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REVISED EUROPEAN SOCIAL CHARTER

6th National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF NORWAY

(Articles 3, 12 and 13
for the period 01/01/2005 – 31/12/2007 ;
Articles 11, 14, 23 and 30
for the period 01/01/2003 – 31/12/2007)

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CYCLE 2009

6th NORWEGIAN REPORT ON THE IMPLEMENTATION OF THE REVISED EUROPEAN CHARTER (2008)

Article 3: The right to safe and healthy working conditions

Reference period: 1/1/2005 – 31/12/2007

Article 3 Para 2

Question 1) – The general legal framework

In the following we will give an account for the legal framework aiming to secure safe and healthy working conditions on shore and off shore. The Working Environment Act of 17June 2005 No 62 (WEA) is the principle Act on safety and health at work. In addition, framework conditions for the petroleum sector offshore are also set out in Act of 29 November 1996 No 72 relating to petroleum activities. Also there exist special regulations which apply to shipping.

- Regulations in the WEA

On 15 January 2006, the **Working Environment Act of 17 June 2005 No 62 (WEA**) came into force. The Norwegian Government notes the Committee's comments concerning any amendments in the field of health and safety at work in Norway. This is discussed below. Attached is an English translation of the new Act. Please note that the translated version is not authorized.

- Shipping

In the shipping sector, there are some new health and safety regulations:

These are Regulation of 1 January 2005 No 8 concerning the working environment, health and safety of workers on board ship laid down by the Norwegian Maritime Directorate on 1 January 2005 and Act of 16 February 2007 No 9 relating to Ship Safety and Security (The Ship Safety and Security Act).

Concerning the **Regulation of 1 January 2005 No 8,** it is mainly based on EU law, and when the Regulation entered into force, the following was repealed:

1. Regulation of 4 August 2000 No 808 concerning the working environment, health and safety of workers on board ship;
2. Regulation of 11 January 2001 No 21 concerning protection of workers on ships against exposure to chemical agents;
3. Regulation of 11 January 2001 No 20 concerning protection of workers on ships against exposure to biological agents;
4. Chapter 6 Special measures for safety and protection of the Regulations of 15 June 1987 No 507 concerning Safety Measures, etc. on Passenger Ships, Cargo Ships and Lighters;
5. Sections 6-17 to 6-20 of Chapter 6 Protection of the crew of the Regulations of 13 June 2000 No 660 concerning the construction, operation, equipment and surveys of fishing vessels 15 m in overall length (LOA) and over.

The objective and scope of application of the Regulation are listed below in sections 1-1 to 1-2:

§ 1-1
Objective

The objective of this Regulation is to ensure that work and off-duty time on board is arranged and organized so that the safety and physical and mental health of the workers is ensured in accordance with the technological and social development of society. This Regulation shall furthermore ensure that the safety and health of workers is protected against risks arising or likely to arise from exposure to chemicals and biological agents in the working environment.

§ 1-2
Scope of application

(1) This Regulation shall apply to workers on Norwegian ships unit subject to the same limitations contained in the Regulations of 31 January 1986 No 222 concerning the scope of the Seamen's Act, Section 1. This Regulation shall also apply to the persons mentioned in Sections 3 and 7 of the same Regulation.

(2) The provisions of Chapters 1-6, including Chapter 14, are general provisions on the working environment, safety and health. Chapters 7-13 contain additional provisions." Consequently, the personal scope of the Regulation is, in general, any person who is employed on board a Norwegian ship and who does not only work on board while the ship is in port.

Act of 16 February2007 No 9
Act of 16 February 2007 No 9 includes provisions concerning prevention of accidents and health hazards, and the Seamen's Act of 30 May 1975 No 18 section 40 concerning prevention of accidents and health hazards is transposed into the new Act. The new Act has therefore not changed prevailing law in this area. The purpose, personal scope and territorial extent of the Act are listed below in sections 1 to 3:

Section 1
Purpose of the Act
This Act shall safeguard life, health, property and the environment by facilitating a high level of ship safety and safety management, including preventing pollution from ships, ensuring a good working environment and safe working conditions on board ships as well as appropriate public supervision of ships.

Section 2
The substantive scope of the Act
This Act shall apply to Norwegian and foreign ships. However, this Act does not apply to ships with an overall length of 24 metres or less which are not used for commercial purposes. The King may prescribe by regulation that this Act, in addition to ships mentioned in the first Paragraph, also shall apply to:
a) offshore drilling units and other mobile offshore units used in the exploration for or exploitation, storage or transport of submarine natural resources and mobile offshore units supporting such activities;
b) floating cranes, dredgers and similar floating units; and

c) ships referred to in the second sentence of the first Paragraph, where someone is working on board.
The King may also prescribe by regulation that this Act shall not apply, either in whole or in part, to:
a) ships with an overall length of 24 metres or less;
b) ships that can carry up to twelve passengers;
c) special purpose ships;
d) ships that are solely used on rivers and lakes;
e) historical ships;
f) ships belonging to the Royal Navy or ships used in such service;
g) other public ships that are not used for commercial purposes; and
h) foreign ships.

The King may, for ships mentioned in the third Paragraph, prescribe special rules for safety management, safety, the environment, protective security measures and public supervision, and also for administrative measures and administrative sanctions which depart from the rules in this Act.

Section 3
The territorial extent of the Act
This Act shall apply to Norwegian ships irrespective of their position.
Subject to limitations following from international law, the Act shall apply to foreign ships:
a) in Norwegian territorial waters, including waters near Svalbard and Jan Mayen;
b) in the Norwegian economic zone; and
c) on the Norwegian Continental Shelf.

The King may issue regulations on the extent to which the Act shall be made applicable to foreign ships outside the areas mentioned in the second Paragraph, insofar as it is in compliance with international law."

- Petroleum activities

The framework for health, safety and environment in the petroleum activities assume prudent health, safety and environment results.

Framework conditions for the petroleum sector offshore are mainly set out in the following Acts:

- **Act of 29 November 1996 No 72** relating to petroleum activities (the Petroleum Act)
- **Act of 17 June 2005 No 62** relating to working environment, working hours and employment protection, etc. (WEA)

When formulating the HSE regulations for the offshore petroleum activities, emphasis has been placed on developing an integrated set of regulations stipulated and enforced by the Petroleum Safety Authority (PSA), the Norwegian Pollution Control Authority (SFT), the Directorate for Health and Social Affairs (Shd) and the Norwegian Board of Health (Htil)

The intention behind this form of regulation is that all issues relating to health, safety and environment are to be viewed in an overall context. In this connection, the authorities place

great emphasis on ensuring that the responsibility for HSE in the activities lies with the decision-makers.

An integrated and coordinated set of regulations has been prepared for the petroleum activities on the Shelf, stipulated in September 2001 and in force as from 1 January 2002.

The regulations are mainly stipulated in accordance with the Petroleum Act the WEA, the Act of 13 March 1981 No 6 relating to protection against pollution and regarding waste (the Pollution Control Act), as well as the health statutes. The HSE regulations are risk-based. Having a joint set of regulations makes it possible to consider risk in context, and measures can be implemented to contribute to overall risk management

The requirements in the HSE regulations are largely formulated as functional requirements, whether they relate to technology, operations, management systems, consideration for human life and health or the external environment. Compliance with functional requirements means that responsible players determine specifically how the requirement will be met, on the basis of the specific risk factors linked to the respective activities. Therefore, the challenge in complying with the HSE regulations depends on the distinctive characteristics of each individual activity

The integrated HSE concept, the health, safety and environment term (HSE), is used to describe the overall scope of current regulations for the petroleum activities. The HSE term, as it is used in the petroleum activities, has broad application and must be understood in light of the areas governed by the respective statutes that apply to the activities. Among other things, HSE includes safety and environment in the sense of the Petroleum Act's provisions, including measures designed to prevent injuries to personnel, harm to the environment and damage to material assets, including measures to maintain production and transport regularity. HSE also includes the working environment which, under the Working Environment Act, is a generic term for all factors in the work situation that can have an effect on the employee's physical and mental health, the ability to work safely, welfare and rights and obligations as regards participation. The HSE term also includes health which, according to health legislation, is intended to cover a more narrowly defined part of the activities, specifically health services, health preparedness, transport of sick and injured personnel, hygienic conditions, drinking water supplies, production and serving of food and beverages, as well as other factors of significance for health and hygiene. Health services mean both curative and preventive services. Hygiene encompasses occupational hygiene and other measures that are implemented with the objective of preventing illness or promoting good health, also beyond that which is normally linked to the development of a proper working environment. Therefore, hygiene includes all factors that cover health protection work aimed at individuals or the working environment.

With regard to preventive health services and hygiene, the authorities' responsibility will be divided between the Ministry of Health and the Ministry of Labour and Social Inclusion, cf. regulations relating to environmental health protection, including water supply, and working environment, respectively. The purpose of the Pollution Control Act is to protect the external environment from pollution. The Act shall ensure prudent environmental quality so that pollution does not lead to damage to health or harm to the natural environment, cf. sections 1 and 6. As regards the land facilities under the PSA's jurisdiction, the safety term must be interpreted in light of the Fire and Explosion Prevention Act and the Electrical Supervision Act as legal basis. The provisional regulations for the land facilities do not govern health

related factors that fall under the jurisdiction of the health authorities or the external environment, which falls under the Pollution Control Act. Nevertheless, for practical reasons, this report will use the HSE term when referring to the entire scope of authority of the Petroleum Safety Authority, unless the context indicates otherwise.

Question 2) – Implementation

Concerning the WEA, reference is made to the report from 2006. There have not been any changes in the consultation mechanism during the reference period.

Concerning shipping, the proposals for Regulation of 1 January 2005 No 8 and Act of 16 February 2007 No 9 were submitted to the social partners in Norway, and their inputs were taken into consideration before the regulation was laid down and the bill was passed. This procedure is stated in the Public Administration Act of 10 February 1967.

When it comes to the Petroleum sector, important governance tools are established to coordinate the involvement from stakeholders and parties (labor unions and associations). Three intuitions are established in order to provide for the cooperation. Two of them are hosted by the authorities and one is hosted by the industry themselves. The intuitions are:

- Regulatory Forum

In order to ensure the best possible involvement of the users of the regulations, an «External Reference Group for Regulatory Issues» (ERR) was established in 1986 in connection with a major regulatory reform. Subsequent to the decision to expand the PSA's scope to also include land facilities, this forum has been expanded to a «Forum for health, environment and safety regulations», the Regulatory Forum. The Regulatory Forum (RF) is composed of the parties within the safety and working environment areas on both the authority and industry sides. Its tasks include facilitating openness and information regarding activities that set the framework for the industry, such as regulatory strategy and regulatory work, adaptation to EU/EEA rules, industrial standardization, principle interpretations, and experience in the use of the regulations or the regulatory framework in general. The environmental authorities, represented by the SFT participate as needed. The RF does not replace formal consultation in relation to new or amended regulations, but comes in addition to the formal system according to the regulatory instructions. RF continues the tripartite cooperation that took place in ERR and it is one of the central arenas for cooperation between the parties in the petroleum sector.

- Safety Forum

The Safety Forum was established in 2001.The Forum's objective included building new trust between the parties, and deriving benefit from mutual exchange of experience following a period when cooperation between the parties had stagnated. The Safety Forum was expanded in the fall of 2004 with member organizations associated with the land facilities under the PSA's jurisdiction. The Safety Forum is the central tripartite arena for HSE in the petroleum industry. Its ambition is to contribute to increased knowledge and understanding of why the petroleum activities are to be a pioneering industry in the field of health, safety and environment. The Safety Forum has also been a reference group for the authorities' work on a new HSE report for the petroleum activities. The Safety Forum has made a significant contribution to constructive development in the tripartite cooperation in recent years. The Risk Level on the Norwegian Shelf project (RNNS), led by the PSA with a foundation in the Safety Forum, has been crucial in ensuring that the parties have largely agreed on a joint description of the current HSE situation in the industry. Such a common understanding is

essential for the cooperation on solutions to HSE challenges. The Forum has also established its own annual conference to ensure broad-based involvement by the industry, employee representatives and safety delegates, as well as by other authorities and research communities. The conference also contributes to course correction and identifying new approaches to HSE processes and projects. After a relatively short period of time, the Safety Forum's annual conferences have become one of the industry's important meeting places to address and discuss relevant and important HSE challenges

- The Working Together for Safety (SfS) project

The Working Together for Safety (SfS) project was commenced in late 2000/early 2001. The participants from employee and employer organizations have the goal of improving safety in human actions on board vessels and facilities, and putting the spotlight on all aspects that have an impact on this. SfS works on issues related to man, technology and organization (MTO) on facilities and on board vessels that take part in the petroleum activities on the Shelf. SfS shall there by focus on all aspects that affect the character and framework conditions for the work. This entails, in part, focus on corporate culture, structure, organization and management. The aim of the work is to provide recommendations to the industry. SfS communicates through gatherings and seminars, with a view towards being able to document and exchange best practice in the industry. Through the organizations that take part in the work, SfS has a contact network that includes all the central players in the petroleum activities on the Shelf. Up to the end of 2005/beginning of 2006, SfS has prepared 27 different recommendations in areas such as crane and lifting operations, falling objects, safety delegate service, platform management, and harmonization of safety procedures and routines.

SfS has also commenced work to look into issues related to the land facilities and has therefore established a working group to develop best practices for being a primary company at the major facilities. Furthermore, development of best practice as regards building a common safety culture and establishing joint terms to harmonize safety training for all the companies is a prioritized task. Work has also been started to examine prevention of substance abuse and follow-up of the Norwegian Oil Industry Association's (OLF) established guidelines in this area. The Ministry views the preparation of recommendations under SfS as a valuable contribution towards improving HSE results in the activities, and assumes that the parties will follow up the intentions that form the basis for this cooperation, while at the same time ensuring that they are adapted to the international activity to the greatest possible extent. By their signatures, the participants in this work have pledged to contribute to implementing the recommendations in their activities. The Petroleum Safety Authority will follow this up by means of audits and active use of the regulatory norms. At the same time, the Ministry encourages the industry to continue to work to identify new areas where procedures can be harmonized on both the national and international level and to actively work to develop and apply these procedures.

<u>Further questions from the ECSR</u>

The ECSR has asked for information on changes or amendments to the WEA.

The new WEA all in all continue the material scope of the old WEA, but the structure is changed with a view to improve clarity and availability for employees and employers. Regarding changes in relation to the European Social Charter, the Norwegian Government wants to emphasize the new legislation section 2-4, which regulates the employee's right to

notify concerning censurable conditions at the undertaking, section 2-5 which regulates protection against retaliation in connection with such notification, and section 3-6 which regulates the employer's obligation to facilitate notification.

We also want to mention the new legislation in section 3-5, which regulates the employer's obligation to undergo education in health, environment and safety work.

Chapters 9 and 13 are new. Chapter 9 contains new legislation about "Control measures in the undertaking". The employer may only implement measures in relation to employees when such measures are objectively justified by circumstances relating to the undertaking and the measures don't involve undue strain on the employees.

New legislation concerning "Protection against discrimination" in chapter 13 regulates prohibition against discrimination. According to this provisions direct and indirect discrimination on the basis of political views, membership of a trade union, sexual orientation, disability or age are prohibited.

There have not been any major changes in the regulations during the reference period in other aspects of the health and safety regulations.

The ECSR has asked some questions concerning the protection against asbestos.

Norway has implemented into our legislation all the relevant EU directives. Most of the EU directives in the field are setting a minimum standard. However, the Norwegian Government has a tradition for setting a higher standard of the occupational safety and health legislation and regulations for the protection of workers. Regarding exposure to asbestos, the Committee has questions concerning the subsequent amendments to Directive 83/477 in Directive 2003/18/EC. The Norwegian Government accepted Directive 2003/18/EC in accordance with national procedures with a decision in the EØS Committee 26 September 2003, and made the necessary amendments in the national regulation on exposure to asbestos of 16 November 2005 No 1288. The regulation states that dispensations cannot be contrary to the minimum standard set in the Directives.

In connection to the ECSR’s comments on the personal scope of the regulations, we would like to inform about the judgment by the Norwegian Supreme Court in 2007, Norsk Rettstidende 2007 page 1458, which concerned the penal provisions in the WEA of 1977 in connection with a fatal diving accident. The court stated that the enterprise which was engaged in diving was not under the scope of shipping. Further the court stated that the person who died was o be treated as an employee, and not an independent contractor. On this basis, the enterprise was considered to fall within the scope of the WEA, and was found liable.

Article 3 Para 3

Question 1) – Enforcement of legislation

Concerning the shipping sector, we refer to our previous reports.
For other sectors, where the WEA applies, please note that the new WEA regulates the same sanctions as the Act of 1977, but we would like to emphasize that section 18-6 "Orders and other individual decisions" is more specific than the similar section in the Act of 1977. The

competence of the Labour Inspection Authority has been defined more precisely in the new Act.

Consequences of violating safety and health regulations:

- Orders:

When laws and regulations are violated, the Labour Inspection Authority may give the enterprise an order to correct the situation within a given time limit. This is done in writing, and the recipient has the opportunity to lodge an appeal.

- Coercive fines:

If the order is not complied with, coercive fines may be imposed. The size of the fine is dependent upon several factors, but the main rule is that it shall be unprofitable to violate the WEA.

- Cessation of work:

An enterprise may be shut down with immediate effect if life and health of its employees are in imminent danger. Cessation of work may also be imposed when enterprises fail to comply with orders given.

- Reports to the police:

The Labour Inspection Authority may report enterprises to the police for serious breaches of the Act. A serious violation can result in fines or imprisonment.

Question 2) – Statistics etc.

The following statistical data are based upon the inspections of the Labour Inspectorate:

The data on accidents at work, including fatal accident, are registered per 23 April 2008. Numbers from 2006 are almost 90 % complete, and numbers from 2007 are almost 60 % complete. This is due to delays in reporting to the Labour Inspection Authority.

Year	**2005**	**2006**	**2007**
Number of accidents at work, including fatal accidents	19879	23109	19372
Standardised accident rates per 100 000 workers	866,36	965,62	791,40
Number of inspections	9868	9927	11097
Number of businesses inspected	7242	7890	8823
Number of workers covered by the inspections	316717	276768	328818
Number of breaches to health and safety regulations	10670	9853	15193

The nature and type of sanctions imposed:

Year	**2005**	**2006**	**2007**
Decisions of orders	7689	6382	9700
Decisions of coercive fines	552	372	238
Cessation of work	1641	1496	1637

Reports to the police	57	107	81

Accidents at work in the shipping sector

The figure below shows the number of maritime casualties and occupational accidents, including personal injury, due to accidents in shipping and fisheries for the period 1 January 2005 to 31 December 2007. There are no statistical reports or analysis available showing the accident rates per 100.000 workers.

2005	Total	Fishing vessels	Passenger ship	Special ship	Tankers	Dry cargo ship	Supply vessels	Combined vessels	Mobile installations
Dead	13	5	1	1	1	5			
Injured	674	201	222	41	75	57	54	22	2
Missing	1				1				

2006	Total	Fishing vessels	Passenger ship	Special ship	Tankers	Dry cargo ship	Supply vessels	Combined vessels	Mobile installations
Dead	9	6	1		2				
Injured	622	192	182	34	66	66	68	11	3
Missing	2				1	1			

2007	Total	Fishing vessels	Passenger ship	Special ship	Tankers	Dry cargo ship	Supply vessels	Combined vessels	Mobile installations
Dead	14	1	1		2	1	8	1	1
Injured	548	146	168	40	46	73	61	13	1
Missing	5	3		1	1				

Health and safety inspections

Information concerning health and safety inspections performed in shipping and fisheries, and the proportion of workers and companies covered by these inspections, is not available for the time being. The Norwegian Maritime Directorate is however developing a new control system which is expected to be in place during the first six months of 2009. This system will provide statistics regarding the number and results of health and safety inspections carried out, including information concerning breach on the legislation and sanctions imposed.

Accident statistics in the Petroleum sector

Year	2005	2006	2007
Workers in the oil and gas industry - offshore	21200	22310	23857
Number of Fatalities	0	0	1
Fatality rate (per 100.000 workers)	0	0	4
Number of accident at work (4 days absence or more)	20	31	23
Accident rate (per 100.000 worker)	94	139	96
Number of occupational illnesses	540	697	1105

Illness rate (per 100.000 workers)	2547	3124	4632

Further questions from the ECSR

The Committee has asked that the next report provide updated information on the number of persons assigned to occupational safety and health tasks in the Labour Inspection Authority.

The Labour Inspection Authority has about 550 employees, and approximately 400 are assigned to occupational safety and health tasks.

Regarding the percentage of workers covered by inspections by the Labour Inspection Authorities, the Norwegian Government wishes to emphasise that the overall objective of the Labour Inspection Authority is a healthy working environment for all, safe and secure employment conditions and meaningful work for the individual. The Labour Inspection Authority encourages enterprises to work systematically towards compliance with the working environment laws and regulations.

Since the 1990s the Labour Inspection Authority has been working systematically with industries struggling with major working environment problems. There have been campaigns in a number of sectors, including the health sector, hotels and restaurants, construction, transport, agriculture and the police. The purpose of these campaigns has been to motivate the enterprises to focus upon the working environment and make improvements through internal control routines. Such inspections are resource-demanding for the Labour Inspection Authority, and inspections have mainly been directed towards enterprises where the Labour Inspection Authority efforts will have the greatest effect.

Regarding the statistic on reactions from 2004 the Norwegian Government wants to inform that there has been a mathematical mistake in table 4 in the report from 2006. The single numbers in the table are correct, but the summary is not correct. The total numbers of the different type of reactions in 2004 is:

Decisions of orders	Decisions of coercive fines	Reports to the police	Cessation of work
11647	1205	1349	13

After this correction the Norwegian Government assumes that the Committees' comments regarding the number and type of sanctions since the last reference period, is no longer relevant.

Article 11: The right to protection of health

Reference period: 1/1/2003-31/12/2007

Since Norway has accepted Article 11 Para 1, we assume that we are not going to answer the questions under the heading "Article 11§2 and Article 11§3" in the form. Thus, below you will find information on the Norwegian position concerning the legal framework, implementation and statistics concerning Article 11 Paragraphs 1-3.

Article 11 Para 1

Question 1 and 2 -The general legal framework/ Implementation

The Patients' Rights Act of 2 July 1999 No 36 shall contribute to securing equal access to good quality health care for patients. The Act should be viewed in accordance with other legal Acts in the field of health care such as the Health Personnel Act, the Specialized Health Services Act, the Municipal Health Services Act and the Mental Health Protection Act. Several amendments have been made to the Patients' Rights Act since it was approved in 1999. This includes, inter alia, amendments in the provisions on the right to necessary health care, the right to medical evaluation and the right to free choice of hospitals.

- Access to health services

One of the purposes of the Patients' Rights Act is to contribute to a fair distribution of health services. In this regard equal access means that the population has a right to be granted health services regardless of age, gender or location as well as economic, cultural and linguistic background and social status.

The Patients' Rights Act applies to all persons staying in Norway, with some exceptions. A legal right to specialized health care (except emergency health care) is awarded only to persons with either permanent address or residence in Norway, who are members of the public social security system or who are entitled to health assistance by mutual agreement with another State. The Act also gives patients the right to freely choose the hospital or treatment facility they prefer.

- Right to evaluation and prioritization

As of 1 September 2004 the Patients' Rights Act states that the specialized health services are obliged to carry out an evaluation of the health condition of all patients referred to hospitals etc within 30 days of referral. Furthermore, the specialized health services are obliged to set a deadline for treatment of entitled patients. The deadline shall be set in accordance with what is medically justifiable in relation to the individual patient.

Entitled patients are those patients who are entitled to "necessary health assistance" within the meaning of the Act. The patient's right to necessary health assistance is determined by what services constitute the concept of "health assistance" and what is deemed as "necessary". Whether a patient has a material claim to receive health assistance from the specialized health services will rest on a concrete, individual evaluation of the patient's condition based on the degree of seriousness of the illness, the patient's diagnosis and current state, the prospect of recovery and the effect of treatment. The expected treatment results have to be in an acceptable proportion to the costs. The requirements for entitlement to necessary health assistance have been specified in the Regulation on prioritization. The health authorities have recently issued prioritization guidelines within several different areas of the specialized health services. These guidelines aim at facilitating both prioritization and equal practice of such prioritization nationwide.

Patients who are entitled to necessary health assistance have a legal right to fulfilment of their claim within a set deadline. The patient is entitled to necessary health assistance without

further delay if the deadline should not be met. Such assistance can, if necessary, be provided by a private service provider or a service provider abroad.

The Regional Health Authorities are obliged to offer the population within their respective regions specialized health services according to the Act on Specialized Health Services and also *to ensure* that the services offered are justifiable. The obligation inherent in the formulation ”*to ensure*” reaches wider than the right to necessary health assistance. This means that the Regional Health Authorities have a duty to ensure that specialized health services are offered also to patients not entitled to “necessary health assistance” within the meaning of the Act.

The right to free hospital choice entails that all patients are to be prioritized on an equal footing irrespective of place of residence.

- Registration of waiting time for hospital treatment

Regulation of 7 December 2000 No 1233 on Registration of Waiting Lists, pursuant to the Act on Specialist Health Care § 2-4, stipulates the provisions for the requirement of waiting lists for patients in the health care system.

Institutions required to register waiting lists are somatic and psychiatric hospitals, outpatient facilities, regional psychiatric facilities and institutions offering specialised treatment for substance abuse, insofar as these are either owned by or has signed a contract with a Regional Health Authority, with reference to the Regulation § 1.

Any institution fulfilling these criteria is required to keep waiting lists for patients registered for examination or treatment. If the actual examination or treatment is carried out in geographically separate units within the same institution, each unit is responsible for keeping individual waiting lists, with reference to the Regulation § 3, section 1. The actual treatment unit is thus responsible for registration of waiting lists.

In practice, the registration will be carried out by the actual unit/head physician. The waiting list is required to specify whether the patient is entitled to necessary health services in accordance with the Patient Act § 2-1. If the patient is thus entitled, the time limit granted in accordance with § 2-1, section 2, shall be made explicit. The waiting list is also required to specify whether the patient is seeking to be admitted to hospital, outpatient care or daily care, with reference to the Regulation § 3, section 2.

The institution shall keep its waiting lists continuously updated, with reference to the Regulation § 4, section 1.

The waiting list is required to specify whether the patient is entitled to necessary health services in accordance with the Patient Act § 2-1. If the patient is thus entitled, the time limit granted in accordance with § 2-1, section 2, shall be made explicit. The waiting list is also required to specify whether the patient is seeking to be admitted to hospital, outpatient care or daily care, with reference to the Regulation § 3, section 2. Patients in need of emergency health care, with reference to the Patient Act § 2-1, section 1, shall not be registered on a waiting list, with reference to the Regulation § 3, section 3.

- Dental care

The Act on Dental Care regulates the access to dental care in Norway. There have not been amendments to the Act on Dental Care in the period (2003-2007). The Norwegian dental care services consist of a public sector, offering dental care services to parts of the population according to this Act, and a private sector offering dental health services to the general population. In 2005, approximately 3 of 4 dental man years took place in the private sector.

Persons with certain illnesses or conditions in their oral cavity may receive publicly financed dental care services according to the regulations of the Norwegian Insurance Scheme. The majority of such treatment is done by private-practicing dentists.

The public dental care service is organised at county level. It shall ensure that dental care services, including specialised services, are accessible for everyone living or residing in the county. The county is responsible for coordinating the public (=county) service and the private sector.

The county shall through the public dental care service organise preventive measures for the general population, as well as give a regular and outreaching offer of dental care services to certain groups defined in §1-3 of the Act:

- Children and young people from 0 to 18
- Mentally handicapped
- Chronically ill elderly and disabled in institutions or receiving home nursing
- Young people who reach the age of 19 or 20 the year the dental care takes place
- Other groups prioritised by the county

The public dental care service may in addition offer services for payment to adults according to county regulations and tariffs.

Question 3) – Statistics etc.

Statistics on physicians in Norway
In total, there are about 20 010 physicians under 67 years in Norway. Among these are 52.7% approved specialists (10 572 persons).

Among approved specialists as of 1 September 2008 are 10 640 persons under 70 years (corrected for double specialities) active in Norway.

Number of physicians in somatic hospitals:

2006: 8 412
2007: 8 640

The change from 2006 to 2007 measured in percentage is 0.4

Number of effective hospital beds per 1 000 inhabitants in 2006 and 2007, corrected for stream of patients and the composition of the population (age and sex):

2006: 2.73
2007: 2.63

The change from 2006 to 2007 measured in percentage is -3.6

Waiting time at Norwegian hospitals
The Norwegian Patient Register compiles statistics on the developments in waiting periods within the specialist health care. Since 2002, waiting periods are reduced with 11 days, and for the first quarter 2008 the average waiting period for all health services amounted to 71 days. Since 2005, waiting periods have increased slightly. Patients in need of necessary health care have shorter waiting periods than patients without such need.

Approximately 66 per cent of all patients are admitted for emergency treatment and are not subject to a waiting period.

Dentists
By the end of 2007, Norway had coverage of approximately 0,8 dentist man years per 1000 citizens.

General practitioners
Based on statistics from the SSB (Statistics Norway) there are today approximately 4 4500 general practitioners in Norway.

Further questions from the ECSR:

Access to health care
Concerning health care systems, the Committee has asked for up-to-date information on the reform of general practitioner services.

The Research Council of Norway has carried out a comprehensive evaluation of The Regular General Practitioner (RGP) Reform and made a report from the evaluation 2001-2005, published in Feb 2006. The report has got ISBN No 82-12-02253-6 or 82-12-02254-4 (pdf). Please contact the Research Council for the report and English summary (post@forskningsradet.no, phone +47 22 03 70 00, fax +47 22 03 70 01).

The Ministry made an evaluation after 2 ½ years of a regular general practitioner scheme and the results by then were very much the same. Please see the attached summary.

The Committee has also asked for up-to-date information and statistics on access to care for the most disadvantaged groups.

Social inequalities in health are a public health concern and an expression of unacceptable systematic injustices. The Ministry of Health and Care Services has in the Government's Report to the Parliament No 20 (2006–2007) recommendations of a National strategy to reduce social inequalities in health.

The Norwegian population enjoys good health. However, averages conceal major, systematic inequalities. We have to acknowledge that we live in a stratified society, where the most privileged people, in economic terms, have the best health. These inequalities in health are socially determined, unfair and modifiable. The Government has therefore decided to initiate a broad, long-term strategy to reduce social inequalities in health. The Norwegian Government sees that fair distribution is good public health policy. The Norwegian policy

will continue to build on the Nordic tradition of general welfare schemes and at the same time implement special measures to help the people with the most problems.

In keeping with the identified need for a broad approach, the strategy operates with four priority areas for the next ten years:

1) Reduce social inequalities that contribute to inequalities in health
2) Reduce social inequalities in health-related behavior and use of the health services
3) Targeted initiatives to promote social inclusion
4) Develop knowledge and cross-sectoral tools

Report No 20 (2006–2007) is attached.

The Committee asks for precise information on the content of the legislation and its implementation, particularly in the light of the entry into force of the November 2003 amendment regarding waiting lists etc.

Regarding this information, we refer to the account given above.

Article 11 Para 2

Question 1) – The general legal framework

The legal framework is to be found in the Act 1982 No 66 relating to the Municipal Health Services and the Act of 8 May 1994 No 55 relating to Control of Communicable Diseases.

Question 2) - Implementation

Counselling and screening
Counselling and screening programmes for pregnant women are free of charge. There is lack of data concerning how many consultations each woman receives during her pregnancy, but it's stated in the guidelines that healthy women should receive 8 consultations (up to week 40) during pregnancy. All pregnant women are screened for anaemia, rubella, HIV and syphilis. Risk groups are screened for hepatitis B and C. Ultrasound screening is advised in week 17-19.

Maternal and child health centres and the school health services
Maternal and child health centres offer general medical services for pregnant women and pre-school children. The service also encompasses health centres for young people and the school health service in primary, lower-secondary and upper-secondary school. The service's main tasks include conducting health interviews surveys, immunisation, providing information, advice and guidance, and implementing measures to help children and young people develop life skills and help guardian master parenting. The service's work covers topics such as sexuality, relationships and contraception, protection against communicable diseases, diet, dental health, anti-smoking, drinking and drug campaigns, physical activity, and preventing accidents and injury.

Almost all children, regardless of their parents' social position, take advantage of the services offered by maternal and child health centres during the first few years of life. The school health services are low threshold services available in children's and young people's own

environment. Through its presences in schools, the school health service has the potential to reach children and young people in all social groups.

Nutrition
In January 2007 the Norwegian Government launched an inter-ministerial Action Plan on Better Nutrition (2007-2011) – Recipe for a healthier diet. Twelve ministries developed the plan, co-ordinated by the Ministry of Health and Care Services, and the same ministries will collaborate on the implementation of the plan in the period 2007–2011. Comments on the plan were also contributed by professional environments, the private sector and non-governmental organizations, trade unions and county authorities.

Health challenges facing Norway today include:

- Increases in diet-related health problems, such as overweight, cardiovascular disease, type 2 diabetes and diet-related cancer
- Social inequality in health and in diet

To address these issues, the plan covers ten main areas for action and lists 73 measures for how change can be achieved. The ten areas for action represent different target groups and different areas where measures will be implemented. These are communication, education and capacity building, food market, pregnancy/infancy, kindergartens and schools, health and social care services, working life, public health efforts at the local level, research and monitoring and international perspective.

The main goals of the Action Plan on Better Nutrition are to change the diet in line with the recommendations from the health authorities, as stated in the Norwegian recommendations for nutrition and physical activity of 2005, and to reduce social inequalities in diet.

The target group comprises the entire population, with a particular focus on children, young people and the elderly.

Physical activity
Physical activity is preventive to a number of diseases and is a source of joy, expression of life and positive self affirmative experiences. The Government's report to the Parliament No 16 (2002-2003) "Prescription for a healthier Norway" emphasises the importance of physical activity for the health and well-being of the population. The Paper describes public health work as the total effort of society to "strengthen whatever contributes to improved health and impair whatever involves health risks." The report as well as the World Health Organization (WHO) points out that physical inactivity is the great health challenge of the future.

One of the Government's answers to this challenge is The Action Plan on Physical Activity 2005-2009. The Action Plan on Physical Activity aims at increasing and strengthening factors that promote physical activity in the population and reduce factors that lead to physical inactivity. Increased physical activity will be attained through a total strategy that includes measures in diverse areas of society – in kindergartens, schools, at work, in transport, in the local environment and in leisure. This initiative requires co-operation between different sectors and levels of administration, and eight ministries collaborate in the development and the follow-up of this plan.

The Action Plan on Physical Activity is a national mobilisation in order to promote improved public health through increased physical activity that runs from 2005 until 2009.

The areas of priority within the Action Plan on Physical Activity are as follows:

- Physical activity in leisure time – sports, recreation, etc.
- Physical activity in everyday life – workplaces, schools and kindergartens
- Physical activity promotion through environmental laws and planning
- Physical activity according to capacity
- Working together for physical activity
- A better foundation of knowledge
- Communication and motivation

The plan's vision is a general improvement in public health through increased physical activity in the population:

- Main target No1: An increase in the number of children and youth who are physically active for at least 60 minutes per day.
- Main target No2: An increase in the number of adults and elderly people who are moderately physically active for at least 30 minutes per day.

Question 3) -Statistics etc.

Births
There are about 60 000 births in Norway annually. 2005 birth rate: 1,84

Immunisation
Figures from The Childhood Vaccination Register (SYSVAK) show high vaccination coverage against infectious diseases in the Norwegian childhood vaccination programme. 95% among 2-year infants are vaccinated against Haemophilus influenza type B and 93% against diphtheria, tetanus, pertussis and polio. The vaccination coverage against measles, mumps and rubella (MMR-vaccine) are somewhat lower, 92%, but the coverage has risen since 2002-2003. 93% among 16-year old youth are vaccinated against diphtheria, tetanus, measles, mumps, rubella and tuberculosis, and 91 % are vaccinated against polio.

Obesity
According to figures from the Norwegian Institute for Public Health, approximately 18 % of the Norwegian population aged forty have a Body Mass Index (BMI) above 30. This number has doubled over the last twenty years.

Further questions from the ECSR

- Health care professionals and facilities

The Committee asks for up-to-date information in the next report on health education in schools, particularly regarding the content of the various programmes.

In addition to the information above, we would like to add the following:

- Tobacco preventive education programme "FRI" (in English "FREE"):

The programme "FRI" was evaluated for the report "Forebyggende innsatser i skolen" ("Preventive Education in Schools", 2006, Directorate of Education and Training/Directorate for Health). The researchers found it to be of the highest level ("Programme has a documented effect" - recommended for use in schools). It was found that the programme had a positive

effect on reducing the use of tobacco among young people. The programme was revised in 2007 in accordance with the new national curricula, The Knowledge Promotion.

- Other programmes

In the abovementioned report "Preventive Education in Schools" (2006) programmes concerning behaviour problems (inappropriate behaviour), drug/tobacco and alcohol preventive programmes were evaluated by an independent group of researchers. The report was issued by the Directorate of Education and Training and the Directorate for Health. The report divided the programmes according to whether they had documented effects on their target group or not. The report also gives principles and strategies for successful implementation of preventive education in schools.

- Counselling and screening

The Committee has asked for up-to-date facts and figures on counselling and screening for pregnant women and the rest of the population.

We refer to the information given above.

Article 11 Para 3

Question 1) – The general legal framework

On alcohol legislation
Alcohol has potentially negative effects on health. Furthermore, alcohol contributes to damaging individuals, families, professional life and generates high social costs. Alcohol is no ordinary commodity, and therefore, cannot be subjected to legislation for other ordinary commodities without necessary adjustments of the legislation.

The alcohol legislation consists of a general set of measures to restrict consumption of alcohol and the damages alcohol consumption may have. These measures complement each other, and constitute an overall construction of means where the means cannot be seen individually. The influence of each measure rest upon and depends on the existence and use of other measures. The total effect of the overall construction is likely to be reduced if one of the measures is removed.

The Norwegian legislation separates alcoholic beverages according to per cent alcohol by volume. Non-alcoholic beverage is beverage containing less than 0.7 per cent alcohol by volume, low-alcohol beverage contains between 0.7 and 2.5 per cent alcohol, alcoholic beverage category 1 contains more than 2.5 and a maximum of 4.7 per cent alcohol, alcoholic beverage category 2 contains more than 4.7 and less than 22 per cent alcohol and alcoholic beverage category 3 contains between 22 and 60 per cent alcohol by volume. Serving, retailing or wholesaling of spirits containing more than 60 per cent alcohol is prohibited. According to Norwegian legislation, alcoholic beverages can only be imported from abroad by someone who is registered as a wholesaler at Norwegian customs, with some exceptions e.g. for gifts and legacy (at this moment, the Ministry of Health and Care is planning to change the law so that private importation will be allowed).

Licence to retail and serve alcoholic beverages is required, and shall be granted by the municipality (whit the exception of some licences given by the state). Alcoholic beverages

containing more than 4.7 per cent alcohol by volume may only be retailed through AS Vinmonopolet. Production of alcoholic beverages requires license given by the Norwegian Directorate of Health. The Alcohol Act sets requirements to the license holder, and a license can be withdrawn if the holder no longer fulfils these requirements. The municipality is free to decide whether an application for license should be granted, even if the applicant fulfils the requirements.

The legislation sets age limits, and it is illegal to retail, serve or supply alcoholic beverages containing maximum 4.7 per cent alcohol to someone under the age of 18, the age limit for beverages containing over 4.7 per cent alcohol is 20 years. The legislation also holds maximum time restrictions on retailing, supply and serving of alcoholic beverages.

According to the Alcohol Act and regulations, Norway has a ban on advertising alcoholic beverages. Furthermore, the legislation contains several prohibitions and orders, e.g. that it is prohibited to use alcoholic beverages as winnings or prizes (unless in a private setting), to dispense alcoholic beverages for marketing purposes and to purchase alcoholic beverages for someone that does not fulfil the age limits.

Tobacco
The main legal tool in the tobacco field is the Act of 9 March 1973 No 14 on Protection against harm from tobacco. The major new measures taken since Norway's last reporting involves a total ban on smoking in all public places, including restaurants and bars, effective from June 1, 2004 (§6, section 2).

Question 2) - Implementation

Measures to combat smoking, alcoholism and drug addiction

- Objectives - Tobacco

The National strategy for the prevention of harmful effects of tobacco use 2006-2010 has as its overriding goal to promote health in all parts of the population and contribute to an increased average age through the reduced use of tobacco products. The focus areas of the strategy are: preventing smoking debuts, quitting, protection against tobacco smoke, prevention of the use of snuff, information measures, local public health work, research and international cooperation. The goal for the period 2006-2010 is halving the percentage of young smokers and pregnant smokers in the last trimester, as well as reducing the number of daily smokers in the general population to less than 20 %.

Measures
Restrictions in accessibility and price mechanisms are central features of Norwegian policy to prevent harmful effects of tobacco use. Norway has a general high taxation level for tobacco products, but the level for snuff has been lower than for smoking tobacco. In order to reduce the increase of snuff use, in particular among young people, the Government has proposed to increase the tax on snuff and chew tobacco with 10 % exceeding the normal price regulation. The tax was similarly increased in 2008. In order to further minimize the accessibility of tobacco products, the Minister of Health and Care Services will propose a regulation to the Parliament in 2008 with a ban on visible display of tobacco products for commercial purposes.

Central authorities on health and education have requested regional authorities to restrict the use of tobacco in schools. A survey in 2008 shows a positive trend, but few schools still have a total ban on smoking in the school area or vicinity of the school. 60% of junior secondary schools participated in the Directorate for Health's educational programme for tobacco prevention in 2007-2008.

The Directorate for Health, the Regional Commissioners and NGO's are collaborating on nation-wide educational programs for smoke-quitting. The Directorate for Health is running a hotline assisting smokers to quit, offering free counselling and follow-up. Mass media campaigns have been executed in 2007 and 2008. As part of the follow-up of the national strategy for chronic obstructive pulmonary disease (COPD)(2006-2011), the National Council for COPD was established in 2007.

More than 120 000 young people (over 60 % of the age group) take part in the anti-smoking educational programme in lower-secondary schools. The programme has excellent results. It builds directly on the latest national curriculum and is organised so that it does not entail extra classes, rather it replaces other classes.

- On alcohol and drug policy

The overriding objective of the Norwegian alcohol and drug policy is to reduce the negative consequences of substance use for individuals and for society. This overriding objective can be divided into five main targets:

Target 1: Clear focus on public health
Target 2: Better quality and more expertise
Target 3: More accessible services and greater social inclusion
Target 4: Binding collaboration
Target 5: Greater user influence and better care for children and next-of-kin

The Norwegian National Action Plan on Alcohol and Drugs (2008–2010) lays out the areas of priority in the field of alcohol and drug problems. The scope of the Action Plan is the entire field of alcohol and drug problems in context, and work in this area is based on the Government's general policies. The goal is to offer good services that focus on the user. The basic dignity of all human beings must be respected, even in the most demanding situations. The services must be designed on the basis of the individual's need for help, at the same time as we must continue to follow the broad strategies that we know work.

The five main targets in the National Action Plan are anchored in the main challenges in the alcohol and drug dependence area:

Clear focus on public health: We need to do more and better preventative work. This applies to alcohol and drugs alike. We are going to maintain an effective policy aimed at the population as a whole, at the same time as we must target preventative efforts so that they are adapted according to gender, ethnic background and high-risk groups. We want Norway to be an active participant, collaboration partner and driving force in international processes regarding alcohol and drugs. Measures to meet the challenges regarding public health are discussed under target one.

Better quality and more expertise: We must improve skills and quality in the area of substance dependence. We need to strengthen research and teaching on alcohol and drugs, and ensure

that the knowledge generated is communicated and applied. People who work in this field need further training to improve their qualifications, we need to recruit more people, and systematic steps must be taken to improve the quality of services. We need better documentation and quality assured statistics. Measures to meet these challenges are discussed under target two.

More accessible services and greater social inclusion: We must offer help at the first opportunity and make sure that services are available when they are needed. This means we need to increase the number of treatment institutions at all levels. It must be assumed that all people with substance dependence need acute help. People with substance dependence must be guaranteed access to help more quickly on all levels. The aim must be that anyone who wants help will be offered help without any unnecessary delay. People who have started treatment (for example detoxification) must be guaranteed immediate follow-up. Follow-up, rehabilitation and inclusion must be integrated in the individual's treatment programme. Measures to meet these challenges are discussed under target three.

Binding collaboration: We must increase and improve collaboration throughout the entire alcohol and drug field, on the individual level and on the system level. Bodies that work with children and young people have a particular need for better systems for coordination. Measures to meet these challenges are discussed under target four.

Greater user influence and better care for children and next-of-kin: We must ensure that users can influence their own treatment and that their children and families receive better care and follow-up. Better follow-up and help for children and siblings of people with substance dependence problems are especially important. We must ensure that users' experiences are systematically used in quality assurance, and that users are given more opportunity to influence how the services are organised and policy design in this area. Measures to meet these challenges are discussed under target five.

Question 3) - Statistics etc.

Tobacco
In 2007, approximately 22 % of the population were daily smokers, down from 24 % in 2006. The percentage of daily smokers has been relatively stable for several years. In 2006, approximately 9 % of pregnant women were smoking in the last trimester.

Smoking is an important cause of social inequality in health. Smokers are overrepresented in low income groups and correspond with lower education levels and manual labour. Among young people (aged 16-24) the share of daily smokers are down from 28 % in 2002, to 16 % in 2007. In junior secondary school, the number of smokers is halved from 2000 to 2005. Approximately 6 % of the population, mainly males, are daily snuff users (2006-2007). Approximately 20 % of men ages 16-34 are snuff users. Among young males snuff has become as common as cigarettes.

In 2006, only half as many respondents in the 21–30 age-groups were smokers relative to 1998 (17 per cent in 2006 and 29 per cent in 1998). The percentage of occasional smokers has remained stable (at around 12 per cent). Daily smokers smoke as many cigarettes as before. The proportion of daily smokers in the Oslo sample tumbled from 27 per cent in 1998 to 14 per cent in 2006. The proportion of occasional smokers has been stable here too (around 15 per cent). In contrast, fewer respondents in the Oslo sample smoke more than ten cigarettes

daily. The differences in smoking habits between the sexes are minor or non-existent. Education level appears to have a strong effect on smoking behaviour, as increasing education correlates with less likelihood of being a smoker and, inversely, low education predicts a higher likelihood of being a smoker.

Wide differences prevail, however, between the sexes in use of snuff. The chances of a male respondent taking snuff daily doubled between 1998 and 2006 (from 7 to 17 per cent). Ten per cent of male respondents in the Oslo sample used snuff daily in 1998, 16 per cent in 2006. 1–2 per cent of both female samples in both years (1998 and 2006) took snuff daily. Individuals with a history of snuff use irrespective of frequency etc. were more likely to have quit smoking.

SIRUS has conducted surveys of young adults aged 21–20 on drug and alcohol use in 1998, 2002 and 2006. Using the same procedure as the annual surveys of adolescents, each of these young adult surveys operates with two samples, one of people officially resident in Oslo, the other of people resident in Norway, including Oslo.

Alcohol consumption

2 Turnover of spirits, wine, beer and alco pops per capita 15 years and over. Litres

	Pure alcohol, total	Spirits		Wine		Beer		Alco pops	
		As sold	Pure alcohol	As sold	Pure alcohol	As sold	Pure alcohol	As sold	Pure alcohol
1996	5.04	2.56	1.02	9.42	1.12	65.38	2.88	0.43	0.02
1997	5.28	2.71	1.01	10.75	1.28	67.19	2.95	0.81	0.04
1998[1]	.	.	.	.	.	.	.	.	.
1999	5.45	2.66	1.05	12.59	1.49	64.68	2.84	1.19	0.06
2000	5.66	2.67	1.05	13.61	1.62	64.92	2.93	1.48	0.07
2001	5.49	2.54	1.00	13.49	1.60	63.80	2.82	1.54	0.07
2002	5.89	2.83	1.12	15.19	1.81	65.34	2.89	1.63	0.07
2003	6.03	3.09	1.22	15.42	1.84	62.35	2.76	4.87	0.22
2004	6.22	3.17	1.25	15.77	1.90	67.93	2.96	2.38	0.11
2005	6.37	3.25	1.28	16.61	2.00	67.20	2.98	2.39	0.11
2006	6.46	3.29	1.30	16.95	2.05	67.88	3.01	2.42	0.11
2007	6.60	3.43	1.35	17.51	2.11	67.83	3.02	2.61	0.12

Drug Consumption:
There was a rise between 1998 and 2006 in the percentage of respondents aged 21–30 reporting having used cannabis at some point both in the national and Oslo samples. The percentage in the national sample was 22 in 1998, 30 per cent in 2002 and 34 per cent in 2006. For the Oslo sample, 35 per cent said in 1998 that they had some personal experience of cannabis use. By 2002 the percentage had grown to 41 and by 2006 to 47 per cent. The national average of respondents reporting use of cannabis in the past six months was 10 per cent in both 2002 and in 2006. For Oslo, the figure was 15 per cent in both years. Male respondents are more likely to use cannabis. Cannabis is more readily available. It seems that cannabis users are more likely to be unemployed, not involved in a training/education programme and belong to a low income bracket.

For the other types of drug the highest increase was in the use of cocaine and amphetamine. The number of respondents in the national sample that reported using cocaine at some point raised from 3 per cent in 1998 to 9 per cent in 2006, while for those reporting amphetamine use at some point grew from 5 per cent in 1998 to 10 in 2006.

For the Oslo sample, 7 per cent said in 1998 they had used cocaine at some point, rising to 14 per cent in 2006. Respondents reporting the use at some point of amphetamine grew from 10 per cent in 1998 to 13 per cent in 2006.

For other drugs, it is more problematic to identify clear trends, since so few people report use and random factors can go in both directions. Among young people under the age of 20, lifetime prevalence for amphetamine, cocaine and ecstasy, the most reported drugs, appears to have declined during the period 1998-2006. Among young adults, the opposite trend is even clearer. In an eight-year' perspective, lifetime prevalence for all the three drugs has increased considerably; for amphetamine it has doubled and for cocaine it has increased even more. But the prevalence for use during the past six months has not increased, with the exception of cocaine, which has seen a doubling during the last four years. The biggest increase in the use of cocaine is among men in Oslo.

Drug- related deaths
There are two bodies that register drug deaths, Statistics Norway and the National Crime Investigation Service – Kripos. Both series of figures peak in 2001 and decline thereafter. According to the statistics from Kripos, 244 persons died as a result of drug use in 2007.

<u>Further questions from the ECSR</u>

- Food safety

The Committee has asked for detailed information on the new food safety authority.

An important dimension of health protection is securing food safety. On 1. January 2004, the Norwegian Animal Health Authority, the Norwegian Agricultural Inspection Service, the Norwegian Food Control Authority, the Directorate of Fisheries' Seafood Inspectorate and the Municipal Food Control Authorities were merged to form the Norwegian Food Safety Authority (NFSA). The NFSA is also responsible for legislation concerning cosmetics and animal health personnel.

The goals of NFSA are to promote:
- Safe food
- Healthy plants, fish and animals
- Ethical keeping of fish and animals
- Good quality, honest production and fair trade
- Environmentally friendly production

Within the framework of these goals the NFSA shall work in a way that takes care of the interests of the enterprises in the entire food chain.

The NFSA comprises three administrative levels, and has some 1300 employees. Routines for the organization as a whole and the interconnection between the three administrative levels are under continuous development.

The central level: The head office of the NFSA has the overall responsibility for the surveillance and control, the updating of the legislation and the continuous monitoring of the food chain in general, including animal welfare and animal and plant health.

The regional level: Eight regional offices coordinate the activities of the district offices and are instances of appeal of decisions made by the district offices. Each regional office is responsible for eight to ten district offices.

The local level: Sixty-two district offices carry out all the inspections and enforce the Food Act and legislation on animal and plant health and animal welfare and thus form a vital foundation for the organization as a whole.

The district offices report to the regional offices, which report to the head office. The district offices deliver reports regarding the budget, tertian reports and yearly reports on their activities.

The main Norwegian Act creating the general framework for the functioning of NFSA is Act No 124 of l9 December 2003 relating to food safety and plant and animal health (the Food Act). The responsibility for the Act is divided between the three ministries; Ministry of Agriculture and Food, Ministry of Fisheries and Coastal Affairs and Ministry of Health- and Care Services. The head office reports to the three responsible ministries depending on the fields.

The NFSA is also acting after Act relating to Animal Welfare, (this Act is now being remodelled), Act relating to veterinarians and other animal health personnel, Act relating to the plant breeder's rights and Act relating to cosmetic products and body care products, etc.

The Ministry of Fisheries and Coastal Affairs is responsible for regulations concerning fish health and fish welfare during the primary production in water and also regulations concerning public health in this part of the production chain. After the primary production the Ministry is further responsible for regulations concerning fish health including by- products as well as regulations concerning quality and hygiene on fish and fish products from other aspects than public health.

The Ministry of Agriculture and Food is responsible for animal health, plant health and animal welfare in the primary production on land and also regulations concerning public health in this part of the production chain. After the primary production the Ministry is further responsible for regulations concerning plant health, animal health including by- products as well as regulations concerning quality and hygiene from other aspects than public health, for instance ecology (organic farming) and particular regulations on labelling of origin and rules concerning protection of geographical indications and designations of origin for agricultural products and foodstuffs. In addition, the Ministry of Agriculture and Food is administratively responsible for the NFSA.

The Ministry of Health and Care Services is responsible for hygiene and quality regulations concerning public health in food and food production. Further the Ministry is responsible for general labelling, additives, food contaminants, nutritional and health claims, gmo- food, foodstuffs intended for particular nutritional uses/food supplements and other substances and

packaging materials. The Ministry is also responsible for drinking water through the whole chain.

The Norwegian Scientific Committee for Food Safety (Vitenskapskomiteen for Mattrygghet) was established in 2004. The committee performs risk assessments on request by the NFSA in the food safety area as well as in the animal and plant health and animal welfare areas. The Ministry of Health and Care Services is administratively responsible for the committee.

- Measures to combat smoking, alcoholism and drug addiction

The Committee has also asked for statistics on trends in tobacco, alcohol and drug Consumption.

Information on trends concerning tobacco is given above.

Alcohol:
There has been no major change in statutory regulations concerning alcohol. Excise duty on alcohol has been changed according to price index. There are relatively few violations of the advertising ban, which is general and comprehensive. The regulation of on- and off-premises sale of alcohol is delegated to the municipalities within certain national limitations on opening hours etc. (The off-premises sale only covers alcohol beverages not stronger than 4.7% by vol.)

After many years with an increased number of licensed outlets and allowing the legislation's maximum opening hours, we now notice a tendency, particularly in cities and larger towns, of sharpening the control and reaction on violations of the Alcohol Act as well as shortening the regulated opening hours, particularly on on-premises sale.

The state monopoly on alcohol beverages stronger than 4.7% by vol has increased their number of outlets over the last years, mainly to cover areas where there have not been wine monopoly outlets previously.

Estimates of the national annual alcohol consumption rate of young adults averaged at 4.5 litres pure alcohol in 1998 and 5.3 litres in 2006. Oslo residents aged 21–30 drink at least one litre more on average than the national average. Males aged 21–30 drink about twice as much as females in the same age-group. Alcohol consumption rates fall with increasing age (21-30 years), but rise with increasing income. The rate of self-reported episodes of binge drinking is relatively stable. About 80 per cent of both samples report obvious sensations of drunkenness in the past six months. Males prefer beer and liquor; females tend to drink wine more frequently. The rate of illicit alcohol consumption (privately distilled and smuggled alcohol) fell sharply between 1998 and 2006.

Turnover of spirits, wine, beer and alco pops per capita 15 years and over. Litres

	Pure alcohol, total	Spirits		Wine		Beer		Alco pops	
		As sold	Pure alcohol	As sold	Pure alcohol	As sold	Pure alcohol	As sold	Pure alcohol
1996	5.04	2.56	1.02	9.42	1.12	65.38	2.88	0.43	0.02
1997	5.28	2.71	1.01	10.75	1.28	67.19	2.95	0.81	0.04
1998[1]	.	.	.	.	.	.	.	.	.
1999	5.45	2.66	1.05	12.59	1.49	64.68	2.84	1.19	0.06
2000	5.66	2.67	1.05	13.61	1.62	64.92	2.93	1.48	0.07
2001	5.49	2.54	1.00	13.49	1.60	63.80	2.82	1.54	0.07
2002	5.89	2.83	1.12	15.19	1.81	65.34	2.89	1.63	0.07
2003	6.03	3.09	1.22	15.42	1.84	62.35	2.76	4.87	0.22
2004	6.22	3.17	1.25	15.77	1.90	67.93	2.96	2.38	0.11
2005	6.37	3.25	1.28	16.61	2.00	67.20	2.98	2.39	0.11
2006	6.46	3.29	1.30	16.95	2.05	67.88	3.01	2.42	0.11
2007	6.60	3.43	1.35	17.51	2.11	67.83	3.02	2.61	0.12
2006									
1. quarter	1.32	0.66	0.26	3.56	0.43	13.79	0.61	0.47	0.02
2. quarter	1.70	0.75	0.29	4.47	0.54	18.99	0.84	0.66	0.03
3. quarter	1.66	0.77	0.31	4.08	0.49	18.83	0.83	0.71	0.03
4. quarter	1.78	1.11	0.44	4.84	0.59	16.27	0.73	0.58	0.03
2007									
1. quarter	1.47	0.74	0.29	3.97	0.48	15.16	0.67	0.52	0.02
2. quarter	1.67	0.74	0.29	4.34	0.52	18.44	0.83	0.75	0.03
3. quarter	1.64	0.81	0.32	4.19	0.51	17.80	0.79	0.74	0.03
4. quarter	1.81	1.13	0.45	5.00	0.60	16.43	0.73	0.60	0.03
2008									
1. quarter	1.51	0.76	0.30	4.10	0.51	15.30	0.68	0.57	0.03
2. quarter	1.69	0.73	0.28	4.40	0.55	18.62	0.83	0.80	0.04

[1] Figures not available.

Figure 3. Percentage of youth ages 15-20 in Norway stating that they have used cannabis either "at all"(blue) or "during the last six months" (red)

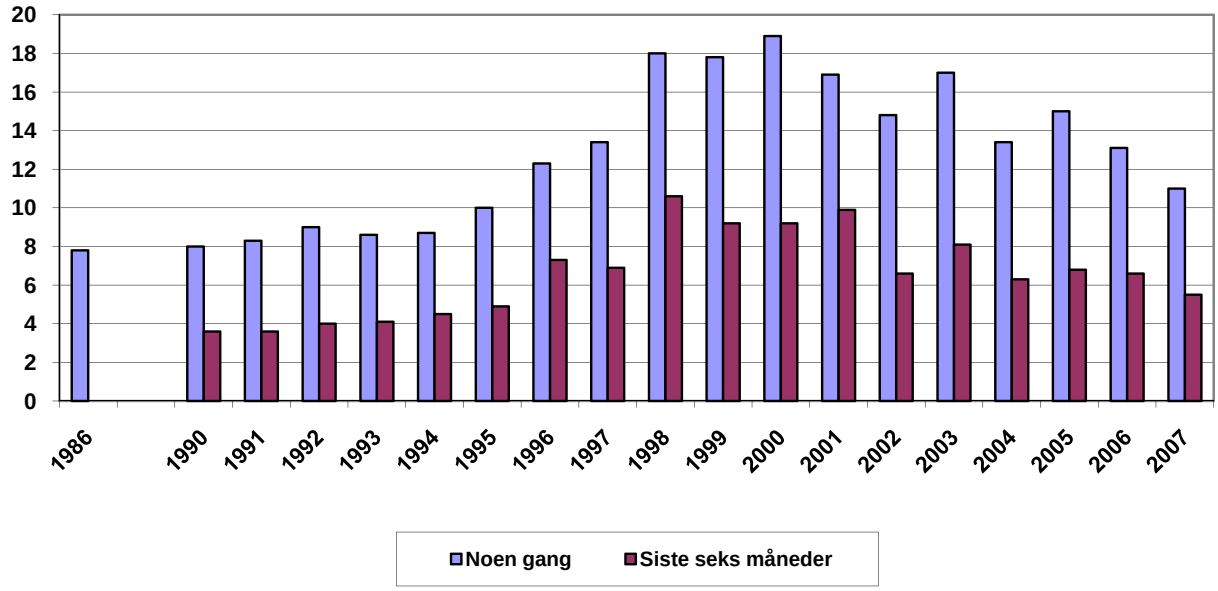
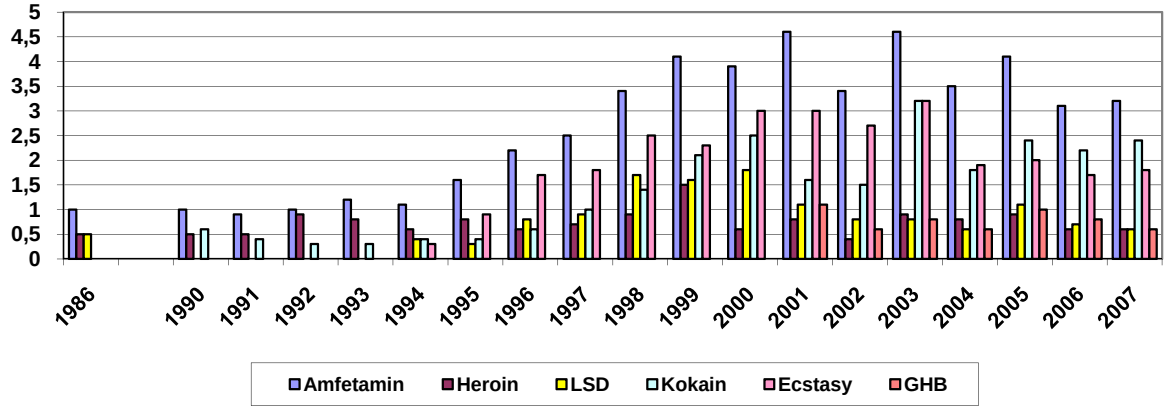


Figure 5. Percentage of youth in Norway ages 15-20 having used drugs, 1986 - 2007.



- Prevention of accidents

The Committee has asked for up-to-date information on road accidents, accidents at home, accidents at school and during leisure time, and accidents caused by animals.

We have statistics for road accidents, se below. We also have some statistics regarding other accidents, but we have not statistics for accidents caused by animals. The statistics are provided by Statistics Norway.

People killed or injured, by road-user and degree of injury. 1998-2008

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Killed or injured, total	12 472	11 764	12 003	11 797	12 705	12 131	12 378	11 438	11 368	12 315
Killed, total	352	304	341	275	310	280	257	224	242	233
Injured, total	12 120	11 460	11 662	11 522	12 395	11 851	12 121	11 214	11 126	12 082
Severly injured, total[1]	1 329	1 148	1 265	1 043	1 151	994	980	977	940	879
Slightly injured, total	10 791	10 312	10 397	9 046	10 274	9 402	9 489	9 455	8 866	8 843
Degree unspecified[2], total	-	-	-	1 433	970	1 455	1 652	782	1 320	2 360
Drivers and passengers of passenger car/van										
Total	8 690	8 257	8 608	8 571	9 179	8 762	8 925	8 102	7 959	8 975
Killed	212	201	205	177	205	180	172	137	152	149
Injured, total	8 478	8 056	8 403	8 394	8 974	8 582	8 753	7 965	7 807	8 826
Severly injured, total[1]	774	695	776	617	705	619	593	606	530	520
Slightly injured	7 704	7 361	7 627	6 571	7 406	6 706	6 683	6 656	6 244	6 291
Degree unspecified	-	-	-	1 206	863	1 257	1 477	703	1 033	2 015
Drivers and passengers of bus										
Total	221	247	136	130	129	118	144	95	179	189
Killed	3	6	6	3	2	1	1	-	-	4
Injured, total	218	241	130	127	127	117	143	95	179	185
Severly injured,	13	12	6	6	15	4	7	6	6	15

People killed or injured, by road-user and degree of injury. 1998-2008

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
total[1]										
Slightly injured	205	229	124	109	110	99	117	86	134	140
Degree unspecified	-	-	-	12	2	14	19	3	39	30
Drivers and passengers of lorry										
Total	269	230	218	233	247	258	229	246	250	266
Killed	11	7	13	9	8	11	7	12	8	5
Injured, total	258	223	205	224	239	247	222	234	242	261
Severly injured, total[1]	28	17	22	29	27	15	27	18	20	26
Slightly injured	230	206	183	162	191	193	162	196	196	198
Degree unspecified	-	-	-	33	21	39	33	20	26	37
Drivers and passengers of motor cycle										
Total	748	783	743	721	758	690	673	654	682	682
Killed	36	33	40	28	37	30	33	31	34	33
Injured, total	712	750	703	693	721	660	640	623	648	649
Severly injured, total[1]	154	153	154	138	138	100	102	121	124	112
Slightly injured	558	597	549	523	558	525	499	490	479	477
Degree unspecified	-	-	-	32	25	35	39	12	45	60
Drivers and passengers of moped										
Total	449	404	396	403	532	592	723	617	580	544
Killed	10	5	6	5	6	7	8	4	3	7
Injured, total	439	399	390	398	526	585	715	613	577	537
Severly injured, total[1]	63	45	51	47	55	49	69	54	53	48
Slightly injured	376	354	339	328	457	500	609	542	491	431
Degree unspecified	-	-	-	23	14	36	37	17	33	58

People killed or injured, by road-user and degree of injury. 1998-2008

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Drivers and passengers of cycle										
Total	913	821	808	703	808	745	726	743	739	741
Killed	25	15	13	6	12	14	10	7	8	7
Injured, total	888	806	795	697	796	731	716	736	731	734
Severly injured, total[1]	115	91	80	57	66	77	54	53	68	60
Slightly injured	773	715	715	590	713	620	644	675	596	607
Degree unspecified	-	-	-	50	17	34	18	8	67	67
Pedestrians/sledging, skiing										
Total	1 074	954	1 023	945	922	866	894	895	913	823
Killed	52	34	49	45	35	34	22	32	36	23
Injured, total	1 022	920	974	900	887	832	872	863	877	800
Severly injured, total[1]	169	123	165	128	124	115	119	104	125	84
Slightly injured	853	797	809	701	744	684	727	747	685	640
Degree unspecified	-	-	-	71	19	33	26	12	67	76
Others										
Total	108	68	71	91	130	100	64	86	66	95
Killed	3	3	9	2	5	3	4	1	1	5
Injured, total	105	65	62	89	125	97	60	85	65	90
Severly injured, total[1]	13	12	11	21	21	15	9	15	14	14
Slightly injured	92	53	51	62	95	75	48	63	41	59
Degree unspecified	-	-	-	6	9	7	3	7	10	17

[1] Very seriously and seriously injured.

[2] Degree unspecified was introduced in 2001.

Deaths from accidents, by place of occurrence, activity, time and contents

	2005	2006
	Number of deaths	Number of deaths
Home		
Education, military and sivil service	0	0
Sports activity	0	0
Other activity	3	2
Unknown activity	391	438
Other accident on street (non-traffic)		
Education, military and sivil service	0	0
Sports activity	0	0
Other activity	0	2
Unknown activity	3	6
Nursery school, kindergarten		
Education, military and sivil service	0	0
Sports activity	0	0
Other activity	0	0
Unknown activity	0	0
School		
Education, military and sivil service	0	0
Sports activity	0	0
Other activity	0	0
Unknown activity	1	1
Hospital, nursing and care institutions		
Education, military and sivil service	0	0
Sports activity	0	0
Other activity	1	1
Unknown activity	62	57
Sports area		
Education, military and sivil service	0	0
Sports activity	0	1
Other activity	0	2
Unknown activity	0	0
Outdoor, forest, lake, sea		
Education, military and sivil service	1	2
Sports activity	3	6
Other activity	17	25
Unknown activity	108	104
Other places		

Education, military and sivil service	0	0
Sports activity	0	0
Other activity	3	8
Unknown activity	65	226
Unknown place		
Education, military and sivil service	0	0
Sports activity	0	0
Other activity	4	2
Unknown activity	866	657

Footnote(s):
ICD-10 codes V01- X59. Place of occurrence- and acitvity codes used in Norway, ref. pages 988 -998 in Norwegian version of ICD-10. Norwegian Board of Health, 1998.

Article 12: The right to social security

Reference period: 1/1/2005-31/12/2007

No decisions have been made by courts concerning the application of this Article of the revised Charter. When it comes to case law, reference mainly is made to previous reports. However, we have some complementary information to the Articles.

Article 12 Para 1

Questions 1-3: The general legal framework/ Implementation/ Statistics etc.

The Norwegian National Insurance Scheme is a comprehensive system which in practice covers all persons who are residing or are employed in Norway, i.e. for any practical purposes 100 per cent of the population. Exemptions are limited to such categories of persons as e.g. foreign diplomats stationed in Norway, workers posted in Norway who remain insured in their home country according to provisions of an agreement between Norway and that country on social security or who have been exempted upon application. On the other hand, as a certain number of persons residing abroad will have a similar affiliation to Norway, the actual number of insured persons may in fact just as well exceed 100 per cent of the actual population. We have no precise statistics of these groups, but it can fairly be estimated that both comprise approximately 25,000, or about 0.5 per cent of the total population.

The Norwegian National Insurance Scheme, seen in conjunction with the Family Allowance Scheme, comprises all branches of Social Security. Reference is made to the enclosed survey "The Norwegian Social Insurance Scheme", updated as of 1 January 2008, which also gives relevant information as to the more specific nature of the system and its various branches, its financial arrangement, the level of the different benefits and the conditions for entitlement to them. Reference is also made to what is said under Article 12 paragraph 2 below.

Further questions from the ECSR:

- Existence of a social security system

The Committee concludes that the situation in Norway is not in conformity with Article 12 Para 1 of the Revised Charter on the grounds that legislation does not foresee an initial reasonable period during which an unemployed person may refuse an offer of employment not corresponding to his previous qualifications without losing the right to unemployment benefits.

We would like to add some remarks to this comment.

The primary goal for the Labour and Welfare Service (LWS) is to assist in finding work that corresponds with the jobseekers wishes, education and qualifications. This is the basis for all public employment service in Norway. The LWS will initially devote a lot of time to identify the jobseekers qualifications, work experience and job-requests. The goal is to help the unemployed getting a suitable job. The right for all jobseekers to get an individual service declaration, which was implemented 1 July 2005, gives the jobseekers a more individually fitted service.

The LWS will avoid referring jobseekers to a job if he or she doesn't match the employer's request, as it is in everyone's interest to offer a good service to both employers and jobseekers. However, the employer and not the LWS will have the last to say in appointing or engaging an unemployed to a position. The basic requirement to be entitled to unemployment benefit in Norway is to be considered a "genuine jobseeker". This means inter alia that the unemployed in principle is obliged to accept any job he or she is offered if the remuneration offered for the job is in accordance with the accepted norm or agreed rate for the particular trade or occupation. When considering whether the work is suitable, the LWS should according to the Directorate of Labour and welfares guidelines section A, Article 4.18 also consider:

- How long the jobseeker has been unemployed.
- The probability of getting a job which corresponds to his or her qualifications,
- If the offered job can give valuable working experience.
- If the remuneration offered for the job involves an unreasonable reduction of income compared to what the person is receiving by way of unemployment benefit.

The first three months of unemployment the jobseeker himself will have the primary responsibility of finding a job, and will therefore by himself determine which jobs he or she finds suitable. The unemployed will normally not get offered jobs from the Labour and Welfare Service, unless it is a job that corresponds to his or her qualifications. In 2007 less than 200 jobseekers got their benefit stopped the first three months of unemployment because of refusal to take offered work, to work in another part of the country or to take part time work. However, as time passes the jobseeker must be ready to adjust his or hers demands and level of ambition, and expand the job-search. This principle is considered important, as the employers will consider it positive that the jobseeker have been in a less skilled job and with that have got work experience and kept in contact with working life. A period of long-term unemployment, instead of taking a less skilled job, can make it more difficult for the jobseeker to get a suitable job. On the basis of the jobseekers CV and the labour market, the job-request will be evaluated every third month. This evaluation can result in an agreement between the jobseeker and the LWS to expand the job-search.

Article 12 Para 2

Questions 1–3: The general legal framework/ Implementation/ Statistics etc.

The European Code of Social Security and its Protocol is ratified by Norway. Norway has accepted all parts of the Code with the exception of Part VIII - Maternity Benefit. The latest detailed report on the application of the Code and its Protocol covers the period up to 30 June 2006. The latest general report on the application of the Code and its Protocol covers the period up to 30 June 2008. The latest report on the non-ratified part covers the period from 1 July 2006 to 30 June 2008. As far as we are able to discern, there is no branch of the Norwegian social security system, including the non-accepted part, which does not fulfil the level provided for by the Code. Reference is made to the conclusions of the committees in charge of the supervision of the accepted and non-accepted parts of the Code. Reference is also made to the enclosed survey "The Norwegian Social Insurance Scheme", which gives relevant information as to the level and the qualifying conditions of the different benefits.

Article 12 Para 3

Questions 1-3: The legal framework/ Implementation/ Statistics etc.

Reference is made to previous reports, the information given under Paragraph 2 and the enclosed survey, in addition to the following remarks:

The Basic Amount

The basic amount, which is fundamental to the long-term benefits in the social security system and which is also of importance for determining the level of other benefits, was increased from NOK 58,778 to NOK 60,699 with effect from 1 May 2005. With effect from 1 May 2006 it was further increased to NOK 62,892, and with effect from 1 May 2007 to NOK 66,812.

The increase in the average (calendar year) basic amount from 2005 to 2007 was thus 3.8 per cent per year, well above the inflation rate.

The average inflation rate (consumer prices) from 2005 to 2007 was 1.5 per cent per year.

Reference is moreover made to the annual reports on the Code submitted to the Council of Europe during the reference period.

Further questions from the ECSR:

The Committee recalled that it in its previous conclusion (Conclusions 2004, p. 419) noted the preparation of a reform of the pension system and repeats its question for information on this issue. Similarly, it asked information on the proposed reform of the employment injury benefit system.

No Acts have been passed, nor proposed yet, neither as regards the reform of the pension system, nor as regards the reform of the employment injury benefit system. We would, however, like to offer the following additional information:

Pension reform (preparations):

Reference is made to the enclosed translation into English of the executive summary of the Government's Report to the Parliament No 5 (2006-2007).

Reform of the employment injury benefits system (preparations):

Financial compensation in the event of occupational injury and occupational disease is currently provided partly through the state-run National Insurance Scheme (Act 28 February 1997 No 19 on National Insurance) and partly through the occupational injury compensation insurance that all employers are required to take out for their employees (Act 16 June 1989 No 65 on Industrial Injury Insurance). Together the benefits and compensation under these statutory provisions should provide full compensation to victims of occupational injuries. The Government body, the Labour and Welfare Service, decides the National Insurance cases, whereas the insurance companies decide the cases under the occupational injury

compensation insurance. The complaints and appeals systems are different for cases under these two statutes.

The current twin-track system involves a number of disadvantages, including double processing and unnecessary use of scarce medical and legal resources. In addition, a victim of an occupational injury may receive conflicting decisions from the Labour and Welfare Service and the insurance companies. This is difficult to explain and justify.

In 2001, partly because of this criticism, an Occupational Injury Committee was set up to evaluate possible changes in the current system. The Committee presented its recommendation in Official Norwegian Report (NOU) 2004:3 “Industrial Injury Insurance”, which was subsequently sent out for public hearing. The hearing showed that there was broad agreement that the current occupational injury system is not fit for its purpose. However, there were differing views both in the Committee and between the consultation bodies concerning several important questions, including how a future occupational injury scheme ought to be organised.

In 2007 the Norwegian Ministry of Labour and Social Inclusion sent out a draft of a possible organizational solution. The proposal involves the combination of today's two statutes into a single Insurance Act, and that an independent entity (*arbeidsskadeenhet*, or occupational injury unit) under state auspices should decide claims for occupational injury compensation.

The consultations showed that there was a basis for further work on the proposal. The Ministry is therefore currently elaborating the model with a view to have a new round of consultations on the matter during the fourth quarter of 2008.

The Ministry of Labour and Social Inclusion aims at forwarding a parliamentary bill on an Industrial Injury Insurance Act in 2009.

Article 12 Para 4

Questions 1-3: The general legal framework/ Implementation/ Statistics etc.

Reference is made to the enclosed survey Section 18 (list of bilateral and multilateral agreements on social security) and previous reports. All agreements entail provisions on equal treatment of nationals and aggregation (accumulation) of benefits.

During the report period, Norway has signed an agreement with Australia, which entered into force on 1 January 2007, and an agreement with Israel, which entered into force on 1 April 2008.

The EEA Agreement has been extended, so as to include Romania and Bulgaria, with effect from 1 August 2007. It now comprises 30 European states – the 27 EU-states, as well as the following three EFTA-states: Iceland, Lichtenstein and Norway.

Negotiations regarding a bilateral agreement are under way with Morocco.

The revision of the bilateral agreement with Canada is in its final stages.

Negotiations with India started in September 2008.

Furthermore, negotiations with the Republic of Korea are expected to begin in the coming months.

Several other countries have approached Norway, expressing a desire to initiate negotiations, but Norway has found it necessary, due to a limited administrative capacity, to confine the number of ongoing negotiation processes.

Further questions from the ECSR:

The Committee has asked the next report to indicate whether agreements exist with the following countries: Albania, Armenia, Georgia and Turkey, or, if not, whether it is envisaged to conclude them and in what time delay.

Norway has, as previously stated, a bilateral social security agreement with Turkey. As regards Turkey, we would like to make reference to previous reports, and to the enclosed information survey, chapter 18. The bilateral agreement on social security between Norway and Turkey was signed 20 June 1978, and entered into force on 1 June 1981. Article 8 of the agreement concerns the "child residence requirement"; it ensures that nationals of one of the two countries are entitled to family allowances from the other country for children residing there.

Norway does not at present have any bilateral social security agreements in force with Albania, Armenia or Georgia, nor have we been approached by these countries with requests to initiate such negotiations.

However, the European Commission has confirmed that Albania is a "potential candidate country" for future rounds of enlargement. It thus seems plausible that social security coordination between Norway and Albania at some point in the future will be regulated by Council Regulation (EEC) No 1408/71 (or its successor Regulation (EC) No 883/2004).

As mentioned in the reply to question 1-3 above, Norway has found it necessary, due to a limited administrative capacity, to confine the number of ongoing negotiation processes. It is thus not possible to give a precise answer to the question concerning when social security coordination instruments will be in place between Norway and the abovementioned countries.

Article 13: The right to social and medical assistance

Reference period: 1/1/2005-31/12/2007

Article 13 Para 1

Question 1) – The general legal framework

Norwegian citizens have a general legal right to social and medical assistance. This legal right is based on three different laws: The Municipal Health Services Act, the Social Services Act, and the Patients' Rights Act. This legislation regulates the responsibilities of the municipalities in the health sector and the social services sector. In addition, the Health Personnel Act, the Specialised Health Services Act and the Mental Health Protection Act should be viewed in accordance with the Patients' Rights Act.

There have been no major changes in the individuals' right to social assistance benefits in the reference period, 01.01.2005 – 31.12.2007, but the national guidelines on what is considered to be a reasonable social assistance benefit amount were revised in January 2007.

Patients' Rights Act

The object of the Patients' Rights Act (Act of 2 July 1999 No 63) is to help ensure that all citizens have equal access to good quality health care by granting patients rights in their relations with the health service. The provisions of the Act shall help to promote a relationship of trust between the patient and the health service and safeguard respect for life, integrity and human dignity of each patient.

As elaborated in our report on Article 11, the right to medical assistance is regulated in the Patients' Rights Act of 2 July 1999. This right applies to all persons staying in Norway with certain exceptions. A legal right to priority health care is awarded only to persons with either permanent address or residence in Norway, who are members of the national insurance scheme or are entitled to health assistance by mutual agreement with another State.

Specialised Health Services Act

Act 2 July 1999 No 61 on the Specialised Health Services (Specialised Health Services Act) regulates the financing of treatment and care in Norwegian health institutions under the public specialised health services. Annual maximum levels apply for the consultation of general practitioners, specialists, medication etc.

For the specialised treatment, the main rule is that the Regional Health Authority in the patient's region covers all costs related to treatment. This applies independently of the patient's citizenship. Whether the patient is a member of the Norwegian National Insurance Scheme or is entitled to treatment free of charge through a mutual agreement with another country is also relevant to the question of access to free treatment from the state.

The State covers all costs related to *enforced mental health* care even if a person has not a permanent resident permit or is not entitled to free treatment through the National Insurance Scheme or a mutual agreement with another country.

Social Services Act

The purpose of the Social Services Act (Act 13 December 1991 No 81) is to promote financial and social security, to improve living conditions of disadvantaged persons, to

contribute to greater equality of human worth and social status, and to prevent social problems. The Act shall also contribute to give individuals opportunities to live and reside independently and to achieve an active and meaningful existence in community with others.

There has been an amendment to the Social Services Act during the reference period.

This is a new chapter 5A, "Individual qualification program", included in the Act 26 October 2007.

The general objective is to include more recipients of subsistence allowance in work oriented activities, while securing the applicants a minimum income.

The programme will be adapted to individual needs, and may consist of services provided both by local authorities and the State. Applicants must have severely diminished capacity for work, and the program must be considered necessary and relevant for a successful (re)employment of the applicant. The duration is two years, with possible prolongation if there are specific personal considerations. There are no nationality requirements. It applies to all persons within working age (16-67 years) with no, or only limited rights to benefits from the National Insurance Scheme or unemployment benefits. All participants are required to at any time accept an offer of adequate employment.

Claims for benefits from the National Insurance Scheme or unemployment benefits must have been exhausted.

Determination of the minimum yearly amounts (2007):

Persons under 25 years;	NOK	89 127
Persons from 25 years;	NOK	133 624
Dependent children;	NOK	7 020

The level of the benefits is set by law. If a participant has earned income outside the program, the qualification benefits will be reduced accordingly. Participation in the qualification programme can be combined with up to 50% paid employment. Other incomes, e.g. child allowances, are not taken into account.

Owing to the fact that qualification benefit is paid on an interim basis pending the processing of claims to other social security benefits, deduction takes place from the benefit subsequently awarded. Deduction may also take place if fraud or failure to give adequate information has caused overpayments.

The level of benefits is adjusted yearly according to the basic amount in the National Insurance Scheme. Benefits are subject to taxation. The implementation of the individual qualification programme is provided by the Labour and Welfare Service in cooperation with the municipalities.

The Municipal Health Service Act
The Municipal Health Service Act (Act of 19 November 1982 No 66) gives the general provisions that all municipalities shall provide necessary health service for all persons resident or temporarily resident in the municipality. Municipal health services comprise

publicly organized health services which do not belong to the Government or the county municipality, and private health services run in accordance with agreement with the municipality.

According to the Municipal Health Services Act the municipality shall, through its health service, promote public health and good social and environmental conditions, and seek to prevent and to treat illness, injuries, and physical defects. The municipality shall spread information on and encourage interest in what individuals themselves and the public may do to promote their own well-being and health and the public health.

The Government has announced a legal reform based upon a revision of the Municipal Health Service Act and the Social Services Act. The reform will combine the two laws into one law in order to make the legal framework more coherent and to ensure the users of municipal services a better legal protection.

Question 2) – Implementation

Norwegian legislation is promulgated in "Lovdata"; the legal database of Norway. All legislation in force is also published on paper every second year in "Norges lover", the laws of Norway.

To implement new legal framework or amendments to existing framework, the Ministries can arrange courses or seminars for the municipalities, County governors and other public administrative bodies. The Government also use ordinary information channels, circulars etc. to inform the municipalities, the County Governors and other public administrative bodies about new laws and regulations.

The responsibility for primary health care services is delegated to the local level, but the state supervise the quality of services. The public supervision ensures that health services and social services are provided in accordance with national Acts and regulations. Methods used are area surveillance (an overall perspective, supervision of specific services such as nursing homes, hospitals etc) and individual cases of deficiencies in services. The main actor in performing the public supervision is the Norwegian Board of Health, a subordinate institution under the Norwegian Ministry of Health and Care Services. In cooperation with the County Governors' offices, the Board of Health uses various methods to monitor the primary health services.

Question 3) – Statistics etc.

In 2002 approximately 2.3 % of the overall population in Norway had a three-year total income below the level of the three-year total median income figure. This group was then defined as being poor. Specific statistical information about this group and their use of municipal health and social services are not available, but it is likely to believe that the use of municipal services within this group is extensive.

We generally refer to the websites of Statistics Norway: www.ssb.no

Recipients of social assistance and the total amount of expenditures:

Year	Number of recipients	Expenditures (mill. NOK)
2005	128 964	4 953
2006	122 402	4 602
2007	109 608	4 262

Table: Average payments of social assistance per month on assistance.
Figures of duration of benefit and family cycle phase. 2007. NOK

Family cycle phase	**Average** payments per month	**Nb of months on social assistance** 1	2	3	4	5	6	7	8	9	10	11	12
Total	7 272	6 030	5 662	5 857	5 857	6 085	6 245	6 430	6 808	7 178	7 767	8 256	8 647
Single males	6 752	5 497	5 158	5 330	5 402	5 705	5 654	5 949	6 478	6 644	7 198	7 572	7 939
- 19 years	5 535	4 282	4 370	4 438	4 891	5 188	5 231	5 399	5 592	5 516	6 288	7 076	7 303
20 - 24 years	6 035	5 062	4 539	4 829	5 144	5 468	5 358	5 574	5 924	6 133	6 388	6 947	7 304
25 - 44 years	7 042	5 788	5 560	5 688	5 582	5 860	5 956	6 245	6 752	6 866	7 451	7 737	8 120
45 - 66 years	6 945	5 614	5 278	5 516	5 420	5 796	5 414	5 882	6 607	6 792	7 456	7 758	7 939
67 years or more	5 363	5 613	4 286	3 730	5 454	4 804	4 482	3 338	7 344	6 693	5 977	4 662	6 577
Single females	6 230	5 334	4 991	5 008	4 808	5 265	5 335	5 638	5 876	6 131	6 798	7 047	7 446
- 19 years	5 565	5 200	4 727	4 883	4 720	5 381	5 390	5 687	5 549	5 920	5 954	6 212	6 819
20 - 24 years	5 921	5 295	4 950	4 902	4 980	4 996	5 245	5 928	6 188	6 020	6 430	6 313	7 131
25 - 44 years	6 648	5 721	5 472	5 226	5 101	5 639	5 814	5 903	6 147	6 176	7 378	7 494	7 686
45 - 66 years	6 211	5 156	4 702	5 027	4 543	5 063	4 997	5 024	5 319	6 247	6 572	7 123	7 421
67 years or more	4 626	4 790	4 416	3 887	3 063	3 979	2 735	3 829	4 880	5 846	5 434	5 674	5 880
Single parents	7 543	7 073	6 358	6 395	6 505	6 521	6 767	6 815	6 968	7 463	8 039	8 246	8 848
Males	7 366	6 402	5 690	5 691	5 855	5 915	6 281	6 342	6 279	7 064	7 357	7 748	8 921
Females	7 619	7 239	6 530	6 610	6 718	6 713	6 940	6 996	7 234	7 630	8 343	8 485	8 798
Couples without children	7 137	5 676	5 468	5 817	5 933	5 963	6 175	6 625	6 673	7 300	7 558	8 206	8 588
Couples with children	10 322	7 799	7 611	8 216	8 124	8 106	8 808	8 645	9 169	9 879	10 561	11 851	12 788
Unknown	2 500	2 500	-	-	-	-	-	-	-	-	-	-	-

Source : Statistics Norway

Poverty threshold in the country defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat:

Table: Median income in Norway

	OECD-scale		EU-scale	
	Current NOK	2006-NOK	Current NOK	2006-NOK
2005	192 000	196 000	231 000	236 000
2006	201 000	201 000	242 000	242 000
Average				
2003-2005		190 000		229 000
2004-2006		195 000		235 000

Source : Statistics Norway

Basic Pension Program
The basic pension program is constructed by a two level system. The public pension benefits to members of the National Insurance scheme is given as a monthly payment consisting of a set amount and a differentiated amount based upon individual compulsory contributions during all years of earned income. Membership in the National Insurance scheme is compulsory for everyone with citizenship and all working and taxpaying inhabitants. Pension age is set to 67, but it is possible to retire from work at age 62. This depends on individual arrangements.

The unemployed may receive public financial support from the state in between jobs. Those who are not able to work because of injuries etc. may receive financial support for a period until the injury is healed.

The social security benefits to people unable to keep jobs for some reason or another, are a part of the municipal social services. In 2007 there were 109 600 persons in total receiving social security benefits. This equals 2.3 % of the total population. Approximately 4.3 billion Norwegian kroner were used on direct financial support in 2007. The amount of people receiving this sort of benefit has dropped the last few years.

Every fourth person in the entire group of social assistance recipients is aged between 30 and 39. Close to 60 % of all recipients in 2007 were single without financial responsibility for children, and nearly 70 % of this group were men.

There are also different governmental as well as municipal benefit programs related to housing.

Further questions from the ECSR:
The Committee has asked the next report to provide updated statistics showing how much benefit a typical claimant receives.

We refer to our answer on question 3) above.

Article 13 Para 2

Question 1) – The general legal framework

General
All individuals have equal fundamental political and social rights both nationally and municipally. Participation in programs or schemes attached to municipal health services or municipal social services does not disqualify from any legally given right. The legal framework is implemented on the basis of equal rights for all.

United Nations Convention on the Rights of Persons with Disabilities
The Government has signed the Convention and is now handling the question of ratification. A proposal will be submitted to the Parliament in the autumn 2009.

Anti-discrimination and Accessibility Act

The Government considers the fight against discrimination an important task. Coordinating anti-discrimination work has since 18 October 2007 been a responsibility of the Ministry of Children and Equality. The various grounds for discrimination are seen in conjunction with each other. Grounds for discrimination include gender, ethnicity, religion or belief, disability and sexual orientation.

A new Act relating to prohibition against discrimination on the basis of disability (the Anti-Discrimination and Accessibility Act) was adopted by Parliament on 17 June 2008. It will enter into force on 1 January 2009. Attached is an unofficial translation of the Act.

The first draft for new legislation was prepared by a law commission. Its report is NOU 2005:8 Equality and Accessibility, Draft statute- Act relating to prohibition against discrimination on the basis of disability (Discrimination and Accessibility Act). The report contains an English summary which may be found at this web page:

http://www.regjeringen.no/nb/dep/jd/dok/NOUer/2005/NOU-2005-8/20.html?id=390816

A bill was presented to the Parliament 4 April 2008 (Ot.prp.nr. 44 (2007-2008)) An English translation of its summary is attached.

The bill and the adopted Act, is more comprehensive than the Law Comission's draft. It sets i.a. time limits for Universal Design of information and communications technology (ICT). It also contains an obligation for private undertakings to include information on their efforts to promote equality and equal opportunities in their annual report. Public authorities shall give similar reports in their annual budgets.

The Commission to propose a comprehensive anti-discrimination legislation
In Norwegian legislation protection against discrimination on the basis of personal characteristics or opinions is dispersed. Different Acts prohibit discrimination on the basis of gender, ethnic origin, national origin, descent, colour, language, religion, ethical and cultural orientation, political views, membership of a trade union, sexual orientation, disability or age, as well as discrimination of employees who work part-time or on a temporary basis.

The Commission shall submit a proposal for a compiled and more comprehensive anti-discrimination legislation. According to the mandate, the Commission shall consider the following questions:

- A compiled Act against discrimination, including an evaluation of whether new groups should be protected by the anti-discrimination legislation.
- Abolition of the special exceptions for religious communities from the prohibition on discrimination on the basis of gender or homosexual cohabitation in the Gender Equality Act and the Working Environment Act.
- Ratification and implementation of The European Human Rights Convention Protocol 12 on discrimination.
- Anti-discrimination provisions in the Constitution, unless a commission appointed by the Parliament gets the mandate to consider this question.

The Commission was appointed by the Government 1 June 2007. The Commission shall submit its recommendations within 1 July 2009. A partial recommendation on the exceptions for religious communities was submitted during spring 2008.

Question 2) - Implementation

The municipal health services and the municipal social services are supervised by the Norwegian Board of Health and the County Chief Administrative Officer. They act as both supervisors and as court of appeal for complaints on the municipal services offered to the inhabitants.

The ongoing Action Plan for promoting accessibility has a website. For more information in English:
www.universell-utforming.miljo.no

The Government is now working on a new Action Plan for promoting accessibility. Key areas in the plan will be transport, information technology, buildings, planning and outdoor areas and work. The plan shall inter alia support the implementation of the new Discrimination and Accessibility Act and the Planning- and Building Act.

Question 3) – Statistics etc.

Number of complaints settled by the Norwegian Board of Health from 2003 until 2007:

The numbers include both complaints on national and municipal health and social services, and reflect complaints both on the nature of the service given and disputes concerning the legal basis of decisions.

2007	**2006**	**2005**	**2004**	**2003**
2112	2333	2059	2040	1850

Article 13 Para 3

Question 1) – The general legal framework

The Public Administration Act (Act 2 October 1967) regulates the rules of procedures regarding the individual application process and procedures for complaining, if the applicant does not agree with the decisions that are made.

The Municipal Health Services Act instructs the municipalities to establish different health services, such as long term care, home care service and nursing homes. The right to primary health service is regulated by the Municipal Health Services Act:”Everyone has the right to necessary medical aid in his municipality of residence or in the municipality where he is staying”.

The duties of the municipal, health service shall comprise the following:

1) The promotion of health and prevention of illness, injuries and physical defects and for this purpose, measures are organizes as; board of health service, school health services, health centres and informative activities.

2) Diagnoses and treatment of illness, injuries or physical defects
3) Medical rehabilitation
4) Nursing and care outside health institutions

To perform these duties, municipalities shall provide the following services (among others):
1) General medical practice, including Regular General Practitioner Scheme
2) Physical therapy
3) Nursing, including health visitors and home services
4) Nursing homes or housing for round the clock services

In addition, the Social Services Act regulates the care for persons that cannot take care of theme selves, including practical help and training, support person, assistance etc.

The social services shall comprise:
1. practical assistance and training for those who are in need of assistance owing to illness, disability, or age or for other reasons,
2. measures to provide respite for persons and families with especially burdensome caring work,
3. support contact for persons and families in need of them owing to disability, age or social problems
4. places in institutions or accommodations with 24- hours caring services for those who need them owing to disability or age or for other reasons
5. pay to persons with especially burdensome caring work

The Act also states that those subject to burdensome social work, may request auxiliary services etc.

Question 2) – Implementation

The initiatives introduced to increase quality of services and strengthening services, such as advice and personal help are summarised in the Care Plan 2015, a strategy described in the Government's Report No 25 (2005-2006) to the Parliament. The Care Plan is based on the report's five strategic approaches: Quality development, research and planning; Capacity growth and skills upgrading; Better cooperation and medical follow up; Active care; and Partnership with families and the local community. These approaches require a long-term planning of investment in buildings, personnel efforts, skills development, educational capacity and adapting the physical and social surroundings.

The planning must be carried out at both municipal and national level, and requires a close interaction between national authorities and the municipal sector. The Government puts with this relevant care policy issues in to a long-term perspective and ensures that the long-term objectives and strategies are followed with efficient and definitive initiatives. The plan is an overall care-plan, and is not restricted to services towards elderly alone.

Question 3) – Statistics etc.

The annual supervision report from the Norwegian Board of Health for 2007, give an overview of the complaints regarding failure to meet people's rights to receive social services and health services. The report also sums up the system audits related to the supervision of social services and health services. In 2007 the offices of the County Chief Administrative

Officers had 181 system audits. This supervision was carried out in 176 municipalities and urban districts. Five system audits were carried out in other organizations. In 38 of the system audits, no breaches of laws or regulations were detected.

In 2007 the offices of the County Chief Administrative Officers carried out countrywide supervision in two areas, according to guidelines developed by the Norwegian Board of Health:

1) Municipal health- and social services for adults with mental disorders- 68 system audits
2) Respite care and support services, pursuant to the Social Services Act- 66 system audits

In 2007 the offices of the County Chief Administrative Officer did not issue instructions pursuant to the Social Services Act.

Article 13 Para 4

Question 1-3) – The general legal framework/ Implementation / Statistics etc.

The right to receive help according to the Municipal Health Services Act and The Social Services Act is regardless of nation and nationality. The Municipal Health Services Act says:"Everyone has the right to necessary medical aid in his municipality of residence or in the municipality where he is staying". The Social Services Act (Section 1-2) states that; "The provision in this Act concerning services and measures apply to everyone staying in the Realm". This means that the services regulated by these acts apply to everyone that stays in the municipality, regardless of nationality, age or finances.

Norway has signed bilateral mutual agreements with certain countries on the access to specialised health services for their citizens, in some cases also covering persons being residents or receiving their pensions in these countries. The agreements mainly cover medical aid in case of needs while the person stays in Norway. For each case, an individual assessment is made to conclude whether the medical aid is covered by the agreement.

Within the European Economic Area (EEA), the EEA agreement constitutes a mutual agreement on social security. Norway has signed mutual agreements on hospital treatment with Australia and the Canadian province Quebec in addition to the EEA countries and Switzerland.

For Patients covered by these agreements, user payment is on equal footing with those of patients being residents in Norway.

There have been no major changes in the individuals' right to social assistance benefits, accommodation included, in the reference period, 01.01.2005 – 31.12.2007.

Article 14: The right to benefit from welfare services

Reference period: 1/1/2003-31/12/2007

Article 14 Para 1

Question 1) – The general legal framework

There have been no major changes in the individuals' right to social assistance benefits in the reference period, 01.01.2005 – 31.12.2007, but the national guidelines on what is considered to be a reasonable social assistance benefit amount were revised in January 2007.

The legal framework for the right to benefit from social services is Act No 81 of 13 December 1991 relating to Social Services etc. (as amended, most recently on 4 June 1993 in connection with the new Local Government Act).

Regarding the purpose of the present Social Services Act, reference is made to Article 13 Para 1.

Nationals of other Parties to the Revised Charter and nationals of other Contracting Parties to the Charter are guaranteed equal treatment as regards access to social services.

Regarding access to home-based services, reference is made to the reporting on Article 13 §§1 and 3, where the services which follows from The Municipal Health Service Act are listed.

Access to financial support

Means of support (Section 5-1)

Those unable to support themselves by working or exercising financial rights are entitled to financial support. The support should aim at making the person self-supporting.

The Ministry can issue recommended guidelines concerning levels of support – in which has been done since 2001.

Support in special cases (Section 5-2)

In special cases, and even if the conditions in Section 5-1 are not met, the social service can grant financial assistance to persons who need it in order to overcome or adjust to difficult circumstances.

According to the Social Services Act social welfare services are a municipal responsibility. If a person needs care, practical, personal or financial help one may contact the social services department in the municipality where one lives. The causes of problems have no effect on this responsibility. Most municipalities offer a wide range of services and service arrangements to meet the needs of the person applying for help. The most important services are: practical help and training to elderly and disabled people, adapted housing or housing with care services, shelter for homeless people, financial support and special care and treatment for drug abusers and their families.

To provide the most effective help possible, social services are required to work with other public agencies, such as public employment services, health services and mental health care to provide in- and patient care. If the reasons for seeking help are linked to personal or practical difficulties the social services has a legal obligation to provide counselling and guidance. The

target groups for social welfare services are: elderly and disabled people, people with alcohol or drug abuse problems, homeless people and people in need of financial social assistance.

Rights of children during the handling of cases (Section 8-3)
A child under the age of 18 shall be consulted when the child's development and maturity and the nature of the case so indicate. A child can act as a party in a case and claim the rights of a party if it is aged 12 or over and understands what the case is about. In cases concerning measures to be adopted for alcohol or drug abusers aged under 18 years, the child shall always be considered a party.

Obligation to consult with the client (Section 8-4)
The service to be offered shall as far as possible be planned in cooperation with the client. Great importance shall be attached to the client's opinion.

Complaints/appeals
Application of the Public Administration Act (Section 8-1)
The Public Administration Act 10 February 1967 applies with the special rules laid down in the present Act. Decisions relating to the granting of social services shall be considered individual decisions. If there are several applicants at the same time for a limited service, they shall nevertheless not be reckoned parties in the same case. Nor can one applicant who considers himself passed over complain that the service has been granted to another.
The King can issue Regulations stating that the Public Administration Act shall apply to decisions taken while clients are staying in institutions or homes with 24-hour caring services.

Appeals against decisions by the social service and the Health and Social Welfare Committee (Section 8-6)
Individual decisions taken by the social service can be appealed to the County Governor. The first Paragraph does not apply to cases which according to Chapter 9 fall under the County Board.

Competence of the County Governor in appeal cases (Section 8-7)
The County Governor can try all aspects of a decision. When it comes to trying freely exercised judgement, however, the County Governor can only change a decision if the conclusion so reached is manifestly unreasonable.

If a decision in favour of the appellant cannot be implemented at once, the County Governor can decide that temporary measures to meet immediate needs shall be implemented at once.

The reform of the new Norwegian Labour and Welfare Administration (NAV)
Organisation of social services
The Norwegian Labour and Welfare Administration (NAV) consists of the municipalities' social services and the Norwegian Labour and Welfare Service. On 1 July 2006, the Labour and Welfare Service took over the responsibilities and tasks of the national employment service (Aetat) and the National Insurance Service (Rikstrygdeverket - RTV). This has been one of the largest administrative reforms in recent times.

Legislation of the Norwegian Labour and Welfare Service
The Norwegian Labour and Welfare Service administer a large proportion of the most important welfare benefits and social security schemes in Norwegian society, e.g.

unemployment benefits, sickness benefits, rehabilitation allowances, disability pension, and retirement pension.

In addition to administering important economic welfare schemes, the Service is to make a contribution to the efficient operation of the labour market. This implies that the Service is required by law to provide jobseekers with advice and help, whether they are already unemployed or are merely seeking to change employment. In this context, the Service also provides assistance to employers looking for new staff.

You will find below a short description of the most important statutes that form the basis for the Service's activities. There is unfortunately, no *official* English translation of these statutes.

The Labour and Welfare Administration Act (Lov om arbeids- og velferdsforvaltningen)
The Norwegian Labour and Welfare Service is a new service that was set up on 1 June 2006 when the Directorate of Labour and Welfare took over responsibility for the previous Labour Market Administration and the National Insurance Service. The Labour and Welfare Administration Act concern the purpose of the new Service, its organizational provisions, and its interaction with the individual local authority. The Act lays down important principles of confidentiality, consumer involvement, and the duty to provide information and guidance to individual user.

The National Insurance Act (Folketrygdloven)
The National Insurance Act is one of the most important statutes concerning the central national insurance and welfare schemes in Norway. In the National Insurance Act, you will find the conditions for national insurance membership that is essential to your rights according to the Act. The Act also contain provisions on unemployment benefits, sickness benefits, and benefits related to the course of life and family situations, retirement pension and rules for processing cases.

The Labour Market Act (Arbeidsmarkedsloven)
The aim of the Act is to facilitate an inclusive working life through a well-functioning labour market with high levels of occupational employment and low unemployment. Among other things, the Act imposes duties on employers in connection with job vacancies that the employer seeks to fill, and rules governing mass redundancies and lay-offs. The Act stipulates the basic services and rights for users at NAV local services offices. In addition, the Act regulates employment agencies and hiring of labour.

The Social Services Act (Sosialtjenesteloven)
This Act governs the responsibilities of each local authority in respect of a number of social welfare services provided to the municipality's inhabitants, like for example, practical help for those with assistance needs, places in institutions and so on. The Norwegian Labour and Welfare Service works alongside local authorities on the local offices. It is a condition that local authorities will administer financial assistance benefits at these local offices. This means that applications for social assistance benefits must be directed to the local NAV office.

Nationals of other Parties to the Revised Charter and nationals of other Contracting Parties to the Charter are guaranteed equal treatment as regards access to social services.

Question 2) – Implementation

The first 25 NAV offices opened in the autumn of 2006. 121 new offices were established in 2007. 140 new offices are planned for 2008 and a further 160 in 2009. By 2010, all the inhabitants of Norway will have access to a NAV office in their municipality.

In these offices, users of the services will find an integrated office where staff of the Labour and Welfare Service (formerly the Labour Market Service and the National Insurance Service) and the relevant municipality's social welfare service work together to find sound solutions for their users.

Municipalities and the Labour and Welfare Service have engaged in a cooperative agreement that describes what services the NAV office will offer. The cooperative agreement is mandatory by law. This is the first time that central Government and local authorities/municipalities have worked so closely in a common service. The local cooperative agreement lays down what services the individual office will provide in accordance with and in addition to the minimum requirement. The range of services will therefore vary from municipality to municipality. The minimum requirement is for a NAV office to offer financial social assistance and the qualification programme from the local authority and the whole range of Government services earlier provided by the former National Insurance Service and the Labour Market Service.

The aim of the NAV-reform is to

- Get more people into work and useful activity, and less people on benefits.
- Make it easier for users, and adjust administration to the user's needs.
- Attain a uniform and efficient labour and welfare administration.

The NAV

- has about 16.000 employees across the whole country,
- has almost the whole population as its users and
- administers one third of the state budget through schemes such as unemployment benefits, rehabilitation allowances, pensions, child benefits and cash benefits.

To apply for or to receive social services are free and are not subject to fees.

Information about a client shall as far as possible be obtained in cooperation with the client or in such a manner that the client knows it is being obtained. In cases concerning services according to the present Act, the social service can request information from other public bodies. Organizations and private persons engaged in assignments for the central Government, county municipality or municipality are considered equivalent to public bodies. If the client has not consented to the collecting of information, the question of whether the information can be given notwithstanding the obligation of secrecy shall be decided according to the secrecy rules applicable to the public body possessing the relevant information.

Concerning establishing an effective monitoring system to prevent damage, reference is made to the report on Article 13 on the role of the Board of Health.

Question 3) – Statistics etc.

Reference is made to the tables above on Article 13.

The expenses for community based health and social services per year are approximately 63 billion NOK.

Article 14 Para 2

Question 1) – The general legal framework

The Social Services Act section 3-3, states that the social services should cooperate with user group organizations and with voluntary organizations engaged in the same tasks as the social services.

The municipality makes a resolution for the user of social services. This authority cannot be delegated from the municipality to others. When the user has a resolution he or she can get the social services from the municipality or non-governmental organizations assumed that the municipality has a contract with the non-governmental organization. It is the same regulations that apply to the municipality and the non-governmental organizations when they provide social services.

The non-governmental organizations are divided into non-profit and profit organizations. It is only a small part of the social services that are provided by non-governmental organizations and these are mostly non-profit based.

Question 2) – Implementation

A new forum for dialogue between the Government and organizations of the poor and disadvantaged groups of citizens is established mainly after 31 December 2007.

Since the first years of the millennium the Norwegian Government has sought for new models for dialogue and consultation with representatives of organizations of the poor, disadvantaged and marginalised citizens. In spring 2008 the Ministry for Labour and Social Inclusion established the *contact committee* - a model with three main elements:

(1) A contact committee with representatives of the Government and organizations of the poor and disadvantaged groups of citizens – chaired by the Minister.
(2) A forum of organizations and groups representing the latter for e.g. making preparations for the contact committee meetings.
(3) The Battery[1] in the role of serving as secretariat and provider of practical support, assistance and backup for this forum, promoting organizational development, capacity building and the articulation of joint policy positions and demands on the part of the associations and spokespersons of the poor and disadvantaged citizens.

The main purposes of this committee are:

- To establish a forum for closer and more regular contact with the representatives of the poor and disadvantaged citizens.

[1] The service office, called the 'Battery', is a meeting place for groups and persons to establish networks and support for self-organization, advice and guidance for organizational development, etc. After a two-year pilot period, the Church City Mission has been granted yearly grants for the work of the Battery.

- To make a policy innovation by linking participation of the committee to the new joint arena for capacity-building and policy-articulation among organizations of the poor and disadvantaged citizens, facilitated and supported by the Battery.

Article 23: The right of elderly persons to social protection

Reference period: 1/1/2003-31/12/2007

Article 23 Sentence 1: Full members of society

a) Adequate resources

Question 1) – The general legal framework

Reference is made to the description of the legal framework given in the previous reports and the enclosed information survey entitled: "The Norwegian Social Insurance Scheme", updated as of 1 January 2008.

Question 2) – Implementation

Measures taken to ensure that elderly persons have adequate monetary resources have in the reporting period inter alia included adjustments of the minimum pension. Reference is made to the information about the increase in the basic amount given on Article 12 above.

Increase in minimum pension

During the reference period (1 January 2003 to 31 December 2007), the level of the minimum pension has increased considerably. The minimum pension for a single pensioner increased from NOK 97 140 in 2003 to NOK 119 820 in 2007, and for a married couple the minimum pension increased from NOK 167 208 in 2003 to NOK 219 600 in 2007.

The minimum pension is admittedly lower than the average wage level. This is, however, in part compensated by more lenient taxation rules for pensioners and other schemes available to pensioners with low income (housing allowances etc).

The minimum pension is regulated once or several times a year in accordance with the increase in the consumer price index as well as the increase in the general real income level with a view to give the pensioners a fair share of the general economic growth.

The minimum pension is non-contributory. As a main rule, all residents of Norway, irrespective of nationality, will receive a minimum old age pension when reaching the age of 67. A three year residence requirement is imposed for the acquisition of entitlement to an old age pension. To receive a full minimum pension, the person concerned must have lived in Norway for 40 years.

Supplementary allowance scheme

However, by Act 29 April 2005, in force from 1 January 2006, a new supplementary allowance scheme was introduced.

The purpose of this scheme is to provide financial support for elderly persons with less than 40 years of insurance under the National Insurance Scheme. It is intended to guarantee a minimum income (necessary means of subsistence) for persons who have reached the age of

67 and find themselves without sufficient pensions or other financial means because they have less than 40 years of residence. Persons who have reached the pensionable age (67) and who are permanent residents of Norway are entitled to this allowance.

The maximum amount of the allowance was at the end of the reference period set at a level corresponding to the minimum social insurance pension rate. Per 31 December 2007 this level was NOK 119 820 per year for single persons and NOK 219 600 for couples (NOK 109 800 for each person).

The allowance is subject to a strict means inquiry and is reduced if the person or his/her spouse or cohabitant has other income from work, from capital assets or Norwegian or foreign pension schemes. Also the capital asset itself and other property may in principle be taken into account.

The allowance is supplementary in relation to ordinary pension benefits from the National insurance scheme. This excludes persons who are entitled to an ordinary, unreduced conventional benefit.

The allowance is granted without conditions of qualifying periods or completed periods of insurance. Recipients are required to make a reapplication once a year by personal attendance at the local office of the Labour and welfare service.

The supplementary allowance scheme is neither a part of the comprehensive National insurance scheme (the National Insurance Act) nor of the Social Assistance (the Act on Social Services). It is fully financed through the State Budget and is managed by the social insurance/welfare administration.

Question 3) – Statistics etc.
By 30 June 2007, there were 636 556 old age pensioners in Norway, of which 179 809 received the minimum pension.

In December 2007, 2 575 persons were receiving supplementary allowances, of which 37 per cent were men and 63 per cent were women.

b) Information about services and facilities

Question 1) – The general legal framework
All municipalities shall provide necessary health services for all persons resident or temporarily resident in the municipality.

The duties of the municipal health service shall comprise services such as medical rehabilitation and nursing and care. To perform these duties services as nursing homes and home nursing services must be provided. These services are not exclusively offered to elderly persons.

The Municipal Health Act also instructs the municipals to inform all its inhabitants of available health services, and to plan its health services in accordance with the needs of the population. This also includes the needs of elderly persons.

The municipalities are also instructed to provide a general practitioner service to all its inhabitants, and to offer medical rehabilitation to everyone in need of such services.

Question 2) – Implementation

If fulfilment of duties by law is not done by all municipalities, the supervisor of municipal health services will report the failures. The municipalities in question must then make changes in its service in order to fulfil their obligations.

The municipalities have various methods of securing the inclusion of elderly persons in everyday society and to offer care services etc. The most common activity especially offered towards elderly is activities in daytime centres. These organised activities are often low cost offers and include social stimulation of different sorts.

Question 3) – Statistics etc.

The average net amount of money spent per inhabitant on nursing and care in the municipalities have risen from 8 973 NOK in 2002 to 11 237 NOK in 2007.

The average available places in institutions by percentage of the total amount of 80 year olds and older in the municipalities have fallen from 20.4 % in 2003 to 18.3 % in 2007. This decrease is due to transformations from institutions to adjusted residences.

The average amount of places in institutions and community care houses (with 24 hour service) in percentage of the total amount of 80 year olds and older has risen from 27 % in 2005 to 28 % in 2007 – an increase by approx. 3.7 % in two years. The total amount of places in institutions and community care houses is about 68 000. This includes nursing homes, community care housing, and a small number of care institutions for elderly persons.

The average net amount of money spent on social activity per inhabitant aged 67 and older has also risen in this period from 3 974 NOK in 2002 to 4 556 NOK in 2007.

Article 23 Sentence 2: Free choice of life-style

a) Housing

Question 1) – The general legal framework

Regarding the Social Services Act § 1-1 and the purpose of this Act, reference is made to Article 13 Para 1.

The historical development of the long term care services in Norway can be described as having undergone a deinstitutionalisation process from institutional to domiciliary care services, were the boundaries between nursing homes and old people's homes and community care housing with home care services have been diminished.

The Social Services Act also says that the social services shall help to provide housing for persons who are unable to look after their own interest in the housing market, including

specially adapted houses and housing offering aid and protection facilities for those who because of age or disabilities or for other reasons need them.

The Municipal Health Services Act instructs the municipalities to establish different health services, as long term care, home care service and nursing homes. The right to primary health services is regulated by the Municipal Health Services Act:"Everyone has the right to necessary medical aid in his municipality of residence or in the municipality where he is staying".

Question 2) – Implementation

For implementing the legal framework, reference is made to the description on Article 13.

In 2006 the Government made the Report No 25 (2005-2006) to the Parliament. The Care Plan 2015 is an action plan in this Report, and summaries the Governments strategy for the next 10 years for meeting current as well as future long term challenges. This action plan has measures to both improving the capacity of buildings and accommodation offer and to ensure access to sufficient health and social services personnel. Improving professional expertise is one of the most important strategies for safeguarding the quality of the services.

As a basis for the Care plan 2015 there are some stated values or principles. The future welfare state must focus on the individual and have greater emphasis on freedom, diversity and user influence. When formulating the contents of the services, this means more individual adaption and customisation, and less conformity, standardisation, "stop- watch" care and pre-designed package solutions. The services shall, as far as possible, be formulated as based on the individuals' wishes and needs, regardless of social status, personal finances, place of residence or way of living.

To ensure housing suited to individual needs the Government has established a new investment grant for nursing homes and community care housing. The grant will also be given in order to adapt individuals own housing and the access to their homes (e.g. lifts).

As a part of the Care Plan 2015, the Government has worked out a competence plan for the years to come; the Competence Lift 2015. The aim is to procure enough personnel and the necessary professional expertise in the municipal long term care service. The plan focuses on qualification of personnel, especially those already in work, and further education and training for health care workers. Another measure is expansion of the personnel capacity by new man-years in the municipal long term care by the end of 2009.The new personnel man-years will provide more care in community housing, strengthening the medical coverage and medical expertise, expanding day care offers and centres for elderly and strengthening the care for patients suffering of dementia.

Dementia Plan 2015 is one of the sub plans to Care Plan 2015 and emphasizes three main focus areas to strengthen the dementia care in Norway: day programs, living facilities better adapted to patient needs and increased knowledge and skills.

For more information about the Care plan 2015 and the Dementia Plan 2015, please use these internet links:

http://www.regjeringen.no/Upload/HOD/Vedlegg/Omsorgsplan_2015/Report_No_25_to_the_Storting.pdf
http://www.regjeringen.no/upload/HOD/Hoeringer_KTA/Dokumenter/Subplan%20of%20Care%20Plan%202015%20-%20Dementia%20Plan%202015.pdf

Question 3) – Statistics etc.

Reference is made to the information under Article 23, first sentence, litra b.

b) Necessary health care and services

Question 1) – The general legal framework

The Municipal Health Services Act instructs the municipalities to establish different health services, as the long term care; home care service and nursing homes. The right to primary health service is regulated through Municipal Health Services Act: which says:"Everyone has the right to necessary medical aid in his municipality of residence or in the municipality where he is staying".

Reference is made to Art 13 Para 1 regarding the Social Services Act and the purpose for this Act.

Elderly persons shall receive the health care and the services necessitated by their condition. The services shall, as far as possible, be based on individual wishes and needs of their condition, regardless of social status, personal finances, and place of residence or way of living.

Question 2) – Implementation

Reference is made to the report on Article 23, second sentence, litra a.

Question 3) – Statistics etc.

Reference is made to the report on Article 23, first sentence, litra b.

Article 30: The right to protection against poverty and social exclusion

Reference period: 1/1/2003-31/12/2007

Article 30 a: Effective access to employment, housing, training, education, culture and social and medical assistance to persons who live or risk living in a situation of social exclusion or poverty

Question 1) – The general legal framework

Individuals right to protection against poverty

There have been no major changes in the individuals' right to protection against poverty and social exclusion in the reference period, 01.01.2003 – 31.12.2007.

Housing

There have been only minor changes in Norwegian policy and legal framework concerning housing since 2005, which affects protection against poverty and social exclusion.
For a description of the general legal framework, reference is made to previous reports submitted in 2004 regarding Article 31, in 2005 regarding Article 16 and in 2007 regarding Article 15. There has been one amendment of the Tenancy Act in 2007, which gives the landlord right to notify the local municipality through the Social Security Office, if the tenant fails to pay the rent. This is a measure to reduce evictions. The Ministry of Local Government and Regional Development has also started the work on reforming the Housing Allowance scheme. The main reason for the reform is to make the scheme simpler and more effective, and to target a larger group of poor. The scheme is today very complex and difficult to understand.

Education

There are certain rights implemented in the legal system to level out social inequality, some of those especially reserved for pupils from minority cultures. They have the right to individual Norwegian language teaching in both primary and lower secondary school. For upper secondary school they got the same right since August 2008.

In the Government's Report No 23 (2007-2008), "Språk bygger broer", to the Parliament, several measures are introduced to improve the teaching both in Norwegian and mother tongue language. In the Government's Report No 16 (2006-2007),"Early Intervention for Lifelong Learning", to the Parliament, it is strongly focused on how it is possible to level out social inequality in schools. In this relation "Early intervention" is a key term. This is further followed up in the Government's Report No 31 (2007-2008) to the Parliament.

From 1 April 2004 a new chapter was included in the Norwegian Education Act about the pupils` school environment. The first section reads as follows:

"Section 9a-1 General requirements
All pupils attending primary and secondary schools are entitled to a satisfactory physical and psychosocial environment conducive to health, well-being and learning."

Please find enclosed the sections from the whole chapter in an unauthorized translation.

A new section, § 13-5, was from 1 July 2008 included in the same Act. The section says that the owner of the school shall be under the obligation to give the pupils fruit and vegetables for

free. So far it includes schools at lower secondary level (age 13 to 16) and schools with both primary and secondary level (age six to 16).

Transferring from *Reform 94* to the *Knowledge Promotion Reform* a change within the health care education at the level of upper secondary was accomplished. The three-year school based education in auxiliary nursing and the vocational education in the welfare/social workers trade (two years in school and two years in a training establishment as an apprentice) was compressed into a new education in the health care workers trade. This new vocational training comprises two years in school and two years of training as an apprentice in a training establishment.

Medical assistance
No particular references to the legal basis are mentioned here. Reference is made to the report on previous Articles.

Question 2) – Implementation

Individuals right to protection against poverty
The main and most important strategies to prevent and combat poverty in Norway are through universal designed labour market policies, family policies, education policies, housing policies, social protection policies and insurance policies and health and social services policies. These measures are aimed towards individuals and groups who are considered to be at risk of poverty, including those who are on low income for less than three years. The Action Plan against poverty, cf. below, also covers measures in the field of health.

In addition to universal measures there is also need for more targeted and individually designed measures aimed at the most marginal and poor groups of the Norwegian society, e.g. measures to reduce the risk of marginalization and poverty, to recover from poverty, and to have as worthy life as possible.

The Government's overriding long-term goal is to eliminate poverty in the Norwegian society. The Government wishes to improve the living conditions and opportunities available to those members of society who have the lowest income and the poorest living conditions. Everyone shall have equal opportunities, rights and obligations to take part in society and make use of their resources, irrespective of economic or social background.

Action plan against poverty
The Government aims to eradicate poverty and reduce social and economic differences through universal welfare schemes, strong collective solutions and by providing individual with an opportunity to participate in employment. The Government presented a proposed action plan against poverty together with the National Budget for 2007 for the amount of 710 million NOK.

The action plan focuses on three sub-goals:

- that everyone be given an opportunity for employment
- that children and young people shall be able to participate in society and develop themselves
- to improve living conditions for the most disadvantaged

Homelessness
Norway had a strategy to prevent and combat homelessness for the period 2005-2007. There was a peer review on the strategy in 2006, which was very positive. The strategy was also evaluated in 2008. The main focus of the strategy was to raise awareness and competence in municipalities and relevant organizations and to contribute to more cooperation between relevant actors. The strategy will be implemented in the ordinary work of the State Housing Bank.

Measures/policies aimed at children and youth to avoid poverty
The Ministry of Children and Equality has in 2008 allocated in total 41.1 million NOK to measures against poverty within the ministry's policy area (31.5 million NOK to measures in urban areas through the subsidy programme *Children and Youth in large urban communities* and 9.6 million NOK to combat poverty through measures applied by Child Welfare Service). Contributions on the urban field and on the Child Welfare Service field are corresponding.

Contribution on the urban field
The subsidy programme *Children and Youth in large urban communities* has the overall aim to improve living conditions for youth in large urban communities (the programme includes 23 cities and 7 townships in Oslo). Within the programme there is emphasis on outreach to children, youth and families affected by poverty. The means are used for holidays and spare time activities, as well as measures to improve access to the job market for youth with limited or no education. (The programme is a continuation of the work that was initiated in 2003).

Contribution in 29 municipalities
The Government contribution in the Child Welfare Service field was initiated in 2004 with regional conferences addressing poverty, how poverty affects children and how to reach marginalised children and youth by public measures. To meet the regional challenges in the poverty area, 29 municipalities which have a high score as regards child poverty have established a collaboration programme for the municipal Child Welfare Service. The municipal Child Welfare Service has allocated means to participate in the programme. A collaboration agreement with the Directorate of Labour and Welfare regarding child poverty and the Social Services was made in 2005.

Cultural and sport activities
Cultural activities
It is a central aim of cultural politics in Norway to ensure that all citizens have the opportunity to take part in cultural activities regardless of their social background or income level. Culture and the arts are resources that should be available to all. Free entrance to museums and free library services are examples of measures that give people the opportunity to access culture without encountering economic obstacles.

In the ongoing effort to make culture and the arts accessible to all, a particular focus has been put on children and youth. One of the most important strategies for reaching this groups is The Cultural Rucksack, a national programme for culture and the arts in school. The programme is intended to allow school pupils to become familiar with, understand and appreciate different forms of artistic and cultural expression at a professional level. It is offered to all pupils aged 6-16 and will now be expanded to include pupils in upper secondary education.

Voluntary sector
The Government pursues a new, comprehensive volunteer policy, in which the primary goal is to give active support to developing a dynamic civil society. The background for this policy is the Government's Report No 39 (2006-2007), "Volunteering for everyone", to the Parliament. The Government regards the voluntary sector as a pillar of democracy and the welfare state, and one of the Government's main goals is to encourage greater participation and engagement, particularly from groups who fall outside organizational life. The Ministry of Culture and Church Affairs has four main strategies as its basis for active support for the voluntary sector and promotion of greater participation:

- A better regulatory framework for the voluntary sector
- Greater focus on resources for local activities and `low threshold' activities
- More attention to inclusion and integration
- Stronger knowledge and research

The Government has established a special research programme relating to civil society and voluntary sector in 2008. The programme focus on participation, changes in structures and contain, inclusion and how framework influence voluntary sector. The programme will last three to five years.

Medical assistance
Government's Report No 20 (2006-2007) to the Parliament: National strategy to reduce social inequalities in health
The Norwegian population enjoys good health. However, averages conceal major, systematic inequalities. Health is unevenly distributed among social groups in the population. The Government therefore in Report No 20 (2006-2007) to the Parliament presented a broad national strategy to reduce social inequalities in health. The primary objective of this strategy is to reduce social inequalities by levelling up. The work to reduce social inequalities in health will require long-term, targeted effort in many areas. The strategy lays down goals for this work in the following areas: income, childhood conditions, employment and working environment, health behaviour, health services and social inclusion.

The implementation of the plan involves different ministries and sectors, not just health authorities.

Question 3) – Statistics etc.

Individuals right to protection against poverty
Table: Trend in persistent low-income. 1996-2006. Proportion of people with equivalent income below 50 per cent and 60 per cent of average median equivalent income for different three-year periods. Two different equivalent scales

Period	OECD-scale		EU-scale		Number of observations
	50 percent	60 percent	50 percent	60 percent	
All people					
1996-1998	2.4	7.5	4.0	9.7	17 351
1997-1999	2.3	6.8	3.7	9.0	17 334

Table: Trend in persistent low-income. 1996-2006. Proportion of people with equivalent income below 50 per cent and 60 per cent of average median equivalent income for different three-year periods. Two different equivalent scales

Period	OECD-scale		EU-scale		Number of observations
	50 percent	60 percent	50 percent	60 percent	
1998-2000	2.1	6.1	3.4	8.8	17 214
1999-2001	2.2	6.1	3.3	8.5	17 162
2000-2002	2.7	6.6	3.7	9.0	17 259
2001-2003	2.9	6.5	4.0	8.9	17 339
2002-2004	3.6	7.2	4.1	9.6	13 671
2003-2005	3.9	7.4	4.9	9.5	18 500
2004-2006	3.8	7.8	4.5	9.3	4 424 148
All people excluding students[1]					
1996-1998	2.0	6.8	3.5	8.9	17 204
1997-1999	1.9	6.2	3.1	8.1	17 187
1998-2000	1.7	5.6	2.9	8.2	17 089
1999-2001	1.8	5.5	2.8	7.8	16 999
2000-2002	2.1	5.9	3.0	8.1	17 073
2001-2003	2.4	5.8	3.3	7.9	17 110
2002-2004	3.0	6.4	3.3	8.5	13 516
2003-2005	3.0	6.1	3.6	7.9	18 246
2004-2006	2.9	6.7	3.4	7.9	4 307 976

[1] People living alone in the last year of a three year period and in receipt of a student loan.

In addition, we refer to the following website of Statistics Norway:
Persons with persistent low-income, by various characteristics:
http://www.ssb.no/inntind_en/tab-2008-06-27-02-en.html

Homelessness

The last registration of homelessness in 2005 indicates that there is approximately 5500 homeless in Norway. There will be a new registration late 2008.

Appendixes:

1) **The Working Environment Act**
2) **The Norwegian Social Insurance Scheme**
3) **Government's Report to the Parliament No 5 (2006-2007)**
4) **Act June 20 2008 No 42 relating to a prohibition against discrimination on the basis of disability (the Anti-Discrimination and Accessibility Act)**
5) **Proposition to the Odelsting (Ot.prp.) no. 44 (2007-2008) Concerning an Act relating to prohibition against discrimination on the basis of disability (the Anti-Discrimination and Accessibility Act)**
6) **Norwegian Education Act chapter 9a**
7) **Report No 20 (2006–2007) to the Parliament**