipal and county activities, for example, are released in June each year, that is, after this report has been submitted to the Ministry of Health and Care Services, which means that the report only contains figures from the preceding year.

The report is generally based on figures from a number of data sources, and far from all of these are updated annually. One example is the Survey of Living Conditions from Statistics Norway, conducted every 3 years, which is a statistics bank from which many figures for our indicators have been obtained.

Cross-sectoral work is also a challenge. This is a report compiled in collaboration with national agencies within a wide range of sectors with different working methodologies and cultures. Getting all partners to arrive at a common understanding of the problems and solutions to them has cost time and resources. However, this collaboration across sectoral divides is in itself one of the most important outcomes of this reporting system. We all have much to learn from each other, and all face challenges that we cannot resolve in isolation within our own sector. This is true not least of social inequalities in health.

Work on the reporting system will be ongoing for many years, and this year's report should be seen as a first step. When we commence work on next year's report, we will benefit from the reporting structure and collaborative relationships already established.

1. INCOME

1.1 INCOME AND HEALTH

Many studies point to statistical correlations between income and health: the health of individuals increases in proportion to increasing income. For both men and women – but especially for men – the mortality rate increases, statistically, in lower income groups. The lower the income, the higher the mortality rate, making this an inverse exponential correlation.

There are a number of explanations for the correlation between income and health, and the phenomenon exists in the majority of countries (Mackenbach et al. 2005). Firstly, personal finances affect health more or less directly through various forms of healthy/unhealthy consumption. Sound finances also improve access to healthy homes, recreation, healthy eating and health services. The academic term for this is usually *causality:* the direct causal connection between income and health.

Another explanation for the correlation between income and health is what is termed *selection*: poor health produces low income. For example: a person who retires from employment for health reasons in order to live on a disability pension, will, because of the structure of this pension, end up on a reduced income.

A third explanation for the correlation between income and health is that they share the same underlying cause. For example: occupations involving severe occupational health impacts are also often low-wage occupations. In this instance there is no direct causal connection between income and health, but the occupation affects both factors.

A fourth explanation for the correlation between income and health is the so-called income-inequality hypothesis. According to this hypothesis, income inequality *intrinsically* disfavours public health, and a society with great income inequalities will suffer poorer average health than a society with minor disparities in income. For Norway there are research findings to suggest that this theory has some basis in fact. A comparison of mortality and income inequality in Norwegian residential regions in the 1990s shows that low-income groups especially have lower mortality in regions where income inequality is relatively low (Elstad, Dahl & Hofoss 2005). The exact mechanisms behind such correlations are uncertain however.

It is difficult to determine the relative significance of these differing explanations for the correlation between income and health because research in this area has only to a limited extent addressed the temporal dimension and the relationship between income and health from a life-course perspective. The relatively few longitudinal studies (investigating individuals over time) of income and health that are available (summarised in Benzeval & Judge 2001) indicate, among other things, that

- income over time is more significant for health than income at a specific time
- income level is more significant than income change
- persistent low income is more significant than low-income episodes
- a reduction in income is more significant than an increase in income

The white paper on inequalities in health bases its interpretation of the correlations between socioeconomic status and health on a gradient perspective. According to this perspective, the same types of mechanisms are at work at every stage in the socioeconomic hierarchy but have stronger impact lower down in the hierarchy. The explanations for the correlations between low income and health will therefore be the same for the correlations between income and health in a more general sense. Any precise definition of the "low income group" will thus, from a health perspective, be somewhat arbitrary.

Equally, there is much to suggest that, as discussed above, *selection* has relatively greater influence in the lower income segment. In this segment, selection effects – which cause poor health to result in lower income – are likely to have a reinforcing effect on the causal correlations between income and health, thus giving rise to vicious health-income circles.

The following sectors and national bodies are involved in the reporting on measures and indicators within this target area:

- Ministry of Finance
- Statistics Norway
- Ministry of Labour and Social Inclusion
- Directorate of Health

The objectives for public health policy in the area of income are to:

- Reduce economic inequalities in the population
- Eliminate poverty
- Ensure fundamental economic security for everyone

1.2 SUB-OBJECTIVE: REDUCE ECONOMIC INEQUALITIES IN THE POPULATION

1.2.1 Indicators

There are a number of different methods for presenting inequality of income and not all metrics will show identical trends over time. For this reason it may be useful to select just a single metric for inequality when assigning indicators to inequality of income.

Here we present three inequality metrics which are expected to provide a comprehensive picture of the trends in income inequality in Norwegian society.

- Gini coefficient
- S80/S20
- P90/P10

Gini coefficient

The Gini coefficient is the most commonly used income inequality metric. The metric ranges from 0 to 1; the greater the coefficient, the greater the income inequality. The Gini coefficient is based on the ratio between the cumulative proportions of the population ranked by increasing income, and the cumulative proportion of the income that they receive.

One of the advantages of the Gini coefficient is that it responds to changes in all segments of the distribution. This may also pose a problem, however. The Gini coefficient may for example be heavily affected by extreme values. This applies for example to a few individuals with extremely high income. (see Figure 1.1)

In recent years, the trend in income inequality in Norway has been heavily affected by trends in share dividends. Dividends on shares increased substantially in the years 2002-2005 before new tax rules in 2006 made it less profitable to cash in dividends. The result was a considerable decrease in dividends and reduced inequality of income. This produces relatively marked effects on the Gini coefficient for the years 2005 and 2006.

As shown by Figure 1.1, income inequality otherwise increased almost year on year after 1986 and until 2005. However, we see that inequality decreased significantly from 2000 to 2001 before it again increased heavily up to 2005. The trend in 2001 was largely due to adaptations to amendments to the tax rules on share dividends. The fiscal year 2001 saw the introduction of personal taxation on share dividends, although this tax was withdrawn only a year later. This resulted in a number of shareholders refraining from cashing in dividends in 2001.

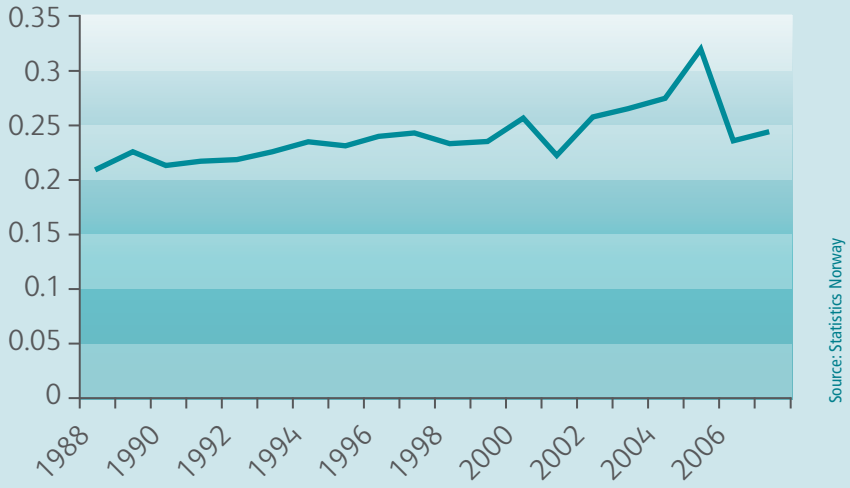
If we discount share dividends from the income concept, income distribution is far less unequal, and the same dramatic increase in inequality also falls away.

S80/S20

S80/S20 shows the ratio between the share of total income achieved by the 20 per cent of the population with the highest income, and the share of the 20 per cent with the lowest income. The greater this ratio, the greater the disparity in income between those at the bottom and the top of the income range.

One of the advantages of this inequality metric is that it is relatively easy for most people to understand, being less technical than the Gini coefficient for example. However, in the same way as for the Gini coefficient, S80/S20 is heavily affected by extreme observations at the upper end of the distribution. It should also be pointed out that this metric does not take account of changes

Figure 1.1 Trend in income inequality measured using the Gini coefficient. Income after tax per consuming unit (EU scale), excluding students. 1988–2007



in inequality occurring within the 60 per cent of the population in the mid-range of the distribution (i.e. those with an income higher than the lowest fifth of the population and with an income lower than the fifth with the highest income).

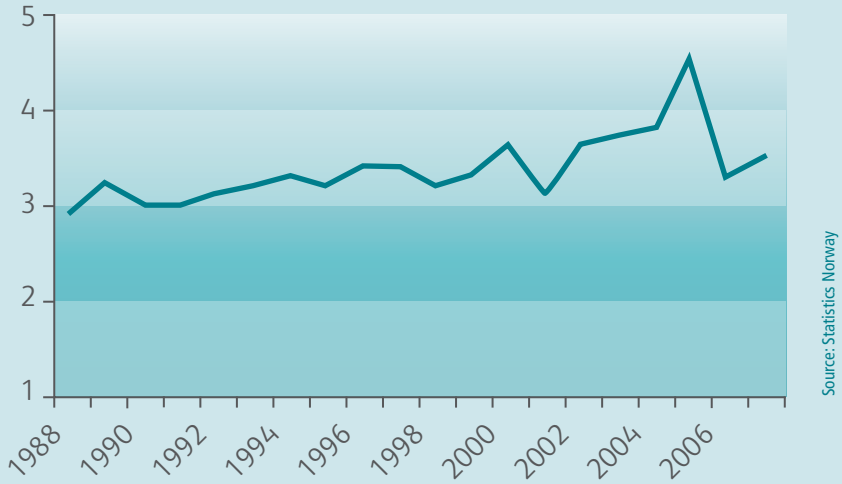
Figure 1.2 shows that the average income of the fifth with the highest income was 3.7 times higher than the average income of the fifth with the lowest income in 2007. Two years previously, the difference in income between the two groups was as high as 4.8. This is connected with the amendments to the tax rules on share dividends discussed above.

P90/P10

The P90/P10 index shows the ratio of the income of a person with an income higher than 90 per cent of the population (P90) to a person with an income lower than 90 per cent of the population (P10).

The advantage of this indicator is that it is not affected by extreme values at the top and the bottom of the distribution, since the income of

Figure 1.2 Trend in income inequality measured using S80/S20. Income after tax per consuming unit (EU scale), excluding students. 1988–2007



the 10 per cent with the highest income and the income of the 10 per cent with the lowest income cannot affect the ratio. But again, this means that this metric, unlike the other inequality measures, does not reflect changes in inequality occurring at the very top and bottom of the distribution.

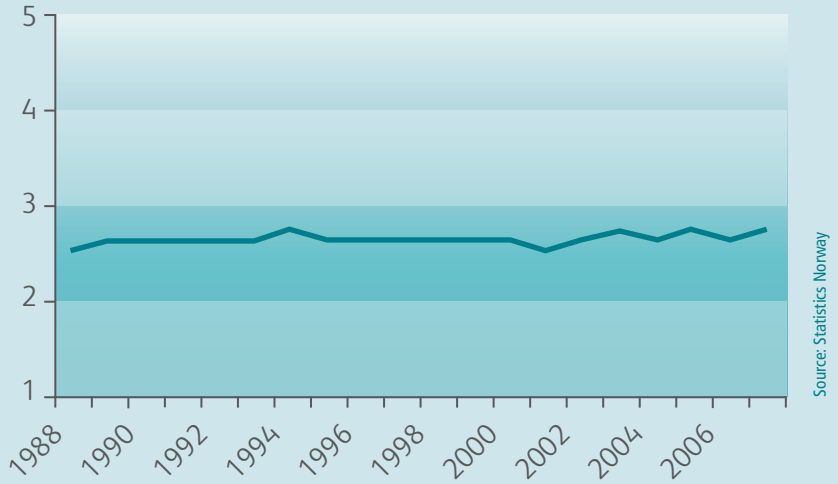
Figure 1.3 shows that P90/P10 has been surprisingly stable over the entire period 1988-2007. One interpretation of this might be that the increase in inequality registered in the years pre-2005 was attributable to an increase in income among a few individuals (fewer than 10% of the population) that was considerably higher than among the rest of the population As stated earlier, one important explanation for this would be the large dividends paid out between 2002 and 2005.

Besides establishing inequality metrics, *income* and *population* must be clarified as terms. According to official income statistics, the recommendation is to use income after tax as the income metric. This concept comprises the majority of cash income received by households (the total of employment income, capital income and various benefits, with tax deducted). The best unit for elucidating financial living conditions is considered to be the household, that is all persons who are assumed to have collective finances. In order to be able to compare households of different size and composition, household income has to be corrected using so-called equivalence scales. There are several such scales and no agreement has been reached on which is best suited to correcting household income. In devising inequality indicators, we would however propose using the same equivalence scales as those currently employed by the EU which are also those currently most used in Europe.

From the perspective of living conditions, the individual is the best countable unit, rather than the household. The corrected household income is therefore assigned to each individual person in the same household, in other words, persons in the same household will have the same income after tax per consuming unit.

The student population is in this case omitted from the indicators for income distribution and low-income shares. For the indicators of income inequality (Gini coefficient, S80/S20 and P90/P10 indexes), this has no significant bearing on the findings, although the indicators for low-income shares drop slightly when students are discounted. There is however good reason not to include students in the low-income group, among other reasons because student loans are not counted as income here.

Figure 1.3 Trend in income inequality measured using P90/P10. Income after tax per consuming unit (EU scale), excluding students. 1988–2007



Development needs

The basis for the inequality indicators that were employed was annual household income. However, it might be worth extending the observation period to several years. Based on previous experience, extending the observation period from one to three years for example, might not produce significant changes in terms of depicting trends in inequality over time. However, disparities in income will generally be somewhat smaller due to the fact that some individuals move in the distribution over time, tending to move up on the scale (income mobility).

1.3 SUB-OBJECTIVE: ELIMINATE POVERTY

Poverty in Norway has different causes, is differently expressed and is difficult to describe using a single figure. The proportion of the population living on an income below a certain level of the general income level in society is a simplified, but widely accepted indicator for measuring trends in poverty. Low income is an important indicator of poverty, but other factors are also of crucial importance for the living conditions of the individual.

1.3.1 Indicators

According to customary practice in the majority of European countries, a relative definition of low income is applied. This means that low income is defined according to what is the general or typical income level in the population. A common method has been to define all persons with a household income distinctly less than this level, for example only 50% or 60% of the middle-income in society, as belonging to the low-income group. As a measure of middle income, the median tends to be used now, rather than the mean.

For many individuals, a low-income situation may be relatively short-lived, and may not result in significant changes in their financial standard of living. It would therefore appear to be a better indicator for the incidence of low income over a period of several years. In the following, we therefore propose examining the incidence of "persistent low income", according to various definitions.

In order to elicit the sensitivity of assumptions concerning household economies of scale (choice of equivalence scale), we propose that low income be based on both the EU scale and the old OECD scale.

- Percentage with persistent low income, 3-year period, EU method
- Percentage with persistent low income, 3-year period, OECD method
- Percentage with persistent low income for 3 in 4 years

Percentage with persistent low income, EU and OECD methods

Percentage with persistent low income, 3-year period, EU method: the percentage of persons who within a three-year period belong to a household with an average equivalent income lower than 60% of the median average for the entire population within the same period. Income adjusted using the EU equivalence scale.

Percentage with persistent low income, 3-year period, OECD method: the percentage of persons who within a three-year period belong to a household with an average equivalent income lower than 50% of the median average for the entire population within the same period. Income adjusted using the OECD equivalence scale.

Figure 1.4 shows the trend in the proportion of persons with persistent low income, according to the EU and OECD definitions, respectively. For both definitions, the percentage with persistent low income is somewhat lower than it would have been had we looked at annual low income. It therefore seems clear that some persons, for various reasons, have only transient low income.

The figure indicates that the period from 1997 to around 2001 is characterised by a reduction in the proportion of persons with persistent low income, applying both the OECD and EU low-income definition. The trend post-2001 is slightly different for the two low-income definitions. For the EU low-income definition, the trend is fairly stable with minor changes in the proportion of

persons with persistent low income. Using the OECD method, however, we see an increase in the proportion of persons with persistent low income year on year from 2001 (1.8%) and up to 2004 (3.0%).

For persons of working age, there is a close connection between being unemployed over a period of several years and experiencing persistent low income. Among all persons aged 25-65 years and who had belonged to a household in which no individual was in employment over a three-year period, as many as 33% experienced persistent low income in 2006 (Table 1.1). Since the proportion with persistent low income (EU definition) among all persons in the same age-group was only 6%, this suggests that those without any employed person in their household were at just under 5 times greater risk of experiencing persistent low income as compared with all persons in this age group. However, equally we note that persons in households with more sporadic labour market participation have almost as great a probability of experiencing persistent low income as those with no employment at all. Among persons who within the three-year period had belonged to a household in which at least one member was in employment for at least one of the years, as many as 30% experienced persistent low income. Not until persons belong to a household in which at least one member is in stable employment is the probability of experiencing persistent low income dramatically reduced. Among persons in a household with one member in employment for all three years in the period, only 4% experienced persistent low income in 2006.

For persons in the age-group 25-65, there is also a strong correlation between personal labour market participation and the incidence of persistent low income. According to the EU low-income definition, more than one fifth of all those who were non-participants in the labour market over the three-year period 2004-2006 experienced persistent low income. This percentage has scarcely changed in recent years. Against that, hardly any of those who were in employment in each of the years in the three-year period experienced persistent low income.

Percentage with persistent low income for 3 in 4 years

This is the percentage of persons with an equivalent income below the low-income limit in the current year and who were also below the low-income limit during 2 of the preceding 3 years. The low-income limit corresponds to 50%

Figure 1.4 Trend in persistent low income. 1996–2006. Proportion of persons with income after tax per consuming unit under 50 % (OECD) and 60 % (EU) of the median average during the period, excluding students. Two different equivalence scales

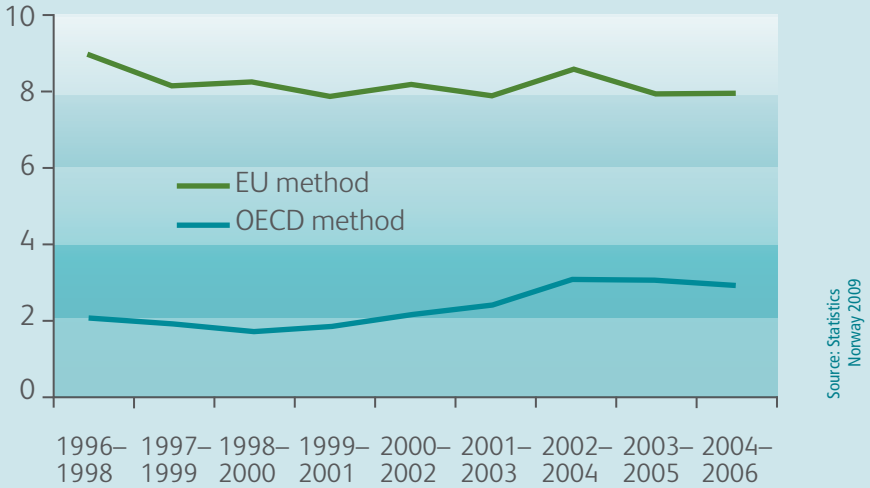


Table 1.1 Persons aged 25–65 years, by number of working household members and own labour market participation. 1996-2006. Proportion with persistent low income. Age refers to the last year in the reference period.

	OECD definition (50%)						EU definition (60%)					
	99-01	00-02	01-03	02-04	03-05	04-06	99-01	00-02	01-03	02-04	03-05	04-06
CHARACTERISTICS OF THE HOUSEHOLD TO WHICH PERSON BELONGS:												
Persons (25–65 years) in households in which no member participated in the labour market in any of the years	11	14	19	14	13	17	29	34	35	32	33	33
Persons (25–65 years) in households in which there was one member who participated in the labour market in at least one of the years	11	8	8	11	18	13	28	20	22	30	34	30
Persons (25–65 years) in households in which there was one member who participated in the labour market in all of the years	1	1	1	1	1	1	3	4	4	4	3	4
CHARACTERISTICS OF THE INDIVIDUAL:												
Persons (25–65 years) who have not participated in the labour market in any of the years	7	9	9	10	12	11	18	20	19	22	22	21
Persons (25–65 years) who participated in the labour market in at least one of the years	6	5	5	4	5	6	14	11	14	14	14	16
Persons (25–65 years) who participated in the labour market in all of the years	0	0	0	0	0	0	1	1	1	1	1	1
All persons 25–65 years	**2**	**2**	**2**	**3**	**3**	**3**	**5**	**5**	**6**	**6**	**6**	**6**

Source: Statistics Norway 2009

and 60% of the median, adjusted using the EU equivalence scale.

Table 1.2 shows how many persons were below the low-income limit in a given year and who at the same time had been below the low-income limit for at least 2 of the 3 preceding years. Here we limited ourselves only to using the EU equivalence scale. Due to the switch in Statistics Norway's income statistics to a full census as of 2004, more recent figures are not yet available.

As shown by the table, 6.3% of the population (that is, those who belonged to the population in all the years between 2000 and 2003) had persistently low incomes according to this definition. This method thus produces a somewhat lower figure for persistent low income than when low income is defined on the basis of average income for a three-year period (see above). One of the reasons for this is that the observation period is now a year longer (four years) and that more individuals have had the opportunity to 'escape' from the low income group. But the figures will also be affected by the fact that this definition is somewhat "stricter" than that which defines low income on the basis of average income over a three-year period. More individuals, who in one year are in the low-income group, may by the following year have gained an income just above the low-income threshold. Such individuals will then no longer be defined as chronically poor according to this definition. But the same individuals

Figure 1.2 Trend in persistent low income. 1999–2003. Proportion of individuals with equivalent income (EU scale) below the annual low-income threshold and who were below the low-income threshold for at least 2 of the 3 preceding years

	50%	60%	Number of observations
All persons excluding students			
1999	1,9	6,3	16,139
2000	1,9	6,0	16,002
2001	1,7	5,7	16,077
2002	1,9	6,1	15,852
2003	1,8	5,7	16,043

Source: Statistics Norway 2006

may nonetheless have an average income for several years that is so low that, if the other definition of persistent low income is applied, they will still end up in the low-income group. (Theoretically, a household may have had a substantial income in the year it was not in the low-income group, but in practice this is unlikely to be the case for many households).

All the indicators for low income used here have their strengths and weaknesses. The two first indicators, for example, may, to some extent, be affected by the fact that some individuals end up in the low-income group because, in one of the years, they had a large negative income, which affected their average income. The last definition also fails to detect individuals who in some of the years may have had an income above the annual low-income threshold. Such individuals are thus no longer defined as belonging to the low-income group. In this way, the two definitions of permanent or persistent low income are in many ways mutually complementary.

As a supplement to pure income indicators, in future, consideration could be given to including a selection of rather more subjective "deprivation indicators". A number of these are presented in the Statistics Norway report published in 2009: Økonomi og levekår for ulike lavinntektsgrupper. 2008 (Finances and living conditions among different low-income groups). For this context, we would also refer to the Statistics Norway report from 2009 on poverty risk: Fattigdomsrisiko. En levekårstilnærming. Examples of such indicators might be the proportion of individuals who would agree with the following statements:

- Have problems making ends meet
- Cannot afford a week's holiday away from home
- Cannot afford to eat meat or fish every other day
- Have problems meeting different types of expenses (rent, electricity, loans etc.)

The Norwegian Government monitors developments in poverty via a set of indicators, and efforts are ongoing to improve and enhance the indicators to provide a broader picture of the state and level of different aspects of poverty and social exclusion. For a broader presentation of poverty indicators than those presented here, we would refer to the printed annex to Proposition no. 1 to the Storting (2008–2009) for the Ministry of Labour and Social Inclusion: Action Plan to Combat Poverty – situation report 2008 and intensified efforts in 2009.

1.4 SUB-OBJECTIVE: ENSURE FUNDAMENTAL ECONOMIC SECURITY FOR EVERYONE

Basic principles of the national insurance scheme

The government income guarantee and benefits schemes for private individuals are intended to provide financial security in specifically defined situations in which the capacity to provide for oneself is lost or reduced for various reasons. The benefit schemes in the national insurance scheme are universal since they in principle comprise the whole population.

The objective of providing an income guarantee comprises several elements. It includes guaranteeing a minimum income, irrespective of the individual's contribution to the labour market, such as a minimum pension for elderly persons, widows/widowers and people with disabilities, and compensation for special expenses incurred in extension of the situations and causes that give rise to the need for financial benefits.

Another aim is to protect individuals against a drastic fall in accustomed income achieved while in employment, by linking a number of benefits to previous income and accumulated pension credits. The rules for granting and disbursing benefits and the means by which they are financed are instrumental in reducing inequality. Regulations concerning means testing and the fact that higher percentage compensation is awarded for loss of income for those on low incomes than those on high incomes are also important levelling elements.

Further – the premiums – the national insurance taxes – are proportional to income from employment, with no ceiling on income and are charged independently of the individual's risk and behaviour.

Overall, the Norwegian transfer schemes are intended to contribute to a desirable distribution of income in society in which the level of services and financing/tax system determines the degree of equalisation between the recipients of those services and those who contribute to value creation through income-generating employment.

The recipients of permanent and temporary benefits within the national insurance scheme have their benefits regulated annually in line with the increase in the scheme's basic amount. Exceptions to this include unemployment benefit and sickness benefit, which are adjusted in relation to former income. This ensures benefit recipients of an increase in ongoing benefit payments in line with pay and price increases in society at large.

The level of compensation and minimum level for the various benefits are determined by the regulations. The trend in the number of persons receiving minimum benefits is to a great extent determined by conditions on the labour market and in the economy generally. Changes in minimum benefits for example are discussed under strategies and measures (see appendix).

So far, no indicators have been developed for this target area.

2. CHILDHOOD CONDITIONS

2.1 CHILDHOOD AND HEALTH

We find relatively minor social inequalities in health in childhood and adolescence. But we see increasing inequalities in health later through the course of life. The state of health develops gradually and an individual's health at a certain stage of life is a consequence both of factors in the recent past and factors much earlier in life. Factors present even at the foetal stage can affect health in later life.

Childhood is therefore a critical phase for the individual's potential for enjoying sound health in later life and for the potential to reduce social inequalities in health. Growing up in sound health requires stimulation of physical, cognitive, social and emotional development. Sound health development in childhood is one of the most crucial building blocks of lifelong health (WHO CSDH 2008).

Unfavourable material circumstances during childhood, such as a less healthy and less varied diet, poor living conditions or a lack of physical activity and motor development, may gradually accumulate through childhood to produce impaired health potential in later life. Similarly, psychosocial stress during the sensitive years of childhood and adolescence – caused by a lack of security, bullying and neglect for example – may be a precursor of mental problems in adulthood (Elstad 2005).

A good environment in which to grow up, good welfare schemes, guaranteed income, services that reach out to children in high-risk groups, maternal and child health centres and the school health service, day-care institutions (kindergartens) and schools are therefore crucial investments in good public health and reduced social inequalities in health.

Kindergartens have an important preventive function, since some children require special attention and individualised measures. Good kindergartens are able to compensate for a lack of stimulation in the home. Good kindergartens with competent staff can therefore help to prevent young people from dropping out of school further down the line.

Education is the foundation for, and is instrumental in, a number of processes which promote health well into adulthood. The links between education and health are complex, but we can identify two main mechanisms. Firstly, education influences lifelong living conditions. In this way, education is a determinant of the negative or positive health factors individuals are exposed to. Secondly, learning stimulates the acquisition of psychological resources, which in turn influence the individual's potential for achieving good health. Put more simply: learning stimulates coping skills and coping skills stimulate health (Elstad 2008).

Since learning and education are health determinants, inequalities in education and learning will thus contribute to inequalities in health. Consequently, measures to reduce educational disparities will help to reduce inequalities in health. From a health perspective, it is important that the schools sector succeeds in its measures to give all children equal opportunities for learning.

Low-threshold services are vital for children and adolescents. Low-threshold means that the services are for example nearby, available without an appointment, and carry no stigma for users who go there to share confidential information. The school health service and youth health centres are examples of this type of low-threshold service. A study conducted among children and adolescents in Akershus suggests that there is no social inequality in access to youth health clinics and the school health service. Use of the school health service and youth health centres appears to be determined by needs as opposed to social background factors (Clench Aas 2007).

The following sectors and national bodies are involved in the reporting on measures and indicators within this target area:

- Ministry of Education and Research
- Directorate for Education and Training
- Ministry of Culture
- Ministry of Children, Equality and Social Inclusion jointly with the Directorate for Children, Youth and Family Affairs (Bufdir)
- Directorate of Health

The objectives for public health policy in this area are:

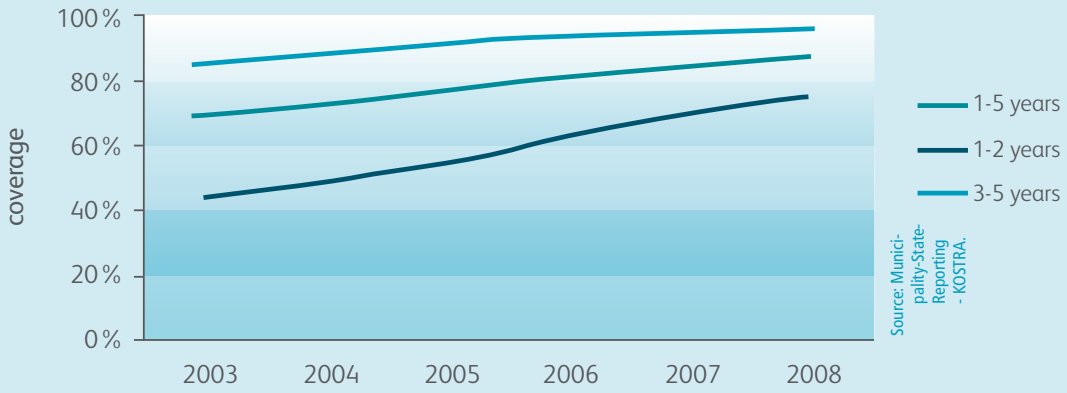
- Full kindergarten coverage and reduced social inequalities in the use of kindergartens
- Reduction in the number of pupils starting school with inadequate language skills
- Reduction in the number of pupils who finish their compulsory schooling without good basic skills
- Reduction in the number of pupils who do not complete upper secondary training
- Early identification and good follow-up of children in high-risk groups
- Greater accessibility of the school health service
- Reduction in social inequality in children's and adolescents' organisational and cultural participation

2.2 SUB-OBJECTIVE: FULL KINDERGARTEN COVERAGE AND REDUCED SOCIAL INEQUALITIES IN THE USE OF KINDERGARTENS

Full kindergarten coverage and affordable fees are important policy instruments in giving all families with young children the option of using kindergartens. A child inspectorate survey from 2002 reveals a close correlation between kindergarten attendance and parental educational attainment and income. In addition, figures from the national information system for municipal and county activities, KOSTRA, show that children from ethnic minorities are less likely to attend kindergarten than other children (see indicator 4). Parents can of course opt out of kindergarten since it is non-compulsory. However, increasing numbers of parents are opting to put their children in kindergarten (see indicator 1). TNS Gallup, commissioned by the Ministry of Education and Research, conducted a questionnaire-based survey among parents whose children attend kindergarten. This found that 93% of parents are satisfied with the kindergarten provisions in terms of their own needs and those of their child.

- Coverage in kindergartens, different age-groups
- Number of children on a waiting list with the right to a place as at 20 Sept.
- Number of municipalities with means-tested fees to parents and/or who offer free places and number of municipalities who do not operate sibling-discount schemes.
- Number of minority-language children in kindergartens as at 15 Dec. (Municipality-State-Reporting - KOSTRA).

Figure 2.1 Coverage in kindergartens within different age-groups. 2003–2008. %.



2.2.1 Indicators

Coverage in kindergartens within different age-groups

This indicator is obtained annually via kindergarten figures submitted by the kindergartens (Municipality-State-Reporting – KOSTRA) (See Figure 2.1).

Number of children on a waiting list with the right to a kindergarten place

This indicator is obtained annually through a separate survey commissioned by the Ministry of Education and Research. Together with the previous one, this indicator shows if we are achieving the first part of the sub-objective; *full kindergarten coverage*.

For the age-group 1-5 years, coverage in 2008 was 87.2 per cent for all children attending kindergarten. For the sub-objective of full kindergarten coverage, figures from 20 September 2008 indicate that an estimated 5,000 children with the right to a kindergarten place were on a waiting list. The corresponding figure for 2007 was 6,000 children.

Percentage of municipalities with sibling-discount schemes

The percentage of municipalities with means-tested fees to parents and/or who offer free day-care places and the percentage of municipalities who do not make sibling-discounts are obtained annually (in January) by Statistics Norway through a fees for day-care survey.

Figures from 2009 show that 24% of municipalities have means-tested day-care fees; 83% offer free places; while 8% have no discount schemes beyond the statutory sibling-discount (Statistics Norway's fees for day-care survey, January 2009).

Minority-language children

The number of minority-language children in kindergartens as at 15 December, see Table 2.1, is estimated by the Ministry of Education and Research, based on figures from Statistics Norway.

Table 2.1 Share of children from a minority-language background in kindergarten out of all children from a minority-language background in the population. 2006–2008. %

	2006	2007	2008
1-5 years	**57%**	**63%**	**67%**
1-year-olds	20%	25%	30%
2-year-olds	36%	43%	49%
3-year-olds	66%	72%	76%
4-year-olds	82%	86%	91%
5-year-olds	87%	90%	93%

Source: Statistics Norway and Ministry of Education and Research

As indicated by the table above, children from ethnic minorities are less likely to attend kindergarten than other children.

Combined with indicator 3, this provides some indication of the degree of attainment of the second part of the sub-objective; *reduced social inequalities in the use of kindergartens*.

2.3 SUB-OBJECTIVE: REDUCTION IN THE NUMBER OF PUPILS STARTING SCHOOL WITH INADEQUATE LANGUAGE SKILLS

2.3.1 Indicators

The Ministry of Education and Research does not have data available on the number of children who have language difficulties in and outside of kindergartens. Figures are however available for how many children are offered Norwegian language stimulation, through data on the subsidies awarded for measures to improve language comprehension among minority-language children of pre-school age, but this figure does not indicate how many children actually need language stimulation. At present, no indicators are available for this sub-objective, so methods for measuring and monitoring trends in this area need to be developed.

2.4 SUB-OBJECTIVE: REDUCTION IN THE NUMBER OF PUPILS WHO FINISH THEIR COMPULSORY SCHOOLING WITHOUT GOOD BASIC SKILLS

2.4.1 Indicators

- Percentage whose academic performance is at the lowest proficiency levels (levels 1 and 2) in national literacy, numeracy and English tests in year 8 of lower secondary school, by parental level of educational attainment
- Percentage whose academic performance is at the lowest proficiency levels (levels 1 and 2) in national literacy, numeracy and English tests in year 9 of lower secondary school, by parental level of educational attainment
- Lower secondary school grade points attained after year 10 of lower secondary school, by parental level of educational attainment

Proficiencies in year 8

Figures for low pupil scores in national tests in year 8 (age 13), by parental educational attainment, have been available annually since 2007 (Schools portal/Statistics Norway) and reflect the level of acquisition of basic skills (literacy, numeracy) among pupils, by parental educational attainment. This indicator is important because basic skills are fundamental for academic attainment, social inclusion, higher education and labour market inclusion.

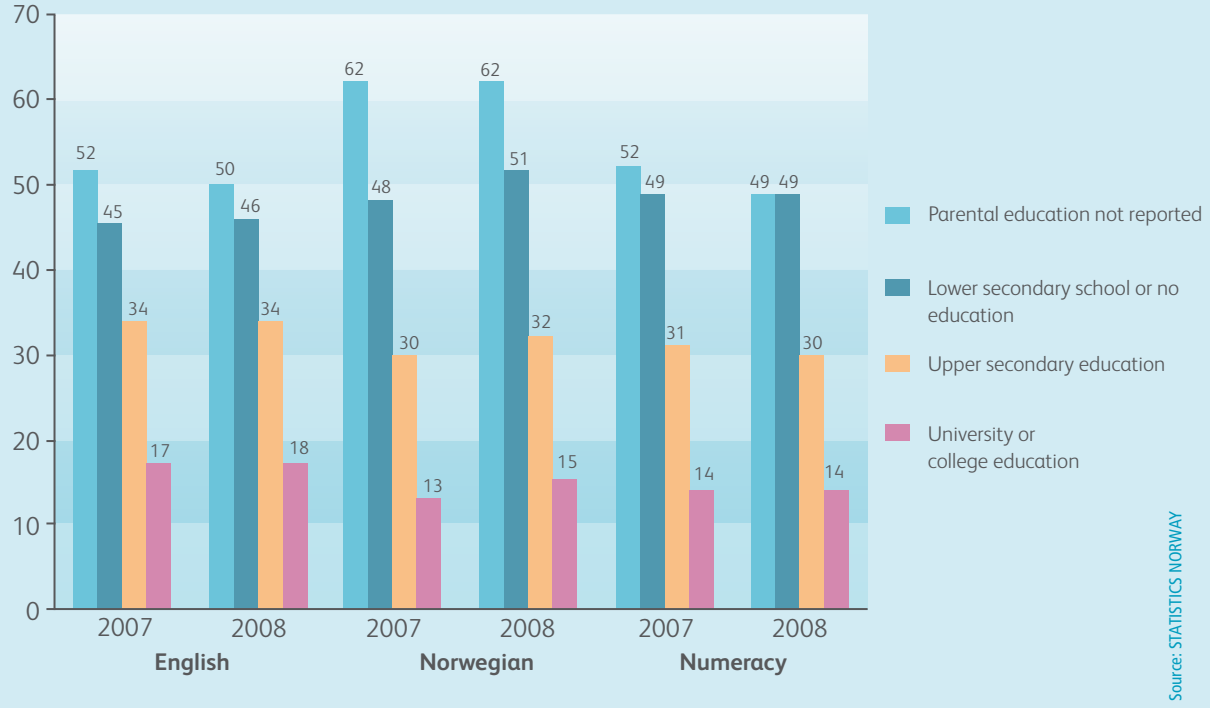
Statistics indicate that the lower the level of parental educational attainment, the greater the risk that their children will be among the 1 in 4 pupils who achieve the lowest scores in national tests. The scores in national tests in year 8 are even poorer if the parents' educational attainment is not registered in Norwegian statistics. This applies primarily to pupils of immigrant origin. All education gained in Norway is reported to Statistics Norway by the national academic institutions, and data on immigrant education gained abroad is obtained via questionnaires. The basis for the statistics presented here is highest level of parental educational attainment.

Figure 2.2 reveals that a full 49% of pupils in year 8 whose parents completed only lower secondary education (leaving school at age 16) or who completed no education at all achieved scores at the two lowest levels for numeracy, while this applied to 30% of pupils who parents completed upper secondary education (schooling until age 18-19) and 14% of pupils whose parents completed tertiary (university/college) education in 2008. The disparities between the different social groups are however most pronounced for Norwegian literacy.

The distribution of pupils at the different levels is extrapolated from total scores in the national tests, and almost 25% of pupils with the lowest scores are ranked in the two lowest categories of 1 and 2. The extrapolated percentage of 25% will however be somewhat dependent on the different sub-scores and overall scores in the tests.

Table 2.2 reveals that pupils whose parents completed upper secondary education or tertiary education of 1-4 years' duration represent 76% of pupils in year 8 with poor scores in Norwegian literacy in 2008. Pupils whose parents completed

Figure 2.2 Pupils in year 8 achieving the two lowest scores in national literacy tests in 2007 and 2008, by parental level of educational attainment (3 levels).



only lower secondary education or for whom data on parental education is not available make up the remaining 24% of pupils with poor scores in year 8.

In both relative terms (percentage of the group) and in absolute numbers, there is reason for concern about the poor scores among pupils whose parents completed upper secondary education and pupils whose parents completed tertiary education. The level of Norwegian pupils' literacy measured in 2006 in year 4 in PIRLS and for 15-year-olds in PISA indicates that the proportion of Norwegian pupils at the lowest levels of proficiency is somewhat higher than the average for the countries that participated in these surveys. In science and mathematics, pupils in Norwegian schools perform well below average in both the PISA survey in 2006 and the TIMSS survey in 2007. And this is in spite of the relatively high level of educational attainment in the Norwegian population and the fact that Norway, together with the other Nordic countries, is among those nations that show the least differences in scores by the pupils' socioeconomic background.

Table 2.2 Number of pupils in year 8 achieving the two lowest scores in national literacy tests, by parental level of educational attainment (5 levels) in 2007.

Parental level of educational attainment	Number of pupils with poor scores in Norwegian literacy
All	15,427
Lower secondary school or no education	2,731
Upper secondary school level	7,926
University or college education	3,809
Not reported	961

Proficiencies in year 9

Information concerning pupils with low scores in national tests in year 9, by parental level of educational attainment, has to be obtained annually (Schools portal/Statistics Norway) and as of 2010 will show the trend in goal attainment regarding basic proficiencies among pupils with high and low social background, by parental educational

PIRLS Progress in International Reading Literacy Study is conducted every five years to assess reading skills among fourth-grade (9- and 10-year-old) pupils.
TIMSS Trends in International Mathematics and Science Study is conducted every four years and assesses aptitude in science and mathematics among fourth and eighth graders.
Both **PIRLS and TIMSS** are conducted by the International Association for the Evaluation of Educational Achievement, **IEA**.
PISA Programme for International Student Assessment – is an international comparative study of school systems in different countries. Every three years, the OECD conducts this survey to assess mastery of reading, mathematical and scientific literacy among 15-year-olds.

Source: www.udir.no (Norwegian Directorate for Education and Training website)

attainment. This indicator is comparable with results in literacy and numeracy for the same pupils in year 8 in the previous year. This indicator is important because basic skills are fundamental for academic attainment, social inclusion, higher education and labour market inclusion. It will not be presented until the report for 2010.

Lower secondary school grade points after year 10

Information concerning lower secondary school academic grade points attained after year 10 of lower secondary school has been available annually since 2007 (Schools portal/Statistics Norway). Studies show the trend in average proficiency attained for pupils with high and low socioeconomic background, by parental education. This indicator should be developed further. Consideration should be given to setting a threshold for what constitutes poor lower secondary school scores that are cause for concern, and determining how many pupils this applies to in different social layers.

Academic grade points form the basis in Norway for admission to upper secondary education. The divide between those who can choose which upper secondary educational institution and which study programme they wish to attend, and those who cannot, varies between the counties.

Table 2.3 shows that the differences in lower secondary school grade points vary depending on parental educational attainment. Pupils whose parents completed higher education of more than four years' duration as their highest level of educational attainment have at least 11 grade points more than pupils whose parents completed only lower secondary education. On average, this represents a whole grade higher in all subjects. In all probability, this reflects even greater disparities in common core subjects, as the majority of pupils achieve high grades in the practical and aesthetic (humanities and arts) subjects in lower secondary school.

Table 2.3 Average lower secondary school grade points for 10th graders in 2007 and 2008, by parental level of educational attainment

Parental level of educational attainment	Lower secondary school grade points	
All persons excluding students	2007	2008
Lower secondary school	34.1	34.0
1–2 years of upper secondary education/training:	36.9	36.7
Completed upper secondary education/training of 3-4 years	38.1	38.1
Tertiary level education - undergraduate	39.4	39.8
Tertiary education 1-4 years	42.5	42.5
Tertiary level education - postgraduate	45.6	45.6

Source: County administrative data system for upper secondary education (VIGO) and Statistics Norway

Pupils are sorted according to the Norwegian Standard Classification of Education (NUS2000), which classifies educational programmes by level and field of study:

- Primary and lower secondary school: levels 1 and 2
- 1-2 years of upper secondary school/vocational training: level 3
- 3-4 years of upper secondary school/vocational training: level 4
- Tertiary level education - undergraduate: level 5
- Tertiary education 1-4 years: level 6
- Tertiary level education - postgraduate: levels 7 and 8

Because inclusion in schooling involves more than academic attainment, consideration should be given to developing indicators for psychosocial wellbeing at school. Average figures for psychosocial wellbeing for year 7 and year 10 of lower secondary school and year 1 of upper secondary school/college show a score of more than 4 out of 5. However, the fact that the education authorities have no *individualised data* for psychosocial wellbeing in secondary schools poses a challenge. This means that it is not possible to determine from official figures whether social inequality in psychosocial wellbeing is present in schools. In the ongoing process of developing this reporting system, it will therefore be useful to consider other sources of information on social inequality in confidence and general wellbeing in schools.

2.5 SUB-OBJECTIVE: REDUCTION IN THE NUMBER OF PUPILS WHO DO NOT COMPLETE UPPER SECONDARY TRAINING

2.5.1 Indicators

The Directorate for Education and Training is currently engaged in a process of indicator development in extension of the programme to enhance the National quality assessment system for compulsory education. To that end, results from national tests form an important element. Selection of indicators to be reported on in joint reporting systems must be seen in the context of these efforts. This includes selection of background variables which will be used in future for the selected indicators. The Directorate for Education and Training conducts annual surveys of pupils' academic scores in national tests and proficiencies attained by the end of compulsory secondary school. The background variables that are used and how the results are presented may vary over time. In connection with reporting to a common reporting system, the Directorate for Education and Training believes that it would be effective to be able to use national and possibly regional-level indicators developed for use in lower secondary education.

Such indicators are important because the level of proficiency at upper secondary level forms the basis for further education and training and labour market inclusion.

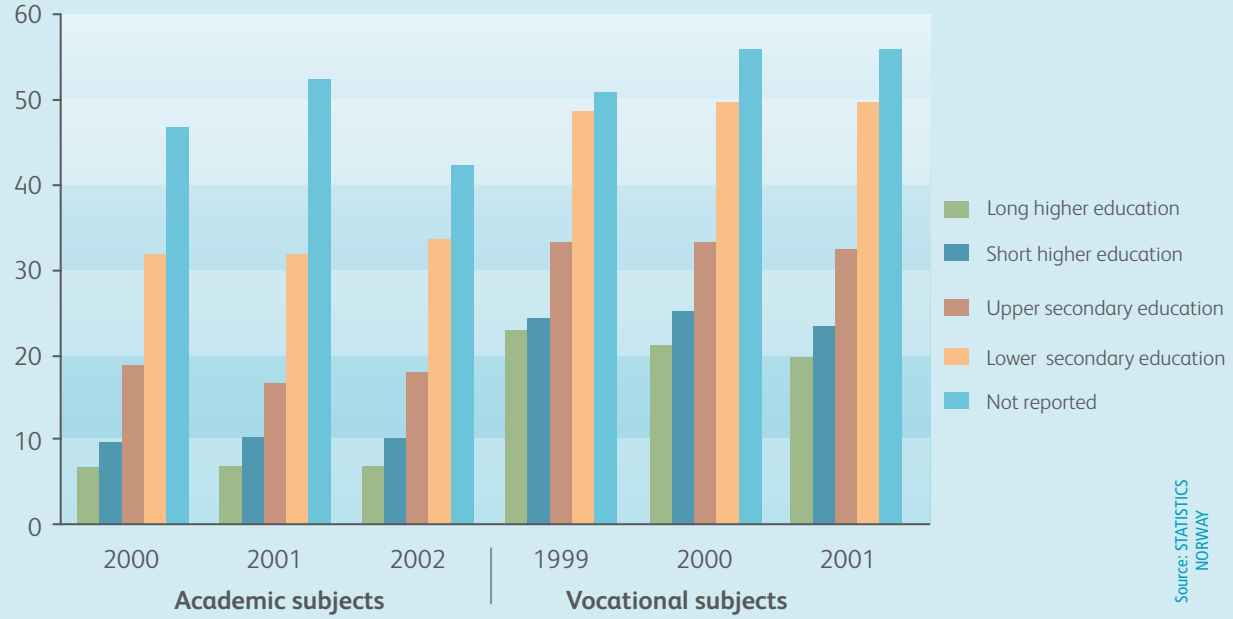
- Percentage of pupils/trainees in each year-group who started *academic subjects* at upper secondary school but who had dropped out five years later or who completed year 3 of upper secondary school/sat an exam at a vocational college without passing, by parental level of educational attainment
- Percentage of pupils/trainees in each year-group who started studying *vocational subjects* but who had dropped out six years later or who completed year 3 of upper secondary school/sat an exam at a vocational college without passing, by parental level of educational attainment
- Percentage of pupils and trainees who completed upper secondary level education whose performance was at a lower level
- Overall grade for the year and at examination in selected subjects in years 2, 3 and 4 of upper secondary school and on vocational training programmes

Drop-out and failure rate in upper secondary education and training

Parental education influences whether young people complete the courses in upper secondary level education/training that they commence. The figure below shows that dropping out of upper secondary education/training, completing year 3 of upper secondary school without a pass mark or failing a vocational studies exam is linked with parental level of educational attainment. The "not reported" group is made up mainly of immigrants where the parents' level of education is unknown. This is due to the fact that not all education gained abroad is registered by Statistics Norway.

The first indicator has been available annually since 2007 (Statistics Norway), and shows the trend in pupils who drop-out or complete year 2 of upper secondary school or vocational college without passing common core subjects, by parental

Figure 2.2 Year-groups who started in 1999, 2000 and 2001 who dropped out or failed to complete their studies or failed year 3 of upper secondary school/vocational exams and share of year-groups who started in 2000, 2001 and 2002 who dropped out or failed exams in academic subjects, by parental education. %.



level of educational attainment. The second indicator has also been available annually since 2007 (Statistics Norway) and shows the trend in pupils and trainees who drop-out or who have completed year 3 or sat a vocational exam without passing their chosen course in upper secondary education/vocational training, by parental level of educational attainment.

Figure 2.3 shows the percentage who dropped out or failed their exams in year-groups who started foundation courses (common core subjects) in 2000, 2001 and 2002 and who started vocational courses in 1999, 2000 and 2001. Here we see that dropping out or failing examinations correlate with parental educational attainment. Although the figures vary slightly from one year to the next, the correlation is clear for the three years represented by the figure.

An average of between 6% and 7% of pupils drop out of upper secondary education/training within the five years that they have a statutory entitlement to receive that education or training. Almost as many (6-7%) complete their programme of study without passing. There are great disparities between pupils whose parents have a high level of educational attainment and pupils whose parents completed fewer years of education. The largest proportion of pupils who drop out or fail is found among pupils whose parental level of educational attainment is not reported.

The proportion that drops out of or fails to pass vocational training programmes is far higher than among pupils taking academic subjects. The proportion that drops out of or fails to pass vocational study programmes also varies depending on parental level of educational attainment, but the differences are not as great as for the non-vocational, academic pupils at upper secondary schools. An average of between 26% and 28% of pupils drop out and around 6% fail to pass. The disparities in completion of education/training between pupils whose parents completed a long education and pupils whose parents completed short education are to be regarded as relatively substantial for the vocational college pupils also. The largest proportion of pupils who drop out or fail is found among pupils whose parental level of educational attainment is not reported.

In the group of pupils whose parents completed only lower secondary education, around half

drop out or fail to pass. In groups of pupils whose parents completed upper secondary education, the figure is around 30%. Even in the group with the longest education, the drop-out/failure rate is 20%.

The figure shows that social inequalities in the degree of completion of vocational studies increased during the period under review. This was due to the slight increase in the drop-out/failure rate in the group of pupils whose parents completed tertiary education.

Pupils completing upper secondary education/ training with lower level qualifications

Information concerning the number of pupils and trainees who completed upper secondary level education/training at a lower level will not be available until 2010 at the earliest (Directorate for Education and Training/Statistics Norway). Studies will show the trend in completion with qualifications at a lower level for those who fail to complete ordinary upper secondary level education/training, by study programme, for pupils and trainees from different social backgrounds, by parental educational attainment.

Overall achievement grades

Information concerning overall achievement grades and examination grades for selected subjects in each of the three years of upper secondary education and for vocational training programmes will be available annually as of 2010 (Directorate for Education and Training/Statistics Norway). Studies will show the trend in average proficiency attained by subject and study programme for pupils, by parental level of educational attainment.

2.6 SUB-OBJECTIVE: GREATER ACCESSIBILITY OF THE SCHOOL HEALTH SERVICE

The Norwegian maternal and child health centres and school health service consist of three statutory subordinate services: health centres for children aged 0-5 years; health centres for youth, and the school health service for ages 5-20 years. The provision for the youngest children reaches out to virtually all children in Norway (99.5%).

In the white paper on inequality in health, the school health service is identified as the subordinate service most vulnerable in terms of capacity. An explicit objective has therefore been set to increase the accessibility of this subordinate service.

2.6.1 Indicators

It has not been possible to develop indicators for school health service accessibility this year.

There is currently little reporting from the Municipality-State-Reporting system, KOSTRA, on the school health service. Besides reporting on the child vaccination programme to the Childhood Vaccination Register (SYSVAK), KOSTRA reports on the following areas:

- The number of health checks performed in the first year of school.
- Number of targeted health checks in year 3 of lower secondary school (8-year-olds).
- Number of targeted health checks in year 8 of lower secondary school (13-year-olds).
- Number of targeted health checks in year 1 of upper secondary school (16-year-olds).

A report on the maternal and child health centres and school health service in the municipalities (Kjelvik 2007) reveals that the majority of children receive health checks at the maternal and child health centres before starting school, but it would appear that the number of children who undergo health checks decreases with age. With a single exception, all municipalities provided a school health service to lower secondary schools in 2005. The vast majority of municipalities that have upper secondary schools also offered them a school health service.

Through the national Municipality-State-Reporting system, KOSTRA, we receive information about resource consumption in the form of total health centre and school health service man-hours and expenditure. The KOSTRA statistics do not provide information about opening hours, organisation or circumstances indicating how accessible the services are, nor do they provide information on the number of staff full time equivalents (man-

- Percentage of reports to child welfare service originating from kindergartens
- Percentage of reports to child welfare service originating from schools
- Percentage of reports to child welfare service originating from maternal and child health centres/school health service

Table 2.4 New children under child welfare protection, by notifying entity 2000–2006. %.

	2000	2002	2004	2006
Mother/father	26.8	25.7	24.2	22.8
Child Welfare Service	6.6	10.8	7.9	7.8
Child welfare protection officer	5	5.3	6	6.1
Social services office	4.7	5	4	3.8
School	9.5	9.9	10	10.8
Police	4.4	4.4	6.1	7.3
Kindergarten	1.9	2.3	3.1	3.1
Maternal and child health centres	6.2	5.6	5.9	6.4
PPT paedagogical psychological service	2.6	2.1	2.1	1.7
BUP -Children's and Young People's Psychiatric Out-Patient Clinic/Adult Psychiatry	3.8	3.8	4.5	4.1
Others*	28.5	25.1	26.2	26.1
Total	100	100	100	100

Source: Statistics Norway

* child itself, other member of family, neighbours, doctor/hospital, not reported

years) per child in each of the age groups. As such, the statistics provide scant information about use of the services, who uses the services, why, and what measures are implemented and the nature of follow-up the users receive. In other words, little information is available on the quality of the school health service.

The Directorate of Health will be working to develop indicators to provide better metrics for both capacity and quality in the Norwegian school health service.

2.7 SUB-OBJECTIVE: EARLY IDENTIFICATION AND GOOD FOLLOW-UP OF CHILDREN IN HIGH-RISK GROUPS

It has not been possible to develop adequate indicators for this area for this year.

2.7.1 Indicators available at present

One indication of early identification might be where a maternal and child health centre, kindergarten school or the local NAV office reports its concern for a child to the child welfare service.

As shown by the table, around 20% of reports to the child welfare service come from these entities. Only 3% of all reports which result in an investigation come from kindergartens. An increase in this percentage would be a sign of earlier identification. The schools and maternal and child health centres should in all likelihood be more rigorous than they are at present in reporting concerns to the child welfare service.

But there is also a need to continue the efforts to identify good indicators for early identification and follow-up of children at risk. However, designing good indicators in this area is no easy task.

Who are the children who are referred to as "high-risk groups"? We know that risk factors include parental mental illness or substance abuse, domestic violence, parents who are long-term unemployed/living on benefits, poverty in the family etc. The more of these factors a child is exposed to, the greater the probability of adverse development. The earlier these risk factors are identified and measures taken, the greater the likelihood that the child will thrive.
Who is in a position to identify these risk factors? Parents themselves will often be able to see negative development in a child and ask for assistance from the authorities. In addition, services which monitor children regularly from their earliest years, such as the local maternal and child health centres, kindergartens and schools, will discover any misdevelopment.

A key success criterion for early identification and help is effective and close cooperation between the different services. Good assessment tools are also crucial in detecting adverse development in children and adolescents.

There are currently no data on cooperative relations within municipalities or on use of state assessment tools. KOSTRA, however, maintains comprehensive reporting on child welfare service activities. There are for example data on all reports resulting in an investigation and on all children on a child protection programme.

2.8 SUB-OBJECTIVE: REDUCTION IN SOCIAL INEQUALITY IN CHILDREN'S AND ADOLESCENTS' ORGANISATIONAL AND CULTURAL PARTICIPATION

2.8.1 Indicators

No indicators have been developed for this target area.

Participation in cultural and organisational activities varies depending on social background factors such as education and income. However, no adequate data sources are available to provide an overall picture of cultural and organisational participation, by socioeconomic distribution (income and/or education), for this group.

There is a need to take a closer look at the correlation between participation in cultural and organisational activities, social capital and quality of life and health. The Ministry of Culture has launched a drive to raise awareness of these correlations and will be continuing its development of measures in this target area.

The possibility of developing a set of general indicators for cultural and organisational participation as a measure of social capital in the population has been discussed . To that end, the Directorate of Health has commissioned a project which will provide an overview of which currently available indicators may be used to describe the level, variation and trend in social capital over time.

3. WORK AND WORKING ENVIRONMENT

3.1 WORK AND HEALTH

For the majority, holding down a job is an advantage that adds to increased quality of life. By working, we put our personal resources to use, join a social 'community' and provide for ourselves. Being employed is intrinsically conducive to good health. Individuals excluded from working life consistently suffer poorer health than those in employment. This applies not only to recipients of health-related benefits, but also to long-term unemployed persons and the recipients of social assistance.

But even among those in employment, the inequalities in health are pronounced. This is due to differences in negative occupational health and safety impacts between occupational groups. Employees exposed to different types of health hazards at work may be at risk of both immediate and late-onset health problems. Such exposure factors range from chemical hazards and ergonomic strain to more psychosocial factors at work affecting personal health.

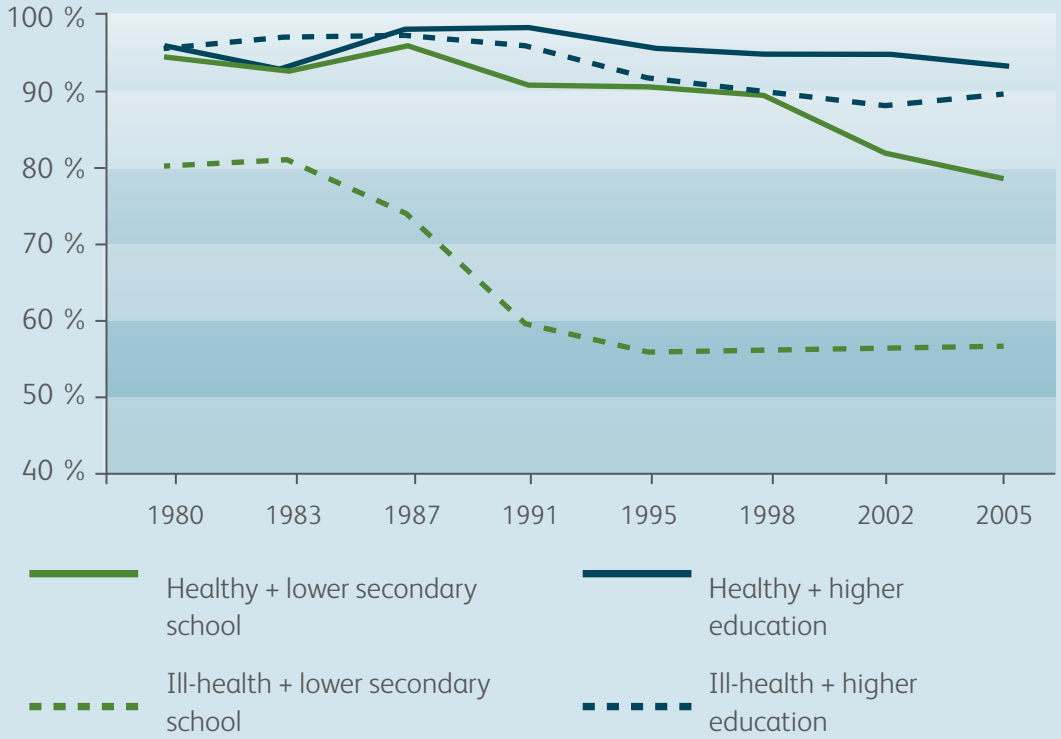
3.1.1 Labour market affiliation and health

Exclusion from working life is known to have major mental and somatic consequences for health. Weak labour-market affiliation and long-term exclusion from working life constitute the principal cause of poverty, which in itself increases the risk of ill health and disease. Studies have been conducted which show distinct, negative health impacts from downstaffing and retirement on a disability pension (Rege, Telle & Votruba 2005).

In particular, there would appear to be a connection between occupational passivity and mental health complaints. One study reveals that as many as 22% of long-term unemployed persons were categorised as having depressive disorders as against 2% in the occupationally active segment of the population (Claussen et al. 1993). A number of Nordic studies also reveal a link between unemployment and increased morbidity (Nylen, Voss & Floderus 2001, Martikainen & Valkonen 1996).

Exclusion from working life is unequally distributed socially. Level of educational attainment appears to play a crucial role in occupational activity – including among people with long-term illness, as shown by Figure 3.1.

Figure 3.1 Occupational activity among men with higher and lower education, with and without long-term health problems. 1980-2005.



Source: Survey of Living Conditions for the years stated, Kjetil Van der Weel 2009 (not yet published)

3.1.2 Occupational health and safety

Health problems arising from the working environment may be due to various types of exposure that occur at work. If we look at work-related sickness absences in Norway, we find that physical strain injuries and mental problems predominate. These may be linked to ergonomic impacts and various types of psychosocial exposure factors.

There are a number of studies dealing with the psycho-social working environment and how it affects health. This type of study is often based on two main models – the demand-control model and the effort-reward model. Basically, according to the demand-control model (Karasek 1987, Karasek & Theorell 1990), if employees are faced with demands at work that are not matched with sufficient control, the result will be negative health impacts. Access to social, co-worker support acts as a buffer against this type of exposure. The effort-reward model (Siegrist 1986) is about achieving reasonable reciprocity between efforts spent and rewards received. In other words, any imbalance between effort put in and anticipated benefit, such as pay, career opportunities and recognition, may elicit negative emotions and stress responses.

3.1.3 Employment and inequalities in health

Research into sickness absences and the transition from paid employment to state benefits indicates that exclusion mechanisms on the labour market are unequally distributed in social terms. Persons with a low income and short education are over-represented among those with long-term illness, vocational disability and recipients of disability benefit. An important measure in reducing inequalities in health is to prevent exclusion and to aim for a more inclusive working life.

Negative occupational health and safety impacts also appear to be unequally distributed in social terms. There is a concentration of different types of negative health impacts in occupations held by unskilled workers and persons with short education. An important measure for reducing inequalities in public health will be to ensure that everyone works in sound and healthy workplace environments.

The following sectors and agencies will be reporting up to year 2017 on a selection of indicators showing the progress of efforts to create

The objectives for public health policy in this area are:

- A more inclusive working life
- Healthier working environments

a more inclusive working life and to contribute to occupational health and safety for everyone:

- Norwegian Labour and Welfare Administration
- Labour Inspection Authority
- National Institute of Occupational Health
- Directorate of Health

Below we present the indicators contributed by the various official bodies, and which will constitute the provisional core indicators for this target area.

3.2 SUB-OBJECTIVE: A MORE INCLUSIVE WORKING LIFE

3.2.1 Indicators

- Number (and percentage) on long-term sick leave (< 13 weeks) who return to work after 2 (or 1) years, by occupational group
- Number (and percentage) of long-term unemployed persons (still registered as unemployed after 6 months), by occupational group

The stated objective is based on Report no. 9 to the Storting (2006–2007) . Work, welfare and inclusion and Letter of Intent on a more inclusive working life.

Sickness absences

The first indicator is based on the linking of the sickness absence register and a register of links between employees and employers. In order to ensure the validity of employment data, separate controls are run against NAV's income register. This indicator can be broken down by occupational groups.

Measurement of the rate of transition to employment is based on the linking of registers and an annual user survey. NAV is currently working to develop methods with a view to ensuring that such measures can be based more extensively on register data. Since this is a work in progress within NAV, it has not been possible to obtain figures for this year's report.

Unemployment

Due to restructuring of NAV registers, the figures for the stated indicators will not feature in our report until next year.

At the end of August 2009, NAV had registered 77,109 fully unemployed persons against 44,364 at the end of August 2008. It is worth noting that the rate of unemployment is highest among the youngest age-group, with 20-29-year-olds representing around one third of all unemployed persons. Gender differences are also appreciable in this age-group, with the unemployment rate among men almost double that among women (NAV, Report no. 2/2009).

Development needs

As regards objectives for socioeconomic distribution, it will be useful to be able to make correlations showing distribution by educational attainment groups. At present, NAV is only in a position to correlate this type of statistics with background variables such as occupation and pensionable income. Occupation as the socioeconomic background variable will not for example reflect disparities masked by a single occupational designation (e.g. "Departmental Manager", "Consultant" and so forth), and it will not be adaptable to changes in the labour market – when new job titles are established or old ones are assigned new content. The educational attainment variable is regarded as a more stable and accurate metric of socioeconomic status, although the occupational variable often serves as an important supplement.

3.3 SUB-OBJECTIVE: HEALTHIER WORKING ENVIRONMENTS

3.3.1 Indicators

- Occupational health and safety exposure factors, by educational attainment:
  - Chemical/biological exposure
  - Physical exposure
  - Ergonomic exposure
  - Organisational exposure
  - Psychosocial exposure

As described earlier, we find disparities in negative physical and psychosocial occupational health and safety impacts between the different occupational groups. Through the National Surveillance System for Work Environment (NOA), it is possible to quantify social disparities in the distribution of positive and negative occupational health and safety factors and potential work-related health impacts. The main report released in 2008 is based on Survey of Living Conditions 2006 from Statistics Norway in which some 10,000 employed persons were interviewed on occupational health and safety issues. In this report, occupations are classed in 45 different categories which were ranked according to the Erikson-Goldthorpe-Portocareros system for socioeconomic classification. This shows a concentration of negative occupational health and safety impacts among unskilled and low-wage occupations.

Table 3.1 Occupational health and safety exposure, by level of educational attainment. %.

Level of educational attainment (number of interviewees)	Cleaning agents/ solvents	Dust/gas/fumes	Dust	Arm/hand vibrations	Work above shoulder-height	Lifting in awkward position	Restructuring	Downstaffing	Little decision-making authority	Job insecurity
Junior school (n = 683)	17	17	15	8	28	31	22	26	21	13
Upper secondary education (n = 5517)	15	14	12	8	23	25	30	27	18	11
University or college education, for up to 4 years (n = 2701)	7	5	4	1	7	11	43	34	12	9
University or college education, for up to 4 years (n = 880)	3	2	2	1	3	1	45	30	7	9

Source: Statistics Norway, National Institute of Occupational Health (STAMI)

Observations were also broken down by education, which revealed socioeconomic disparities in occupational health and safety exposures.

Chemical and biological factors: Cleaning agents/solvents together with a combined exposure variable for dust/gas/fumes (aggregating metal dust, mineral dust, organic dust and gas/fumes). The figure stated here is the percentage of persons exposed one quarter of the time or more.

Physical factors include noise and arm/hand vibrations. Again, the figure reflects exposure at least one quarter of the time.

Physical ergonomics: Key exposures are work above shoulder height and lifting in an awkward posture. Again, the figures are for persons exposed one quarter of the time or more.

Organisational factors include re-structuring processes (percentage affected by restructuring processes within the last three years) and downsizing (percentage working for companies who shed employees within the last three years, in their own department or another department).

Psychosocial working environment: Lack of decision-making authority (percentage stating that they have very little or little influence on decisions affecting their own work) and job insecurity (percentage stating that they are at risk of losing their job due to closure, downsizing or other causes within the next few years).

4. HEALTH BEHAVIOUR

4.1 HEALTH BEHAVIOUR AND HEALTH

Health behaviour influences a number of non-communicable diseases such as cardiovascular disease, type 2 diabetes, cancer and chronic respiratory diseases, but other types of health problems are also linked to health behaviour, such as sexually transmitted diseases and diseases associated with alcohol and drugs.

According to the World Health Organization, non-communicable diseases pose a mounting health challenge worldwide (WHO 2003). World Cancer Research Fund estimates that more than half of all cancer cases could be prevented by lifestyle change (World Cancer Research Fund 2007).

Differences in lifestyle and the incidence of classic risk factors account for a substantial proportion of the social inequalities in heart disease mortality in Norway (Strand & Tverdal 2004), Sweden (Kilander et al. 2001) and a number of other countries (Beaglehole & Magnus 2002). Norwegian estimates suggest that cardiovascular disease, lung cancer and chronic pulmonary disease account for almost 60% of the inequality in mortality before the age of 67 between persons with short and long education (Elstad 2007).

Efforts to reduce the prevalence of behaviour that is harmful to health are central to WHO's strategy for combating non-communicable diseases. WHO recognises that health behaviour is not only an outcome of individual choices, but is also linked to social circumstances and structural factors. Accordingly, the WHO strategy emphasises the importance of strengthening people's framework conditions for sound health behaviour.

4.1.1 Significance of diet and nutrition

The last three decades have seen improvements in Norwegian diets. People are consuming less fat overall and, in particular, are eating less of the unhealthy fat. Consumption of fruit and vegetables has increased and sugar consumption has decreased (Directorate of Health 2008). Since 1970, mortality from myocardial infarction (heart attack) has decreased by 70% among Norwegians in the age-group 40-69 years, and changes in diet account for much of this decrease (Johansson, Drevon & Bjørneboe 1996; Pedersen, Tverdal & Kirkhus 2004; Jenum et al. 2007). In spite of this, many people maintain a diet consisting of too much saturated fat, sugar and salt and not enough foods such as fish, wholemeal bread, fruit and vegetables.

Such dietary failings increase the risk of developing the commonest diseases – cardiovascular disease, cancer, clinical obesity, type 2 diabetes and osteoporosis (brittle bone disease), together with lesser complaints such as dental caries and constipation (NNR 2004). Persons with a long education and sound personal finances eat healthier foods than persons with a short education and poor personal finances. A number of nutritional problems are more prevalent among certain groups of immigrants in Norway.

The greatest nutritional challenges in future consist in increasing intake of fruit, vegetables, wholemeal products and fish, and in reducing intake of saturated fat and salt in all groups of the population, as well as reducing sugar intake among children and adolescents.

Significance of obesity and overweight

The incidence of overweight (body mass index over 25) and obesity (body mass index over 30) is increasing in the majority of age-groups in Norway, as it is in many other countries. This disfavours public health because obesity increases the risk of heart attack, stroke, cancer, type 2 diabetes and muscular and joint complaints.

Health surveys among the adult population indicate that approximately 20% of Norwegians in their forties are overweight. This is twice as many as just twenty years ago. More than 10% of the population now has reduced glucose tolerance or type 2 diabetes. In the United States, for comparison, obesity has increased from 15% to more than 30% since 1980. Experience indicates that it is difficult for the majority of people to achieve a permanent reduction in weight once they have become overweight. Prevention of overweight and obesity through healthy eating and physical activity is therefore crucial.

4.1.2 Significance of physical activity

Physical activity can mean many things including play, outdoor recreation, sports and athletics, exercise training, keep-fit, gym training, fitness training, physical education and physical labour. All activities which require us to make a physical effort and use our bodies are physical activity.

Regular physical activity is important for normal growth and development and is a preventive factor for a number of diseases. Health-promoting physical activity also gives us more energy, is mood-enhancing and can also be an opportunity for socialising with other people. There is solid scientific evidence that regular physical activity has a number of beneficial effects on health.

Individuals who have been more or less physically inactive will enjoy great health benefits in the form of reduced risk of disease, enhanced quality of life and improved physical ability if they become regularly physically active. he recommendation for children and adolescents is 60 minutes of daily, varied physical activity. For adults, including elderly persons, the recommendation is for at least 30 minutes of moderate, daily physical activity.

Regular physical activity reduces the risk of diseases such as cardiovascular disease, various types of cancer and type 2 diabetes. In addition, it is conducive to improved lung function, greater energy and well-being, an improved ability to cope with stress, increased work capacity, a strengthened immune system, improved blood circulation, better sleep quality, improved digestion and bowel function and body balance. Physical activity also reduces the risk of osteoporosis and spinal problems, strengthens the muscles and results in improved joint function and mobility. It is well documented that physical activity prevents and has applications in the treatment of more than 30 difference diagnoses and medical conditions (Directorate of Health 2009).

4.1.3 Significance of tobacco use

Tobacco use is the one preventable factor that has the greatest impact on health of all (WHO 2008). In Norway, for many years now, we have seen a positive trend in smoking habits – increasingly few young people and adults are smokers. However, there is still great disparity in tobacco use between different groups in society.

Preventing young people from starting to smoke yields great, long-term health benefits. To achieve health benefits in the short term, the focus should be on smoking cessation. For people who quit smoking, the health risks are rapidly reduced, especially for cardiovascular and respiratory disease (such as COPD). But the risk of cancer is also reduced gradually from day one.

The Norwegian Institute of Public Health estimates that the number of deaths attributable to smoking in Norway in 2003 was around 6,700 – 16% of all deaths (Vollset et al. 2006). The percentage of deaths attributable to smoking was higher for men than for women. Deaths from smoking represented approximately 72,500 lost potential life-years. Based on 25 years of monitoring data from the Norwegian county surveys, deaths between the ages of 40 and 70 years attributable to smoking were an estimated 40% among men and 26% among women.

Statistics Norway's statistics on causes of death from 2006 show an increase in deaths from lung cancer and chronic obstructive pulmonary disease (COPD) of 22% from 1996 to 2006 (Statistics Norway 2006). The increase occurred mainly among women. However, cardiovascular disease is the greatest cause of lost life-years among smokers. Statistics Norway's statistics on causes of death show that mortality attributable to cardiovascular disease is continuing to decline. The causes of cardiovascular disease are complex, but the heavy decrease in smoking in recent years is likely to be a significant contributory factor.

Smoking persists as one of the risk factors associated with miscarriage, low birth weight, premature birth and perinatal death (death in the first weeks of life), which is possible to prevent. Smoking during pregnancy also increases the risk of sudden infant death syndrome and infant respiratory distress.

4.1.4 Significance of alcohol and drugs

Alcohol has major negative consequences for society and is the cause of considerable harm to health. Babor et al. (2003) demonstrate that the prevalence of alcohol-related conditions in the population correlates with total alcohol consumption in the population and drinking patterns.

Accidents, injuries and physical assault are closely linked to a drinking pattern which results in a rapid increase in blood alcohol concentrations, that is, acute intoxication. The correlation between alcohol intoxication and its harmful effects are especially manifest when it comes to physical assault, traffic incidents and other serious accidents. A drinking pattern of excessive and frequent alcohol intake is associated with chronic health problems such as cirrhosis of the liver, cardiovascular disease and depression. The same is found for cancer of the oral cavity, pharynx, larynx and oesophagus (NOU1995:24). Long-term high alcohol use can also lead to alcohol dependence.

The greater the alcohol use, the greater the risk of both acute and chronic damage to health and alcohol dependence. A change in drinking patterns and a reduction in total alcohol intake helps to reduce the risk of damage to health, disease and dependence.

Average alcohol consumption per capita in the adult population offers some indication of the prevalence of high-level consumption. High-level alcohol consumption is in turn linked to the incidence of damage to health. Total consumption of alcohol in the population is therefore an important indicator. The relationship between average consumption and the extent of harmful effects on health is also influenced by how large a proportion of the population drinks, and how they drink.

As regards illegal drugs, we find that drug addicts often have severe social problems, a low standard of living, poor health, poor nutrition and elevated mortality. For many, there is a strong correlation between substance abuse and mental disorders. A study by Sille Ohrem Naper (2007) shows that mortality among people living on financial social assistance is patently increased in the category "mental disorders and drug-related deaths". Moreover, drug addiction and poverty are often linked.

The objectives for public health policy in the area of health behaviour are:

- Reduced social inequality in health behaviour

The objective comprises reduced social differences in:

- Diet
- Physical activity
- Smoking
- Alcohol and drugs

4.2 SUB-OBJECTIVE: REDUCED SOCIAL DIFFERENCES IN DIET

4.2.1 Indicators for diet

- Percentage of 10th graders who consume fruit and vegetables daily, by gender and parental socioeconomic status
- Percentage of adults who consume fruit daily, by gender and socioeconomic status
- Percentage of 10th graders who consume sugary drinks and snacks daily, by gender and parental socioeconomic status
- Percentage of adults who consume sugary drinks daily, by gender and socioeconomic status
- Percentage of children exclusively breast-fed at age 4 months, by maternal socioeconomic status
- Percentage of adolescents who are overweight/obese, by parental socioeconomic status

Fruit and vegetables

Intake of fruit and vegetables is important for health. The Ministry of Health and Care Services' Action plan on Nutrition 2007–2011 Recipe for a healthier diet sets goals for changes in consumption of selected food groups. During the action plan period, the objective is a 20% increase in the proportion who consume fruit and vegetables daily. Consumption of vegetables and fruit has increased in recent years. Since 1999, vegetable consumption at wholesale level has increased from approximately 60 to 67 kg and fruit consumption for approximately 69 to 91 kg per capita and annum. We would like to have seen a greater increase in vegetable consumption.. The health authorities recommend eating at least five portions of fruit and vegetables a day.

Data from the survey of Trends in health and lifestyle in children and adolescents (HBSC) and the Norwegian Survey of Living Conditions reveal distinct social inequalities among children and adolescents with regard to daily intake of fruit and vegetables (Figure 4.1). Among adults the proportion of those who consume fruit and vegetables also varies according to socioeconomic status. (Figure 4.2). The highest consumption is found in the group with the longest education.

Figure 4.1 10th graders who consume fruit and vegetables daily, by gender and parental socioeconomic status (SES). %.

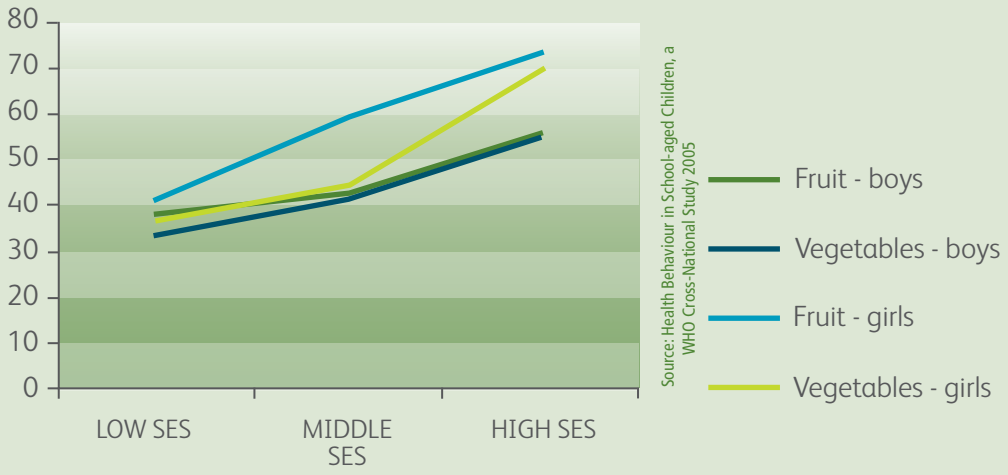
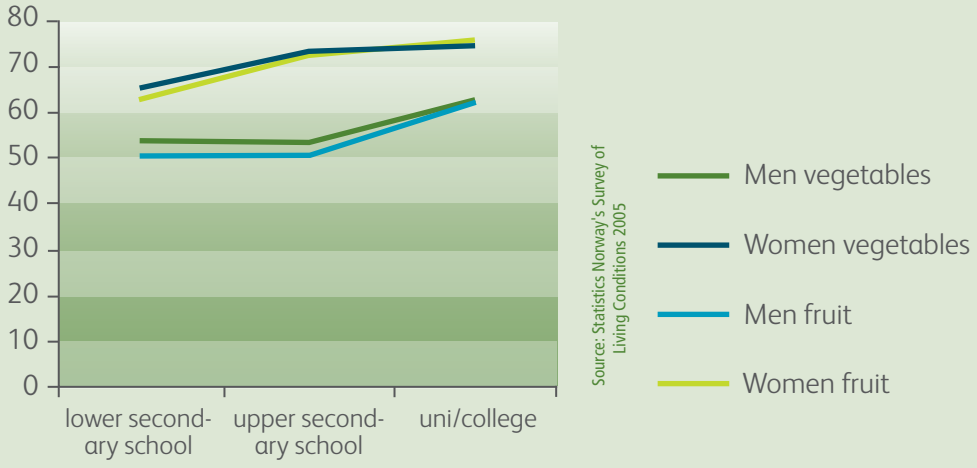


Figure 4.2 Adults who consume fruit and vegetables daily, by gender and level of educational attainment. %.



Sugar intake

A high sugar intake is detrimental to health. Carbonated and other soft drinks are a high source of sugar, especially among children and adolescents. The Ministry of Health and Care Services' Action plan on Nutrition 2007–2011 Recipe for a healthier diet sets goals for changes in consumption of selected food groups. During the action plan period, a 20% reduction was measured in the number of people with a daily intake of sugary drinks and snacks.

Sugary drinks and snacks are the main sources of sugar in the Norwegian diet. Sales of (carbonated) sugary drinks have seen a high increase since the 1970s. Sales peaked in 1997 at 93 litres per capita, but have since decreased to 67 litres per capita in 2007. Sales increased slightly again in 2008. This gives cause for concern since there is a great probability that a high intake of sugary drinks will increase the risk of overweight. Consumption of confectionery has increased substantially over the last thirty years, reaching almost 15 kg per capita in 2007.

Data from HBSC and the Norwegian Survey of Living Conditions reveal distinct social disparities in the percentage with a daily intake of sugary drinks and snacks (Figures 4.3 and 4.4).
As indicated by Figure 4.3, the percentage

Figure 4.3 10th graders who consume sugary drinks and snacks daily, by gender and parental socioeconomic status (SES). %.

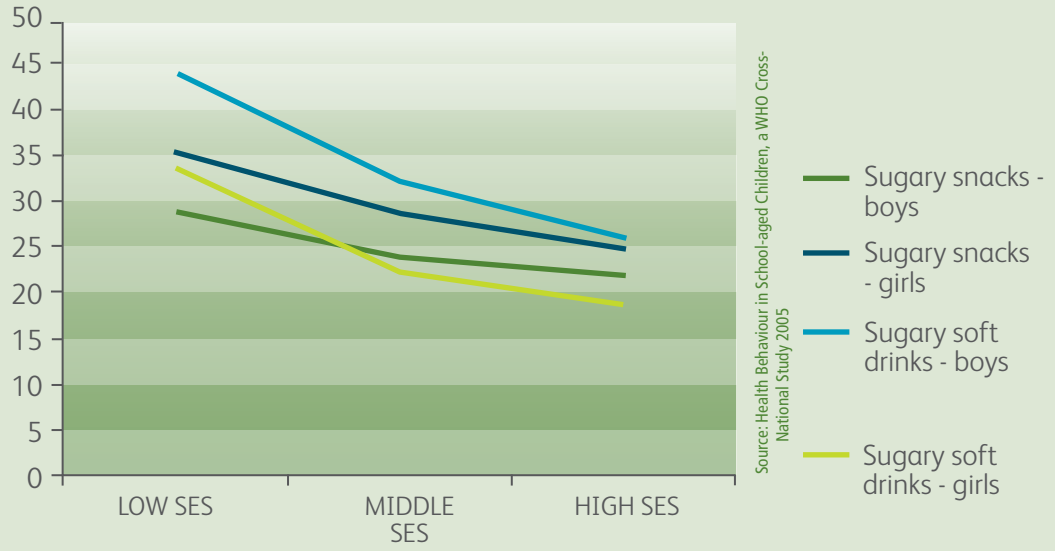
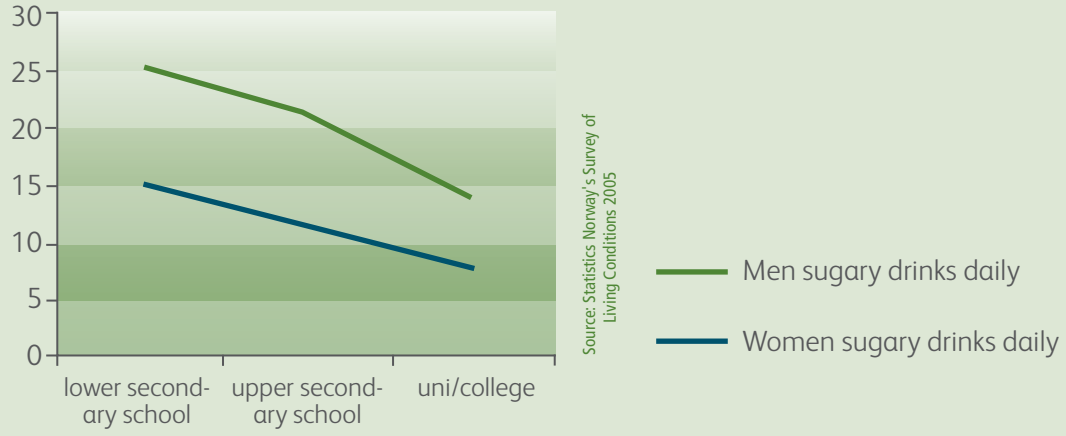


Figure 4.4 Adults with a daily intake of sugary drinks, by gender and level of educational attainment. %.



of children and adolescents with a daily intake of sugary drinks and snacks decreases with increasing socioeconomic status. Among adults also we find that the percentage with a daily intake of sugary drinks decreases with increasing socioeconomic status.

Breast-feeding

Breast-feeding is one of the most effective means of promoting health and preventing disease in infants and may also have a favourable effect on health in later life. In the Ministry of Health and Care Services action plan on improving the national diet 2007-2011, one objective is to increase the proportion of infants who are exclusively breast-fed (i.e. no food other than breast milk) for the first six months of life. In the action plan period, the object is for infants exclusively breast-fed at 4 months to increase from 44% to 70%.

The proportion of infants exclusively breast-fed at 4 months increases with increasing level of educational attainment. This result was obtained for both 1998 and 2006.

Table 4.1 Infants exclusively breast fed at 4 months, by maternal education. %.

Maternal education	Percentage exclusively breast fed at 4 months	
	Infant diet 1998	Infant diet 2006
Lower secondary school level	27	23
Upper secondary school level	37	35
University or college level	56	53
Total	44	46

Source: Infant diet 1998 and 2006. The definition of exclusively breast-fed' varies somewhat between Infant diet 6 months in 1998 and 2006. Data on exclusively breast-fed in 1998 also includes children who may have been fed water in addition to breast milk.

Overweight and obesity

Body Mass Index (BMI) > 30 is applied as the indicator, since this is the threshold for clinical obesity. Overweight and obesity are detrimental to health. The health authorities in Norway and internationally are working to curb weight gain in their populations and to reduce social inequality in the incidence of overweight and obesity. Measures to that end are to improve the population's diet and encourage physical activity. Figure 4.5 shows that the incidence of overweight among children and adolescents decreases with increasing socio-economic status. For obesity, the trend is just as pronounced. Similarly, Figure 4.6 shows that the incidence of obesity among adults decreases the higher their level of educational attainment. Over time, the incidence of obesity has increased among both those with short and long education.

Figure 4.5 10th graders defined as overweight/obese according to Cole's criteria for BMI, by gender and parental socioeconomic status (SES) %.

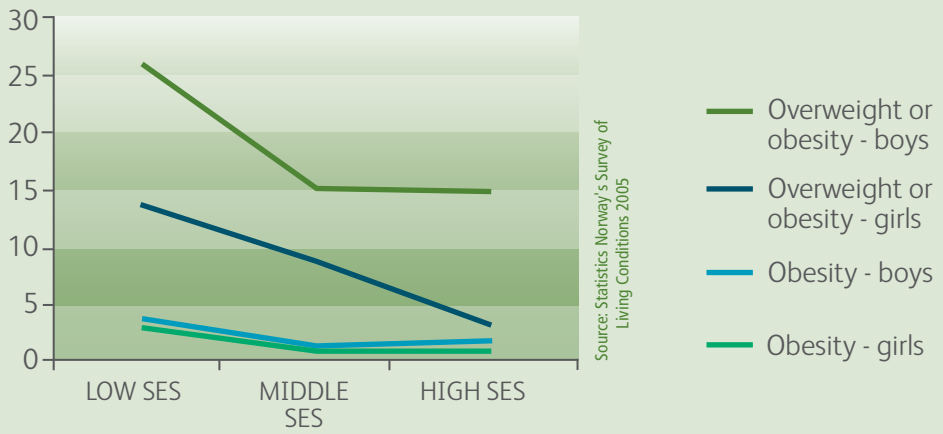
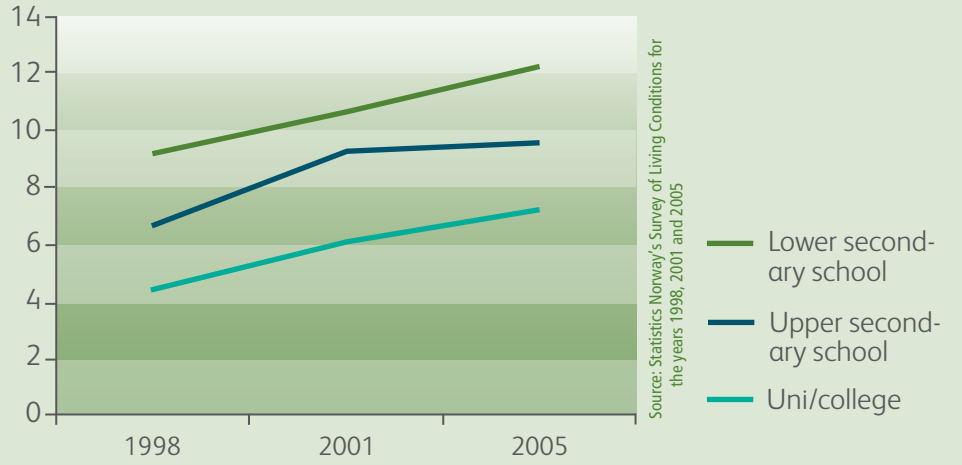


Figure 4.6 Trend in number of adults with BMI >30, by level of educational attainment. %.

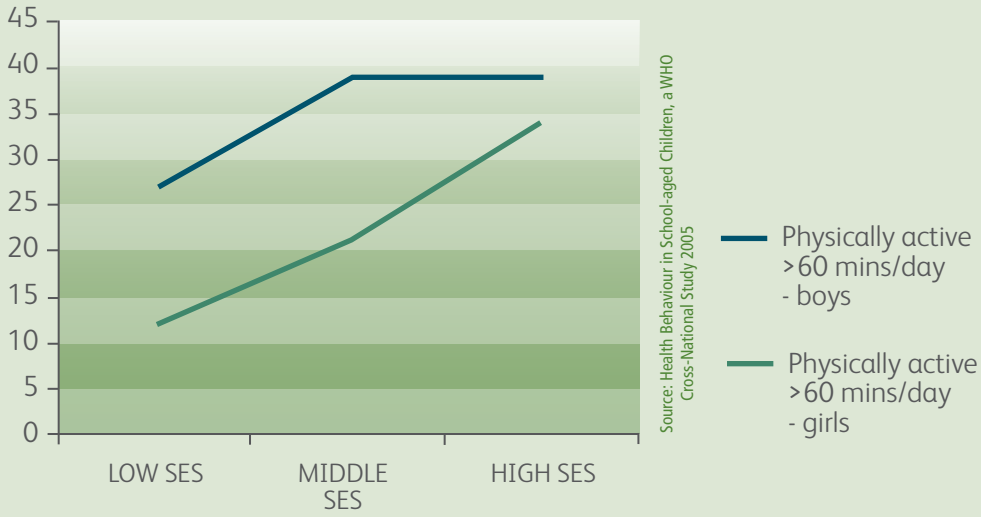


4.3 SUB-OBJECTIVE: REDUCED SOCIAL DIFFERENCES IN PHYSICAL ACTIVITY

4.3.1 Indicators for physical activity

- Physical activity among young people, by parental socioeconomic status
- Physical activity among adults, by socioeconomic status (level of education)

Figure 4.7 10th graders stating that they are physically active for at least 60 minutes a day, by gender and parental socioeconomic status (SES). %.



Physical activity among adolescents

The figure shows the proportion of adolescents stating that they are physically active at least 60 minutes a day, by parental socioeconomic status. This indicator is important in examining inequalities in the physical activity level among adolescents in relation to their parents' socioeconomic status. For both genders, we see a distinct gradient from low to high socioeconomic groups. Physical activity was recorded using a questionnaire. However, the results of a state assessment survey in which physical activity was recorded using activity meters registering all physical activity among 9-year-olds and 15-year-olds showed no difference in physical activity level in relation to parental level of educational attainment (Directorate of Health 2008). This indicates that the trend is complex and that there appears to be no difference if a broader range of activities is included under 'physical activity'.

Table 4.2 Adults (aged 20–80) who meet the recommendation of at least 30 minutes' daily moderate physical activity in relation to highest level of educational attainment. %.

	Women	Men	Total (N=3400)
Lower secondary school	14	18	16
Upper secondary school	20	15	18
College < 4 years	25	17	22
College min. 4 years	24	25	25

Source: Norwegian School of Sport Sciences, oral report Sigmund A. Andersen, 20 May 2009

Physical activity among adults

In facilitating physical activity for different target groups, it is important to look for differences in physical activity level between different groups in the population in relation to socioeconomic status. The proportion who do not engage in high-intensity training in their spare time is twice as high among 40-50-year-olds with lower secondary school as their highest level of educational attainment, compared with those who completed at least 4 years' education at college/university (Ministry of Health and Care Services 2007). Physical activity in Table 4.2 was recorded using an activity meter registering all 10-minute spells of moderate-intensity activity over the course of a day. Again, this indicator shows a social gradient, but this time weaker when all activity is compared with those who do not engage in high-intensity training. The indicator also reflects that the level of physical activity is generally low in the Norwegian adult population.

Figure 4.8 Adults stating that they went on walking trips in the last 12 months, by educational attainment. Includes walking trips in forests and mountains. %

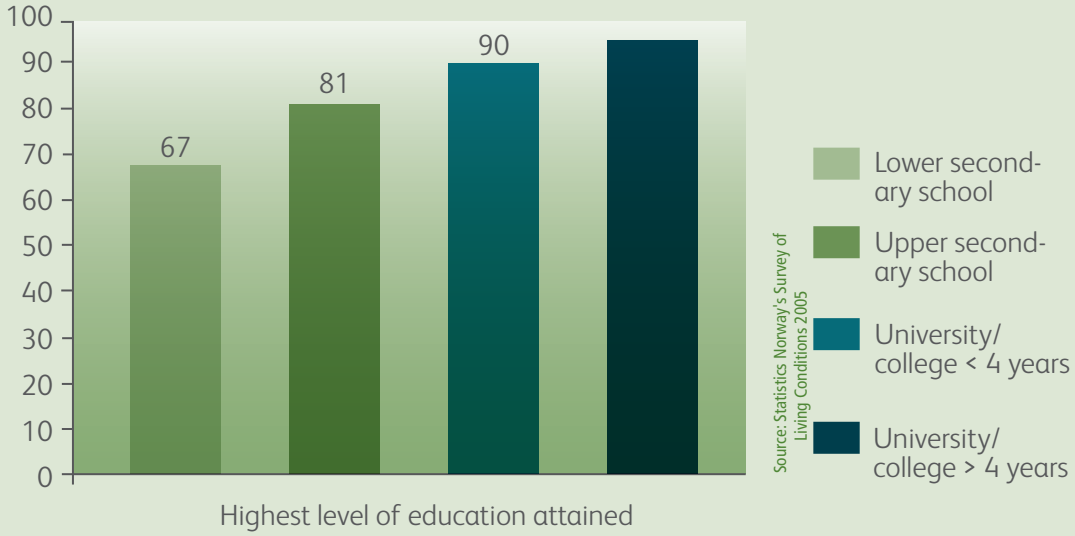
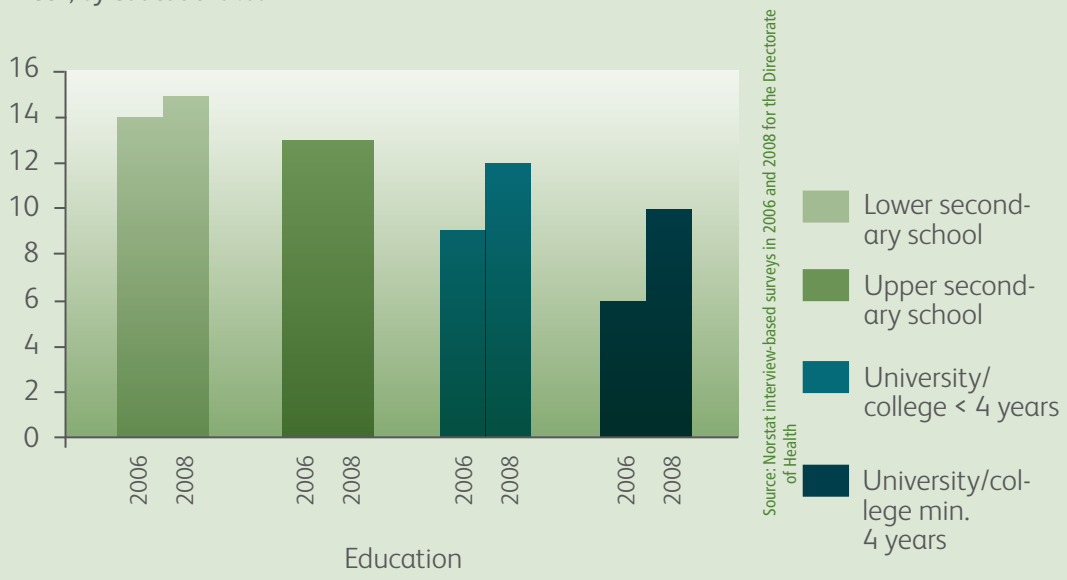


Figure 4.9 Adults stating that they have not walked for 10 minutes continuously in the past week, by education. %.



Walking is the commonest type of physical activity among adults. It is also an activity which many people can easily engage in. The survey from which this indicator derives reveals that eight in ten Norwegians aged 16-79 years have been on a walking trip in the last 12 months. It was found that on average, Norwegians went on 35 walking trips per year.

Well laid out and safe pedestrian routes and pathways will serve to encourage this type of activity. Persons with lower secondary school as the highest education attained are less likely to go on walking trips than persons with a longer education.

Daily physical activity of low intensity occurring in relatively short spells is known to be important from a health perspective. This indicator measures a typical low-threshold activity. Figure 4.9 indicates disparities among those who did not spend at least 10 minutes walking continuously during the past week. If we look at those who spend at least 10 minutes on continuous walking all seven days of the week, we find an even distribution between the different education groups. Around four in nine persons spend at least 10 minutes walking every day regardless of socioeconomic status. This shows that walking is a form of activity attainable by all segments of the population.

4.4 SUB-OBJECTIVE: REDUCED SOCIAL DIFFERENCES IN SMOKING

4.4.1 Indicators for tobacco use

- Smoking among 10th graders
- Use of oral tobacco among 10th graders
- Smoking in the adult population
- Use of oral tobacco in the adult population
- Exposure to tobacco smoke

Smoking among adolescents

A very strong link exists between socioeconomic status and smoking, with around four times as many smokers among individuals with the lowest socioeconomic status compared with individuals with the highest socioeconomic status (Figure 4.10). There are distinctly parallel patterns among daily and occasional smokers.

Use of oral tobacco among young people

Among girls there is no correlation between socioeconomic status and the use of oral tobacco (snus), however, only few girls use oral tobacco (Figure 4.11). Among boys, the majority of those who use oral tobacco are defined as having either low or high socioeconomic status, and again, there is no clear gradient. There are distinctly parallel patterns among daily and occasional oral tobacco users.

Smoking among adults

There are three times as many smokers among those with lower secondary education, compared with those educated at university or college level (Figure 4.12). Smoking is the health behavioural factor for which the correlation with state of health is best documented, and also the factor for which social inequality is most pronounced.

Use of oral tobacco among adults

Figure 4.13 illustrates that there is no marked social gradient in daily oral tobacco use among adults. The group with the longest and shortest education report more or less identical use of use oral tobacco. There are also large gender differences in the use of oral tobacco.

Passive smoking

Exposure to tobacco smoke increases the risk of the same diseases that smokers are prone to. There are significant differences between social groups when it comes to exposure to tobacco smoke or passive smoking (Table 4.3).

Figure 4.10 10th graders who smoke daily or weekly, by gender and guardians' socioeconomic status (SES). %.

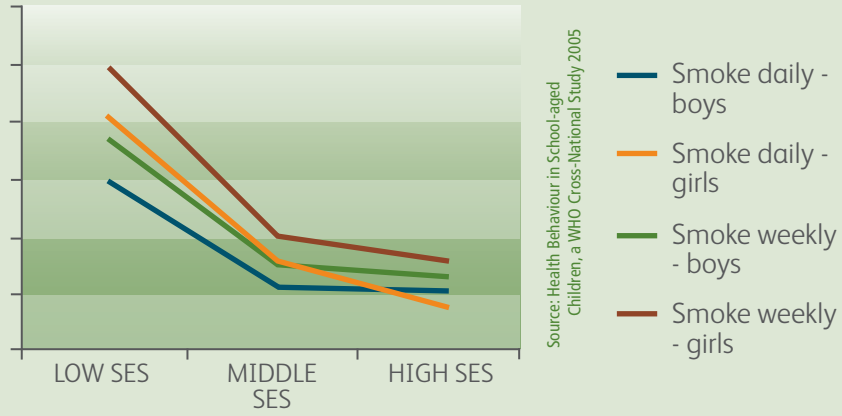


Figure 4.11 10th graders who use oral tobacco daily or weekly, grouped by gender and parental socioeconomic status (SES). %.

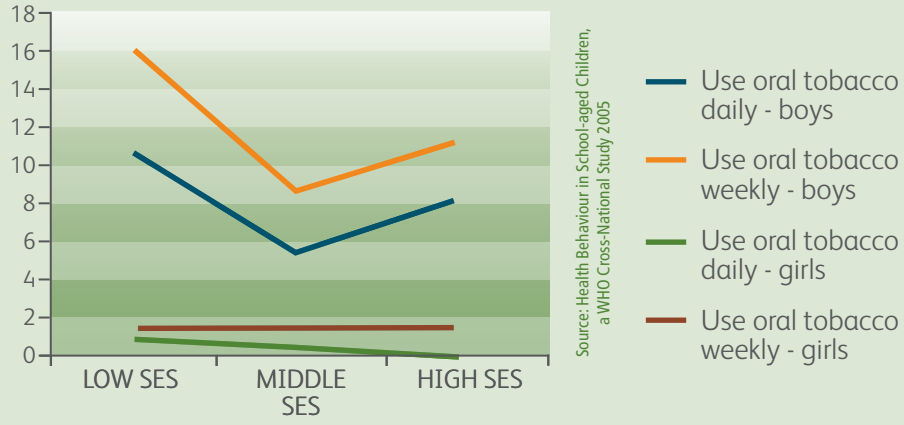
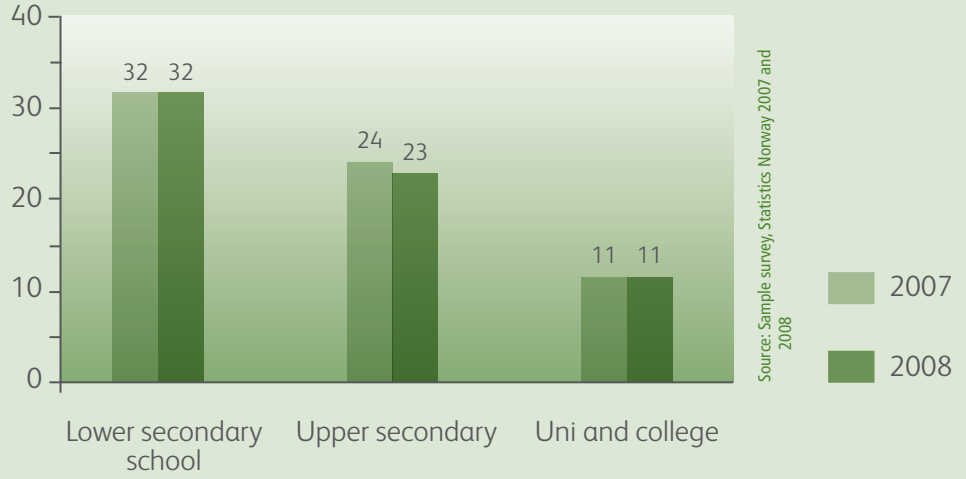
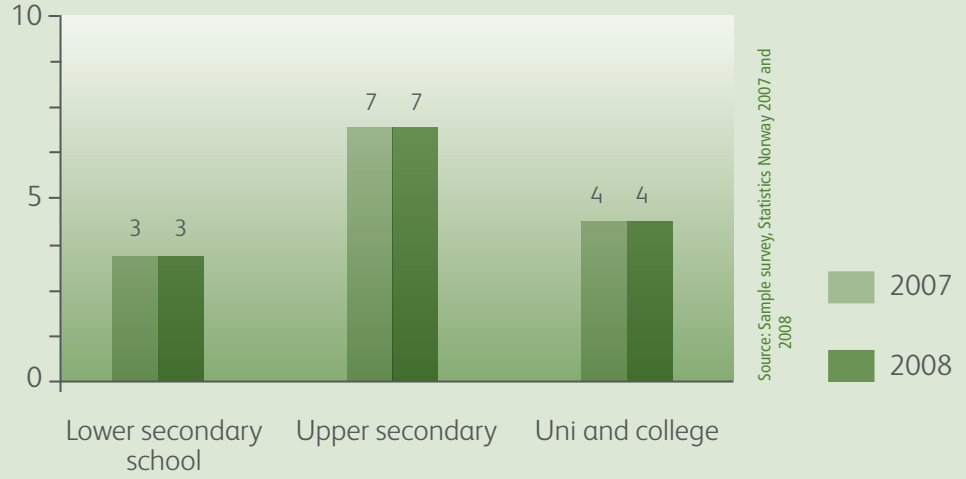


Figure 4.12 Adults (25–74 years) who smoke daily, by level of educational attainment. %.



Source: Sample survey, Statistics Norway 2007 and 2008

Figure 4.13 Adults (25–74 years) who use oral tobacco daily, by level of educational attainment. %.



Source: Sample survey, Statistics Norway 2007 and 2008

Table 4.3 Adults (16–74 years) reporting that they are not exposed to tobacco smoke at home or at work, by level of educational attainment. 2007–2008. %.

		Lower secondary school	Upper secondary	University or college	N
Never exposed to passive smoke at home	2007	72	81	92	(1008)
	2008	73	86	91	(922)
Never exposed to passive smoke at work	2007	78	81	93	(797)
	2008	78	86	93	(722)

Source: Sample survey, Statistics Norway 2007 and 2008

4.5 SUB-OBJECTIVE: REDUCED SOCIAL DIFFERENCES IN OTHER HEALTH BEHAVIOUR – SUBSTANCE ABUSE

4.5.1 Indicators for substance abuse

- Intoxication among young people
- Weekly alcohol intake among young people
- Median alcohol consumption in the adult population, by socioeconomic status
- Binge-drinking among adults, by socioeconomic status
- Drug use

Intoxication and alcohol intake among young people

As noted above, the principal causes of alcohol-related injuries in the population are associated with heavy episodic ("binge") drinking. The correlation between alcohol intoxication and its harmful effects is especially manifest when it comes to physical assault, traffic incidents and other serious accidents. It is important to assess young people's alcohol intake and drinking patterns to determine whether measures aimed at this group are effective and in order to improve how measures are targeted.

The most recent survey of young people by the Norwegian Institute for Alcohol and Drug Research (SIRUS) shows that young people's alcohol consumption underwent an appreciable increase from the mid-1990s to the turn of the millennium, while consumption has receded somewhat in recent years. Males drink appreciably more than females. In recent years, the average age of drinking onset has been just under 15 years for beer, around 15 for "alcopops"

Figure 4.14 Estimated average annual alcohol consumption among young people in Norway aged 15-20 years, by gender and age. Litres of pure alcohol.

Figure 4.15 10th graders stating that they have been intoxicated at least once, by gender and parental socioeconomic status (SES). %.

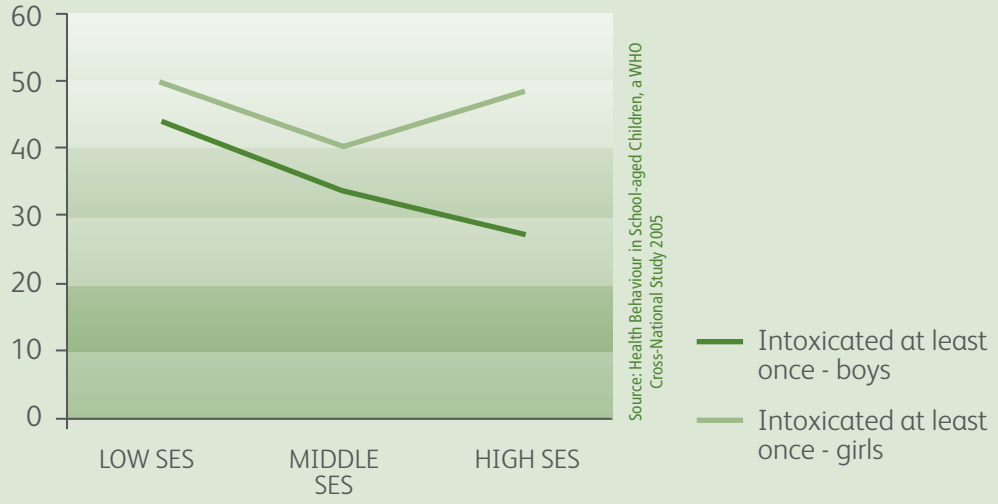
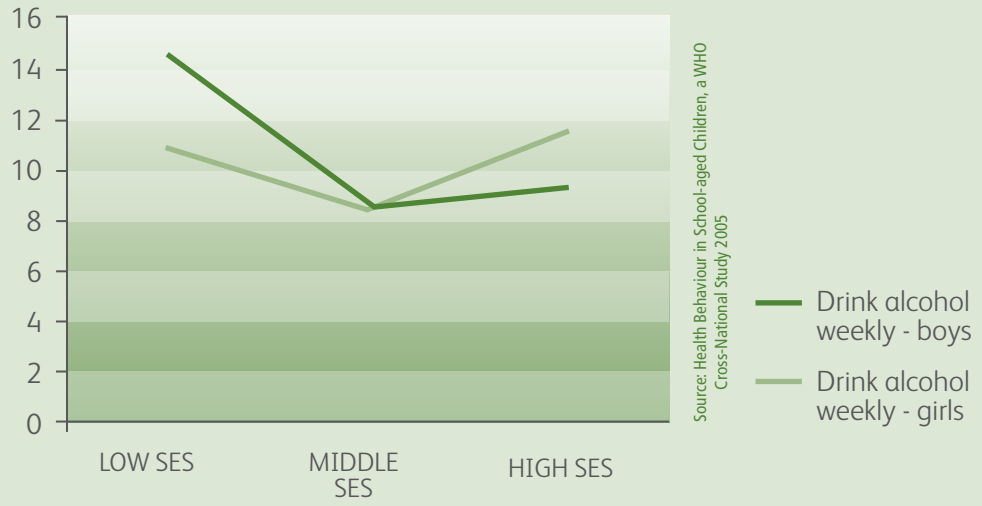


Figure 4.16 10th graders stating that they drink alcohol weekly, by gender and parental socioeconomic status (SES). %.

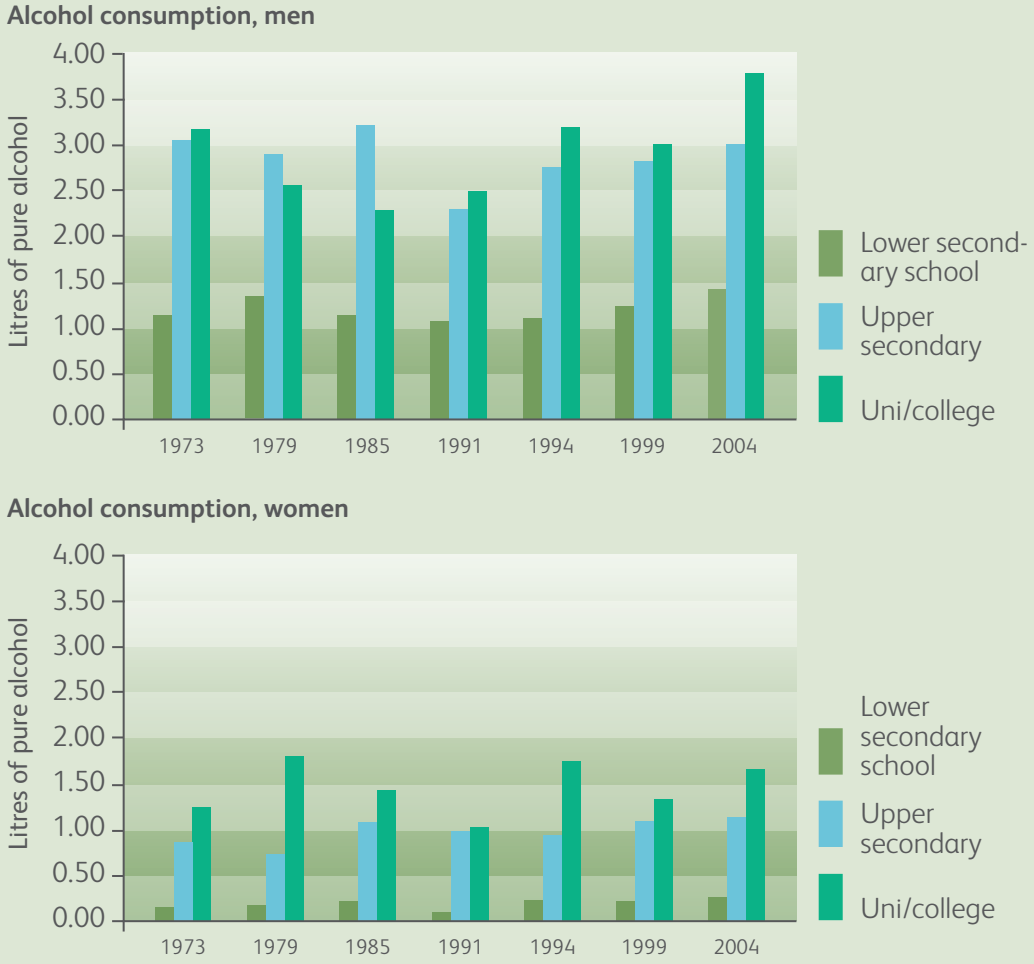


(4-7% alcohol by volume) and around 15.5 for wine and spirits. The average age of drinking onset for the various alcoholic beverages has gone up slightly in recent years.

The indicator shows the proportion of young people who state that they have been intoxicated at least once, by parental socioeconomic status. The proportion of young males stating that they have been intoxicated at least once is higher in the group with low and middle socioeconomic status than in the group with high socioeconomic status. The proportion of young females stating that they have been intoxicated at least once is however smallest in the group with middle socio-economic status and around the same level in the groups with low and high socioeconomic status. The figure also shows that it is commoner for girls than boys to have been intoxicated in this age-group.

The figure shows that the proportion of young males stating that they drink alcohol weekly is higher in the group with low socioeconomic status than in the two other groups. Among young females there is no distinct gradient: Girls with low or high socioeconomic status, respectively, report almost the same degree of weekly drinking, while girls with middle socioeconomic status tend to be less likely to drink on a weekly basis.

Figure 4.17 Median consumption of alcohol in litres of pure alcohol, by level of educational attainment for men and women.



Source: SIRUS surveys of drinking habits (1973–2004)

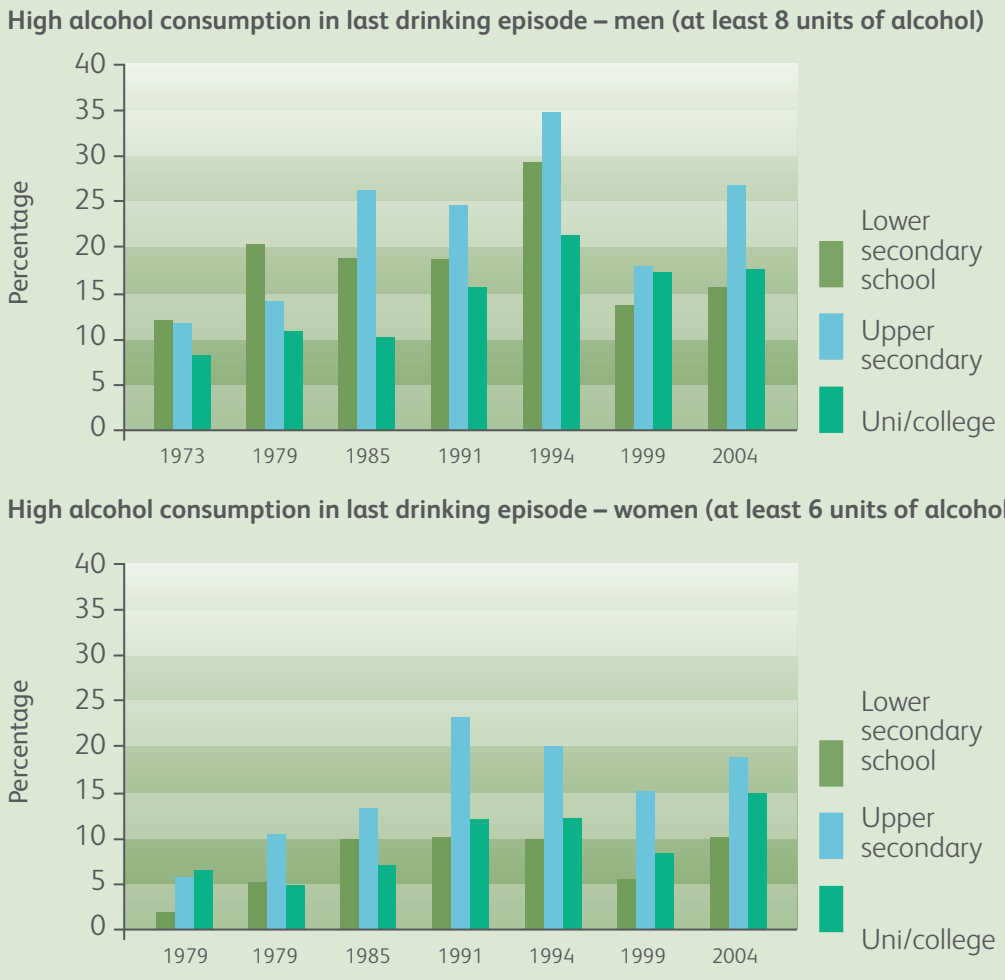
Alcohol consumption in the adult population

The indicator shows the median value for per capita alcohol consumption in the adult population, by level of educational attainment. The median value is the consumption that divides the population into two, i.e. that 50% consume less than and 50% consume more than this value. Studies have shown that alcohol consumption is unevenly distributed in the population: the 10% who drink most, account for 50% of total national alcohol consumption. Almost 3 in 4 drink less than the average. The figure for average consumption therefore gives a false impression of how much people generally drink. Monitoring the trend in national alcohol consumption provides important evidence that national alcohol policy has a social levelling effect. The figure shows that for males there is a tendency towards an inverse social gradient, where the highest alcohol consumption is in the group with upper secondary and university/college education. For women, the figure also shows a distinct inverse social gradient, with increasing alcohol consumption with longer education.

Binge-drinking among adults

Alcohol-related injuries are not only linked to total intake, but also to drinking patterns. As noted above, the principal causes of alcohol-related injuries in the population are associated with heavy episodic ("binge") drinking. The correlation between alcohol intoxication and its harmful effects is especially manifest when it comes to physical assault, traffic incidents and other serious accidents. The indicator "high alcohol intake in most recent drinking episode" provides relevant information about drinking patterns in the adult population, by educational attainment. If we compare total alcohol consumption for males with the drinking pattern, we

Figure 4.18 Proportion of men and women reporting high alcohol consumption (8 units of alcohol for men and 6 units for women) in the most recent drinking episode, by educational group.



Source: SIRUS surveys of drinking habits (1973–2004)

find that the highest alcohol consumption is in the group with medium and long education, while the group with medium and short education drank the most in the last drinking episode. For women, the figure shows that the largest proportion with high alcohol intake is in the group with upper secondary school education, although total consumption was greatest in the group with university/college education. The figure also shows that the proportion of men reporting high alcohol consumption is higher than among women in all education groups. The drinking pattern is thus unequally distributed.

Documentation of the population's drinking patterns is important in determining whether measures aimed at this group are effective, while documentation also permits measures to be more closely targeted.

Drug use

A review of substance abuse will necessarily also include narcotic substances. However, it has not been possible to present an indicator of drug use in all different socioeconomic groups. Surveys by the Norwegian Institute for Alcohol and Drug Research (SIRUS) chart the use of illegal drugs in the age-group 21-30 years, but the number of respondents who took different illegal substances over the last year is too low to permit presentation of clear-cut trends.

5. HEALTH SERVICES

5.1 HEALTH SERVICES AND HEALTH

Although the population's health is to a great extent determined by factors outside of the health service, universally accessible health services with an emphasis on primary health care are vital for good public health. Health services prevent and treat disease, relieve suffering and restore good health. Access to good health services is therefore important for the security and welfare of citizens.

It is difficult to estimate with any precision the extent to which an increase in life expectancy, for example, can be ascribed to health service interventions. But one way to shed light on this is to examine the trend in avoidable mortality, which refers to causes of death for which effective treatment exists in the health service. Since the 1970s, Norway has seen a strong decrease in mortality from treatable diseases. But equally, we are seeing marked social inequality in mortality. Assessing temporal trends in avoidable deaths or making comparative studies across countries is a productive method of assessing the availability and quality of services in the broadest sense. However, the answers yielded by this method do not mean that the main causes in the differences in avoidable mortality are to be found in the health services or traditional policy. Inequalities in morbidity and mortality are attributable to a wide range of determinants. The extent of the health service contribution depends on contextual factors such as which causes of death prevail at any given time etc. Equally, social inequalities in avoidable mortality represent a potential for redressing those inequalities through the right priorities, quality and use of health services (Directorate of Health 2008).

We know that the health service had significant influence on life expectancy through the twentieth century. Access to improved antenatal and perinatal care was a key factor in reduced infant mortality and extended life expectancy. Through the 1980s and 1990s, the health service had significant influence on mortality attributable to cardiovascular disease. Besides influencing mortality, the health service also plays an important part in reducing the debilitating effects of illness and disabilities (Directorate of Health 2008).

An increasing body of research is finding universally accessible primary health care to be of particular importance. American and international systematic reviews are finding evidence that well-developed primary health care systems are associated with improved and more equitable distribution of health in populations (Starfield, Shi & Macinko 2005).

Equitable health and care services constitute a core objective of the white paper on inequalities in health. The Norwegian health and care services must be equitable in terms of accessibility, use and outcomes alike.

Health policy instruments such as financing schemes, organisational formats, regulations, prioritisation efforts and health advisory measures may have consequences – positive and negative – for inequalities in health. Equitable distribution must therefore be a focal consideration in any further development of the services provided, and in ongoing and new evaluations of the health service.

Knowledge is currently limited as to whether the use of health services in Norway varies with socioeconomic status. We therefore know too little about the extent to which the health service is instrumental in redressing, maintaining or reinforcing social inequalities in health. Consequently, reference to the health service in the white paper on inequalities in health includes two goals associated with knowledge production:

- Better data on social inequalities in the use of health services
- Better data on factors that contribute to social inequalities in the use of health services and factors that can counteract these imbalances

A third goal in this chapter (better health services for at-risk groups) is discussed in the chapter on social inclusion.

The white paper points to a number of measures to fulfil the aim of equitable distribution and better knowledge of social inequalities in the use of health services:

- Assess changes to user out-of-pocket payments
- Develop indicators of quality and prioritisation which include measures of social inequalities in accessibility
- Place emphasis on the distribution effects of introducing new, or of amendments to existing, control mechanisms
- Surveying social inequalities in the use of health services
- Strengthen research on factors which contribute to social inequalities in the accessibility and quality of health care
- Ensure that social levelling is taken into account when evaluating reforms of the health service
- Assess measures for reducing social inequalities in the use of health services.

To be able to establish indicators of social inequality in the use of health services, the first step is to establish better knowledge of the distribution of health care in Norway. Statistics Norway, commissioned by the Ministry of Health and Care Services and the Directorate of Health, has compiled two reports on this topic (Jensen 2009, Finnvold 2009). This chapter will describe social inequalities in the use of health services and the determinants of such inequalities. The presentation in the chapter is in the main based on these two reports.

5.2 SOCIAL INEQUALITY IN THE USE OF HEALTH SERVICES

In studies of health service usage, a distinction may be drawn between macro studies and micro studies. Macro studies employ aggregate metrics for health service usage and control these against users' self-reported needs. Micro studies deal with specific treatments or services aimed at special patient groups and based on clinical assessments of the patient's state of health.

The report compiled for the Ministry of Health and Care Services by Arne Jensen (Jensen 2009) is an example of a macro study. Jensen draws on data from the national Survey of Health and Living Conditions to examine social inequality in the use of health services.

The Survey of Health and Living Conditions contains a number of questions concerning both use of different health services and state of health. It also provides the possibility of controlling for age, gender and socioeconomic status. If one assumes that individuals who state that they have a certain type of health complaint have more or less the same need for services, one can then examine socioeconomic differences in the use of health services and apply controls for need.

Jensen identifies four groups of respondents with different types of health complaints. These groups are not mutually exclusive, but it is assumed that they consist of individuals with "virtually the same need for health services, where that need is determined by the indicator for degree of illness employed":

- individuals who self-report that they are in a poor state of health (N=405)
- individuals with a long-term illness (N=2469)
- individuals with cardiovascular disease (N=1100)
- individuals with diseases of the musculoskeletal system (N=1601)

In this report, Jensen defines social inequality in the use of health services as "differences which vary systematically according to education, income and socioeconomic status in groups with equal need for those services". For the variables for which he finds social inequalities, health service usage increases with increasing socioeconomic status when controlled for need. Education dominates, but for some variables there are also statistically significant differences based on income and socioeconomic status. Jensen follows Statistics Norway's norm for income-band break-down. He points out that larger income bands would perhaps have yielded more robust findings, but stresses that this has not been tested empirically. Socioeconomic status is a grouping based on occupation, education and labour market participation.

Previous studies have indicated minor social differences in the use of primary health care, while the use of specialist health care increases with increasing social status (Van Doorslaer & Masseria

2004). However, Jensen finds social differences in both tiers of health care.

Studies from other countries have found a steeper social gradient in the use of health services among men than among women. For Norway, however, Jensen finds only minor gender differences. What he does find of more significance, are certain differences between age-groups. Social inequalities in health service usage are most pronounced in the age-group 67 years and over and second-most in the age-group 44-66 years.

It should be emphasised that this study deals only with the variables and groups in which social inequalities are present. For many other variables, inequalities are found in one of the age-groups, but not in all of them, or among one sex, but not the other. When it comes to use of a psychologist, we actually find an inverse social gradient in some of the four needs-defined groups. However, the general impression is that where inequalities are present, they follow a traditional social gradient. However, the figures do not tell us whether this pattern is due to over-use of health services among persons with high socioeconomic status or under-use among persons with low socioeconomic status.

This conclusion is confirmed by a recent master's thesis based on the same data. In this thesis, Lisbeth Smeby (2009) concludes that there is a weak trend in socioeconomic differences in use of a general practitioner, and a stronger trend in socioeconomic differences in use of specialist health care. However, Smeby also finds social disparities in terms of both income and educational attainment. Smeby divides income into quartiles, which may account for the fact that her findings depart from those in the Jensen report.

Smeby's study indicates that need is the main explanation for use of general practitioners, but that socioeconomic variables also appear to have an independent effect. Less usage among low-income groups may be indicative of some form of financial barrier, while low usage among groups with short education may indicate that the patients' insight into their condition and ability to communicate with the doctor present a barrier to use.

Studies of dental health care indicate that adults with long education are more frequent users of these services. The requirement for relatively large out-of-pocket payments for adults in the dental health service are likely to present a significant barrier to establishing equitable dental health care for those with intensive treatment needs.

Children receive free dental care up to the age of 18. A research project at the University of Oslo is currently investigating children's dental health in relation to parental educational attainment. This project will provide information about the extent to which the public dental health service is instrumental in redressing social inequalities.

One researcher who has taken a micro-approach to health service usage is Jon Erik Finnvold (Finnvold 2006). In his study he looks at health service usage among children diagnosed with asthma. The data analysis indicates that health service usage varies depending on parental educational status: the longer the parents' education, the less contact with the health service. Once the figures are controlled for severity of disease, this variation disappears. The socioeconomic pattern in usage frequency is thus due to the fact that children of parents with short education have a greater need for health care. If we look at general use of health services, it would therefore appear that there is no social inequality in the use of health services for this group.

If, instead, we look at which types of health services these children use, a different picture emerges. Finnvold distinguishes between those who use emergency admission/doctor-on-call services and those who used specialist health care (in this case the Voksentoppen centralised clinic for asthma and allergy). Emergency admissions may be interpreted as signifying inadequate control of the medical condition, while specialist health care signifies a strategy for coping with the condition.

The study showed that children of parents with the shortest education are the most frequent

users of doctor-on-call services, including when statistical controls for need were applied. In the case of specialist health care, Finnvold found that need is the factor which most increases the likelihood of residential care, but that the probability of a child receiving residential care at Voksentoppen increased the longer the parents' education. This correlation is reinforced when controlled for need.

Finnvold concludes that indicators of need provide the main explanation for variations in the use of health services. The severity of the condition or disease follows a social gradient, and usage frequency is therefore higher in the groups with short education. At the same time, we find that aggregate metrics of usage frequency may mask significant variations in usage. High socioeconomic status is linked with more extensive use of specialised health services. This variation may be due to how the health service deals with different socioeconomic groups, but may also reflect how different social groups deal with a given medical condition.

International studies

Finnvold has also reviewed international literature in the field. In other countries, more research has been done on social inequality in health service usage. The main conclusions from two British systematic reviews (Goddard & Smith 1998), (Dixon et al. 2005) are that:

- Specialist health services are used more by groups with high socioeconomic status
- Preventive health services are used more by groups with high socioeconomic status
- Emergency services are used more by groups with low socioeconomic status
- General practitioner services follow no consistent social gradient, but there appears to be a tendency for increased usage among groups with low socioeconomic status

Dixon Woods et al. (2005) focus on the interaction between user and service. They maintain that it is inappropriate to draw a sharp distinction between service provider and recipient, and see health service provision as a dynamic process in which use of services is a result of the practitioner's discretionary assessment of the patient's needs, but in which patients also have a 'job' to perform, in presenting themselves to the health service. (Finnvold 2009). This requires a certain level of social or cultural competence.

The authors find no consistent correlation between access to services and socioeconomic status, although groups with low socioeconomic status use easily accessible services more than others. However, the authors claim that groups with low socioeconomic status have a tendency to deal with health problems as a series of crises rather than a strategic continuous 'project' in personal health management. They also point out that health services based on an appointment system may present a particular challenge for at-risk and vulnerable groups.

5.3 DETERMINANTS OF SOCIAL INEQUALITIES IN THE USE OF HEALTH SERVICES AND FACTORS TO COUNTERACT SUCH DISTORTIONS

Norwegian and international research has posited a number of hypotheses for the mechanisms that are instrumental in creating inequality in the use of health services.

The white paper points to a number of explanatory models:

- There may be social disparities in use of a general practitioner as regards treatment, follow-up and referral to the specialist health service
- There may be mechanisms at work in the specialist health service that make it less accessible to groups with low socioeconomic status
- The organisation of services may make the health service threshold too high for certain groups in difficult circumstances, such as e.g. drug addicts
- Legal instruments may exacerbate social disparities since exercising one's rights requires resources in the form of knowledge of application processes and accessibility
- Enhanced user choice may permit patients to select health services to match their particular needs, but in so doing favours those who are sufficiently well-informed to be able to make the choice
- The financing system affects the health services offered; performance-based financing may disfavour patients and statutory tasks not comprised by the scheme. A bias of this nature may have a distortive effect in that chronic and complex medical conditions become socially misdistributed.
- The correlation between out-of-pocket payments and the use of health services is well documented. Out-of-pocket payments reduce demand for both essential and inessential services. Persons with low socioeconomic status bear the brunt of this.
- Health service insurance and privately financed health care may result in disparities and undermine the intention underlying the out-of-pocket scheme – of curbing demand for low-priority health services.

In the report compiled by the researcher Jon Erik Finnvold on commission from the Directorate of Health, he reviewed Norwegian and international research in order, among other things, to discuss possible biasing mechanisms (Finnvold 2009).

The organisation of the health system influences how well the system works, but may also affect the distribution of health services. The significance of out-of-pocket payments has already been mentioned, but other organisational factors may also be significant.

Recent years have seen greater emphasis on user choice in the Norwegian health service. The introduction of freedom of choice is designed to

make the service more responsive to user preferences and needs. Although the freedom to choose may be a benefit, some aspects of user choice may actually widen social gaps. Finnvold points out that not all patient groups are equally able to exercise their freedom of choice. Resourceful groups have greater access to information and social networks to help them make sound choices. Recourse to private health care is an option only for those can afford it, and opting for health care that requires travel, taking time off work or childminding may be difficult for some groups.

However, it is conceivable that individuals with low socioeconomic status are more at the mercy of practitioners in the health service. Greater freedom of choice would enable this group to stop using services they might be dissatisfied with. This would result in empowerment and a sense of control in the users, but might also serve to change attitudes in the health care professions.

A number of researchers argue against the need for freedom of choice, among other things with the rationale that patients do not have the necessary insight to determine which treatment they need or who is best suited to providing this treatment. The patient is not a benefit-maximising and fully informed consumer of health services, and so necessarily has to place his trust in the physician. Researchers find little empirical evidence that user choice produces any improvement in services or makes health professionals more responsive to patient needs (Finnvold 2009).

One practical limitation is that many of the groups who are offered a choice of services are incapable of making the choice, such as people with dementia, people with learning disabilities, people with mentally debilitating illness, and children. These groups are dependent on resources in their social networks. User choice may also mean that those mentally incapable of making a choice are relegated to below-standard institutions. Patients with active relatives may end up in the best institutions, while the other institutions lose the resourceful relatives who act as "watchdogs".

User choice is just one of several market-style organisational models that tend to be associated with New Public Management. Other examples are DRG financing in the hospitals sector and the organisational divide between the requisitioner and performer of health services. DRG stands for diagnosis-related group – and is a method of reporting which provides a standardised categorisation of activities at hospitals. A Norwegian study asserts that DRG and performance-managed financing results in a finances-first mindset when it comes the type of patients that are "most profitable" for hospitals to treat. The 'winners' are medical conditions with short admission and a standardised course of treatment. Such mechanisms are likely to have a distortive effect.

Finnvold's systematic review concludes however that evaluations of such reforms have mainly concerned financial and administrative consequences rather than their effects of different groups of patients. It is therefore important to study the effects of future reforms on different socioeconomic groups to ensure that they do not exacerbate social inequalities in health.

5.4 DEVELOPMENT NEEDS

One general challenge in studies of – and development of indicators for – inequalities in the use of health services is the necessity of controlling for disparities in demand. Equal use of health services in different socioeconomic groups may reflect great social inequalities if the incidence of the disease differs between groups. The basis employed is typically self-reported health, but there may well be systematic variation between different groups in how they report disease.

Another challenge is to take into account the fact that the health services must be equitable in terms of accessibility, usage and outcomes (Grue 2008). But it is difficult to provide evidence for the fulfilment of such objectives. Access in itself is an objective that has to be operationalised. Actual usage does not always reflect accessibility. It also tells us nothing about the quality of the service provided. Variations in use may reflect the benefit different groups feel they derive from a given

treatment: Some groups may feel that the service they receive is poor and refrain from using it. Conversely, the treatment system may register that the service is disfavoured by some users and so limit the services. There is also no certainty that high usage frequency is a good thing. Doctor-on-call visits or emergency admissions may for example reflect lack of control of an otherwise manageable medical condition. Differences in usage may also reflect differences in user preconditions or preferences. Whatever the case, there is a need for information about how the health service works for different patient groups.

As of 15 April 2009, the anonymity of data on individuals in the Norwegian Patient Register (NPR) was removed. A non-anonymous patient register makes it possible to follow any patient's course of treatment so that one can calculate how many persons have been treated in hospital for different diseases or conditions for example. This also makes it meaningful to link the patient register with other registers, such as socioeconomic registers of the kind that exist in Norway. Inter-registry linkages of this kind provide a basis for studying social disparities in the incidence of diseases for which the Norwegian public receives hospital treatment. It also makes it possible to look for differences in the use of health services between socioeconomic groups.

When looking for insights into whether health services are equitably distributed in the population, it is important to consider the facts from the perspective of the health system as a whole. The universal health system is founded on the principle of redistribution from healthy to sick, from rich to poor, from worker to child, elderly and other non-earning individuals. A health system perspective entails that assessment of inequality must include equitable financing, equitable resource allocation/prioritisation and equitable use of services (including: accessibility, usage and outcome).

6. SOSIAL INCLUSION

6.1 LIVING CONDITIONS AND HEALTH

Social inequalities in health are created through living conditions and socioeconomic distribution. Education, employment, income and housing conditions are key social determinants of health and its distribution in the population. Health services that are accessible to everyone to an equally high standard are also essential in reducing social inequalities in health.

Unemployment is one of the main causes of a life of persistent low income, which in turn affects how individuals lead their lives, how they are housed and their means of self-expression and participation in society. The inability to provide for oneself from one's own earnings from employment and a life lived on benefits produces a clear correlation with impaired health. A study of persons living on social assistance conducted by Oslo University College found that 20% living on social assistance reported poor general health – against around 2% in the normal population (Van der Vel et al. 2006). But the researchers also found that more than half of the persons living on social assistance reported that their state of health was so poor it affected their ability to cope with everyday life. When the health of people on social assistance was compared with the health of people living on a disability pension, those on social assistance did less well in certain aspects. This applied to persons over the age of 30. The study reveals that the incidence of mental health problems especially was elevated among those receiving social assistance, with as many as 58% of the sample reporting such problems. This picture is confirmed by a survey conducted by the Norwegian Institute of Public Health to identify risk groups for mental health problems (Myklestad, Rognerud & Johansen 2008).

Low income is a risk factor for mental health problems, and if the individual also lives alone and has a short education, the probability that he or she will have mental health problems increases substantially. In fact, what this survey also reveals is a concentration of mental problems, psychosocial risk factors and negative health behaviours in certain groups of the population – especially among recipients of social assistance and a disability pension.

Access to good and stable living conditions represents an important resource conducive to self-expression and social participation, and constitutes a key component of our living conditions. The link between housing and health is obvious when one looks at housing standards and factors such as hygienic conditions, damp and other physical indoor climate factors. Housing location is also significant for health. The quality of drinking water and air quality, noise, traffic and infrastructure and proximity to recreation areas are factors that have physical health impact. Housing standards and the residential environment vary depending on personal finances. For deprived groups in the population, access to stable and adequate housing conditions is not a given. Among homeless persons, a high proportion suffer from severe alcohol-related and/or mental problems (Ytrehus, Sandlie & Hansen 2008).

These are people with a diminished ability to procure accommodation and cope with independent living. A lack of housing, including local authority housing provision, will in such cases contribute to a deterioration in the state of health of persons who in the first place need assistance and supervision. But other marginalised groups are also at risk of a deterioration in their living conditions if they lack accommodation. One example is the group of ex-prison inmates who on release have no place to live. A study shows that one third of inmates have no accommodation when they are sent to prison (Friestad & Hansen 2004). On release from prison, as many as two thirds of former inmates have no home of their own to go to (Løslatt og hjemløs – bolig og bostedsløshet etter fengselsopphold (Released and homeless – housing and homelessness after prison) (Dyb et al. 2006), Norwegian Institute for Urban and Regional Research).

The correlation between education and health among children and young people is discussed more extensively under the intervention area of "childhood conditions". But education has a clear correlation with every single aspect of living conditions – the longer the education, the better the standard of living, the more stable and rewarding the employment, the healthier the lifestyle and

the fewer the psychosocial stress factors. (Elstad 2008). An inadequate or short education will thus be a contributory factor to poorer living conditions.

Weak literacy, numeracy and ICT skills in adults often present a barrier to pursuing further education and cause many people to fall out of the labour market. BKA, an adult education scheme run by Vox, Norwegian Agency for Lifelong Learning, aims to improve adult literacy and numeracy by inviting private and public-sector enterprises to partner with adult education providers and labour market organisations to apply for subsidies for motivational schemes and training in literacy, numeracy and ICT for employees and job-seekers.

In sum, a combination of persistent low income, short education and unhealthy housing conditions are strongly linked with an unhealthy lifestyle and poor health. Strategies and instruments aimed at assisting disadvantaged groups in gaining employment through training and qualifications, access to secure and stable housing and equitable options in and access to adequate health care, will be instrumental in reducing social inequalities in health.

Up to 2017, the following sectors and ministerial agencies will be reporting on a selection of indicators showing the progress of efforts to ensure that disadvantaged groups improve their living conditions through greater social inclusion:

- Directorate for Education and Training
- Vox – Norwegian Agency for Lifelong Learning
- Norwegian Labour and Welfare Administration
- The State Housing Bank
- Directorate of Integration and Diversity (IMDi)
- Ministry of Justice and the Police/Norwegian Correctional Services Department/Office of the County Governor of Hordaland
- Directorate of Health

The objectives for public health policy in this area are:

- Reduce the number of adults who leave school with poor basic skills
- Enable more people to work
- Eliminate homelessness
- Improve the accessibility of health and social services for disadvantaged groups
- Reduce inequalities in living conditions between different geographical areas

6.2 SUB-OBJECTIVE: REDUCE THE NUMBER OF ADULTS WHO LEAVE SCHOOL WITH POOR BASIC SKILLS

6.2.1 Indicators:

- Number of adults receiving and entitled to lower secondary education under Sections 4A-1 and 4A-2 (special education) of the Education Act.
- Number of adults (pupils and vocational trainees) over the age of 25, receiving and entitled to upper secondary education under Section 4A-3 of the Education Act.
- Number (percentage) of persons receiving lower secondary and upper secondary education within the Norwegian Correctional Services

Lower secondary level education for adults

Basic (literacy and numeracy) skills are described in Report no. 16 to the *Storting (2006-2007) Early Intervention in Lifelong Learning*.

There is currently no general overview of how many adults in Norway lack skills at lower secondary school level or equivalent elementary skills since the Knowledge Promotion Reform (KPR), a comprehensive curriculum reform, was introduced in autumn 2006, and hence no information exists as to the number of adults in need of basic education who are currently attending adult education programmes. There is a need to develop better statistics in this area. The Directorate for Education and Training is currently engaged in a process of indicator development in extension of the programme to enhance the National quality assessment system for compulsory education. The development of indicators for adults with poor literacy and numeracy skills should be seen in the context of the accumulation of data at the Directorate of Education and Vox, Norwegian Agency for Lifelong Learning. Selection of indicators to be reported on in joint reporting systems must be seen in the context of these efforts.

Surveys of the number of adults receiving lower secondary level education, by ethnic origin, and the number who receive special education, again by ethnic origin, including adults with a special need to improve and maintain basic skills, have been available annually since 2006 (GSI lower secondary database information system).

Under Section 4A-1 of the Norwegian Education Act, persons over compulsory education age who need lower secondary education are individually entitled to receive such education. Local authorities undertake to provide such education to persons who have not completed lower secondary level education, persons who have completed lower secondary level education but who still require more education at that level, and both Norwegian nationals and foreigners with a settlement permit, work and/or residence permit or who are under collective protection. Asylum seekers are not entitled to receive adult lower

Table 6.1 Participation in adult lower secondary education. Number

Adults receiving lower secondary education as at 1 October	2008	2007	2006
Lower secondary education for adults receiving education only under Section 4A1 of the Education Act on the right to lower secondary education for adults			
Number of participants in lower secondary education for adults, not including linguistic minorities	1033	1252	1160
Number of participants from linguistic minorities in lower secondary education for adults	2846	2876	3108
Total lower secondary education	**3879**	**4128**	**4268**
Special education under Section 4A-2 of the Education Act on the right to receive special lower secondary education			
Number of participants in special education, not including linguistic minorities	5021	5210	5997
Number of participants from linguistic minorities receiving special education	458	400	355
Total special education	**5479**	**5610**	**6352**
Number of participants in special education under Section 4A-2 who are also receiving lower secondary education under Section 4A-1	259	151	127

Source: GSI lower secondary database information system

secondary level education, but are permitted to participate in any suitable adult education programmes if the local authority is running such programmes.

Table 6.1 shows participants receiving special education pursuant to Section 4A-2 of the Education Act, including whether they are receiving lower secondary level education under Section 4A-1. Under Section 4A–2, adults who have not made sufficient progress on ordinary adult education schemes are entitled to receive special education. This also applies to adults with special needs for learning in order to improve or maintain basic skills.

The figures reveal a slight decrease in the number of persons receiving adult education under both Sections 4A–1 and 2 from 2006 to 2008. The number of adults from a minority-language background receiving both special education under Section 4A–2 and lower secondary level education under Section 4A–1 is low, but more than doubles (approx. 204%) over the period.

Adults receiving upper secondary level education

The other indicator is linked to upper secondary level education. The figures have been available annually since 2006 (Statistics Norway/County administrative data system for upper secondary education (VIGO)) and show the distribution of adult students and vocational trainees over the age of 25 who are receiving upper secondary level education, by ethnic origin.

All told, fewer adults were receiving upper secondary level education in 2008 than in 2006 and 2007. There was however an increase in the number of adult participants among immigrants and Norwegian-born persons with parents of immigrant origin. The number of Norwegian-born persons with parents of immigrant origin who received adult education was however exceedingly small. This low figure is presumably explained by the fact that the immigrant population in Norway is still young and that we are only just beginning to see adult children among those who immigrated to Norway in the late 1970s.

There are relatively large differences between the Norwegian counties in the prevalence of adult education. There is also variation from one year to the next. In 2008, the counties of Nordland, Hordaland and Akershus recorded high adult attendance. Counties with the lowest participation were Oppland and Østfold. Given that the vast majority of immigrants live in Oslo, it is somewhat surprising that Oslo does not have more immigrants receiving adult education. The counties of Akershus, Buskerud, Telemark and Hordaland all have more immigrants receiving adult education than Oslo. There are too few Norwegian-born individuals with parents of immigrant origin in adult education for it to be worth examining their distribution by county.

In general, adult students are most prevalent on vocational study programmes/training programmes. Health and social services subjects are the most popular among ethnic Norwegians (31-38%) and among immigrants (39-42%). We also find many adults on mechanical, construction and electrical study programmes. Out of the study/

Table 6.2 Number of adults (pupils and trainees) aged 25+ receiving upper secondary level education, by pupils of Norwegian ethnicity (including other Scandinavians), immigrants and Norwegian-born persons with immigrant parents (Statistics Norway's definitions of immigrant origin).

Year	Total	Norwegian ethnicity	Immigrants	Norwegian-born with immigrant parents
2008	8,171	6,345	1,798	28
2007	10,038	8,196	1,824	18
2006	10,582	8,651	1,919	12

Source: Statistics Norway

training programmes that qualify students for admission to higher education, it is largely only the general, financial and administrative subjects and specialised studies that attract adults. The share of adults on these study programmes is 18–20% for adult ethnic Norwegians, and 32–35% for adult immigrants. Norwegian-born persons with parents of immigrant origin are so few in number it is not worth examining their distribution by education/ training programme.

Education and training within the Norwegian Correctional Services

The third and last indicator shows the number of persons attending education within the Norwegian Correctional Services. This includes education both at lower secondary and upper secondary level, and a wide range of specialised courses. The majority of students are distributed between upper secondary level education (57%) and specialised courses (40%), while only 3% apply for lower secondary education (Office of the County Governor of Hordaland's *report on educational and training programmes within the Norwegian Correctional Services, 2007).*

The reason for the variations from one year to the next may be many; internal prison-management issues, interest and motivation among inmates, liaison between school and work operations (in terms of learning contracts and subject tests). This overview does not reflect the great number of prison inmates who take short courses qualifying them for employment, or that many take short, non-qualifying courses and that the emphasis is also on evaluating prior learning.

A report from 2006 reveals that no fewer than 38% of inmates of Norwegian prisons have lower secondary school as their longest education, compared with 19.5% in the population as a whole. 7.2% of inmates had not completed lower secondary education (Eikeland, Manger and Diseth 2006).

A full 83.7% of inmates under the age of 25 in Norwegian prisons have not completed upper secondary level education. More than half of the inmates are keen to receive education. More than one third of the inmates report reading and writing difficulties (27.2 % "slight" and 10% "great"). Almost half of inmates report reading and writing difficulties (35.7% "slight" and 12.3% "great").

Table 6.3 Number of pupils in Norwegian prisons who sat an exam, number of exams, number of teaching contracts signed and number of passed vocational exams/certificates of apprenticeship. 2001-2007.

Year	Number of pupils who sat exams (lower secondary + upper secondary)	Number of exams (lower secondary + upper secondary)	Number of teaching contracts concluded	Number of passed vocational exams/certificates of apprenticeship
2001	339 (16+323)	815 (72+743)	16	10
2002	371 (10+361)	766 (70+696)	10	7
2003	361 (15+346)	858 (63+795)	12	6
2004	379 (10+369)	972 (65+907)	7	16
2005	388 (6+382)	870 (20+850)	16	17
2006	447 (3+444)	943 (6+937)	19	23
2007	348 (1+347)	684 (2+682)	17	14

Source: Office of the County Governor of Hordaland

6.3 SUB-OBJECTIVE: ENABLE MORE PEOPLE TO WORK

6.3.1 Indicators

- Number/proportion of persons with reduced capacity for work who progress from employment-incentive schemes to employment
- Immigrants progressing to employment after a scheme
  - Number (and percentage) of immigrants who progress to employment after participating in an employment-incentive scheme run by NAV
  - Number of immigrants progressing from the introductory programme to employment/education
- Participants in the qualification programme
  - Number/percentage of participants in the qualification programme in total
  - Number/percentage of participants in the qualification programme who progress to employment

The declared objective is based in the main on Report no. 9 to the Storting (2006-2007) *Employment, Welfare and Inclusion* and *Action Plan on Poverty*. This white paper ushers in a stronger focus on proactive measures for recipients of temporary benefits, with the emphasis on close follow-up and individualised programmes. The object is to establish a qualification programme as an intensified intervention for persons with weak labour market affiliation.

Persons with reduced capacity for work

The first indicator – the number and proportion of persons with reduced capacity for work who progress from employment incentive schemes to ordinary employment – tells us something about the success rate of the schemes run by NAV for job-seekers who are assessed as having a special need for assistance in returning to the labour force. This indicator is based on links between NAV registers of job-seekers and the Aa register (a register of data linking employees and employers). Owing to a major restructuring process in the NAV data system, no figures for this indicator will be available before some time in 2010.

NAV is currently carrying out a project to establish new statistical routines for surveying the number and percentage of users who progress to employment after their names are taken off the job-seeker register. The plan has been for the new routines to be established for continuous statistical reporting as of July 2009. There is also a plan to produce retrospective number series. This will only include ongoing transitions to paid employment. Transitions to education and self-employment will not be included in the source data. In order to achieve a more comprehensive perspective on the situation among the users, NAV is consequently planning to conduct an annual follow-up survey of former NAV clients to ascertain their principal activity on completion of the schemes.

Immigrants

The other indicator, the first sub-indicator, comprises job-seekers of immigrant origin. Here the same comment as for the preceding indicator also applies. The second sub-indicator is a performance target for the Norwegian government's Introductory programme and Norwegian language training for newly arrived immigrants. The figures for 2008 are based on a QuestBack survey in the Norwegian municipalities, conducted annually by the Norwegian Directorate of Integration and Diversity (IMDi). The figures for 2007 are based on figures from the QuestBack survey and from the National Introduction Register (NIR). This means that the figures for 2007 and 2008 are not quite comparable. IMDi is in the process of establishing new routines for capturing this type of data to facilitate trend monitoring from one year to the next. Figures from NAV for 2008 reveal that as many as 76% of participants who registered as job-seekers at the end of their introductory programme progressed to employment/education within a year of completing the programme. Employment here means ordinary employment on ordinary pay. Everything exceeding one hour's work a week, irrespective of whether the person is permanently or temporarily employed counts as employment. Education means that the

participant progresses to upper secondary level or higher education.

It is possible to supplement these figures with Statistics Norway's annual monitoring survey of the introductory programme. The monitoring survey permits cohorts of participants in the introductory programme to be followed over an extended period of time.

Participants in the qualification programme

The last two sub-indicators will show participation and transition to employment for persons participating in the qualification programme. This programme has been established as a dedicated function within Municipality-State-Reporting – KOSTRA, and will provide figures for individual key indicators in future. In addition, alternatives are being considered for a common system-based reporting initiative from central and local government within the local NAV offices for completion of the qualification programme.

6.4 SUB-OBJECTIVE: ELIMINATE HOMELESSNESS

6.4.1 Indicators

- Number of temporary occupancies of longer than three months
- Number of temporary accommodation solutions for persons discharged from an institution or released from prison
- Number of homeless persons

Temporary accommodation longer than three months

The first indicator concerns the objective of ensuring that no-one has to stay more than three months in temporary accommodation. Until permanent accommodation becomes available, the municipality is under obligation to find temporary accommodation for persons unable to manage this themselves, cf. Section 4-5 of the Social Services Act. Temporary accommodation must not last for a long time and may be wholly or partially paid for by the municipality. Here, the statistics register municipal housing for which daily rates are paid. Housing for which a rental contract or temporary rental agreements are made are not included. Temporary accommodation provided by a local authority may include a hostel, boarding house, hotel, country cabin, camping chalet and the like.

For temporary housing, no rental agreement is concluded and the intention is for this form of municipal housing to be an interim solution until it is possible to establish permanent accommodation for the individual concerned. The use of the number of temporary housing facilities has gradually been reduced. Table 6.4 shows that in 2008, the number of temporary housing units had been reduced by 13% in relation to 2006.

Temporary housing after discharge from an institution or release from prison

The second indicator shows the number of temporary housing solutions following discharge from an institution or release from prison. Release from prison in this context includes release from remand in custody, after serving a prison sentence, and release from a custodial institution or from preventive detention. It includes both release on probation and parole and final release. Discharge from an institution includes discharge from round-the-clock residence at various treatment and/or residential institutions. It does not include discharge following day-patient or out-patient treatment. The reporting solely includes persons discharged from institutions within the last three months prior to moving into temporary accommodation.

Table 6.4 Number of temporary occupancies in total and number of temporary occupancies longer than 3 months.

Year	Number of occupancies	Number of occupancies longer than 3 months
2005	4235	29%
2006	4488	29%
2007	3881	21%
2008	3388	16%

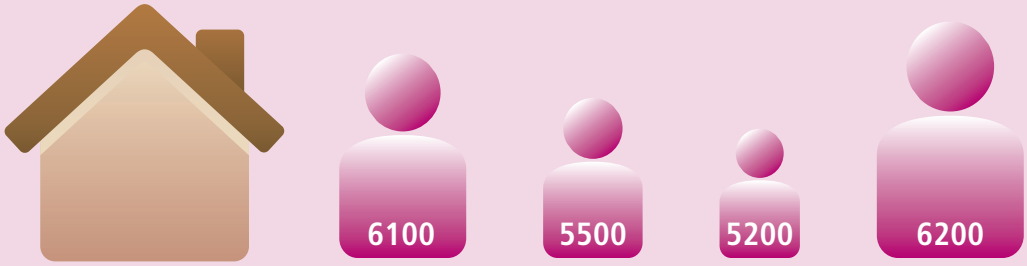
Source: Municipality-State-Reporting – KOSTRA

Table 6.5 Percentage of temporary housing solutions after release from prison or discharge from an institution out of all occupancies for the whole of Norway.

Year	All occupancies	Number released from prison	Number discharged from an institution
2005	4235	3%	5%
2006	4488	2%	5%
2007	3881	4%	3%
2008	3388	2%	4%

Source: Municipality-State-Reporting - KOSTRA.

Figure 6.1 Number of homeless persons in Norway.



Source: Norwegian Institute for Urban and Regional Research

Table 6.5 shows that the proportion who had to go straight from prison or an institution to a temporary solution is fairly stable, which meant that in 2007 this affected 280 persons.

Number of homeless persons

The third indicator shows the number of homeless persons in Norway. Reporting for this indicator will not be done annually. Neither homeless persons as a group nor the characteristics of that group changes significantly from one year to the next. A total of four surveys of homeless persons are available. These surveys provide valuable information about the social circumstances of homeless persons, including education and main source of income, together with the issues surrounding lack of permanent abode.

Municipality-State-Reporting - KOSTRA

The indicators show the trend in a sample of variables obtained from Municipality-State-Reporting - KOSTRA. The KOSTRA system is based on electronic data reported from the municipalities to Statistics Norway, as well as data from a number of other sources within and outside of Statistics Norway. The KOSTRA indicators are somewhat unreliable, but the quality of the data is improving all the time as the figures are increasingly being put to active use. These indicators reflect only aggregate factors, which has the effect of reducing the uncertainty associated with the figures. In using percentages for the total number of occupancies in temporary housing, Hordaland county has been excluded since Bergen municipality reported only the number of households in temporary housing and not the number of occupancies or any of the other sub-categories. The means that there may actually have been more temporary occupancies in 2007.

Under the cooperation agreement between the government and the Norwegian Association of Local and Regional Authorities (KS), and the cooperation agreement between the State Housing Bank and KS, the parties assume a mutual commitment to achieving better data on homelessness,

municipal housing and relevant supervisory services. Improvement of the data is to be developed within the frameworks of KOSTRA. In addition, the State Housing Bank and the Norwegian Association of Local and Regional Authorities (KS) are planning to launch a network dedicated to efficiency improvements in the area of housing.

6.5 SUB-OBJECTIVE: IMPROVE THE ACCESSIBILITY OF HEALTH AND SOCIAL SERVICES FOR DISADVANTAGED GROUPS

6.5.1 Indicators

- Waiting time for a treatment place within the interdisciplinary specialised treatment system
- Number of contract places for interdisciplinary specialised treatment taken out by the HELFO Patient Referral Unit.
- Number and percentage of patients within the alcohol and drugs dependency care services who have individual plans

The white paper on inequalities in health identifies people with alcohol and drug dependencies as presenting a particular challenge as regards provision of adequate health care provisions. Both within the municipal health service and specialist health service, studies have revealed underuse in this group of patients.

In the autumn of 2007, the Norwegian Government presented an escalation plan for the area of substance abuse which stresses improved access to health care and better liaison between different sections and levels of the public-sector care services. It ensues from the statutory and ethical principles of the health and welfare services that the services are to be offered and provided on the basis of the service recipient's needs, regardless of gender, financial means or other cultural and socio-economic circumstances. The Directorate of Health has a range of policy instruments and measures at its disposal for ensuring improved health care accessibility for disadvantaged groups. But in the majority of these areas, there is not sufficient data to form the basis for indicator development. The indicators in this area are restricted to health and welfare services for persons with alcohol and drug dependency problems.

Waiting time for interdisciplinary specialised treatment

The first indicator represents capacity within interdisciplinary specialised treatment. This type of treatment is not an explicitly defined therapeutic form, other than the requirement for it to be medically valid. Waiting times will offer some indication of the availability of and capacity of this health care provision.

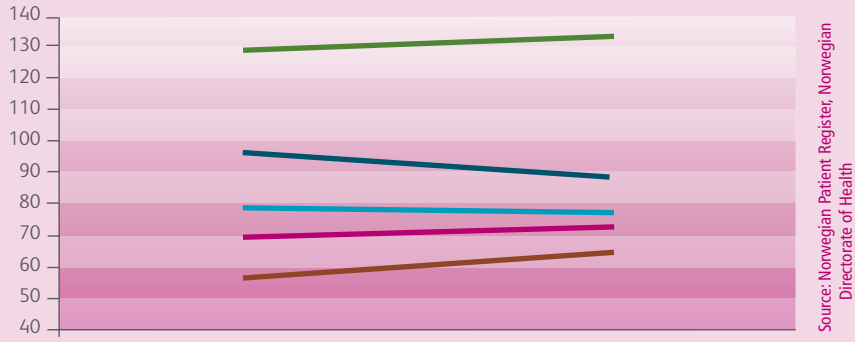
The Norwegian Patient Register (NPR) recorded large regional variation in the average waiting time for treatment. The average waiting time was longest within Northern Norway Regional Health Authority at 133 days, and shortest within South-Eastern Norway Regional Health Authority at 65 days in 2008. The fact that the average waiting time within South-Eastern Norway Regional Health Authority is shorter than in the other regions is due largely to the short waiting time at the acute treatment institutions of Storgata and Montebello.

NPR also recorded an increase in the average waiting time for treatment within South-Eastern Norway Regional Health Authority and within Northern Norway Regional Health Authority, of nine and four days respectively. Within Western Norway Regional Health Authority and the Central Norway Regional Health Authority, there was a decrease in the average waiting time of eight and two days, respectively, from 2007 to 2008.

Contract places providing interdisciplinary specialised treatment

The second indicator shows the number of contract places for patients referred via the Norwegian Health Economics Administration (HELFO). HELFO was recently transferred from NAV to the Directorate of Health. HELFO administrates reimbursement schemes for health services covered under the National Insurance Act. The reimbursement is disbursed to both treatment providers and service providers who provide health services on behalf of the public-sector, and to individuals entitled to reimbursement for health services they

Figure 6.3 Interdisciplinary specialised treatment for substance abuse. Average waiting time (number of days) for treatment, by health authority region. Corrected for lack of reporting. 2007-2008.



Source: Norwegian Patient Register, Norwegian Directorate of Health

2007	2008	
56	65	South-Eastern Norway Regional Health Authority
96	88	Western Norway Regional Health Authority
80	78	Central Norway Regional Health Authority
129	133	Northern Norway Regional Health Authority
70	73	Total

are wholly or partially exempt from paying for. The number of contract places agreed with the interdisciplinary specialised treatment system by the HELFO Patient Referral Unit is another indicator of how many patients within the interdisciplinary specialised treatment system contact the HELFO Patient Referral Unit due to breach of the waiting time guarantee. Where the right exists to essential health care, a final date is set for when the patient is to receive treatment. If the patient has not received treatment within this time limit, the patient can contact HELFO.

If the HELFO Patient Referral Unit increases its share of contract places within the interdisciplinary specialised treatment system, this is indicative of undercapacity in the regional health authorities. However, concluding sufficient contracts with institutions in a position to offer interdisciplinary specialised treatment for substance abusers may pose a challenge for the regional health authorities.

In 2008, 198 persons with alcohol/drug dependence notified breach of the waiting time guarantee to the HELFO Patient Referral Unit (until 31 December 2008, under NAV). Treatment was purchased for 163 of these patients. The remainder cancelled or declined the treatment arranged by the HELFO Patient Referral Unit.

Previously, the number of breaches of the waiting time guarantee have been considered as a single entity, rather than broken down by different groups of patients. From the first tertial of 2008, it will be possible for the HELFO Patient Referral Unit to extract cases involving alcohol and drug rehabilitation from the statistics.

Patients within the alcohol and drugs dependency treatment and care services with individual plans

The third indicator shows the prevalence of 'individual plans' within the Norwegian alcohol and drug dependency treatment and welfare services. Evaluation of the reform that introduced the right to individual plans indicated that the greatest challenge facing users of alcohol and drug dependency treatment and welfare services was the lack of continuity of the services provided. An individual plan is an instrument for achieving better coordination between the various service levels. If greater numbers are assigned individual plans, this would indicate that the services are better coordinated and that the availability of the services has improved. Data on the use of individual plans and coordination

with other bodies has to be sourced at individual level, and figures for this are not available for the activity year 2008. With the removal of anonymity from the National Patient Register in 2009, it will be possible to obtain these figures. The first figures should be available over the course of 2010.

6.6 SUB-OBJECTIVE: REDUCE INEQUALITIES IN LIVING CONDITIONS BETWEEN DIFFERENT GEOGRAPHICAL AREAS

In the white paper on inequalities in health, reference is made to another white paper, Report no. 31 to the Storting (2006-2007) on achieving a transparent, secure and productive capital region, which refers to state policy instruments for reducing geographical social disparities within Oslo. The white paper presents the Government's programme in Groruddalen, Oslo's most deprived district. The Groruddal programme will run for 10 years, from 2007 until 2017.

The Groruddal programme is concentrated around four programme areas, in which programme area 4: Childhood and education, living conditions, cultural activities and inclusion is what will be discussed here. The other programme areas are:

- Programme area 1: Eco-friendly transport within Groruddalen
- Programme area 2: Public access to the Alna countryside, green planning, sports and culture
- Programme area 3: Housing and urban regeneration

A process evaluation has been launched of the Groruddal programme, and a mid-term review will be available by 2010/2011. There are already registry data and indexes of living conditions for the district that will permit developments to be monitored over time. At present, no clear indicators have been defined or quantitative targets set for the programme. Under programme area 4, the following main aims and sub-aims have been formulated (City of Oslo, City Council Dept of Urban Development, Planning Office for Groruddalen, 2008):

"The object is to improve living conditions, education and childhood conditions, the culture and local community, and to strengthen inclusion through involvement, participation and voluntary initiatives. These efforts are designed to develop and strengthen neighbourhoods and schools, even after the programme is concluded".

Six sub-aims have been established under the programme area discussed here. On the basis of these sub-aims, indicators will be established that can be monitored throughout the programme period. Proposed indicators for the first three sub-aims are reported on in the following.

SUB-AIM 1: Children of pre-school age are to have sufficient Norwegian language skills to enable them to cope with starting school, and parental involvement must be increased.

PROPOSED INDICATOR:

- Number/percentage of children with satisfactory Norwegian language skills at the age 4 health check.

In 2007, the Health and Welfare Agency (HEV) in City of Oslo conducted a city-wide survey in which maternal and child health clinics in each district reported on their language assessment tests of 4-year-olds. The table below is based on the HEV figures, and shows the results from the deprived neighbourhood comprised by the Groruddal programme.

Table 6.6 Language assessment among 4-year-olds in the urban districts of Bjerke (BBJ), Grorud (BGR), Stovner (BSR), Alna (BAL) and total for City of Oslo, 2007.

	BBJ	BGR	BSR	BAL	OSLO
Number of 4-year-olds	396	341	425	607	6772
- of which multilingual individuals	158	187	231	305	881
% immigrants of the population aged 0-5 years	40%	55%	54%	50%	28%
Number of language assessments	268	319	336	483	1406
- of which multilingual individuals	152	195	202	313	862
Interpreter-assisted assessment	5	9	44	9	67
Reported to kindergarten	33	74	40	72	219
- of which multilingual individuals	28	72	23	46	169
Notified to other language supervisory body in district	7	21	7	17	52
- of which multilingual individuals	7	20	6	15	48
Referred to other professional bodies	14	6	5	16	41
- of which multilingual individuals	7	4	3	7	21

Source: City of Oslo Health and Welfare Agency

SUB-AIM 2: Learning scores and throughput at schools in Groruddalen to be raised to the Oslo average. School-district-home cooperation models to be further developed.

PROPOSED INDICATOR:

- Percentage of pupils whose academic performance is at the lowest proficiency levels (levels 1 and 2) in national Norwegian literacy, numeracy and English tests in year 8 of lower secondary school

- Percentage of pupils whose academic performance is at the lowest proficiency levels (levels 1 and 2) in national Norwegian literacy and numeracy in year 9 of lower secondary school

- Percentage of pupils and vocational trainees who have completed upper secondary education within the nominal duration

- Percentage of pupils and vocational trainees who have completed upper secondary education within more than the nominal duration

- Overall grade for the year and at examination in selected subjects in years 2, 3 and 4 of upper secondary school and on vocational training programmes

SUB-AIM 3: More persons from disadvantaged groups to participate in the labour market.
Unemployment and the rate of employment in the Groruddal district should not differ substantially from the Oslo average.

PROPOSED INDICATOR:

- Registered unemployment/participation in a qualification programme/transition from a scheme to ordinary employment at the NAV office in the Groruddalen district and for NAV Oslo overall

The following NAV offices are affected by the Groruddal programme

- NAV Stovner
- NAV Grorud
- NAV Alna
- NAV Bjerke

The other sub-aims for this programme area are:

- Sub-aim 4: Reduction in inequalities in health among the residents of Groruddalen. The state of health of residents of Groruddalen must not differ substantially from the Oslo average.

- Sub-aim 5: Amenities for young people in Groruddalen must be maintained and upgraded as attractive and inclusive meeting places. Young people must be able to participate in positive activities and given the opportunity for adult contact.

- Sub-aim 6: Maintain and develop varied and inclusive opportunities for engaging in arts, culture and associations, with broad participation from all population groups in the district. Voluntary initiatives must be given encouraging frameworks and development opportunities.

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Appendix:

SECTORAL REPORTING ON STRATEGIES AND MEASURES FOR FOLLOW UP ON REPORT NO. 20 TO THE STORTING (2006-2007)

NATIONAL STRATEGY TO REDUCE SOCIAL INEQUALITIES IN HEALTH

REPORT ON MEASURES IMPLEMENTED – INCOME

Reduce economic inequalities in the population

In a comprehensive welfare state such as that of Norway, there is at any given time substantial economic redistribution between different groups in the population. This is achieved both through benefit schemes for groups who fall out of the labour market for example, and in the form of transfers to special groups such as families with children, old age pensioners, disability pensioners and so forth. In Norway, free or heavily subsidised access to public sector services such as school, kindergarten and health care also has a levelling effect on the standard of living for the population as a whole. Many of the transfer schemes are linked to different life phases. This means that the transfer systems to a great extent redistribute income from one phase of life to another.

Much of the redistribution of income among individuals in a given year, but also between the same individuals over the course of their entire life, is effected through the tax and transfer system. In order to illustrate how the taxation and transfer system affects income distribution, Statistics Norway has computed Gini coefficients for market income, total income and income after tax.

Table 1 Distribution of market income to households, total income and income after tax per consuming unit (EU scale). Gini coefficients and percentage contribution to redistribution.

				PERCENTAGE CONTRIBUTION TO REDISTRIBUTION		
	Market income	Total income	Income after tax	State transfers	Taxes	Total
ALL						
1986	0.35	0.25	0.21	27.5	11.3	38.8
1991	0.38	0.26	0.22	31.3	11.1	42.4
1996	0.41	0.29	0.25	30.2	10.2	40.4
2001	0.39	0.28	0.23	29.7	12.2	41.9
2005	0.48	0.35	0.33	26.4	5.0	31.4
2006	0.40	0.28	0.24	30.3	11.2	41.5
2007	0.40	0.29	0.24	28.0	11.2	39.2

* In 2005 and 2006 market income did not include child maintenance payments.

Source: Income statistics for households. Statistics Norway

Market income is the sum of total income from employment, from capital, and from private (non-state) transfers such as company pension payments and child maintenance payments. The first column in Table 1 is heavily affected by the high dividends figure in 2005. The second column shows the Gini coefficient for total income before tax. Besides market income, total income also includes state transfers. As illustrated by the

table, the Gini coefficient is reduced by around 30% once state transfers are included. Although we cannot draw the conclusion that the difference in income would have been 30% higher in the absence of such state transfers, it does however go to show that the transfer system has a considerable redistributive effect. The last column shows the contribution to income levelling from personal taxation. The steep fall in this contribution in 2005 is attributable largely to adjustments made in the 2006 tax reform. Because dividend payments in 2005 were tax free, tax as a fraction of market income was markedly low for that year. Since the scale of the levelling effect in the table above will depend on which order the effects are measured in, estimates of this kind should not be taken too literally, yet they do serve to illustrate that the levelling contribution from state transfers is patently greater than the contribution from taxes. Given that the Norwegian state pension system to a great extent entails a transfer of income from one life phase to the next, the figures in the table above, for the contribution from state transfers especially, will be affected by this. If we look at the age-group 25-55 years in isolation, the contribution from state transfers decreases by 18.7%.

In recent years, the Norwegian Government has introduced reforms to the taxation system which have contributed to greater economic redistribution. Reforms to property tax have raised taxes for the wealthiest individuals, while the raised basic allowances have reduced tax for those with more modest assets. The 'shareholder discount' which granted special tax relief to shareholders has been withdrawn completely. This was also the so-called "80-percent-rule", the actual effect of which was to reduce the property tax liability of Norway's wealthiest individuals.

In the national budget for 2009, inheritance tax was amended with a reduction in the discount for unlisted shares. This has also had the effect of raising the tax liability of the wealthiest individuals. The wealthiest 10% owned around 90% of the value of all unlisted shares in Norway in 2006.

At the same time, the inheritance tax rates were reduced and the inheritance tax threshold was raised considerably, with the effect that those who inherit moderate assets do as well or better from the new inheritance tax system.

Easements in the minimum deduction from gross income and an increase in the parental allowance introduced widespread tax breaks for persons on moderate and low income. Increased minimum pensions have also had the effect of raising the income of a large group of people with low incomes.

A budget amendment with great impact on individuals with especially low incomes came with the Government bill for a new housing allowance scheme due to come into effect on 1 July 2009. The new model will entail additional state expenditure in excess of NOK 1 billion once the scheme has been fully phased in. The effect of this scheme is a considerable income boost both for households that are already on the scheme and for new households that will now qualify. It is estimated that some 50,000 new households will be granted housing allowance, around 10,000 of which are families with dependent children. In 2009, just under NOK 2.5 billion was disbursed in state housing allowances, i.e. an average of just under NOK 25,000 per household.

State services provided to citizens free of charge or at reduced rates have welfare impacts that generate ideal data for distribution analysis. A number of such services are typically universal services for the whole population such as public sector administration, the judicial system, defence etc, where it is reasonable to assume that everyone receives approximately the same services. However, a number of state

services such as education, health care and care services for elderly persons benefit only individual citizens. A study by Aaberge & Langørgen (2006) shows that, by taking into account the distribution of such services, income distribution measured using the Gini index for example, becomes somewhat more even, with a strong reduction in low income.

In this area also, the Government has introduced reforms contributing to more equitable income distribution. Increased transfers to the kindergarten sector especially have a levelling effect on income, while they also make it possible for more people to gain and stay in employment.

In the spring of 2008, the Government appointed a commission to examine the causes of the increasing economic inequalities – the Commission on Income Distribution (Fordelingsutvalget). The Commission was headed by Ådne Cappelen, research director, and submitted its final report on 6 May 2009. The Commission undertook a wide-ranging analysis of the determinants of income distribution, and presented proposals for measures to contribute to reducing economic inequality.

Eliminate poverty

One of the objectives of Report no. 20 to the Storting (2006-2007) was to eliminate poverty. This calls for wide-ranging and long-term measures. Key elements consist of:

- An economic policy conducive to a high rate of employment, stable economic growth and sustainable welfare schemes
- Further enhancements to the Nordic welfare model
- A broad-based preventive perspective
- Targeted measures to eliminate poverty

To coincide with National Budget 2007, the Government presented its Action Plan to Combat Poverty. The initiative centres around the three sub-objectives of the action plan:

- Enable everyone to work.
- All children and young people are to have the opportunity to participate and develop.
- Improved living conditions for the most disadvantaged groups.

This special intervention on poverty forms part of a coherent policy on social levelling, inclusion and poverty reduction. *The Action Plan to Combat Poverty should* be seen in the context of strategies and measures in white papers such as Report no. 9 to the Storting (2006-2007) *Employment, welfare and inclusion;* Report no. 16 to the Storting (2006-2007) *Early Intervention in Lifelong Learning;* Report no. 20 to the Storting (2006-2007) *National strategy to reduce social inequalities in health; Action Plan for the Integration and Inclusion of the Immigrant Population;* and *the National Action Plan on Alcohol and Drugs.*

The Action Plan to Combat Poverty was followed up with measures in the national budgets for 2007, 2008 and 2009.

Enable everyone to work

Employment is the most important policy instrument in eliminating poverty and reducing social and economic inequalities. Labour-market affiliation is important in securing an income and for the individual's sense of inclusion and participation.

A new, coherent labour and welfare administration provides a better basis for assisting persons marginalised from the labour market and who need a wide range of state and municipal services. Report no. 9 to the Storting (2006–2007) *Employment, Welfare and Inclusion* presents a review of how schemes, services and welfare benefits can be used to incentivise more people to gain employment. The aim is an employment and welfare administration and a system of policy instruments that are highly conducive to empowerment, welfare protection and inclusion of individuals who have problems on the labour market.

A new qualification programme with associated qualification benefit was introduced from 1 November 2007. The target group consists of individuals with substantially reduced capacity for work or for earning income and with no or very limited subsistence support from the National Insurance Scheme. Many such individuals are long-term recipients of financial social assistance. The object of the qualification programme is to encourage more people in the target group to gain employment. The programme is open to individuals who are regarded as having potential for gaining employment through closer and more committed social assistance and supervision. The qualification programme and associated qualification benefit is offered by an increasing number of municipalities as a result of the establishment of local NAV – Norwegian Labour and Welfare Administration offices. The drive for labour market measures for long-term recipients of social assistance and others was introduced nationwide as of 2006 and has subsequently been intensified.

All children and young people are to have the opportunity to participate and develop

Measures to combat child poverty are essential in providing for the welfare and inclusion of children in the short term and in preventing poverty in the long term by preventing children and young people from becoming marginalised in later life. The Government's main strategy for preventing and reducing poverty among children is to strengthen their parents' employability. State welfare schemes and affordable universal benefits are important in achieving the inclusion of disadvantaged children and young people. The Government is effecting a major reform of kindergartens. A well-developed educational kindergarten provision gives children positive and more equitable conditions for development and learning. The Government is implementing measures to reduce social inequalities in the education and training system. Special measures have been implemented, including competence building and professional development measures within the child welfare service and social services in order to prevent and reduce child poverty; child and youth measures in major urban areas; and measures for young people in risk zones.

Improved living conditions for the most disadvantaged groups

A number of measures have been implemented to improve living conditions and opportunities for the most disadvantaged groups in society. Municipal finances have been strengthened, and state grants have been awarded for pilot and development projects. This allows local authorities to play a more active role in efforts to prevent and reduce poverty. Improvements have also been made to housing allowance and other policy instruments for housing and welfare. 2009 saw the introduction of an extensive reform of the housing allowance scheme, the effect of which will be to extend the scheme to more people and also simplify it. An intensified intervention has been implemented on

homelessness, among other measures, through subsidies for follow-up services in the home, and measures for persons living in temporary local authority housing to ensure that such persons are offered permanent accommodation. Measures to reduce social inequalities in health, measures for people with alcohol or drug dependencies and measures for people with mental disorders are key intervention areas in a coherent action to combat poverty. The Government has strengthened cooperation and dialogue with user organisations and other voluntary organisations dedicated to socially and financially disadvantaged persons, including the establishment of a liaison committee between the Government and these organisations. In order to improve the financial situation and living conditions of persons who for any period of time are dependent on social assistance, the rates in the guidelines for calculating benefit to cover living expenses have been increased, most recently from 1 January 2009. A full national insurance assessment was carried out in 2007 and 2008, and minimum benefits for short-term benefits within the National Insurance System were increased.

A full presentation of the action plan to combat poverty is provided in the printed annex to Proposition no. 1 to the Storting (2008–2009) for the Ministry of Labour and Inclusion: *Action Plan to Combat Poverty – situation report 2008 and intensified efforts in 2009*.

Ensure fundamental economic security for everyone

Basic principles of the national insurance scheme

State income guarantee and benefit schemes for private individuals comprise the transfers within the National Insurance Scheme and a small number of other benefit schemes operated by central and local government. The national insurance system is an important pillar of the Norwegian welfare state. National insurance has three main objectives: It is to provide financial security, have a levelling effect on income and living conditions and stimulate empowerment of the individual. These objectives must be weighed against each other in terms of how the system is designed and administrated.

The most important and prime objective is to provide financial security in specifically defined situations in which capacity to provide for oneself is lost or reduced for various reasons.

The objective of providing an income guarantee comprises several elements. It includes guaranteeing a minimum income, irrespective of the individual's contribution to the labour market, such as a minimum pension for elderly persons, widows/widowers and people with disabilities, and compensation for special expenses incurred in extension of the situations and causes that give rise to the need for financial benefits. Another aim is to protect individuals against a drastic fall in accustomed income achieved while in employment. By linking a number of the benefits to previous income and accumulated pension credits, the national insurance system offers a strong element of welfare insurance. Through compulsory membership and by spreading the risk across all members with the state as guarantor, we have achieved a national insurance scheme for all citizens that is both reliable and inexpensive.

In this way, the Norwegian national insurance system is also instrumental in levelling income and living conditions over the course of the individual's life. The system is also designed to level out differences between groups of persons and especially between groups with high and low or no income. At the same time, benefits to cover expenses (e.g. basic benefits and supplementary benefits, benefits to cover assistive disability

devices etc) also serve to reduce inequalities in both income and living conditions.

This redistribution is effected by various means including the rules laid down for granting and disbursing benefits and the way in which they are financed. Key elements are the provisions for minimum benefits and maximum benefits in proportion to income, and often in the case of higher percentage compensation in relation to lost income for low income than for high income. Equally – the premiums – the national insurance taxes – are proportional to income from employment, with no ceiling on income and are charged independently of the individual's risk and behaviour.

Besides national insurance, Norway has a long-standing tradition of income transfers to families with dependent children in the form of child benefit, and in recent years through the uniquely Norwegian cash-for-care subsidy (paid to parents of children aged 1-3 who are not using or only partially using state-subsidised kindergartens) as an alternative to transfers in the form of kindergarten places. Income transfers at local government level include financial social assistance, introductory programmes for immigrants and housing allowance, which are especially vital for persons on low incomes.

A distinction is usually drawn between universal and selective or needs-assessed schemes. The benefit schemes within the national insurance system, child welfare and cash-for-care subsidies are universal in the sense that they are in principle available to all citizens.

The local authority schemes – social assistance, the introductory scheme and the more recent qualification programme – are available less as a direct right, being distributed more on a discretionary, individual-need basis.

Overall, welfare benefits are intended to contribute to a desirable distribution of income in society in which the level of services and financing/tax system determines the degree of equalisation between the recipients of those services and those who contribute to value creation through income-generating employment.

The objective of empowerment emphasises that transfer schemes for persons of working age are intended not only to guarantee the individual a source of income and provide for national income distribution, but also to encourage individuals to cope independently in working life and life generally. The design of such schemes influences how the individual adapts to the relationship between earned income and state benefit.

In recent years, greater emphasis has been placed on realigning resource consumption from passive income support towards measures conducive to employment and activity. Vocational activity has gained greater importance by the linking and to some extent conditionality of various policy instruments and requirements from the individual regarding the right to certain subsistence benefits.

One key question is which incentives should be built into and linked to the schemes in order to promote labour market participation and inclusion in society. The specific design of a scheme or policy instrument that influences the individual's behaviour in a desirable direction may result in undesirable distribution outcomes and vice versa.

New reforms and planned amendments

Work assessment allowance

In December 2008, Parliament adopted amendments to statutes under which the then system of rehabilitation allowance, rehabilitation benefit, time-limited disability benefit was to be replaced by a new interim national insurance allowance called 'work assessment allowance'.

The object of this scheme is to facilitate earlier and closer supervision of benefit recipients and in order to speed up the process of returning to employment or vocational activity. The merger of the three original benefit/allowance schemes is also designed to simplify the regulations and reduce the complexity of benefits assessment.

Qualification programme

In the Government bill, Proposition no. 70 to the Odelsting (2006–2007) *On the act regarding amendments to the social services act, and in certain other acts*, a proposal was made for a new scheme called the 'qualification programme' with associated qualification benefit. This statutory amendment was adopted by Parliament on 22 October 2007 and came into force on 1 November 2007.

The qualification programme and associated qualification benefit are aimed at people with significantly reduced capacity for work or for earning income and with no or very limited subsistence support from the National Insurance Scheme. This largely includes people who in the absence of such a programme would be dependent on financial social assistance as their main source of income over an extended period.

Changes to the housing allowance scheme

Changes to the housing allowance scheme entailed a restructuring and extension of the scheme, which came into force on 1 July 2009. Instead of the requirement for childless people to be on social security in order to qualify for housing allowance, everyone (except students and individuals completing military service) were to be entitled to housing support subject to means testing. The income threshold for eligibility for housing allowance will be raised and the terms and conditions applicable to the design and financing of the home are to be eased. The object of these amendments is to combat poverty, reduce the number of people at risk on the housing market and to eliminate homelessness.

Under the new rules, around 10,000 multi-child families and 40,000 single person households and childless couples will qualify for the scheme. These numbers are in addition to the some 100,000 households that already qualify for housing allowance.

REPORT ON MEASURES IMPLEMENTED – CHILDHOOD CONDITIONS

Full kindergarten coverage and reduced social inequalities in the use of kindergartens

The Norwegian Government believes that kindergartens that are of a good standard, are affordable and accessible are conducive to providing all children with equal opportunities. Kindergarten is to be an educational undertaking providing children under compulsory-school age with development and activity stimuli. The governmental framework plan for the contents and tasks of kindergartens, prescribed by the Act on Day Care Institutions, is an important management and quality assessment tool since it serves to ensure children of equitable provisions of a high standard.

The statutory right to a place in kindergarten came into force on 1 January 2009. This means that children reaching the age of one by the end of August in the year for which a place is applied for have the right to a place. This right must be honoured from August of the same year, and the child is to be accorded the right to a place in

a kindergarten accredited under the Act on Day Care Institutions in the municipality in which the child resides. The municipality is required to set a final date for application for admission to its kindergartens and enrol at least one intake each year.

Measures for fulfilling the objective of full kindergarten coverage, include state subsidisation schemes as investment grants for new kindergarten places; operating grants for kindergartens; discretionary subsidies to compensate municipalities for additional expenditure associated with running kindergartens; and subsidies for permanent places in temporary premises.

The regulations pursuant to the Act on Day Care Institutions stipulate that fees to parents for a place in a kindergarten shall not be set higher than a maximum limit. Payment for meals may be required separately. The maximum limit is set by Parliament's annual budget resolutions. Fees to parents for a standard full-time place in kindergarten in 2008 is to amount to no more than NOK 2,330 per month and NOK 25,630 per annum. The regulations appurtenant to the Act on Day Care Institutions stipulate that all municipalities shall offer low-income families a reduction in or exemption from payment of fees. Both the maximum fee and schemes for parents on low incomes are to result in good accessibility of kindergarten places for all parents wishing to make use of them.

Policy instruments for ensuring that kindergartens are inclusive and provide inclusive and tailored facilities for all children consist of: state subsidies for programmes for children with disabilities in kindergartens, prioritised admissions, and state subsidies for measures to improve Norwegian language comprehension in minority language children of pre-school age.

In spring 2009, the Government presented a white paper on the quality of day care institutions, cf. Report no. 41 to the *Storting (2008–2009)*.

This white paper reports on the prevailing quality and content of children's day care provisions, emphasising the need to preserve the unique characteristics of Norwegian kindergartens and the holistic approach to care, play, learning and cultural education. Equally, the white paper highlights, pursuant to the societal mandate of day care institutions, three goals for the sector in the years ahead, and lays down a number of strong guidelines for individual areas in the government framework plan for the content and quality of kindergartens. The three goals are:

- strengthen equitable and high quality in all kindergartens
- strengthen kindergartens as learning arenas
- all children are to be given the opportunity to engage actively in an inclusive community.

Reduction in the number of pupils starting school with inadequate language skills

A research report from the Norwegian Institute of Public Health in association with the Ministry of Education and Research states that kindergarten attendance promotes language acquisition in children. In particular, kindergarten attendance favours language development in children of parents with low incomes, short education and a first-language other than Norwegian. These findings support the Government's commitment to full kindergarten coverage as conducive to achieving the next sub-objective: *Reduction in the number of pupils starting school with inadequate language skills.*

Through legislative guidelines and in the Government's framework plan, kindergarten staff are under obligation to work to ensure that all children receive good language stimulation. Many municipalities also make language stimulation provisions for children who do not attend kindergarten. Municipalities with many minority-language children tend to be more active in making such provisions. The state grants subsidies for measures to improve language comprehension among minority-language children of pre-school age. Such subsidies are to encourage local authorities to set up tailored language-stimulation schemes for minority-language children of pre-school age, which in turn is to make starting school easier for children whose first language is not Norwegian.

Free core time in kindergarten

The Government aims for all children born and raised in Norway to be proficient in the Norwegian language before they start school. The free core-time scheme is a key element in a series of measures to ensure that children are competent speakers of Norwegian by the time they reach compulsory-school age.

Under this scheme, all four- and five-year-olds attending kindergarten in urban neighbourhoods with a high proportion of minority-language children are offered free kindergarten places during 'core time', that is 5 x 4 hours a week. This scheme is aimed at all children in urban neighbourhoods and comprises all four- and five-year-olds in the last years of kindergarten preceding the start of compulsory education. The pilot version of this scheme was launched in 2006 in City of Oslo when the district Bydel Stovner was granted funding to set up a scheme for all five-year-olds, and was extended in 2007 to four neighbourhoods in Groruddalen and Bydel Søndre Nordstrand. Within 2007, the pilot was extended to include all four-year-olds in the respective neighbourhoods. The pilot will be continued in 2009. In 2008, the then Ministry of Labour and Inclusion granted NOK 50 million for 2008 for free core-time in kindergartens in the districts of Alna, Stovner, Grorud, Bjerke and Søndre Nordstrand. The scheme will be evaluated.

National language promotion

Early intervention and close supervision of children and pupils are priority action areas in Report no. 23 to the Storting (2007–2008) *on language stimulation and language training for children, young* people and adults and Report no. 31 to the Storting (2007-2008) *on the quality of school education.* Measures in national strategies and programmes are intended to promote Norwegian language proficiency, improved academic attainment, social inclusion and social levelling. Good language development is fundamental in ensuring that pupils leave lower secondary education well qualified for further education/training and working life, and with motivation for lifelong learning.

The national strategy plan *Equal Education in Practice Strategy for increased learning and greater participation for language minorities in kindergartens and schools* 2007–2009 contains targeted measures to facilitate sound and comprehensive language development and language training in kindergartens and schools:

The national language promotion programme – follow-up on children based on language assessment at maternal and child health centres is a four-year project (2007-2011). Key aims for the project are proficient language development, acqui-

sition of proficient Norwegian language skills and social skills in children of pre-school age and at school; to ensure a smooth transition for children between kindergarten and school; and joint efforts across governmental levels, institutions and professional groups. The target group is a selection of children for whom language assessment conducted by maternal and child health centres identified a need for language stimulation and follow-up. The language promotion drive should be seen in the context of *Development projects in schools with more than 25% minority-language pupils.* Key goals are a high standard of language training and organisation of the school day so as to improve pupils' academic attainment. The projects are being carried out as demonstration programmes in 9 municipalities where various local measures are to be developed and tested. Both projects are also incorporated in the urban regeneration programme for the deprived Groruddal district in City of Oslo.

Reduction in the number of pupils who finish their compulsory schooling without good basic skills

National quality assessment system for compulsory education, NKVS, early intervention, adapted training, new teacher training, a permanent system for continuous and supplementary education and measures for skills building among school principals are all key action areas in the efforts to ensure that children and adolescents acquire basic skills for learning and social competencies.

Systematic follow-up on the results of state assessment tests and national tests in Norwegian literacy, numeracy and English language acquisition for selected years in lower secondary schools are key elements in an integrated assessment system designed to ensure that more pupils are better able to acquire basic skills. National strategies and drives based on targeted measures such as the project on improved assessment practices are intended to interact to achieve improved learning environments and better academic grades and skills acquisition.

State assessment materials and national tests

National quality assessment system for compulsory education, NKVS is to be further developed to provide municipalities and schools with a better basis for assessment and early intervention. In lower secondary education, one prime element in this effort is gradual new design of compulsory and voluntary state assessment tests in several school grades in Norwegian literacy, numeracy and English language acquisition. A system will also be developed for sample tests in subjects for grades 8-10 (age 13-16). State assessment tests are designed to provide information about weak comprehension and skills at an early stage as a basis for adaptation and coaching of individual pupils . The national literacy and numeracy tests will be extended to include 9th grade pupils. National tests are designed to provide information about whether academic attainment among pupils is meeting curriculum targets.

For minority-language pupils, the curriculum for basic Norwegian literacy and in the pupil's native language and the development of a range of assessment tools are core components of the programme for early intervention.

Supervisory team

A supervisory team will be established to assist schools and local authorities with the special challenges posed by the efforts to improve pupils' academic attainment.

Lengthened school day, school meals and physical activity

The school day is to be gradually lengthened. For grades 1-4, the number of hours of daily school attendance is to be extended by 5 weekly classes of 60 minutes in the core subjects of Norwegian, mathematics and English starting from the school year 2008-2009. Physical activity, free fruit and vegetable snacks, school meals, help with homework are other key intervention areas to facilitate a varied and coherent school day and a sound learning environment.

Reduction in the number of pupils who do not complete upper secondary training

National quality assessment system for compulsory education, NKVS – state assessment tests of literacy and numeracy for the second year of upper secondary education.

Further development of NKVS comprises the development of compulsory state assessment tests for literacy and numeracy for year-one of upper secondary school, to be implemented from 2010. This is a continuation of the efforts to assess basic skills at lower secondary school level; follow-up of individual pupils, adapted learning and preventing drop-outs from upper secondary education.

Systematic education and vocational advice

The efforts to strengthen the advisory service in lower secondary education takes priority in the measures to prevent drop-outs from upper secondary education and training. The service is to be divided into a socioeducational advisory service and a vocational and educational counterpart. A trial project for 'Individual development plans for educational and vocational advisory services' is one component of these measures. The development plan is a digital reflection tool designed to assist pupils in making the right choice of education/training and occupation. The project is being piloted in a number of counties in the school years 2008/2009 and 2009/2010.

Improved assessment practices

The project for improved assessment practices is designed to achieve a more explicit set of regulations on academic assessment and contribute to more academically relevant and fairer assessment of pupils' performance. 78 educational institutions are participating in a trial of the indicators of academic attainment in a selection of subjects. Four different models are being employed.

Trial of work experience certificate

A trial has been launched for a work-experience certificate scheme in all counties where pupils who complete lower secondary school are given the opportunity to receive on-the-job training on a two-year scheme, where the main component will be work-experience with a company. The training will result in formal proof of completion in the form of a work-experience certificate. The skills attainment goals are obtained from ordinary curricula and the work-experience certificate will count towards the standard vocational education and training certificate.

Greater accessibility of the school health service

The white paper, Report no. 20 to the Storting (2006–2007) *National Strategy to reduce social inequalities in health*, stated that an assessment was to be made of the current situation in and future capacity and content requirements of the school health service. Report no. 47 to the Storting (2008-2009) on the *Coordination Reform* (on continuity of treatment in the health service) also confirms that the school health service has insufficient capacity in many municipalities. The report also points out that in spite of the fact that requirements are made of the service in the regulations, in supervisory cases it is difficult to make requirements regarding prevention. The report explains that the defensibility requirement is closely linked to the risk to life and health, which, with the exception of protection against infectious diseases, is difficult to apply when it comes to health promotion and disease prevention activities. This report states that there is therefore a need to review the regulations. The Directorate of Health is examining the possibility of standardising requirements applicable to personnel for the maternal and child health centres and school health services.

The planning period for 'Escalation plan for mental health' expired in 2008, but the area of mental health still has high priority. The object was for capacity at the maternal and child health centres and school health service to be increased by 800 man-years over the period. Reporting on earmarked funds as at 2007 was 665 man-years. At year-end 2008, it was estimated that the services would be around 35 man-years below target. Reports received by the Directorate of Health from municipalities indicate that some municipalities have reduced the number of self-financed positions during this period. In the national budget for 2009, the earmarked subsidies for mental health have been incorporated in the municipal budgets. This means that the funds will be transferred. Efforts to step up capacity in the field of mental health care in the municipalities are required to have lasting effect and not be scaled down after the planning period comes to an end.

In its annual letter of instruction to the offices of the county governors, the Directorate of Health requests that the offices assist the municipalities in stepping up capacity at the maternal and child health centres and the school health service. In addition, the offices are required to follow up on the Government's strategic plan for children's and adolescents' mental health with increased recruitment and psycho-social competence building at the maternal and child health centres and the school health service.

In a circular to municipalities, offices of the county governors, regional health authorities and counties, IS-1 National Goals and Priorities 2009, maternal and child health centres and the school health service are referred to as crucial for preventive and health promotion work within the municipalities. The offices of the county governors are requested to ensure that the municipalities oversee and strengthen the maternal and child health centres and school health service pursuant to statutes and regulations, recommended programme for the service and the white paper on inequalities in health. The school health service especially is in focus. The counties are requested to follow up on and extend their cooperation with the school health service, especially as regards children at risk.

In order to meet the major public health challenges, efforts to strengthen the capacity of mental health care services/low threshold measures in the municipalities, prevention and early identification and treatment will be given priority.

Report no. 16 to the Storting (2006–2007) *Early Intervention in Lifelong Learning* advises that the Ministry of Education and Research will be evaluating changes to the Education Act and appurtenant regulations to ensure that liaison between the maternal and child health service and school health service is given greater support on the part of schools also. The Directorate of Health has a dedicated schools task force which has links with the Directorate of Education. In that forum, the school health service is a specific topic, and proposals have been made for amendments to the Education Act, although no amendments have been implemented so far.

In the national budget for 2008, the Parliamentary committee on health and care services passed a motion to allocate NOK 3 million for strengthening capacity of the school health service in areas with marked socially determined inequalities in health. For the year under review, NOK 6.5 million has been allocated for the same purpose. The Directorate of Health has distributed this allocation to the municipalities in line with the preconditions.

Early identification and good follow-up of children in high-risk groups

A number of measures have been implemented for the purposes of earlier identification and follow-up of children and adolescents in high-risk groups:

Programme for children whose parents are mentally ill or have substance abuse problems – the Model Municipality Pilot.

This programme is informed by the Government's objective to identify such children at the earliest possible stage and to provide them and their parents with follow-up and assistance as early as possible, with measures adapted to the age of the child and the parents' circumstances.

As part of this programme, the National Office for Children, Youth and Family Affairs has been charged with assisting municipalities with measures to strengthen interdisciplinary collaboration and coordination within the municipalities and between municipalities and the specialist health services. The National Office for Children, Youth and Family Affairs will also be stimulating competence building and the development of effective models (screening/assessment tools and implementation of targeted measures) within the municipalities. In 2007, the Norwegian Ministry of Children, Equality and Social Inclusion included 26 municipalities in what is referred to as the 'Model Municipality Pilot' (*modelkommuneforsøket*). The mandate for the model municipalities is to develop effective solutions for early intervention and to adopt methods for systematic follow-up of children whose parents have mental problems and/or children whose parents have substance abuse problems – from pregnancy to school age.

The National Office for Children, Youth and Family Affairs is responsible for stimulating progress and assisting the municipalities with competence building measures. As of autumn 2008, the same national office, as represented by regional coordinators working with specialist teams, has maintained focus on monitoring the Model Municipality Pilot. From 2009, experience gained from the model municipalities will gradually be communicated to, and serve to promote measures in, more municipalities.

The Directorate for Children, Youth and Family Affairs is responsible for organisation and follow-up of an evaluation in selected municipalities, based on a knowledge-based,

systematic and integrated model being implemented in certain municipalities, and for recording and comparing the effects of this in relation to municipalities where the model is not in use. This responsibility will be devolved to a research environment.

Cooperation between the child welfare service and kindergartens

A great many children under the age of five spend time in kindergartens. Good cooperation between kindergartens and the child welfare service is crucial for the capacity to identify children at risk and in need of assistance and to intervene at an early stage with targeted measures for the child and its parents.

The Ministry of Children, Equality and Social Inclusion has developed a guide entitled "In the child's best interests – cooperation between kindergartens and the child welfare service" (*Til barnets beste – samarbeid mellom barnehagen og barneverntjenesten*). The main theme of this guide is how the two services can and should cooperate on early identification of children at risk and their families and assist in ensuring that they receive help. When the kindergartens draw on the expertise of the child welfare service concerning children at risk and their need for help and support, this has the effect of raising the quality of the service provided by the kindergarten. More systematic cooperation between the two services will serve to raise awareness among kindergarten staff of the need to focus on the child's overall care situation, and to seek help from/report concerns to the child welfare service where relevant. This will strengthen the capacity of kindergartens to realise the intention of prevention and early intervention.

In addition, the Ministry of Children, Equality and Social Inclusion has now submitted proposals for amendments to the Child Welfare Act which will be instrumental in achieving improved follow-up of children at risk:

Feedback to entity reporting concern for a child

At present, the Child Welfare Service is under no obligation to report back to the entity that reported concern for a child whether or not a case has been investigated or not. This lack of feedback to the reporting entity may cause uncertainty and result in reluctance to report concerns for a child to the service. The proposal is to replace the current discretionary reporting to notifiers with a statutory duty to provide such feedback.

Individual Plan

There is also a proposal to make the Individual Plan scheme within the Child Welfare Service statutory in order to achieve greater continuity in child welfare provisions. The proposal is for the Child Welfare Service to be required to draw up an individual plan for children in need of long-term and coordinated assistance from several welfare services.

Aftercare assistance for young people leaving foster or residential care

It is also proposed that the child welfare service should provide justification in each individual instance of why assistance is to be discontinued after a young person turns eighteen, or for why an application for aftercare assistance is rejected. Young people who have declined to accept aftercare assistance on leaving residential or foster care should also be contacted when they turn nineteen as to whether they wish to receive aftercare assistance after all.

Reduction in social inequality in children's and adolescents' organisational and cultural participation

Arts, culture, sports and voluntary activities are enriching for society and are vital for the individual's quality of life, sense of community and personal development. These aspects are of great value in themselves, but are also of great significance for other sociocultural goals for dimensions such as childhood conditions, inclusion, health, learning and creativity. A proactive commitment on the part of the public sector is essential in ensuring breadth, diversity, accessibility and participation in the area of arts and culture, sports and voluntary activities.

The most important undertaking of cultural policy is to facilitate civic access to a diversity of arts and culture amenities and participation in an active cultural life. Children and young people should have access to arts and culture amenities comparable with those available to adults. Access to and opportunities for self-expression in arts and culture must not be determined by geographical or social divides.

The voluntary sector is a pillar of democracy and welfare societies. Participation in voluntary organisations is fulfilling and stimulates a sense of community, learning and democratic competence, and is conducive to good conditions in childhood, community spirit and quality of life. Joining an organisation and engaging in voluntary activities will in itself have a health-promoting effect, among other things because such activities are perceived as meaningful and involve participation in social groupings.

There are however great disparities in the Norwegian population when it comes to organisational and cultural participation. Low-income groups are underrepresented in organisations and spend far less than other groups on state-financed cultural amenities. The object is therefore to increase organisational and cultural participation among groups that tend not to participate at present, and to extend and strengthen policy instruments for reducing social inequalities and hence also inequalities in children's and adolescents' organisational and cultural participation.

The Cultural Rucksack

The Cultural Rucksack provides lower secondary school pupils with professional arts and cultural amenities. The scheme is a national programme for arts and cultural appreciation among children and young people and comprises all forms of artistic and cultural expression: music, drama, cinema, literature, cultural heritage, visual arts or a combination of all of these. The scheme is financed via proceeds from Norsk Tipping's national lottery and gaming activities, which are distributed annually by royal decree. Lottery funds for The Cultural Rucksack amounted to NOK 167 million, of which NOK 122 million was allocated to the scheme in lower secondary schools, NOK 25.5 million to upper secondary schools and NOK 19.5 million to state cultural initiatives. As of 2010, lottery funds for The Cultural Rucksack will be allocated exclusively to the counties and the scheme in lower and upper secondary schools.

The public library as a meeting place and civic actor

The Norwegian public libraries are important meeting places and learning and cultural arenas in local communities. The public libraries are to communicate information, culture and knowledge and serve as guarantors of freedom of speech and provide a forum for diverse cultural experience for everyone. One aim is for the public libraries, in association with relevant actors in local communities, to serve as arenas

for inclusion and integration of different social groups. In order to develop the libraries as public meeting places and to raise the profile of public libraries with good functionality, meeting place functions and good partnerships, the Ministry of Culture will be establishing a scheme for model libraries. In order to stimulate cooperation and coordination between libraries and voluntary organisations across a broad front, the Ministry will also be establishing a project to strengthen public libraries as civic bridge builders and meeting places for groups who are currently under-represented in cultural and organisational life. The specifics of these schemes will be detailed.

Reading Year 2010

Good reading skills are empowering and facilitate participation in working life and leisure activities. The Ministry of Culture will be promoting interest in reading and literacy by developing the public libraries as arenas for reading and literary appreciation by establishing year 2010 as National Reading Year, as a kick-off project for the national literacy campaign for the period 2010-2014 aimed at children, adolescents and adults.

Culture card for young people

All young people are to be assured of opportunities for making use of a range of cultural amenities through a 'culture card' discount scheme for young people, including students. Ten Norwegian counties are participating in the scheme. The pilot scheme will be evaluated in spring 2009. The state subsidy for 2009 amounts to NOK 3.9 million.

Inclusion in sports associations

A number of the largest towns and cities in Norway face special challenges in recruiting children and adolescents to sports associations. The main aim of state grants for this area is to include new groups in the ordinary activities offered by the associations by counteracting financial and cultural barriers to participation in organised sports activities. The target group consists of children and young people who face financial and or cultural barriers preventing their participation in organised sports activities. The grants will be made available for initiatives aimed at juniors (6-12 years) and youth (13-19) of immigrant origin – with special emphasis on girls, and children and young people from low-income families. The state grant for 2008 amounted to NOK 8 million.

Frifond grants for children and youth

The grants from the national Frifond cultural fund are awarded for cultural activities for children and youth at community level. The object of the grant-making is to improve the conditions for community activities among voluntary organisations and groups. The aim is for the scheme to reach out to a wide range of organisations and groups supporting a variety of causes and with differing types of activity. With Report no. 39 to the Storting (2006–2007) *on promoting voluntary activities for everyone*, the Government wishes to support the national fund with a view to intensifying measures to stimulate integration and inclusion. The Frifond cultural fund was boosted by a total of NOK 13 million in 2009, and received total funding for 2009 of NOK 168 million.

Grants for inclusion and poverty reduction measures

The object of this funding is to boost local cultural and organisational participation among under-represented groups. In pursuance of Report no. 39 to the Storting

(2006–2007) on *promoting voluntary activities for everyone*, a grant was made to fund a project position within the Association of NGOs in Norway to raise awareness within the traditional Norwegian voluntary sector concerning the integration of immigrants in non-governmental organisations. A new item was entered in Proposition no. 1 to the Storting (2008-2009) on the government budget on measures for inclusion and poverty reduction. The activities of the Association of NGOs in Norway to promote inclusion were extended and stepped up in 2009 with funding of NOK 1 million. In addition, a further NOK 3 million has been granted to boost efforts for inclusion and poverty reduction through a range of measures. The concept of 'inclusion' extends beyond immigrants to all groups and individuals marginalised from Norwegian society.

REPORT ON MEASURES IMPLEMENTED – WORK AND WORKING ENVIRONMENT

A more inclusive working life

Inclusive Working Life Agreement

The Norwegian Government has implemented a number of measures and strategies to reduce sickness absences in Norwegian enterprises and to counteract exclusion and transition to occupational rehabilitation benefit and disability benefit. In 2001, a binding agreement was made between the authorities and the social partners for a more inclusive working life (IA Agreement). The IA Agreement has two main aims: 1) To prevent sickness absences, increase focus on maintaining links with the workplace and preventing exclusion from working life and 2) To increase recruitment to working life of persons who do not have established employment.

The IA Agreement is founded on the following sub-aims:

- **Sub-aim 1 –** Reduction in the sickness absence rate
- **Sub-aim 2 –** Recruitment of people with disabilities
- **Sub-aim 3 –** Increase in the average age of retirement

Sub-aim 1:

After the 4th quarter of 2008, the sickness absence rate was 6% lower than in the same period in 2001. Medically certified sick leave was 10.6% lower than in the 4th quarter of 2001. The decrease in medically certified sick leave was greatest in the oil and gas extraction sector (21.9%); energy and water supply sector (20%) and industry and mining sector (18%) and smallest in the primary industries (6.2%) and merchandise trade (5.5%).

IA Agreement's sub-aim of recruiting people with disabilities

One objective is to reduce the number of people who progress from employment to passive benefits. The aim is for the share of people on long-term sick leave who return to work four weeks after recovery to exceed 70%. The shares in the second and third quarters of 2008 were 73.8% and 72.2% respectively. Compared with the same periods in 2007, the shares are stable. Any fluctuations in this period are small.

Another aim is to increase the share of persons commencing vocational rehabilitation during their sick leave. The share who commenced vocational rehabilitation in this period was 1.1% after the 4th quarter of 2008. On average, the share was 0.9%

in 2008, representing a decrease of 0.2 percentage points over 2007.

The object is to increase the number of people with disabilities who progress from income support to employment. The indicator for this is the number of people receiving health-related benefits who progress to employment. The aim is for this share to be increased to 45%.

The share of persons receiving health-related benefits who progressed to employment was 41% in the first tertial of 2008. This represents an increase over the first tertial of 2007 when the share was 39.5%.

Another objective is to increase the anticipated retirement age by 6 months in the period 2001 to 2009. Following a moderate decrease from 2001 to 2003, the anticipated age of retirement (at 50 years) has increased within the last few years. In 2008, the anticipated retirement age at 50 years of age was 64 years. This is an increase of 0.5 years (6 months) over 2001 when the anticipated retirement age was 63.5 years.

New rules and measures for following up on sickness absences

As part of the efforts to reduce the sickness absence rate, two main measures have been implemented. One is to achieve greater commitment on the part of employers to following up on employees absent due to sickness. Examples of this would be the compulsory requirement for employers to draw up a follow-up plan within 6 weeks, and to conduct dialogue meetings at 12 weeks and 6 months of sickness absence. The possibility of applying sanctions in the form of daily penalties to employers who fail to comply with the requirement has been established.

The other measure, for accelerating the return to work, is a scheme for purchasing health and rehabilitation services in the health sector for employees who are already on or are at risk of having to take sick leave.

In order to better monitor progress in reducing the sickness absence rate, NAV has proposed indicators for measuring initiatives for sickness absence follow-up directly. Suitable indicators would include:

- Number of dialogue meetings held between the physician, employer and patient
- Use of the "pending sickness absence" scheme under which an assessment is made of employees on the verge of taking sick leave to determine whether their work can be adapted so that a period of sick leave can be prevented (will have to be developed in NAV's own specialist system)

Follow-up plans from employer after 12 weeks' sick leave

The employer is required to draw up a formal follow-up plan jointly with the employee not later than six weeks after the start of the sickness absence and the plan must be obtained by NAV within 12 weeks.

Looking at the number of persons absent due to sickness for a period of at least 12 weeks, in the third tertial of 2008, a follow-up plan from employers was received by NAV for just over 5,000 employees out of the 14,000 passing the 12-week sick leave time limit. This corresponds to just over 1/3 (36%) of the target group. For 2008 as a whole, a follow-up plan was recorded as received for just over half (56%).

Dialogue meetings between employer and employee at 12 weeks' sick leave

Employers are responsible for arranging a dialogue meeting once the employee is on

full sick leave. This meeting must be conducted no later than at the end of the first 12 weeks of a sickness absence.

In relation to the flow of all persons passing the 12-week sick-leave mark within a single month, an estimated average of around 14,000 persons, relatively few employers have reported that they conducted a dialogue meeting.

The rules stipulate that the first dialogue meeting is to be held once the employee is on full sick leave. An estimated one third of persons on sick leave who pass the 12-week mark, are on graduated benefit (for persons not receiving full sick pay because they are able to work some of the time). If we include these individuals, the number of dialogue meetings recorded as held by employers in the third tertial of 2008 amounted to around 7%. For the whole of 2008, the proportion is 16%.

NAV's statistics on employer follow-up activities are somewhat flawed. Firstly, the data on the employer's efforts are obtained at 12 weeks of sick leave. No records are kept of employers' follow-up of employees declared fit for work before the 12-week limit. Secondly, NAV has faced challenges in terms of sufficiently close supervision of users. As a consequence of this, failure to record notifications from employers cannot be excluded.

Dialogue meetings after six months' sick leave under NAV

If the sickness absence is long-term, the local NAV office has to arrange a new dialogue meeting within six months of the sick leave commencing.

Based on the figures for the first half of 2008, an estimated 7,250 employees within a month pass the 26-week mark for sickness absence. Taking this as our basis, 1,827 out of 7,250 (25%) of employees on sick leave attended a dialogue meeting arranged by a local NAV office. For the whole of 2008, the proportion is 23%.

If holding a dialogue meeting after six months of sick leave is not appropriate, exceptions can be made. If we take this into account, a second dialogue meeting was held for just under 31% of employees in the target group.

Healthier working environments

Working environment legislation

The purpose of the Norwegian Working Environment Act is to ensure full protection against occupational injury and disease, secure terms of employment and local safety measures for and development of the working environment. The Act lays down requirements for enterprises themselves, through systematic health, safety and environment activities (HSE), to prevent occupational health and safety factors giving rise to accidents and injuries. Responsibility for ensuring that the working environment and safety at work are appropriate and satisfactory is lodged with the employer. Employees have a right and duty to assist in this.

HSE activities are essential both for the efforts to achieve a more inclusive working life and in the efforts to prevent occupational disease, injury and accidents.

Labour Inspection Authority

The Norwegian Labour Inspection Authority is responsible for overseeing that enterprises fulfil their responsibilities in compliance with the Working Environment Act, including that they establish systems for HSE activities. The Authority manages to inspect 8% of enterprises in Norway, and thus has to prioritise its activities for enter-

prises with a high risk of working environment health impacts. Inspection resources are prioritised following risk assessment based on knowledge and experience of which occupational groups, industries and sectors are most likely to give rise to occupational health and safety impacts. A large proportion of inspection resources are prioritised for major drives aimed at especially risk-prone sectors, which in itself contributes to the efforts to reduce social inequalities in health. A number of the Inspectorate's projects are also aimed at high-risk occupational groups and/or employees.

According to the Inspectorate's risk assessments, the sectors that are most exposed to occupational health and safety impacts include the health and social services, transport and business service sectors (e.g. cleaning services). The Inspectorate has therefore implemented inspection drives in these sectors, and conducted 2,727 inspections in 2008. During the inspections, the focus is especially on auditing enterprises for their establishment, as part of their systematic HSE activities, of effective routines and practices in prevention and adaptation for all employees generally and for employees with reduced capacity for work especially. The focus is also on ensuring that enterprises have effective routines for following up on employees on sick leave, and that those enterprises that are required to have an occupational health service duly have one in place and make relevant use of it.

The Inspectorate has also launched a drive aimed at improving insight into labour market regulations and key conditions for a sound working environment among junior employees and their employers, to ensure that young workers get a good start in working life.

Another action area for the Inspectorate is to amass information on, and audit, the enterprises' systematic work to prevent and reduce the risk of disease or injury caused by noise and chemical and biological exposures at the workplace.

Occupational health service

The occupational health service is a vital working environment measure, the purpose of which is to assist enterprises in disease prevention and health promotion work. As of 1 January 2010, occupational health services will be mandatory for enterprises in eight new high-risk sectors, which have been identified as facing major health and safety challenges. At the same time, a mandatory accreditation scheme will be introduced to ensure that each occupational health service works to the standards of quality and has the competence required for effective HSE work, and for preventing exclusion of employees from enterprises.

Action plan against social dumping

To counter the challenges entailed by the influx of migrant workers following enlargement of the EEA, the Government introduced two action plans against social dumping. The action plans include important measures to help achieve the goal of proper pay and working conditions for everyone and a professional labour market with safe and healthy workplace environments. A key measure in the plans is to increase resources within the Norwegian Labour Inspection Authority and Petroleum Safety Authority Norway for information and advisory activities concerning obligations and rights vis-à-vis employees and enterprises, and to extend the sanctions available to the two authorities so that they may now issue orders, coercive fines and require shutdown of operations in connection with inspections of pay and working conditions pursuant to the Act relating to general

application of wage agreements and the Immigration Act. One of the action plans also considers the introduction of ID cards in the cleaning services sector and possibly other sectors, the introduction of regional employee safety representatives in the hotel and catering industry and joint and several liability in the building and construction industry.

Increased health and safety awareness among junior employees

The Norwegian Labour and Inspection Authority will be proactive in providing information to junior employees. Statistics show that junior employees are more at risk from accidents, noise and heavy lifting in their work than more senior employees. Many young employees work in industries with a high percentage of new disablements. Young people often have defective employment contracts and less experience of occupational health and safety and the consequences of adverse occupational health and safety conditions. To minimise the extent of potential occupational health and safety problems, it is important to act early and reach those who are entering the labour market, with relevant information.

System for national monitoring of work and health

A trial project for 'Individual development plans for educational and vocational advisory services' is one component of these measures. The National Surveillance System for Work Environment (NOA) has been established at the Norwegian National Institute of Occupational Health (STAMI). The purpose of this system is to amass knowledge for use by all actors in this field and for the formulation both of policies and strategies for improved capacity for measuring and assessing results achieved.

REPORT ON MEASURES IMPLEMENTED – HEALTH BEHAVIOUR

Reduced social differences in diet Action plan on Nutrition 2007–2011 Recipe for a healthier diet

This action plan consists of 73 measures within 10 focus areas. Twelve ministries were involved in drawing up the action plan. The vision is: better public health through a healthy diet.

The main goals are to 1) Change diets in line with health authority recommendations and 2) Reduce social inequalities in diet. General and quantitative goals have been set for dietary changes in the population. Sub-goals have been defined under each action area.

The action plan stresses five strategies:

- Improve the availability of healthy food products
- Consumer knowledge
- Qualifications of key personnel
- Local basis of nutrition-related activities
- Strengthen focus on nutrition in health care services

Lower secondary school pupils participating in the school fruit scheme

Pupils at primary schools (years 1-7) can subscribe to school fruit and vegetable snacks through a national scheme laid down in regulations on subsidies for price rebates on fruit and vegetables at lower secondary schools. A dedicated information office (OFG)

runs this scheme for the Directorate of Health/Ministry of Health and Care Services. Over the period 2005 to 2009, the proportion of subscribers to the School Fruit and Vegetable scheme (primary-only schools) increased from 15% to 20%; see the tables below. The peak in 2007 and 2008 was largely due to the project in Drammen, Finnmark and four districts in Oslo offering free fruit and vegetables, and other municipalities who established a free scheme on their own initiative. An estimated 344,000 pupils attended the primary schools (1st-7th grade) covered by the scheme, in 2009.

Table 2. Pupils in primary-only schools (years 1-7) participating in the school fruit and vegetables scheme.

	2005	2006	2007	2008	2009
Pupils, %	15	17	26	27	20

Source: Information office for the school fruit and vegetables scheme

From autumn 2007, the Ministry of Education and Research established framework grants to the municipalities to enable them to offer free fruit and vegetables snacks to all pupils at junior schools (grades 8-10) and combined primary and junior schools (grades 1-10). Amendments to the Education Act and Private Schools Act from 2008 and appurtenant regulations require school owners to offer fresh fruit and vegetable snacks daily at all schools with junior-level pupils (ages 13-16). OFG, the information office for the scheme, offers municipalities administrative assistance via an intranet and website. Some municipalities offer free fruit and vegetable snacks on their own initiative to primary-only schools.

In autumn 2009 there were around an estimated 272,000 pupils attending lower secondary schools (grades 8–10) and combined schools (grades 1–10). Via its system, OFG has an overview of schools, which represent 218,000 pupils (approx. 80% of the pupil body in lower secondary schools) and at these schools, fruit is ordered for around 185,000 pupils: This corresponds to 85% of the pupil body at these schools.

In spring 2009, OFG conducted a survey in which 94% of municipalities stated that all schools in the municipality with lower secondary pupils were receiving free fruit and vegetable snacks. For 2% of the municipalities, the free scheme was available only to a few schools in the municipality, while 3% of municipalities had not introduced free fruit and vegetables. However, it should be noted that less than half of the Norwegian municipalities (178) responded to the survey.

Tax on non-alcoholic beverages

The state levies a special tax on non-alcoholic beverages containing added sugar or sweeteners. This tax helps to limit consumption of sugary beverages. The tax increased from NOK 1.52 to NOK 1.68 between 2002 and 2008 and to NOK 2.71 in 2009 (Directorate of Customs and Excise).

Table 3. Special duty on non-alcoholic beverages. NOK per litre.

2002	2003	2004	2005	2006	2007	2008	2009
1.52	1.55	1.58	1.58	1.61	1.64	1.68	2.71

Source: Directorate of Customs and Excise 2009

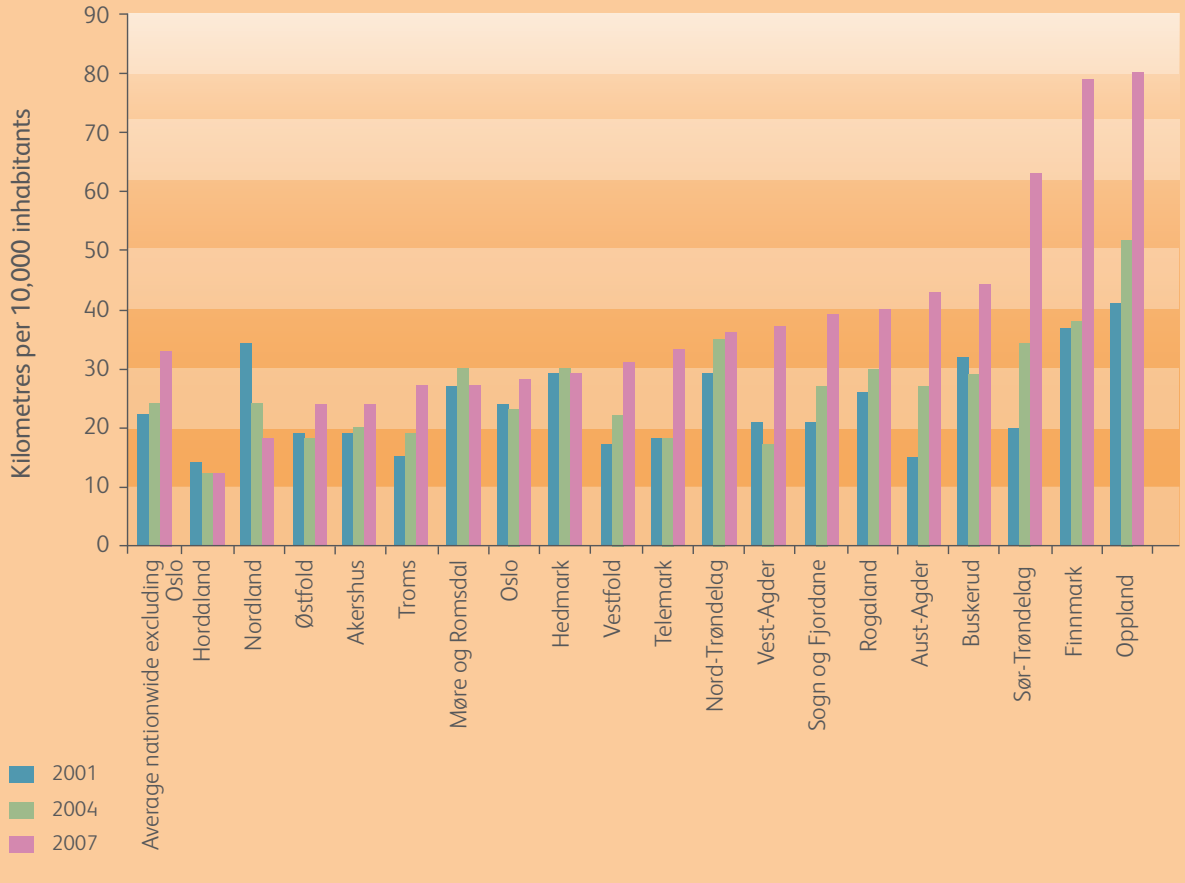
Reduced social differences in physical activity: Action Plan on Physical Activity (2005–2009)

This action plan comprises 108 measures for encouraging an increase in physical activity. Eight ministries were involved in this action plan. The vision is *better public health through physical activity*. The plan operates with two main objectives and eight sub-objectives. The main objectives are 1) to increase the proportion of children and young people who are moderately physically active for at least 60 minutes every day, 2) increase the proportion of adults, including elderly persons, who are moderately physically active for at least 30 minutes every day.

Support for the action plan among several ministries shows that several sectors are responsible for facilitating physical activity. This is especially important in view of the challenges associated with reducing social inequalities in health. The Action Plan on Physical Activity places emphasis on seven arenas:

- Active leisure time
- Active everyday life
- Active local environment
- Active according to capacity (social and health services)
- Working together for physical activity (supra-sectoral programme)
- A better foundation of knowledge
- Communication

Figure 1. Number of kilometres of cycle tracks/pedestrian zones/excursion trails etc. under municipal management per 10,000 inhabitants.

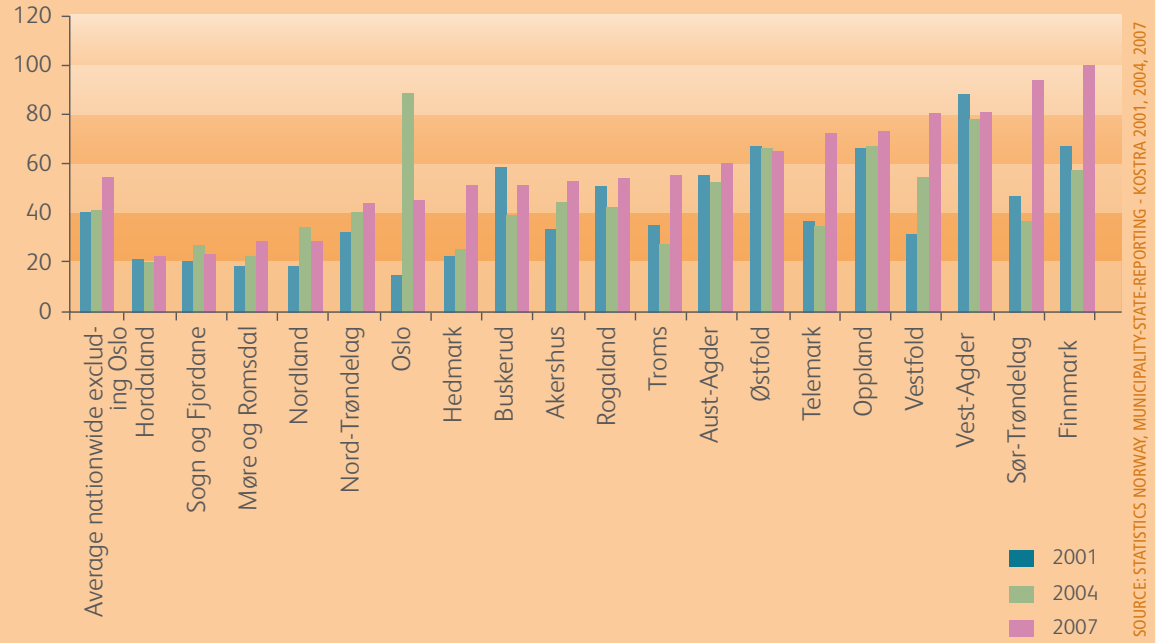


Source: STATISTICS NORWAY, MUNICIPALITY-STATE-REPORTING - KOSTRA 2001, 2004, 2007

The measures set out in this action plan are varied. Some structural measures that will contribute to the efforts to reduce social inequalities in health include the extension of pedestrian paths and cycle tracks; reduction in speed limits in urban areas and conurbations; ensuring and creating activity-friendly neighbourhoods; increased knowledge about physical activity and health among teachers, health personnel, urban planners and other key professional groups; daily physical activity in schools; promoting physical activity in working life; incorporating facilities for physical activity in municipal planning and the adaptation of low-threshold amenities in the municipalities.

The creation of physical surroundings conducive to physical activity is key to the efforts to encourage increased physical activity.

Figure 2. Net operating expenditure per capita on countryside management and outdoor recreation, by county. NOK



Extension of cycle tracks/pedestrian zones/excursion trails

Structural adaptations such as the extension of pedestrian zones and cycle tracks and excursion trails are vital measures in creating neighbourhoods conducive to physical activity. Commitment to this area will be of great importance, especially for children and young people and their activity to and from school. The efforts are linked to dimensions such as the National Transport Plan. Figure 1 above reveals great disparities between the Norwegian counties, but for the period 2001 to 2007 the majority of counties display a positive trend as regards the creation or extension of pedestrian zones and cycle tracks.

Countryside management and outdoor recreation

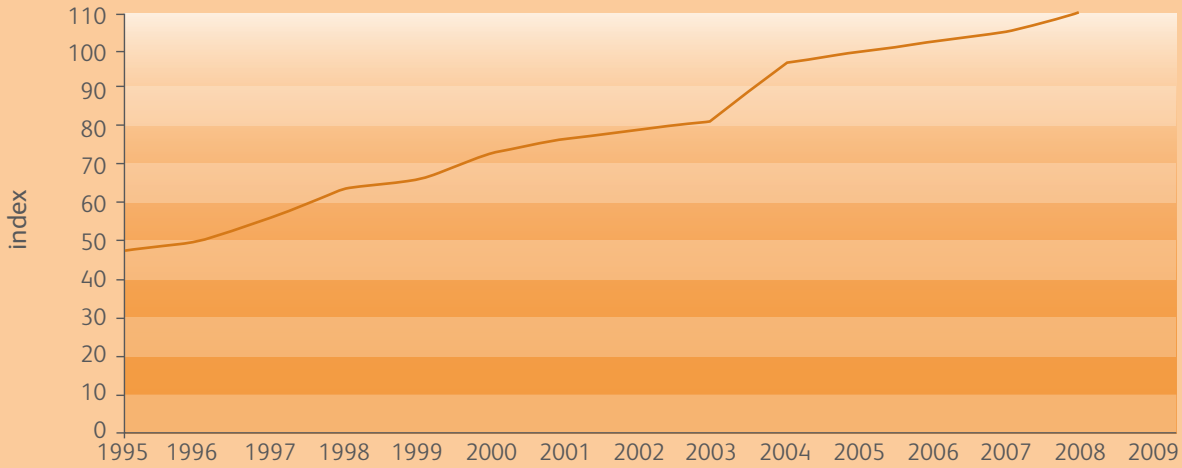
The commonest types of physical activity take place outdoors in Norway. In the efforts to get the Norwegian population to be more physically active, the design of neighbourhoods conducive to activity is an important action area. This was emphasised in the *Action Plan on Physical Activity (2005–2009) – Working together for physical activity.* Figure 2 above offers a snapshot of local and regional involvement

in countryside management and outdoor recreation, and shows great variation between the counties. However, the figures are subject to some uncertainty as only a small number of municipalities reported on this indicator.

Reduced social differences in smoking: National Strategy for Tobacco Control 2006–2010

The main goal of this strategy is to promote health in all parts of the population and to achieve more healthy life years by reducing the use of tobacco. The plan lays down a joint strategy for smoking prevention activities for the Ministry of Health and Care Services, the Directorate of Health and the offices of the county governors in association with municipalities, counties and non-governmental organisations. Tobacco prevention efforts in Norway are three pronged: prevent people from starting smoking, offer help in smoking cessation, and protect people against exposure to tobacco smoke. The strategy makes the special point that there is a strong over-representation of individuals with short education among smokers, and that this social disparity results in major inequalities in health that could have been prevented. In order to reduce these social inequalities in health, there is a need to employ policy instruments that make it easier for everyone to adopt a healthy lifestyle. Structural instruments have greater impact on public health at national level than instruments aimed primarily at individuals. However, little knowledge exists of effective, individualised instruments for reducing social disparities in smoking, and highly targeted measures are potentially stigmatising.

Figure 3. Harmonised consumer price index (2005=100) tobacco. 1995–2008.



Source: Statistics Norway.

Price of tobacco

Restricting the availability of tobacco products is an important policy instrument. Internationally, pricing has long been regarded as one of the most effective means of reducing tobacco use (WHO 2008). A Norwegian estimate indicates that a 10% increase in the retail price results in a fall of around 5% in total tobacco use, even allowing for cross-border trade (Melberg 2007). WHO refers to the fact that raising the retail price of tobacco products is a particularly effective deterrent for adoles-

cents and people on low-incomes, and that the positive effects outweigh any negative ones.

Availability will be restricted even further by the ban applied as of 2010 on visible display of tobacco merchandise at sales outlets. The object is to remove the indirect advertising effect tobacco packing has had in shops. By making oral tobacco (snus) and other tobacco products less visible in everyday life, the aim is to prevent young people from starting to use tobacco and to make quitting easier for those who try.

There is also the possibility of restricting access to engaging in this behaviour. Smoking bans in public places have been shown to have a positive effect on the health of employees who previously had to work in smoke-filled environments. Consistent rules on tobacco use in schools will help to reduce the number of young people who start using tobacco. School is also an arena for other preventive measures; around 60% of pupils in lower secondary education are participating in the FRI programme to combat smoking and oral tobacco use.

A new set of regulations require pictorial warnings to feature on cigarette packs by 1 July 2011 and on other tobacco products by 1 January 2012. Experience and research indicate that pictorial warnings are more effective than text warning labels as they elicit greater recall, communicate the health risk more immediately and increase motivation to quit smoking. Warning labels hit home with everyone in the target group, and large, illustrated warnings work irrespective of language and literacy. Other information-related measures such as mass media campaigns should also have the potential to both increase and reduce disparities, depending on the choice of message and profile.

Prevention among young people is important and necessary, but the positive effects will not be seen in public health until several decades later. For a more immediate effect on health, it is vital to work to ensure that more people quit smoking. Advice and guidance is available in several settings in the health service (GP surgery, low-threshold services etc.) or via a telephone helpline, or combined with the use of medicinal smoking-cessation products. Different types of smoking cessation programmes are offered locally, at work or over the internet.

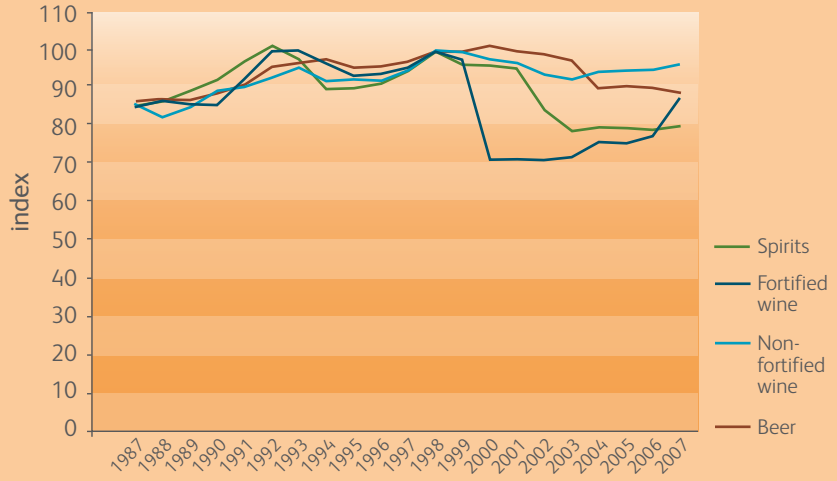
Reduced social differences in substance abuse. Measures to restrict the use of alcohol and drugs

The age limit on purchasing alcohol, the Norwegian Vinmonopol (state monopoly on retail sales of alcoholic beverages), the hours of the day in which alcohol may be sold and served, and duty on alcohol are all effective measures for reducing the total consumption of alcohol.

Price of alcohol

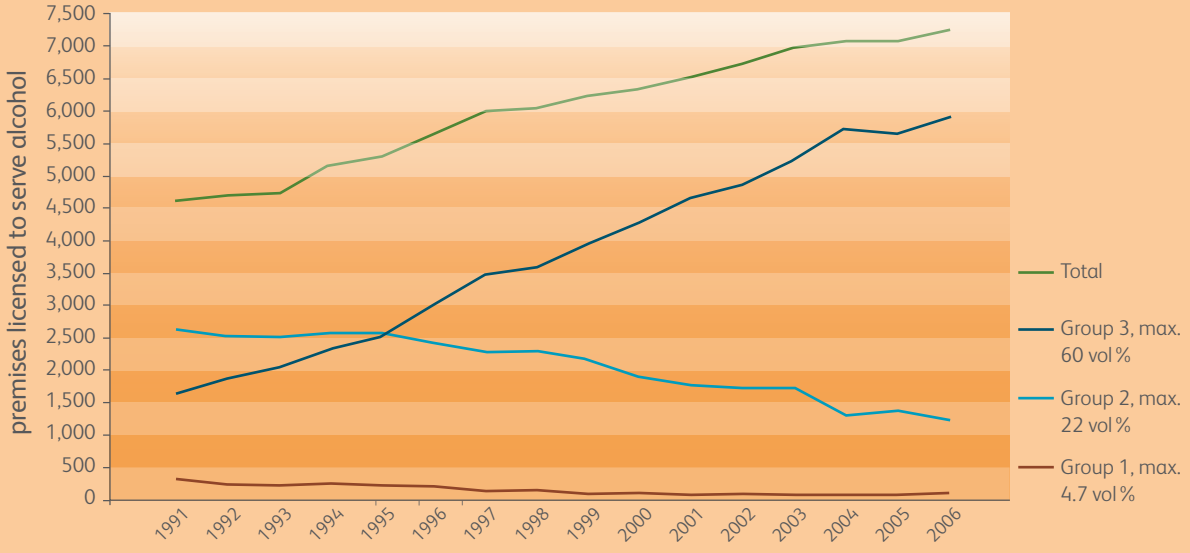
Changes in the price of alcoholic beverages will have greatest effect on consumption within groups with poor finances. For this reason, it is reasonable to assume that a reduction in the price of alcoholic beverages will cause consumption, and its harmful effects also, to increase most in groups with poor finances. Maintaining the restrictive alcohol policy with a high excise duty has the effect of reducing the harmful effects to which these groups are exposed. Reducing the duty on alcohol would increase social inequalities in health by affecting different socioeconomic groups differently.

Figure 4. Real price trend for alcohol. 1987–2007.



Source: Norwegian Institute for Alcohol and Drug Research (SIRUS) – statistikk.sirus.no

Figure 5. Number of premises licensed and not licensed to serve spirits. 1991–2006.



Source: Norwegian Institute for Alcohol and Drug Research (SIRUS) Kommunenes forvaltning av alkohol-loven (Municipal enforcement of the Alcohol Act)

Figure 4 shows the price trends for alcohol. The index shows how the prices for the different types of beverages have increased in relation to general price increases. The curves show that the relative price of alcohol has gone down since 2000. The largest decrease is found for fortified wine and spirits. Pricing is a key policy instrument for restricting alcohol consumption and it is important to monitor the trend in actual prices in the interests of documenting the effects of Norwegian alcohol policy.

Number of premises licensed to serve alcohol

Availability is an important determinant of alcohol consumption. A large proportion of alcohol-related assaults and disturbances of the peace occur where alcohol is served. Figure 5 shows how the Norwegian municipalities administer the central and local government control instruments laid down in the Act on the sale of alcoholic beverages when it comes to premises licensed to serve alcohol. The figure shows that the number of licensed premises increased from 4,644 in 1991 to 7,263 in 2006.

It also shows that the number of premises licensed to serve spirits (Group 3 beverages) increased heavily over the period. The number of premises licensed only to serve the weaker group 1 and group 2 alcoholic beverages has decreased.

Early intervention vis-à-vis children, adolescents and adults at risk is also an effective measure for reducing the scale of harm that may be caused by alcohol and illegal drugs. A number of groups in the population are especially at risk of developing substance abuse problems. This applies particularly to children of parents with mental disorders, children of parents with substance abuse problems and children and adolescents who themselves suffer from mental disorders. There is reason to assume that these risk factors also vary depending on social background. Substance abusers are over-represented in groups with short education and low income.
In many cases, alcohol or drug dependency will result from the loss of employment and social problems, which reinforce the substance abuse and exacerbate poverty and social exclusion.

REPORT ON MEASURES IMPLEMENTED – HEALTH SERVICES

The white paper on inequalities in health stresses the need to acquire better data on social inequalities in the use of health services, and of the determinants of social disparities in the use of health services as well as factors that redress such imbalances.

As part of the follow-up on the white paper, the Ministry of Health and Care Services commissioned a report on social inequalities in the use of health services based on data from Statistics Norway's Survey of Living Conditions. The report was compiled by Arne Jensen at Statistics Norway.

The report reveals inequalities in certain types of primary health care and specialist health care in some age groups, but not all. As regards use of a psychologist, an inverse social gradient was actually found for some groups. However, the general impression is that where inequalities are present, they follow a traditional social gradient (Jensen 2009) For a more detailed discussion of the Jensen report, see the foregoing chapter on Health Services.

The Directorate of Health also commissioned a systematic review of the research literature on social inequality in the use of health services. The review was compiled by John Erik Finnvold, a researcher at Statistics Norway. This review indicates certain potential distortion mechanisms that may give rise to inequality and focuses especially on social inequalities in the use of different types of services. Finnvold finds that the state of health of children diagnosed with asthma, for example, varies depending on parental socioeconomic status. The likelihood of asthmatic children receiving treatment at the most specialised level in the treatment system increases the longer the parents' education (Finnvold 2009). A more exhaustive discussion of this systematic review is presented in the foregoing chapter on Health Services.

The Norwegian Institute of Public Health has also investigated whether different social groups have different degrees of access to medicines requiring decisions concerning individual reimbursement and whether the requirement for treatment to be instituted by a specialist results in social inequalities.

The Norwegian Institute of Public Health concludes that the data available justifies no assumption that the system of individual reimbursements creates systematic inequalities between social groups. There is also no basis for concluding that individuals with high socioeconomic status have easier access to medicines pre-approved for reimbursement which must be instituted by a specialist (Hjellvik, Berg, Mahic, Tverdal 2009).

In 2009, the Government presented Report no. 47 to the Storting (2008–2009) on the *Coordination Reform (concerning continuity of treatment)*. With this reform, the Government is seeking to establish future health and care services which both respond to patients' needs for coordinated services, but which also respond to key socioeconomic challenges. Equal access to good and equitable health and care services, irrespective of personal financial means, and place of residence must continue to constitute the mainstay of the Norwegian welfare model. The policy instruments outlined in the Coordination Reform will support pursuit of the objective of ensuring equitable health services regardless of social status.

REPORT ON MEASURES IMPLEMENTED – TARGETED INITIATIVES TO PROMOTE SOCIAL INCLUSION

Reduce the number of adults who leave school with poor basic skills

Knowledge Promotion Reform for adults

Efforts to strengthen targeted services and measures are designed to build the competence of different target groups in the adult population. Amendments have been made to the Education Act which affect the right of adults to upper secondary level education, and establish the principle of adapted learning for adults. Measures to step up information activities concerning the rights of adults and BKA, an adult education scheme run by Vox, Norwegian Agency for Lifelong Learning, are priority measures for increased participation in lower secondary education and an increase in basic skills among adults. A dedicated framework consisting of competence targets and rights has been created in line with the curriculum for the Knowledge Promotion Reform. In the efforts to promote the quality of adult education, statistical material on adults in education needs to be improved.

Amendments to the Education Act

Amendments affecting the right of adults to receive upper secondary education came into force on 1 August 2008. The amendments comprise the terms and conditions governing who has the right to receive upper secondary education as an adult under Section 4A–3 of the act, and the right to upper secondary education for adults. This right applies from the year the person turns 25. In addition, the principle of adapted education for adults was demonstrated by the reference made in Section 4A–12 to Section 1–3. Under this amendment, young people with the right to upper secondary education under Section 3–1 of the Education Act may, subject to application and where due justification exists, alternatively receive education under Section 4A–3 of the Education Act.

Adult education scheme (BKA)

This programme is designed to improve elementary literacy, numeracy and ICT skills among adult employees and job-seekers so that fewer people fall out of the labour market and more people can engage in education and training. Private-sector enterprises and public-sector organisations can apply for subsidies for both motivational programmes and training in literacy, numeracy and ICT. The training providers and

Table 4. Number of BKA projects and participants by funding-award year.

	Number of projects	Number of participants registered as having started training
2009	106	
2008	96	1778
2007	70	1769
2006	65	2076
Total	337	5623

Source: Vox, Norwegian Agency for Lifelong Learning

Table 5. Participants in BKA projects, by gender, foreign-language origin and level of educational attainment, by funding-award year. %.

	2008 (N=1778)	2007 (N=1778)
GENDER		
Male	28	37
Female	72	63
Total	100	100
Of which foreign language speakers	29	14
LEVEL OF EDUCATIONAL ATTAINMENT		
- No education attained	9	1
- Lower secondary school:	36	39
- Upper secondary school, vocational subjects	41	42
- Upper secondary school, academic subjects	4	6
- University/college	11	12
Total	101	100

Source: Vox, Norwegian Agency for Lifelong Learning

social partners can also apply jointly for a subsidy with a private-sector enterprise or a public-sector organisation. In extension of the Government's package of measures, an additional NOK 20 million was allocated for the BKA programme in 2009, and special focus was placed on employees in vulnerable sectors who are affected by the economic recession, unemployed persons through cooperation with NAV, and participants in arenas other than the labour market in association with adult education associations. Adults with short formal education make up a key target group for the BKA programme. For 2009, increasing the number of participants who receive education through the BKA programme is a priority objective.

Table 4 presents a list of projects awarded BKA funding, by award-year and in total. The figures follow the years in which the projects were awarded funding. This means that for 2008, additional participants will have joined the scheme so that the figures are not final. This table shows that the number of projects is increasing, while the number of participants is decreasing. This is explained by the fact that the education/training has a higher literacy and numeracy component, AND less ICT than the guidelines for the programme originally proposed. Literacy and numeracy education requires longer courses and smaller classes.

Table 5 shows the number of participants, by gender, foreign-language origin and level of educational attainment, by funding-award year. As education and training courses for projects awarded funding in 2009 have not yet been launched, we consequently have no demographic background variables for the 2009 projects yet. Because the reporting routines for the first year of the BKA programme (2006) were not identical with present routines for reporting on the projects, we have not presented corresponding background variables for participant levels for 2006 as for 2007 and 2008.

Education and training within the Norwegian Correctional Services

Inmates of Norwegian prisons have the same right to education as other citizens. Recent years have seen a substantial increase in educational provisions for people in prison. Education is currently available at all Norwegian prisons where such provision is appropriate.

Report no. 27 to the Storting (2004–2005) on education within the Norwegian Correctional Services signals a new direction. The object is to realign the education offered to make it more vocational. Greater emphasis is to be given to short courses providing vocational skills. This responds to the preferences and needs of the inmates themselves. In addition, special consideration must be given to the needs of women inmates for vocational training. On the basis of the Report to the Storting, a plan has been produced for follow up. Various projects have been launched to achieve a higher standard, greater volume and more tailored education and training provision for inmates of Norwegian prisons. Projects include assessment of existing skills, internet-supported learning, follow up on release and in relation to linguistic minorities.

Under the Education Act, all students have the right to adapted education. Adapted education is especially important in prisons, both because learning problems are more extensive and because there is a greater range of abilities among inmates. The University of Bergen (UiB), commissioned by the Office of the County Governor of Hordaland, carried out a pilot project on literacy problems among inmates of Bergen prison. In addition, a doctoral researcher at UiB is currently investigating literacy problems among inmates of Norwegian prisons generally (the findings of the

thesis will be available in 2010/2011). In 2009, the Office of the County Governor of Hordaland, in association with UiB, will be conducting a new survey of the educational background of inmates of Norwegian prisons. Through these projects and surveys, we will gain more knowledge to permit education and training to be better adapted to the target group.

Enable more people to work

The main aim of the new labour and welfare administration is to get more people in employment and engaged in activity and fewer people to live on social security. This entails that policy instruments and strategies must be directed more intently at individuals at risk of falling out of the labour market or who have problems gaining access to the labour market. To that end, NAV is responsible for creating qualification programmes through the state employment incentive schemes and through the Qualification Programme implemented through local NAV offices under the municipal social services.

Employment incentive schemes are offered to unemployed persons and persons with reduced capacity for work who require job training or further qualifications in order to retain or gain employment.

The qualification schemes available include short vocational training programmes held in association with different training providers, local businesses and individual employers. For users with more comprehensive qualification requirements, longer training and school attendance provisions are made in conjunction with the education system. On-the-job training is designed to test the individual's capabilities on the labour market and develop skills in a real-life work situation. In addition, wage supplements are offered in connection with ordinary jobs, adapted workplaces and qualification provisions in labour market enterprises, as well as permanent, adapted employment for persons whose capacity for work has been permanently reduced.

After the Government's package of measures (Proposition no. 37 to the Storting, 2008-2009) was adopted in February 2009, the funding allocation for NAV for 2009 was equivalent to 78,000 places on schemes. Of these, 62,000 places were to be prioritised for people with reduced capacity for work.

In 2008, the number of places on schemes added up to an average of 65,600 per month. Of these, 54,700 places were offered to people with reduced capacity for work.

Qualification programme

In the Government bill, Proposition no. 70 to the Odelsting (2006–2007) *On the act regarding amendments to the social services act, and in certain other acts*, a proposal was made for a new scheme called the 'qualification programme' with associated qualification benefit. This statutory amendment was adopted by Parliament on 22 October 2007 and came into force on 1 November 2007.

The qualification programme and associated qualification benefit are aimed at people with significantly reduced capacity for work or for earning income and with no or very limited subsistence support from the National Insurance Scheme. This largely includes people who in the absence of such a programme would be dependent on financial social assistance as their main source of income over an extended period.

The purpose of a qualification programme and qualification benefit is to enable more people in the target group to gain employment. The programme is to be offered to persons who are judged as having potential for gaining employment through closer and more binding assistance and follow-up, including in instances where the way forward may be relatively long. The qualification programme is a full-time programme. The programme is to be individualised and vocational so that it supports and prepares participants for the transition to ordinary employment. Activities in the programme include a wide range of state labour-market measures together with municipal on-the-job training and employment incentive measures, as well as various types of coaching in motivation and confidence building. In addition, time may be allocated for health assistance, physical activity and independent activity.

Persons meeting the eligibility requirements have the right to a place on the qualification programme provided that the labour and welfare administration is in a position to offer an adapted programme. Programme duration is up to one year, and subject to special assessment, up to two years. A further extension may be possible in certain situations.

Participants on the qualification programme are entitled to qualification benefit, which is paid as an individual standardised allowance at the same level as introductory benefit (for newly arrived immigrants), i.e. twice the national insurance basic amount. Persons under the age of 25 receive two-thirds of the adult amount. A child supplement is also payable. The qualification benefit is taxed as earned income. Participants on a qualification programme are also among those eligible for a state housing allowance.

Qualification benefit offers predictability, permitting recipients to plan their personal finances over time. Qualification benefit is distinct from financial social assistance in that it is not means-tested.

Responsibility for running the scheme rests with the municipality. Administration of the programme, like the administration of financial social assistance, is lodged with the municipal section of the local NAV office. For 2009, NOK 559.7 million has been allocated to cover additional costs incurred by municipalities from the programme. This funding matches the estimated additional costs for the municipalities. The estimates are based on the number of participants on the programme increasing to 8,850 by the end of 2009. The phasing in of the qualification programme and qualification benefit will be effected as the local NAV offices are established in the municipalities. The plan is for the scheme to go nationwide from 1 January 2010. By year-end 2008, the scheme was available in 276 municipalities. Over the course of 2008, 5,279 applications were made for participation. Out of the applications that were processed by the turn of the year, 4,411 were granted and 160 were rejected. The number of participants at year-end was 4,133. In 2009 what is now the Ministry of Labour allocated funding for the qualification of inmates due for release from prison. NAV in cooperation with the central administration of the Norwegian Correctional Services launched the project Coordination of measures for rehabilitation – from prison to Qualification Programme, in 7 municipalities with prisons. The local NAV office in each prison municipality is responsible for planning the launch of the Qualification Programme at the time of release, in conjunction with the municipality the inmate will be released to.

Introductory programme and Norwegian language training for newly arrived immigrants

This scheme was established in all the Norwegian municipalities on 1 September 2004. The object is to support newly arrived immigrants in finding employment and participating in Norwegian society, and in achieving financial independence. The Introduction Act accords newly arrived immigrants aged between 18 and 55 years with a need for basic qualifications the right and duty to participate in a full-time introductory programme. The programme lasts up to two years and comprises training in the Norwegian language and social studies subjects, together with activities to prepare the participants for further training or employment. Activities may include work experience, lower secondary education or vocational training and/or health promotion measures. The programme is to be adapted to the individual's previous experience and qualification requirements. Where special justification exists, programmes can be arranged to last for up to three years. During the period in which an individual participates in the programme, he or she is entitled to introductory benefit. On an annual basis, this amounts to twice the National Insurance basic amount, which as at 1 May 2008 is NOK 140,512. Participants under the age of 25 receive two-thirds of the adult benefit amount.

New Chance

"New Chance" is a pilot scheme designed to test methods for qualifying immigrants, who after several years still have no permanent foothold on the labour market, to undertake education or employment. New Chance is modelled along the structure and methods of the introductory programme for newly arrived immigrants. The target group consists of individuals who, after several years in Norway, still have no permanent foothold in the labour market and depend on financial social assistance. Activities in New Chance consist mainly of language training, work-experience and social sciences. From 2009, a new direction has been proposed for New Chance – New Chance part 2 – to aim it at selected country groups among immigrants with especially low rates of employment: Pakistan, Morocco, Turkey, Somalia, Afghanistan and Iraq. The aim is to arrive at a methodology and experiences of measures aimed at immigrant women and immigrant youth who are not registered as unemployed or receiving social assistance. An important target group will for example be women working in the home with extensive care-giving responsibilities.

So far, for 2008, the results for New Chance indicate that out of 413 persons who completed the programme by 31 December 2008, 133 progressed to the NAV Qualification Programme. Of the remaining 280 persons, approx. 42% progressed to employment/education/training. Of these, women accounted for 65%. For the period 2005-2007, Ministry of Immigration report no. 4 for 2008 shows that of the 453 who completed the programme, 46% progressed to employment/education/training. The projects receive a slight preponderance of female participants (57%).

As part of the Norwegian Government's package of measures, the qualification pilot New Chance was allocated an additional NOK 15 million for 2009. The aim is to step up efforts to help newly arrived immigrants to gain employment more quickly. This is because working life is the most important arena for inclusion in society for immigrants and Norwegians alike. The intensified efforts are intended to enable more immigrant women to participate in the labour market and in so doing improve the earnings capacity of many households and give women greater independence.

Eliminate homelessness

It is the responsibility of the State to set overarching housing welfare targets and create conditions that enable municipalities to carry out the activities locally. Besides creating conditions to ensure that municipalities have sufficient discretionary powers to deal with local challenges, central government efforts consist of establishing legal framework conditions, allocating funding for prioritised purposes and facilitating competence building measures.

The national strategy for preventing and eliminating homelessness was concluded in 2007. Efforts to combat homelessness however are continuing apace, and the Norwegian State Housing Bank is to retain its coordinating role, in addition to reporting on performance indicators from the strategy. Through the use of housing grants, grants for research and development in the housing and building sectors, and start (first-home) loans, the Housing Bank enables more housing to be procured for homeless persons and other severely disadvantaged persons on the housing market.

The efforts to prevent and combat homelessness will be intensified in 2009. Measures to that end will be given first priority within all of the Housing Bank's loan and grant schemes. In addition, the Housing Bank, in cooperation with relevant actors, will be working to ensure that:

- Persons who are released from prison or discharged from an institution are provided with suitable municipal housing
- Young people leaving residential or foster care, and other disadvantaged young people are given assistance in finding housing under integrated provisions for school, employment and leisure together with the necessary follow up in their new home
- Homeless persons are offered suitable temporary municipal housing seen in the context of more long-term housing solutions
- The necessary emergency housing is fit for occupancy and used only for a short period
- No one is to stay more than three months in temporary municipal housing

Through the use of housing grants, grants for research and development and start (first-home) loans, the Norwegian State Housing Bank has facilitated procurement of a larger stock of housing to ensure that persons released from prison or discharged from an institution have suitable accommodation to go to. At the same time, many municipalities have concluded cooperation agreements with the prisons. The Housing Bank also awarded a Grant for Research and Development to the Correctional Service of Norway Staff Academy (KRUS), which has created a website devoted to housing welfare activities within the correctional services. This measure is part of the Government's strategy for everyone to be offered a permanent home after release from prison (see Section 6.4.1 above). The website (www.boligpaanett.no) is a new tool for prison and parole officers to assist people in finding and retaining accommodation. Higher standards in reporting may mean that the real figures for previous years were actually higher than reported.

New housing allowance scheme

The state housing allowance is an entitlements-based scheme for households with low incomes and high living expenses. 1 July 2009 sees the entry into force of new regulations for the scheme, see Proposition no. 11 to the Storting (2008–2009). Under the new regulations, any person over the age of 18 who is registered in the National Registry (Folkeregister) as a resident of a Norwegian municipality is entitled to housing allowance. This means that the scheme is open to households with no children and people who are also not receiving income support. The housing allowance is not granted to students without children or persons completing mandatory military/civilian service. Ultimately this will mean around 150,000 recipients of housing allowance; approximately 50,000 more than on the present scheme. This initiative should be seen in the context of the housing policy objectives of reducing the number of disadvantaged persons on the housing market and the efforts to eliminate homelessness.

The new housing allowance scheme will entail an increase in housing allowance disbursements in 2009 in the region of NOK 300 million. Once the new scheme has been fully phased in by 2012, restructuring of the system is estimated to entail increased housing allowance disbursements of around NOK 1 billion.

More municipal rental accommodation for disadvantaged persons

Many municipalities are struggling to secure rental accommodation for disadvantaged persons on the housing market. The Government has consequently established funding for housing subsidies for municipal rental accommodation for 2009, both through the 2009 National Budget and the package of measures adopted by Parliament on 13 February 2009. The aim is to provide 3,000 municipal rental accommodation units in 2009, that is, three times the number in 2008. In addition, the Government will now permit up to 40% of a subsidy to be spent on projects aimed at persons with a need for integrated follow-up.

Increased State Housing Bank lending facility for start loans

In the Government's package of measures adopted by Parliament on 13 February 2009, the Norwegian State Housing Bank's lending facility was increased from NOK 12 to 14 billion. Start loans take first priority within the lending facility. The Norwegian State Housing Bank is making active efforts to ensure that more municipalities make effective use of the possibilities afforded by the start loan scheme in their housing welfare operations. Use of the start loan scheme may mean that more households currently residing in municipal rental accommodation will be able to afford to purchase their own home, and in so doing free up the rental accommodation for other households in greater need.

The Housing Bank has reported an increase in municipal demand for loans for 2009 compared with the same period in 2008.

Housing on release from prison

Approximately 70 municipalities have concluded cooperation agreements with prisons on assistance in providing housing on release from prison. The Norwegian State Housing Bank has subsidised 7 housing officer positions within the Norwegian Correctional Services. Planning in securing housing starts earlier than in the past so that more inmates can be settled in permanent housing on their release from prison.

Improve the accessibility of health and social services for disadvantaged groups

Norwegian National Action Plan on Alcohol and Drugs

The Norwegian National Plan on Alcohol and Drugs runs until 2010 and operates with five main aims:

- Clear focus on public health
- Better quality and more expertise
- More accessible services
- More binding collaboration
- Greater user influence and better care for children and next of kin

A number of specific measures have and will be implemented to improve health care provision for substance abusers. Measures include a pilot of coordinating representation officers in 26 municipalities and subsidies are available for low-threshold health initiatives. The coordinating representation officers are to facilitate improved coordination between the different levels and services. As of 2008, substance abuse advisory positions have been established at the offices of the county governors. The substance abuse advisers will be assisting municipalities in making use of various state grant schemes for providing clients with individual follow-up, continuity of assistance and increasing the number of clients assigned an individual plan. The subsidies for municipal substance abuse work will be boosted by NOK 60 million for 2009. Additional funding has been allocated to the Salvation Army's Street Hospital for a separate section for women.

To raise the quality of services, policies and guidelines are to be produced for the entire field of substance abuse up to 2015. This applies for example to guidelines for identification, treatment and follow-up of patients with concomitant mental disorders and alcohol or drug-related conditions, guidelines for follow up of pregnant women in medication assisted rehabilitation and their children, and guidelines for people with an opioid dependency. In addition, policies have been produced for assessment for referral to interdisciplinary specialised treatment. During 2009 and 2010, the Directorate of Health will be producing policies on referral for interdisciplinary specialised treatment, a policy on municipal substance abuse work and guidelines for interdisciplinary specialised treatment.

Through the Action Plan, the ambition is to make the services more accessible. Persons with an alcohol or drug dependency are to be guaranteed of swifter assistance at all levels. More treatment places are to be created, municipal substance abuse work is to be boosted with more individual follow-up, low-threshold measures and outreach services. The services are to be made more readily accessible to the some 60% of inmates of Norwegian prisons who have substance abuse problems.

Coordination models within mental health care

NOK 50 million have been earmarked in the National Budget 2009 for development of different coordination models and for establishment of outreach treatment teams according to the ACT (Assertive Community Treatment) model. These measures are aimed at people with severe mental illness and a need for specially adapted care.

ACT teams are based on an outreach treatment model aimed at individuals who have little capacity to make use of ordinary treatment provisions. The ACT teams will be providing and facilitating both health services and social services.

The focus is on patient/client coping skills, functioning and integration in the community. The scheme will be evaluated.

Direct contact with the specialist health service for at-risk groups

This measure is aimed at women who have been circumcised and who require treatment. Out-patient clinics have been established in all five regional health authorities for women to contact directly to book an appointment and receive treatment. This measure is designed to make it easier for the women to seek help from a single place of treatment, and it is easy for them to pass the telephone number on to their female friends.

Prisons health service

The prisons health service is based in the municipality in which the particular prison is located. This service is to be of equal standard to the municipal health service available to the rest of the population. The Norwegian prison population has extensive drug dependency problems. In addition, a considerable number of inmates suffer from mental problems/illness. This poses major challenges for the health service and makes great demands of the professional content of the service. The service has worked to establish individual plans as a resource for inmates in need of long-term and coordinated services. Cooperation with other actors (specialist health service in mental health care and drug rehabilitation, the correctional services, municipal social services and NAV) has been extended by establishing a health professionals resource group, which will also be expanded to include representatives of the social services. The majority of prisons have also introduced medication assisted rehabilitation. The Prisons Health Service appears to be making good progress and has built up its capacity to meet the challenges it continues to face. It is assumed that agreements will be concluded between the specialist health service and municipal health service for care provisions for inmates. The aim is to improve coordination and demonstrate responsibility for the services. A cooperation has been established between local NAV offices and a number of the large prisons.

Crisis centres for victims of domestic violence and sexual assault

In order to reduce harm to victims of domestic violence and sexual assault in the short and long term, intermunicipal/municipal crisis centres have been established in all counties. In the summer of 2007, the Directorate of Health published guide IS-1457 for the health service on crisis centres for victims of domestic violence and sexual assault. The guide is intended as a resource for staff at crisis centres to enable them to provide improved services, including help immediately after the incident occurred and the necessary follow up with a view to reducing long-term harm.

Table 6. Legislation prohibiting direct and indirect discrimination and harassment

Gender Equality Act	Anti-Discrimination Act	Anti-Discrimination and Accessibility Act	Working Environment Act Chapter 13
• Gender	• Ethnicity • National origin • Race • Colour • Language • Religion • Creed	• Disability	• Sexual orientation • Age • Political beliefs • Union affiliation

Anti-discrimination protection

Anti-discrimination protection shall promote gender equality and equitable treatment, ensuring equal opportunities for participation in society and prevent discrimination.

The Gender Equality Act, Anti-Discrimination Act, and Anti-Discrimination and Accessibility Act prohibit discrimination based upon gender, ethnicity, national origin, race, colour, language, religion, creed and disability (Table 6). The prohibition applies to direct and indirect discrimination and harassment, while positive prejudicial treatment is permitted. The Gender Equality Act has long required Norwegian enterprises to report on the actual status of gender equality in their organisation. As of 1 January 2009, an activity and reporting duty was also introduced in the Anti-Discrimination Act and Anti-Discrimination and Accessibility Act in relation to disability, ethnicity, language, religion and creed.

Employers, public bodies and labour-market organisations are required to work actively, purposefully and according to plans to promote the objects of these acts and are to report planned and implemented measures ('activity and reporting duty').

Reduce inequalities in living conditions between different geographical areas

The Groruddalen programme

There is broad political consensus that a concerted regeneration project is required to improve environmental and living conditions in the deprived Groruddalen district. City of Oslo launched the project to draw up a development plan for the Groruddalen district in 2001. The central-local government partnership was initiated in 2003 with Groruddalen Environmental Zone. In January 2007, the state and City of Oslo signed a letter of intent on a 10-year partnership to raise environmental and living standards for residents in the Groruddalen district. The principal aim of the programme is sustainable urban development, visible environmental regeneration, improved quality of life and better living conditions in the district.

The Government will be concentrating the joint programme with City of Oslo on four programme areas to improve environmental and living conditions (responsible Ministry and City Council department shown in parentheses):

- Eco-friendly transport in Groruddalen (Ministry of Transport and Communication and the City Council Department for Environment and Public Transport)
- Alna countryside access, green planning, sports and culture (Ministry of the Environment and City Council Department for Environment and Public Transport)
- Housing, Urban- and Neighbourhood Development (Ministry of Local Government and Regional Development and the City Council Department for Urban Development)
- Childhood conditions, education, living conditions, cultural activities and inclusion (Ministry of Labour and City Council Department for Welfare and Social Services)

The partnership between central and local government will be governed by policy meetings between the Minister for the Environment and the chair of the city council together with implicated cabinet ministers and city councillors. The annual policy meeting will set goals and directions for the programme, discuss the project as a whole and the financial frameworks. The state and City of Oslo intend for this to be a reinforced, co-financed partnership for up to 10 years. In 2007, approximately NOK 136 million was jointly earmarked by the parties (NOK 86.3 million from the state and NOK 50 million from City of Oslo). In 2008, the parties earmarked NOK 170 million (NOK 120 million from the state and NOK 50 million from City of Oslo) and in 2009 funding totals NOK 181.1 million (NOK 131.1 million from the state and NOK 50 million from City of Oslo).

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