European Social Charter | Charte Sociale Européenne

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EUROPEAN SOCIAL CHARTER

10th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF NORWAY

(Articles 3, 12, 13, 14, 23 and 30 for the period 01/01/2008 – 31/12/2011)

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CYCLE 2013

10th NORWEGIAN REPORT ON THE APPLICATION OF THE EUROPEAN SOCIAL CHARTER

Reference period for all articles: 1 January 2008 to 31 December 2011

Article 3: The right to safe and healthy working conditions

Article 3 Para 2

Question 1) – The general legal framework

- The Act relating to working environment, working hours and employment protection, etc. (Working Environment Act).

Reference is made to previous reports.

- Shipping

Reference is made to the previous report.

- Petroleum sector

The HSE regulations for petroleum activities were discussed in detail in the previous report.

Since the report was submitted, new regulations for HSE in petroleum activities have been laid down, and these entered into force on 1 January 2011. The new regulations carry forward the principles embodied in the regulations set forth in September 2001, which were discussed in the last report, but their application has been extended to include activities subject to the scope of authority of the Petroleum Safety Authority Norway onshore, particularly in the field of safety and the working environment.

The extension of the application of the regulations resulted from the ever-increasing integration of activities on the shelf and onshore to facilitate the highest degree of coordinated management of activities by the industry, as well as to ensure the most uniform enforcement basis for the supervisory authorities.

Question 2) – Implementation
Reference is made to the previous report concerning the Working Environment Act and shipping.

In the case of the petroleum sector, reference is made to the discussion of the central tripartite arenas in the 2006 report, which continue to function in accordance with existing mandates.

Further questions from ECSR

- *The Committee asks whether the authorities have considered drawing up an inventory of all contaminated buildings and materials. Bearing in mind the importance of this question in the light of the right to health of the population, the Committee asks for the next report to provide specific information on steps taken to this effect.*

There are no plans to ensure that all buildings containing asbestos will be mapped since this would be an extremely comprehensive task. Nor is it likely that all asbestos would be detected because the material is often concealed in the building structure or in various installations. The Norwegian environmental authorities are of the opinion that an overview of buildings containing asbestos would create a false sense of security for those who undertake demolition and repair work later on, both for the personnel involved and for waste disposal.

However, in Norway requirements on the mapping of asbestos in specific demolition and rehabilitation work are set out in two sets of regulations. The TEK 10 regulation of 26 March 2010 no. 489 on technical requirements for buildings introduced requirements on the environmental mapping of all demolition and rehabilitation projects (Chapter 9). This requires documentation in the form of a description of the disposal of hazardous materials if the usable floor area exceeds 100 square metres or if over 10 tonnes of waste is produced (the latter applies only to structures such as bridges, docks and the like where the area is difficult to define). The technical regulations are authorized by the Planning and Building Act, and the municipalities are responsible for following up the requirements on environmental mapping and the disposal of hazardous materials. Moreover, asbestos is deemed to be dangerous waste in both Norway and the EU.

The Norwegian Labour Inspection Authority has not evaluated the compilation of an overview of all contaminated buildings and materials. If asbestos is discovered during inspections, the safety of the working environment will be assessed and legal instruments employed to ensure a safe working environment.

Shipping: The Norwegian Maritime Authority has not compiled an overview of ships or material on ships that contain asbestos. We refer also to section 10-1 of the Regulation of 1 January 2005 no. 8 on health, safety and the working environment for employees on ships. These state that asbestos is permitted on vessels built prior to 1 July 1987, and that pre-fabricated asbestos gaskets and friction coatings etc. that do not require processing on the vessel are also permitted on newer ships.

- *The Committee asks whether temporary workers are entitled to representation at work.*

In accordance with section 6-1 of the Working Environment Act of 17 June 2005, a safety representative shall be elected at all undertakings. The safety representative shall safeguard the interests of employees in matters relating to the working environment. This also applies to those employed on a temporary basis, cf. section 1-8.

Shipping: Section 28 of the Act of 16 February 2007 no. 9 relating to Ship Safety and Security (The Ship Safety and Security Act) sets forth requirements on safety representatives and the working environment committee, and supplementary provisions are set out in Chapter 5 of the Regulation of 1 January 2005 no. 8 on the working environment, health and safety of workers on board ship. No distinction is made between permanent and temporary employees regarding the representation of workers on board.

Article 3 Para 3

<u>Question 1) – Enforcement of legislation</u>

- Enforcement of health, safety and environmental provisions in the Working Environment Act.

Pursuant to the Working Environment Act, the Norwegian Labour Inspection Authority monitors compliance with the provisions of the Act. The Labour Inspection Authority may issue orders and make the individual decisions necessary for the implementation of the Act.

Consequences of violating the provisions:

Orders: The Labour Inspection Authority may give the undertaking an order pursuant to the Working Environment Act to implement the provisions of the Act. The order is given in writing and a time limit is set to rectify the situation. The order may be appealed to a higher authority.

Coercive fines: If an order is not complied with within the time limit, the Labour Inspection Authority may impose a penalty. This may be imposed as a single payment fine or as a continuous coercive fine imposed until the order is implemented. The amount of the fine depends on a number of factors, but the main rule is that it should not be profitable for the undertaking to violate the Working Environment Act.

Cessation of work: An undertaking's activities may be wholly or partly halted until the order has been complied with. In the event of immediate danger, the Labour Inspection Authority may halt activities linked to the dangerous situation even if no order has been issued.

Reports to the police: The Authority may report an undertaking to the police in the case of serious breaches of working environment legislation. Serious or repeated breaches may result in a fine or imprisonment.

- Petroleum activities and shipping

Reference is made to the previous report.

Question 2) – Statistics etc.

The following statistical data are based on inspections undertaken by the Labour Inspection Authority.

No.	Year	2008	2009	2010	2011
1	Number of accidents at work (including fatal accidents)	21 267	17 845	15 927	11 566
2	Accident rate per 100 000 workers	842.39	711.52	635.04	454.8
3	Number of inspections	13 794	15 280	14 834	14 208

4	Number of different undertakings inspected	11 123	12 914	12 923	12 256
5	Number of employees in the undertakings inspected	339 785	403 910	349 713	393 566
6	Number of notifications of orders	17 422	19 988	19 508	20 076
7	Number of decisions on orders	17 422	21 066	20 726	20 076
8	Decisions on coercive fines	1 104	1 222	1 636	1 517
9	Decisions on cessation of work	905	774	632	465
10	Reports to the police	69	68	46	67

The source for 3, 8, 9 and 10 is the 2011 Annual Report. The remaining figures are derived from the Labour Inspection Authority's register of undertakings and occupational injuries as of August 2012.

Further to nos. 1 and 2:

Metadata 2012:
Since the Labour Inspection Authority has recently revealed the serious challenges posed by data used in previous reports, it is deemed essential to inform Eurostat about the situation in Norway.

Background
In recent years the Labour Inspection Authority has detected a marked decline in the number of notifications of work-related illness or injury forms (NLW 13-07.05) that it has received. These forms constitute the basis of previous reports to European Statistics on Accidents at Work (ESAW). In 2004 the Labour Inspection Authority registered approximately 25 000 notification forms, in 2010 approximately 14 000 forms and in 2011 approximately 11 000 forms.

In 2011 the Labour Inspection Authority contacted the Norwegian Labour and Welfare Service (NAV) to find out whether they had experienced a similar decline in the number of forms received. It came to light that the Labour Inspection Authority does not receive paper copies of many of the notification forms that are sent to NAV, and that a comparison of the number of forms received by NAV compared with the number of forms received by the Labour Inspection Authority shows that fewer have been forwarded in recent years. As a result, NAV's routines for forwarding paper copies to the Labour Inspection Authority have

been tightened. The Authority is now receiving a fast-increasing number of notification forms.

The consequences
The considerable decrease in the number of notification forms received from NAV therefore means that the number of accidents at work reported to Eurostat has been too low, particularly in recent years, and this applies to accidents at work registered in 2010 and 2011. Appropriate measures have been carried out and we hope that the figures from and including 2012 will be accurate.

Weighting
In the 1990s it was estimated that 40 per cent of accidents at work were reported, and from then on all cases reported to Eurostat were given a weighting of 2.5. Later investigations indicate that a 2.5 weighting was an overestimate. Unfortunately the Labour Inspection Authority's database does not contain valid information about absence from work (the number of lost working days). Due to the decline in reported accidents in recent years, the weighting today ought to be more accurate, but it is not known exactly how accurate the weighting is, and no existing studies have estimated a new weighting.

Data on accidents at work as of 29 August 2012.

Further to 5:
The number of employees shows the number of employees registered at the Brønnøysund Register Centre by the organization number of the undertaking that has been inspected. Employees are deemed to be all recorded employees who work more than five hours per week. The information registered at the Brønnøysund Register Centre is based on data reported by the undertakings themselves. The reporting on employee numbers can be deficient in that all the employees in a multi-enterprise corporation are reported under one company, and that the removal of the names of former employees and the reporting of new employees may be delayed. The data on employees are as at August 2012.

Further to 6:
The number of notifications of orders. Based on the date of the notification (not the date of inspection).

Further to 7:
Decision on order. Based on data for the decision on an order (not the date of inspection). Some orders are given directly and not notified so that there is some disparity between the figures. The undertaking may also have rectified the situation before a decision on an order is made.

Further to 8:
The number of decisions made annually on coercive fines, based on the registration date in the case processing system for the register of undertakings and occupational injuries. These do not need to be linked to an inspection conducted in the same year. For example, a decision on a coercive fine issued in 2011 may be based on an inspection conducted in 2010. Furthermore, there are often a number of reactions in the same undertaking leading to coercive fines

Further to 9:

The number of incidents involving the cessation of work is linked to immediate danger to life and health, cf. section 18-8 of the Working Environment Act. The figures state the number of inspections with one or several reactions leading to the halting of work. (The method of calculation may differ for 2005–2007 since the number of legal authorizations for halting the work are reported and not the number of cessations of work.)

Further to 10:
A report to the police is a request from the Labour Inspection Authority that the police investigate the circumstances as a criminal offence. In the view of the Labour Inspection Authority, a violation of the Working Environment Act and/or regulations has occurred, or a violation is suspected. In cases involving accidents at work with injury to persons or death, the police have an independent duty to investigate. In such cases the Labour Inspection Authority assists the police by preparing a recommendation. The number gives the number of inspections that have resulted in reports to the police, not the number of legal authorizations for the reports.

- Shipping

Statistics on fatalities, injured and missing persons in the period 2008–2011 are attached to the report.

New statistics on accidents for the period 2008–2011 can be accessed on the following link: http://www.sjofartsdir.no/ulykker-sikkerhet/ulykkesstatistikk/generell-statistikk/ (Norwegian only).

The figures for ILO 178 inspections in 2010 and 2011 are given below. The new control system has not yet been put in place, so the figures are registered manually in a spreadsheet.

Report on ILO 178 inspections.

Inspection carried out from: *01.01.2010* *to:* *31.12.2010*

2010				
Quarter	***Total no. of inspections***	***No. of inspections with no deficiencies***	***No. of inspections revealing a non-conformity***	***No. of inspections with observations***
1st	*58*	*13*	*36*	*21*
2nd	*82*	*20*	*51*	*32*
3rd	*71*	*14*	*44*	*34*
4th	*93*	*21*	*54*	*48*
Sum	*304*	*68*	*185*	*135*

Report on ILO 178 inspections.

Inspection carried out from: 01.01.2011 to: 31.12.2011

2011				
Quarter	**Total no. of inspections**	**No. of inspections with no deficiencies**	**No. of inspections revealing a non-conformity**	**No. of inspections with observations**

1st	91	20	44	50
2nd	98	34	45	42
3rd	88	23	51	41
4th	76	23	43	36
Sum	353	100	183	169

- Petroleum sector

Accident statistics for petroleum activities on the Norwegian continental shelf

	2008	**2009**	**2010**	**2011**
Workers in the oil and gas industry - offshore	25 026	26 136	25 866	27 997
Number of fatalities	0	1	0	0
Fatality rate (per 10 0000 workers)	0	4	0	0
Number of accidents at work (3 days absence or more)	51	57	37	22
Accident rate (per 100 000 workers)	204	218	143	79
Number of occupational illnesses	833	648	857	1141

Further questions from ECSR:

- *The Committee asks that the next report provide data and information on occupational illnesses on all sectors. The only data given concerns the petroleum sector and shows a sharp increase during the reference period. The Committee asks for an explanation concerning this increase and measures taken to improve the situation.*

An overview of approved compensation for permanent injuries for 2008–2011 categorized by sector. Please note that official statistics on occupational illnesses (approved compensation for permanent injuries) are not available. The figures are derived from The Norwegian Labour and Welfare Administration's case processing system (Infotrygd).

Sector	2008	2009	2010	2011
Agriculture, forestry and fisheries	3	1	4	2
Oil and gas extraction	0	1	1	0
Mining and quarrying	2	0	1	1
Manufacturing	138	151	85	40
Electricity, water supply and waste management	37	61	46	29
Building and construction	0	3	1	2
Retail trade; repair of motor vehicles	88	137	109	55
Transportation and storage	23	37	30	5

Data and communication	36	50	46	32
Accommodation and food service activities	3	8	3	1
Financial and insurance activities	3	2	3	1
Professional, scientific and technical activities	15	16	12	3
Business services	1	2	1	0
Education	13	12	5	0
Human health and social work activities	1	2	1	2
Other service activities	5	11	5	3
Not stated	2	3	1	1
Total	**370**	**497**	**354**	**177**

We have seen an increase in the number of reported work-related injuries and illnesses in petroleum activities over several years. The reporting activities have also revealed large annual variations. The causes are complex:

1. The knowledge of health professionals about work-related injuries and illnesses has increased and there is growing awareness of the duty to report. In particular the production companies have developed sound competence and good systems to identify such injuries and illnesses, to report to the authorities and not least to utilize the information for preventive activities in their own undertaking.

2. Reporting of work-related injuries and illnesses is in many cases not a regular activity but may be the result of an all-out effort, the revision of journals etc.

3. The reporting criteria have changed. In 2006 the reporting criteria for hearing impairment due to noise were changed and the threshold for reporting was lowered. This resulted in a total of 200–300 more reported injuries per year.

4. The Petroleum Safety Authority Norway has regular activities that promote an increase in both direct and indirect reporting. In recent years the number of hearing impairments due to noise has increased. This is partly related to our increased emphasis on this and the follow-up by undertakings of noise that causes damage to hearing as well as the industry's own initiatives in this area.

5. Noise-related work injuries and illnesses constitute the largest part of the increase in reporting. In addition to the elements mentioned under points 3 and 4 there are indications that several companies report the summarized total of all hearing impairments without assessing the exposure ratio. This may mean that a proportion of these injuries can be attributed to circumstances other than noise in the working environment. This issue has been addressed, and a working group has now been set up at the industrial level to harmonize practices and ensure better-quality reporting.

6. While production companies generally have good routines in place, this is not always the case for many contractors. Employees in contracting companies represent 60-70 per cent of the employees in petroleum activities and are often groups subject to high exposure. If we consider the distribution of work-related injuries and illnesses, these employees account for 50 per cent of the total number

reported. Therefore there is reason to believe that numbers in this industrial sector are underreported.

7. As a point of departure the threshold for reporting is low in the regulations and the development in reporting practices apparently favours lowering the threshold even further. Conditions/symptoms are constantly being reported where previously there was no such practice.

The Petroleum Safety Authority uses the statistics on reported work-related injuries and occupational illnesses as a basis for prioritized efforts, while at the same time we are aware of the weaknesses in the statistics. Therefore it has been important for us to acquire supplementary data on exposure ratios and on how employees experience working environment risks and health-related problems. Such data are derived from the "Risk level in Norwegian petroleum activities" project, and together with the inspection results, this has brought about a clear prioritization with the aim of helping to reduce the level of exposure to harmful noise.

- *The Committee asks how many labour inspectors there are.*

The figures given below show the number of employees who have conducted at least one inspection during the year. Some inspectors carry out many more inspections, while others carry out fewer since they are also involved in the Labour Inspection Authority's other work tasks such as processing building applications, project management or national responsibilities. On some occasions it is normal practice for two inspectors to conduct the inspection, for example in the case of large-scale, complicated inspections, or of inspections where for safety reasons it is better to have two inspectors. When two or more inspectors carry out an inspection together, this is registered under only one inspector. Several employees in the agency are not registered in our system as having conducted any inspections but they have supported external work and the inspection process in various ways such as by sending letters or evaluating inspection reports – for example, lawyers.

	2008	2009	2010	2011
Number of inspectors who conducted one or several inspections	336	354	370	360

Shipping: There are 86 inspectors in the Norwegian Maritime Authority. These carry out inspections on board vessels in accordance with the Act relating to ship safety and security (The Ship Safety and Security Act).

The Petroleum Safety Authority: Working environment: 14. Technical and operational safety and emergency preparedness: 72.

- *The Committee asks an explanation for the significant decrease in the number of coercive fines imposed directly by the LIA which fell from 552 in 2005 to 238 in 2007.*

The reasons for the decline in the number of decisions on coercive fines from 2005 to 2007 have not been analyzed. However, there may be many reasons for this decline, for example that undertakings have become better at complying with orders so that the case can be closed without resorting to coercive fines.

Article 11 – The right to protection of health

Article 11 Para 1

Question 1 and 2 -The general legal framework/ Implementation
The Patients' Rights Act of 2 July 1999 no. 36 (which changed its name to the Patient's and User's Rights Act as of 1 January 2012) 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 and Care Services Act (which replaced the Municipal Health Services Act as of 1 January 2012) and the Mental Health Protection Act.

- Access to health services

We refer to the previous report.

- Right to evaluation and prioritization

We refer to the previous report.

- Registration of waiting time for hospital treatment

We refer to the previous report.

- Dental care

The Act relating to dental health services governs the responsibility of the county authority for the public dental health service in Norway. Only minor amendments have been made to the Act in the period 2008–2012. The dental health service in Norway comprises a public sector that provides dental health services to groups of the population in line with rules set out in the Act, and a private sector that offers dental health services to the remainder of the population. In 2011, approximately three out of four man-years in the dental health service were carried out in the private sector.

The county authority is responsible for the public dental health service and must ensure that dental health services, including specialist services, are available to all those resident or temporarily resident in the county. In addition, the county authority has responsibility for coordinating the public dental health service and private dental practice.

The public dental health service shall organize preventive dental measures for the entire population. It shall offer and provide dental services on a regular basis to:

• children and adolescents from birth and up to and including the year they reach the age of 18
• mentally retarded persons in and outside institutions
• groups of elderly, chronically ill and disabled persons who are in institutions or receive home-based nursing care
• young people from the age of 18 up to and including the year they reach the age of 20
• other groups that the county authority has decided to prioritize.

In addition to performing the prioritized tasks, the public dental health service may perform services for paying adult clients in accordance with the plan adopted for the county.

Persons with a right to dental treatment under the auspices of the county authority pay a small or no patient's charge. Those with specific illnesses or conditions may have the right to publicly funded treatment in accordance with the provisions of the National Insurance Act.

Question 3) – Statistics etc.
Information derived from the OECD report "Health at a glance" (2011):

Health in Norway is generally good, with a higher life expectancy and lower morbidity and mortality than the OECD average. Increased incidence of overweight, obesity and diabetes reveals a negative trend in the OECD, which also applies to Norway even though the incidence in Norway is below the OECD average. We also have an under-average consumption of tobacco and alcohol. "Health at a Glance" for 2011 shows that Norway is one of the OECD countries with the best results for survival after myocardial infarction, stroke, breast cancer, cervical cancer and colorectal cancer. The indicators linked to patient safety and the primary health service place Norway around the OECD average.

Norway has the highest proportion of employees in the health and social sectors among the OECD countries. In 2008 some 20 per cent of all employees worked in the health and social sector, an increase of 2.3 percentage points from 1995. At the same time Norway lies under the OECD average when it comes to annual growth in employment in the health and social sector. In 2009 Norway had four practising doctors per thousand population, and on average there were 14.2 nurses per thousand population. Norway educates approximately 72 nurses per 100 000 inhabitants.

Dental coverage, measured as the number of dentist man-years per 1 000 inhabitants amounted to 0.8 per cent at the end of 2011 (almost unchanged since 2007).

The average waiting time for commencement of treatment for all patients in the first four months of 2012 was 74 days, a decrease of three days on the first four months of 2010. This applies to both patients who have the right to essential health assistance and to those who do not have such a right but still require health assistance in the specialist healthcare service.

General questions from ECSR – Article 11

- *The Committee asks that the next report on Article 11 contain information on the availability of rehabilitation facilities for drug addicts, the range of facilities and treatments as well as whether supply matches demand under Article 11.*

In Norway the regional health authorities are responsible for substance abuse treatment – interdisciplinary specialist treatment. This includes detoxification, emergency treatment, screening and specialist treatment (outpatient clinic or institution), institutional placement where the substance abuser can be detained without consent (coercion) and opioid replacement therapy.

There has been a 4 per cent increase in operating costs for the interdisciplinary specialist service in the period from 2010 to 2011. In 2011 the regional health authorities spent a total of NOK 3 565 billion on substance addiction treatment.

We face challenges concerning waiting times for treatment, but the statistics show a positive trend. Waiting times for substance addiction treatment are declining, and the proportion of violations of the specified time limits were substantially reduced in 2010. During the same period there was a growth in interdisciplinary specialist treatment at all levels. In the period from April 2011 to April 2012 the average waiting time fell from 74 to 60 days (Norwegian Patient Register, NPR).

Figures for 2011 from the NPR show that approximately 25 000 persons received interdisciplinary specialist treatment for their substance problems. In addition, a considerable number of patients with substance addiction problems as a secondary diagnosis were treated in the mental health care sector with a primary diagnosis of a psychiatric nature. Alcohol and the use of opiates are the most commonly occurring drugs among patients with substance abuse problems in the specialist health service.

Further questions from ECSR:

- *Strategy to reduce social inequalities in health: The Committee asks to be informed in the next report of the results of this strategy in addressing the above-mentioned inequalities, including statistical data on the situation of disadvantaged groups, both as regards their state of health and their access to care.*

The Norwegian strategy to reduce social inequalities in health was launched in 2007. It is a broad, long-term strategy to reduce social inequalities in health by levelling them out. It includes actions on the following key areas:

Income – to ensure that taxes and social benefits promote fairer income distribution in society.

Children – ensuring that all children have equal opportunities regardless of their parents' financial situation, education, ethnic identity and geographical identity.

Work and working life – investments to promote a more inclusive labour market and steps to ensure a healthier working environment for all.

Diet, physical activity, smoking and other health-related behaviours – priority to policy instruments that influence cost and availability of healthy behaviours.

Health services – investigation is taking place on the question of whether Norwegian health services are helping to level out health inequalities or if they are reinforcing them.

Preventing social exclusion of marginalized groups, measures to promote inclusion in the workplace, inclusion at school and adapted health and social services.

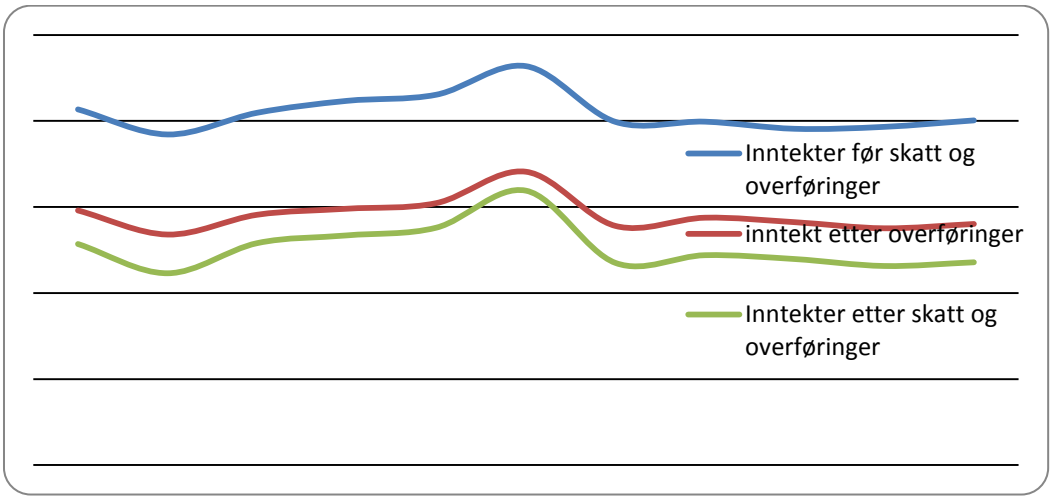
Strengthening considerations for health and distribution of health in all sectors – including a review and reporting system for monitoring progress, cross-sectoral tools such as health impact assessments and more systematic policy planning in the municipalities.

Progress reports on the strategy are published annually. The 2011 report showed progress in several areas, including income distribution, kindergarten coverage and inclusion and health behaviours among adolescents. Major challenges remain, however. For instance, drop-out rates in secondary schools remain too high and working life is not as inclusive as we would like it to be.
Reference: National strategy to reduce social inequalities in health. Norwegian Ministry of Health and Care Services. Report no. 20 (2006-2007) to the Storting.
http://www.regjeringen.no/pages/1975150/PDFS/STM200620070020000EN_PDFS.pdf

(Norwegian only): St.meld. nr. 20 (2006-2007) om nasjonal strategi for å utjevne sosiale helseforskjeller (Report no. 20 (2006–2007) to the Storting on the national strategy to reduce inequalities in health)
http://www.regjeringen.no/pages/1936477/PDFS/STM200620070020000DDDPDFS.pdf

2011 progress report (Norwegian only): Folkehelsepolitisk rapport 2011: Public health policy report 2011 – the Norwegian Directorate of Health's Annual Report on initiatives to reduce social inequalities in health. Oslo: Directorate of Health, 2012
http://helsedirektoratet.no/publikasjoner/folkehelsepolitisk-rapport-2011/Publikasjoner/folkehelsepolitisk-rapport-2011.pdf

Income inequality



Explanation:
BLUE: Income before tax and transfers
RED: Income after transfers
GREEN: Income after tax and transfers

Figure: The significance of tax and transfer systems for the distribution: Gini coefficients for income before tax and transfers, income after transfers and income after tax and transfers.

2000–2010. Source: Statistics Norway

The figure shows income inequality measured by the Gini coefficent before and after taxes and transfers. A high Gini coefficient means a high degree of inequality. When measured with this indicator, inequalities are reduced by approximately 30 per cent as a result of public

transfers, and by approximately 10 per cent due to the taxation system. A fall of 40 per cent in the Gini coefficient means a redistribution equal to taxing all incomes at 40 per cent and then distributing the tax revenues equally to everyone. This shows that taxes and transfers have a considerable redistributive impact in Norway, even though it cannot be concluded that income inequalities would be 40 per cent higher without them.

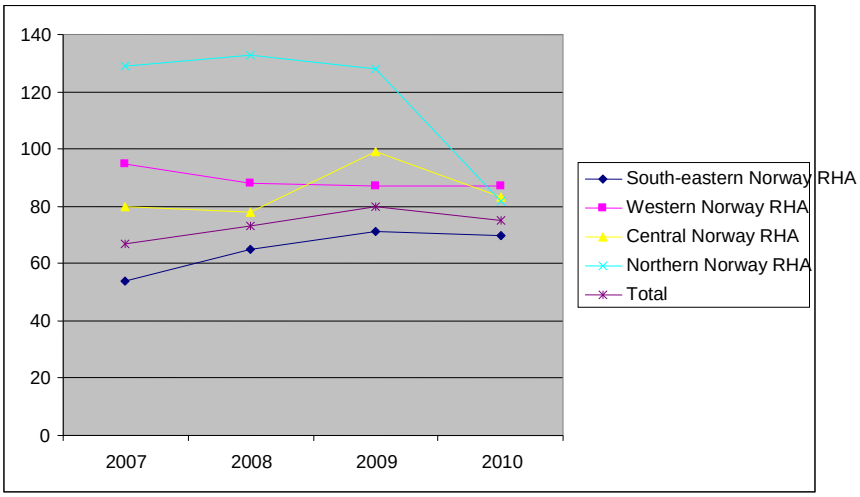
Access to health services

Substance abusers constitute a particularly challenging group in respect of providing an adequate range of health services. An under-utilization of health services by this patient group has been documented in both the municipal health service and the specialist health service. In the autumn of 2007 the Government presented an escalation plan for the substance abuse area that emphasizes better accessibility to health services and improved coordination between the various segments and levels of the support system.

Waiting time for interdisciplinary specialized treatment for substance abuse

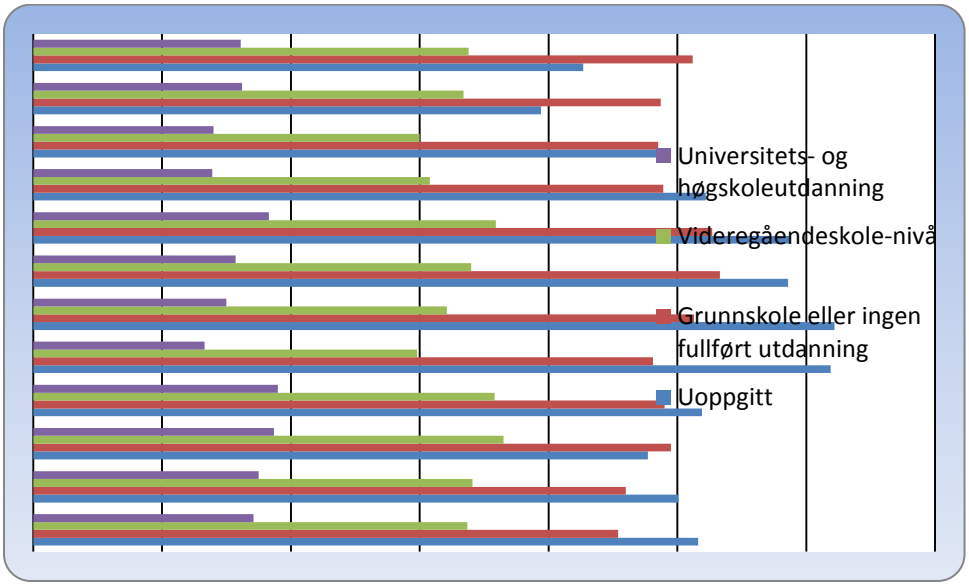
The first indicator sheds light on the capacity within interdisciplinary specialized treatment for those with substance abuse problems. The term 'interdisciplinary specialized treatment' entails that substance abuse problems must be met with an interdisciplinary approach that includes medical, psychological and social measures. In addition, the measures provided must be of an appropriate professional standard. The waiting time indicator can shed light on the accessibility and capacity of the health services offered.

Figure below: Average waiting time (number of days) for treatment distributed among the regional health authorities. Corrected for missing data. Interdisciplinary specialized treatment for persons with substance abuse problems. 2007-2008. Source: Norwegian Patient Register, Norwegian Directorate of Health



Education and social differences in health

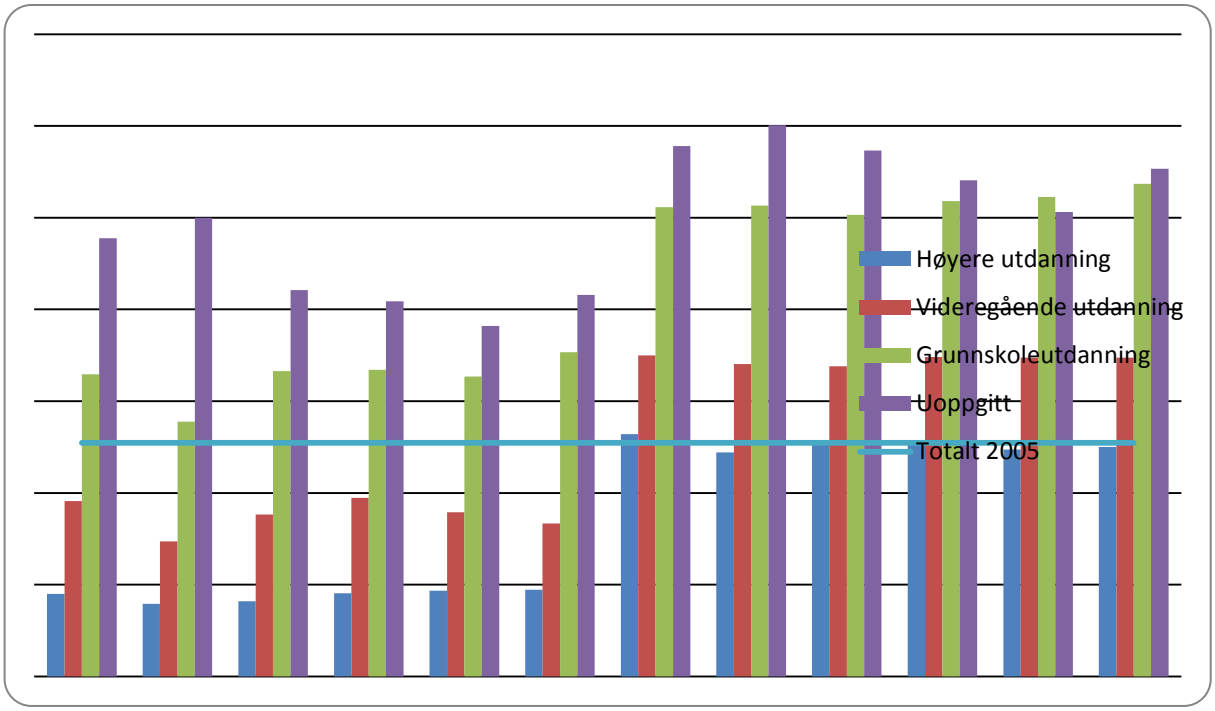
Figure below: The percentage of pupils aged 13 (Grade 8) whose score lies at the two lowest levels for the national tests in mathematics, reading and English in 2007–2010, by parents' level of education. Source: Skoleporten (The School Portal) /Statistics Norway.



Explanation:
Left column from top: Mathematics Reading English
VIOLET: University and university college education
GREEN: Upper secondary school
RED: Compulsory education or incompleted education
BLUE: Not stated

The parents' educational level affects whether young people complete upper secondary education and training. Figure 2.3 shows that dropping out underway in upper secondary education and completing the second year of upper secondary schooling or a trade examination without passing correlates with the educational level of the parents. The group "not stated" consists mainly of immigrants where the parents' level of education is not known. This is because not all education undertaken abroad is registered in Statistics Norway's statistics.

Figure below: The proportion of students/apprentices per cohort who commenced a university-preparatory field of study and a vocational field of study and who five years later had dropped out underway or had completed the second year of upper secondary schooling/trade examination without having passed, by parents' educational level. Source: Directorate for Education and Training, Statistics Norway



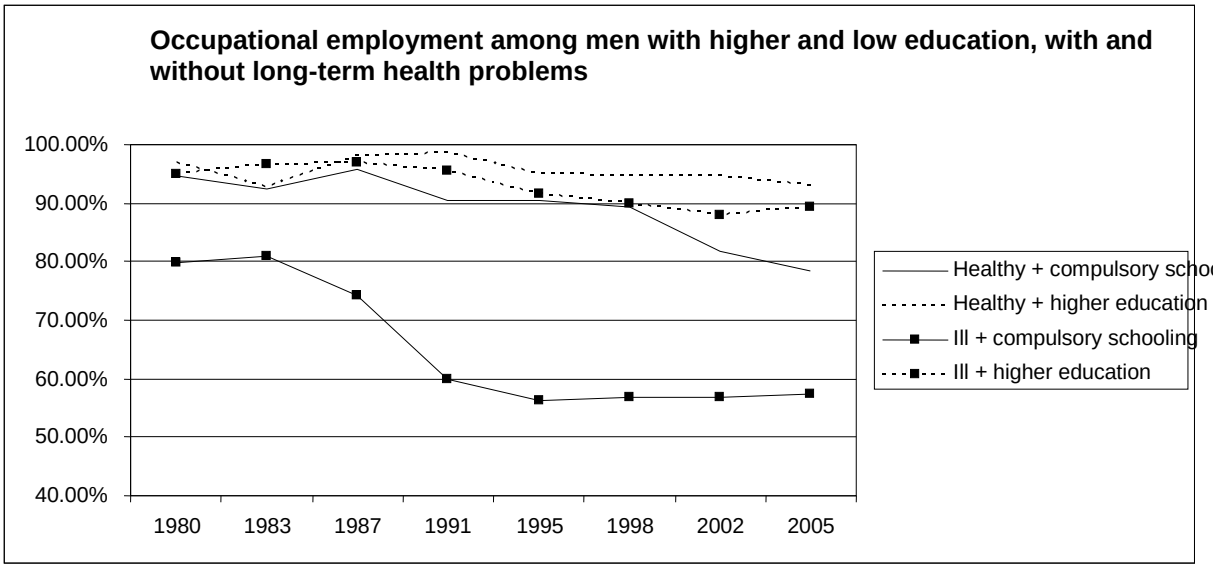
Explanation:
RIGHT HAND SIDE:
BLUE: Higher education
RED: Upper Secondary education
GREEN: Compulsory education
VIOLET: Not stated
BLUE HORIZONTAL LINE: Total 2005

BOTTOM LINE
University-preparatory subjects
Vocational field of study

The proportion of children from minority language backgrounds in kindergartens as of 15 December, is calculated annually on the basis of figures from the kindergartens' annual reports and population statistics from Statistics Norway.

	2005	2006	2007	2008	2009	2010
1-5 years old	53.8	57.6	63.1	67.8	71.1	71.7
1-year-olds	18.9	19.7	25.7	30.5	33.0	34.5
2-year-olds	31.0	36.2	43.2	48.9	55.5	56.8
3-year-olds	62.3	66.4	72.5	76.3	81.8	84.1
4-year-olds	79.4	82.3	86.3	91.3	92.4	93.0
5-year-olds	82.8	87.7	90.5	93.4	95.2	94.7

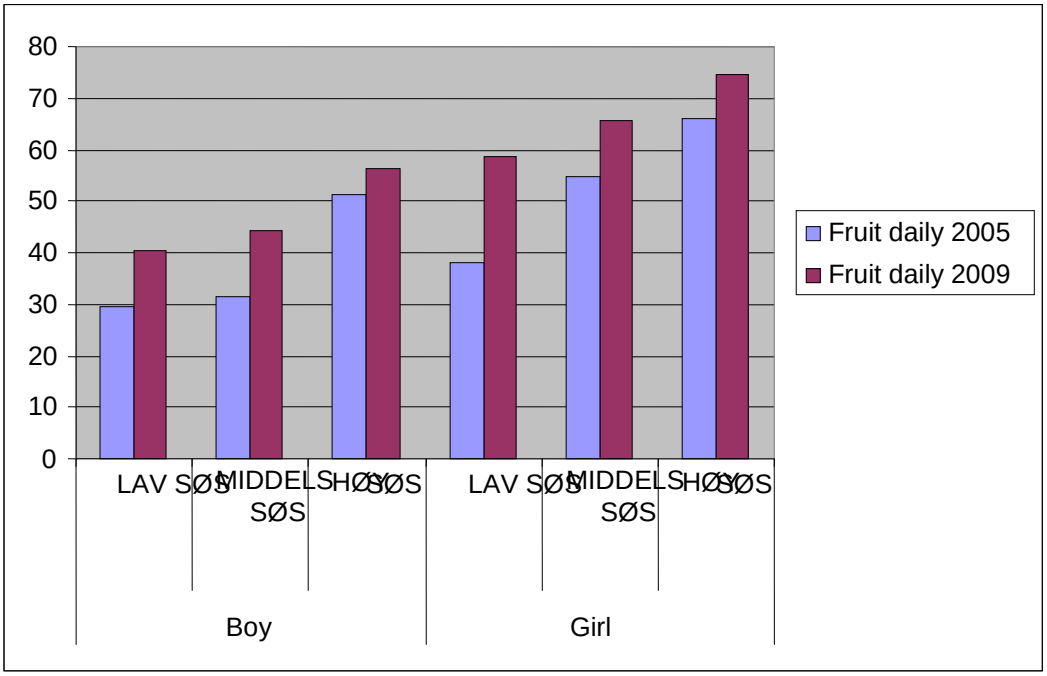
Work and health inequalities
Exclusion from work is socially imbalanced. Educational level appears to play a decisive role for occupational employment – also among those who state that they suffer from long-term illness, as illustrated in figure 3.1.



Health behaviour and social health differences

Data from the Health Behaviour in Schoolchildren study in 2005 and 2009 show clear social gradients in the intake of fruit and vegetables among Grade 10 pupils. During this period the proportion of children who eat fruit or vegetables daily increased most among pupils with the lowest socioeconomic status. However, in both 2005 and 2009 the proportion who ate fruit or vegetables daily was considerably higher among those with high socioeconomic status than those with low socioeconomic status.

Figure below: The percentage of Grade 10 pupils who state that they eat fruit daily by socioeconomic status. Per cent. Source: Health Behaviour in Schoolchildren study 2005 and 2009



LINE BELOW DIAGRAM FROM LEFT
LOW SES (Socioeconomic status)
MEDIUM SES
HIGH SES

LOW SES
MEDIUM SES
HIGH SES

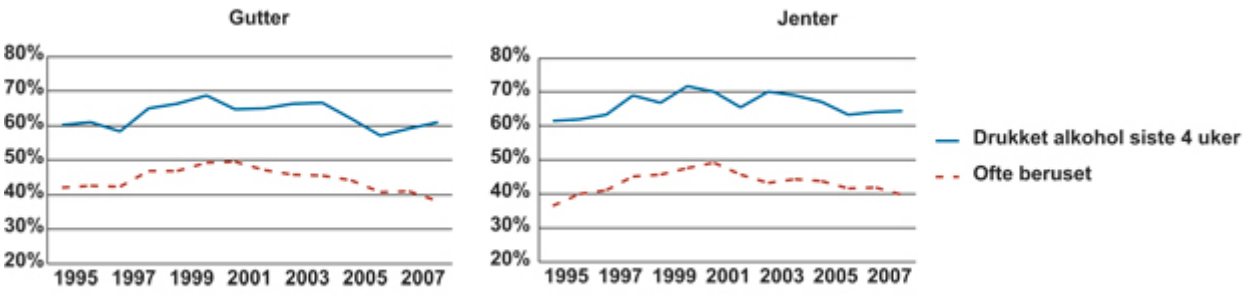
Data from the Health Behaviour in School-aged Children study on health habits among schoolchildren in 2005 and 2009 show clear social gradients in the intake of soft drinks containing sugar among Grade 10 pupils. In this period the proportion who drank soft drinks containing sugar on a daily basis declined among pupils with low and medium socioeconomic status.

Alcohol consumption increased steadily in the post-war years. In the 1980s consumption fell, especially the consumption of spirits. From and including 1993 an increase was again registered, and this levelled off somewhat from 2009 onwards. The decline in consumption of spirits stabilized in the 1990s while the consumption of wine rose sharply. Beer consumption has remained fairly stable throughout the entire period. In 2010 consumption was registered as 6.7 litres pure alcohol per inhabitant over the age of 15 as against 4.8 litres in 1995. This constitutes an increase of 40 per cent.

The total consumption of alcohol, including unregistered consumption, was estimated in 2010 as being just over 8 litres per inhabitant over 15 years of age. The corresponding figure for 1995 was 5.4 litres. In comparison, the average consumption for Europe as a whole totals 12.5 litres pure alcohol.

Data from population surveys show that Norway is ranked low in the use of cannabis, cocaine, heroin and ecstasy compared with other countries. In recent years there has been a large increase in the availability and use of amphetamines in Norway, and in particular of methamphetamine. A larger proportion of the population in Norway than in a number of other countries have experience of the use of these substances.

According to nationwide surveys of adolescents carried out by the Norwegian Institute for Alcohol and Drug Research, approximately 80 per cent in the age group 15–20 years had drunk alcohol during the last year. There were no major changes in this proportion in the period 1995–2008. A comprehensive European school survey is conducted every fourth year among 15–16-year-olds – the European School Survey Project on Alcohol and Other Drugs (ESPAD). The ESPAD surveys reveal that there is also a high proportion of 15–16-year-olds (60 per cent) who have consumed alcohol despite the fact that in Norway the age limit for the purchase of alcohol is 18. Surveys of Norwegian teenagers indicate that alcohol consumption among the youngest increased up to the Millenium and then declined somewhat. However, drinking frequency remains high in this group.



HEADING
Boys
Girls
BLUE: Drunk alcohol in the last four weeks
RED: Often intoxicated

Figure 2.2 The proportion of 15–20-year-olds in the period 1995–2008 stating that they have drunk alcohol in the last four weeks, and the proportion stating that they have been intoxicated more than four times during the last six months, by gender. Weighted figures.

Source: Norwegian Institute for Alcohol and Drug Research

Compared with other European countries, the proportion of young people in Norway who have tried narcotic substances is low. The 2011 ESPAD survey shows that the proportion of young people stating that they had used drugs was 5 per cent.

In 2009 a total of 387 deaths were registered as a direct consequence of long-lasting and high alcohol intake. These constitute a small proportion of all fatalities wholly or partly attributable to alcohol. In the same year 285 deaths were attributable to drugs.

- *The Committee wishes to receive up-dated information on waiting times in the next report.*

We refer to the answer to question 3 above.

Article 11 Para 2

Question 1) – The general legal framework
As of 1 January 2012 the statutory basis is the new Norwegian Public Health Act in addition to the Act relating to control of communicable diseases. The Municipal Health Services Act was repealed from the same date.

Recently separate statutory provisions have been introduced in both the Act relating to primary and secondary education [Education Act] and the Independent Schools Act regarding the provision of training in augmentative and alternative communication when required. This is targeted towards persons who wholly or partly lack the ability to speak. The provisions entail that current rights stipulated in the statutory framework are clarified. The statutory amendments do not introduce new rights. It is uncertain how relevant this is in relation to Article 11, Paragraph 2. We will therefore not go into greater detail on these rules.

Question 2) - Implementation

Counselling and screening

Pregnant women are screened for HIV and syphilis and also in weeks 18–19 ultrasound will be used to establish the estimated date of delivery and the like. Furthermore, newborn babies are screened to detect congenital metabolic diseases. Women between the ages of 50 and 70 are screened using mammography to detect breast cancer. Women in the age group 25–69 are screened for cervical cancer by means of a cell sample test.

Maternal and child health centres and the school health services
We refer to the previous report.

Question 3) – Statistics etc.

Births
A total of 60 200 infants were born in Norway in 2011. The number of births corresponds to each woman giving birth to an average of 1.88 children during her reproductive period.

Immunization
Figures from the Childhood Vaccination Register show high vaccination coverage against infectious diseases in the Norwegian childhood vaccination programme. As many as 95 per cent of 2-year-old infants are vaccinated against Haemophilus influenza type B and 94 per cent against diphtheria, tetanus, pertussis and polio. The vaccination coverage against measles, mumps and rubella (MMR-vaccine) is 93 per cent. Among 16-year-old adolescents, 92 per cent have been vaccinated against diphtheria and tetanus during the last five years and 94 per cent against measles, mumps, rubella and polio. Vaccination against tuberculosis is no longer a part of the Norwegian vaccination program. The HPV vaccine was introduced in the vaccination programme in 2009 and is offered to all 12-year-old girls. The vaccination coverage is about 80 per cent.

Further questions from ECSR

- *The Committee has asked for information on the impact of the action plans on better nutrition and on physical activity.*

Action Plan on Physical Activity
Physical activity as a subject area and a tool in public health initiatives is a cross-sector responsibility. The health sector promotes preventive efforts for groups at risk as well as the use of physical activity in patient treatment and the development of expertise and methodology and other initiatives at the societal level and population level. Eight ministries have introduced policy instruments and measures within their fields of responsibility in the Action Plan on Physical Activity (2005–2009). This highlights three factors that are decisive for the opportunity to be physically active from childhood to adulthood:

- Arranging the physical environment appropriately, for example by providing paths and tracks for pedestrians and cyclists, creating local areas of activity and emphasizing accessibility for everybody
- Providing good opportunities for physical activity during leisure time and in arenas such as kindergartens, schools and workplaces
- Encouraging an active lifestyle for both children and adults regardless of age via websites, courses, meeting-places, the media and the like.

Measures in the action plan have been carried forward after the expiry of the plan period. The 2009 assessment recommends that the work be followed up by even stricter provisions, for

example it will be followed up by an inter-ministry public health strategy that will be presented in 2013.

National surveys show that the level of physical activity in the population is low and that there is a negative trend. The proportion of the population who are physically active rises with higher socioeconomic status and declines with increasing age.

A 2011 survey shows that 96 per cent of six-year-old boys and 87 per cent of six-year-old girls satisfy the recommendation of an average of 60 minutes' daily physical activity. Among nine-year-olds the proportion fell by five percentage points from 2005–2006 so that 86 per cent of boys and 70 per cent of girls had a satisfactory level of physical activity in 2011. Among 15-year-olds the proportion had fallen by five percentage points to 45 per cent of girls, and it had increased by five percentage points to 59 per cent of boys. Only one out of five adults satisfies the recommendation of at least 30 minutes daily physical activity.

Norwegian Action Plan on Nutrition (2007-2011) "Recipe for a healthier diet"
Through a comprehensive round of interviews in Norway in spring 2012, a WHO expert group assessed the measures set out in the Norwegian Action Plan on Nutrition (2007–2011) in light of efforts to improve nutrition in Norway over time. A report with recommendations for further work will be completed in December 2012.

It is therefore too early to answer this question, but the WHO report can be forwarded when it has been completed.

Nonetheless, we wish to highlight some specific measures based on current knowledge of tools used in nutritional efforts that the Ministry of Health and Care Services believes have good effect and that in the long term will promote improved eating habits in the population and will reduce social differences in diet – the main objective of the work on nutrition.

- A label with a keyhole symbol identifying healthier food products has been introduced making it easier to choose healthier food products regardless of knowledge of nutrition, language and the like. This is a joint Nordic scheme and is provided for in the regulations. The keyhole symbol is the best-known and most often used brand in grocery shopping. In January 2012, 98 per cent of the population had heard of the brand, 60 per cent expressed trust in it and know that the authorities are behind the scheme, and half say that it helps them to make healthier choices. The number of keyhole-labelled products on the market, excluding fruit and vegetables, increased from 550 in 2010 to approximately 1 550 in 2011.

- In 2011 the Directorate of Health issued revised nutritional guidance based on a new research report from the National Council on Nutrition.

- In 2007 the special duty on alcohol-free beverages was altered. A special duty was imposed on beverages sweetened with sugar or other sweeteners in order to achieve a price difference between sweetened and unsweetened beverages such as bottled water, juice and the like.

- A scheme has been introduced whereby free fruit and vegetables are provided to pupils at lower secondary schools. This is authorized by the Education Act.

- A cookery book based on the health authorities' nutritional guidance is offered free to all lower secondary pupils.

- Norway has actively promoted WHO's recommendations, endorsed by the World Health Assembly in May 2010, on the marketing of food and non-alcoholic beverages directed at children. The recommendations provide the member countries with a platform for designing new and/or strengthening existing policies in this area. Follow-up efforts have been initiated in Norway. In cooperation with the Ministry of Children, Equality and Social Inclusion, the Ministry of Health and Care Services has examined the need to introduce statutory provisions and regulations on the marketing of unhealthy food and drink targeted at children and adolescents. As a result a draft proposal for legislation regulating such marketing has been submitted for consultation**.**

- A number of measures have been implemented to improve competence and the range of food and meals in kindergartens. The measures appear to have been successful since more people are aware of the guidelines for food and meals in kindergartens, and compared with 2005 healthier food is served. The evaluation of the seafood project "Fiskesprell" in cooperation with the Ministry of Fisheries and Coastal Affairs and the fisheries industry shows that more fish is served in the kindergartens that have participated in the project.

- A system certifying child health clinics with special expertise in breastfeeding has been established to increase the quality of guidance on breastfeeding at Norwegian child health clinics. To achieve such status, staff must be regularly updated on breastfeeding. The guidelines for such child health clinics are based on the baby-friendly hospital initiative and WHO/UNICEF's 10 steps to successful breast feeding, and are adapted to conditions at the child health centres.

We refer also to the status summary below concerning the quantitative objectives set in the action plan.

- The Action Plan defines some dietary goals for children and young people (Table 2). The proportion of young people who said they daily drink soft drinks or eat sweets decreased significantly in 2001–2009, among both 15-year-olds and those aged 15-24. Dietary surveys show that the proportion of one-year-old children who are given sweet drinks decreased from 64 to 20 per cent from 1998 to 2006. The total intake of added sugars decreased from 10 to 4 per cent of dietary energy among one-year-old children and from 12 to 7 energy per cent among two-year-olds. During the same period the dietary content of saturated fat decreased among two-year-olds. We have no more recent surveys that might shed light on the dietary content of sugar and saturated fat among children and adolescents. The Action Plan defines a separate objective to increase the proportion of adolescents who eat breakfast daily. Among 15-year-old students the proportion who ate breakfast five days a week changed little among girls and decreased slightly among boys from 2001 to 2009. In the age group 15-24, the proportion who said they ate breakfast at home daily or ate breakfast had changed little from 2001 to 2009. The proportion who only took drinks for breakfast or had failed to eat breakfast at least twice during the last seven days decreased from 2003 to 2009. The proportion of infants who are exclusively breastfed at 4 and 6 months of

age increased slightly from 1998 to 2006, but is far from the target for 2011 set in the Action Plan (Table 3). The proportion of infants who are breastfed at 12 months increased significantly from 1998 to 2006 and was close to the target in the Action Plan. There are no recent national data on the proportion of infants who are breastfed.

- *Table 2. Quantitative goals for the development of the diet 2007–2011, and trends evaluated by data from Norwegian Eating Facts and Health Behaviour in School-aged Children.*

	Goal	2001	2005	2009	Evaluation
20% change in the proportion that eat:					
Vegetables daily, %	Promote	39*	36	42	Increased 17% 2005-2009
Fruit and berries daily, %	Promote	43*	40	50	Increased 25% 2005-2009
Fish for dinner 3 times/w, %	Promote	23	22	22	Unchanged
Fish spread (mackerel in tomato sauce) >1 time/w, %	Promote	17	20	26	Increased 30% 2005-2009
Water as a thirst quencher, daily drink tap water, %	Promote	73	83	87	Increased
Children and adolescents					
Sweets daily (15 y), %	Decrease	19	13	9	Decreased 31% 2005-2009
Soft drinks and squash daily (15 y) , %	Decrease	27	18	15	Decreased 17% 2005-2009
Breakfast daily at home (15-24 y), %	Promote	56	55	58	Small change
Sugar intake above 10 E%	Decrease				Decreased for 2-year-olds from 11.7 to 6.7 E%
Saturated fat intake above 10 E%	Decrease				Decreased for 2-year-olds from 14.2 to 13 E%

- * 2003, data missing for 2001.

- *Table 3. Breast-feeding goals 2007-2011, and trends evaluated by data from Spedkost (Infant diet).*

Breast-feeding among infants, %	Goal	1998-99	2006-7	Evaluation
Exclusively breastfed at 4 months, %	44 to 70%	44	46	Goal not reached
Exclusively breastfed at 6 months, %	7 to 20%	7	9	Goal not reached
Breastfed at 12 months, %	36 to 50%	36	46	Goal almost reached

- *The Committee asks that the next report contain up-dated information on counselling and screening for the population at large.*

We refer to the discussion under question 2 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 damage alcohol consumption may cause. These measures complement each other, and constitute an individual single structure. The influence of each measure rests upon and depends on the existence and use of other measures. The total effect of the overall structure 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. The private import of alcoholic beverages was permitted with effect from 1 July 2009.

A licence to retail and serve alcoholic beverages is required, and shall be granted by the municipality (with 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. Commercial production of alcoholic beverages requires a licence given by the Norwegian Directorate of Health. Any production of alcoholic beverages in category 3 (spirits) requires licences given by the same body. The Alcohol Act sets requirements to the licence holder, and a licence can be withdrawn if the holder no longer fulfils these requirements. The municipality is free to decide whether an application for a licence 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 includes maximum time restrictions on retailing, supply and serving of alcoholic beverages.

In accordance with 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 who does not fulfil the age limits.

- Tobacco

The Tobacco Control Act (Act of 9 March 1973 no. 14) is the main legal instrument in the tobacco field. The major new tobacco control measures implemented since Norway's last reporting is the introduction of graphic health warnings on all tobacco packaging, except the oral tobacco snus (in effect from 1 July 2011), and a ban on the visible display of tobacco products at points of sale (in effect from 1 January 2010).

- Food safety

New regulations in the area: The EU's hygiene regulatory framework for the production, sale and inspection of food and foodstuffs of animal origin was implemented in Norwegian law in 2010 through the regulations concerning the hygiene of foodstuffs, the regulations concerning specific hygiene rules for food of animal origin, and regulations concerning official controls on products of animal origin. The 'hygiene package' encompasses the production of foodstuffs throughout the entire food chain from primary production to sales. It will ensure both a high level of protection for consumers and similar rules in the EEA countries in order to achieve the free movement of foodstuffs.

Overview of the regulations:

> *Regulation concerning the hygiene of foodstuffs (FOR-2008-12-22-1623)* (Norwegian)
> Regulation (EC) No 852/2004 of the European Parliament and of the Council of 29 April 2004 on the hygiene of foodstuffs
>
> *Regulation concerning specific hygiene rules for food of animal origin (FOR-2008-12-22-1624)* (Norwegian)
> Regulation (EC) No 853/2004 of the European Parliament and of the Council of 29 April 2004 on specific hygiene rules for food of animal origin
>
> *Regulation concerning official controls on products of animal origin (FOR-2008-12-22-1622)* (Norwegian)
> Regulation (EC) No 854/2004 of the European Parliament and of the Council of 29 April 2004 on the official controls on products of animal origin intended for human consumption

<u>Question 2) – Implementation</u>

- Measures to combat smoking, alcoholism and drug addiction

Objectives - Tobacco
Two of the main goals of the national tobacco strategy for the period 2006–2010 (described in the previous report) were reached: halving the percentage of young smokers and reducing the number of daily smokers in the general population to less than 20 per cent. The goals of halving the number of pregnant smokers and stopping the increase of snus users were not reached. WHO undertook an evaluation of the tobacco control work in Norway in 2010. The

recommendations from the evaluation report will form an important basis for the new national tobacco strategy, which is expected to be launched in 2012.

Measures

Restrictions on accessibility and price mechanisms are central features of Norwegian policy to prevent tobacco use. Norway has a general high taxation level for tobacco products, but the level for oral tobacco is lower than that for smoking tobacco.

The Directorate of Health, the Regional Commissioners and NGOs are collaborating on nationwide educational programmes for tobacco-quitting. The Directorate for Health is running a quitline, offering free counselling and follow-up.

On alcohol and drug policy

Reference is made to previous reporting, including the discussion of the Norwegian National Action Plan on Alcohol and Drugs (2008–2010). The plan has been extended up to and including 2012.

A review of current status shows that almost all the measures have been carried out or put into operation. While this is of course positive, it is also important to evaluate the results achieved during the plan period. This is difficult to accomplish in a methodical manner. The escalation plan is very complex. Moreover, the extent to which the results can be attributed to the measures in the plan varies: many other factors may play a role in the chain of cause and effect. A large number of the objectives have a long-term impact and must be monitored over a lengthy period of time. Nor are many of the objectives quantifiable, and it can be difficult to point to large measureable results, such as for example the Norwegian State Housing Bank's grant for 3 400 adapted dwellings for persons suffering from mental illness and the building of 72 district psychiatric centres under the auspices of the escalation plan for mental health. No evaluation was planned at the start of the action plan and the extent to which the plan can actually be measured is limited.

Some of the results:

- There has been a positive decline in the use of both alcohol and cannabis among young people.
- Just over 40 per cent of the participants in the qualification programme have transferred to work, education or work-related measures in the period 2008–2010.
- Grants for and the capacity of municipal initiatives on alcohol and drugs have increased: in 2006 about 50 municipalities received grants while in 2011 there were 297. Altogether 92 per cent of the population live in municipalities that have received grants for municipal initiatives on alcohol and drugs.
- Greater investment in earlier detection and intervention: the establishment of the website www.tidligintervensjon.no opens up for recommendations and specific tools for the various services to help service providers to progress from concern to action.
- Knowledge about alcohol-free pregnancy and alcohol and health has been reinforced through information campaigns.
- The Country Governors have appointed 19 alcohol and drugs dependence advisors who play a major role in implementing a considerable portion of the escalation plan.

Other programmes:

In 2012 the Directorate of Health launched guidance material entitled *Rusforebyggende arbeid i skolen – forslag til læringsaktiviteter* (Drug and alcohol prevention activities in school – suggestions for learning activities). The material was compiled by the North Norway Competence Centre – Drug and alcohol abuse (KoRus-Nord). The competence centre provides expertise nationally in the area of drug and alcohol prevention activities with the school as the basis arena. The Directorate of Health commissioned the guidance material in close cooperation with the Norwegian Directorate for Education and Training.

The aim of the guidance material is to disseminate knowledge of how the school can facilitate drug and alcohol preventive activities and act as a support in instruction on intoxicants. The target group is primarily school owners, school heads, teachers and the school health service.

The Directorate of Education and Training's initiative "A better learning environment" is the foundation of all health-promoting and preventive activities in schools. "Learning environment" means the combined cultural, relational and physical conditions at school that have significance for the pupil's learning, health and well-being.

Background: According to Chapter 3 on information and attitude-changing measures in the Norwegian Institute for Alcohol and Drug Research's report 5/2010 "Interventions to prevent alcohol related harm", it is highly uncertain what effects so-called preventive school-based programmes have on young people's use of alcohol and other drugs. Programmes that aim at promoting psychosocial skills (so-called "life skills training") and demand active participation by the pupils show positive results. According to research, increasing the pupils' knowledge about alcohol and drugs can favourably influence young people's attitudes. Therefore this material primarily provides support for instruction on intoxicants and is adapted to the relevant competence objectives in all curricula. The school's contribution to creating a positive situation for pupils in the year they celebrate the conclusion of their final year of upper secondary education is described in a separate chapter since this is a risk factor for excess use of alcohol and drugs. Moreover, mention is made of other central features of local preventive efforts such as local prevention plans, cooperation with parents and parent/teacher meetings at school. These factors can be viewed in connection with local public health initiatives and the implementation of the Norwegian Public Health Act which governs the tasks and responsibilities of the municipality and the county authority for promoting the health and well-being of the population.

The material is *not* a guide for teachers' follow-up of concerns in connection with individual pupils and specific situations involving drug use among pupils. We refer to the Directorate of Health's early intervention strategy in the alcohol and drug field and the guide "From concern to action".

- Approximately 700 users in 26 municipalities have received follow-up from a support person who – together with the user – acts as a door-opener and bridge builder for different services.
- The capacity in interdisciplinary specialized treatment has increased in line with policy signals from the Ministry of Health and Care Services.
- There has been a major investment in quality and competence enhancement. One of the policy instruments intended to clarify the distribution of responsibility between the municipalities and the specialist health service and to improve the quality of the services provided has been the development of guides, national policy guidelines and mapping tools. One example is www.snakkomrus.no.
- Thirteen units for mastering drug and alcohol problems have been established in

prisons in order to provide improved services for convicted persons and inmates. A joint circular letter and guide is in preparation to give these units clear parameters and expert recommendations.

- A follow-up programme has been introduced as an alternative to imprisonment for those convicted of having driven under the influence of alcohol or drugs
- Children as family members have been given greater rights and stronger focus. New health legislation has given health professionals a duty to help to safeguard the children of their patients.
- Organizations for users and family members have received increased support, and as of 2012 a total of 499 self-help groups have been mapped in the substance abuse area.
- Research in the field of alcohol and drugs has been strengthened. A separate website and telephone line providing financial advice have been established.

- Food safety

We refer to the previous report. The number of district offices under the auspices of the Norwegian Food Safety Authority has been reduced to 58.

Question 3) - Statistics etc.

- Tobacco

Tobacco smoking is still the main preventable cause of premature death and mortality in Norway. Each year approximately 5 100 deaths are caused by smoking (13 per cent of all deaths).

In 2011, approximately 17 per cent of the population (aged 16-74 years) were daily smokers, down from 24 per cent in 2006. In addition, approximately 11 per cent were occasional smokers. The differences in smoking habits between the sexes are minor or non-existent. Among young people (aged 16-24) the proportion of daily smokers was 11 per cent, down from 20 per cent in 2006. In addition, roughly 14 per cent were occasional smokers. 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. In 2011, about 7 per cent of pregnant women smoked in the last trimester.

Approximately 8 per cent of the population are daily snus users. Among young males (aged 16-24 years), approximately 25 per cent used snus daily in 2011, in addition 16 per cent used snus occasionally. Among young women 11 per cent used snus daily and 11 per cent occasionally. The use of snus among young people has increased significantly during the last decade. Prior to the year 2000, only 5 per cent of young males used snus daily and hardly any women.

- Alcohol consumption

Year Type of beverage	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total	5.66	5.49	5.89	6.03	6.22	6.37	6.46	6.60	6.75	6.68	6.66	6.62
Spirits	1.05	1.0	1.12	1.22	1.25	1.28	1.30	1.35	1.33	1.31	1.26	1.26
Wine	1.62	1.60	1.81	1.84	1.90	2.00	2.05	2.11	2.23	2.28	2.32	2.39
Beer	2.93	2.82	2.89	2.76	2.96	2.98	3.01	3.02	3.06	2.96	2.94	2.83

Fruit drink*	0.07	0.07	0.07	0.22	0.11	0.11	0.11	0.12	0.13	0.13	0.14	0.14

Description: Annual sales of alcohol in Norway per inhabitant aged 15 years and over, as a total of litres of pure alcohol.
*Includes alcopops
Source: Statistics Norway

Development in the use of alcohol: Alcohol is the intoxicant that causes most health and social problems. According to WHO, alcohol is the second most important factor in illness and premature death in industrialized countries.

There are roughly between 80 000 and 120 000 persons with heavy alcohol consumption in Norway, but it is the large group with a moderate alcohol consumption that suffer most harm and illness. There is a clear, documented correlation between total consumption of alcohol and acute injuries, accidents, chronic ailments, addiction and social problems. Harm and problems that the drinker inflicts on others – so-called passive drinking – constitute a considerable part of alcohol-related harm.

Alcohol consumption in Norway has been on the increase for a long period of time. In 2011 the registered consumption of alcohol was 6.6 litres pure alcohol per person over 15 years of age. According to questionnaires, consumption among young people increased up to the Millenium but has declined somewhat since then. The rise in alcohol consumption among adults remains a challenge.

There are fewer and fewer people who do not consume alcohol, and just over 80 per cent of young people between the ages of 15 and 20 have drunk alcohol. Alcohol consumption in Norway is still low in the European context. In recent years several European countries have adopted regulatory provisions that have already been put into effect in Norway. While alcohol consumption in Norway is rising, the trend is the opposite in a number of European countries.

- Drug consumption

The development in the use of illegal drugs: The use of illegal drugs increased in the 1990s, reaching a peak around the Millenium, but has declined since that time and appears to have stabilized. Cannabis remains the most commonly used illegal substance, followed by amphetamines. In 2010 a total of 29 per cent (18–30-year-olds) stated that they had tried cannabis several times, while approximately 6 per cent in the age group 15–34 years state that they have used amphetamines several times. Inhalants (glue and solvents) are used more than amphetamines, methamphetamine and ecstasy. Amphetamines, cocaine, heroin and other opioids are the narcotic substances that give rise to the greatest problems and harm. The number of injection drug users is assumed to have remained fairly stable since 2003, and in 2009 there was estimated to be between 8 800 and 12 000 injection drug users. Among these, addictive medications are very widespread: more than three out of four heroin users and just over half of amphetamine users report such use.

- Drug- related deaths

Drug use in Norway is relatively low in the European context but the number of drug-related deaths (deaths by overdose) remains high. In 2009 a total of 285 drug-related deaths were registered. Norway has a low incidence of HIV among injection drug users, while at the same time there is a relatively high proportion who are carriers of hepatitis C.

Further questions from ECSR

- *Air, water and noise pollution: The Committee asks the next report to provide updated information on any new measures taken in these fields as well as progress made in reducing pollution.*

Air pollution
Norway has national goals for the volume of harmful gases we can emit to the air, in addition to the national goals and legally binding threshold limit values for concentrations of permitted air pollution that are set forth in the legislation on pollution.

The deposition of pollutant gases such as sulphur dioxide (SO2), nitrogen oxide (NOx), volatile organic compounds (VOC), ammonia or particles is largest from other countries in Europe. To reduce long-range air pollution that can damage both health and the environment, Norway participates in international work. The goal is that health and the environment shall not be damaged by air pollution from sulphur dioxide (SO2), nitrogen oxide (NOx), volatile organic compounds (VOC), ammonia or particles. Examples of the regulation of emissions from long-range air pollution are the 1999 Gothenburg Protocol to Abate Acidification, Eutrophication and the Ground-level Ozone and Directive 2001/80/EC of the European Parliament and of the Council of 23 October 2001 on the limitation of emissions of certain pollutants into the air from large combustion plants. In addition, upper limits for the emission of such substances are stipulated in the Directive 2001/81/EC of the European Parliament and of the Council of 23 October 2001 on national emission ceilings for certain atmospheric pollutants.

In addition to international activities, Norway imposes national measures to improve air quality and to reduce health and environmental dangers linked to air pollution.

In respect of local air pollution, Norway's goal is to limit the concentration of suspended dust particles. The daily mean concentration of fine particulate matter shall not exceed 50 µg/m3 on more than seven days per year, and measurements show a general decline in the levels of suspended dust particles since 2004. The reason is that emissions caused by road traffic and wood-burning appliances are declining even though there are still pollution problems in the largest towns due to a combination of exhaust, especially from diesel vehicles, and periods of cold, stationary air in addition to wood-burning appliances.

Authorized by legislation on pollution, the municipalities are allowed to initiate a number of measures to improve air quality locally. Examples of such measures are restrictions on the use of studded tyres, speed limits, the improvement of collective transport and maintenance of roads, higher charges during rush hour and increased toll charges. Other measures include the active use of the Planning and Building Act in connection with the localization of enterprises and housing so as to reduce overall transport needs and achieve a transition to environmentally-friendly forms of transport.

Requirements regarding wood-burning stoves in order to achieve a reduction in fine particulate matter have also been introduced to improve air quality locally. To reduce the proportion of older, polluting wood-burning stoves the municipalities have the option of introducing a system of partial rebates to encourage the replacement of old polluting stoves by new stoves with low emissions. Other measures that the municipalities can implement include

the installing of a filtration system in the chimney or converting an old polluting stove by installing a clean burner combustion system.

Water pollution

The Norwegian Regulation on a Framework for Water Management was adopted in 2006 as a follow-up of the EU's framework directive of 2000 for water: Directive 2000/60/EC of the European Parliament and of the Council of 23 October 2000 establishing a framework for Community action in the field of water policy. This affirms that all freshwater, groundwater and coastal water must be managed jointly and that efforts must be made to attain clear environmental goals. Standard environmental goals are to achieve a good ecological and chemical state in water resources in 2015 and 2021 respectively. Most water resources in Norway deviate to only a small extent from their natural condition, i.e. there is no risk that the environmental goal for good ecological status will not be attained. A number of environmental measures are being implemented aimed at protecting or improving the water environment in Norway. Examples are physical measures targeted at reducing the impact of watercourse regulation or other physical encroachments, recreating the natural watercourse, improving habitats for biological diversity, limiting pollution, liming, reducing runoff from agriculture and providing protection through restrictions on land use. Moreover, Norway has set ambitious national goals whereby emissions of environmental toxins on the priority list will be halted by 2020.

Measures to reduce emissions include the strict regulation of products and strict requirements for industrial emissions, waste management and clean-up measures. International efforts are of major importance in reducing emissions, and through the EEA Agreement Norway participates actively in the development of a regulatory framework for chemicals under the auspices of REACH – Registration, Evaluation, Authorization and Restriction of Chemicals, etc. Furthermore, Norway is working for stricter regulation of a number of substances through regional and global conventions. In the case of most environmental toxins on the priority list, emissions have been substantially reduced in Norway but there are still challenges regarding others.

Noise

The main source of noise is road traffic, but noise from planes, railways and industry also contributes. Despite the fact that calculations reveal a decline in noise from railways and aviation from 1999 to 2006, the total noise burden in Norway increased by approximately 3 per cent in this period. The decline in noise from railways is due to quieter-running trains and improvements in the surface smoothness of the rails while in aviation the decline is linked to less noisy plane types and changes in landing and take-off patterns at a number of airports. However, this positive trend does not counteract the increase in traffic in a mobile society. The total noise burden in Norway has been reduced by 1 per cent from 1999 to 2007.

Norway's goal is to reduce the noise burden by 10 per cent by 2020 compared with the 1999 level. The action plan for noise reduction describes a range of measures that are essential to achieving the goal in addition to the measures mentioned above. Many of those who are most exposed to noise have already received façade insulation and acoustic barriers in and near their dwellings, but source-control measures have also been adopted – for example low-noise road surfaces, engines and tyres. In addition, municipalities, regional authorities and involved public agencies must use noise guidelines as a basis for area planning linked to major noise sources in the external environment and land use in areas exposed to noise. The guidelines provide recommended outdoor noise threshold values when establishing new housing and other noise-sensitive buildings. Likewise, recommended outdoor noise levels are given for the

establishment of new sources of noise, for example road construction works, business enterprises and shooting ranges.

- *Ionizing radiation and asbestos – the Committee has asked for updated information on these topics, in particular information on the legal rules on removing asbestos from buildings.*

Ionizing radiation
The Ministry of the Environment is responsible for the legal framework concerning ionizing radiation and its pollution of the environment, i.e. radioactive pollution and radioactive waste. As of 1 January 2011 the scope of the Pollution Control Act was expanded to include radioactive pollution and radioactive waste. A declaration system for radioactive waste has been introduced, and will provide better information on the quantities and types of waste.

The main goal for the Pollution Control Act is to reduce pollution and hazard to the furthest extent possible. Any release of radioactive pollution to water or air requires a licence, and there are strict regulations for the handling and disposal of radioactive waste, as well as rules of declaration. Finally, all licences include requirements for the use of best available technology (BAT).

Possible exposure to radioactive substances is regulated through the HSE regulations, and falls under the field of responsibility of the Ministry for Health and Care Services.

Asbestos
The prohibition on the use of asbestos was earlier authorized by the product regulation of 1 June 2004 no. 922, but is currently authorized by the REACH regulation of 30 May 2008 no. 516. This change was adopted on 17 November 2011. When the REACH regulation was amended, Regulation EC No 552/2009 was implemented, allowing the EEA countries under certain conditions to sell on the market articles in their entirety containing asbestos fibres which were already installed and/or in service before 1 January 2005.

Norway has employed this sanction, and when the aforementioned revision of the product regulations took place, a similar provision was included in the product regulations, section 2-31 *Products containing asbestos – exemptions from the prohibition in entry 6 of Annex XVII to the REACH Regulation.*

We refer to the answer given to ESCR's question under reporting for Article 3.

- *Prophylactic measures – Epidemiological monitoring: The Committee asks the next report to provide updated information.*

Infection control
Protecting the population against communicable diseases and preventing the spread of diseases in the population plays a central role in infection control efforts. Areas of special priority are combating resistance to antibiotics, reducing the incidence of institutionally-acquired infections in the health service, reducing new HIV infections and other sexually-transmitted infections, and ensuring that all those infected are guaranteed good follow-up. Moreover, priority is given to providing a well-functioning vaccination programme and maintaining good preparedness to counteract infectious. These areas are followed up by means of national strategies and preparedness plans etc. and in addition the Communicable

Disease Control Act ensures that the authorities put into effect the measures necessary to prevent the spread of infection and to coordinate their activities while ensuring that the protection accorded by law to the individual is maintained.

The statutory framework for infectious diseases
The combating of infectious diseases is regulated by the Act of 5 August 1994 relating to control of communicable diseases (Communicable Disease Control Act). Protection against infectious diseases that can be a burden on society and a threat to public health requires a diversity of precautions and measures. The legislation on communicable diseases states that these diseases demand a special duty of care from the public authorities. A special duty of care means that measures must often be implemented, partly to prevent the spread of infectious diseases and partly to counteract their transmission among the population. Such measures are often unique and demand special efforts on the part of the public authorities. Therefore in Norwegian legislation the decision has been made to authorize this through special legislation rather than general health legislation. The Communicable Disease Control Act, together with a number of regulations authorized by the Act, constitutes the statutory framework for combating communicable diseases.

The Act is a general Act in that it applies to all infectious diseases and includes measures directed at the individual as well as systems. This provides greater flexibility and easier adaptation to the existing epidemiological situation and development, while at the same time avoiding the stigmatization of a particular disease or group of diseases. In addition, the Act is an enabling statute in that it sanctions the implementation of preventive measures and the provision of regulations on preventive measures that are to be further specified. This means that the legislation is of a dynamic nature.

The Act shall help to protect the population against communicable diseases by:
- preventing them
- counteracting their transmission among the population
- counteracting the transmission of communicable diseases into or out of Norway.

The Act shall safeguard the protection accorded by law to any individual affected by preventive measures in accordance with the Act, and consists of four main pillars in this respect:
- Voluntary compliance – must always be tried first
- Necessity
- Clear medical justification
- Proportionality between the means and the goal

The Communicable Disease Control Act bestows duties and rights in connection with preventive work on all involved parties: individuals covered by the Act, health professionals, municipalities, the specialist health service and the central health authorities. The responsibility assigned to the various parties must safeguard the objectives of the Act, i.e. ensure that preventive measures are implemented and counteract the transmission of communicable diseases in the population.

Special measures to combat communicable diseases

<u>Acceptance and coping – National HIV strategy (2009–2014)</u>
The strategy plan has two general objectives:

1) New infection with HIV shall be reduced – especially in groups with high vulnerability to HIV.
2) Everyone living with HIV shall be ensured good treatment and follow-up regardless of age, gender, sexual orientation and/or practice, domicile, ethnic background and personal finances.

Taken together, this amounts to a framework that gives direction and creates the foundation for follow-up in the form of knowledge-based, effective measures.

The strategy document is available in English at:
http://www.regjeringen.no/upload/HOD/Dokumenter%20FHA/Acceptance%20and%20coping-National%20HIV%20strategy.pdf

National strategy for prevention of infections in the health service and antibiotic resistance (2008–2012) in Norway
National goals for the period 2008–2012 are:
1. The incidence of antibiotic resistance in Norway shall not increase.
2. The incidence of infections acquired in the health service in Norway shall be reduced.
3. Knowledge about incidence, cause and effect correlation and the impact of measures to counteract infections in the health service and antibiotic resistance shall be improved.

The strategy document is available in English at:
http://www.regjeringen.no/nb/dep/hod/tema/folkehelse/national-strategy-for-prevention-of-infe.html?id=528882

Influenza pandemic preparedness plan
The last official version of the National Influenza Pandemic Preparedness Plan (Version 3.0) was adopted on 16 February 2006. A new version of the plan was in preparation when the influenza pandemic hit in 2009. The completion of the revised plan has been delayed pending various assessments of the response to the pandemic. In parallel with the preparation of a Report to the Storting on the pandemic response that will be completed around the turn of the year 2012/2013, work is underway to complete a new version of the pandemic preparedness plan. This will incorporate lessons learned from the pandemic in 2009/2010 and new knowledge that has been brought to light since the 2006 plan.

- *The Committee asks for information on any measures taken to reduce or prevent accidents, in particular domestic accidents, such as information campaigns etc.*

Approximately 1 800 persons in Norway die each year as a result of an accident. Accidents are the largest cause of death for persons under the age of 45. Figures from the NPR reveal that in 2011 there were over 90 000 overnight stays at Norwegian hospitals where the primary reason for admission was injury and poisoning. During the years leading up to 2014 the Government will make efforts to quantify national goals to reduce accidents involving bodily injury and to improve cross-sector initiatives to prevent injuries and accidents, cf. Accidents in Norway – National Strategy for Prevention of Accidents Leading to Injury 2009–2014.

The follow-up of the national strategy for the prevention of accidents is organized through an inter-ministry steering group chaired by the Ministry of Health and Care Services. Accountable to the steering group is a working group at the directorate level chaired by the

Directorate of Health, which will propose measures and coordinate the ongoing implementation of the strategy.

The NPR has the objective of providing data as a basis for the prevention of injuries and accidents, and hospitals and a number of Accident and Emergency units (Oslo, Bergen and Trondheim) are obliged to report data giving more information about the circumstances leading to injuries and accidents. The reporting is inadequate and efforts are being made to ensure that more hospitals report to NPR so as to acquire a better overview of the challenges in connection with accidents.

During the years leading up to 2014 emphasis will be placed on acquiring a satisfactory status report on the number of personal injuries in Norway. A report is under preparation that will provide an overview of injuries and accidents in all sectors. The Norwegian Institute of Public Health has been commissioned to coordinate the report. The report, which will be published regularly, will be available for the first time in 2013 and will form the basis for initiating preventive measures.

Uniform guidance material as well as training material for preventive measures locally is also being prepared, including a local register of injuries that is expected to be completed in 2012-2013. In 2013 accident preventive measures targeted towards the elderly as well as children and young people will be prioritized – and accidents in the home will be a key priority. Measures in this connection have not yet been specified.

Measures in Norway to reduce or prevent road accidents
In the period in question Norway has implemented a number of road safety measures and campaigns to reduce the number of road traffic accidents. The work is based on Vision Zero – a vision of zero fatalities and severe injuries in road traffic. A national plan for road traffic safety for the period 2010-2013 has been compiled. The plan is a collaboration between the Norwegian Public Roads Administration, the police, the Directorate of Health, the Directorate for Education and Training and the Norwegian Council for Road Safety, and contains an overall presentation of how the various national actors shall participate in traffic safety work. A total of 152 traffic safety measures targeting road users, roads and vehicles are proposed. The English version can be viewed at
http://www.vegvesen.no/_attachment/130037/binary/370917

Road user measures
Key policy instruments aimed at road users consist of training and information, preferably combined with monitoring activities to strengthen the impact. Several measures addressing driver training and road traffic knowledge have been implemented. In addition, special measures have been targeted towards young people and information campaigns such as “Hvilken side av fartsgrensen er du på?” (What side of the speed limit are you on?), “Husk bilbelte” (Don’t forget your seatbelt) and “Si ifra” (Speak up) have taken place. The Norwegian Public Roads Administration (NPRA) has also recently concluded a four-year research project on high-risk groups in road traffic with a special focus on young drivers, motor cyclists, elderly drivers and some immigrant groups. The project will provide an improved knowledge base for preparing measures directed at these groups.

Road measures
Investments have been made in the systematic improvement of high-risk road sections. In addition come new roads of a higher standard and better land use and transport planning. The

use of speed cameras is another important tool that has been taken into use (Automatic Speed Control (ASC) and Automatic Section Speed Control (ASSC)).

Measures to enhance vehicle safety
Focus has been directed at various measures to enhance the safety of the national fleet of vehicles. Efforts are being made to ensure increased use of intelligent transport systems (ITS), including alcohol interlocks and Intelligent Speed Adaptation (ISA). The NPRA has installed alcohol interlocks in all the agency's vehicles and is in the process of installing ISA in all the new vehicles it acquires.

Accident investigation
The NPRA investigates all fatal accidents in road traffic using regional accident analysis groups. Information from this work has provided key knowledge and data on what factors contribute to serious accidents. Lessons learned can be employed in traffic safety efforts locally and centrally, and in planning both short-term and long-term measures. The accident analysis groups that have been in operation since 2005 put forward recommendations on measures targeted at road users, vehicles, roads and organizational changes.

Updated statistics for the period 1 January 2008 to 31 December 2011

Oppdatert statistikk for perioden 01.01.2008 - 31.12.2011

All traffic groups	2008	2009	2010	2011
Killed and injured, total	10571	9319	8840	8051
Killed, total	255	212	208	168
Injured, total	10316	9107	8632	7883
Severely injured	908	796	719	680
Lightly injured	9408	8311	7913	7203
Unknown injury	459	603	298	325
Car/van, Drivers and passengers				
Killed and injured, total	7303	6590	6296	5655
Killed, total	157	132	136	105
Injured, total	7146	6418	6160	5590
Severely injured	503	462	460	386
Lightly injured	6643	5956	5700	5164
Unknown injury	403	491	257	256

Bus, Drivers and passengers

Killed and injured, total	218	163	158	141
Killed, total	1	1	4	5
Injured, total	212	162	154	136
Severely injured	11	8	6	14
Lightly injured	201	154	148	122
Unknown injury	6	5	4	36

Lorry/Truck, Drivers and passengers

Killed and injured, total	201	166	164	135
Killed, total	9	9	8	8
Injured, total	192	157	156	127
Severely injured	22	17	10	11
Lightly injured	170	140	146	116
Unknown injury	12	15	11	5

Motor cycle, Drivers and passenger

Killed and injured, total	658	549	532	492
Killed, total	32	27	26	13
Injured, total	626	522	506	479
Severely injured	115	112	81	72
Lightly injured	511	410	425	407
Unknown injury	19	24	8	7

Moped, Drivers and passengers

Killed and injured, total	495	471	352	340
Killed, total	5	2	0	4
Injured, total	490	469	352	336
Severely injured	42	35	17	22
Lightly injured	448	434	335	314
Unknown injury	8	16	3	5

Bicycle	2008	2009	2010	2011
Killed and injured, total	690	630	566	545
Killed, total	11	9	5	10
Injured, total	679	621	561	535
Severely injured	69	66	55	56
Lightly injured	610	555	506	479
Unknown injury	1	25	3	3

Pedistrian				
Killed and injured, total	874	679	642	638
Killed, total	32	24	24	18
Injured, total	842	655	618	620
Severely injured	124	84	67	97
Lightly injured	718	571	551	523
Unknown injury	2	23	10	6

Others				
Killed and injured, total	137	111	130	105
Killed, total	8	8	5	5
Injured, total	129	103	125	100
Severely injured	22	12	23	22
Lightly injured	107	91	102	78
Unknown injury	8	4	2	7

Kilde: Statens vegvesen

Article 12: The right to social security

Reference is made to previous reports.

No decisions have been made by courts concerning the application of this Article of the revised Charter.

Article 12 Para 1

The Norwegian National Insurance Scheme is a comprehensive system which in practice covers all persons who are residing or employed in Norway, i.e. for any practical purposes 100 per cent of the population. Exemptions are limited to such categories of persons as for example foreign diplomats stationed in Norway, or workers posted in Norway who remain insured in their home country according to provisions of a bi- or multilateral social security coordination instrument in force between Norway and the country in question. On the other hand, as a certain number of persons residing abroad will have a similar affiliation to the Norwegian National Insurance Scheme, 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 groups 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 as set out in the European Code of Social Security. Reference is made to the survey "The Norwegian Social Insurance Scheme", updated as of 1 January 2012, 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.

The survey is available on the Internet:

http://www.regjeringen.no/en/dep/ad/doc/veiledninger_brosjyrer.html?id=2122

Reference is also made to what is said under Article 12 paragraph 2 below.

Work assessment allowance replaces medical and vocational rehabilitation benefits

As of 1 March 2010 rehabilitation allowance, benefits during vocational rehabilitation and the time-limited disability benefit were replaced by a new, temporary benefit called the work assessment allowance. Rehabilitation allowance was granted during medical rehabilitation, benefits during vocational rehabilitation for work-related issues, and the time-limited disability benefit for permanent illness, active treatment and rehabilitation, where it was likely that earning ability can be improved. Even though the benefits varied somewhat, all three were intended to safeguard against temporary loss of income due to health problems. To ensure speedier and closer follow-up of the individual with the result that more people would be able to return to work or work-related activities at an earlier stage, the three benefits were replaced by the work assessment allowance.

The work assessment allowance is granted to persons insured under the National Insurance Scheme between the age of 18 and 67 whose working capacity is reduced by at least 50 per cent due to illness, injury or defect. It shall cover living expenses and is normally granted when the person in question is undergoing active treatment or vocational measures. It is also granted when he/she has tried such measures and it is still deemed probable that he/she can gain employment and is being followed up by NAV in order to be enabled to acquire or keep suitable employment.

Insured persons may be entitled to Work Assessment Allowance if they reside in Norway and have been insured for at least three years immediately prior to claiming the allowance. An insurance period of one year is sufficient, if the claimant has been physically and mentally capable of carrying out ordinary, paid work during that year.

The work assessment allowance is calculated on the basis of the pensionable income of the year before the working capacity was reduced by at least 50 per cent. The allowance shall, however, be calculated on the basis of the average pensionable income of the last three calendar years prior to the contingency, if this results in a higher basis. The maximum benefit basis is 6 B.a (basic amount) (NOK 475 296 as of 31 December 2011). The benefit rate per year is 66 per cent of the calculation basis, and is paid for five days a week. Insured persons who had low, or no, pensionable income before their working capacity was reduced by at least 50 per cent are guaranteed a minimum yearly benefit of 2 B.a. (NOK 158 432 as of 31 December 2011). For persons born disabled or having become disabled before reaching the age of 26, the minimum allowance is 2.44 B.a. (NOK 193 287). In addition, a child

supplement of NOK 27 is granted for each dependent child under the age of 18. The supplement is paid for five days a week.

Supplementary allowances are granted to insured persons between the ages of 16 and 67. These allowances shall fully or partially compensate for expenses which they have incurred while undergoing vocational measures.

Closer follow-up in the case of sickness
Sickness absence in Norway is high compared with other countries. The employer and the employee are the most important actors when it comes to return to work in the event of sickness absence. The employer is required to adapt work activities in cases of sickness and the employee is required to contribute to this process. Moreover the person reporting the illness (the doctor) plays a major role. The rules on requirements for follow-up of those on sick leave were therefore amended as of 1 July 2011. The amendments entail a speedier and closer follow-up with clarification of the responsibilities and duties of the various actors in the case of sickness absence.

Further question from the ECSR:

- *Risks covered, financing of benefits and personal coverage*

The Committee asks for figures in percentage indicating the personal coverage of each branch of social security.

The nine branches of social security set out in the European Code of Social Security are:

- Medical care
- Sickness benefit
- Unemployment benefit
- Old-age benefit
- Employment injury benefit
- Family benefit
- Invalidity benefit
- Survivors' benefit

Norway does not have a register of persons covered by the mandatory and universal social insurance scheme. We are thus unable to provide the Committee with the exact number of persons covered by the different branches. We would, however, like to present the following detailed information:

As stated above, the entire population are mandatory members of the national insurance scheme, with the only exceptions being diplomatic personnel and other posted workers, their non-active family members etc.

- Medical care covers all members of the National Insurance Scheme, i.e. the entire population (100 per cent).

- Sickness benefit covers the entire occupationally active population, i.e. 100 per cent of the intended target group. The occupationally active population is 2.6 million people, 52 per cent of the total population of 5 million.

- Unemployment benefit covers all employed persons (excluding self-employed persons), which numbers 2.5 million people, or 50 per cent of the total population.

- Employment injury benefit covers all employed persons (excluding self-employed persons), which numbers 2.5 million people, or 50 per cent of the total population. Self-employed persons are not covered by the mandatory employment injury benefit, but may apply for voluntary coverage. In addition to this, certain other groups are mandatorily covered, such as pupils, students and conscripts.

- Invalidity benefit covers the entire population, within prescribed age limits, i.e. 100 per cent of the target group. (Persons above the prescribed age limit will normally qualify for old-age pension and/or benefits from the supplementary allowance scheme, cf. information provided under Article 23.)

- Old-age benefit, family benefit and survivors' benefit cover the entire population, i.e. 100 per cent.

General question from the ECSR – Question 14:

In general question 14, the Committee asks for information on the coverage of self-employed persons with regard to all social security schemes under Article 12 Para 1.

As shown above, self-employed persons are mandatorily covered with regard to all the branches of social security as set out in the Code, with the exception of unemployment benefit and employment injury benefit. Self-employed persons may, however, apply for voluntary employment injury coverage.

It must, however, be pointed out that self-employed persons pay a lower contribution to the National Insurance Scheme than the total contributions paid for employees. Self-employed persons pay only 11 per cent of the pensionable income, while the total contribution for employees equals 21.9 per cent of the pensionable income (7.8 per cent paid by the employee and 14.1 per cent paid by the employer).

As regards the Committee's observation that self-employment is becoming a more widespread form of economic activity, we would like to point out that this is not the case in Norway. The number of self-employed persons has been steadily decreasing, from 290 000 in 1970 to 162 000 in 2010.

- *The Committee asks the next report to indicate the number of cases of suspension of benefits and their duration over a 12 months period.*

In 2010 a total of 32 job seekers had their unemployment benefits suspended in the first three months of the period of unemployment because they refused to accept employment offered or to work in another part of the country or to take part-time work. In three of these cases unemployment benefits were suspended for twelve weeks and in the remaining cases they were suspended for eight weeks.

- *The Committee asks whether the decision to suspend unemployment benefits may be appealed. In the affirmative, the report should contain information on any relevant case law.*

The decision on temporary suspension of unemployment benefits when unemployed can be appealed to NAV Complaints and Appeals which will review all aspects of the case. NAV Complaints and Appeals will assess the viewpoints of the appellant and can also of its own initiative examine circumstances that are not mentioned in the complaint. Decisions made by NAV Complaints and Appeals can be appealed to the National Insurance Court, an independent appeals body that hears appeals against NAV's decisions on the rights and duties of the individual pursuant to the National Insurance Act. The National Insurance Court has a duty to examine the case and to ensure that all aspects of the case are adequately elucidated. The decisions of the National Insurance Court can be appealed to the Court of Appeal.

In 2010 the National Insurance Court examined two decisions of temporary suspension of unemployment benefits during a period of unemployment because the recipient had refused to take the employment offered, to work in another part of the country or to take part-time work. In one case the decision of temporary suspension of unemployment benefits was upheld. In the other the decision was set aside because of insufficient evidence that the benefit recipient had been assigned the employment in question.

Article 12 Para 2

A. – B. 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 2011. The latest *general* report on the application of the Code and its Protocol covers the period up to 30 June 2012. The latest report on the non-accepted part covers the period from 1 July 2010 to 30 June 2012.

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 abovementioned survey "The Norwegian Social Insurance Scheme", which i.a. gives relevant information as to the level and the qualifying conditions of the different benefits.

Article 12 Para 3

A. – B. Reference is made to previous reports, the information given under paragraph 2 and the abovementioned survey, in addition to the following remarks:

The Basic Amount
The basic amount, which is fundamental to the majority of long-term benefits in the social security system and which also is of importance for determining the level of several other benefits, was increased from NOK 66 812 to NOK 70 256 with effect from 1 May 2008. With effect from 1 May 2009 it was further increased to NOK 72 881, and with effect from 1 May 2010 to NOK 75 641. The basic amount was finally increased to NOK 79 216 with effect from 1 May 2011.

The increase in the average (calendar year) basic amount from 2008 to 2011 was thus 4.3 per cent per year, well above the inflation rate.

The average inflation rate (consumer prices) from 2008 to 2011 was 2.4 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:

- *Mandatory occupational pension schemes: the Committee asks the next report to provide information in this regard, including details concerning the minimum level of such pensions.*

The Act relating to mandatory occupational pensions entered into force on 1 January 2006. The Act means that most employers must have an occupational pension scheme for their employees. Employers who already have an occupational pension scheme must ensure that the scheme satisfies the Act's minimum requirements. The Act does not apply to employers who have a pension scheme in accordance with legislation or collective agreements that apply to state or local authority employees.

Employers must either have a defined contribution or a defined benefit pension scheme. Defined benefit schemes provide pre-defined benefits, usually a certain percentage of the members' salary on retirement. In defined contribution schemes, employers pay a pre-defined annual contribution. Defined contribution schemes are offered by banks, life insurance companies, pension funds and companies that manage securities funds. Defined benefit schemes are offered by life insurance companies and pension funds.

Employers will pay contributions into the scheme every year, so that employees earn pension entitlements. The contribution must be at least 2 per cent of the employees' earnings between 1 G and 12 G (G = the National Insurance basic amount) in a defined contribution scheme. A corresponding requirement applies to defined benefit schemes. In addition to the contribution, the pension scheme shall also contain an insurance element that ensures that employees continue to earn pension entitlements in the event of disability. It is permitted to exclude employees under the age of 20 and those in part-time employment of less than 20 per cent of a full-time position from the pension scheme. Employees may be required to also contribute to their own pensions, but such contributions will not reduce the minimum requirement for employers' contributions. Employers are also obliged to cover the costs of administering the pension scheme.

The main rule is that pensions shall be paid for at least ten years from the age of 67 years. The size of the annual pension will depend on several factors. In contribution schemes, pension payments will depend on the size of the contribution, the number of years contributions have been paid, the return on the pension assets and the length of the period during which a pension is paid. In defined benefit schemes, the pension will normally be stipulated as a certain percentage of the employee's salary on retirement. The size of the annual pension will therefore depend on how many years the employee has worked and his/her salary on retirement.

In the case of defined contribution schemes pursuant to the Act on defined contribution occupational pension, it is estimated that the minimum statutory requirement will give an annual pension of approximately NOK 19 500 for 10 years for a wage-earner with a salary of NOK 235 000 on reaching pension age (8.3 per cent of salary). A wage earner with a salary of NOK 350 000 on reaching pension age will receive an annual pension of NOK 32 500 (9.3 per cent of salary). For those with a salary of NOK 470 000 the annual pension will total approximately NOK 45 500 (9.7 per cent of salary).

These figures apply to defined contribution schemes but also indicate the minimum requirements for defined benefit occupational pension pursuant to the Act on defined benefit occupational pension. However, in this case the degree of compensation (pension as a percentage of salary) will increase somewhat when salary increases compared with defined contribution schemes.

There is uncertainty linked to the final amount of pension benefits in both these schemes. The calculations given above, obtained from the Banking Law Commission and reported in Norwegian Official Report: 15 Annex 1 (NOU 2005: 15 vedlegg 1), is based on a number of preconditions including qualifying period in the pension scheme (40 years) wage growth throughout working career (real wage growth of 2 per cent per annum) and yield on pension capital (annual real return of 2.5 per cent).

By the Act of 5 June 2009 no. 32 to amend the National Insurance Act (new old-age pension), new rules were adopted for earning and calculation of old-age pension in the national insurance system based on wholly different principles than previously. New rules on flexible drawdown of old-age pension were also adopted. Currently there is underway work on evaluating and making adjustments to the pension acts to match changes in the National Insurance Act. The first part of this work is apparent from The Banking Law Commission's Report no. 23, NOU 2010: 6 the Pension Acts and National Insurance Reform I. In the report the Banking Law Commission proposed amendments to the pension acts involving necessary adaptations of the acts for entry into force of the rules on a new old-age pension in the National Insurance Act of 1 January 2011. This involves inter alia an opening for flexible withdrawal from the old-age pension from the age of 62. In addition, draft amendments to the Defined-Contribution Pensions Act, the Act on Individual Pension Schemes and the Act on Mandatory Occupational Pension have been prepared, so that these are adapted to the other main principles of the new old-age pension in the national insurance system. For defined-benefit company pension a transitional arrangement was established that means an adaptation to a flexible drawdown of old-age pension, but that the limitation rules at the time were otherwise continued. The Banking Law Commission found that the transition scheme should apply until a review and clarification had been made of how insurance-based service-pension schemes in the private sector should be adapted to the new national insurance future. The set-up that the Banking Law Commission proposed in this report and the proposals for legislative amendments were followed up by the Ministry of Finance and the Storting and Amending Act no. 83 of 17 December 2010 entered into force on 1 January 2011.

The Banking Law Commission's Report no. 26, the Pension Acts and National Insurance Reform II contain a draft for a new act on collective service-pension insurance. A bill based on this report is currently under preparation by the Ministry of Finance.

As Phase III of the work on adaptation of the pension acts to the national insurance reform The Banking Law Commission is currently preparing a report that will look at the questions

related to the connection of existing pension schemes and new service-pension schemes and what transitional rules and transitional periods that are necessary before a final adaptation to the new national insurance system is in place. It will also be looked at what ought to be done with the existing company pensions acts plus amendments to other acts.

- *The AFP scheme*

The Committee makes a reference to the collectively bargained early retirement scheme (AFP), which exists outside the scope of the National Insurance Scheme.

We would like to make the following comment in this respect:
Before 1 January 2011, the AFP scheme in the *private sector* was a time limited early retirement scheme for persons between the ages of 62 and 67 (which was the pensionable age in the National Insurance Scheme). The AFP scheme was, however, reformed with effect from 1 January 2011, and adapted to the new, flexible old-age pension of the National Insurance Scheme, which may be drawn from the age of 62. The AFP scheme is now designed as a neutral supplement to the old-age pension of the National Insurance Scheme, to be granted throughout the pensioner's life. The annual AFP amount increases the longer pension drawing is deferred. The new APF scheme has been designed in close cooperation with the social partners.

The AFP scheme in the *public sector* remains a time limited early retirement scheme for persons between the ages of 62 and 67.

- *The Industrial Injury Insurance Act*

The Committee asks whether the new Industrial Injury Insurance Act has been adopted.

The Act has not yet been adopted. However, the Ministry of Labour intends to forward a parliamentary bill on this topic in 2013.

- *The Pension Reform*

The Committee requests information concerning the changes which have entered into force as a result of the reform and a description of the initial impact of these changes.

By an act of 5 June 2009, a new Chapter 20 was introduced in the National Insurance Act. This Chapter contains the provisions concerning the new, general old-age pension system.

The main features of the new pension system are:

- Pensions may be drawn from the age of 62.

- The system of pension earning in the new old-age pension scheme is designed in such a way that pension capital is accumulated through income from work or through other types of pension earning, between the ages of 13 and 75.

- The individuals will each year increase their pension capital with an amount corresponding to 18.1 per cent of their pensionable income, up to a ceiling of 7.1 times

the basic amount. (The basic amount was at the end of the reporting period NOK 79 216.)

- The pension capital may also be increased as a result of e.g. unpaid care, service as a conscript or receipt of unemployment benefits.

- The pension capital is adjusted annually in line with the growth in wages.

- The level of the annual pension is found by dividing the pension capital by the life expectancy based annuity divisor, which mainly reflects the expected number of years as a pensioner. As a result, the annual pension will increase the longer one defers the drawing of pensions.

- The life expectancy based annuity divisor will be determined when the cohort attains the age of 61, based on observed mortality rates for previous cohorts over the span of a decade. After the figures have been determined, they will not be adjusted.

- If life expectancy of the population increases, a person will have to remain occupationally active slightly longer in order to have the same compensation rate as previous cohorts.

The new provisions on old-age pension from the National Insurance Scheme will apply to persons born in 1963 or later, while persons born from 1954 to 1962 will be granted pensions with proportional parts from the current scheme and the new scheme. This means that persons born before 1954 will earn their pensions solely according to the old provisions.

The flexible pension drawing from the age of 62 was introduced with effect from 1 January 2011. The first cohorts that have the opportunity of drawing a flexible old-age pension from the National Insurance Scheme will have their entire pension earning under the old scheme. The first pensioners with part of their pensions earned under the new scheme will begin drawing their pensions in 2016. This will be the 1954 cohort, drawing 1/10 of their pensions from the new scheme.

For this reason, descriptions of the impact of the reform can at the earliest be presented in Norway’s next report.

Article 12 Para 4

A. Reference is made to previous reports as regards states with which Norway has a bilateral social security agreement. All agreements entail provisions on equal treatment of nationals and aggregation (accumulation) of insurance periods with the aim of establishing pension rights.

During the report period, Norway has signed a bilateral social security agreement with India. The agreement has not yet entered into force.

After the report period, Norway has signed a revised bilateral social security agreement with Canada. The agreement has not yet entered into force.

Negotiations with the Republic of Korea started in 2009.

Negotiations regarding a bilateral agreement are also under way with Morocco.

The EEA Agreement now comprises 30 European states – the 27 EU states, as well as the following three EFTA states: Iceland, Lichtenstein and Norway. Furthermore, as a result of the Vaduz Convention and the Nordic Convention on Social Security, the provisions of the relevant EU regulations on social security coordination also apply between Norway and Switzerland, and between Norway, Greenland and the Faroe Islands.

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

Further question from the ECSR:

The Committee asks whether the Norwegian Government plans to conclude bilateral social security agreements with Albania, Andorra, Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Georgia, "the former Yugoslav Republic of Macedonia", Moldova or Ukraine.

Norway has entered into treaty succession agreements with both Croatia and Bosnia and Herzegovina, which means that the bilateral social security agreement of 1974 between Norway and the Socialist Federal Republic of Yugoslavia still applies between Norway and these two states.

Norway is not currently planning to initiate negotiations with the remaining eight states, nor have these states approached Norway with requests for such negotiations.

Further question from the ECSR:

The Committee furthermore asks whether the Norwegian Government there is any bilateral social security agreements concerning family benefits with Albania, Armenia, Georgia and Turkey.

Norway has at present no bilateral agreement which allows for the exportation of family benefits outside of the EEA.

B. Equality of treatment is provided throughout Norwegian social security legislation, with a few exceptions mainly concerning foreign citizen seafarers not residing in Norway or comprised by the EEA Agreement, the Vaduz Convention or the Nordic Convention. (Seafarers not subject to the National Insurance Act are covered by the Seafarers Act of 30 May 1975.)

Please observe, as previously underscored, that all insured persons residing in the Norwegian Realm are subject to equality of treatment, regardless of citizenship (nationality) under the social security legislation.

Reference is moreover made to previous reports.

Remark to the conclusion of the ECSR:

The European Committee of Social Rights is of the view that the situation in Norway is *not* in conformity with Article 12 (4) of the Revised Charter, on the grounds that Norwegian legislation does not provide for the accumulation of insurance or employment periods completed by nationals of states which are party to the Revised Charter, but who are not covered by Community regulations or bound by bilateral or multilateral social security co-ordination agreements with Norway.

Reference is made to previous reports, in which it has been stated that it is the opinion of the Norwegian government that the concept of "accumulation of insurance or employment periods" is only relevant in the context of bilateral or multilateral social security co-ordination agreements with other countries. Reference is furthermore made to the memorandum on Article 12 of the European Social Charter and the European Social Charter (Revised), which was drawn up by the Council of Europe's Committee of Experts on Standard-Setting Instruments in the Field of Social Security during their 4th meeting in 2002 (CS-CO (2002) 3 final).

One of the core principles of social security co-ordination is the principle of reciprocity. Therefore, Article 12 (4) of the Revised Charter places an explicit obligation upon the Contracting Parties to work towards the establishment of bilateral or multilateral agreements with the other Contracting Parties, with a view to achieving the goals set out in subparagraphs(a) and (b). The fact that Article 12 (4) of the Revised Charter simply mentions the possibility that these goals might also be achieved through unilateral means does in our opinion not justify the non-reciprocal human rights approach of the European Committee of Social Rights.

We would also like to point out that the wording of Article 12 (4) of the Revised Charter for all intents and purposes is identical to the wording of Article 12 (4) of the original Charter of 1961. Norwegian legislation has at no point in time since the Charter entered into force for Norway, on 26 February 1965, allowed for accumulation of insurance or employment periods for nationals of states not bound by bilateral or multilateral social security co-ordination agreements with Norway. Nevertheless, as far as we have been able to ascertain, this was not regarded as a problem by the European Committee of Social Rights before the late 1990s.

In our view, the inclusion of the words "… subject to the conditions laid down in such agreements …" would seem rather odd, perhaps even nonsensical, if the Contracting Parties had an obligation to allow for accumulation of insurance or employment periods *unilaterally*. Consequently, it is our opinion that it cannot be construed as an infringement of the Revised Charter that no unilateral provisions, providing for the accumulation of insurance or employment periods, are found in Norway's social security legislation.

In light of the European Committee of Social Rights' dynamic interpretation, it might at some point in the future be necessary for Norway to consider the option of denouncing Article 12 (4) of the Revised Charter.

C. The length of the prescribed periods of residence before nationals of Contracting (and Non-Contracting) Parties become eligible for benefits which are granted independently of contributions are the same as for Norwegian nationals. With regard to pension benefits (old age, invalidity and survivors) the required period varies from 3 years (persons residing in Norway or a country with which we have an agreement covering this category of people) to

20 years (persons residing outside Norway or a country with which we have an agreement as mentioned). The prescribed period must have been completed between the year the person concerned becomes 16 years of age and the year in which he or she becomes 66. Reference is moreover made to previous reports and our information survey:

http://www.regjeringen.no/en/dep/ad/doc/veiledninger_brosjyrer.html?id=2122

Article 13: The right to social and medical assistance

Article 13 Para 1

Question 1) – The general legal framework

Reference is made to the general introduction regarding this question in the last report, where among other things it was stated that the legal right to social and medical assistance is based on the Municipal Health Services Act, the Social Services Act and the Patients' Rights Act.

From 1 January 2010 the provisions in the Social Services Act concerning financial benefits were transferred to a new Act on Social Services in the Norwegian Labour and Welfare Administration. More information on this is given below.

From 1 January 2012 the Municipal Health Services Act and the Social Services Act were replaced by the Municipal Health and Care Services Act. This took place after the reference period. Information on the Municipal Health Services Act and the Social Services Act can be found in the previous report. The new Municipal Health and Care Services Act is described below.

From 1 January 2012 the Patients' Rights Act has changed its name to the Patient's and User's Rights Act. Information on this can be found in the previous report. Moreover, a new regulation has clarified the right to health and care services for persons without permanent residence in Norway. This regulation was implemented in June 2011. It clarifies that all children are entitled to necessary health and care services in addition to emergency care, unless consideration for the child requires that help shall not be given.

Specialized Health Services Act
Reference is made to the previous report.

Act on Social Services in the Norwegian Labour and Welfare Administration
Those who reside in Norway are entitled to social services. From 1 January 2010 the regulation of the right to social services was transferred from the Act of 13 December 1999 no. 81 relating to social services etc. to the Act of 18 December 2009 no. 131 relating to Social Services in the Norwegian Labour and Welfare Administration.

The objectives of the Act are, as before, to improve living conditions for disadvantaged persons, to promote financial and social security, including giving individuals opportunities to live and reside independently, and to promote the transition to work, as well as social inclusion and an active and meaningful existence in community with others. The Act shall also help to ensure that vulnerable children and young people and their families are offered uniform and coordinated services. In addition it is intended to promote greater equality of human worth and social status and to prevent social problems.

The transfer to the new Act entails no changes to the rights or obligations of the individual. However, state supervision of the municipal social services was introduced from 1 January 2010. The supervision is carried out as system audits on selected municipalities, and a case is not closed until all the deficiencies revealed have been remedied by the municipality. In addition a provision has been included that establishes by law that all services provided in accordance with the Act must be appropriate.

As before, financial benefits will be allocated in line with the needs of the individual. The support can be the main income or can be paid as a supplement to other income – for example income from work, or from social assistance benefits or the qualification programme benefit.

Since the benefit is calculated according to needs rather than on the basis of accrual or fixed rates, the amounts paid will vary. A single person can receive a small monthly amount as a supplement to other income, or a family may have the benefit as its primary income. The benefit can also be paid as a lump sum grant in special situations such as moving home, upgrading necessary equipment in the home, short-term loss of income and the like. The applicant's income, expenses, assets and debts are taken into consideration when assessing applications and calculating the amount of the benefit or grant. Everyone is to be ensured a modest but acceptable level of subsistence, and special account is taken of the needs of children and young people to participate in activities at school and in their leisure time.

All the facts mentioned above mean that statistics showing the average monthly payment do not give an accurate picture of the benefit recipient's actual financial situation. Surveys indicate that those who receive financial benefits over a long period of time have higher income than that actually indicated by the recommended guidelines, with the addition of housing expenses.

When assessing the benefit recipient's total financial situation, a number of important services must also be taken into consideration, such as the fact that day-care centres, schooling and health and care services are either free of charge or require a small personal contribution.

During the period there has been a reduction in the proportion of recipients whose main income comes from social assistance benefits: in 2008 47.2 per cent of the recipients had social assistance benefits as their main source of income, in 2009 the proportion was 46.6 per cent, in 2010 it was 45.3 per cent, and in 2011 a total of 44.5 per cent of the recipients had social assistance benefits as their main source of income.

The level of financial benefits recommended in the guidelines is adjusted upwards in line with the increase in prices each year during the period. In 2009 all rates were also raised by 5 per cent in addition to the price increase.

Individual qualification programmes with a qualification programme benefit were introduced stepwise in the country's municipalities from 1 November 2007. From 1 January 2010 the scheme was offered in all municipalities in Norway.

All those of working age who have a severely diminished work and earning capacity and who have no or very limited resources for subsistence pursuant to the National Insurance Act or the Labour Market Act have the right to an individual qualification programme. These can be people who have little or no affiliation with working life, who lack basic schooling and

education, who have physical or mental problems or who are struggling with drug or alcohol abuse. They may also have several of these problems. At the same time a prerequisite is that the person can benefit from the programme so that work is assumed to be a realistic goal within a period of up to two years. There is no requirement for the person concerned to be in receipt of or to have received financial benefits. Those who meet the conditions, but who for example are provided for by their spouse/partner, can apply to take part.

Individuals who want to take part in the programme have to undergo a work capacity assessment that establishes whether he or she meets the entrance requirements mentioned above. The programme must encompass work-oriented measures and job-seeking initiatives and can contain other activities that are supportive and that help to prepare the transition to work – such as education, training in motivation and the like. Time may also be allocated to health assistance, rehabilitation, specialized activity etc. The participants are given close and coordinated assistance throughout the programme. Job-seeking will primarily be relevant towards the end of the programme, and participants can submit applications on their own initiative or may be given help and guidance from the office of the Norwegian Labour and Welfare Service (NAV). Clarification as to the type of work that can be relevant for the participant will be a subject of the follow-up throughout the programme. If a participant gets a job before the end of the agreed programme period, the programme is concluded, but if participants do not enter the labour market before the total programme period is over and they still do not have the right to national insurance benefits, they can be given financial benefits (social assistance benefits).

To encourage those who would otherwise be dependent on financial benefits for subsistence to participate in the programme, participants receive a qualification benefit, which for most of them is higher than the social assistance they would have been given. The benefit is similar to a wage, is paid monthly and is liable for tax. On an annual basis it is twice the basic amount of the national insurance, and it is adjusted each year. Participants under the age of 25 are given two-thirds of the benefit.

At the end of 2010 the grant was (per year):

Persons under 25: NOK 100 855
Persons over 25: NOK 151 282
Child supplement: NOK 7 020

If this amount is not sufficient to cover the participant’s subsistence, including his or her obligation to support a child or children, supplementary financial assistance can be given which is allocated according to need.

The qualification programme is a key tool aimed at helping those who do not receive benefits from the national insurance – or whose benefits are extremely limited and who are at risk of entering into a passive situation characterized by problems with living conditions – back into work and activity.

The numbers of participants in individual qualification programmes in the period were as follows:

Number of participants in 2008: approximately 4 100
Number of participants in 2009: approximately 8 500

Number of participants in 2010: approximately 8 800
Number of participants in 2011: approximately 7 800

The objective of the individual qualification programme is to get the participants, who at the outset have significantly reduced work capacity, completely or partially in work. Of those who in the period 2008–2011 attended and completed such programmes under the auspices of the NAV office, 32 per cent went into ordinary work, 6 per cent went on to education initiatives, and 8 per cent went on to other work-oriented measures. The proportion of those who have entered ordinary work or an initiative with work as a goal has increased considerably in recent years.

Regulations relating to social services for persons without a fixed address in Norway
The regulations were adopted on 16 December 2011. They carry forward the provisions in Chapter 1 of the Regulations issued on 4 December 1992 pursuant to the Act of 13 December 1991 no. 81, now repealed.

The only material change is that the new regulations specify that individuals who are victims of human trafficking have the same right to social services as residents of Norway, even though their stay in the country is short term. This is stated in section 1, subsection 4, of the regulations.

New Municipal Health and Care Services Act
The new Municipal Health and Care Services Act entered into force on 1 January 2012. The Act replaces and combines the previous Municipal Health Service Act and the Social Services Act, thus abolishing the statutory distinction between health services and social services. This means that the part of the social services that was regulated in the Social Services Act now forms part of the health and care services. The objective is to help to ensure overall and coordinated services to patients and users. In the new Act, patients' and users' rights pursuant to the current legislation are maintained at the current level, but are collected and regulated in the previous Patients' Rights Act. The title of the latter Act has been changed to the Patient's and User's Rights Act. In general, the prevailing provisions are therefore carried forward.

The objectives of the new Act are in particular:

1. To prevent and treat illness, injury, suffering and reduced functional capacity and to facilitate the mastering of these conditions.
2. To promote social security, to improve living conditions for disadvantaged persons, to contribute to equality of human worth and social status and to prevent social problems.
3. To ensure that each individual has the opportunity to live and reside independently and to achieve an active and meaningful existence in community with others.
4. To secure the quality of the services offered and to provide equal services for everyone.
5. To ensure coordination and that the services provided are available for patients and users and are adjusted to individual needs.
6. To ensure that the services are organized in a manner that guarantees respect for the individual's integrity and dignity.
7. To contribute to a maximum utilization of resources.

Question 2) – Implementation

State supervision of the municipal social services is conducted by the Norwegian Board of Health Supervision and is carried out by the County Governors in collaboration with this Board.

The rights to social services for victims of human trafficking are provided by the municipality in which the victim is resident.

Question 3) – Statistics etc.

In the period 2008-2010 the proportion of people with a three-year equivalent income below 50 per cent of the median average was 4.2 per cent according to the OECD scale, and those with an income below 60 per cent of the median average in the three-year period was 9.3 per cent according to the EU scale. See also the statistics under Article 30.

Recipients of financial benefits and total costs per year:

	Recipients	Costs (NOK millions)
2008	109 349	4 355
2009	117 727	4 462
2010	119 444	4 581
2011	118 009	4 503

Source: Statistics Norway, www.ssb.no

Table: Average amount of benefits per month (NOK) according to family phase and months receiving benefits

Family phase	1 mth	2 mths	3mths	4 mths	5 mths	6 mths
Single men, total	6 083	5 410	5 624	5 928	6 068	6 113
Single men under 20	4 551	4 316	4 372	5 158	5 674	5 534
Single men 20-24	5 050	4 606	4 844	5 217	5 284	5 681
Single men 25-44	6 214	5 858	6 123	6 359	6 449	6 329
Single men 45-66	6 919	5 725	5 889	6 081	6 264	6 402
Single men aged 67 and older	6 870	5 172	4 342	4 940	4 934	4 587
Single women, total	6 256	5 414	5 555	5 749	5 729	5 757
Single women under 20	4 967	4 812	4 951	5 429	6 003	6 167
Single women 20-24	5 358	4 949	5 081	5 508	5 371	5 783
Single women 25-44	6449	5 869	6 276	6 368	6 145	6 402
Single women 45-66	6 831	5 518	5 393	5 435	5 413	4 780
Single women aged 67 and older	6 632	5 060	4 010	3 950	4 938	3 893
Single with children under 18	8 597	7 709	7 550	7 783	7 966	7 757
Single men with children under 18	9 634	7 971	7 569	8 414	7 516	7 960
Single women with children under 18	8 370	7 657	7 546	7 657	8 052	7 725
Couples without children under 18	6 277	6 027	6 581	6 681	6 577	6 775
Couples with children under 18	9 043	8 331	8 404	8 846	9 107	8 530

Family phase	7 mths	8 mths	9 mths	10 mths	11 mths	12 mths
Single men, total	6 339	6 710	7 013	7 161	7 973	8 315
Single men under 20	5 495	6 076	6 192	5 958	7 035	6 790
Single men 20-24	5 820	6 238	6 417	6 674	7 054	7 460
Single men 25-44	6 670	7 033	7 332	7 520	8 170	8 651
Single men 45-66	6 420	6 725	7 136	7 223	8 386	8 319
Single men aged 67 and older	4 190	5 647	6 561	5 128	8 388	6 129
Single women, total	6 184	6 267	6 614	6 953	7 582	7 699
Single women under 20	6 336	6 355	6 952	7 086	7 183	7 182
Single women 20-24	5 953	6 272	6 422	7 140	7 034	7 540
Single women 25-44	6 740	6 869	7 098	6 783	8 131	7 976
Single women 45-66	5 642	5 401	6 220	7 124	7 467	7 802
Single women aged 67and older	4 685	4 467	4 296	5 060	6 066	3 875

Single with children under 18	8 198	8 215	8 342	8 852	9 721	9 928
Single men with children under 18	8 728	7 991	8 647	9 168	9 659	9 651
Single women with children under 18	8 100	8 252	8 288	8 792	9 731	9 981
Couples without children under 18	6 520	7 127	7 236	7 430	7 885	8 822
Couples with children under 18	9 166	10 052	9 805	10 910	11 749	13 000

Source; Statistics Norway, www.ssb.no

Median income per consumption unit. OECD and EU scales. Income after tax 1996–2010.

	OECD scale		EU scale	
	Current NOK	2010 NOK	Current NOK	2010 NOK
2007	218 000	237 000	262 000	285 000
2008	236 000	247 000	283 000	296 000
2009	239 000	245 000	287 000	294 000
2010	247 000	247 000	296 000	296 000
Average for three-year periods				
2007-2009		243 000		292 000
2008-2010		246 000		295 000

Source: Statistics Norway, www.ssb.no

Further questions from ECSR

- *Individual qualification programme: The Committee asks what "severely diminished capacity" means and whether anyone who has exhausted their social security claims and is without resources can apply for this programme.*

See the information given under Question 1 above.

- *The Committee asks what "adequate employment" signifies and whether social assistance is withdrawn as a penalty for having refused a job offer.*

Reference is made to the description of the individual qualification programme given above under Question 1. The requirement stating that those who receive financial benefits must apply for and accept suitable work results from the fact that the benefits are subsidiary. Everyone must primarily attempt to provide for themselves and everyone is entitled to benefits when they are unable to do so. The work must be of a character that matches the competencies of the individual and that he or she can manage in his/her life situation. It can be part-time or full-time work. The benefits recipient is not required to move. If he or she refuses to accept the offer of work, an assessment will be made as whether the benefits are to be stopped or reduced for a short period. In such situations emphasis will be placed on the reason why the person concerned refuses to work. Special consideration will also be given to whether the benefits recipient provides for children. Children shall not be penalized for the actions of their parents.

- *The Committee wishes to receive more detailed information on the implementation of this programme, including the number of participants.*

See the information on the individual qualification programme given under Question 1 above.

- *The Committee asks whether participants in the individual qualification programme, and in particular those under 25 years of age, are also entitled to receive means-tested social assistance benefits to top-up their income and, if so, whether there is a recommended minimum income which would be taken into account in assessing whether participants are entitled to additional benefits.*

There is no minimum income level or fixed amount limit that is to be used as a basis when assessing whether participants in the individual qualification programme are entitled to receive supplementary benefits. Applicants for such benefits are assessed in the usual way, specifically according to the individual applicant's expenses and income. This applies to participants in the qualification programmes and to employees and others.

Article 13 Para 2

Reference is made to the previous report.

Regarding the work on amending the legislation relating to discrimination, as mentioned in Norway's previous report different acts are implemented to prohibit discrimination based on inter alia gender, ethnicity, religion, sexual orientation, disability, age, political views or membership of a trade union. The Government is preparing a legislative proposal with adjustments in existing legislation and a new act against discrimination on the grounds of sexual orientation, gender identity and gender expression. The aim is to strengthen the legal protection against discrimination as well as to harmonize and simplify the legislation. The Government plans to submit a bill to the Parliament in 2013.

A commission appointed by the Government considered in 2009 whether to ratify the Human Rights Convention Protocol no.12 on discrimination. The commission was divided in the question. The Government is considering the question in conjunction with the bill on discrimination legislation.

A human rights commission appointed by the Parliament has considered a limited revision of the Constitution with the aim to strengthen human rights in the Constitution. The commission submitted its report in January 2012. Anti-discrimination is one of the human rights proposed by the commission to include in the Constitution.

Article 13 Para 3

<u>Question 1) – The general legal framework</u>
The municipality and the social services must provide information, advice and guidance that can contribute to resolving or preventing social problems. If the municipality itself is unable to provide such help, it must as far as possible ensure that others do so. This duty applies for everyone who requests such help, regardless of whether or not the person concerned is entitled to other services or benefits.

The Municipal Health Services Act of 19 November 1982 and the Social Services Act of 13 December 1991 were repealed on 1 January 2012. Both these Acts were replaced by the Municipal Health and Care Services Act (the Act of 24 June 2011 no. 30). This Act combines the legislation concerning municipal services that was previously authorized by the two

former Acts. The regulations are in essence carried forward, and reference is therefore made to previous reporting on the Act's material content.

The health and care services legislation requires the municipality to ensure that all those who reside there are offered the necessary health and care services. Municipal responsibility encompasses all patient and user groups and includes individuals with somatic or mental illnesses, and those with injury or ailments, substance abuse problems, social problems or reduced functional capacity.

To meet this responsibility the municipality's services must include:

- Health-promoting and preventive services, such as:
  a. health services in schools
  b. public health centre services
- Pregnancy and post-natal care services
- Help in the event of accidents and other emergency situations, including:
  a. Accident & Emergency facilities
  b. 24-hour medical emergency services
  c. medical emergency notification services
- Medical examinations, diagnoses and treatment, including the GP scheme
- Social, psychosocial and medical care and rehabilitation
- Other health and care services, such as:
  a. home-based health services
  b. personal assistance, including practical assistance and training and support persons
  c. places in institutions, including nursing homes
  d. relief measures

Question 2) – Implementation

The Norwegian Board of Health Supervision is a national institution organized under the Ministry of Health and Care Services. The politically adopted acts and regulations provide the framework for the supervision.

Supervisory authorities work independently of political governance. To a large extent they assign their priorities themselves regarding the services they are to supervise and the areas the supervision is to cover. This prioritization partly takes place on the basis of information concerning risk and vulnerability.

Such authorities shall help to ensure that the population's needs for child welfare services and social and health services are met, that these services are provided in accordance with sound professional standards, that deficiencies in the provision of the services are prevented, and that the resources are utilized in an appropriate and effective manner.

Supervision reports and other findings and experience from the supervision carried out, as well as information about supervision methods and other types of information, are available to the public. Most of this can be viewed at the website www.helsetilsynet.no. Contact with the mass media and professional media is intensive. This policy of public access is necessary to enable the findings of the supervision to be used by the services as a basis for learning and quality improvement. To create confidence in the Board it is also necessary for professional communities, user organizations and other public bodies to be able to criticize the knowledge base, methods and results.

Area surveillance is supervision with an overall perspective and consists of collecting, systemizing and interpreting information about social and health services. Such information provides a basis for evaluating whether needs are being met (is the population being offered the services they should have?) and whether the quality of the services is adequate (are the services being delivered with the requirements laid down in the legislation?). Reports from area surveillance are disseminated to the services and the general public.

System audits based on internationally recognized methodology are used in the supervision of organizations (municipalities, children's and young people's homes, nursing homes, hospitals etc.). The enterprise is investigated through document review, interviews, inspections and random checks. The reports from the supervision describe the points where conditions or other factors are not in accordance with acts or regulations – referred to as non-conformities. The supervisory authority follows up such non-conformities until the requirements stipulated in the acts and regulations are met. The follow-up involves the management of the enterprise and, if necessary, the owner (the municipality, board of directors etc.).

Between 700 and 900 system audits of organizations are conducted each year. The supervision reports are available to the public and are accessed each year more than one million times on www.helsetilsynet.no.

About half of all the supervision activities take place as nationwide supervision each year in two to four areas selected by the Norwegian Board of Health Supervision. Nationwide supervision is summarized in the Board's reports. The areas selected for nationwide supervision in 2009, 2010 and 2011 are:

- municipal health services: compulsory treatment in accordance with the Patients' Rights Act, Chapter 4A (applies to people who are not able to give consent to treatment themselves)
- municipal social and health services for frail, elderly individuals
- municipal child welfare
- specialist health services' treatment and rehabilitation of elderly stroke patients and those with hip fractures
- specialist health services (subjects selected in the five health regions)
- financial support in accordance with the new act on social services in the Norwegian Labour and Welfare Administration (NAV)
- social services in NAV
- psychiatric specialist health services for adults (district psychiatric centres)
- municipal social and health services for children in short-term relief care homes and auxiliary housing

The supervisory authorities work actively to ensure that organizations that provide health and social services use supervision reports in their work on developing management systems and on improving the quality of services.

The Care Plan 2015 is the Government's action plan that is to ensure that society is prepared to meet the care challenges of the future as they are described in Report no. 25 (2005–2006) to the Storting: Long term care – future challenges. New younger user groups with reduced functional capacity demand different professional competencies and a life-cycle perspective in the care offered. Demographic changes will require a capacity expansion and improved

competence in the field of ageing, with particular focus on dementia and complex illnesses. At the same time there may be a shortage of both health and social personnel and of voluntary care providers. The lack of medical and interdisciplinary follow-up of the care service's users and the lack of social, cultural and physical activity are also pointed out as the greatest weaknesses of current care provisions

The Government's main strategy is to use the relatively stable period (from a demographic point of view) during the next 10–15 years to gradually expand the range of services and to plan and prepare for the rapid growth in the number of elderly people over the age of 80 that is expected from 2025.

The Care Plan has four main areas of priority:

- 12 000 nursing home places and community care housing places
- Dementia Plan 2015
- 12 000 new man-years
- Competence Lift 2015

The Care Plan 2015 covers the complete life cycle and constitutes an investment for all users of the care services, regardless of age, diagnosis or degree of incapacity. Approximately two-thirds of the care services' 265 000 users are still elderly people over the age of 67. The elderly are therefore an important target group in the Care Plan 2015.

Care challenges affect many areas of society and require interaction between several sectors. It is therefore vital that the planning in this area is a key subject in local municipal and financial planning work and is not limited to sector plans for the care services. The challenges will also require the public services to interact to a greater extent with family care, non-profit organizations and a robust civil society. Both the development in needs and the future shortage of health and social personnel indicate that tasks must be resolved in other ways and in closer collaboration with the third sector. The need to find new solutions formed the basis for the Government appointing the Hagen committee, which in June 2011 submitted its recommendation in Norwegian Official Report NOU 2011: 11: Innovation in the Care Services. One of the points that the investigation stresses is that many of the new concepts will develop in the gap between the public sector and civil society. The investigation will be followed up through a separate report to the Storting on innovation in the care services.

The Care Plan 2015 has helped to draw attention to future care challenges in the municipalities, and in recent years the municipal sector has given priority to strengthening capacity, competence and quality in the care services.

Question 3) – Statistics etc.

12 000 24-hour care places

Investment grants for 24-hour care places in nursing homes and community care housing were introduced in 2008. One objective is to commit to providing grants for 12 000 such places in the period 2008–2015. The grants are intended to encourage the municipalities to renew and increase the number of places in nursing homes and community care housing for those who need round-the-clock health and care services, regardless of the resident's age, diagnosis or degree of incapacity. The grant will give the municipalities greater predictability and will provide the possibility for long-term planning of the investments in the care sector.

Figures from the Norwegian State Housing Bank show that at the end of August 2012 as many as 280 municipalities had submitted preliminary applications and inquiries with a total of 12 451 units since the start-up of the grant in 2008. The units consisted of 6 514 units in nursing homes and 5 937 in community care housing. The applications include new buildings, renovation/alterations, and common areas attached to existing community care housing. The applications come from municipalities in all the counties. In the same period, the State Housing Bank has received final applications from the municipalities corresponding to 6 002 units, and grants have been assured for a total of 5 923 units comprising 2 804 community care housing places and 3 119 nursing home places. At the end of August 2012 a total of 225 municipalities had sent in final applications, and 220 of these municipalities have so far been guaranteed the grant. According to the figures from the municipalities, over 75 per cent of the total number of units with a guaranteed grant are intended for people over the age of 67. Approximately 80 per cent of the total number of units with a guaranteed grant are long-term places.

Dementia Plan 2015
The goal of the Dementia Plan 2015 is to promote an improvement in competence, capacity and quality in the service provisions for those with dementia and their family members. The Dementia Plan 2015 presents three main goals: building a greater number of adapted resident facilities, increasing the range of daily activities and ensuring greater knowledge and competence.

A number of initiatives were put into action in the first four-year period of the Dementia Plan to ensure a long-term quality improvement of the services offered to those with dementia and their families – for example through investment in skills, research and development, courses for family members and information. In 2010–2011 a national mapping of the service provisions for persons with dementia was conducted. The mapping shows that in the period 2007–2010 there was an increase in courses for family members and educational measures as well as in diagnosing and examining persons with dementia. The number of municipalities that offer courses for family members or discussion groups has risen from 66 municipalities in 2007 to 246 in 2010–2011. Over 10 000 employees in more than 300 municipalities have started dementia courses through the course material for training in dementia care and geriatric care – *Demensomsorgens ABC* and *Eldreomsorgens ABC*. The number of municipalities with a dementia team or a dementia coordinator has increased from 25 per cent in 2007 to 57 per cent in 2010–2011. This shows that the municipalities are prioritizing dementia care and are developing service provisions for those with dementia and their family members in line with the Dementia Plan 2015.

12 000 new man-years in the care services
The Ministry reports that, with the level in 2004 as the point of departure, the Government's goal of 10 000 new man-years in the care services by the end of 2009 was exceeded and reached the figure of approximately 14 800 man-years. The Norwegian Association of Local and Regional Authorities has concluded that the Government's goal of creating 10 000 new man-years has been achieved. Approximately 80 per cent of the growth in man-years consisted of personnel with education in health and social services.

The Government's goal is to increase the staff in the municipal care services by 12 000 man-years in the period 2008–2015, to be measured at the end of the year. Roughly 2 570 of the man-years will be related to increasing the offer of daily activities to persons with dementia. For the period 2008–2010, figures from Statistics Norway show that the number of man-years rose by approximately 5 000 while figures from this agency also show that the growth in 2010

was around 2 700 man-years. Approximately 80 per cent of the increase in man-years has consisted of personnel with training in health and social services.

Competence Lift 2015
The Competence Lift 2015 is the Government's plan for expertise and recruitment. Its main goal is to ensure the care sector has adequate, competent and stable staffing.

In the first four years of the plan period more than 12 500 persons have received grants for basic education or for continuing and further education, and roughly 10 000 persons have completed the courses in geriatric care and dementia care – *Eldreomsorgens ABC* and *Demensomsorgens ABC*. In 2010 approximately 3 700 persons completed an educational programme, course and other training with support from the Competence Lift 2015. Of these, about 180 persons completed decentralized university college education in various health and social subjects, approximately 869 persons took a qualification programme leading to a certificate of completed apprenticeship corresponding to skilled healthcare workers, around 670 persons completed vocational college education in health and social subjects, and roughly 500 have completed the training course in geriatric care (*Eldreomsorgens ABC* course). In addition, around 2 600 have completed the *Demensomsorgens ABC* course in dementia care, and in 2011 approximately 7 800 persons are being educated or trained with support from the Competence Lift 2015.

Further questions from ECSR

- *Care Plan 2015: The Committee wishes to be kept informed about the implementation of this plan.*

See the discussion above.

Article 13 Para 4

The right to receive help according to the Municipal Health Services Act and the Social Services Act was regardless of nation and nationality. The Municipal Health Services Act stated: "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) stated that: "The provision in this Act concerning services and measures apply to everyone staying in the Realm". This meant that the services regulated by these Acts applied to everyone staying in the municipality, regardless of nationality, age or finances.

Paragraph 1 of section 3-1 of the Health and Care Services Act, applicable from 1 January 2012, maintains the same starting point since it states that the municipality shall ensure that persons resident or temporarily resident in the municipality are offered necessary health and care services.

The provisions relating to services in the Act on Social Services in the Norwegian Labour and Welfare Administration apply for all individuals who are resident or temporarily resident in the country. The right to municipal social services applies regardless of the applicant's nationality, but requires the applicant to be staying in the municipality.

A new regulation on social services for persons without a permanent address in Norway was laid down on 16 December 2011 but did not enter into force until 1 January 2012. It is thus not within the reference period for this report. The regulation is a continuation of previous legislation.

Article 14: The right to benefit from welfare services

Article 14 Para 1

Question 1) and 2) – The general legal framework/ implementation
The Act of 18 December no. 131 on Social Services in the Norwegian Labour and Welfare Administration, which entered into force on 1 January 2010, does not entail any changes in individual rights to social services.

However, an addition has been made to the Act in the statement of legislative purpose in section 1. As before, the purposes of the Act are to improve the living conditions of disadvantaged persons, to promote social and financial security, including giving individuals opportunities to live and reside independently, and to promote the transition to work, social inclusion and an active and meaningful existence in community with others. Furthermore the Act is to contribute to greater equality of human worth and social status and to prevent social problems. From 1 January 2012 there is a new purpose clause that specifies that the Act shall contribute to ensuring that vulnerable children and young people and their families are offered a uniform and coordinated provision of services.

In accordance with the Act on Social Services in the Norwegian Labour and Welfare Administration, social services are a municipal responsibility. If a person needs services or financial support, he or she can contact the NAV office in his or her municipality of residence. The cause of the problems is irrelevant to the municipality's responsibility. Most municipalities have a wide range of services and measures that are intended to meet the needs of those who seek help. The most important social services are financial support, temporary housing and information, advice and guidance.

To ensure that services are as good as possible, the social services are obliged to collaborate with the other services at the NAV office, and also with other agencies and services such as the health and care services. It is the duty of the social services to give advice and guidance to all those who want it – regardless of whether they have the right to other services or benefits.

Further information can be found in section 1 of Article 13. The new Act on Municipal Health and Care Services is also described here as well as the Acts it replaces, the purpose of the new Act etc.

Access to financial support
Means of support – Section 18
Persons who cannot support themselves by working or by exercising financial rights are entitled to financial support. The support should aim to make the person concerned self-supporting. The Ministry can issue recommended guidelines regarding the level of support, and has done so since 2001. The state guidelines for the level of financial support for certain basic expenses for subsistence are adjusted annually in line with price increases. In addition, in 2009 all rates were raised by 5 per cent in addition to the price increase.

See also Article 13, section 1.

Support in special cases – section 19

In special cases the municipality can, even if the conditions in section 18 are not met, provide financial assistance for persons who need it in order to overcome or adapt to difficult circumstances.

Obligation to consult the service recipient – section 42
As far as possible the offer of services must be drawn up in collaboration with the service recipient. Considerable emphasis must be placed on the opinion of the person concerned.

Complaints/appeals
Act on Social Services in the Norwegian Labour and Welfare Administration
Individual decisions taken by the municipality in accordance with this Act can be appealed to the County Governor who can try all aspects of the 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 straightaway.

The Social Services Act and the new Municipal Health and Care Services Act
The Social Services Act was repealed on 1 January 2012. The provisions on complaints have been transferred to the Patient's and User's Rights Act. According to section 7-6 of this Act, the provisions in the Public Administration Act apply when handling complaints about individual decisions as far as this is appropriate, with the special provisions that are given in the Act. The County Governor can try all aspects of the matter. When trying municipal decisions on health services, the County Governor shall attach due importance to the interests of local self-government when trying discretionary issues, cf. section 34, subsection 2, sentence 3 of the Public Administration Act. With regard to other municipal decisions (including those that were previously regarded as decisions pursuant to the Social Services Act), the administrative appeal body shall also attach due importance to the interests of local self-government when trying discretionary issues.

In general, this is a continuation of previous applicable rights laid down in the Social Services Act.

Question 3) – Statistics etc.
See the tables under Article 13.

Further questions from ECSR

- *The reform of social welfare services: The Committee asks for information on the results of this reform to be included in the next report.*

In general the NAV reform has been fully implemented. The last office was set up in 2011. Both the organizational establishment and the introduction of major reforms of NAV's content have been completed. Further work is being done on improvements – for example of ICT solutions.

In the first phases a certain amount of criticism was levelled at various aspects of the implementation of the reform. This has provided significant input for the Ministry's follow-up. The effects of the NAV reform are evaluated by external research communities, and the

process itself is assessed as well as the results for the organization. We have no final results from any of the evaluations and this feedback is therefore based on preliminary reports.

At the start of 2012 there is a noticeable improvement in results within areas that have been under considerable pressure. A number of measures have also been implemented that have produced results for case-processing times and for the quality of benefit management. Since 2009 there has been considerable focus on reducing any backlog, and the situation in benefit management has now materially improved even if the case-processing times are still too long for some benefits – in particular for certain family benefits and at NAV International.

The scope of the follow-up activities has increased steadily through 2011. The Labour and Welfare Administration has managed to implement improvements related to the follow-up of important groups such as job-seekers, those on sick leave and recipients of the work assessment allowance.

The NAV reform gives the local NAV offices a certain autonomy regarding their own organization. Most NAV offices are organized in a way that maintains the division of labour from the previous agencies. NAV offices are also free to add more municipal services to their repertoire than those that are mandatory, and there is considerable variation in the services offered. So far we have no evaluation to show whether the type of organization of the individual office is of significance for the quality of the services or for the rate of success in transferring clients from benefits over to work.

- *Legislation reform: The Committee asks for information on the progress of this reform to be included in the next report.*

Reference is made to the discussion under Article 13, section 1, question 1.

- *The Committee asks for more detailed information in the next report on how decisions on the provision of social welfare services are taken. It also asks again how users are involved in decision-making processes which affect them.*

<u>Decisions on providing services in accordance with the new Municipal Health and Care Services Act, applicable from 1 January 2012</u>
According to section 2-2 of the Municipal Health and Care Services Act, in general the Public Administration Act applies for the activities of the municipality. The application of the rules of the Public Administration Act on individual decisions is regulated in section 2-7 of the Patient's and User's Rights Act. According to this provision, Chapters IV and V of the Public Administration Act (concerning the preparation of cases and administrative decisions) shall as a rule not apply for decisions that are taken pursuant to Chapter 2 of the Patient's and User's Rights Act. Nonetheless, special rules apply for decisions concerning services in accordance with section 3-2, subsection 1, no. 6, a-d, and section 3-6 and section 3-8. These provisions concern services that were previously regulated in the Social Services Act (personal assistance, including practical assistance and training, and support persons, relief measures, pay for care providers and user-controlled personal assistance) in addition to home-based health services and nursing home places. The proposal suggests that Chapters IV and V are to be applied when allocating such services and when such services cease if the services are expected to last longer than two weeks.

Section 3-10 of the new Municipal Health and Care Services Act concerning patients' and users' influence and collaboration with voluntary organizations states the following:

> *The municipality shall ensure that representatives of patients and users are heard when the municipality's health and care services are drawn up.*
>
> *The municipality shall ensure that undertakings that provide health and care services encompassed by this Act establish systems for collecting patients' and users' experience and viewpoints.*
>
> *Health and care services shall be organized in a way that facilitates collaboration with user groups' organizations and with voluntary organizations that work on the same tasks as those of the health and care services.*
>
> *Municipalities within the administrative area for the Sami language, cf. section 3-1, no. 1 of the Sami Act, shall in addition to that stated in the first and second subsections, ensure that the needs of Sami patients and users for adapted services are given priority when the services are drawn up. This also applies to the individual's extended right to use the Sami language in the health and care services pursuant to section 3-5 of the Sami Act.*

Section 3-1 of the Patient's and User's Rights Act states the following on the patient's and user's right to participate:

> *The patient and user are entitled to participate in the implementation of health and care services. This includes the right to participate in choosing between available and medically sound methods of examination and treatment. The form of participation shall be adapted to the individual patient's ability to give and receive information.*
>
> *The provision of services shall as far as possible be drawn up in collaboration with the patient and the user. Pursuant to section 3-2, subsection 1, no. 6, a-d, and section 3-6 and section 3-8 of the Health and Care Services Act, considerable emphasis shall be placed on the opinions of the patient and user when the service provisions are drawn up. Children under the age of 18 shall be consulted when the child's development and maturity and the nature of the case so indicate.*
>
> *If the patient is not competent to give consent, the patient's next of kin is entitled to participate together with the patient.*
>
> *If the patient or user wishes other persons to be present when the health and care services are given, these wishes shall in general be accommodated.*

<u>Social Services in the Labour and Welfare Administration Act</u>

All cases concerning individual services pursuant to the Act on Social Services in the Labour and Welfare Administration start with an enquiry from a private individual asking for help or seeking services. The Act stipulates that as far as possible the service provisions shall be drawn up in collaboration with the service recipient, and considerable emphasis shall be placed on the opinion of the person concerned. Participation in qualification programmes is granted only on application and is not a duty but a right.

The Act also states that the municipality should collaborate with the user groups' organizations and with voluntary organizations that work on the same tasks as the municipality in labour and welfare administration.

The Government has set up a liaison committee between itself and representatives for socially and economically disadvantaged persons.

Article 14 Para 2

Question 1) – The general legal framework
With regard to legislation related to home-based health and care services, reference is made to the reporting in Article 13.

The Health and Care Services Act requires municipalities to ensure that representatives of patients and users are heard when the municipality's health and care services are being drawn up. Organizations that provide services pursuant to the Act must establish systems for collecting patients' and users' experience and viewpoints. Health and care services shall be organized in a way that facilitates collaboration with user groups' organizations and with voluntary organizations that work on the same tasks as those of the health and care services. Municipalities within the administrative area for the Sami language, cf. Section 3-1, no. 1 of the Sami Act, shall in addition to that stated in the first and second subsections, ensure that the needs of Sami patients and users for adapted services are given priority when the services are drawn up. This also applies to the individual's extended right to use the Sami language in the health and care services pursuant to section 3-5 of the Sami Act.

Question 2) – Implementation
One of the main strategies described in Report no. 25 (2005–2006) to the Storting: Long term care – future challenges, is to ensure better collaboration with voluntary organizations and the local community. The solution for future care challenges must be based on public responsibility that involves most of the sectors of the community and on supporting and developing the voluntary commitment from families and the local community and from organizations and agencies.

Measures will be taken to ensure that the extent of voluntary care is maintained and strengthened. The policy must be rooted in a perspective of equality that makes it possible to combine care work with occupational activity and that divides the provision of care more equally between men and women.

Future care services will be designed at the interface between formal and informal care, between the home and the institution, and between the family and the care services. However, this interaction can take new forms, and the distribution of tasks may be changed.

The dimension of voluntary and general family-based care is almost equal to that of the municipal care services. The community's care provisions would therefore most likely break down if the voluntary care disappeared or was substantially reduced. The number of potential care providers is not growing at the same pace as the number of elderly people who will need care as 2030 approaches. Family care will therefore in the future constitute a smaller proportion of the total care provided.

The Care Plan 2015 is therefore concerned about making it possible for the family to combine occupational activity with care for children and the elderly. In line with the work focus in welfare policy, this requires schemes that strengthen a development in which both women and men can combine work with caring for children and elderly people. This can primarily take place through improved framework conditions for those who carry out voluntary care work.

In Report no. 7 (2008-2009) to the Storting: An innovative and sustainable Norway, the Government chose the health and care services as an area of priority for innovation and renewal. The Hagen committee was set up, and in June 2011 it presented its recommendation

in Official Norwegian Report NOU 2011:11 Innovation in the Care Services. In its recommendation, the Hagen committee emphasized that a new modern policy should be drawn up for family members as well as a policy for voluntary care. The committee submitted the following proposals to facilitate changes:

- New forms of ownership and operation, such as cooperatives, user-driven schemes and social entrepreneurship, which create service provisions with added value
- New work methods and professional approaches that give higher priority to active care-giving, ordinary rehabilitation, group methodology, culture and well-being
- A new modern policy for family members characterized by visibility, gender equality, flexibility, guidance, relief and value
- Care services that are organized with the family and local community in mind and that generate values that neither of these could create alone through emphasis on home-based services, open nursing homes and networking activities

The Government will submit a separate report to the Storting based on the official report NOU 2011:11 Innovation in the Care Services. This report can constitute the foundation for a future-oriented policy for the municipal care services and must be viewed in connection with the work of developing a separate innovation strategy for the entire municipal sector. The report will examine society's total care resources and will give priority to strengthening community solutions through reinforcing the interplay between municipal services and civil society. It will also provide good framework conditions to inspire voluntary resources within the family and the local community.

Question 3) – Statistics etc.

The municipalities are responsible for the health, social and care services in Norway. The municipalities are therefore free to provide the services themselves or to make use of private and non-profit organizations by purchasing such services.

Private non-profit organizations play a key role in, for example, the overall service for those dependent on alcohol and drugs. Approximately 50 per cent of the municipal sector report that they have purchased health and care services for this group of people from private and non-profit organizations. However, we do not have a national overview of the municipalities' purchase of such services from such organizations. In addition, an annual grant is provided for private and non-profit organizations through the national budget – for example in 2012 approximately NOK 175 million was granted for measures carried out by volunteers and non-profit organizations for alcohol and drug abusers.

However, public care does not replace family-based care in Norway. It appears that public care and voluntary family-based care interact and complement each other. Research shows that family-based care has been remarkably stable for the past 20–30 years, and that at the turn of the century it amounted to about 100 000 man-years (Daatland and Solem 2000, Rønning 2009). Nor is there anything to suggest that the family withdraws when the public care system starts to provide help from home-based services. Even though the welfare state has replaced the family's previous obligations with regard to old age, illness and disability, this does not seem to have undermined family solidarity (Langsether and Hellevik 2002). Nonetheless, in the future it will be crucial to sustain, strengthen and maintain the resources represented by voluntary care-giving in its various forms when facing future care challenges.

In many Norwegian municipalities it has been common to outsource tasks to private enterprises by the municipality entering into agreements with a non-profit organization on running nursing homes. Figures from Statistics Norway from the year 2000 show that 90 per cent of the institutions are owned by the municipalities. The remaining 10 per cent are owned by non-profit organizations, limited companies and individuals, with only 3 per cent owned by commercial actors. Nursing homes that are owned by non-profit organizations form part of the municipalities' total care provisions and are very similar to publicly-owned nursing homes. These nursing homes are therefore included in the same collaborative relationships with other parts of the health service and meet the same challenges as nursing homes owned by the municipality.

In recent decades the exposure of nursing and care to competition has attracted increasing attention – partly because several municipalities outsource this type of service and partly because exposure to competition in general and in particular applied to the nursing and care sector provokes political controversy in the regional health authorities. It is not possible to provide an exact picture of how many municipalities have exposed nursing and care services to competition since this picture is constantly changing. It is particularly large urban municipalities or municipalities near towns with a large population that have used this system or who consider using the system for nursing and care services. First and foremost it is the institution-based service, the nursing home, which has been exposed to competition. Home-based services have to only a small extent affected by this system.

The municipalities' nursing and care services encompass community care housing, old people's homes and nursing homes, in addition to different forms of home-based services. In this field voluntary organizations also perform many man-years of work. In 2000 it was estimated that 10 per cent of nursing homes were owned by non-profit organizations, limited companies and individuals, while 3 per cent were owned by commercial actors (Official Norwegian Report NOU 2005:3, p. 60). However, nursing homes and institution-based services comprise a field where the municipalities have to an increasing extent exposed the services to competition, particularly in large towns and in highly-populated areas near towns. The commercial proportion has therefore presumably increased since 2000. The services that the non-profit organizations offer have in most cases a long history, are more or less completely financed by public funds, and are included as part of the municipalities' total care provisions and coordinated with other health facilities. They are thus very similar to services run by the public sector.

According to Statistics Norway, in 2009 there were 664 private companies, personal enterprises, self-employed people and private consumer-oriented organizations working on a non-profit basis in the care services. The last category amounts to approximately 267 organizations.

In total it is estimated that almost 95 per cent of the care services are purely municipally run, while the non-profit organizations encompass about 4-5 per cent and the commercial around 1 per cent (figures from 2000). There is little reason to presume that these figures have changed materially during the past ten years.

Nursing homes are a type of housing facility that is largely owned by the municipality, voluntary organizations and foundations, or in some cases by private companies. Previous figures show that about 10 per cent of nursing homes are run by voluntary organizations/non-profit organizations, while 3 per cent are run by commercial actors.

Community care housing can be organized as rented accommodation, housing cooperatives or joint ownership property. There is no exact overview of how many community care dwellings there are of each form of ownership, but approximately 75 per cent of all the estimated 24 000 community care dwellings built in Norway after state subsidies were introduced in this area in 1994 are rented dwellings. Housing cooperatives probably amount to less than 25 per cent, while joint ownership property is only a marginal factor in overall community care housing.

- *The Committee finds no information on any examples of how non-public bodies contribute to the provision of social services or any figure on the state subsidies they are awarded.*

See the above discussion.

Article 23: The right of elderly persons to social protection

Question 1) – The general legal framework
Adequate resources
Reference is made to the description of the legal framework given in previous reports. Reference is furthermore made to information provided under Article 12 above and in the information survey entitled: "The Norwegian Social Insurance Scheme", updated as of 1 January 2012.

The survey is available on the Internet at:
http://www.regjeringen.no/en/dep/ad/doc/veiledninger_brosjyrer.html?id=2122

Other aspects
Reference is made to the reporting and information given in Article 13. Most of the Norwegian health and care legislation is based on the universal principle, which means that the legislation is the same for all patients and users regardless of their age, gender etc. Reference is made to previous reporting on this subject.

Question 2) – Implementation
Adequate resources
Measures taken to ensure that elderly persons have adequate monetary resources have in the reporting period inter alia included adjustments to 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 2008 to 31 December 2011), the level of the minimum pension has increased considerably. The minimum pension for a single pensioner increased from NOK 119 820 (1 January 2008) to NOK 143 568 (31 December 2010), and for a married couple the minimum pension increased from NOK 219 600 (1 January 2008) to NOK 279 872 (31 December 2010).

With the introduction of the Pension Reform (cf. under Article 12 above), with effect from 1 January 2011, there is no longer a *general* minimum pension level for old-age pension from the Norwegian National Insurance Scheme. The minimum pension level will vary between different cohorts.

In order to show the level of the minimum after the reform, pensions for the 1944 cohort, applicable as per 2011 were: NOK 157 639 for a single pensioner, and for a married couple NOK 291 644.

The minimum pension level 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 level is regulated once a year in accordance with the expected increase in wage levels 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 qualify for 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. In order to receive a full minimum pension, the person concerned must have lived in Norway for at least 40 years.

Supplementary allowance scheme
Reference is made to Norway's previous report concerning the supplementary allowance scheme act of 29 April 2005, in force from 1 January 2006.

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 age of 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 a defined minimum social insurance pension rate.

Per 31 December 2011 this level was NOK 157 639 per year for single persons and NOK 291 644 for couples (NOK 145 822 for each person).

The allowance is subject to a strict means test 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 to any ordinary pension benefit received 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 Norwegian 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 Labour and welfare service.

Other aspects

One of the main strategies described in Report no. 25 (2005–2006) to the Storting: Long term care – future challenges, is to promote more active care services. The goal is to ensure that each individual has the opportunity to live and reside independently and to achieve an active and meaningful existence in community with others.

The Government emphasizes culture, activity and well-being as key and fundamental elements of holistic care provisions.

Through the Care Plan 2015, active care is strengthened by the following initiatives:

- Extending the care services' professional repertoire with more professional groups can contribute to giving these services a more active profile: occupational therapists, physiotherapists, activators, cultural workers etc.

- The Cultural Walking Stick programme, which offers initiatives and activities in the fields of music, theatre, film etc. In 2010 more than 275 municipalities received a grant for cultural initiatives for the care services' users (NOK 28 million).

- Developing the daily activities offered to those with dementia. The goal is to introduce a statutory obligation for the municipalities to offer such activities to persons with dementia. Daily activities give life meaning and provide positive experiences. In 2012 an earmarked grant was set up for establishing such activities for this group of patients.

- Developing course material in the field of active care for employees.

Reference is also made to the information on measures in the reporting for Article 13 and in the previous report.

As part of the Care Plan 2015, a new investment grant was introduced in 2008 for community care housing and nursing homes. The Care Plan 2015 is an action plan with measures in a number of areas designed to face current and future care challenges. The plan is based on five strategic approaches to future care provisions, and it gives the planning both direction and content. The plan requires long-term planning of investments in buildings, personnel resources, skills upgrading, educational capacity and adaptation of physical and social surroundings. The planning work is carried out at both municipal and national level and demands close interaction between national authorities and the municipal sector.

The objective of the investment grant is to renew and increase the offer of places in nursing homes and community care housing for those who need round-the-clock health and social services, regardless of age, diagnosis or disability. This encompasses elderly people, those with disabilities, and others with reduced functional capacity, psychological and social difficulties, substance abuse problems and long-term somatic illnesses.

The grant is given for building, purchasing, renovating, repairing, renting or other forms of acquiring round-the-clock care places in community care housing and nursing homes, as well as for the common areas that are necessary to achieve 24-hour services in existing community

care housing. It is also given for building short-term places in nursing homes. One of the requirements of the scheme is that the community care housing and nursing home places are universally designed and are adapted for people with dementia and cognitive failure.

The municipalities can collaborate with non-profit organizations, housing associations, commercial actors and suchlike on the establishment of round-the-clock care places in nursing homes and community care housing. The grant will be given to the municipality as the body responsible for the service, regardless of whether the municipality itself builds the places or whether it completely or partially procures the places in collaboration with other parties. When the municipalities collaborate with other parties, a condition is that the regulations for public procurement are followed.

Question 3) – Statistics etc.
By 30 June 2011, there were 697 331 old-age pensioners in Norway, of which 44.8 per cent were men and 55.2 per cent were women.

In December 2011, 3 013 persons were receiving supplementary allowances, of which 34.7 per cent were men and 65.3 per cent were women.

The table below shows the recipients of nursing and care services, 2011, according to age, type of service and gender.

2011[1]	**Number**	**Percentages**			
	No. of recipients[2]	**Total**	**Practical assistance and/or home-based nursing**	**Other services for those living at home**[3]	**Staying in institutions**[4,5]
Total	268813	100	65.9	18.0	16.2
0-17	14951	100	10.9	79.8	9.3
18-49	49220	100	78.5	19.1	2.3
50-66	35533	100	80.1	13.7	6.2
67-79	46806	100	69.8	14.2	16.0
80-89	87775	100	64.0	14.2	21.7
90 and older	34527	100	56.3	8.5	35.2
Women					
Total	168765	100	66.3	16.5	17.3
80 and older	89775	100	61.2	13.2	25.6
Men					
Total	99317	100	65.2	20.5	14.3
80 and older	32202	100	63.6	10.9	25,5

[1] The figures for 2011 are preliminary.

[2] 730 recipients have not indicated gender, 1 has not indicated age.
[3] e.g. support persons, pay for care providers, relief measures outside the institution or delivering food.
[4] Most of those under the age of 50 have stays that are time-limited, while most of those over 50 have long-term stays.
[5] Nursing homes and forms of residence with 24-hour nursing and care as authorized by the Municipal Health Service Act, and old people's homes, children's homes and relief housing/institutions authorized by the Social Services Act.
Source: Statistics Norway

In Norway approximately 35 000 people with dementia live at home. Surveys show that only 10.3 per cent of these are offered daily services. A grant has therefore been established, earmarked for persons with dementia.

The net operating expenses per inhabitant in 2011 for nursing and care services was on average NOK 14 030.

The average available places in institutions by percentage of the total amount of 80-year-olds and older in the municipalities was 18.6 per cent in 2011. There is an increasing shift from institutional services to home-based services.

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 was 28 per cent in 2011.

The total number of *places* in nursing homes and old people's homes in 2011 was 41 208 (39 833 in nursing homes and 1 447 in old people's homes). The number of *residents* in housing with 24-hour staffing in 2011 was 21 696.

Figures for 2011 show that the average spending on activating individuals, as adjusted gross operating expenses, was NOK 5 970 per person aged 67 and over. The net operating expenses are not available from Statistics Norway/Kostra (the municipal-state reporting system).

In 2012 the investment grant was given on the basis of a construction cost of a maximum of NOK 2.290 million for a nursing home place or community care dwelling. A nursing home place can be given a maximum of NOK 916 000 per place in grants (40 per cent of the construction costs) and a community care dwelling with a common area can be allocated a maximum of NOK 687 000 per residential unit (30 per cent of the construction costs). The common area that is necessary for providing 24-hour services in existing community care housing can be financed with up to 40 per cent of approved construction costs.

For the period 2008-2015 the objective is to give grants for the building and renovation of 12 000 nursing home places and community care housing with 24-hour services. In the period 2008–2011 a total of 5 241 community care dwellings and nursing home places have been guaranteed, i.e. just less than half of the goal of 12 000 residential units midway in the planning period. Of these, 2 479 are community care dwellings and 2 762 are nursing home places. In addition the building of 40 414 square metres of common area has been assured in order to upgrade existing community care dwellings. A total of 2 418 community care dwellings and nursing home places have been completed and put to use. Two out of three residential units are intended for elderly people, while the remainder are intended for disabled

and handicapped individuals, substance abusers, persons with mental health problems and the like. In general these people live in community care housing. The nursing homes are to a great extent reserved for elderly persons.

In 2011 a guarantee was given for 1 230 residential units, of which 665 were community care dwellings and 565 were nursing home places. A guarantee was also given for the building of about 13 500 square metres of common area in connection with existing community care dwellings so that 24-hour services can be provided there. For 2012 the goal is 1 500 community care dwellings and nursing home places.

Further questions from ECSR:

- *The Committee asks if anti-discrimination legislation (or an equivalent legal framework) to protect elderly persons outside the field of employment exists, or whether the authorities plan to legislate in this area.*

The elderly are protected against discrimination also outside the field of employment through the ban on discrimination in the Anti-discrimination and Accessibility Act due to reduced functional capacity, and through the requirements regarding impartiality in public sector administration. The Government has no further plans for new Acts against the discrimination of elderly people.

- *The Committee asks for information on the legal framework related to assisted decision making for the elderly, and, in particular, whether there are safeguards to prevent the arbitrary deprivation of autonomous decision making by elderly persons.*

In some cases elderly persons will need a guardian in order to obtain the necessary assistance to look after their interests in the financial or personal area. This is currently regulated more closely in the prevailing Guardianship Act of 1927, and from 1 July 2013 in the Act of 26 March 2010 no. 9 on guardianship.

1. The prevailing Guardianship Act

A person who because of unsoundness of mind, other mental disorders, senile dementia, retarded mental development or physical disability cannot manage his own affairs may if necessary have a provisional guardian appointed, cf. section 90a of the Guardianship Act. The provisional guardian's tasks shall be adapted to the need, and are primarily those of looking after financial and legal matters. Before the provisional guardian is appointed, the consent of the person who is to have the provisional guardian must be obtained. This can only be waived if obtaining consent is impossible or inadvisable for special reasons.

If the client's interests cannot be looked after in an appropriate manner through a voluntary provisional guardian scheme, it may in a few cases be appropriate to declare him incapable in accordance with the Act of 28 March 1898 relating to the declaring of a person as incapable of managing his own affairs. However, pursuant to prevailing law it is not possible to adapt the declaration to a partial declaration of incapability, and declaring the person as incapable must therefore be the last resort.

2. New Guardianship Act

The authorities aim to bring the Act of 26 March 2010 no. 9 on guardianship into force on 1 July 2013. This Act contains several safety mechanisms to ensure that the interests of elderly people will be looked after and that this will take place with respect for the individual's dignity and integrity.

A guardian is only to be appointed if the appointment is deemed to be in the best interests of the person concerned, and the guardianship shall never continue for longer than necessary. Below is a list of key safety mechanisms:

1. If the person is competent to give consent, consent is necessary for establishing a guardian for the person, for choosing the guardian and for the content and scope of the mandate of the guardian, cf. section 20 of the Act.
2. To ensure that the decision on guardianship is in line with the wishes of the person concerned, the person is entitled to discuss this with an executive officer before the decision is made, cf. section 59, subsection 1 (e).
3. When guardianship has been established, section 31 states that the guardian shall look after "the interests of the person under guardianship".
4. It follows from section 33, subsection 2, that if the person is competent to give consent, the guardian cannot make a transaction if the person under guardianship opposes it.
5. As far as possible the person shall be heard, even if he or she is not competent to give consent, in the event of significant decisions and when this seems natural, cf. section 33, subsection 1.
6. If, in spite of the safety mechanisms above, the person under guardianship disagrees with the guardian's decision, he or she can take the case to the County Governor, cf. section 33, subsection 3, point 3.

- *Prevention of elder abuse - the Committee wishes to know what the Government is doing to evaluate the extent of the problem, to raise awareness on the need to eradicate elder abuse and neglect, and if any legislative or other measures have been taken or are envisaged in this area.*

WHO's report "European report on preventing elder maltreatment" from 2011 shows that the elderly should be defined as a vulnerable group. This particularly applies in the oldest age groups and to those with cognitive and/or physical functional problems. Available studies show that only a few of those who are exposed to maltreatment contact the help network. This applies to those who have been exposed to abuse that led to physical and other injury and to both genders. The Norwegian Centre for Violence and Traumatic Stress Studies was commissioned to initiate more comprehensive research on this subject in 2011. An in-depth study on violence and abuse against elderly people in Norway was conducted in 2011-2012, addressing behaviour regarding seeking help. The study is to form the basis of an assessment of the need for a more comprehensive survey of the scope of this issue.

It is important to view any failure of care and any violence against elderly people and the mental health consequences in the same context. Persons over the age of 60 constituted 23 per cent of all suicides in Norway in 2007, even though this age group represents only 13 per cent of the population. Annually, between 100 and 120 elderly individuals take their own lives, and suicide attempts in this group conclude more often with suicide than suicide attempts among younger people. Several coincidental risk factors such as functional decline, social

isolation and lack of close care providers may represent a cumulative vulnerability that in the long term can affect a considerable proportion of the population. There is therefore a need for greater competence in this field to both identify and intervene in the event of any failure of care or any violence against the elderly.

A free national contact telephone line has been set up for elderly people who are exposed to violence. The target group is those over the age of 62. The purpose of the contact telephone line is to provide a nationwide service for support, information, advice and guidance for elderly people who are exposed to violence, their family members and employees in the public health network, in addition to contributing to drawing the attention of society as a whole to such problems of violence against the elderly. The contact telephone line for protecting the elderly is financed by the Norwegian Directorate of Health, and the initiative was started in 2008.

- *The Committee asks the next report to provide more detailed information on any other services available to elderly persons in addition to home care and nursing services. It also wishes to know the number of people living in ordinary housing whom receive home care.*

Reference is made to the reporting for Article 23.

- *The Committee asks whether the elderly have an automatic right or entitlement to services they might require or whether a needs assessment is carried out, and what avenues of complaint are open in the event a service is denied.*

Pursuant to section 2-1a of the Patient's and User's Rights Act, both patient and user are entitled to the necessary health and care services from the municipality. Elderly people thus have the same rights as all other inhabitants. In essence, individuals must themselves approach the health and care services for help. These services will then be responsible for mapping the individual's needs and of ensuring an appropriate provision of services (section 3-1 of the Health and Care Services Act). When drawing up service provisions, the individual patient and user shall be heard (section 3-10 of the Health and Care Services Act). If the patient and/or the user is of the opinion that the provision of services is not appropriate or adequate, this can be appealed to the County Governor (section 7-2, Patient's and User's Rights Act).

- *New investment grant - the Committee asks to be kept informed on the implementation of this new scheme, namely how many old people have benefited from this grant for the improvement of their private home, and if the grant covers the entire cost of the adaption. In general, the Committee asks to be kept informed of any future measures taken to promote adapted and quality housing for elderly persons.*

We refer to the reporting and description of *12 000 24-hour care places* (Investment grant for 24-hour care places) under Article 13. According to Report no. 25 (2005-2006)to the Storting, the investment grant was also to be given for adapting private houses and access to the house (for example a lift). When the scheme was established in 2008, an assessment was made on where the need for investment was greatest, with the result that a decision was taken not to use the investment for this purpose. Instead, the Government gave priority to building new and renovating existing community care housing and nursing home places.

However, elderly people can receive grants for measures in their own houses so that they can live at home longer after their health begins to decline. These grants for adapting residences are given to elderly and disabled people. In 2011 the average grant was NOK 48 000 and can cover the entire adaptation costs. If the cost is higher, the grant can be given together with a loan. Each year 1 500–2 000 persons receive a grant for this purpose. The Government has reinforced the allocations to the scheme substantially in recent years, and in the proposal for the national budget for 2013 it has suggested that the allocation should be increased to NOK 172 million from a previous annual level of approximately NOK 80-100 million.

- *The Committee asks the next report to provide information on how the different types of residential structures for the elderly (whether public or private/community-based or not) are controlled and inspected with a view to ensuring that the services provided and care standards are adequate.*

Reference is made to the information and reporting on the Norwegian Board of Health Supervision in Article 13.

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

Question 1) – The general legal framework

Individuals' right to protection against poverty
There have been no material changes in the individual's right to protection against poverty and social exclusion in the reference period.

Housing
From 1 July 2009 the rules for allocating housing support were reorganized. The main objective of the reorganization was to combat poverty. This was to be achieved by removing rules that could reduce the recipients' motivation to enter paid work and by increasing the support to households with high housing expenses and low income who had previously been excluded from the scheme. Another goal was to make the regulations more user-friendly through simplifying them. The evaluation of the reorganization has concluded that it was successful with regard to removing rules that were instrumental in preventing participation in work, to opening the scheme to a greater number of smaller households with poor economy and high housing expenses, and to simplifying the rules. The reorganization also contributed to increasing benefits to large households and to families with children who had already entered the scheme before the change, but it opened the scheme for new, large households to only a small extent. In 2011 a total of 155 500 households received housing support for one or more months, i.e. 23 per cent more than before the reorganization (2008).

Beside this, there have been no essential changes in Norwegian policy and legal framework concerning housing since 2008, which affects protection against poverty and social exclusion.

Education
Extension of the right to upper secondary education for adults
A legislative amendment has been made entailing that everyone who has not completed or utilized the right to upper secondary education and training as an adolescent is entitled to take this course of education as an adult as of the year he/she becomes 25 years of age. Prior to this, only adults born before 1978 had the right to take upper secondary education for adults. The

legislative amendment was stipulated in section 4A-3 of the Education Act and entered into force on 1 August 2008.

The right to upper secondary education for young people pursuant to the right for adults when there are special reasons
A legislative amendment has been made entailing that young people with the right to upper secondary education and training pursuant to section 3-1 of the Education Act may on application receive this course of education in accordance with section 4A-3 of the Act. It is stipulated that there must be "special reasons" for this. Examples of "special reasons" may be the age of the person in question or that he/she is in work and has therefore difficulties completing education and training pursuant to section 3-1 of the Act. For young people between the ages of 20 and 24 who are outside the labour market and lack education at upper secondary level that can provide entrance qualifications for higher education, it will be easier to combine education and training in accordance with section 4A-3 of the Act with work practice, close follow-up and other NAV services than if they use the young people's right to upper secondary education and training stipulated in section 3-1 of the Act. This amendment was made in section 3-1 of the Act by adding a new tenth paragraph. The amendment entered into force on 1 August 2008.

Both these amendments concerning upper secondary education and training for adults are described in more detail in Circular F-14-08 (Norwegian only) issued by the Ministry of Education and Research.

A circular from the Directorate for Education and Training – UDIR-2-2008 – describes the applicable regulatory framework on the rights of adults to upper secondary education and training pursuant to the Education Act, Chapter 4A.

The right to adapted language education for pupils from language minorities
In 2008 a provision was introduced that clarifies the right of language minority pupils in upper secondary education to adapted language education pursuant to section 3-12 of the Act. Pupils have the right to adapted education in Norwegian until they are sufficiently proficient in the language to follow the normal teaching of the school. If necessary, such pupils are also entitled to mother tongue instruction and bilingual subject teaching. The school owner must map pupils' proficiency in Norwegian before any decision on adapted language education is reached. The provision entered into force on 1 August 2008.

In 2008 the Directorate issued a circular entitled *Rett til grunnskoleopplæring for barn og unge i asylmottak, UDIR-5-2008.* (Right to primary and lower secondary education for children and adolescents in asylum reception centres).

In 2009 the Directorate issued a guide entitled *Veileder om regelverket knyttet til minoritetsspråklige elevers og voksnes opplæringssituasjon* (Guide on the regulatory framework concerning the educational situation of minority language pupils and adults). This is available on the Directorate's website.

The curricula in basic Norwegian for minority language pupils and in the pupils' native languages have legal status as regulations in common with other school curricula. They are employed in the exercise of the right to adapted language education.

Guides on the use of the curricula in basic Norwegian for language minority pupils have been compiled. This is to facilitate the implementation of the curricula and the right to adapted language education. To supplement the curricula, guides with examples have also been published.

In addition, comprehensive training plans have been compiled. The courses offered apply to the use of these curricula and are mainly targeted at teachers. In other settings school heads are also a target group for the regulatory framework and the curricula.

In June 2010 the Norwegian Official Report *NOU 2010:7 Mangfold og mestring* (Diversity and mastery) was published. This is an official report that provides a general review of the education and trainings options for minority language children, adolescents and adults. The Ministry has worked on assessing and following up the measures in this report since 2010. The work is still in progress.

The Ministry of Education and Research has identified a need to reinforce the work on information, guidance and competence enhancement with respect to the municipalities that are responsible for the education and training of young asylum seekers and the children of asylum seekers. A competence enhancement programme will therefore be conducted in the period 2010−2012 for school leaders, school owners and teachers in municipalities where there are asylum reception centres, as well as for those who are responsible for education at these centres and care centres. As part of the programme, the municipalities and county authorities will be informed about the regulatory framework applicable to the education and training of asylum seekers. The programme will help to increase knowledge of the right of children and young asylum seekers to education and training and of the appropriate organization and content of educational programmes for newly arrived pupils.

Competence enhancement initiatives and networks with different target groups are organized under the National Centre for Multicultural Education (NAFO) and in cooperation with several important actors in public administration.

NAFO also has responsibility for other projects and initiatives to improve the education and training of minority language pupils. For example it contributes to skills development in kindergartens, schools, universities, university colleges and adult education centres.

Early initiatives
A number of Reports to the Storting – Report no. 16 (2006-2007) to the Storting …*og ingen sto igjen* (…and none were left behind) and Report no. 32 (2007-2008) to the Storting *Kvalitet i skolen* (Quality in schools) – documented the importance of early initiatives to improve pupils' skills and academic development. With effect as of 1 August 2009 a legislative amendment was therefore introduced with the objective of ensuring early initiatives and extra resources targeting pupils in the first years of schooling who needed this for reading and mathematics. The intention was to ensure a good start in relation to pupils' basic skills and to help to prevent pupils dropping out at a later stage of their school careers. A statutory duty was introduced for municipalities to ensure that adapted education for Grades 1 to 4 in Norwegian or Sami and mathematics includes a very high teacher density and is targeted specifically at pupils with poor skills in reading and mathematics. The legislative amendment was included in the Education Act section 1-3 relating to adapted learning and early initiatives.

Right to up to two years' additional upper secondary education and training for pupils who have the right to adapted language education
In 2009 the right to additional upper secondary education and training was extended in accordance with section 3-1 paragraph 5 of the Education Act to include also pupils who have the right to adapted language education pursuant to section 3-12 of the Act. Before a decision is made on additional education, an expert assessment shall be made of the special needs of the pupil.

Right of pupils with disabilities to transport to and from after-school care facilities
In 2010 a right to transport to and from after-school care facilities was introduced for pupils with disabilities, temporary sickness or injury. Pupils had previously only had a right to transport to and from school.

Sami and national minorities
Some schools/municipalities have groups of pupils with education in Sami as the first and second language. In this event the local school authorities are allowed to reallocate approximately 3 per cent of the subjects to cover the teaching hours for optional subjects in the timetable. This also applies to pupils with Finnish as a second language. There are some restrictions regarding reallocation of timetabled hours. These changes apply from the school year 2012-2012.

The Sami Parliament has submitted a report on education and training. This may lead to changes but a closer follow-up has not yet been implemented. Work is also underway on the distribution of subjects and teaching hours for pupils with Sami/Finnish as a second language.

Reference is also made to the Ministry of Education and Research's new project *Ny Giv* (New possibilities). This was started in 2011 and is still in progress.

Ny Giv is the Ministry's main project to increase completion rates in upper secondary education and training in collaboration with county authorities and municipalities. Some relevant facts about the project:

- The national goal is to increase completion rates from 70 to 75 per cent by 2015
- A completion rate of 75 per cent for upper secondary education and training will mean that in the course of ten years a total of 30 000 more young people will have undergone and passed upper secondary education and training
- A 5 per cent higher completion rate will save society NOK 2.7 billion per year.
- A total of approximately NOK 500 million will be allocated to the *Ny Giv* project in the period 2011−2013

The project is further divided into a transition and a follow-up project.

The transition project

- From the school year 2012−2013 all Norwegian municipalities will participate in the project
- A total of 13 000 pupils will be included in the project during the three years it lasts.
- A total of 3 500 teachers will receive training in methodology suited to this group of pupils
- All primary and lower secondary schools participate in *Ny Giv*, and they are invited to send teachers on courses on how their teaching can be made more practical and

relevant. The aim is that all pupils benefit from teachers' increased competence over time
- This year NOK 20 million has been granted for summer activities in all counties
- As part of the *transition project* the pupils with the weakest performance in Grade 10 will be offered an agreement on extra initiatives in the last six months of their lower secondary education to improve their skills in reading, writing and mathematics
- A hub school putting emphasis on the vocational aspects of common subjects has been designated in all counties. These schools will form a network to develop education and training in the common subjects in vocational education programmes so that pupils experience these as relevant for their chosen profession.

The follow-up project
- The aim of the *follow-up project* is to strengthen cooperation between county authority professional training and NAV regarding young people between 16−21 years of age who are not included in education and work
- All NAV's county offices participate in the project together with NAV's local offices in the municipalities
- A total of 760 employees in the municipal follow-up service and NAV have taken part in a skills enhancement programme under the auspices of Lillehammer University College
- From and including autumn 2012 a further education programme (30 credits) at the Telemark and Finnmark University Colleges has been offered to employees in the follow-up service, in schools and in NAV
- The county's follow-up responsibilities have been made more binding in that the regulations for the follow-up service have been amended and clarified
- The project has now helped to reduce the number of young people who were previously registered as unknown by the follow-up service. The number has been reduced from approximately 10 000 to 2 500
- A considerable number of young people are now engaged in activities or are being followed up and supervised by the follow-up service. The number of young people who are engaged in activities increased from approximately 5 000 in November 2011 to 9 000 in June 2012.

Medical assistance
Reference is made to the reporting 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.

In 2008 the Government appointed the Allocations Committee to examine the development in income inequalities over time, what factors affect allocations and what measures can contribute to a more even distribution. The Committee submitted its recommendation in a Norwegian Official Report (NOU 2009:10) to the Ministry of Finance in May 2009. The Committee has considered measures that can help to prevent the reinforcement of income inequalities over time, including poverty that is inherited.

The Government followed up the recommendation, issuing Report no. 30 (2010–2011) to the Storting which underlined the importance of growing-up conditions, school and education, housing policies and an inclusive working life. These policy instruments are for the most part universal, but some of the instruments are particularly targeted at socially excluded and vulnerable groups.

The Government's Action Plan against poverty was launched in 2007 and is discussed in Norway's 6th Report. 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, and that living conditions for the most disadvantaged shall be improved. The action plan was carried forward and followed up by measures and the strengthening of annual national budgets in the period 2008–2011.

Examples of measures targeting children/young people:

- 2004–2009: The municipalities on application were awarded grants for holiday and leisure activities, summer jobs for young people, stores of equipment, help with homework, and competence-building measures.
- The municipalities and urban districts have received grants for competence and development measures in the social services. Examples of efforts in this field are leisure activities for children and young people (grants to cover the cost of membership fees, equipment, trips, championships in various clubs/associations, activity weekends for young people etc.), and activities in connection with school (grants to cover the cost of school events and trips, help with homework and after-school activities and open school in the summer holiday). The funds have also been used to provide alternative activities for young people who have dropped out of upper secondary school (traineeships, close follow-up) and financial contributions to families with children (furniture, equipment, shoes, clothes, food at Christmas, confirmation, baptism, school equipment, sports equipment, holiday, transport costs).
- *Measures for young people in risk zones – Losprosjektet (Mentor project)*: In the autumn of 2010 the Ministry of Children, Equality and Social Inclusion initiated a mentor project. This is a three-year project to strengthen the follow-up of at-risk young people. A total of 15 municipalities from altogether 9 counties are participating in the project. The objective is to improve affiliation with school and work especially among disadvantaged young people aged 14-23 years.

Through *Losprosjektet* young people will be attached to a mentor who will follow them up and help them to utilize the various initiatives offered by the help services. This can be compared with the Ministry of Education and Research's implementation of the programme *Ny GIV*. The project will continue up to and including 2013. NOVA (Norwegian Social Research) has been commissioned to assess goal achievement in *Losprosjektet.* The final assessment report will be submitted in 2014.

Grants to voluntary work were strengthened in 2008 and 2009 to reinforce and extend dialogue and cooperation with non-profit organizations that work to combat poverty and social exclusion. In 2008 a Contact Committee was established to liaise between the Government and representatives of organizations helping the poor and disadvantaged groups, and also a Collaborative Forum for the organizations participating in the Contact Committee. "The Battery" which is a nationwide self-help centre under the auspices of the Church City Mission, acts as the secretariat for the Collaborative Forum. Four such self-help resource centres have been established outside Oslo; in Bergen, Trondheim, Bodø and Kristiansand. In 2008 a grant scheme was established to cover the operating costs of organizations that combat poverty and social exclusion and for projects and activities run by non-profit organizations. The objective is to support self-organization, self-help activities, user influence and work to influence the government's social policies. In addition to funding for the Collaboration Forum, the Contact Committee and the Battery resource centres, operating grants were allocated in 2012 to 16 organizations and financial support to 21 projects. In 2011 operational funding was awarded to 19 organizations and support to 30 projects. Grants for activities and work training under the auspices of non-profit organizations were strengthened in 2009. A total of 41 projects received grants in 2012. A total of 21 projects were the continuation of projects already underway and 20 were new projects. In 2011 a grant scheme was established to promote the development of social entrepreneurship and social entrepreneurs combating poverty and social exclusion. Six enterprises have received grants through this scheme in 2011, and seven enterprises received funding in 2012.

Cultural and sports 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 these 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 to19, in primary school and lower and upper secondary school.

In 2011 the Government presented a Report to the Storting on culture, inclusion and participation. The objective of the report was that cultural life shall to a greater extent be directed at everyone, particularly groups and individuals who today participate very little in

cultural life. Art and cultural institutions with public funding shall ensure that they take into account inclusion and diversity in their ordinary activities.

As a follow-up of the Report the Government is for example supporting a pilot project in the county of Møre og Romsdal with discount cards for children and young people. The discount cards are intended to give children and young people from low-income families the opportunity to take part in cultural and leisure activities at no cost. Moreover, a cultural programme has been established under the scheme "Measures for children and youth in urban areas", an initiative to improve childhood and adolescence and living conditions for children and youth in urban areas. The scheme is administered by the Ministry of Children, Equality and Social Inclusion.

Voluntary sector
Reference is made to the previous report.

Sport
The overall goal of government policies for sport is to contribute to *open and inclusive sport.*

The most important policy instrument in this area is the funding given to the Norwegian Olympic and Paralympic Committee and Confederation of Sports (NIF).

The Government assumes that an inclusive sports movement is well aware of the challenges linked to social inequality in patterns of participation. It is vital that the range of sporting activities does not entail such high costs for the participants that this represents in practice a real financial barrier for parts of the population. The Government takes it for granted that within the total spectrum of sports activities there will still be a broad, all-round range for everyone, irrespective of the individual's or the parents' economic situation.

The Ministry of Culture administers a special grant scheme that is based on the ability and potential of sports associations to be arenas for inclusion in the local environment. The general objective of the grant scheme *Social inclusion in sports clubs* is to include new groups in the club's ordinary activities by combating financial and cultural barriers that may hinder participation in organized sporting activities.

Question 3) – Statistics etc.

The development in persistent low-income. Three-year period. Proportion of persons with 3-year equivalent income below 50 and 60 per cent of the median average in a 3-year period. Two different scales of equivalence.

Population as a whole:

	OECD-scale		**EU-scale**	
	50 per cent	**60 per cent**	**50 per cent**	**60 per cent**
2004−2006	3.8	7.8	4.5	9.3
2006−2008	4.1	8.1	4.7	9.5

2007−2009	4.1	8.0	4.7	9.5
2008−2010	4.2	8.0	4.5	9.3

Excluding students *:

2006−2008	3.2	6.9	3.6	8.2
2007−2009	3.3	6.8	3.5	8.1
2008−2010	3.3	6.8	3.4	7.9

* Persons who live alone in the last year of the period and who receive a student grant.

Source: www.ssb.no Statistics Norway

Homeless: The last mapping of homeless persons was carried out in 2008 and showed that there were 6 100 homeless persons.

Further question from ECSR:

- *The Committee asks if people whose incomes have been low for less than three years are also considered poor.*

Persons whose incomes have been low for less than three years belong to the low income group in the years their income is low. They are assessed as financially disadvantaged. Many experience low incomes in transition periods, for example from academic studies to work, in periods between different jobs, etc. There is high mobility in these groups.

- *The Committee recalls that Article 30 does not only cover poverty but also social exclusion and the risk of social exclusion. It asks that the next report indicate how this phenomenon is tackled.*

Financially disadvantaged persons are in danger of social exclusion. To prevent social exclusion, financial support can be given for leisure activities to persons/families who depend on financial benefits for their subsistence. Participation in the qualification programme is an important tool in helping people out of social exclusion, since the programme can also contain initiatives targeted at this. For example women can participate even though they are married to men whose income is sufficient so that the family is not poor, if the woman so wishes and satisfies the conditions for participation on an independent basis. The Contact Committee, liaising between the Government and representatives of organizations helping the poor and disadvantaged is also required to have a focus on problems linked to social inclusion. Reference is made to the discussion at Question 2 above.

- *The Committee asks for information, backed up by practical examples, on how individuals and voluntary associations take part in assessing measures to combat poverty.*

A number of non-profit organizations help to combat poverty and social exclusion. Activities are organized for children and adults. Political work is targeted at influencing national and

local authorities. In addition, food and clothing is distributed to the poor, homeless people and substance abusers. The authorities provide grants for this type of work and these are awarded through open application processes. Reference is also made to the discussion at Question 2 above.