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Immigrant Health Status and Access to Healthcare. The Case of Norway

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STATEMENT OF AUTHORSHIP

I hereby declare that this PhD dissertation is my own work and contains no material that has been accepted for the award of any degree or diploma from any tertiary institution. To the best of my knowledge and belief, this thesis contains no material previously written or published by another person, except where due reference is made in the text.

Signed:	Date
Emmanuel Aoudi Chance	12th February 2018

STRESZCZENIE

Zdrowie jest bogactwem społeczeństwa, gwarantującym jego rozwój społeczny i ekonomiczny, ponieważ tylko zdrowe społeczeństwo jest w stanie tworzyć dobra materialne, rozwijać się oraz osiągać odpowiednią długość życia. W tym podejściu uważa się, że zdrowie powinno być podstawowym zasobem jednostki i społeczeństwa jako całości i musi być wspierane poprzez inwestowanie w warunki życia, gdyż chore, zubożałe społeczeństwo nie daje gwarancji ani bezpieczeństwa rozwoju społecznego i ekonomicznego. Pojmowanie zdrowia jako fundamentalnego prawa każdego człowieka daje podstawę do podejmowania działań w kierunku poprawy zdrowia społeczeństwa i jego kształtowania.

Celem niniejszej pracy doktorskiej jest wskazanie roli dostępu do usług zdrowotnych jako jednego z istotnych działań na rzecz poprawy stanu zdrowia imigrantów oraz zidentyfikowanie i przedstawienie ekonomicznych i społecznych uwarunkowań oraz konsekwencji tych działań w zakresie korzystania ze świadczeń zdrowotnych imigrantów w Norwegii. W pracy badany też jest wpływ satnu zdrowia na kształtowanie kapitału ludzkiego. Zastosowano podejście interdyscyplinarne, odwołując się do takich dziedzin jak: ekonomia, polityka społeczna w tym polityka zdrowotna czy politologia, aby pełniej poznać uwarunkowania stanu zdrowia imigrantów.

Aby zrealizować cel pracy przeprowadzono badanie terenowe. Badaniem objęto 60 osób mieszkających w Norwegii: 20 imigrantów afrykańskich, 20 imigrantów europejskich i 20 Norwegów (45 mężczyzn i 15 kobiet) poprzez wywiady, obserwacje i ankietę, które poparto przeglądem literatury. Hipoteza badania terenowego dotyczącego stanu zdrowia imigrantów mówi, że istnieje zależność między stanem zdrowia a dostępnością do usług zdrowotnych. Istnieją różnice w dostępie do usług zdrowotnych między obywatelami Norwegii i imigrantami, a także między imigrantami. Różnice między imigrantami zależą od ich pochodzenia, płci, dochodów i wykształcenia. Do najważniejszych pytań badawczych należą: Czy świadczenia zdrowotne i placówki zdrowotne są dostępne dla imigrantów w Norwegii oraz czy norweski system ochrony zdrowia reaguje na potrzeby ekonomiczne i zdrowotne imigrantów? Czy działania w zakresie rozwiązywania problemów zdrowotnych imigrantów i kwestia ich dostępu do świadczeń zdrowotnych wpływa na poprawę ich zdrowia?

Wnioski z badania wskazują, że chociaż rząd norweski podjął znaczne działania, aby poznać i poprawiać stan zdrowia legalnych i nielegalnych imigrantów, jednak imigranci

wciąż zmagają się z problemami związanymi ze zdrowiem i zazwyczaj ostatecznie nie korzystają z pomocy medycznej, kiedy jej potrzebują. Stres związany z problemami finansowymi i trudności wynikające z wyzwań, jakie stawia integracja społeczna, w połączeniu z niskim statusem społeczno-ekonomicznym i brakami finansowymi mają negatywny wpływ na ich zdrowie. Wykluczenie społeczne, brak wiedzy o systemie zdrowia i niski wykształcenie ograniczają dostęp do świadczeń zdrowotnych. Natomiast wyższy poziom integracji społecznej, ekonomicznej i politycznej może umożliwić migrantom zrozumienie norweskiego systemu opieki zdrowotnej i tym samym daje szansę im na lepszy dostęp do świadczeń zdrowotnych. Status społeczno-ekonomiczny imigrantów ma istotny wpływ na ich stan zdrowia i dostęp do świadczeń zdrowotnych.

Istnieją różnice w dostępie do świadczeń zdrowotnych pomiędzy obywatelami Norwegii a imigrantami, jak również różnice pomiędzy samymi imigrantami, w zależności od miejsca ich pochodzenia, płci, dochodów i wykształcenia. Wobec powyższego rząd norweski powinien podjąć kroki, aby upewnić się, że wszelkie bariery w dostępie do opieki zdrowotnej, szczególnie jej wysokie koszty i czasami nieprzychylne nastawienie Norwegów wobec imigrantów, mogą zostać wyeliminowane. Integracja społeczna, ekonomiczna i polityczna imigrantów, istnienie lokalnych placówek oferujących świadczenia zdrowotne i edukację, zaangażowanie mediatorów ze społeczności imigranckich oraz dostrzeganie indywidualnych potrzeb stanowią kluczowe czynniki, które mogą umożliwić poprawę dostępu imigrantów do świadczeń zdrowotnych.

Słowa kluczowe: zdrowie, stan zdrowia, majątek, imigranci, imigracja, system opieki zdrowotnej, kapitał ludzki, gospodarka, dostęp do świadczeń zdrowotnych.

ABSTRACT

Health is one of the most important assets of a society; it is necessary for social and economic development and for achieving ample length and quality of life for its members. This thesis asserts that health should be a basic resource of the individual and of society as a whole. Understanding health as a fundamental right of every human being is the basis for taking action to improve the health of a society and its development.

The aims of this doctoral thesis are to indicate the role of access to health services in improving the health of immigrants, as well as to identify and present the economic and social conditions and consequences of immigrants' limited access to health benefits in Norway. The study also examines the impact of health on the formation of human capital.

The hypothesis of the field study is that there is a relationship between a society's state of health and the availability of its health services. The most important research questions are whether health services and health facilities are available to immigrants in Norway, whether the Norwegian health care system responds to the economic and health needs of immigrants, and whether activities in the field to solve immigrants' health problems and enhance their access to health services improve their health.

To answer these questions, a field study was conducted of 60 people living in Norway: 20 African immigrants, 20 European immigrants, and 20 native Norwegians (45 men and 15 women). The study consisted of interviews, observations, and surveys, which were supported by a review of literature. An interdisciplinary approach was applied, referring to areas such as economics and social policy, including health policy and political sciences, to better understand the determinants of the state of health of immigrants.

The findings show that there are differences in the ease or difficulty of access to health services between Norwegian citizens and immigrants, as well as among immigrants. The differences in access among immigrants depend on their origins, genders, incomes, and educations. The findings also show that although the Norwegian government has taken significant steps to ensure that the health of both documented and undocumented immigrants is addressed, immigrants still face health-related challenges, and most end up not seeking medical assistance in times of need. Stress associated with financial adversity and hardship resulting from the social challenges of integrating, together with low socio-economic status,

have negative impacts on health. Feelings of social exclusion, lack of knowledge about the health-care system, and socio-economic barriers limit access to health-care services.

The findings indicate that a higher level of social, economic, and political integration could enable migrants to understand the Norwegian healthcare system and, thus, give them the opportunity to better access health services. Because immigrants are a such an important source of human capital, an investment in immigrants as such and in their overall health could provide a subsequent increase in productivity, which in turn could promote the economy.

Therefore, the Norwegian Government should take steps to ensure that any barriers to access to health care services, in particular its high costs and sometimes the unfavorable attitude of Norwegians toward immigrants, are eliminated. The social, economic, and political integration of migrants, the existence of local health-care services and education, the use and involvement of mediators from immigrant communities, and the recognition of individual needs are found to be key factors that would enable improved immigrant access to health services.

Keywords**:** *Health, health status, wealth, immigrants, immigration, health-care system, human capital, economy, access to health-care services.*

CHAPTER I: INTRODUCTION

This part presents the foundation for understanding the research problem. The focus is on immigrants' health statuses, access to health services, and economy. It contains the characteristics and statement of the problem, the research assumptions, the aims and significance of the study, the summary of chapters, and the main aims of this dissertation.

1. Characteristics of the Problem

This thesis seeks to provide a clear understanding of immigrants' health statuses and experiences in accessing health services in Norway, thereby providing a basis for further improvements. This thesis addresses the impact of immigrants' access to health services on the economy, considering the role of the human capital[1] of immigrants. Like many other countries today, Norway is a diverse and complex society because of immigrants.[2] Immigrants come to Norway for various reasons, including education, jobs, refuge, and family. According to *Statistics Norway*, at the beginning of 2016, there were 698,500 immigrants and 149,600 Norwegians born to immigrant parents in Norway. Furthermore, the number of immigrants is increasing each year, and this poses major economic challenges.

Norway is known as a country with good social policies[3] that provide equal health services for all population groups, regardless of their beliefs and affiliations.[4] However,

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[1] $\boldsymbol{C_h = (y + 0.1d \times (e_r + 0.5e_s + x + 5b + 0.25n + 0.5i + z)) \times \mathrm{Log}(h)}$
where C_h, is a factor for human capital that can be applied to a person income today to predict this persons' future lifetime income**,** drive for advancement ***d***, e_r for education — related, e_s for education — supplemental**,** remaining years of work ***y,*** years of experience ***x,*** brand cultivation ***b,*** involvement in a community ***i,*** Bonus points ***z,*** human network $n<60$. Available at: http://www.consumerismcommentary.com/proposal-a-formula-for-your-personal-human-capital/. Accessed 24.02.2017.

[2] Immigrants are according to norwegian law, a persons born abroad with two foreign-born parents and four foreign-born grandparents, in addition to persons born in Norway with two foreign-born parents and four foreign-born grandparents. Available at: http://www.ssb.no/en/befolkning/statistikker/innvbef/aar/2017-03-02?fane=om. Accessed 02.03.2017.

[3] Sustainable Governance Indicators (SGI). *Social policies, Norway.* 2016. Available at: http://www.sgi-network.org/2014/Norway/Social_Policies. Accessed 01.04.2017.

[4] Social policies are subject concerned with those state and non-governmental activities within one country that are designed to intervene in the operations of the free market in the interests of social protection and social welfare. The social policies refer to legislation, principles, guidelines and activities affecting the living conditions conducive to human welfare (the individual's quality of life). Social policies are public services governing citizen'swell-being. They deal with social problem such as lack of education, poverty, poor health, inadequate housing, and unemployment. The implementation of social policies is for improving the quality of life for citizens and correcting societal health problems. Available at:

immigrant health concerns have not been considered by many Norwegian governmental and non-governmental organizations.

Immigrant health care in Norway is distinct from Norwegian citizen health care due to various political, social, and economic factors. Woolf et al. (2015, p. 1) suggested that "… income is a driving force behind the striking health disparities that many minorities experience."[5] Consequently, individuals with lower incomes are less able to afford health-care services and health insurance, whereas people with higher incomes have greater resources to afford high-quality health-care services. The research demonstrates that immigration status has a significant connection to access to health care. This thesis reveals that the acts of limiting and regulating health care based on immigration status are not the only obstacles to accessing and obtaining health care; the challenges that hinder or prevent immigrants from accessing health services are economic, educational, structural, and social. Discriminatory social policies, health policies,[6] patient–provider miscommunication, feelings of alienation and mistrust, and economic deprivations impair immigrants' access to health care and the quality of health care they receive.

Furthermore, scarcity negatively impacts immigrants' health. Unhealthy immigrants may negatively impact the economy in Norway because they cannot work harder and longer and bring their human capital to technological progress and innovation. Income inequality, unequal distribution of income, and wealth play key roles in determining variations in human well-being.

2. Statement of the Problem

The 1946 Constitution of the World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Health is a human right. According to the Universal Declaration of Human Rights, Article 25,

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https://courses.lumenlearning.com/boundless-politicalscience/chapter/the-history-of-economic-policy/. Accessed 06.05.2017.

[5] S. H. Woolf, S.M. Simon, L. Aaron, E. Zimmerman, L. Dubay, K.X. Lux , *How are income and wealth linked to health and longevity?* Urban Institute 2015, p.1.

[6] Health policies refer to decisions, plans, and actions that are undertaken in a country to achieve specific healthcare goals within a society. Health policies focus on the financing of healthcare services to spread the economic risks of worsen health. Health policies outline health priorities and expected roles of different groups. Health policy helps build consensus and inform people. Available at: http://www.who.int/topics/health_policy/en/. Accessed 25.06.2017.

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.

The right to health was recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. Health is an important economic asset for economy. By accessing health services, citizens are more likely to be healthy enough to invest and use their *human capital* to be productive (economically and socially) and to contribute to economy.

Immigrants in Norway face challenges linked to immigration, integration, and access to health care. The stress of immigration begins as soon as immigrants leave their home countries. Immigrants from developing countries may have different experiences in accessing health-care services in Norway than immigrants from Europe. Immigrants are seen as a source of population growth, problems, and crisis.

All immigrants must adapt to a new socio-economic environment and political and educational systems that differ materially from those of their home countries. Stress can have terrible physical and subjective health consequences, as immigrants face many obstacles when settling in and building new lives. Stress associated with financial adversity is believed to have harmful biological effects on the body.[7] Immigrants may also face difficulties accessing health-care services. They may have a lower socio-economic status on arrival than in their previous lives, and they may have problems covering their initial medical expenses after arrival. Immigrants' social and economic conditions affect their health and interpersonal relations (and each other) over the course of their lives. Being an immigrant can have a negative effect on economy because of the non-use of their human capital.

Immigration also strains Norwegian society. Immigration, including growing illegal immigration and trafficking, presents challenges to the sustainability of the Norwegian welfare state. The improvement and maintenance of immigrants' health and well-being are essential human concerns and are necessary to ensure the well-being of the entire Norwegian population and the country's economy. However, socio-economic differences impede the communication between health personnel and immigrant patients and make it challenging for health-care professionals to provide quality care.

[7] B.S. McEwen, *Protective and Damaging Effects of Stress Mediators: Central Role of the Brain*, Dialogues in Clinical Neuroscience 8 (4), 2006, p.368.

Immigrants' socio-economic statuses and their perceptions of access to health-care services are both significant concerns. Immigrants may have their own understandings of various health problems, making it challenging to treat them without some knowledge of their socio-economic backgrounds. Health is an important asset for the economy, and unhealthiness depresses the development of human capital and income. Despite these problems, little research has been done to assess how health services in Norway can improve immigrants' health care or how their ability to access health services impacts economy.

3. Research Assumptions

Immigrants in Norway face different challenges in relation to their health statuses and access to health care. Consequently, this study is based on the assumption that the immigration status of immigrants in general is static. This suggests that when immigrants enter Norway, they will always be immigrants—thereby limiting their rights to have equal access to health care. This is due to income disparities between immigrants and citizens that make health-care services less affordable for individuals with low socio-economic status. However, this assumption does not translate to all immigrants in Norway, and, thus, advantages in relation to equal access to health care may increase over time. This assertion is in association with the assumption that immigrants in Norway, particularly the undocumented ones, remain uninsured, which makes access to health-care services expensive.

It is also assumed that immigrants and Norwegians have different perceptions and views regarding health care. Due to socio-economic differences, immigrants may have a different understanding about the policies and health services offered in Norway, thereby resulting in their resistance to seek health care from Norwegian health-care centers and institutions. Moreover, this study assumes that immigrants in Norway lack awareness about the laws and regulations enforced by the Norwegian government to ensure their safety. It is assumed that since immigrant health care in Norway is distinct from Norwegian citizen health care, immigrants may view this as a restriction from equal access to health-care services that compromises their health status. Hence, the absence of immigrant adaptation is assumed to be associated with immigrants' health status and access to health care.

4. Research Aims and Significance of the Study

This thesis examines the connection between immigrants' access to health services in the context of socio-economic conditions and seeks to identify the impact of health services on the health statuses of immigrants and to present a conceptual framework to facilitate the design and delivery of competent health services and support for patients with immigrant backgrounds.

Debates pertaining to the relationship between health, access to health-care services, and the economy have been growing among economists and researchers alike. Interestingly, some economists agree that there is a positive association between health and economy, whereas critics (economists) argue that health has no correlation with economics. For example, according to Deaton (2003), the correlation between health and income (economy) is being stimulated by variations in institutional quality, while improvements in the areas of health and income over time are results of knowledge advancement.[8] Furthermore, human capital influences the correlation between health, access to health services, and the economy by allowing people to apply available health knowledge to their own lives for earning more in the labor market. Income inequality causes ill health. Income causes health, and health also causes income that leads to economic progress. Extensive health services are important for improving both the population's health and the distribution of income.[9]

Clearly, underlying factors make this relationship a complex subject. The aim of this paper is to explore the underlying factors that determine the correlations between immigrants' health, access to health service, and income. The research investigates immigrants' health and explores the importance of their having access to health services in Norway. It may contribute to European policy discussions about immigration and access to health-care services.

This research is of particular significance for the relevant parties of Norwegian health-care institutions and the Norwegian government's immigrant budgetary sector. It will help improve the understanding of how the research is progressing and of its future direction in improving the immigrants' health statuses and access to health services for immigrants in Norway. The poor health of immigrants can lead to job loss, financial crisis, and work absence. This topic can contribute to European policy discussions about immigration and help to conceptualize the shifting effects of structural inequalities on health dispositions. This

[8] D. N. Weil, *A review of Angus Deaton's the great escape: Health, wealth, and the origins of inequality*, Journal of Economic Literature, 53(1), 2015, p.12.
[9] A. Deaton, *Health, Inequality, and Economic Development,* Journal of Economic Literature, XLI, 2003, p.133.

thesis may also contribute to addressing the access barriers to health-care services facing immigrants in Norway.

This study is grounded in particular on the conceptual health models that show how social networks and relationships influence a broad array of health outcomes. Social capital and social relationships have an impact on health and access to health services and can increase the distribution of information about, and thus the application of, those behaviors that improve immigrants' health and access to Norwegian health services. Membership organizations in Norway like the Association of NGOs in Norway, Caritas Norway, often serve as conduits for health information.

Healthy and skilled immigrants are part of the core human resource concerns for building national capability to perform well in the economy.

5. Summary of Chapters

This thesis is organized into ten chapters, including an introduction.

Chapter I introduces the rationale for my thesis contributing to the understanding of the topic. It discusses the fundamentals and overall rationale behind the research, specifically addressing the question of whether health-care services and health-care facilities are accessible and responsive to immigrants in Norway and exploring the impact of immigrants' health concerns and access to health-care services on economic progress for Norway. Additionally, this part highlights the goals and objectives for the study.

Chapter II provides a broad, detailed definition of health. It focuses on the conceptual approach to health. Health is a dynamic process of interaction between people and their bodies with the social, political, natural, and economic environments. Health is the fundamental human needs of everyday routines. Health is an asset with intrinsic value (improved objective and subjective health and well-being) and instrumental value (being able to form and maintain relationships, to work or pursue leisure interests, and to make decisions in everyday life). Health contributes to and is a significant determinant of economy. This chapter focuses on a conceptual approach to health because immigrants' health and access to health services can affect their ability to earn money or income over the course of their lives and to contribute to economic progress. Health has both subjective and objective aspects. Health and well-being influence each other. Health is regarded as crucial to well-being. Well-being incorporates health, happiness, income, welfare, and much more. This chapter presents the determinants of health and the types of health-status measures.

This chapter also provides a description of interdisciplinary health research. The interdisciplinary health research is used to completely answer complex health questions. Disciplines such as sociology, epidemiology, demography, social policy, health policy, social psychology, sociology of medicine, medical geography, ethnography, history**,** public health, health economy, and political sciences are used in order to gain a richer, more nuanced perspective and discover new connections.

Chapter III looks at the relationship between health and wealth, which are linked. Health has an impact on wealth, and health is fundamental to human existence. Learning itself is enhanced or inhibited by personal health. An individual's health is associated with numerous factors, such as schooling, education, environment, behavior, and genetics. By describing the relationship between health and wealth, it is possible to understand the impact of human capital on health status. Health affects wealth and productivity, and these are the best indicators of its level of development. Income or wealth is closely related to health status, as health appears to impact individuals' incomes or earnings. Health is both a kind of human capital itself and an input to producing other forms of human capital. Human capital has a huge influence in promoting economic progress because of the increased productivity delivered by a highly skilled, educated, and qualified workforce. Health is both an integral a component of human capital. With better health and education, people can become more productive. Poor health can lead to financial crisis and work absence. Health is important for human happiness and well-being. Health is an economic engine that drives production of goods and economy. Better health leads to economic development. An investment in human capital can provide an increase in productivity, which in turn can lead to economic development. Economy closely depends on synergies between health, access to health services, and the utilization of human capital resources.

This chapter also focuses on understanding the significance of the relationship between health and income and of income inequality.

Chapter IV gives a description and an understanding of social policy and health policy in Norway and addresses their practical solutions. The Norwegian social policies may control, exclude, or stigmatize (intentionally or unintentionally) certain immigrants and, thus, deny them the personal autonomy that is necessary to their health, well-being, and access to health care. It also sheds light on the right to be a patient, patients' rights, and procedural rights.

Chapter V provides an understanding of health-care systems in general. This chapter also provides an understanding of the Norwegian health-care system, including its legal

aspects. The health service in Norway is funded predominantly by direct income taxation, and there is no specific health contribution fund. There are relatively few fees for health care within the state system except for radiology, laboratory tests, and non-emergency transportation. Private health care also exists. The state's regional health authorities contract with private facilities and medical staff to satisfy patient demand. Treatment in state regional hospitals is free or subsidized.

Chapter VI is about understanding the social category of immigrants. This chapter explains the term *immigrants*, detailing both the legal aspects and problems of "documented" (legal) and "undocumented" (illegal) immigrants. A foreign-born person without a legal right (lacking documentation or authentication) to be or remain in a country is an undocumented immigrant. Documented immigrants have lawful permanent residence in the host country. This chapter also provides information about Norway, the Norwegian health-care system, and the number and types of immigrants in Norway. It focuses on understanding the health problems of immigrants in Norway, the immigrants' access to health-care systems, and factors that likely influence their access to health care.

Chapter VII describes and explains the economic aspects and impacts on immigrants' access to health care. This chapter focuses on the economic circumstances of immigrants with uncertain future access to the Norwegian health-care services and investigates how immigrant access to health care affects Norway's economy. Conditions that affect health include education, employment, family structure (e.g., single motherhood), neighborhood characteristics, social policies, health policies, socio-economic status, health beliefs, and country of origin. Good health plays a substantial role in economy. This chapter sheds light on the significance of the relationship between immigrants' access to health services and their incomes. Immigrants' incomes vary not only by country of origin but also with respect to how long they have lived in Norway. The relationship between human capital and economy is measured by how greatly the Norwegian government is invested in the education and health of its citizens. Human capital is directly related to economy. The chapter explores the impacts of refugees and immigrants on the economy, immigrants as important contributors to economy, the employment of immigrants, and the differences in employment.

Chapter VIII presents the research methodology and approaches used to answer the research questions of this thesis. The research is qualitative, featuring economic, interdisciplinary approaches with a focus on social and economic factors that affect immigrants' access to health services in Norway. Both structured interviews and participant observation were used.

A qualitative approach is the foundation of the overall methodology. This research is economic with a focus on social and economic factors that affect immigrants' access to health services in Norway. This chapter also highlights the sampling method, population size, data analysis, and ethical research considerations.

Chapter IX presents, discusses, analyzes, and answers the research questions, which are: Are health-care services and health-care facilities accessible to the immigrants in Norway? Is the health-care system responsive to immigrants' needs? Does addressing immigrants' health concerns and access to health-care services drive or impact economy in Norway?

Low socio-economic status and financial deprivation have negative impacts on immigrants' health. Feelings of social exclusion, lack of knowledge about the health-care system, and language barriers influence access to and use of health-care services. Migrants' social, economic, and political integration enables them to understand the Norwegian health system and, thus, to access health services. Access for immigrants to health-care facilitates earlier diagnoses and treatment of conditions and frees human capital. Healthy immigrants can use their knowledge, abilities, qualifications, and skills in the activities that stimulate an economy. Economic inequalities impair immigrants' well-being and limit economic activities. In Norway, those who have no health insurance can still have access to health services that provide an adequate level of protection, especially from a financial point of view. Employment provides income to immigrants and has an impact on immigrants' health and health-care equity. Healthy immigrants are an important driving force for economy in Norway.

6. The Main Goals of This Entire PhD Dissertation

The main aims of this research are to identify the role of immigrants' access to health care in economy and to improve the health of immigrants as an important factor for accelerating their integration into Norwegian society.

CHAPTER II: HEALTH STATUS

This topic is divided into the following subtopics: understanding health, objective health, and subjective health. This builds on the importance of health for both citizens in Norway and immigrants. It forms the basis for understanding the health status of immigrants in Norway with regard to the accessibility and responsiveness of the health-care system.

1. Understanding Health

Health is regarded as one of the factors that play an important role in determining living standards in developing countries. Every individual desires to have a healthy life in order to achieve good living conditions and an improved quality of life. Health has been a very important issue around the world since the beginning of time. Plagues were devastating in earlier eras, when an immense number of people died due to insufficient resources and lack of health knowledge. In Western medicine, health has been traditionally defined as the ability of the human body to function productively and properly.[10] The term *health* connotes relief from suffering; thus, the life or general well-being of a person is defined in terms of health.[11] Health is a human right. The conception of health is shifting from a disease model to a health model. This emphasizes health promotion more than health management.[12]

Health is a state that allows an individual to adequately cope with the demands of daily life. It is also a state of balance, an equilibrium that individuals establish within themselves and between themselves and their social and physical environments. The concept of health is complex, as there are several interrelated factors that need to be taken into consideration to understand its nature. There are many approaches to health, and the term *health* originated through historic debates over the relationship between economy and human

[10] S. Topolski, *Understanding health from a complex systems perspective,* Journal of Evaluation in Clinical Practice 15, 2009, p.749-754.
[11] Ibid, p.749.
[12] A. Bandura, *The primacy of self regulation in health promotion,* Applied Psychology 54.2, 2005, p.245.

health. Health is a key indicator for social and economic development and well-being, as well as a means for increasing social cohesion.[13]

Health means different things to different people in different contexts. Wheelchair users, people experiencing conflict, rich or poor people, or people experiencing subjective health problems might understand health in very different ways. Looking at different aspects of health helps me to move toward a better understanding of why people behave in certain ways when it comes to their health. It also helps to understand the ways in which interventions intended to improve health are designed, communicated, and implemented.

For economists, health is an asset with intrinsic (improved objective and subjective health and well-being) and instrumental value (being able to form and maintain relationships, to work or pursue leisure interests, and to make decisions in everyday life). Health is also a significant determinant of economy,[14] the basis for job productivity, and the basic capabilities giving value to human life.[15] Nobel Laureates Theodore Shultz and Gary Becker stated that health is one of the cornerstones of human capital and the basis for an individual's economic productivity. Health is a means that bring the capacity for individual development and economic security in the future.[16] Low levels of education, unemployment, underemployment, poverty, poor housing, poor sanitation, malnutrition, and lack of access to health services can affect the health of the poor. Health and socio-economic awareness go hand in hand.

According to the World Health Organization, "Health for all by the year 2000" was regarded as an objective of economic development and not merely as one of the means of attaining it.[17] The terms *disease*, *illness*, and *sickness* are characteristic of unhealthiness. Disease is regarded as a pathological process, a deviation from a biological norm; illness refers to the experience of unhealth or ill health, which is entirely personal; and "Sickness is a social role, a status, a negotiated position in the world, a bargain struck between the person henceforward called 'sick', and a society which is prepared to recognize and sustain him."[18]

Two broad aspects of health have been identified: objective health and subjective health.

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[13] J. Figueras, M. McKee, eds. Health systems, health, wealth and societal well-being: assessing the case for investing in health systems, McGraw-Hill Education, 2011, p.3

[14] J. D. Sachs, *Macroeconomics and Health: Investing in Health for Economic Development*. World Health Organization, 2001, p.3.

[15] Ibid, p.21.

[16] Ibid, p.21

[17] H. Mahler, *The Meaning of" Health for All by the Year 2000".* American journal of public health, 106.1: 2016, p.36.

[18] K. M. Boyd, *Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts.* Medical Humanities, 26(1), 2000, p.10.

1.1. Objective Health

Health status consists of all the factors that impact people's lives, functions, and activities. *Physical health* refers to the physical functions of the body that prevent certain diseases or other negative elements from impairing bodily functions. Diseases, injuries, disabilities, economic resources, and housing or other impairments have their own distinctive elements that can greatly affect and define a person's or a population's health (well-being).[19] Health can also be related to an individual's state of being. As such, health has various interpretations and meanings that accord with different individual and societal expectations. For example, there are people who consider themselves healthy because they are free from illnesses or disabilities, whereas there are others with diseases who also consider themselves healthy because they are able to manage their conditions well.

Physical health or physical well-being simply means a healthy body because of regular physical activity, good nutrition, and adequate rest. Nutrition, health care, living standards, and quality of life are important factors contributing to physical health. Other factors include, bodyweight management, and hygiene. Physical health refers to the structure and all the functions of the body.

Although there are numerous definitions of health, the most common objective definition and explanation is in the 1946 WHO constitution, wherein it stated:

> [G]ood health is a state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities. Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948). It is also an essential component of development, vital to a nation's economy and internal stability.[20]

This definition of health suggests that health has three dimensions, complete physical, mental, and social well-being, and underscores the significance of the functional, subjective, and socio-economic variables that impact performance, independent living, and perceived well-being in any elaborated conception of health. Physical health is an important

[19] D. Trewin, *Measuring Well-being, ABS Catalogue no. 4160.0,* Australian Bureau of Statistics. 2001, p.1.
[20] World Health Organization, *Health.* 2001a. Available at: http://www.who.int/trade/glossary/story046/en. Accessed 11.11.2016.

part of a person's overall well-being. This includes fitness, agility, cardiovascular condition, endurance, muscular strength, etc. Complete well-being is a state in which a person is totally fit to perform his or her daily activities without hindrance. According to the Universal Declaration of Human Rights, Article 25,

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The right to health was recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. The right to health contains entitlements:

- The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health
- The right to prevention, treatment, and control of diseases
- Access to essential medicines
- Maternal, child, and reproductive health
- Equal and timely access to basic health services
- The provision of health-related education and information
- Participation of the population in health-related decision-making at the national and community levels

Health is an important economic asset for economy. By accessing health services, citizens are more likely to be healthy enough to be productive (economically and socially) and contribute to economy.

Health is a priority goal in its own right. As source of human welfare and also an instrument for raising income levels, health has strong impacts on prospective lifespans and life cycle behaviors. Improving health is as important as improving income when the focus is on economic development, poverty reduction, and human welfare.

Health represents the foundation of a life worth living, a means and an end enabling everyone to achieve their goals and dreams. Personal autonomy is a critical part of health and quality of life; good health is influenced by lifestyle habits, enabling people to exercise some measure of control over the state of their health.[21] The WHO description is broad and covers

[21] A. Bandura, *The primacy of self regulation in health promotion,* Applied Psychology 54.2, 2005, p.245.

every aspect of the outward activities of the human body and also includes the perfect performance of the internal organs.

The WHO's definition also allows individuals from diverse backgrounds to have a unified and common measurement of health. The WHO's definition refers to the ability of a particular nation to measure its economy and internal stability, allowing every nation to gauge its own health status in its determination of economic progress. The WHO stresses the importance of health care in all nations due to the notion that "better health is central to human happiness and well-being.[22] Moreover, having a good health status contributes to economic progress because a healthy population can live longer, thereby being more productive over a longer period of time. In the 1986 Ottawa Charter for Health Promotion, the WHO amended this definition by saying that health is "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities."[23] This amended definition provides a positive, holistic view about what health is. Health is a positive concept that emphasizes social and physical capacities, as well as personal resources.

The state of health is highly dependent on lifestyle. Therefore, health cannot be defined as freedom from disease but, rather, as a state of balance between the two parallel, ongoing processes in daily life: disease processes and health processes. These comprise psychosocial factors, lifestyles, emotions, and experiences that create healthful processes. Poverty is detrimental to a population's health status, as it restricts access to health-care systems and healthy living conditions.[24] Therefore, it is essential for every nation to ensure that proper health-care services are offered to all citizens on equal terms.

The health of the mind is like the health of the body. Objective health and subjective health are fundamentally linked. According to Kleinman, when a "physiological stress reaction or a chronic medical disease provides a particular biological substrate, there is a specific channel of established complaint that can be amplified to express distress of varying kinds."[25] Thus, at the very core of complaints is a close integration between physiological and social meanings.

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[22] I. Luginaah, R. B. Kerr, *Geographies of health and development*. Ashgate Publishing, Ltd., 2015, p.2.
[23] World Health Organization, *Health*, op.cit.
[24] A. A. Hamoudi, J. D. Sachs, *Economic Consequences of Health Status: A Review of the Evidence*, Center for International Development at Harvard University, Working Paper no: 30, 1999. p.1.
[25] A. Kleinman, *The illness narratives: Suffering, healing, and the human condition*, Basic Books. 1988. p.4.

The concept of health includes dimensions of well-being that go beyond the mere absence of illness. Subjective health is essential: the WHO has stated that there is no health without subjective health.[26]

Subjective health is a multifaceted concept, and understanding it requires the insights of several disciplines, each contributing a distinctive viewpoint. Subjective health increasingly seems to have genetic, biochemical, and other biological causes. Subjective illness is a form of deviant behavior that arises when an individual's thought processes, feelings, or behaviors deviate from the usual expectations or experiences and when the person affected, or others in society, define it as a problem that requires intervention.[27] There are various types of subjective illnesses and subjective health problems, such as social anxiety, obsessive-compulsive disorder, drug addiction, personality disorders, and so on. *Subjective health* refers to people's inner states—such as emotions, behaviors, thoughts, and ability to make socio-economic decisions.

Post-traumatic stress may occur when needs for security of employment, income, and safety are not met. Individuals who do not feel that they have economic opportunities may experience social depression or anxiety.

Health status is defined objectively by the Australian Institute of Health and Welfare (AIHW) as "a holistic concept that is determined by more than the presence or absence of any disease."[28] In simpler terms, health status refers to an individual's medical conditions and experiences as a health-care recipient that can be measured by an observer, such as a physician. Health status can be classified as both individual and societal. Individual health status is easier to assess than the health status of an entire population. The AIHW definition encompasses a positive meaning that more measures the health status of a particular nation. Through this definition, people across the world will be able to determine the level of a nation's livability in accordance with its health and mortality rates. This definition also describes how health-care accessibility and equality in a nation are being rendered and proportioned.

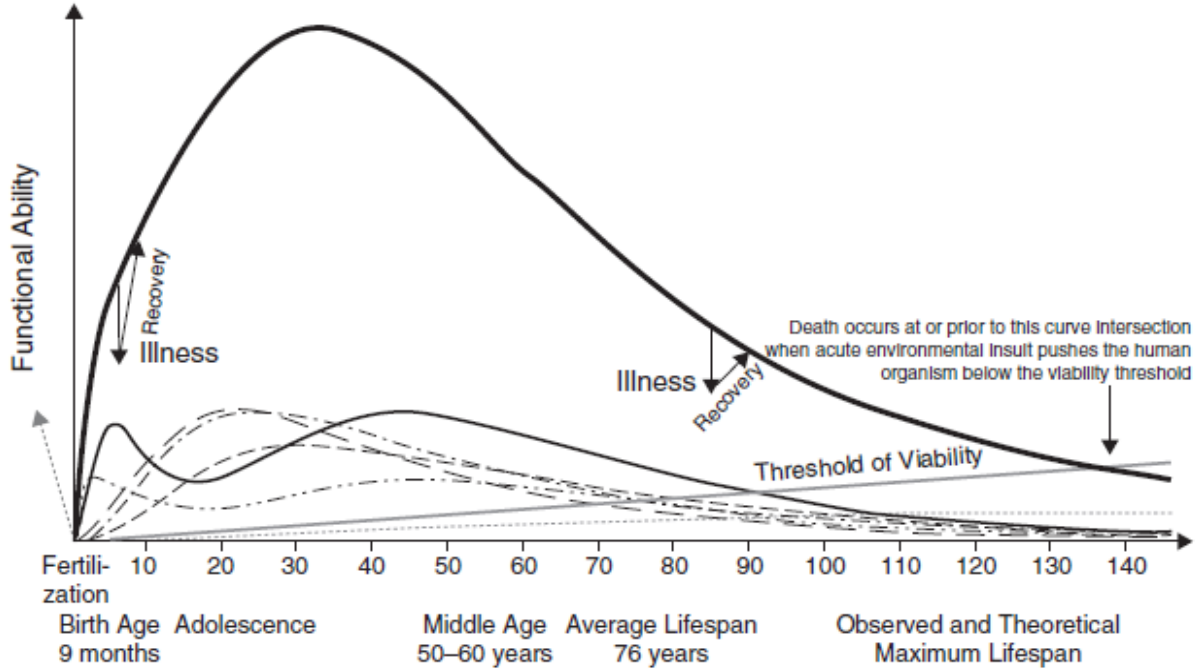
The health status of a population can also be measured through data collected from individuals, of which the findings can be analyzed and "summarized by life expectancy or self-assessed health status, and more broadly include measures of functioning, physical

[26] M. Slade, *Mental illness and well-being: the central importance of positive psychology and recovery approaches*, BMC Health Services Research, 10(1), 2010, p.1-14
[27] A. V. Horwitz, T. L. Scheid, (Eds.) *A handbook for the study of mental health: Social contexts, theories, and systems*, Cambridge University Press. 1999. p.533.
[28] Ibid, p. 533.

illness, and well-being."[29] Determining a population's health status is important in every nation because it allows for the proper development and improvement of the health and well-being of its citizens.

Topolski suggested that "achieving maximum health is a dynamic process with each component having a characteristic pattern of contribution to the maximum health achievable … that is complexity."[30]

Figure 2.1. New health model grounded on the six health parameters.



Source: S. Topolski. (2009). Understanding health from a complex systems perspective, *Journal of Evaluation in Clinical Practice*, 15, p. 752.

The overall health of an individual or a population can be depicted as the sum of six curves over a lifetime, as shown in Figure 2.1. Figure 2.1 shows that experiencing life's difficulties or dangers can lead to a decline in health and viability. The major defense against illness or poor health is having a healthy lifestyle. Being equipped with and aware of the various parameters of health and having harmonious routines can keep the immune system vigorous and hearty. Every part of the body, including the immune system, can perform better when sheltered from ecological attacks and reinforced by healthy living strategies, such as the following:

- Do not smoke.

[29] Ibid
[30] S. Topolski, op. Cit., p.751

- Eat a diet high in fruits, vegetables, and whole grains and low in saturated fat.
- Exercise regularly.
- Maintain a healthy weight.
- Control blood pressure.
- Prevent excessive alcohol intake.
- Get adequate sleep.
- Take steps to avoid infection, such as having proper hygiene and cooking meats thoroughly.
- Get regular medical screening tests in accordance with your age group and risk category.

Lifestyle habits enable people to exercise some measure of control over the state of their health. To stay healthy, people should exercise, reduce dietary fat, refrain from smoking, keep blood pressure down, and develop effective ways of managing stressors. By managing their health habits, people can live longer, be healthier, and slow the process of aging.[31]

Objective health focuses on the importance of moderating daily physical activity, taking in proper nutrition, maintaining a healthy weight, and managing chronic conditions to prevent them from progressing. Physical activity is one of the most effective ways to improve and maintain health. Research shows that physical activity lowers the risk of many chronic conditions (e.g., diabetes, heart disease, obesity, and bone, pain, and joint problems), improves mood, and boosts energy.

Somatic health is bodily health. The "lived" experience of one's own body is a concept that stems from the phenomenological tradition. The *lived* concept refers to the body's experiences and how the body expresses meaning through its manner of being in a reciprocal relationship with the surrounding world. Every subject exists in an established communicative relationship with everything in the world.[32] Merleau-Ponty stated, "Regardless of whether it is a question of the body of another or my own body, I can only get to know the human body by living it, in other words, by undertaking the drama that permeates it, and by merging with this."[33] The human body is seen as a unit, a piece of art in which all the pieces are related to each other. Human consciousness is shaped through the body, and all understandings of existence and the recognition of human existence goes through the body.

[31] A. Bandura, *The growing centrality of self-regulation in health promotion and disease prevention.* European Health Psychologist, 7(3), 2005, p.11.
[32] J. Bengtsson, *Med livsvärden som grund [With Life-world as a Basis]*, Lund: 1999.
[33] M. Merleau-Ponty, *Kroppens Fenomenologi [Phenomenology of the Body]*, Oslo, Norway: Pax Forlag A/S. 1994, p. 30-95.

The understanding of both one's surroundings and one's own situation are possible through bodies. The body and its surroundings exist in relation to each other; human existence is embodied and defined through perceptual experience. The body is both an object and a subject, a thing and a consciousness, perceived and perceiving.[34] The body forms a unit of senses, perceptions, thoughts, emotions, language, and movements and constitutes such a unit from birth.[35] The relationship between the human body and the world is existential, and the idea of the lived body represents the basis for a more nuanced account of health and illness. Health and illness are lived.

The subject is inter-subjective, in that one's own body and the lived bodies of others compose a basic reciprocity. The human body is an expressive space that contributes to the significance of personal actions. The body is also the origin of expressive movement, and it is a medium for perception of the world. Bodily experience gives perception a meaning beyond that established simply by thought. Descriptions of the human body are the prominent feature of Descartes's work on medicine and an important part of his medical project; however, the object of Descartes's medicine is ultimately the human being and not merely the human body. In his philosophy, a human being is a composite of a soul with a body, but not just any body; it is a composite of a soul with a body that possesses the particular organization and operations that make it a proper domicile for the soul. When the human body functions properly as a human body, it is fit for union with a soul, but if it malfunctions, it risks separation and, thus, death for the human being. In this way, the health of the human being depends on a properly functioning body: when the human being's body functions properly, the human being is healthy. Therefore, the goal of Descartes's medicine is to correct and maintain the organization and operations of the human body for the sake of preserving the life and health of the human being and avoiding death, that is, the dissolution of the soul–body union upon bodily malfunction. In this regard, body and soul are very much related when conducting research into health and disease.[36]

Evolutionary biology provides a scientific account of biological function.[37] The biomedical approach views health as the absence of disease, and this approach assumes that diseases are caused by external factors. The main target of the biomedical approach is eliminating external factors or causes of disease. It takes into

[34] M. Merleau-Ponty, *Phenomenology of Perception,* Problemos, (25), 2014, p.94-106.
[35] M. Merleau-Ponty, *Kroppens fenomenologi,* Oslo, Pax forlag. 1994, p.30-95.
[36] R. Descartes, *Description of the Human Body. Philosophical Writings of Descartes, Volume I. Translated by John Cottingham, Robert Stoothoff and Dugald Murdoch,* Cambridge: Cambridge University Press, 1985b, p. 313-324.
[37] C. Boorse, *Health as a Theoretical Concept,* Philosophy of Science, 44, 1977, p.542 –573.

account that all people have biologically similar bodies and treats them in the same way. Health and well-being are, therefore, seen as products of medical interventions. This is an integral part of Boorse's aim of bringing health into the sphere of science. Poor health is any condition that constitutes a "deviation from the natural functional organization of the species."[38] The addition of "natural" enables us to avoid the objection that some conditions are diseases despite being statistically normal. For example, tooth decay has environmental causes.[39]

The human body is an extremely complex ecosystem. In addition to the ten trillion human cells that make up the human body, those cells also contain a hundred trillion bacteria, and we are surrounded daily by trillions of bacterial microbes. In a human body, microbial colonization begins shortly after birth in the gut flora, which aids in digestion, the synthesis of vitamins, and the creation of enzymes not produced by the human body.[40] From scientific research, we know that the human gut consists of different enterocytes that have an inconspicuous impact on human health. Research into health and disease encompasses biological facets. These biological organisms are considered, especially in human biology, when assessing health and providing treatment when someone is ill.

1.2. Subjective Health

Defining the concept of subjective health states may be somewhat complex, but there have been several studies in the health-care field describing it as "quality of life." The concept of "Quality of Life" (QoL) is a multidimensional, broad-ranging concept connecting health, relationships, autonomy, legitimacy, and personal beliefs to salient features of the environment in which people live. So far, there is no generally accepted definition. It's interpreted either as "conditions of life"[41] or as "experience of life."[42] Subjective health is a dependent variable because its usefulness is simple, reliable, and provides an easy way to understand peoples' health states. *Subjective health status* refers to how individuals evaluate their own health status. It is a good predictor of mortality and has a relationship with objective health status. There has been a growing interest in the field of subjective health status among health researchers and physicians who are attempting to use the views and perceptions of

[38] C. Boorse, *On the distinction between disease and illness.* Philosophy & public affairs, 1975. p.59.
[39] C. Boorse, op.cit., p.50.
[40] C.G. Zimmer, *Bacteria Divide People Into 3 Types, Scientists Report,* The New York Times, 2011.
[41] C. E. Ferrans, M. J. Powers, *Psychometric assessment of the quality of life index,* Research in Nursing & Health, 15, 1992, p. 29–38.
[42] G. Meeberg, *Quality of life: A concept analysis,* Journal of Advanced Nursing, 18, 1993, p. 32–38.

patients in formulating treatment plans and monitoring the quality of the results of medical care. In this regard, subjective health status can be associated with people's health-related quality of life.[43]

Subjective health status can also be described as an individual's analysis of his or her health, as well as predictions about treatment results. This is in line with the context of the term *subjective*, which means being perceived in ways that are not evident to others. In the health-care field, *subjective* means the perceptions, beliefs, and/or attitudes of patients about their health that are not evident to the examiner or physician.

Similarly, Liang (1986, cited in Helmer et al., 1999, p. 84) defined subjective health as "the individual's perception and evaluation of his or her overall health."[44] Simply put, subjective health status can be referred to as patients' self-assessment of their health conditions. Subjective health evaluation can be considered a legitimate health status indicator. Interestingly, individuals use different approaches in assessing their own health by comparing their symptoms with those of others.[45]

Today, subjective health status is becoming more commonly noted in the field of health measurement. The growing interest in the concept of subjective health status is associated with its inclusions of functional, subjective, social, and socio-psychological variables that play an important role in achieving quality of life.[46] There is a great significance in looking beyond medical criteria in assessing patients' health statuses because they are the ones feeling or experiencing the symptoms; therefore, it would be helpful if their perceptions were also taken into account.[47] Liang further noted that subjective health status is important in influencing quality of life. In line with this, subjective health status is a good indicator of the use of health-care services and mortality.[48]

Moreover, subjective health status is significant in embodying the WHO's definition of health as "a state of complete physical, mental and social well-being and not merely absence of disease."[49] This definition encompasses health-related quality of life by integrating

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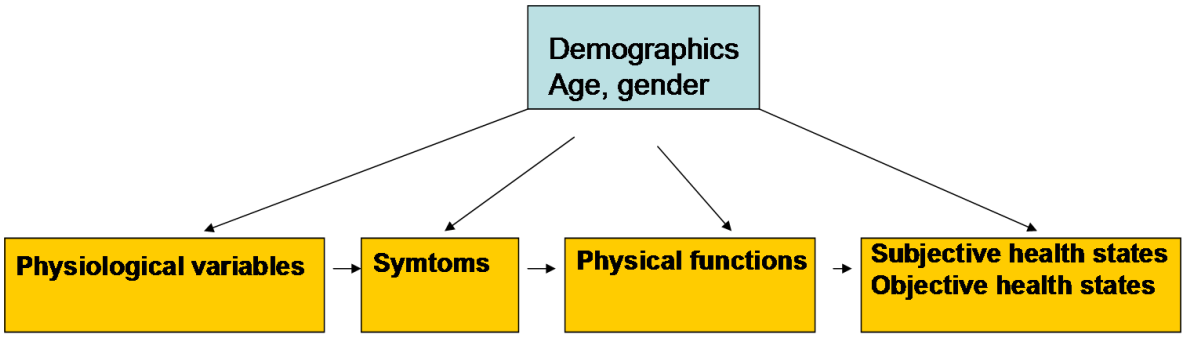
[43] C. Jenkinson, H.M. McGee, *Health Status Measurement: A Brief But Critical Introduction,* Abingdon, Oxon: Radcliffe Medical Press. 1998, p.2.
[44] C. Helmer, P. Barberger-Gateau, L. Letenneur, J. Dartigues, *Subjective Health and Mortality in French Elderly Women and Men,* Journal of Gerontology: SOCIAL SCIENCES, 54B(2), 1999, p. 84-92.
[45] G. Kaplan, O. Baron-Epel, *What lies behind the subjective evaluation of health status?* Soc Sci Med, 56(8), 2003, p. 1669-1676.
[46] C. Jenkinson, HM. McGee, *Health Status Measurement: A Brief But Critical Introduction,* Abingdon, Oxon: Radcliffe Medical Press. 1998, p.2-37.
[47] A. Walker, *Growing Older In Europe*, England: Open University Press, 2004, p.45.
[48] Ibid, p.15.
[49] N. Sartorius, *The meanings of health and its promotion.* Croatian medical journal, *47*(4), 2006, p.662.

personal health status and social well-being into the health assessments of both the public and of individuals. As such, the concept of subjective health status can be deemed significant in designing health-care services and formulating treatment for patients based on self-reported health levels or conditions.

Figure 2.2. Relationships between demographics, physiological variables, symptoms, physical function, and subjective health status



Source: Adapted from S.B. Bentsen, A.H. Henriksen, T. Wentzel-Larsen, B. R. Hanestad, A.K. Wahl, 2008, What determines subjective health status in patients with chronic obstructive pulmonary disease: Importance of symptoms in subjective health status of COPD patients? *Health Qual Life Outcomes*, 6, p.2

Subjective health status can apparently be influenced by demographic variables such as age, gender, ethnicity, etc., as shown in Figure 2.2. This is supported by a study conducted by Bentsen et al. (2008), in which the authors attempted to identify the determiners of subjective health status among patients with chronic obstructive pulmonary disease (COPD). Their research findings suggested that women and older patients suffering from COPD reported worse physical health. .[50]

Table 2.1. Subjective Health Domain

• General quality of life • Feelings • Dignity • Enjoyments • Frustrations

[50] S.B. Bentsen, A.H. Henriksen, T. Wentzel-Larsen, B. R. Hanestad, A.K. Wahl, *What determines subjective health status in patients with chronic obstructive pulmonary disease: importance of symptoms in subjective health status of COPD patients?* Health Qual Life Outcomes, 6, 2008, p.2.

- Confidence
- Quality of relationships (social and personal)
- Depression/anxiety
- Physical safety and security
- Mobility
- Health and social care availability and quality
- Sleep
- Self-esteem
- Bodily image and appearance
- Spirituality, religion, and beliefs
- Work capacity
- Possibility for acquiring new information and skills
- Participation in and new opportunities for recreation and leisure

Source: Adapted from S.B. Bentsen, A.H. Henriksen, T. Wentzel-Larsen, B. R. Hanestad, A.K. Wahl, 2008. What determines subjective health status in patients with chronic obstructive pulmonary disease: Importance of symptoms in subjective health status of COPD patients*? Health Qual Life Outcomes*, 6, p. 2-5.

Table 2.1 shows some influential subjective health factors. Subjective health status is based on patients' viewpoints and perspectives about their own health. Some components that ought to be included in the definition of health-related quality of life are cognition function, emotional state, subjective well-being, general health, life satisfaction, and social support.[51] Moreover, the subjective definition of health is determined by an individual's well-being. A person's mental or psychological state is also an important aspect of his or her health. The quantity and quality of an individual's social connections and support networks can fundamentally influence his or her health.[52] This means that a person's health is not influenced only by one physical factor within his or her lifetime; rather, it can be influenced and enhanced by other factors, such as a subjective health disorder. Hence, in order to have a better understanding about the nature of health, the two major dimensions identified by Trewin, objective and subjective health, must be recognized.

[51] M. Clayton, A. Williams, *Subjective health assessment and distributive justice,* In. Measuring Health and Medical Outcomes. 1994. p.165.
[52] D. Trewin, op. cit. p.1-3.

2. Interdisciplinary Research on Health

This section provides a description of interdisciplinary health research. Interdisciplinary health research aims to completely answer complex health questions. Disciplines such as sociology, epidemiology, economics, demography, social policy, sociology of medicine, medical geography, ethnography, history**,** public health, health economy, and political sciences (Figure 2.4) are used in order to gain a more well-developed perspective and to discover new perspectives.

It is a common misconception that engaging in interdisciplinary research can be done by anyone. Yet, conducting and publishing interdisciplinary research is a complex but beneficial approach among scholars and researchers alike. As such, in order to implement successful interdisciplinary efforts, there needs to be a mastery of specific skills and competencies to be improved and learned.[53]

Figure 2.3. Core competencies for interdisciplinary research.

Major Area	Competencies
Conducting research	• Use theories and methods of multiple disciplines in developing integrated theoretical and research frameworks.
	• Integrate concepts and methods from multiple disciplines in designing interdisciplinary research protocols.
	• Investigate hypotheses through interdisciplinary research.
	• Draft funding proposals for interdisciplinary research programs in partnership with scholars from other disciplines.
	• Disseminate interdisciplinary research results both within and outside his or her discipline.
	• Author publications with scholars from other disciplines.
Communication	• Advocate interdisciplinary research in developing initiatives within a substantive area of study.
	• Express respect for the perspectives of other disciplines.
	• Read journals outside of his or her discipline.
	• Communicate regularly with scholars from multiple disciplines.
	• Share research from his or her discipline in language meaningful to an interdisciplinary team.
	• Modify his or her own work or research agenda as a result of interactions with colleagues from fields other than his or her own.
	• Present interdisciplinary research at venues representing more than one discipline.
Interacting with others	• Engage colleagues from other disciplines to gain their perspectives on research problems.
	• Interact in training exercises with scholars from other disciplines.
	• Attend scholarly presentations by members of other disciplines.
	• Collaborate respectfully and equitably with scholars from other disciplines to develop interdisciplinary research frameworks.

Core competencies for interdisciplinary research identified in Delphi survey.[1]

Source: Adapted from E. I. Larson, T. F. Landers, M. D. Begg, 2010. Building interdisciplinary research models: A didactic course to prepare interdisciplinary scholars and faculty, *CTS Journal*, 4(1), p.38–41.

[53] E. I. Larson, T. F. Landers, M. D. Begg, *Building Interdisciplinary Research Models: A Didactic Course to Prepare Interdisciplinary Scholars and Faculty*, CTS Journal, 4(1), 2010, p. 38-41.

The use of interdisciplinary research is intended to develop skills and to explicate such competencies (Figure 2.3) based on learning and experience.

As defined by Bruce and associates, interdisciplinary research is "…occurring where the contributions of the various disciplines are integrated to provide holistic or systematic outcomes".[54] Similarly, other authors defined interdisciplinary research as "…an approach to advancing scientific knowledge, in which researchers from different disciplines work at the borders of those disciplines in order to address complex questions and problems."[55] Understanding this concept, it can be said that engaging in interdisciplinary research means being able to consider multiple disciplines in pursuit of gaining well-developed perspectives and discovering new perspectives about a particular subject matter.

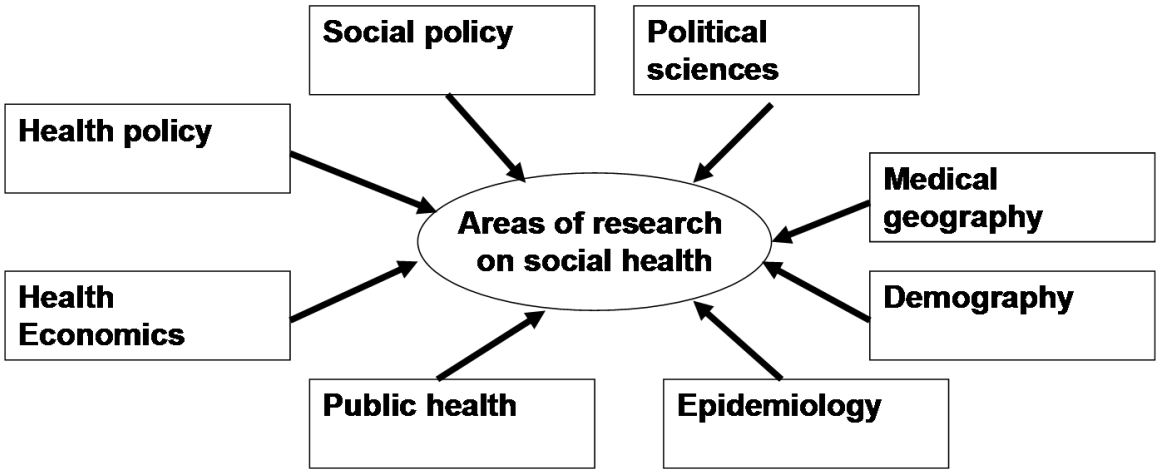
For this study, the definition of interdisciplinary research as suggested by Klein will be used. According to the authors, interdisciplinary research can be defined as:

> A process of answering a question, solving a problem, or addressing a topic that is too broad or complex to be dealt with adequately by a single discipline or profession… [It] draws on disciplinary perspectives and integrates their insights through construction of a more comprehensive perspective.[56]

This definition provides the grounding framework for the purpose of using interdisciplinary research for this study. As such, engaging in interdisciplinary research can contribute to expanding scientific knowledge in answering research questions through combining complementary skills, knowledge, and approaches of different disciplines.[57]

Figure 2.4. Interdisciplinary nature of research on social health.

[54] A. Bruce, C. Lyall, J. Tait, R. Williams, *Interdisciplinary Integration in the Fifth Framework Programme,* Futures, 36(4), 2004, p.457.
[55] *Ibid,* Larson, Landers & Begg, p. 31
[56] J. Klein, *Advancing Interdisciplinary Studies. In W. Newell (Ed.), Interdisciplinarity: Essays from the literature,* New York: College Board. 1998
[57] Canadian Academy of Health Sciences. *The Benefits and Barriers to Interdisciplinary Research in the Health Sciences in Canada,* Framework Document. 2005. Available at: http://cahs-acss.ca/wp-content/uploads/2015/07/2006-01.assessment.pdf. Accessed 12.12.2016.



Source: Adapted and modified from V. Korporowicz, 2008. Health Promotion: Shaping the Future, Warsaw School of Economics, p.78

Figure 2.4 shows some areas of research on social Health. Interdisciplinary research focuses on[58]:

Epidemiology represents a body of research that deals with the relationship between socio-economic status and health status. It can be used to help explain and understand the causal mechanism and existence of the relationship between socio-economic status and health status. More so, *epidemiology* refers to both the study of the distribution and determinants of health-related states or events. Additionally, in relation to the health discipline, Pearce defined epidemiology as "the branch of public health which attempts to discover the causes of disease in order to make disease prevention possible."[59] As noted by the Centers for Disease and Control Prevention, the epidemiologic approach can be associated with the systematic approach, in which the epidemiologist counts, divides, and compares health cases or events.[60] In this regard, methods for conducting epidemiology can also be used in different contexts and disciplines.

Economics is a science that refers to various economic activities and institutions that occur within a defined area. The term *economics* is used in this dissertation to mean utilizing data and econometric techniques to produce more precise estimates of the relationship between socio-economic status and health. Therefore, health economics is couched in the context of economy, whereby economic principles can also be applied to health care.

[58] V. Korporowicz, *Health Promotion: shaping the future: Shaping the Future,* Warsaw School of Economics. 2008, p.78.
[59] N. Pearce, *A Short Introduction to Epidemiology, 2nd edition. Wellington,* New Zealand: Centre for Public Health Research,. 2005, p.9.
[60] Centers for Disease Control and Prevention (CDC), *Principles of Epidemiology in Public Health Practice, third edition,* Atlanta, GA: CDC. 2012.

In relation to this, *health economics* can be defined as a branch of economics concerned with issues related to efficiency, effectiveness, value, and behavior in the production and consumption of health and health care.[61] In broad terms, health economists study the functioning of health-care systems and health-affecting behaviors such as smoking. Variables such as differences in immigrants' ability and willingness to make health choices can affect both income and health.

For economists, health is seen as an economic resource. Issues of relative wages, job status, and fairness in promotion practices or task assignments shape the relationship between socio-economic status and health. In health economics, multiple types of financial information, such as costs, charges, and expenditures, are very important. Health economics provides the tools and analytical framework to help address the key objectives of health-care providers, such as ensuring equal access to health care and generating the greatest health benefits from a finite set of resources. Hence, health economics can be defined as the "…allocation of resources within the health system in the economy, as well as the functioning of the health care markets."[62]

Political sciences focus on how the health phenomenon can be explained by looking at who has control over the distribution of economic and other resources and, therefore, who has the power to determine health outcomes. Political scientists focus on economic factors, together with institutions such as government, unions, and professional associations altering the balance of power within the environment. Interestingly, the discipline of political science can be associated with the development and implementation of social and health policies to ensure efficient and effective health-care practices. Health political science research addresses health-care systems inquiries.[63]

Demography refers to the statistical study of populations, especially human beings. Demography is a science for analyzing any kind of dynamic living population and covers whole societies or groups defined by criteria such as education, nationality, religion, and ethnicity. Demography encompasses the study of the size, structure, and distribution of these populations and spatial or temporal changes in them in response to birth, migration, ageing, and death. Demographics are quantifiable characteristics of a given population. Further, Yi

[61] X. Martinez-Giralt, *Principles of Health Economics*, 2010. Available at: http://pareto.uab.es/xmg/Docencia/Health/HealthEcs.pdf. Accessed 11.11.2016.
[62] Ibid.
[63] E. de Leeuw, C. Clavier, E. Breton, *Health policy–why research it and how: health political science.* Health Research Policy and Systems, 12(1), 55. 2014. p.5.

asserted that there two types of demography—formal demography and population studies.[64] Hence, demography plays an important role in interdisciplinary research because it contributes to identifying and analyzing responses and perspectives of the sample population to be used in the study.[65]

Medical geography, or health geography, is a branch of sociology involved with the area of health research that is a hybrid of geography and medicine and deals with the geographic aspects of health and health care (Table 2.1). Medical geography studies the effects of locale and climate upon health. It aims to improve the understanding of the various factors that affect the health of populations and, thus, individuals. It is a method for studying health, disease, and health care. Although health care is a public good, it is not equally available to all individuals. Demand for public services is continuously increasing, and people need advanced knowledge and the fastest prediction technology, such as Telemedicine, that health geography offers. Therefore, geography can be seen as important to research in that it can become a good source of public safety and effective public health policies.

Table 2.2. Examples of health geography research relevant for health policy

Research area	Examples
Services, infrastructures and land-use planning	• Geographic accessibility of healthy foods[7] • Land-use planning and influences on socio-demographic variation in physical activity[8]
Disease surveillance, modelling and mapping	• Infectious disease control, including mapping malaria outbreaks, leprosy elimination and Lyme disease surveillance[9] • Analysis of geographic clusters of deaths due to breast cancer[10]
Disease etiology and determinants of health	• Geographic variation in inflammatory bowel disease and the identification of potential environmental risk factors[11] • Local and modifiable influences on diet, physical activity and obesity[12]
Environmental health risk factor assessment	• Adverse pregnancy outcomes among women living close to incinerators and sources of environmental pollution[13] • Association between air pollution and mortality[14]
Health service use	• Access to hospitals and family physicians, and the use of hospital inpatient services[15] • Regional reorganization of cardiovascular surgery provision[16]
Inequalities in health outcomes	• Rural-urban and intrarural variations in health in Quebec[17] • Social and spatial polarization in health outcomes across the life course[18]
Therapeutic and healthy landscapes	• Influence of woodland and green space on adolescent mental health[19] • The role of city image, risk perception, environmental stigma and neighbourhood inequality in characterizing healthy and unhealthy places[20]

Source: Adapted from T. J. B. Dummer, 2008. Health geography: Supporting public health policy and planning, *CMAJ*, 178(9), p.1178

Table 2.2 shows some research areas of health geography[66] relevant for health policy. *Services*, *infrastructures*, and *land-use planning* refer to the geographic accessibility of

[64] Z. Yi, *Demography: The Past, Present and Future. Social policy refers to social science,* Encyclopedia of Life Support Systems, 1, p.2008, 1-37.
[65] L. J. G. Van Wissen, P. A. Dykstra, *Population Issues: An Interdisciplinary Focus*, New York: Springer. 2012.
[66] T. J. B. Dummer, *Health geography: supporting public health policy and planning,* CMAJ, 178(9), 2008, p.1177-1180.

healthy food. *Health service use* refers to access to hospitals and family physicians and the use of hospital inpatient services; *inequalities in health outcomes* refers to social and spatial polarization in health outcomes across the life course. We also have disease etiology and determinants of health, therapeutic and healthy landscapes, and disease surveillance.

Social policy refers to the social science wherein science can be described as cold and clinical, hard, and objective.[67] However, it is as much about feelings as about facts. Social policy is the study of human well-being based on doing well for people and entails the study of the social relations necessary for human well-being and the systems that can be used to promote well-being.[68] It is about the many and various things that affect the kinds of lives that everyone can live. Social policy is a science that helps understand what individuals need to make life worth living: essential services, such as health care and education; a means of livelihood, such as a job and money; and vital but intangible things, such as love and security. Social policy is also about the ways in which individual needs can be organized: by government and official bodies; through businesses, social groups, charities, local associations, and churches; and through neighbors, families, and loved ones.

Social policy is a tool that is able to intentionally or unintentionally stigmatize, exclude, or control certain individuals or groups and, thus, deny them the personal autonomy and social relations that are necessary to human well-being. Social policy is about how people may achieve a good life, the social relations necessary for well-being.

Public health is a branch of science grounded in the concepts of social justice. It includes elements of preventive medicine, community medicine, and medical practice.[69] The goal of public health is to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the population. It also deals with determinants of health that deserve attention and medical interventions for the sake of improving a population's health. Moreover, it is associated with the scientific disciplines of epidemiology and biostatics in pursuit of responding to and addressing public health inquiries.[70]

Public health's core function is to identify an assessment, which means to regularly and systematically collect, assemble, analyze, and make available information on the health of the community. This includes statistics on health statuses, community health needs, and epidemiologic and other health problems. Other core functions are policy development and

[67] H. Dean, *Social policy*, Polity. 2012, p.1.
[68] Ibid, H. Dean, p. 4-9.
[69] F. D. Scutchfield, C. W. Keck, *Principles of Public Health Practice*, *2nd edition*, New York: Delmar Learning. 2003, p.11-16.
[70] F. D. Scutchfield, C. W. Keck, op.cit. p.36.

assurance. *Policy development* refers to public health work that serves the public interest in the development of comprehensive public health policies by promoting the use of scientific knowledge based in decision-making about public health and by leading the development of public health policy. *Assurance* is social justice activities referring to a public health agency's determination to work with its community to guarantee access to a basic set of health services for each citizen.[71] Finally, public health works for the availability of good quality and basic services to all.

3. Determinants of Health - Social, Economic, and Physical

The word *determinant* refers both to factors that determine the risk for the problem and the direct causes of the health problem. The determinants of health refers to factors for maintaining good health.in which individuals are born, grow, live, work and age. These factors affect the well-being or health of individuals and communities. In Marc Lalonde's *A New Perspective on the Health of Canadians*, health is determined by the interplay of four broad elements, including human biology, the environment, lifestyle, and health-care organization.[72] These elements are the main health determinants, and Lalonde called them "health fields." The human biology element includes both physical and mental aspects of health and contributes to all kinds of ill health and mortality. Health problems that originate from human biology can cause expenses for treatment services. The environment element includes those matters of health (drugs, devices, water supply, noise pollution, air pollution, radiation, toxic wastes, food additives) that are external to the human body and over which the individual has little or no control. The lifestyles element consists of the aggregation of decisions by individuals that affect their health and over which they more or less have control. Bad personal decisions and habits, from a health point of view, can create self-imposed risks. The health-care organization element includes medical practices, nursing, hospitals, nursing homes, medical drugs, ambulances, dental treatment, and other health services such optometry and podiatry. This element consists of the quantity, quality, arrangement, nature, and relationships of people and resources in the provision of health care. The lack of this care is a determinant of health. Health is determined by the circumstances and environment in which people live; an individual's living place, environment, genetics, income, educational level, relationships with friends and family, and access to and use of health-care services are all

[71] Ibid
[72] M. Lalonde, *A New Perspective on the Health of Canadians*, Ottawa: Information Canada. 1974. p.6.

factors that have considerable impacts on health. As discussed in Chapter II, at least three different meanings of health can be identified: (1) the absence of illness, disease, or injury;[73] (2) a personal characteristic; and (3) a state of equilibrium and well-being.[74] The phrase *social determinant of health*[75] is often used to refer to any non-medical factors influencing health, including health-related knowledge, attitudes, beliefs, and behaviors (such as smoking).[76] In *The Solid Facts*, The WHO Regional Office for Europe summarized some of the major social determinants of health.[77] These determinants include the social gradient, medical care, spiritual aspects, stress, early health and lifestyle, social exclusion, education, work, unemployment, social support, income, addiction, food, and transport.[78] Poor social and economic circumstances affect health throughout life.[79]

Social determinants of health are lifestyle conditions shaped by the political, social, and economic forces in which people are born and raised. They are also shaped by biological factors, such as age and sex; social and community influences; living and working conditions; status hierarchy in work; disruptions in social and family ties due to death, immigration, and social changes within the society; and general socio-economic, and environmental conditions, such as education, and access to health-care services. Income, social status, and education are important health factors. Higher income and social status are linked to better health. We know from experience that the greater the gap between the richest and poorest in a society, the greater their differences in health.[80]

Money helps individuals meet basic needs. More income may enhance subjective well-being (SWB), but more income does not appear to increase SWB over the long-term when it is acquired by well-off individuals whose material desires increase with their

[73] J. G. Maeland, *Health and the quality of life. Concepts and definitions,* Tidsskrift for den Norske laegeforening: tidsskrift for praktisk medicin, ny raekke, *109*(12), 1989, p.1311-1315.
[74] N. Sartorius, *The meanings of health and its promotion.* Croatian medical journal, 47(4), 2006. p.662.
[75] R. G. Wilkinson, M. G. Marmot, *Social determinants of health: the solid facts*, World Health Organization. 2003.
[76] P. Braveman, S. Egerter, D. R. Williams, *The social determinants of health: Coming of age,* Annual Review of Public Health, 32, 2011, p.381-398.
[77] Centre Determinants of health, *The solid facts. In Array Editor (Ed),* World Health Organization, 2003, p.1-33). Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf. Accessed 15.07.2017.
[78] Ibid
[79] R. G. Wilkinson, M. G. Marmot, *Social determinants of health: the solid facts*, World Health Organization, 2003, p.10.
[80] I. Kawachi, B. P. *Kennedy, Income inequality and health: pathways and mechanisms.* Health services research, 34(1 Pt 2), 1999, p.215.

incomes. However, it appears that high SWB may increase people's chances for high income.[81]

People's education levels have a great impact on their health. Low education levels are linked with poor health, more stress, and lower self-confidence. Social support networks are another important health factor. Greater support from families, friends, and communities is linked to better health. The customs, traditions, and beliefs of the family and community also affect health.

Many countries have initiated health policy frameworks inspired by the "health is wealth" principle to reduce their citizens' mortality and morbidity rates and improve their quality of life. These countries' central mission is to promote and protect the health of the population. Investing in health helps provide the nutritional wealth needed to keep people healthy throughout their lives. It also contributes to longer lives, which in turn contributes to the growth and sustainability of society as a whole. Therefore, being healthy means being wealthy in the sense that it encourages productivity, rationality, and creativity—characteristics that constitute a truly wealthy individual.

It goes without saying that health is integral to life. Healthy people are able to live longer and more happily, which in turn enables them to manage their families and other responsibilities more effectively and for longer periods of time. This longevity translates into more beneficial contributions to the economy. Conversely, poor health contributes to uneven work habits and attendance and the production of poor-quality products and services that negatively affect business performance, growth, and success. From a global perspective, poverty is a reliable indicator of poor health because health-care services are not readily accessible to the poor, which is the exact opposite of the health-is-wealth principle.

There are many economic advantages to health:[82]

- Improved physical health leads to reductions in both short-term and long-term costs to health-care purchasers and providers.
- Improved subjective health leads to savings in areas other than health and savings in health-care costs in acute care and preventive care services.
- Primary preventive strategies ensure that people remain healthy longer and identify health problems earlier, when costs are lower and prognoses are better.

[81] E. Diener, R. Biswas-Diener, R. *Will money increase subjective well-being?* Social indicators research, 57(2), 2002, p.119-169.
[82] C. Heginbotham, K. Newbigging, *Commissioning Health and Wellbeing*, Sage, 2013, p.30-31.

- Resilience and recovery programs ensure that the effects of subjective illness are minimized and increase savings due to the reduced use of services, as improved subjective health reduces the risk of subjective illness.
- Better subjective health may reduce unhealthy behavior such as alcohol consumption and smoking.

The physical environment is an important determinant of health. The importance of physical environment to health status became increasingly clear in the last decades of the twentieth century.[83] The physical environment in which people work and live has an enormous impact on their health. Characteristics of the physical environment include the social and economic environment, the natural environment (e.g., air, water), and the built environment, which may include transportation, buildings, green spaces, roads, and other infrastructure.[84] At certain levels of exposure, contaminants in air, water, food, and soil can cause a variety of adverse health effects, including cancers, birth defects, respiratory illnesses, and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, the design of communities, and environmental hazards can be health threats. People are healthier when they have greater control over their lives and working conditions. Personal behavior and coping skills, such as eating practices, exercise levels, smoking, drinking, and dealing with life's stresses and challenges, all affect health.

4. Measurement of Health Status

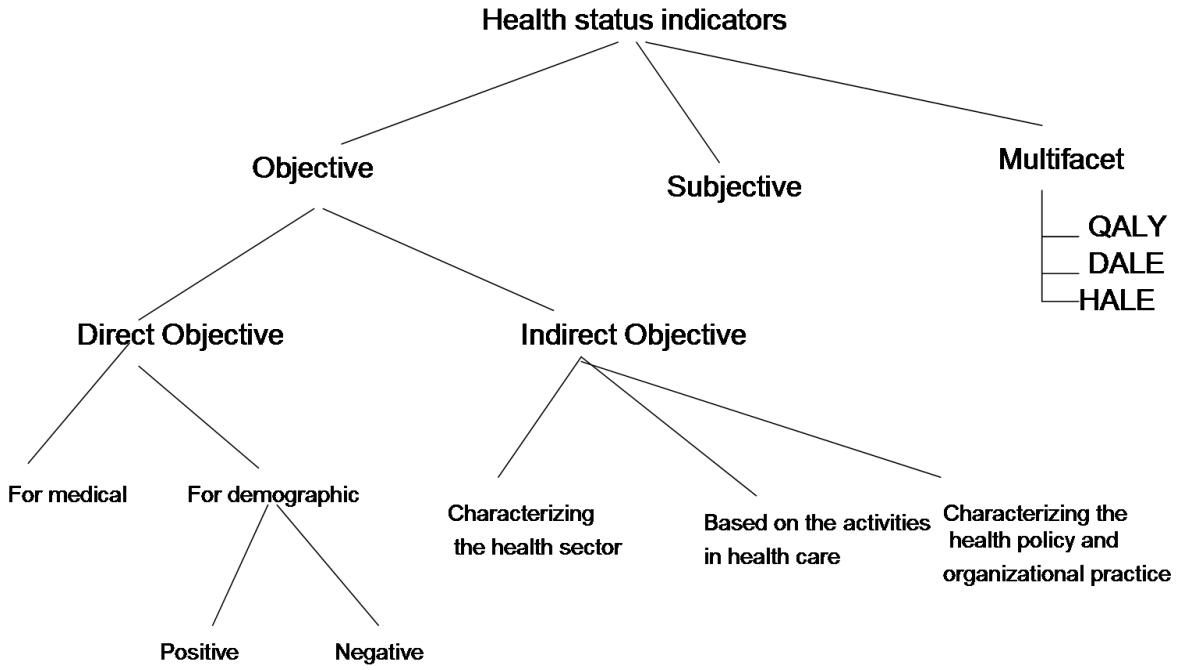
Measurement is fundamental to scientific inquiry; however, there is no standard measurement for determining the health status of individuals or population groups. For a health-status measurement to be truly representative, it must gather information about an individual's sense of economic well-being, level of social integration, educational background, employability, fertility status, self-perception of health, general well-being, and health-care system (public and private) experience, as well as more objective data such as hemoglobin, blood pressure, weight, height, and so on.

Most health measures rely on self-reports rather than empirical observations. Health measures are not easy to define because of assessment difficulties and process costs. In order to measure health, statistical data on social conditions must be collected. Objective health

[83] Institute of Medicine (US). Committee on Assuring the Health of the Public in the 21st Century. *The Future of the Public's Health in the 21st Century*. National Academy Press, 2003.
[84] IOM (Institute of Medicine), *The Future of Public Health*, Washington, DC: National Academy Press. 1988, 192-196.

measurements should be used in order to identify the major health issues faced by a society or a social group; these can then be relied upon both to develop policies and resolutions for identified health problems and also to monitor and sustain medical and health-care effectiveness. However, measuring health is a complex endeavor that remains the subject of much debate. There are no direct elements or factors (e.g., weight or height) that can be used reliably to measure health; rather, the process is indirect and involves several steps. Measuring health requires a careful selection of indicators.[85]

Figure 2.5. Health status indicators.



Source: Adapted and modified from V. Korporowicz, 2008. *Health Promotion: Shaping the Future,* Warsaw School of Economics. p.135

Figure 2.5 shows several health status indicators[86], which are divided into objective and subjective. Objective indicators are collected from information obtained by specialists in the field, for example, doctors, nurses, statisticians, and demographers. Objective measurements are an adequate way to quantify health-related variables. Examples of objectives indicators are blood measure parameters (measures of red cells, white cells, hormones, the immune system [haptoglobin]), urine parameters (leukocytes, glucose, protein,

[85] P. Braveman, S. Egerter, D.R. Williams, *The social determinants of health: Coming of age,* Annual Review of Public Health, *32*, 2011, p.381-398.
[86] V. Korporowicz, op.cit., p.135.

electrolytes, hemoglobin), systolic and diastolic blood pressure, pulse rate, and measures of sensory function.

Intermediate objective indicators characterize the health sector. They concern the department of health (e.g., the number of dental services, the number of surgical procedures, the length of wait for a medical appointment, the number of immunizations), equipment health sector (e.g., the number of beds in hospitals and clinics, specialist equipment); and medical personnel (e.g., the number of doctors, dentists).

Actions in the field of health care refers to the social consent for the execution of programs for promoting and communicating about the health of the population.

5. Types of Health-Status Measurements: Objective and Subjective Measurements

Measuring the health status of individuals has traditionally been the domain of the clinical interview, while measuring the health status of groups has been achieved via survey instruments. Two major ways of classifying health measurements can be distinguished: they may be classified according to *function*, or the purpose for applying the method, or they can be classified on the basis of their *scope* or *methodology*, which considers the techniques used to record data and other types of measurements.

Some indicators of the health status of a population include the measurement of the population's average lifespan, death, and disease prevalence and the availability and accessibility of health-care services. Bombardier and Tugwell (1987) identified three purposes, or functions, for measuring health: the diagnostic, prognostic, and evaluative:[87, 88]

- *Diagnostic* measurements take into account temperature, blood pressure, and erythrocyte sedimentation rates and are judged by their correspondence with a clinical diagnosis.
- *Prognostic* measurements include screening tests, scales such as the Apgar score,[89] and other types of predictive data that assesses the likelihood of a patient living independently following rehabilitation from surgery, drug addiction, and disease.
- *Evaluative* measurements record changes in a person's health over time.[90]

[87] C. Bombardier, P. Tugwell, *Methodological considerations in functional assessment,* Rheumatology, 14 (suppl. 15),1987, p.6-11.
[88] C. Bombardier, P. Tugwell , *A methodological framework to develop and select indices for clinical trials: Statistical and judgmental approaches,* Rheumatology 9,1982, p.753-757.
[89] A. Siderowf, B. Ravina, H. A. Glick, *Preference-based quality-of-life in patients with parkinson's disease,* Neurology *59*, 2002, p.103–108.

The descriptive and objective classifications of health measures are based on the scope or range of topics they cover, as well as the breadth of the concepts being measured. Descriptive classifications include measurements of particular organ systems, such as vision and hearing, and scales used to diagnose anxiety or depression and broader syndromes that affect emotional well-being. They also include measurements of overall health and quality of life.

The objective indicators that affect the health status of a population can be determined from aspects related to work, income, or leisure that, when combined, can be used to evaluate the overall quality of life. In addition, other objective indicators are safety and good living conditions. If the majority of the population of a nation is proven to have a better quality of life, is a good indicator that the nation has a high inclination toward a better and more progressive health-care system.

Mortality assessments (crude death rate, cause-specific death rate, death-to-case ratio, infant mortality rate) and morbidity assessments (incidence rate, attack rate, point prevalence rate, period prevalence rate) are negative demographic characteristics. Live births (the birth of an infant who shows postnatal evidence of life) and average life expectancy (the number of years, based on statistical averages, that a given person of a specific age, class, or other demographic variable may be expected to continue living) are positive demographic characteristics.

Some commonly used morbidity (negative) measures of a population's health status are:

- *Incidence Rate*—The ratio of the number of new cases of a disease occurring in a population during a specified time period to the number of persons at risk of contracting the disease during that same period.
- *Prevalence Rate*—The ratio of the number of cases of a disease present in the population at a specified period of time to the number of persons at risk of having the disease at that specified time.

The above ratios are multiplied by 1,000 or 100,000 to yield statistics that are more readily interpretable.

Mortality measures include:

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[90] E. I. Lubetkin, M. R. Gold, *Areas of decrement in health-related quality of life (HRQOL): Comparing the SF-12, EQ-5D, and HU-I3*, Qual Life Res, *12*, .2003, p1059–1067.

- *Death Rate*—The ratio of the number of deaths in the population during a specified time period to the number of persons in the population during the specified time period.
- *Infant Mortality Rate*—The ratio of the number of infant deaths under the age of one (and multiplied by 1,000) to the total number of live births.

A good measure of the health status of a given population, *life expectancy* is defined as the average number of additional years a person can expect to live from a given age onward. It is calculated by applying age- and sex-specific mortality rates from the population under study to a hypothetical birth cohort of 100,000 individuals. It should be noted, however, that life expectancy is a theoretical measure and, as such, can change for an individual in response to changing trends in disease frequency in the population and with regard to individual behavioral changes.

From a subjective point of view, health indicators are measures that reflect the condition and state of a person within a defined population.[91] The health status of a particular nation can potentially help identify and describe the population's quality of life. Subjective determinations of health status and quality of life can be measured in terms of the level of satisfaction people experience regarding their health and the quality and accessibility of health-care services. In other words, how the population *feels* about the health status of their nation can be used both to measure and provide them a better quality of life. Subjective health assessments improve decision-making to the extent that they provide reliable information about an individual's specific conditions and level of contentment. This information is very important for improving the prospects of successful treatment.

Subjective indicators are determined by the sensations of the patients/individuals affected. According to Schirnding (2012), "indicators" have become widely used in many fields, as they play a functional role in emphasizing problems, monitoring progress, recognizing trends, formulating policies, and contributing to the process of setting priorities.[92] In their basic form, indicators help simplify measurements, especially those involving complex datasets about the environment, the development nexus, and health. It is in this context that indicators are considered to be the most vital, since they concern activities directly related to public information and decision-making, environmental problems and management, and environmental health.

[91] CDC Reproductive Health: *Glossary*, 2012. Available at: http://www.cdc.gov/reproductivehealth/EpiGlossary/glossary.htm#H. Accessed 28.05.2016.
[92] Y. Schirnding, *Health in sustainable development planning: The role of indicators,* World Health Organization, Geneva. 2012, p.9-148.

Subjective health measurements have several advantages. Most importantly, they extend and contextualize information derived from morbidity statistics and physical measures. They describe the quality of a function rather than its quantity. Subjective measurements provide grounded insights about the human experience of pain, suffering, or depression that cannot be deduced solely from physical measurements or laboratory tests. They also help us to understand why some people avoid seeking care. They offer a systematic means of recording and representing the real concerns of patients in their words without requiring expensive laboratory analyses or invasive procedures.

The assessment of subjective health can be done in a variety of ways because various methods can be used to measure outcomes. In a cross-national study conducted by the WHO to measure subjective health among Swedish adolescents, the one-dimensional Rasch model was used.[93] According to the authors, this model measures subjective health using a "symptom checklist" based on reported health complaints, with results analyzed using Rasch analyses. Measuring change in health status is an essential requirement for maintaining and improving the quality of health services. Interestingly, in analyzing data, the Rasch model focuses on latent trait characteristics. The latent trait model is used to design instruments used in observing personal attributes or traits or in testing for unobservable traits.

Another method for measuring subjective health is known as the direct estimation method. This approach is commonly used in research that involves subjective judgments.[94] According to the authors of the study mentioned above, this method is easy to design and understand. Nevertheless, Streiner, Norman, and Cairney (2014) have asserted that the questions developed/used for this method are often grounded on a rating scale that can lead to biased responses.

Thurstone's method can also be used to measure subjective health. According to Maydeu-Olivares and Bockenholt (2008), the Thurstone method is used to quantify subjective health outcomes using ordinal data/information.[95] This method uses rankings to measure subjective health outcomes. Patients/individuals will be asked to rank or select those statements that are most applicable to them, after which scores are calculated based on the average score of selected items.[96]

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[93] C. Hagquist, D. Andrich, *Measuring Subjective Health Among Adolescents in Sweden,* Social Indicators Research. 68, 2003, p.201-220.

[94] D.L. Streiner, G. R. Norman, J. Cairney, *Health Measurement Scales: A Practical Guide to Their Development and Use*, Oxford University Press. 2014.

[95] A. Maydeu-Olivares, U. Bockenholt, *Modeling Subjective Health Outcomes - Top 10 Reasons to Use Thurstone's Method,* Medical Care, 46(4), 2008, p.346-348.

[96] D. L. Streiner, G. R. Norman, J. Cairney, op.cit., p. 53.

QALY (Quality-Adjusted Life-Years), DALY (Disability-Adjusted Life-Years and HALE (Healthy Life Expectancy) are indicators on the borderline of objective and subjective health. These indicators are developed on the basis of disability and death attributable to a specific disease in an individual person. The International Classification of Disease (ICD) that is used for determining appropriate care is the result of the QALY, DALY, and HALE construction. Health-adjusted life years (HALYs) measure a population's health by focusing on morbidity and mortality simultaneously. They help estimate the burden of disease to compare the relative impact of a specific range of illnesses, interventions, and conditions on communities and in economic analyses. HALYs are important in domestic and international policy circles. The morbidity or quality of life component of HALYs is referred to as health-related quality of life (HRQL), with a scale of 0 (the extremes of death) to 1.0 (full health). HALE provides an encompassing view of the morbidity and mortality burden of a population. Measures of population health using HALYs offer the possibility of a more rational allocation of health-related interventions at both the clinical and population levels. The WHO uses HALYs for measuring the average level of health of the populations of its member states for annual reporting.

The goal of the QALYs and DALYs measures is to accurately represent the outcomes that can be generated most efficiently per dollar spent so that the health of the population is maximized. They are allocations of health resources, as they provide a common denominator.

QALYs were developed in the late 1960s by economists and operations researchers and were introduced in 1976 to provide a guiding principle for selecting among alternative tertiary health-care interventions.[97] Quality-adjusted life years are a measure of health expectancy, and they are used to conceptualize the health outcome (denominator) in a cost-effectiveness (CE) ratio. Computing the denominator of the CE ratio by using QALYs leads to the cost-effectiveness analysis referred to as cost-utility analyses (CUA).[98] Quality-adjusted life years are useful in the assessments of medical care and public health interventions. The original formulation of QALYs was drawn from the theoretical underpinnings of welfare economics and expected utility theory. In welfare economics, QALYs is used for resource allocation. Descriptive health status measures include the Quality of Well-Being Scale

[97] R. Zeckhauser, D. Shephard, *Where now for saving lives?* Law and Contemporary Problems; 40: 1976, p.5-45
[98] M. R. Gold, D. Stevenson, D. G. Fryback, HALYS and QALYS and DALYS, Oh My: similarities and differences in summary measures of population Health. *Annual review of public health*, *23*(1), 2002, p.115-134.

(QWB), the EQ-5D (EuroQoL), and the Health and Activity Limitation Index (HALex). The Health Utilities Index (HUI) and (HALex) are used to create QALYs. [99]

Disability-adjusted life years (DALYs) are used to quantify the burden of disease and disability in populations, as well as to set priorities for resource allocation. Disability-adjusted life years is a metric for measuring the gap between a population's health and its hypothetical ideal for health achievement and for conducting national burden of disease studies. DALYs place different value weights on populations based on their age structure, so DALYs in the very young and the very old are discounted compared to other age groups. It states that the value of each year of life depends on age. DALYs focus on disability, or the impact of a disease or condition on the performance of an individual.

[99] D. Brock, *Ethical issues in the development of summary measures of population health status*, See Ref. 15, 1998, p.73–81.

CHAPTER III: HEALTH AS WEALTH

This chapter discusses the determinants of health and elaborates on their various sub-types.

1. Health as Wealth

It has been said that the cost of better health is the need for greater wealth. Both health and wealth are important factors influencing general well-being and are essential components of social well-being. Besides good health's obvious intrinsic value, it also promotes productivity and, thus, overall economy. Governments world-wide prioritize health at all levels, placing it at the core of all policies. Health is considered to be both a key indicator of social development and a means of achieving it. It is important for human happiness and well-being and makes an important contribution to economy. It is an economic engine—with better health and education, people can become more productive.

The association between poverty and poor health has been recognized for centuries. Conventional wisdom correctly links poor health with a lack of financial resources, a relationship that in turn promotes poor health habits and hampers the poor's ability to acquire and accumulate wealth. At the same time, those who do have the ability to acquire wealth but neglect their health in the process are engaged in a self-defeating activity. However, wealth and health need not be mutually exclusive. People can invest in their health through healthy lifestyle choices, just as they would invest in wealth by purchasing stock. Simply put, health and wealth are inherently interconnected in many crucial ways.

From a global perspective, health is a critical component of well-being. Healthy individuals are better able to enjoy leisure time and derive satisfaction from life, learn new skills, and earn more income.[100] For them, health is the greatest wealth a person can have. Without it, productivity is impossible—and so too, are economy and sustainability. Being healthy also means being wealthy.[101] They are related.[102]

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[100] C. A. Jones, *Health status and health care access of farm and rural populations (No. 57),* DIANE Publishing. 2009, p.1.
[101] World Economic Forum, *Health is wealth*, 2014. Available at: http://www.weforum.org/sessions/summary/health-wealth. Accessed 22.12.2016.
[102] D. E. Bloom, D. Canning, D. T. Jamison, *Health, wealth and welfare.* Finance and Development, 2004, p.10-15.

For this reason, the WHO has been actively engaged in building a healthier, stronger, and more competitive global society. Its leaders understand that good health increases the value of human capital, resulting in higher work productivity and wealth potential. Health is an integral part of human capital. Poor health has been shown to reduce GDP (gross domestic product) per capita by lowering labor productivity and the relative size of the labor force.[103]

During the 2014 World Economic Forum Annual Meeting, both public- and private-sector leaders acknowledged the importance of investing in health in order to foster long-term economy. At the same forum, Mauricio Cardenas, Colombia's Minister of Finance and Public Credit, asserted: "[H]ealth doesn't just make us happier. It helps economic growth."[104] Other speakers agreed and encouraged world leaders to consider investment in health a good decision. They noted that a nation seeking economy should focus on improving the health status of its citizens.

Health is placed on the social side of the economic/social divide. Money spent by any country on health promotion should be considered a social investment rather than wealth consumption. Poor health is a major cost to business in the developed world and hurts economy in the developing world.[105] Thus, the theme "health is wealth" is now being disseminated globally in order to convey the essential role of health in stimulating economy, human development, and sustainable environments. More and more nations are adopting the "health is wealth" principle in their efforts in and commitment toward addressing their citizens' common health issues and concerns.

Wealth refers to an abundance of valuable resources or valuable material possessions. To be more specific, wealth refers to things people own and use to produce goods and services but do not consume in the process. Examples include land, natural resources, and market shares. Wealth also includes assets that enable people to generate future income and enhance their sense of well-being. Economists commonly define wealth as the expected present (discounted) value of a future stream of consumption. Thus, wealth is the sum of various types of productive capital goods, measured in physical units and valued in monetary units such as dollars or euros.

There are essentially five kinds of wealth: financial capital, such as funds held in banks; produced capital, such as machines, buildings, infrastructure, and houses; natural

[103] D. E. Bloom, D. Canning, D. T. Jamison, op. cit., p.10-15.
[104] World Economic Forum, *Health is wealth*, 2014. Available at: http://www.weforum.org/sessions/summary/health-wealth. Accessed 03.03.2016.
[105] W. G. Manning, E. B. Keeler, J. P. Newhouse, E. M. Sloss, J. Wasserman, *The costs of poor health habits*, 1991.

capital, such as forests, fish stocks, and mineral deposits; human capital, such as the skills and abilities embodied in a person;[106] and disembodied "knowledge capital."

Income and wealth directly support better health because wealthier people can afford the resources that protect and improve health. Factors such as education, employability, demographics, and socio-economic status are considered when attempting to establish an association between health and income. Lack of education, of knowledge about the health-care system of the country, and of income may affect immigrants' health and access to health services. Education is critical to social and economic development and has a profound impact on a population's health. It contributes to human capital by developing a range of skills and traits, such as cognitive skills, problem-solving ability, learned effectiveness, and personal control. These various forms of human capital may all mediate the relationship between education and health. Health is strongly tied to income and education. The relationship between income and health is a gradient, meaning a step-wise connection at every level of the economic ladder.

A person's health status and access to health services improves with his or her level of education. Education is firmly connected to socio-economic status. Education is a key contributor to well-being and prosperity for people and for the nation.

A person's work status significantly affects his or her subjective and objective health and physical and social well-being. Income or money from work provides social contacts, opportunities for self-improvement, and a sense of identity and purpose. Health status is enhanced at each step up the wage and social hierarchy. The level of wages or income determines people's living conditions, for example, safe housing and the capacity to purchase food and get access to health services. Health spending, which is the sum of both private and public health expenditure, is seen as a share of the GDP for mainland Norway. Health expenditures are very much tied to the available resources devoted to health services. The financial resources of a nation have a great impact on its people's health status and accessibility to health services.

The majority of any person's wealth is likely made possible by his human capital (e.g., personal stock of knowledge, skills, and capabilities) together with his or her institutional and social capital (e.g., the rule of law, the enforcement of property rights, and a stable financial system). Human capital enables the future generation of income, while

[106] K. Hamilton, C. Hepburn, *Wealth*, Oxford Review of Economic Policy, Oxford University Press. *30*(1), 2014, p.1-20.

institutional capital provides the critical social underpinnings needed for income generation, along with the protocols required to prevent the theft or destruction of wealth.

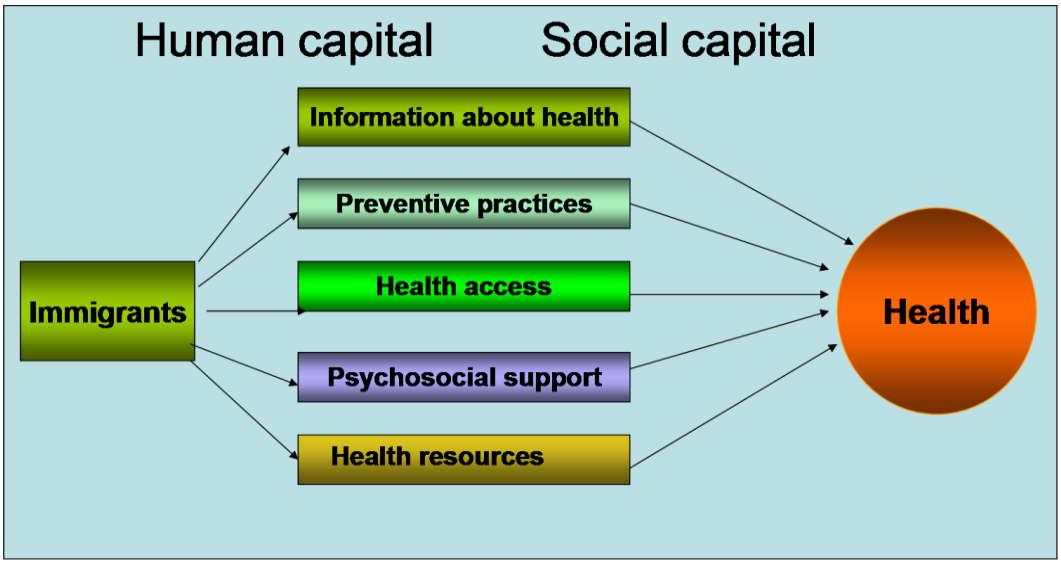
Wealth is distributed according to geographic composition (land, natural resources, produced capital roads, and bridges), political parameters (nations, regions, cities, neighborhoods, and households), economic sectors (public, private, and household), and individual ownership.

Wealth is not the same thing as income. *Income* refers to the flow of money, whereas wealth refers to a stock of assets. Obviously, there are strong links between levels of income and wealth, but *income distribution* is not an adequate substitute for *wealth distribution*. Patterns of global wealth distribution have immense impacts on health, but they have been largely ignored or overlooked by public health specialists and the social sciences more generally. There are two crucial ways in which wealth distribution affects health status: the distribution of a country's stock of marketable assets among its residents and the distribution of global wealth among countries.

2. Health as Part of Human and Social Capital

Wealth affects health, and improvements in health or wealth can contribute to substantial gains in labor productivity.

Figure 3.1. Pathways between human capital, social capital, health, and wealth**.**



Source: Modified and adapted from R. M. Scheffler, T.T. Brown, 2008. Social capital economics and health: New evidence, *Health Economics, Policy, and Law, 3*, (4), p.321–331.

Figure 3.1 shows that social capital and human capital are able to make political organizing more likely, resulting in more health resources being brought into a given area. Social and human capital make political organization possible by shaping the quality and quantity of a society's social interactions and facilitating coordination and cooperation[107]. Social capital has an effect on a community's productivity and well-being; it is the glue that holds institutions, relationships, social networks, and norms together. It shapes social structure and enables norms to develop.

Health resources can improve access to health care and, thus, improve health.[108] Health as wealth has an impact on earnings. Health, like education, is a form of human capital that is a fundamental requirement for economic development. According to economist Angus Deaton, human capital is a crucial economy factor.[109] Many aspects of human capital are of such importance that public policy plays a role in encouraging countries to make efficient investments in health. A country's stock of human resources is the total capacity of its people—a form of wealth that can be directed toward accomplishing the goals of the nation. Human capital affects both individual productivity in the workplace and health-seeking behavior and opportunities. It has various positive effects on economy and technological progress due to its capacity to expand and further develop the global economy. Thus, human capital is one of the key drivers of technological progress and economy. In addition, human capital explains income differences while playing a positive role in determining a country's income.

Health plays a vital role in the formation of human capital. Human capital[110] is skill embodied in workers. The use of human capital can either produce output or generate new human capital. An investment in human capital can provide an increase in productivity, which in turn can lead to economic development (Figure 3.2). Deaton links human capital, income, and health to economic development. Health is both human capital itself and an input to producing other forms of human capital.[111] Kuznets shows that at the early phases of growth, there is a positive relationship between income inequality and economic growth. When incomes rise, people use their extra income on health services.[112]

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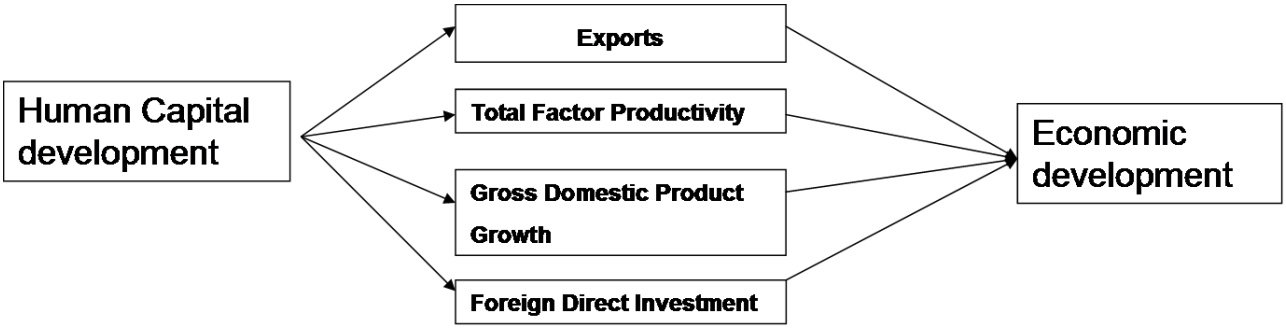
[107] R. M. Scheffler, T.T. Brown, *Social capital economics and Health: new evidence,* Health Economics, Policy and Law, 3, (4), 2008, p.321-331.
[108] I. Kawachi, L. Berkman, *Social cohesion, social capital, and health*, Social epidemiology, 2000, p.174-190.
[109] Deaton, A. *Health, inequality, and economic development,* Journal of economic literature, 41(1), 2003, p.113-158.
[110] R. E. Lucas, *On the Mechanics of Economic Development,* Journal of Monetary Economics 22, 1988, p.3-42.
[111] A. Deaton, A. *Health, inequality, and economic development,* Journal of economic literature, 41(1), 2003, p.113-158.
[112] S. Kuznets, *Economic growth and income inequality,* American Economic Review 45, 1955, p.1–28.

Figure 3.2. Human capital and economic development**.**

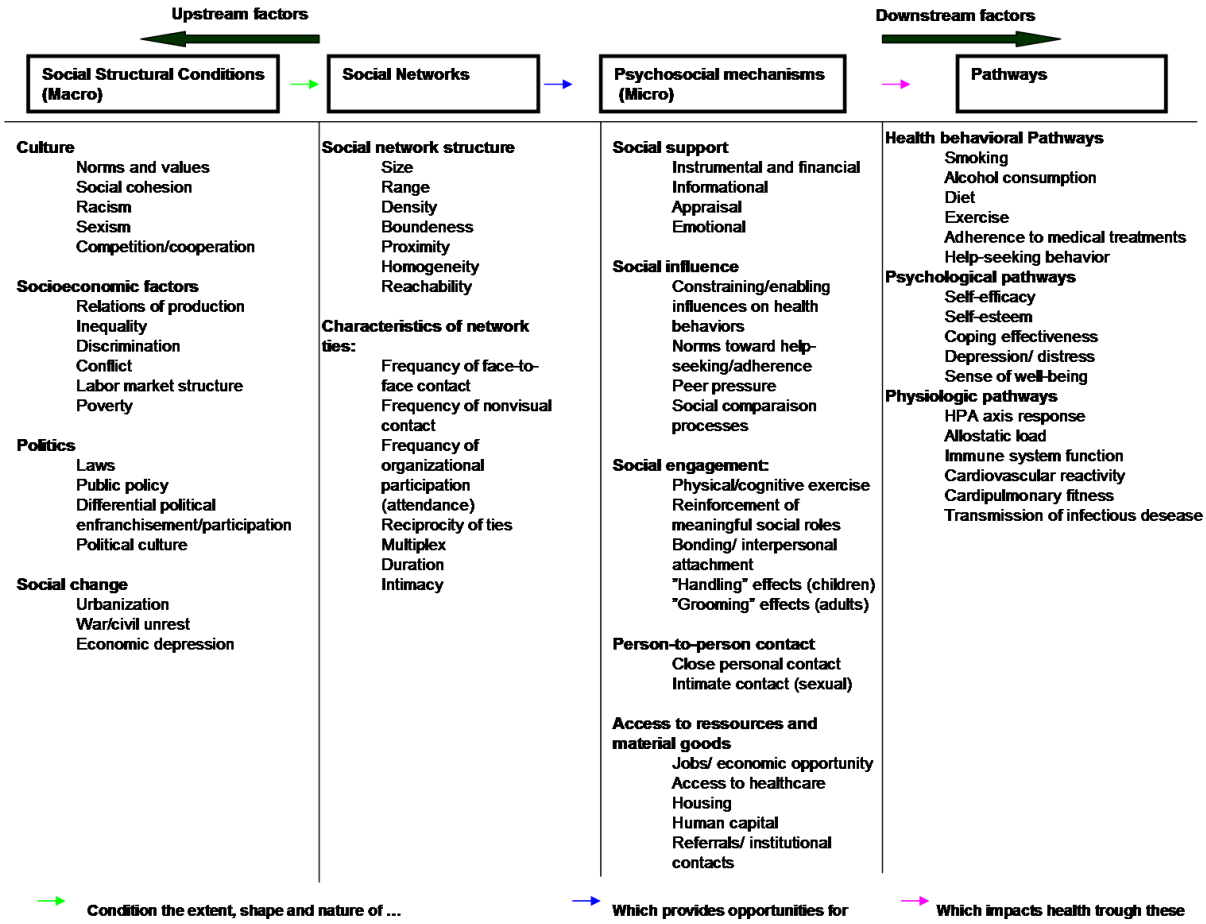


Source: O. O. Adeyemi, 2011. Human capital investment in the developing world: An analysis of praxis, *Seminar Research Paper Series,* p.4.

Figure 3.2 shows how human capital relates to economic development through increased exports, foreign investments, GDP, and productivity, which can potentially lead to technological progress and the future development of the economy. Investment in human capital helps to improve growth performance, provided that we recognize that the impact manifests in the long run. This requires close attention to quality education, as well as broadening access to it.[113] Economy highly depends on synergies between health, access to health services, and the utilization of human capital resources. Comparatively, social capital is a characteristic of communities and social networks. It includes networks of individuals linked by social ties and interactions.

Figure 3.3. Conceptual models of how social networks impact health

[113] J.W. Fedderke, *Technology, human capital and growth (No. 27),* Economic Research Southern Africa. 2005, p.37.



Source: Lisa F. Berkman, Ichirō Kawachi, M. Maria Glymour, 2014. *Social Epidemiology*, p. 143

Figure 3.3 shows how social networks and relations influence a broad array of health outcomes. The nature of human relationships and interconnections are vital both to individuals' health and well-being and to the health and vitality of entire populations. Figure 3.3 shows that social capital or social networks provide opportunities for social support, which, if accessed, can improve health.[114]

Social capital and social relationships have an impact on health and can help increase the distribution of information about behaviors that improve health. Individuals can thus come into possession of such information and apply it to improve their health. Membership organizations often serve as conduits for health information.

[114] L.F. Berkman, I. Kawachi, M.M. Glymour, (Eds.). *Social epidemiology*, Oxford University Press., USA, 2014. p.142-144.

3. The Significance of the Relationship between Health and Income

Debates pertaining to the relationship between health and income have been growing among economists and researchers alike. Interestingly, some economists agree that there is a positive association between health and income, whereas critics argue that health has no correlation with economics. For example, according to Deaton (2003), the correlation between health and income is stimulated by variations in institutional quality, while improvements in the areas of health and income over time are the results of knowledge advancement.[115] In this context, the significance between health and income presents various underlying factors, thereby contributing to the complexity of the subject matter.

In some literature, researchers have attempted to examine and explore the significance of health regarding income and vice versa. Differing views have resulted from various empirical studies, and there is still a lack of evidence to suggest whether there is a positive or negative association between health and income. The significance of health regarding income is uncertain because of the outcomes of the influence of various factors, including inequality, socio-economic factors, and exogenous differences among individuals, among others.

People living in high-income countries tend to have low mortality rates. However, better average mortality rates are apparent in low-income countries (18 percent) as compared to those in high-income countries (12 percent).[116] At the country level, there is an apparent interplay between patterns of health factors and income.

The association between health and income presents certain implications in line with income inequality. The Wilkinson Hypothesis is one of the theories associated with correlating health and income and was developed by Richard Wilkinson. It suggests that income inequality has a negative impact on population health in that the individual's health status is determined by his or her relative income or position, as opposed to the absolute material standards, particularly in developed economies.[117] Thus, it is argued that "…a large

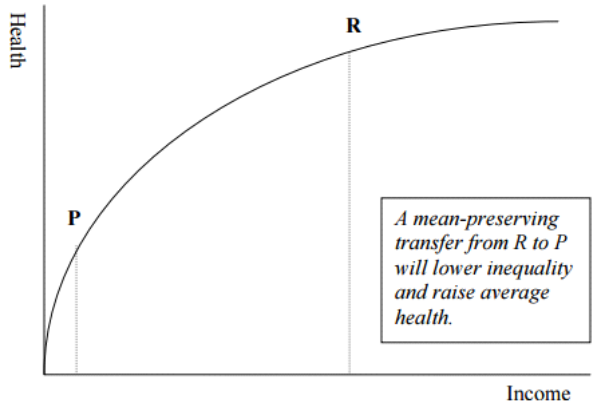
[115] A. Deaton, *Health, Inequality, and Economic Development*, Journal of Economic Literature, XLI, 2003, p.113-158.
[116] D.A. Kindig, *The Link Between Income and Health,* 2012. Available at: http://www.improvingpopulationhealth.org/blog/2012/04/the-link-between-income-and-health.html. Accessed 29.10.2016.
[117] Y. Qi, *Explaining cross-national disparaties in health: The role of income inequality,* Ann Arbor, MI: ProQuest LLC. 2008.

income gap between the rich and the poor can lead to worse health through the breakdown of social cohesion and trust" (p. 5).[118]

Studies on the relationship between income inequality and health reveal that while there are significant differences in income inequality and considerable changes in health, there is no significant association between any measures of income inequality and health. In addition, Jen's (2006) findings support the theory that in developed economies, life expectancy is related to GDP but is not linked to income inequality.[119] Furthermore, other findings show that there is no significant relationship between health and income inequality when considering individual factors.[120]

In addition, exploring the relationship between health and income can also be associated with the absolute income hypothesis. It suggests that, if health depended on the income of individuals, then health gains achieved from having extra units of income would predictably diminish as the individual's income increased (Figure 3.4). In Figure 3.4, R represents the richer individual and P, the poorer individual. If the health of P increases by more than the health of R lowers, and the holding total income is constant, it can be concluded that an equal distribution of income is expected to improve a population's health.

Figure 3.4. Non-linear relationship between income and health**.**



Source: Leigh, A., Jencks, C. & Smeeding, T. M., 2009. *Health and Economic Inequality.* Available at from http://andrewleigh.org/pdf/HealthInequalityOUP.pdf. Accessed 05.25.2017.

[118] Ibid, p.5
[119] M. Jen, *Health outcomes and income inequality : a multilevel analysis of the Wilkinson hypothesis. PhD Thesis*, University of Bristol. 2006, p.98.
[120] M. H. Jen, K. Jones, R. Johnston, *Global variations in health: evaluating Wilkinson's income inequality hypothesis using the World Values Survey,* Social Science and Medicine, 68(4), 2009, p.643-653.

Figure 3.4 shows the pattern of the relationship between average income and average health for OECD countries. As explained by Leigh, Jencks, Smeeding (2009), the richest country (Luxembourg) and three poorest countries (Mexico, Poland, and Turkey) were excluded from estimating the slope. The authors used life expectancy and infant mortality as measures of population health, and the effect of income on health in countries with average incomes of $15,000 to $25,000 US dollars, per capita, was seen to appear substantial. Despite this, the authors claimed that there is a lack of empirical support to justify the claim that as individual and average income increases, it will have less effect on health.[121]

4. Income Inequality: History and Growth Rate

Income inequality is a great economic issue of our time. It's known as a prominent concern in economics policy. Income inequality has worsened significantly world-wide since 1821. From the period of 1821 to the 1880s, the growth rate of wages for common labor workers in US was at 1.04%; artisans received 0.73%, and the clerks reached 1.52%. The growth rate of the clerks' wages (who were considered the major white-collar workers in this period) moderately rose prior to the Civil War compared to the common labor workers. The white-collar workers suffered a decline in their wages before 1930. Paul Douglas explained that the educational expansion might have caused this substantial decline. The educational expansion reportedly increased the supply of educated workers in the early twentieth century[122].

According to Margo, the rising portion of the growth rate appeared in the period of 1820 to 1860. After 1860, during the World War I, wage inequality declined but rose again and peaked in the late 1920s.[123] Between 1929 and 1950, wage inequality continuously decreased and reached two decades of stability from the years 1950 to 1970, after which inequality again increased sharply in the 1980s.

The "Great Compression" of the 1940s resulted in a substantial narrowing of wage inequality within and between groups. Although long-term supply-side forces played a role in generating wage compression, much of the decrease in inequality was associated with the

[121] A. Leigh, C. Jencks, T. M. Smeeding, *Health and Economic Inequality*, 2009, p.6. Available at: http://andrewleigh.org/pdf/HealthInequalityOUP.pdf. Accessed 15.09.2016.
[122] P. Douglas, "What is Happening to the 'White-Collar-Job' Market?" System: The Magazine of Business December, 1926
[123] R. A. Margo, *The History of Wage Inequality in America, 1820 to 1970*, 1999, p.2-16. Available at: http://www.levyinstitute.org/publications/the-history-of-wage-inequality-in-america-1820-to-1970. Accessed 15.12.2016.

effects of World War II on the relative demand for less-skilled labor, as well as government policies specific to the war.[124] The wage compression that occurred in the 1940s was sustained for some time after World War II ended, but by 1960, inequality had begun to creep back toward pre-World War II levels. The baby boom, however, kept wage inequality from rising further in the 1970s.

Several factors explain the increased dispersion in wages in the bottom half of the distribution during the 1980s and the slight decrease afterward. The characteristics of the workforce changed significantly: education levels increased, women increased their share of work, and the workforce grew older. Those compositional changes alone would have somewhat increased the dispersion in the bottom half of the wage distribution, both during the period from 1979 to 1990 and the period from 1990 to 2005.[125] Income inequality in the United States rose during George W. Bush's presidency. But while real median income for households near the top of the income distribution rose, incomes at the middle and the bottom fell. Median incomes fell 0.6 percent ($324) from 2000 to 2007. Income at the lowest 20th percentile fell by 6.0 percent ($1,285) and by 4.5 percent ($579) at the 10th percentile per year. [126]

In an article for the New York Times, Cowen (2014) refuted the claims about free trade contributing to income inequality. As mentioned, numbers did not show that there was global income inequality, even if it has escalated as a political and economic issue. Although Cowen admitted that there was an acute problem with income inequality in most individual nations, the income inequality of the world does not fully represent a global problem.

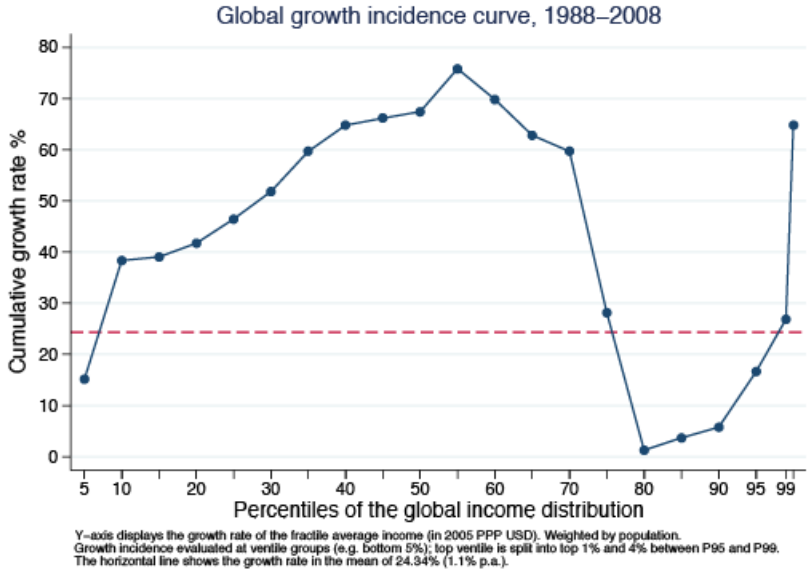
Such claims were based on Lakner and Milanovic's (2014) study and report on global income distribution from the fall of the Berlin Wall to the Great Recession. They stated, the rapid growth in Asia had greatly alleviated poverty since 1988. This meant that "incomes at the very top of the world income distribution have also grown rapidly; whereas median incomes in rich countries have grown much more slowly."[127] Lakner and Milanovic stressed that since the Industrial Revolution, the period between the fall of Berlin and the

[124] Ibid
[125] Congress of the United States, *Congressional Budget Office. Changes in Low-wage Labor Markets between 1997 and 2005*, 2006, p.4. Available at: http://www.cbo.gov/ftpdocs/76xx/doc7693/12-04-LaborForce.pdf
[126] C. Schumer, Carolyn Maloney, *Household income up slightly in 2007, but down since 2000. Highlights from the Census Bureau's Update on Household Income in the United States,* U.S. Congress, Joint Economic Committee, 2008, p.1. Available at https://www.jec.senate.gov/public/_cache/files/716285e1-5e2a-4587-a83f-72b9ead741d5/incomeinamerica.pdf. accessed 22.11.2016.
[127] C. Lakner, B. Milanovic, *Global income distribution: from the fall of the Berlin Wall to the Great Recession,* World Bank Working Paper No. 6719, December. 2013, p.39.

Great Recession depicted the most profound restructuring of individual outcomes. This is said to be caused by the high growth rates of populous and formerly poor countries, such as China, India, and Indonesia.

Lakner and Milanovic also underscored the findings of Anand and Segal (2008) in their work on global income inequality, which served as their rationale for their study in 2013 as well. In Lakner and Milanovic (2013), a household survey of about 120 countries was performed from 1988 to 2008 with the aim of presenting new results. It was identified that each of the country's distributions were divided into ten deciles that contained 10% of the national population, based on their per capita disposable income. To compare these incomes with other countries and time, Lakner and Milanovic (2013) corrected the domestic inflation and differences in price levels between the countries. By doing so, the changes in the positions of the numerous deciles within each country were observed, as well as how the positions of diverse countries changed over time. When they lined up all the individual data in the world (from poorest to richest) and displayed the "percentage increase in the real income of the equivalent group from 1988 to 2008" on the vertical axis, a global growth incidence curve was generated.[128] This incidence curve was noted as the "first of its kind ever." (Figure 3.5).

Figure 3.5. Anonymous global growth incidence curve: Real income change at various percentiles of the global income distribution between 1988 and 2008 (%)**.**



Source: C. Lakner, B. Milanovic, Global income distribution: From the fall of the Berlin Wall to the Great Recession, *World Bank Working Paper* p.31

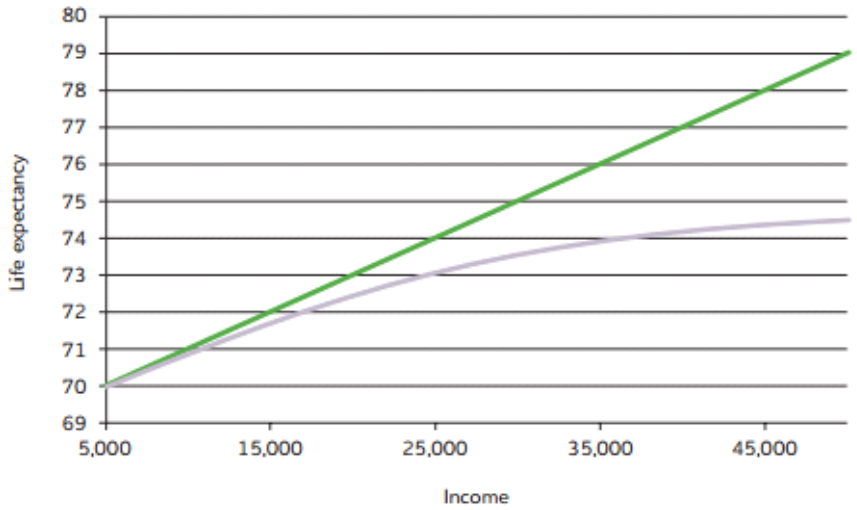
[128] C. Lakner, B. Milanovic, op. cit., p.2.

In Figure 3.5, the curve possesses an unusual supine S shape, which indicates that the biggest gains were acquired by the groups in the global median, or 50th percentile, and among the global top 1%. After the global median, the gains were found to be decreasing rapidly and became "negligible around the 85th to 90th global percentiles and then sprouted up for the global top 1%"(p. 3).[129] The result of such a projection was the income growth of the top ventile (top 5%), which "accounted for 44% of the increase in global income between 1998 and 2008." Indeed, the movements did not only rebalance the East and the West, but resulted in a contradiction between the present world order and the economic forces of globalization, as well.

5. Significance of the Relationship between Health and Income in the Context of Inequality

Health and income inequality have certain associations in the fields of economics, sociology, and epidemiology. The efficacy of spending money to improve health care delivery should be weighed against that of improving school quality and increasing educational attainment to promote health.

Figure 3.6. Hypothetical data to illustrate two possible relationships between income and health.



Sources: M. Benzeval, L. Bond, M. Campbell, M. Egan, T. Lorenc, M. Petticrew, F. Popham, *How does money influence health?* Joseph Rowntree Foundation Report. York: MRC/CSO Social and Public, 2014, p.20.

[129] C. Lakner, B. Milanovic, *Global income distribution: from the fall of the Berlin Wall to the Great Recession*, Op.cit., p.87.

Figure 3.6 illustrates the forecasted outcome of seeking to establish a causal relationship between income and health. According to Kawachi, et al. (2010) cited in Benzeval, et al. (2014, p. 20), "While income is usually found to be associated with health, whether a higher income causes a decrease in the risk of poor health is a more open question in rich countries where extreme poverty is rare."[130] This suggests that there are several underlying factors to consider when attempting to establish an association between health and income. Examples of these factors include education, employability, demographic factors, and socio-economic factors, among others.

Snyder and Evans (2006) asserted that lower incomes encourage individuals to do activities that are considered healthy in the end. However, evidence from their study suggests that different results are expected in terms of the effect of income on health because it is influenced by various factors and certain public policies.[131] For example, in some countries, there is a negative association between income and healthy living, such as in terms of dietary intake.[132] On the contrary, a study by Woolf et al. (2015, p. 1) suggests that "…income is a driving force behind the striking health disparities that many minorities experience."[133] Consequently, the same authors explained that individuals with lower incomes are less able to afford health-care services and health insurance, whereas people with higher income have greater resources to afford over-the-top health-care services.

Table 3.1. Prevalence of Difficulties in Physical Functioning by Income, 2011

[130] M. Benzeval, L. Bond, M. Campbell, M. Egan, T. Lorenc, M. Petticrew, F. Popham, *How does money influence health?* Joseph Rowntree Foundation Report. York: MRC/CSO Social and Public, 2014, p.20.
[131] S. E. Snyder, W. N. Evans, *The effect of income on mortality: Evidence from the social security notch*, The Review of Economics and Statistics, 88(3), 2006, p.482-495.
[132] S. E. Chen, J. Liu, J. K. Binkley, *An Exploration of the Relationship Between Income and Eating Behavior*, Agricultural and Resource Economics Review, 41(1), 2012, p.82-91.
[133] S. H. Woolf, S. M. Simon, L. Aaron, E. Zimmerman, L. Dubay, K. X. Lux, *How are income and wealth linked to health and longevity*, Urban Institute, 2015. p.1.

ACTIVITIES THAT ARE VERY DIFFICULT OR IMPOSSIBLE TO PERFORM	ANNUAL FAMILY INCOME				
	Less than $35,000	$35,000–49,999	$50,000–74,999	$75,000–99,999	$100,000 or more
Any physical activity	24.5	16.6	12.6	9.6	8.7
Walking one-quarter mile	12.5	7.0	5.5	4.1	3.9
Climbing 10 steps	9.6	4.9	3.7	2.7	2.8
Standing for two hours	15.7	9.6	7.1	4.9	5.0
Sitting for two hours	6.2	3.3	2.0	1.6	1.1
Stooping, bending, or kneeling	14.4	9.5	7.4	5.1	4.7
Grasping or handling small objects	3.1	1.7	1.5	1.2	0.9
Lifting or carrying 10 pounds	8.4	3.8	2.6	2.2	2.1
Pushing or pulling large objects	11.8	6.4	4.5	3.6	3.5

Sources: J. S., Schiller, J. W. Lucas, and J. A. Peregoy, "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011." Vital and Health Statistics 10, no. 256 (2012): 1–207, tables 19. http://www.cdc.gov/nchs/data/series/sr_10/sr10_256.pdf. Julia Holmes, Eve Powell-Griner, Margaret Lethbridge-Cejku, and Kathleen Heyman, "Aging Differently: Physical Limitations among Adults Aged 50 Years and over: United States, 2001–2007," NCHS Data Brief No. 20, (Hyattsville, MD: National Center for Health Statistics): 2009. http://www.cdc.gov/nchs/data/databriefs/db20.pdf.

Note: Although these data are not restricted to working-age adults, the association between education and diminished physical function appears to diminish with age. Among non-Hispanic whites in 2001–07, the ratio between the prevalence of physical limitations among adults with less than a high school education and those with more than a high school education was 2.4 at ages 50 to 59, 1.9 at ages 60 to 69, 1.5 at ages 70 to 79, and 1.2 at age 80 and older.

Source: S. H. Woolf, 2015. *How are income and wealth linked to health and longevity?* Available at: http://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf. Accessed 06.22.2017.

Table 3.1 describes the usual relationships between income and health activities. As highlighted, basic health tasks are difficult to performed for individuals with less income. Moreover, income also impacts disease rates and health-care costs. Immigrants can generate higher health-care expenses and costs from their increased risk of bad health.

Furthermore, the link between health and income is also associated with socio-economic factors, such as social and economic inequality. For example, black men in Britain are 17 times more likely to be diagnosed with a psychotic illness than their white counterparts.[134] There were hypothesized factors for why black men are more likely to become psychologically ill, and the most common reasons are poverty and neglect.

In relation to this, the neglect for black people shown by the health institutions that alleviate mental problems is quite alarming. This led to the voluntary creation of black organizations that filled the gap for those black people who are less favored in the mainstream health care the general population receives. One of them is the Black Spaces Project, which molds a key part of the Health Foundation. They consider the fact that most black

[134] E. Davie, *It's time to tackle mental health inequality among black people,* 2015. Available at. http://www.theguardian.com/healthcare-network/2014/oct/28/tackle-mental-health-inequality-black-people. Accessed 04.05.2016.

organizations are not well-credited with services, and through extensive research, this program aims to introduce the mainstream health services that black people are missing. The program advocates for and empowers users by providing siocially sensitive spaces in mainstream health services. Also, one study pointed out that in the past five years, race equality in health services has been well-known in regard to policy development at a national level.[135] However, this is not accorded sufficient importance in discussions on local levels.

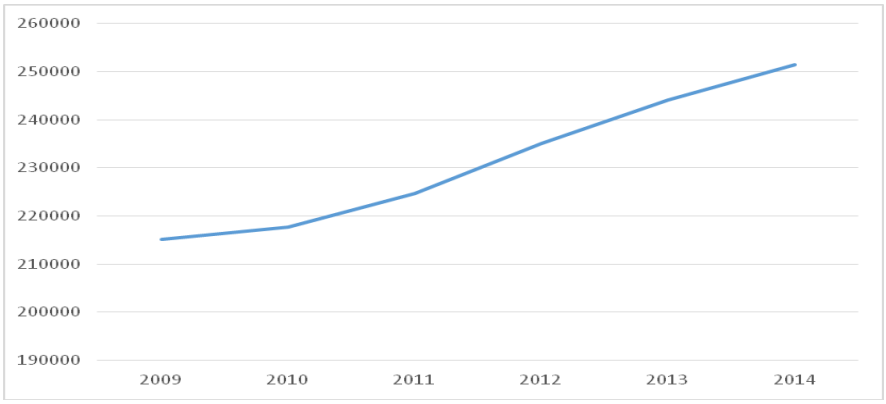
Finally, establishing an association between health and income involves the consideration of economic conditions. As such, some studies suggest that developing economies are capable of developing initiatives to improve health care settings due to their high levels of income and GDPs. According to Rowlingson (2011, p. 5), "The evidence from a range of studies suggests that there is indeed a correlation between income inequality and health and social problems. However, some further correlation analysis would be helpful in testing how sensitive the findings are to: different measures of social stratification; different measures of income inequality; variations in the countries selected; and the treatment of outliers."[136] As explained by the same author, socio-economic factors can be viewed as major influencers in establishing a link between health and income because there is a social gradient in health, which means that an increase in socio-economic standing results in improved health by the same degree.

Many factors determine the existing association between health and income. There is empirical evidence to indicate an established association between the health and income.

Figure 3.7. Norwegian median after-tax income (EU) of immigrants. Income and wealth statistics for households.

[135] F. Keating, D. Robertson, N. Kotecha, *Ethnic Diversity and Mental Health in London,* 2003, p.5. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/ethnic-diversity-mental-health-london-recent-developments-frank-keating-david-robertson-nutan-kotecha-kings-fund-1-august-2003.pdf. Accessed 27.12.2016.

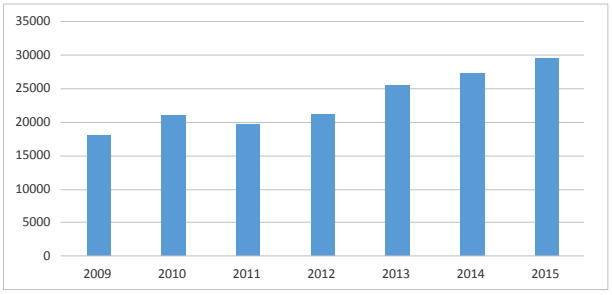
[136] K. Rowlingson, *Does income inequality cause health and social problems?* Joseph Rowntree Foundation. 2011, p.5.



Source: *Statistics Norway*. Retrieved 06.07.2017 from https://www.ssb.no/statistikkbanken/px-igraph/MakeGraph.asp?checked=true

Figure 3.7 shows the median after-tax income of immigrants in Norway, expressed in NOK. The data showed that immigrants earned relatively high after-tax income for the six-year period from 2009 to 2014. In 2014, immigrants working in Norway earned an average of 251,500 NOK, and it continued to increase in subsequent years. The latest statistics indicated dramatic increases in the median after-tax income of immigrants, valued at 258,700 in 2015 and 261,400 NOK in 2016.

Figure 3.8. Population of unemployed registered immigrants in Norway.



Source: Unemployment among immigrants, register-based, *Statistics Norway*. Available at: https://www.ssb.no/statistikkbanken/px-igraph/MakeGraph.asp?checked=true. Accessed 06.15.2017.

Figure 3.8 shows the number of unemployed registered immigrants in Norway from 2009 to 2015. The data indicates that the total population of unemployed registered immigrants experienced a percentage growth rate of 9.11% from 2009 to 2015. The latest statistics showed that in 2015, the unemployed population of immigrants in Norway stood at 29,579, up from 18,059 in 2009. More of the population become unemployed.

CHAPTER IV: UNDERSTANDING SOCIAL AND HEALTH POLICY

This chapter is related to the theory and understanding of social and health policy and the practical solutions that stem from both policies in Norway. I write about social policy as a science. Social policy is more important than health policy.

1. Social and Health Policy as a Social Practice

Social and health policies affect both social- and health-related activities in a person's daily living. **Social practices** can be understood as an individual's everyday practices and how they are typically and habitually performed in a society[137]. They also include practices for creating either social or political change through community-based activities. This is done by creating a practitioner-community relationship that focuses on the integration of skills, knowledge, artefacts, emotions, and understanding of people in their private, family, community, and working lives[138]. Social practices also integrate the individual with his or her surrounding environment while assessing how socio-economic aspects relate to common actions and practices of the individual. In addition, social practices, such as those related to labor, work, and property, help fulfill the economic needs of a society.

Notably, social practices are "shaped by the wider realm of power relations, infrastructure, technologies, and society; while each practice also acts to shape these wider aspects of a social system."[139] They include competences (the practical know-how), materials (consumer goods and infrastructures), and meanings (the embodied understanding of the social significance of practice and past experience of participation)[140].

Social policies are guidelines and interventions that change, maintain, or create living conditions that are conducive to human welfare. They aim to address widening and unjustifiable income inequalities.

Governments in many countries are finding the need to develop and implement effective health policies and social policies to promote citizens' well-being. In doing so, they face several challenges, including the need to balance the expectations of citizens with the

[137] G. Holtz, *Generating Social Practices.* Journal of Artificial Societies and Social Simulation, 17(1), 2014.
[138] A. Reckwitz, *Toward a Theory of Social Practices.* European Journal of Sociology, 5(2), 243–263, 2002.
[139] C. Maller, *Using social practice theory to understand everyday life: Outcomes for health and wellbeing*,2012. p.2.
[140] S. Blue, E Shove, C. Carmona, MP. Kelly, *Theories of practice and public health: understanding (un) healthy practices.* Critical Public Health. 1;26 (1): 2016, p.42.

demands of health-care professionals and public budgets.[141] Thus, looking at the global perspective, health policy is associated with addressing health issues and concerns particularly in relation to socio-economics inequalities. International health issues include food safety, drug regulation, and infectious disease control, which are threatened by changes in the global environment.[142] Other health policy issues that should be taken into consideration include reproductive health, violence against women, social inequality, occupational health and safety, ageing, and health sector reform, among others.[143] Social policies can include the provision of social services in the pursuit of improving the welfare of society at large. Initiatives are developed and implemented in order to foster positive change within the health-services structure and to increase access to health-care and social services. Social policy is a science that looks at the idea of socio-economic welfare and its relationship to politics and society. In economics, "Social policy influences economic performance and is a tool of macro and micro economic management, and currently, austerity."[144] Social policy includes policies for education, health, housing, employment, poverty, old age, disability, welfare, and food for all people. It is a science for improving aspects of society such as quality of life,[145] health, education, citizenship, income, and economics.[146]

Most social policies include certain elements, such as a purpose statement, applicability and scope, effective date, and responsibilities.[147] Social policies are important because they help in improving different aspects of the social context, such as quality of life, education, health access, citizenship, income, and economy. According to Vargas-Hernandez, Noruzi, and Irani (2011, p. 287), "Social policy primarily refers to guidelines and interventions for the changing, maintenance or creation of living conditions that are conducive to human welfare. Social policies aim to address widening and unjustifiable income inequalities. Social policy are education, health, housing, employment and food for all people."[148] Hence, it can be noted that social policies include initiatives that aim to address social issues. Social policies are important for complementing and encouraging the

[141] K. G. Banting, S. M. Corbett, *Health Policy and Federalism: A Comparative Perspective on Multi-level Governance*, IIGR, Queen's University, 2002, p.1.
[142] K. Lee, K. Buse, S. Fustukian, *Health Policy in a Globalising World*, Cambridge University Press. 2002. p.270.
[143] Ibid, p.270.
[144] J. Bradshaw, S. Kühner, *Narratives of Knowing in Social Policy*, University of York, UK. 2015. p.3.
[145] F. N. H. A. Irani, M. R. Noruzi, What is policy? A brief study on policy and social policy; meanings and contents, Res Manageria, May issue (forthcoming), 2011, p.287-287.
[146] Spicker, Paul, (2007), *an introduction to Social Policy, Social Policy. Available at:* http://www.spicker.uk/books/socpol3.htm. Accessed 21.7. 2016.
[147] J.G.Vargas-Hernández, M.R. Noruzi, F.N. Irani, *What is Policy, Social Policy and Social Policy Changing*, International Journal of Business and Social Science, 2(10), 2011, p.287-291.
[148] Ibid.

employment and re-employment of citizens without jobs, with considerable priority on the coherence of social security and labor market policies in order to achieve reductions in the country's unemployment. Social policies support families, particularly those at risk, vulnerable, or in hardship, as well as child development and welfare. Social policies relate to economic, social, and political factors and contribute to maintaining a satisfactory level of social protection in the face of adverse demographic and labor market trends. Some social policies prioritize equal access to health services and reducing inequalities in health outcomes between groups in society.

Health policy is associated with addressing health issues and concerns, particularly in relation to socio-economics inequalities. Health policy is part of social policy, and it is a field of study that is conventionally found within public policy that includes "policies developed by governmental bodies and officials, and thus focus[es] on purposive action by or for governments."[149] Similarly, the World Health Organization defined health policy as referring to "decisions, plans, and actions that are undertaken to achieve specific health care goals within a society."[150] Based from these definitions, it can be ascertained that health policy is important in the development of programs or initiatives that aim to address specific national health issues. As such, policies are vital in promoting the general well-being of the people, because they constitute potential solutions to issues that the government can do something about.

Health policies are a form of health statements and health plans that aim to reach the goal of Health for All set by the WHO. They are developed with the goals of specifying health objectives and priorities and identifying the means and resources required to achieve these objectives. They rationalize decision-making, define the frames of reference required for evaluation and reporting, and rally professionals and other stakeholders around health issues. Health policies help build consensus, which facilitates the introduction of viable and effective actions. The actions undertaken in the health sector in general have significant and long-lasting effects, both on the health of individuals and on other socio-economic sectors**.** A health policy rallies professionals and other sectors around health challenges and problems and legitimizes health actions. Health policy facilitates planning of health needs, develops a vision of the future, defines short-, medium- and long-term strategics, determines objectives,

[149] K. Lee, K. Buse, S. Fustukian, Op.cit. p.269.
[150] World Health Organization, *health policy,* 2017, Available at: http://www.who.int/topics/health_policy/en/ Accessed 05.01.2017.

sets out health priorities, delegates roles, and defines means of action and institutional arrangements**.** Health policy provides a framework for evaluating health performance.[151]

Health policy is commonly associated with social policy. They both strongly advocate for people's well-being. As such, social policy is important because it plays a fundamental role in improving the well-being of people.

2. Practical Solutions that stem from Social and Health Policies in Norway

The Norwegian government is the organ responsible for developing and implementing effective health policies and social policies to promote its citizens' well-being.

During the 1880s, social welfare issues were apparent in Norway due to discontent with the system of relief for the poor.[152] Social issues were associated with factory and/or industrial workers. As such, social welfare issues at that time were related to working conditions and the lack of health incentives. In response to this, the first bill to address relief for the poor was passed in 1845 and was not revised until 1964 the 1900s through the implementation of the Social Care Act.[153] Moreover, in relation to the labor issues of workers, the Labor Commission proposed the provision of accident and sickness insurance, as influenced by the German and British models of social security legislation. Three of the bills that were approved and passed were the Factory Inspection Act of 1892, the Accident Insurance Act of 1894, and the Sickness Insurance Act of 1909.[154]

In addition, some of the bills in Norway have been influenced by social movements, such as the Unemployment Act, which was prompted by the Social Democratic Movement by means of putting pressure on the legislative body. Another social policy that was introduced in Norway was the Children's Act of 1915, which addressed family controversies and debates, particularly in relation to children born in and outside of marriage.[155] Moreover, Norway has also developed social policies related to improving the quality of education and care for children in order to address inequalities in access to education among students, as well as gender pay and benefits for parents.

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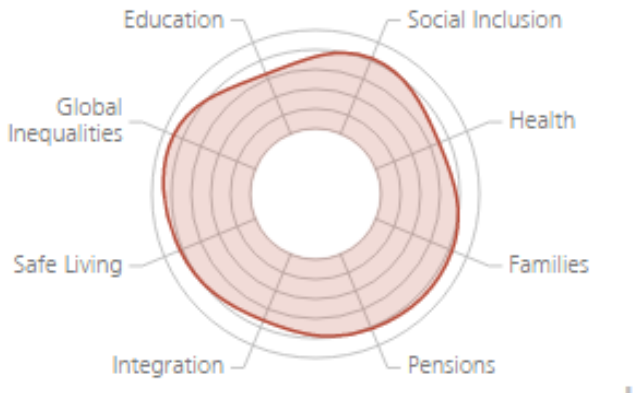
[151] G. Dussault, C. A. Dubois, *Human resources for health policies: a critical component in health policies,* Human resources for health, 1(1), 2003, p.1.
[152] Ø. Bjørnson, *The social democrats and the Norwegian welfare state: some perspectives*, Scandinavian Journal of History, 26(3), 2001, p.197-223.
[153] Ibid
[154] Ibid
[155] A. Skevik, *A Gilded Cage? Help and Control in Early Norwegian Social Policy*, Journal of Family History, 29(3), 2004, p.211-224.

The social expenditure in Norway accounts for 22 percent of the nation's total GDP.[156] This is partially because the country has implemented social policies that relate to social-democratic regimes focusing on gender equality. For example, women are encouraged to participate in the labor force in order to encourage a higher demand for education access, particularly among kindergarten students.

In the 2016 report by Sustainable Governance Indicators (SGI), Norway ranked first in relation to social policies with a measure score increase of 0.2 points from 2014. As highlighted in the same report, Norway has a high-quality universally available health-care system. The country also provides generous family benefits and gender-equality programs in an attempt to address social inequality issues. The Norwegian government provides major support, including funding, to the integration policy in order to foster equal care services for immigrants. Despite this, immigrants still face discrimination in terms of labor and housing markets.[157]

Figure 4.1. Social policy scores of Norway in different areas.



Source: Sustainable Governance Indicators (SGI). *Norway social policies*, 2016.

Norway has successfully implemented social policies in education, social inclusion, health, family, pension, integration, safe living, and global inequalities, as shown in Figure 4.1.

To maintain reasonable and decent standards of living, the social safety net is central in Norway. The social safety net is based on universalism as its fundamental principle, which gives the right to aid, irrespective of factors such as income and assets, to anyone in times of

[156] A. Engel, W. S. Barnett, Y. Anders, & M. Taguma, *Early Childhood Education and Care Policy Review – Norway*, OECD. 2015, p.15.
[157] Sustainable Governance Indicators (SGI). *Norway social policies*, 2016. Available at: http://www.sgi-network.org/2014/Norway/Social_Policies. Accessed 01.04.2017.

need. Health insurance, unemployment insurance, social security benefits, early retirement pensions and old age pensions, and income or maintenance insurance that are contingent on life events are important elements in the social practice in Norway.

There are health administrations at the national, provincial, and local levels. The Norwegian Board of Health Supervision is responsible for the general supervision of the health services, the Norwegian Institute of Public Health (NIPH) is the main source of medical information and advice, the Norwegian Medicines Agency authorizes and monitors monitors the proper economical use and sale of them, and the Norwegian Patient Registry (NPR) is responsible for providing data for the planning, evaluation, and financing for publicly funded specialized health care. The municipalities are responsible for providing the care and treatment for all persons within their boundaries, including health promotion and prevention, emergency care, and immigrant health care. Local authorities are entrusted with providing of a wide variety of primary health services. Norway has enlarged the capacity for both treatment and operations in its hospitals in order to diminish waiting lists. Waiting list systems and financial systems have also been introduced.[158]

The Municipal Health Care Act 1984 made the provision of primary health care in Norway the responsibility of the municipalities.[159] Norway's health-care system can be described as highly organized, but there is a lack of coordination and mediating structures between sectors. In addition, there are also gaps in health care and a rapid increase in the ageing population. Despite the government's commitment to improving the health and well-being of the people, there are certain gaps that need to be filled, particularly in mental and addiction care.[160]

As such, health policy initiatives and reforms have been implemented in order to address health issues in Norway. Health policy in Norway aims to reduce social inequalities and to ensure that society continues to develop and grow. These policies include addressing gaps in health and addiction care, prioritizing healthy ageing, preventing the spread of risk factors associated with cardiovascular diseases, addressing unhealthy use of alcohol, and increasing demand for skilled and qualified health-care professionals, specialists, and personnel.

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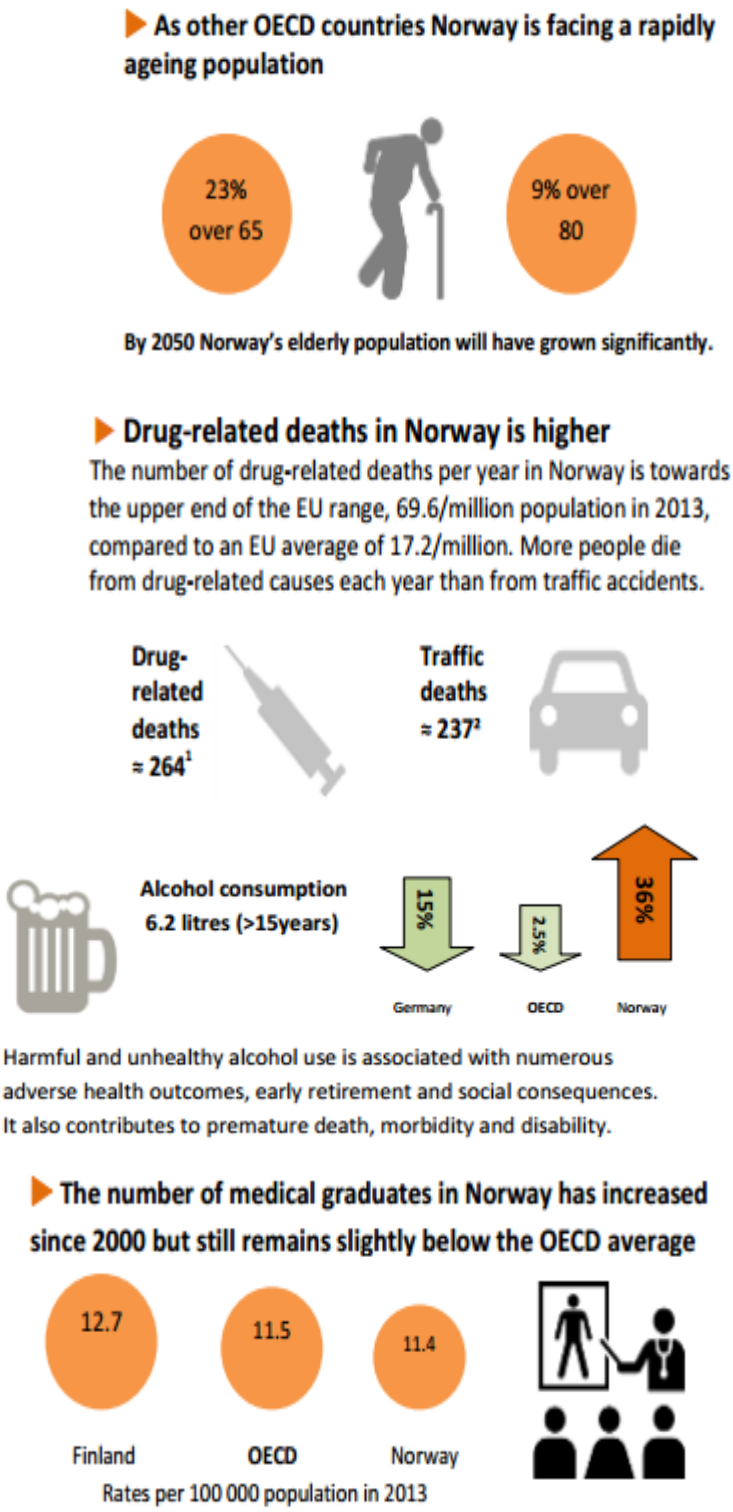
[158] D. T. Kalisch, Aman and L. Buchele , *Social and Health Policies in OECD Countries: A Survey of Current Programmes and Recent Developments, OECD Labour Market and Social Policy Occasional Papers*, No. 33, OECD Publishing, Paris. 1998, p.87.

[159] T. I. Romoren, D. O. Torjesen, B. Landmark, *Promoting coordination in Norwegian health care.* International Journal of Integrated Care, 11, 2011, p.1-8.

[160] OECD, *Health policy in Norway*, 2016, p.1-2.

Figure 4.2. Health policy in Norway (OECD, 2016)

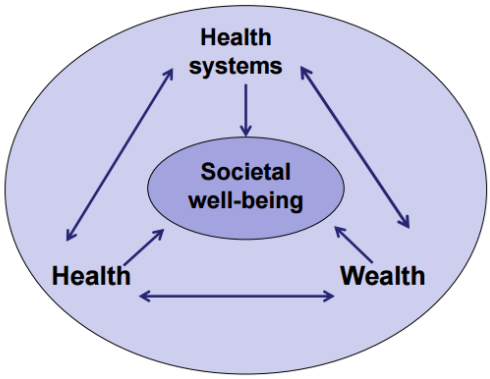


Source: OECD. *Health Policy in Norway.* 2016. Retrieved 12.14.2016 from http://www.oecd.org/norway/Health-Policy-in-Norway-February-2016.pdf

Figure 4.2 highlights the different statistics reflecting the identified health issues/concerns that are being prioritized by the policy makers in Norway.

Health policy is given high priority by the government in Norway because of its impact on the well-being of the people. Interestingly, the health policy framework in Norway is grounded on health being a human right. As explained by Jakab (2014), social determinants have certain impacts on the health divide in Norway, such that health inequities are unavoidable and exist in any country.[161]

Figure 4.3. Health policy framework of Norway**.**



Source: Jakab, 2014. *Health 2020 and Nordic public health*.

The framework for health policy in Norway integrates social welfare and health, as shown in Figure 4.3.

According to Ottersen et al. (2016), the health policy framework of Norway is aimed at addressing the increasing demands for health care in the country, as well as filling social gaps associated with the provision of quality health care.[162] Health and social issues are debated upon in relation to the development of appropriate health policies. Hence, the Norwegian Committee on Priority Setting in the Health Sector was appointed by the Cabinet in June 2013 in order to oversee the proposition of a new health policy framework. Their proposed new framework comprises four general principles (p. 247)[163]:

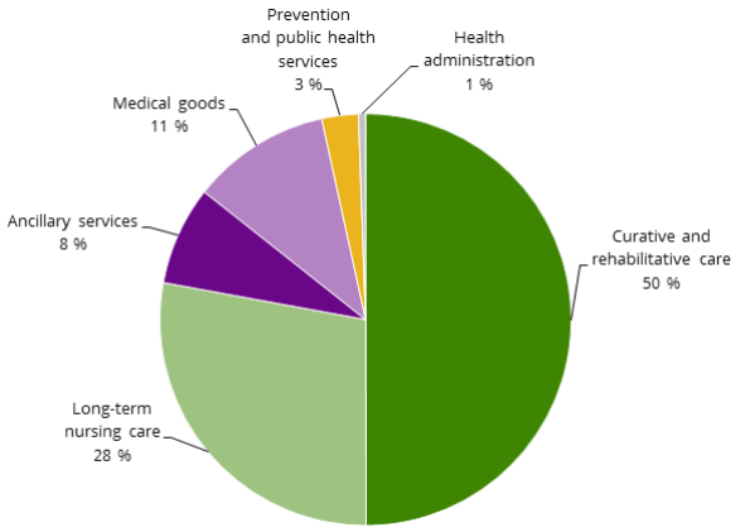
- "Pursue the goal of 'the greatest number of healthy life years for all, fairly distributed,'
- be based on clear criteria,
- be open, systematic, and involve user participation, and

[161] Z. Jakab, *Health 2020 and Nordic public health: a healthier, more equitable Europe*, Trondheim, Norway: World Health Organization, 2014, p.3-4. Available at: http://www.euro.who.int/__data/assets/pdf_file/0019/257203/Health-2020-and-the-Norwegian-Public-Health-Act_NOR-AUG14-FINAL.pdf. Accessed 23.7.2017.
[162] T. Ottersen, R. Forde, M. Kakad, A. Kjellevold, H. O. Melberg, A. Moen, A. Ringard, O. F. Norheim, *A new proposal for priority setting in Norway: Open and fair*, Health Policy, 120, 2016, p 246-251.
[163] Ibid

- be supported by a coherent set of effective instruments."

The government plays a fundamental role in the effective implementation of health-care policies in Norway. Its funding support has a major impact on the success of the health policies in terms of enabling access to the required resources and the improvement of the infrastructure and technology needed to support the systems. According to Statistics Norway, the current health expenditure amounted to 311 billion NOK in 2015, corresponding to 60,000 NOK per capita. The expenditure on health per capita, shown in Table 5.1, increased by 1.1 percent from the previous year, and the gross capital formation in 2015 amounted to about 19 billion NOK. This is a slight decrease from the previous year, when investments amounted to about 21 billion NOK.[164] Norway's health-care expenditure is about $9,715 USD per capita per year.[165]

Figure 4.4. Health expenditures by function of care**.** 2015,



Source: Health Accounts, *Statistics Norway*. Available at: https://www.ssb.no/en/nasjonalregnskap-og-konjunkturer/statistikker/helsesat/aar/2016-03-14. Accessed 12.18.2016.

Figure 4.4 shows that curative and rehabilitative care, such as hospital services, GP services, dental care, and physiotherapy, account for the largest share of the total Norwegian health expenditure.

[164] Statistisk Norway, *nasjonal regnskap og konjunkturer*. Available at: http://ssb.no/en/nasjonalregnskap-og-konjunkturer/statistikker/helsesat. Accessed 18.12.2016.
[165] N. Rancic, V. Dragojevic-Simic, N. Vavic, A. Kovacevic, Z. Segrt, N. Djordjevic, *Economic Evaluation of Pharmacogenetic Tests in Patients Subjected to Renal Transplantation: A Review of Literature*, Frontiers in Public Health, 4. 2016. p.4-8.

In addition, the government is also responsible for approving health bills that can impact the health and safety of the people.[166] Good governance and leadership is important in the efficiency and success of health-care policy implementation in Norway.[167] This is because the government is responsible for making decisions and choices that can foster positive differences in the well-being and general welfare of the people. Moreover, the government also influences the creation of a resilient community, which fosters a supportive environment. Finally, the government drives health-care quality improvements through policies that the health-care industry must adhere to.

Table 4.1. Health expenditure key figures

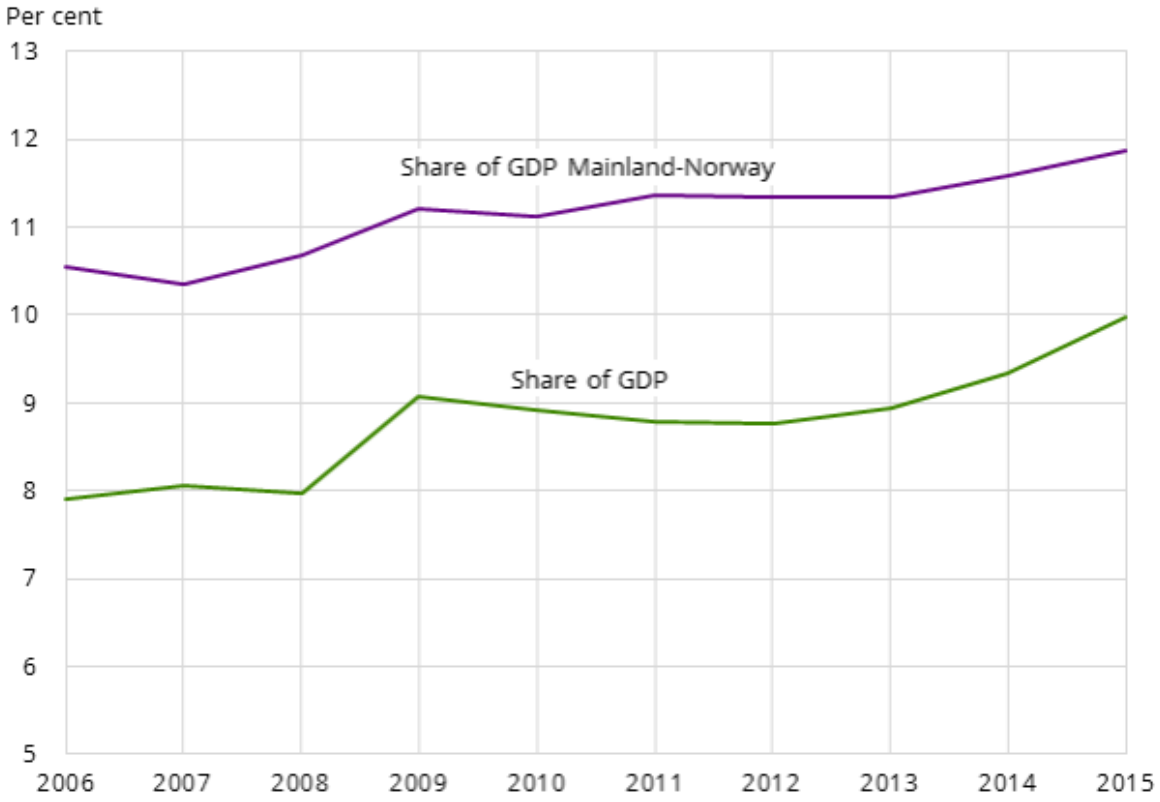
	2012	**2013**	**2014**	**2015**
Current expenditure on health	260,182	274,246	293,507	310,981
Volume growth from previous year		0.9	2.0	2.1
Capital formation in health-care institutions. NOK million	14,458	18,487	20,924	18,793
Current expenditure on health. Percent of GDP	8.8	8.9	9.3	10.0
Current expenditure on health. Percent of GDP Mainland Norway	11.3	11.3	11.6	11.9
Current health expenditure per capita	51,844	53,984	57,131	59,921
Figures for the final year are preliminary.				
Current health expenditure does not include capital formation				
Corrected 10.17.2016.				

Source: 2015, Health Accounts, *Statistics Norway*. Available at: https://www.ssb.no/259253/health-expenditure.key-figures. Accessed 11.16.2016.

[166] T. Ottersen, R. Forde, M. Kakad, A. Kjellevold, H. O. Melberg, A. Moen, A. Ringard, O. F. Norheim, Op.Cit. p.99.
[167] Ibid

The health expenditure (Table 4.1) in Norway has increased from 50,000 in 2011 to 60,000 in 2015 measured per capita.[168] The health expenditure per capita in 2015 was 59,921. The capital formation in healthcare institutions has incresed from 14,458 million NOK in 2012 to 18,793 million NOK in 2015.

Figure 4.5. Health expenditure as a share of GDP and GDP mainland-Norway. 2015

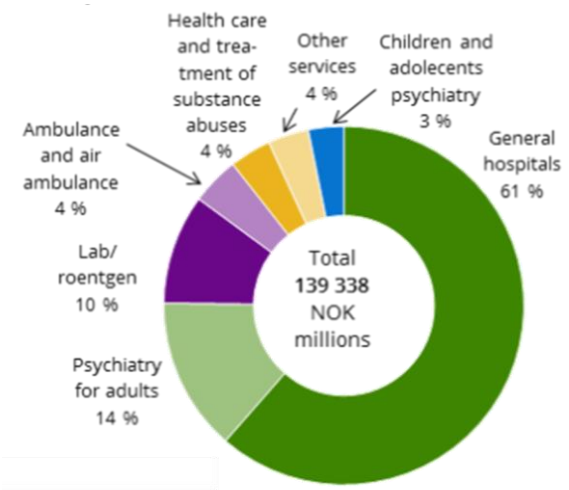


Source: Health Accounts, *Statistics Norway*. Available at: https://www.ssb.no/en/nasjonalregnskap-og-konjunkturer/statistikker/helsesat/aar/2016-03-14. Accessed 07.11.2017.

Figure 4.5 shows an increased health expenditure as a share of the GDP and GDP mainland-Norway. Health spending in Norway accounts for 10 percent of the GDP (Figure 4.5).

[168] Statistisk Norway, *Health accounts*, 2015. Available at. http://www.ssb.no/en/nasjonalregnskap-og-konjunkturer/statistikker/helsesat/aar/2016-10-04. Accessed 29.11.2016.

Figure 4.6. Specialist health services with total expenses by service area. 2015



Source: Specialist health service, *Statistics Norway*. Available at: https://www.ssb.no/en/helse/statistikker/speshelse/aar/2015-06-18. Accessed 05.10.2017.

Figure 4.6 shows the expense of specialist health services by service areas in 2015. The general hospitals' expenses represented 61%, and psychiatry for adults was 14%. There is high expenses in general hospitals services and psychiatry.

3. Quality Health Care Services, Right to Be a Patient, Patients' Rights, and Procedural Rights

Perceptions of quality health care services are defined as either a user's judgment or impression of an entity's overall excellence and/or superiority[169]. Users' expressions are based on the discrepancy between their expectations of service and actual service performance. Interpersonal (interaction and relationship), technical (outcome and expertise), administrative (timeliness, operation, and support), and environmental (atmosphere and tangible) aspects are used to describe the quality of healthcare services. High quality is found in facilities that employ professional providers who possess technical competence. They provide information, counseling, diagnoses, treatments, and care services that fulfil patients' needs in all paths of service: admission, assessment, care delivery, treatment, and discharge.

[169] M.J. Bitner, A. R. Hubbert, *"Encounter Satisfaction Versus Overall Satisfaction Versus Quality,"* in Service Quality: New Directions in Theory and Practice, Roland T. Rust and Richard, 1994.

Respect for as well as the protection and fulfilment of populations' rights to information, privacy, confidentiality, non-discrimination, and non-judgmental attitudes are vital to delivering quality services. Convenient operating hours, a welcoming and clean environment, modern equipment, medicines, supplies, and technology are also critical.

The required quality of services depends on set standards, and consumers must participate in the planning, monitoring, and evaluation of health standards. However, health systems are responsible for informing consumers about their own health as well as providing information about how to access health services. The value of providing health services to consumers and supporting such a provision and the utilization of services is immense

Because health services are interested in measuring consumer outcomes, organizations must collect and analyze data on service utilization and quality of care to support improvement. The overall quality of health services is the measurable value of services delivered by any health care system, which should provide safe, effective, patient-centered, timely, efficient, and equitable care[170]. Effectiveness refers to improvement in health, while efficiency includes health improvements that are achieved via the lowest cost. Methods for assessing efficiency include estimating production functions, cost effectiveness, cost-benefit, and related cost-utility analyses[171]. Equity includes health disparities, fairness, and the effectiveness of procedures for addressing them. Effectiveness, efficiency, and equity are complementary criteria for health services. Improving healthcare effectiveness while holding resources constant increases efficiency, and increases in efficiency create opportunities for improved effectiveness and equity[172].

Measurement is vital for continuous quality improvement efforts in health services. Structural, process, and outcome measures are needed because they assess and compare the quality of health care organizations[173]. Structural measures offer a sense of a health care provider's capacity as well as the systems and processes that they have in place to provide high-quality care. Process measures indicate what a provider does to maintain and/or improve the health of both healthy consumers as well as those diagnosed with a health care condition. These measures generally reflect accepted recommendations for clinical practice. Process measures also inform consumers about the medical care that they should expect to receive for

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[170] W. C. Richardson, *"Crossing the Quality Chasm: A New Health System for the 21st Century"* (PDF). National Academy of Sciences, 2000.
[171] L. A. Aday, C. E. Begley, D. R. Lairson, C. H. Slater, *Evaluating the Healthcare System: Effectiveness, Efficiency, and Equity*, 1st ed. Chicago: health Adminisatration Press, 1993.
[172] Ibid.
[173] A. Donabedian, *"The quality of care. How can it be assessed?"*. JAMA: The Journal of the American Medical Association. 260 (12): 1743–8, 1988.

a given condition or disease, which can improve health outcomes. Processes include treatment, diagnosis, rehabilitation, prevention, and patient education. Notably, most quality measures that are used for public reporting are process measures. Outcome measures, which represent the "gold standard" in measuring quality, reflect the impact of the health care service/intervention on the health status of the patient and include numerous factors, many of which are beyond providers' control. Outcome measures fit into the general categories of mortality, morbidity, disability rates, disease prevalence, incidence rates, and perceived health status, while outcomes include changes in health status, knowledge acquired by consumers, which may influence future care, and changes in both the behavior and satisfaction of consumers regarding the care received[174].

Knowledge is used in improvement efforts and therefore affects consumers' satisfaction and behavioral intentions as well as broader outcomes, such as quality of life[175]. Knowledge is needed for the constant evaluation (measuring, monitoring, and benchmarking) of all health service components' effectiveness.

Quality health Care services are services that focuses on users' needs, rights and wishes. Theses services prevent harm such as health risk, mortality and morbidity. Users' experiences are used in improvement efforts. "Patient-centred health care"[176] in norway is an indication of quality health care service. Users are engaged in planning service delivery and choice of treatment. They participate actively in decisions concerning their own care. Respect, honest information to users, involvement and engagement of users create confidence and satisfaction with the service.

In Norway, the population has a right to health services, and health-care workers must help according to service priorities. Anyone has the right to receive health care, including obtaining a diagnosis and receiving treatment, when specific criteria are met. According to the Norwegian parliament, health-care services must meet at least minimum standards and, in some cases, must be provided within specified time limits. Providers of health-care services cannot refuse to do so on financial grounds or on the grounds of their own priorities. The legislative authority has mandated this in specific terms, due in no small part to the fact that the country generally has a sound economy, which makes the broad provision of health care

[174] A. Donabedian, *"Quality Assurance in Health Care: Consumers' Role,"* Quality in Health Care, 1, 247-251. 1992.
[175] T. S. Dagger, J. C. Sweeney "The Effect of Service Evaluations on Behavioral Intentions and Quality-of-Life," Journal of Service Research, 9 (1), 2-19, 2006.
[176] K. Kvåle, M. Bondevik, *What is important for patient centred care? A qualitative study about the perceptions of patients with cancer.* Scandinavian Journal of Caring Sciences, 22(4), 2008, p.582-589.

possible. Section 2 of the Municipal Health Services Act and section 2 of the Patients' Rights Act provide examples of citizens' explicit rights to "necessary health care."

Norwegian citizens have many explicit rights as patients, rights that are based on the principle of patient autonomy. Patients are regarded as independent in their dealings with public health services and health-care workers. Patients' rights include the right to be informed and have a copy of one's own medical records.

With these rights, patients are free to participate in the process of treatment, be informed, make their own decisions, have access to what is written about them, and be with their parents and others (if patients are children). Health workers see these patients' rights as making the patient–provider relationship more bureaucratic.[177]

In addition to patients' rights, there are procedural rights for putting patients' rights into action should providers not do it themselves. There are two types of procedural rights:

- Patients have the right to have decisions reviewed and reversed;
- Patients have the right to demand that health-care workers and hospitals are corrected by the authorities when they violate patient rights.

Procedural rights allow the formal review of provider decisions and allow patients to enforce their rights in court if necessary. Patients can ask the supervisory authority to review an administrative decision if they think that their rights to receive health care or rights as patients have not been met. This authority is called the County Medical Officer and is established in every county. His main task is to supervise health services on behalf of the state and to ensure that acts and regulations are followed. The County Medical Officer is independent of those who provide health services.

[177] O. Molven, *Health Legislation in Norway*, University of Oslo, Oslo. 2003.

CHAPTER V: UNDERSTANDING HEALTH-CARE SYSTEMS

This chapter explains various components of health-care systems in order to provide an understanding of the health-care environment and to present the issues faced by stakeholders within health systems. This section aims to present empirical evidence to increase the understanding of both general and Norwegian perspectives on the health-care system. I write about social and health policy as sciences and their political and practical implications.

1. Health-Care Systems in General

A system, according to von Bertalanffy (1968), is an arrangement of parts and their interconnections so that they come together for a purpose.[178] A health system, according to Roemer (1991), is "the combination of resources, organization, financing and management that culminate in the delivery of health services to the population."[179] The health-care system is defined as "the organizational arrangements and processes through which a society makes choices concerning the production, consumption, and distribution of health-care services."[180, 181] Each society has to make decisions in terms of the distribution, consumption, and production of these services due to limited health-care resources. The WHO (2000) has stated that a health system is "all activities whose primary purpose is to promote, restore, and maintain health," including the prevention of household poverty due to illness.[182]

The health system concerns people's health. The health-care system is composed of patients, families, communities, ministries of health, health providers, health services organizations, pharmaceutical companies, health financing bodies, and other organizations. Each of these parts plays an important role. The functions and roles played by these parts are based on their interconnections. The functions of the health-care system include regulation, policy making, clinical services, health promotion, financing, and managing resources—such as medical equipment, equities information, and so on. Resources, organization, management,

[178] L.V. Bertalanffy, *General System Theory. Foundations*. *Development, Applications*, 1968, p.17.
[179] M.I. Roemer, *National Heath Systems of the World*, New York: Oxford University Press. 1991, p.31.
[180] E. Rexford, P. Stephen, *Health Economics: Theories, Insights and Industry Studies,* Thomson Learning Pte Ltd. 2012, p.108.
[181] R. Santerre, N. Stephen, *Health economics*: *Theory, Insights, and Industry Studies.* Cengage Learning 2012, p.108.
[182] World Health Organization, *The world health report 2000: health systems: improving performance*, World Health Organization. 2000.

economic support, and delivery of services are principal components of health-care systems.[183] Health-care systems are complex and constantly changing institutions responding to economic, technological, social, and historical forces.

The management of health systems entails several processes, including health planning, administration (supervision, consultation, coordination, etc.), regulation, and legislation. The prevalent political ideology in a state can influence the managerial process of its health-care system. Financial mechanisms—such as governmental tax revenues, social insurance, voluntary insurance, charity, and personal households—play key roles in the health of its population.

The differences in urban and rural health conditions and health care include the utilization, costs, and geographical distribution of providers and health services. Other differences are observed in population health, public health, environmental health, and in health behaviors among rural and urban populations.[184] Health care in an urban poverty context includes little or no access to health care or health insurance. Urban populations may face barriers to care and receive poorer quality care and emergency services. Urban slum dwellers experience a lack of basic sanitation, a lack of water, and a lack of electric utilities. This lack of basic infrastructures exacerbates rates of infectious diseases, perpetuating the cycle of poverty.[185]

Health-care provision varies from country to country. Shah (2011) noted that, in general, wealthy and developing countries provide universal health care, as health care's high costs and other social, political, and economic conditions are otherwise challenging to meet. The WHO is the principal organization overseeing health issues, health-care policies, and anything to do with health in a global perspective. In 2011, it defined "health-care needs" to include "health promotion, preventive care (immunization, general health screening), treatment of acute and chronic illness, and appropriate referral for more specialized needs where required." The WHO (2011) further stressed that these needs must be met through the provisions of primary health care, which should be made accessible to all in order to allow the population to achieve "the highest attainable standard of health and functioning."[186]

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[183] M. I. Roemer, *National health systems throughout the world*, Healthcare reform in the nineties, 1994, p.106-146.
[184] Unite for Sight, *Urban versus Rural Health*, 2010. Available at: http://www.uniteforsight.org/global-health-university/urban-rural-health. Accessed 08.03.2017.
[185] Ibid
[186] World Health Organization, *General Healthcare*, 2011. Available at: http://www.who.int/disabilities/world_report/2011/chapter3.pdf. 2011. Accessed 15.09.2016.

A good health-care system is able to deliver quality health services to all people, and it should be accessible to them at all times. Having an effective health-care system requires a robust financing system, a highly trained and qualified workforce of health-care professionals and staff, reliable information on which to base decision-making and policies, and well-maintained infrastructure, facilities, technology, and logistics.[187] Moreover, health-care systems are expected to achieve three main goals: keep people healthy, treat those who are sick and those who need medical attention, and protect people from excessive medical bills.[188]

As noted in the WHO World Health Report (2008), since entering the globalization era, most countries have been under financial stress with their health-care systems not performing well.[189] Improving the health-care systems across the globe is essential to fostering a healthy population and economy. In order to achieve this goal, the WHO has presented the global goals of reducing the percentage of the population with no access to efficient health care and improving access to drinking water. The WHO also set goals of "reducing child mortality, improving nutrition, and combating HIV, tuberculosis and malaria."[190]

Table 5.1. Global achievement status, 2014

Number of countries according to MDG Target 4.A achievement status, by WHO region, 2012

	MDG Target 4.A – achievement status				
WHO region	**Achieved**	**On track**	**Halfway or more**	**Less than halfway**	**Total**
African Region (AFR)	3	6	21	16	46
Region of the Americas (AMR)	5	3	22	5	35
South-East Asia Region (SEAR)	4	3	4	0	11
European Region (EUR)	17	8	28	0	53
Eastern Mediterranean Region (EMR)	6	2	11	3	22
Western Pacific Region (WPR)	2	1	18	6	27
Global	**37 (19%)**	**23 (12%)**	**104 (54%)**	**30 (15%)**	**194 (100%)**

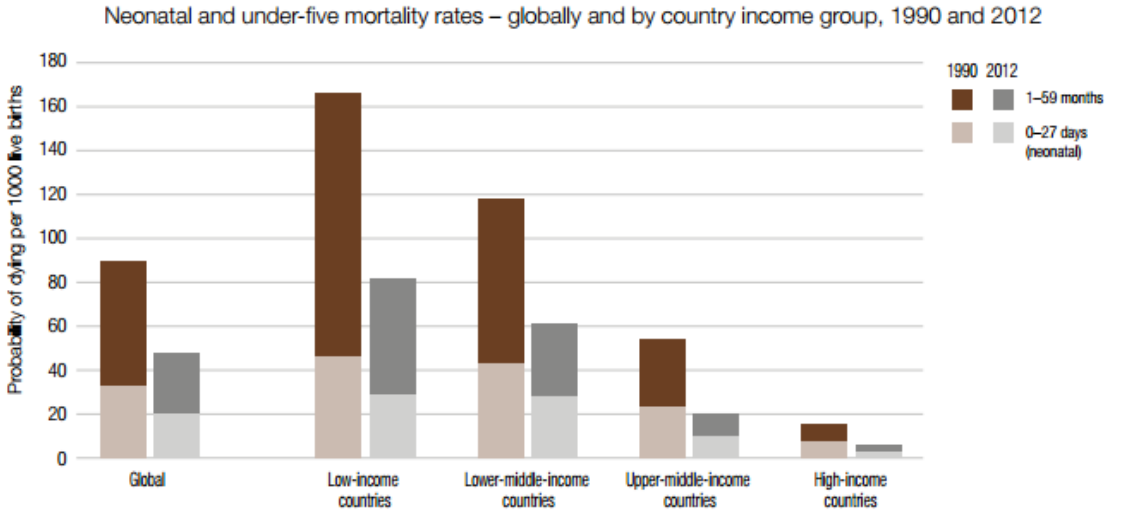
Calculated using unrounded under-five mortality rates, 1990 and 2012.

Sources: World Health Organization, *World Health Statistics*, 2014.

[187] World Economic Forum, *Health Is Wealth*, 2014. Available at: http://www.weforum.org/sessions/summary/health-wealth. Accessed 12.01.2017.
[188] Physicians for a National Health Program [PNHP], 2010.
[189] World Health Organization, *The World Health Report 2008.* Available at: http://www.who.int/whr/2008/whr08_en.pdf. 2008. Accessed 12.01.2017.
[190] Ibid

Table 5.1 describes those countries that were able to achieve the targets set by the WHO, those countries on track to meet those goals, those countries that need to be pushed to do more, and those countries that are unlikely to achieve the goals.[191] As of 2014, only one-third of all countries were on track to meet the health-care WHO goals. Table 5.1 shows that a lot of work still needs to be done.

Figure 5.1. Global status of under-5 mortality by country income group**.**



Source: World Health Organization, *World Health Statistics*, 2014, p.14.

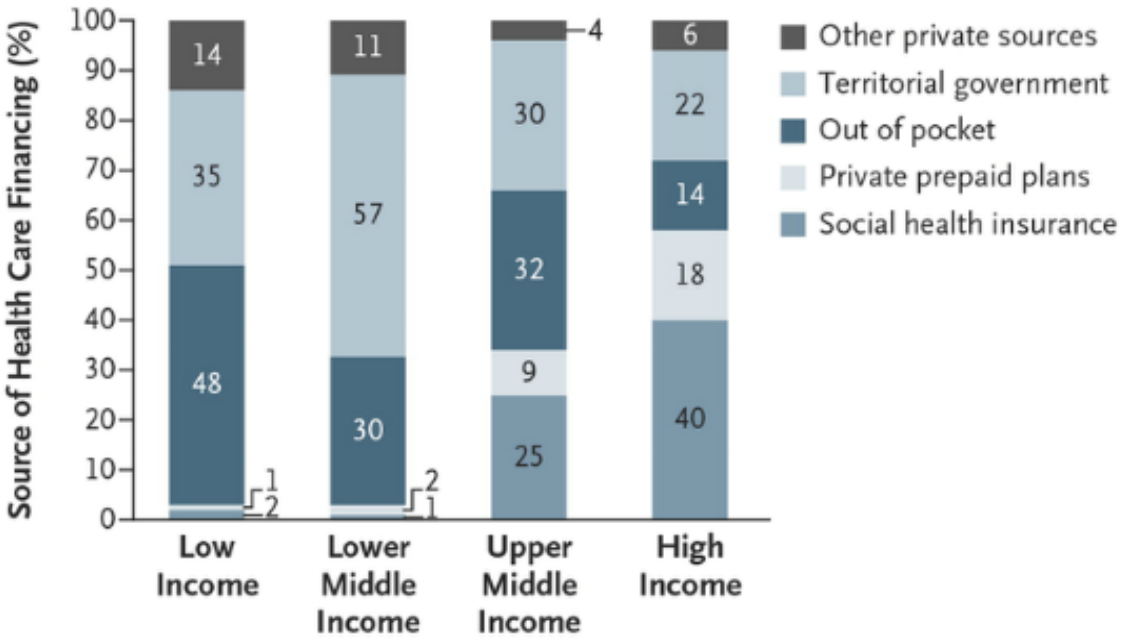
Figure 5.1. above shows that there were approximately 44 out of 1000 under-five deaths per live births worldwide in 2012, highlighting the importance of health-care interventions to address this alarming global issue. According to WHO World Health Statistics (2014), the major underlying cause of death among children less than five years of age is malnutrition. However, the same article reported progress in this area, with the global rate of underweight children declining from 25% to 15%.[192]

The WHO has been implementing health-care initiatives in an effort to improve health-care systems performance and accessibility across the globe. Various programs aiming to "reduce the barriers that prevent access to effective reproductive health interventions"[193] have already been initiated in several countries.

[191] Ibid,, World Health Organization. 2014, p.13.
[192] World Health Organization, *World health statistics 2010*. Available at: http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf. Accessed 09.11.2015.
[193] World Health Organization ,*World Health Statistics*, p.13. 2014. Available at: http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf. Accessed 08.03.2016

Shah (2011) identified the common challenges faced by health-care systems around the world to be inverse care, impoverished care, fragmented care, unsafe care, and misdirected care.[194] Moreover, Mills (2014) noted in her research that the health-care systems in low- and middle-income countries are considered weak.[195] The same author argued that poverty was one of the primary reasons why people refuse to seek and receive health care and posited that health-care systems in low- and medium-income countries must be improved and enhanced in order to foster quality and sustainable health care.[196]

Figure 5.2. Sources of health-care financing by country income



Sources: A. Mills, *Healthcare Systems in Low- and Middle-Income Countries*, The New England Journal of Medicine, 370, 2014, p.555.

Figure 5.2 indicates that nearly half of the health-care financing for low-income countries is being sustained by out-of-pocket expenses, 30% for middle-income countries, and 14% for high-income countries. This illustrates the financial problems faced by low- and middle-income countries in funding health care, resulting in inconsistent and inefficient

[194] A. Shah, *Healthcare Around the World*, 2011. Available at: http://www.globalissues.org/article/774/health-care-around-the-world. Accessed 10.08.2015.
[195] A. Mills, *Healthcare Systems in Low- and Middle-Income Countries*, The New England Journal of Medicine, 370, 2014, p. 552-557. Available at: http://www.nejm.org/doi/full/10.1056/NEJMra1110897. Accessed 05.011.2016.
[196] Ibid

health-care services. Mills (2014) noted that the major problem faced by health-care systems in low- and middle-income countries is a lack of financial support.[197]

Approaches to implementing effective health-care systems vary by country depending on the government and its various constituents. Mills (2014) argued, "[T]here is no one blueprint for an ideal health-care system, nor are there any magic bullets that will automatically elicit improved performance." However, there may be universal characteristics that should be present in a health-care system for it to be deemed effective. These are shown in Table 5.2.

Table 5.2. Characteristics of successful health systems

- Have vision and long-term strategies
- Consider the constraints imposed by history and previous decisions (path dependency)
- Build consensus at the societal level
- Allow flexibility and autonomy in decision-making
- Be resilient and learn from experience, feeding back into the policy cycle
- Receive support from the broader governance and socio-economic context and be in harmony with the population preferences
- Achieve synergies among sectors and actors
- Demonstrate openness to dialogue and collaboration between public and private sectors, with effective government oversight
- Focus on patient safety

Source: Adapted from D. Balabanova, L. Conteh, M. McKee, *The contribution of health systems to good health.* Good health at low cost, 25, 2011, p.271.

Table 5.2 shows the characteristics of successful health systems[198] adapted from Balabanova et al., as cited by Mills (2014) in the *New England Journal of Medicine*. Vision,

[197] A. Mills, *Healthcare Systems in Low- and Middle-Income Countries*, The New England Journal of Medicine, 370, 2014, p.555. Available at: http://www.nejm.org/doi/full/10.1056/NEJMra1110897. Accessed 05.011.2016. from

[198] D. Balabanova, L. Conteh, M. McKee, *The contribution of health systems to good health.* Good health at low cost, 25. 2011, p.271.

strategies, government support, dialogue, collaboration, and synergies are important aspects. Performance standards and expectations for health-care systems must focus greater attention on patient safety. Health systems must be able to provide strong, clear, and visible attention to safety.

Today, the roles of health professionals are even more critical to the community. Such professionals must be provided continual training and education to ensure that only those persons who are knowledgeable in their jobs and have the necessary skills are providing care. The health-care industry, governments, and other concerned groups have all implemented steps to improve the field of medical practice with the goal of administering better services. Health-care workers are instructed in the necessary programs, and intensified efforts are being made to properly define their roles and help them to do better in their jobs.

The health-care industry has been focused on efforts to improve quality through regulations, quality assurance, continuous quality improvement, and the promotion of patient safety. Patient safety is the most significant issue for health professionals. The needs of patients should be effectively recognized and executed so that health-care staffs can be effective in their jobs. To provide quality care to patients, staffs are trained and chosen carefully. The quality of health-care work and the health-care profession have been paramount to hospital administration concerns.[199]

In the context of health-care organizations, population diversity influences both the patients and the practitioners. For practitioners, the socio-economic backgrounds of patients have a major influence on every diagnosis presented, as well as the treatment. For example, Briggance and Burke (2002) noted that U.S. minority groups suffer more from diseases and illnesses compared to the white population.[200] The same authors noted that "[a]side from hereditary factors, minorities face social obstacles to good health because of their low socio-economic status and social marginalization."[201] Furthermore, Leavitt (2012) suggested that in order for medical practitioners to function effectively in desegregated interactions, they should be able to promote socio-economical competence and knowledge.[202] This means that all medical practitioners across the globe should be able to adapt and incorporate the importance of socio-economic aspects, the assessment of socio-economical relations, the need

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[199] L. Hall, *Quality Work Environments for Nurse and Patient Safety*, United Kingdom: Jones and Bartlett Publishers Inc. 2005

[200] B. Briggance, N. Burke, *Shaping America's health care professions: the dramatic rise of multiculturalism*, in West J Med., 176(1), 2002, p.62-64.

[201] Ibid, B. Briggance, N. Burke, p.62

[202] R. I. Leavitt, *Developing cultural competence in a multicultural world: Part 1*, PT Mag Phys Ther, 2012, p.1-9

to be aware of the dynamics resulting from these differences, the expansion of socio-economical knowledge, and the adaptation of services to meet socio-economically unique needs. [203]

The Royal Australian College of General Practitioners contended that a lack of understanding about pluralism in health-care institutions can lead to the following problems[204]:

- *Under-Identification of Needs*—Miscommunication can lead physicians to misunderstand their patients' symptoms, which can lead to restricted identification of health-care needs. How patients present their illnesses is often influenced by their socio-economic backgrounds. Therefore, without socio-economic competence, the consultation and identification of patients' needs can be affected.
- *Underutilization of Health-Care Services and Accessibility Issues*—One of the major identifiers of a person's socio-economic status is his or her identity. There are some instances when accessibility to proper and quality health care is unequal in some nations. Health issues present a challenge to providing quality care to patients with socio-ecnomically diverse backgrounds. Aside from socio-economic status, patients from diverse backgrounds may present a lack of awareness about the kind of health care available to them due to barriers including lack of integrations and socialisations.
- *Financial Issues*—Health care in developed countries can mostly be accessed through health insurance; however, this may be a problem for those who do not have any means of obtaining coverage. In some developed countries, patients from socio-economically diverse backgrounds are often uninsured and also do not have the financial capacity to seek health-care consultations or treatments. Poverty, poor education, and difficulty with transport are likely to impact health opportunities for those from other socio-economic backgrounds.

In order for medical practitioners to provide the best and most appropriate care and treatment possible for their patients, they should possess socio-economic competence to gain deeper insight and understanding of the unique characteristics associated with their patients' backgrounds. For example they should have competance income educational system, financial security, and subjective perceptions of social status and social class. This practice can allow practitioners and clinicians to present the most fitting diagnosis and meet the needs of patients appropriately.

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[203] Ibid

[204] S. Harding, P. Schattner, B. Brijnath, How general practitioners manage mental illness in culturally and linguistically diverse patients: An exploratory study. *Australian Family Physician*, *44*(3), 2015, p147.

There are more than 200 countries in the world, with each nation implementing its own approach to health care. Approaches vary in accordance with a nation's status and the availability of the resources needed to establish a successful health-care system. Nevertheless, according to Reid (2010), there are four basic models followed by health-care systems around the world[205]:

- *The Beveridge Model*—This model was named for its developer, William Beveridge, who designed the national health service of Britain. This model describes health-care systems that are governed and financed by a national government in the same way as other government agencies, with resources coming mostly from taxes. This model entails total government control. It was suggested by Physicians for a National Health Program (2010) that this model "tend[s] to have low costs per capita" because the government controls what health-care professionals can do and can charge people. Countries with this system include Britain, New Zealand, and Cuba.[206]

- *The Bismarck Model*—This model was named after the Prussian chancellor Otto von Bismarck, who was the inventor of the welfare state as part of the unification of Germany in the nineteenth century. Health-care systems utilizing this model make use of an insurance system wherein a "sickness fund" is financed jointly by employers and employees in the form of a payroll deduction. This model is used in Germany, Japan, France, and Switzerland, among others.[207]

- *The National Health Insurance Model*—This model is a combination of the Beveridge and Bismarck models. As explained by Reid (2010), "It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into." It has been found that these universal insurance programs are cheaper because there are no marketing expenditures. National health insurance models also have the capability to control costs by limiting the types of medical services that will be paid for or by making patients wait to be treated. This model is utilized in countries such as Canada, Taiwan, and South Korea, among others.[208]

- *The Out-of-Pocket Model*—As the name suggests, this model is mostly utilized by low-income countries and by some middle-income countries. The out-of-pocket model is implemented in poor or disorganized countries. Such countries lack the capacity to provide mass health care and therefore are reliant on out-of-pocket payments from the patient. This

[205] T. R. Reid, *The healing of America: a global quest for better, cheaper, and fairer healthcare*, Penguin. 2010
[206] RACGP, *Multicultural health,* 2011.
[207] Ibid
[208] RACGP, *Multicultural health,* 2011.

model suggests inequality in health-care accessibility because often, only the rich can afford to pay for medical services. This health-care system model is followed in rural areas of Africa, South America, and India, among others.[209]

Poor city dwellers experience higher risks of water-, air-, and food-borne diseases and are likely to experience an unequal distribution of health infrastructures.[210] Urban populations generally have a low health insurance ratio.[211] Nevertheless, water supplies, sewage systems, and health services are better in urban areas than in rural areas. Moreover, city dwellers are often better fed.[212] The rural poor have even less access to health care. Rural health-care systems also lack skilled workers and primary care physicians.[213] Hence, the rural poor suffer from a lack of diverse providers to meet their community's health-care needs. The health-care insurance ratio should be increased, while the geographical distribution of health care should be improved in low- and middle-income countries. This is a call for action for grassroots policies.

Like other systems, health-care systems are governed by laws to promote orderly implementation and operations. Generally, such laws come from legislation or judicial decisions and can be categorized as either public or private law. *Health law* can be defined as the field of law that governs the delivery of health-care services and needs. Every aspect of medical practice and health-care services are governed and affected by this law. Health laws aim to protect medical professionals, staff, and patients in certain circumstances. Therefore, it is essential that these groups have adequate awareness of existing health laws.

According to Scott (1996), all health care professionals and medical practitioners are at risk of exposure to situations that may result in malpractice liability.[214] Patients may take legal action to seek justice for the unfortunate consequences of negligence on the part of the health-care providers. Scott (1996) identified the most common grounds of lawsuits and legal claims as "professional negligence," "intentional conduct, breach of contract and product liability," "liability for failing to obtain patient-informed consent," and "ordinary negligence."[215] Laws and legislations should be implemented to improve the quality of health

[209] T. R. Reid, *The healing of America: a global quest for better, cheaper, and fairer healthcare,* Penguin. 2010
[210] M. Montogemery, *Urban Poverty and Health in Developing Countries*, Population Reference Bureau, 64,2, 2009, p.1-20.
[211] Unite for Sight, *Urban Versus Rural Health*. Available at: http://www.uniteforsight.org/global-health-university/urban-rural-health. Accessed 28.09.2017.
[212] B. Lomborg, *The Skeptical Environmentalist: Measuring the Real State of the World,* UK: Cambridge University Press. 1998. p.1-32.
[213] Unite for Sight, op.cit.
[214] R. Scott, *Overview of Legal and Ethical Issues Related to Health-Care Malpractice for Prosthists and Orthotists,* American Academy of Orthotists & Prosthetists, 8(1), 1996, p.17-20.
[215] Ibid

care, particularly in low- and middle-income countries. Sanitation and hygiene should be promoted and encouraged in a global context.

2. Health-Care System –And Health-Care Crisis in Norway

The population of Norway is 5 252 166 inhabitants by 2017. Norway is facing challenge of health economics.

Figure 5.3. Statistics about Norwegian society

Source: Statistics Norway, *Norwegian society*, retrieved 01.06.2017 from http://ssb.no/en/.

Figure 5.3 shows the population number of Norway, the GDP per capita, the employment rate, the consumer price index, and the net migration. The information provided in Figure 5.3 presents the socio-economics data of Norway. Norway is one of the countries that have a known comprehensive health system. Despite this, the Norwegian government is also facing challenges in the development and implementation of effective health and social policies. These challenges are mainly a result of the constant changes in the external environment impacting the health-care system. The Norwegian health-care system is facing issues that include an increasing ageing population, lack of skilled health-care professionals and personnel, and a lack of strong community care.[216] Other challenges that need to be addressed include gaps in health care, risk factors for cardiovascular diseases, and harmful consumption of alcohol, which is apparent among the younger generation.

[216] OECD, *Health Policy in Norway*, 2016, p.1-2. Available at: http://www.oecd.org/norway/Health-Policy-in-Norway-February-2016.pdf. Accessed 12.12.2016

Figure 5.4. Health key figures

	Period	Level	Change from previous period. Per cent	Change past five years[1]. Per cent
Health conditions and lifestyle				
Life expectancy at birth	2013	81.7	0.2	1.0
Good self-assessed health. Per cent	2012	76	-6.2[2]	-6.2[3]
Good self-assessed oral health. Per cent	2012	73	-2.6[2]	..
Overweight, BMI >= 27. Per cent	2012	27	3.8[2]	12.5[3]
Exercise weekly. Per cent	2012	79	8.2[2]	11.3[3]
Health expenditures and man-years				
Total health expenditures (NOK million)	2013	288 283	6.8	25.1
Dental health services, man-years	2013	10 600	1.4	9.2
Municipal health services, man-years	2013	13 551	1.7	13.4
Specialist health services, man-years	2013	111 800	0.4	4.0
Long-term care, man-years	2013	132 700	1.2	7.5
Activity				
Persons examined in public dental health services	2013	1 047 700	1.9	6.5
Number of GP agreements	2013	4 407	2.5	8.4
Discharges in specialised health services	2013	989 000	0.9	3.3
Recipients of long-term care services	2013	271 400	0.0	1.9

[1] Refers to the period 2009-2013.
[2] Refers to the period 2008-2012.
[3] Refers to the period 2005-2012.

Source: Statistics Norway.

Source: Statistics Norway. *A healthy look at Norway - Facts and figures about health and health services in Norway*, 2014.

Figure 5.4 shows a summary of key health figures that shape the Norwegian health-care system. The Norwegian government allocates approximately 9.3 percent of its total GDP to health care.[217] As highlighted by the same report, Norway is known as having the second highest health-care expenditure per capita. Interestingly, the majority of the people in Norway have a regular general practitioner (GP), who they see for consultations 2.6 times per year, on average. However, an increase in the proportion of elderly in the population has been witnessed since the mid-1990s and this poses challenges to the macroeconomic stability because of spending on healthcare, and social benefits programs. Despite this, the general health condition of the people in Norway is good.[218]

The citizens of Norway show their trust in their government through their voter turnout. This is also how Norwegians demonstrate their support in political matters, and it

[217] Statistics Norway. *A healthy look at Norway - Facts and figures about health and health services in Norway*, 2014. Available at: http://ssb.no/en/helse/artikler-og-publikasjoner/_attachment/211046?_ts=14e2a15af08. Accessed 07.09.2015.
[218] Ibid.

shows that they are satisfied with their lives. As reported in OECD (2013), "86% of people are saying that they have more positive experiences in an average day (feelings of rest, pride in accomplishment, enjoyment, etc) than negative ones (pain, worry, sadness, boredom, etc)" which means that they feel rested, happy, content, and proud of their accomplishments. Johnsen (2006) noted that:

Norway was highly rated with respect to gender equality. Within education, the labor market, and political life, Norway was among those countries in which women do very well compared to men. In two of the United Nations indices for gender equality, based on the Gender-related Development Index (GDI) and Gender Empowerment Measure (GEM), Norway was ranked as the most gender-equal nation in 2001 (UNDP 2001; UNECE 2000).[219]

Norway is among the top European countries in quality living conditions.

During the 1990s, Norway introduced a universal, public health-care system accessible to all its residents. Funded by tax revenues, this national insurance system is one of the largest employers in the country. A report from InterNations states (2013) states, "Norway's health-care system is excellent, allowing people to enjoy life in the country."[220]

Norway has a good health-care system. Its key strengths include management based on patients' needs (personal income does not determine health-care services), government accountability, public commitment, and government interest in health-care system improvement. The primary goal of Norwegian health-care services is to improve health, treat diseases, and deal with the outpatient illnesses of the entire Norwegian population.

The Ministry of Health and Care Services is the government institution that oversees the country's overall health-care system. It is responsible for formulating and implementing the national health policy, compiling various ordinances, and initiating national guidelines and campaigns.[221] The Norwegian health-care system is made up of public and private facilities. As stated by Johnsen (2006):

"The Norwegian health-care system is organized on three levels, i.e. national, regional, and local levels. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services."

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[219] J. R. Johnsen, *Health Systems in Transition: Norway in the European Observatory on Health Systems and Policies*, 2006, p.4.

[220] InterNations, *Healthcare in Norway*, 2013. Available at: http://www.internations.org/norway-expats/guide/living-in-norway-15585/healthcare-in-norway-2. Accessed 09.08.2016.

[221] Helsedirektoratet, *Norway and Health. An introduction*, 2009. available at: http://helsedirektoratet.no/english/publications/norway-and-health--an-introduction/Publikasjoner/norway-and-health-an-introduction.pdf. Accessed 11.12.2016.

Figure 5.5. Regional health authorities map

Source: GoNorway, *Norway*, Available at: http://www.gonorway.no/norway/articles/map/449/index.html. Accessed 12.7.2016.

The regional level (Figure 5.5) is represented by five regional health authorities who have responsibility for specialist health care; the local level, represented by 434 municipalities, has responsibility for primary health care (including nursing care).[222]

At the national level, the Ministry of Health and Care Service is responsible for formulating and implementing national health policy with the help of several subordinate institutions. The Norwegian Directorate of Health, under the Norwegian Ministry of Health and Care Services, is responsible for the compilation of various ordinances, national guidelines, and campaigns. The Norwegian Directorate of Health advises the ministries concerned with health policy and legislation. Its work involves the management of grants for service projects and research, the Norwegian Patient Registry, and the implementation of certain statutes. It executes diverse projects to promote public health and improve overall living conditions. At the national level, the Norwegian Board of Health Supervision is the independent authority responsible for the general supervision of health services.

The Norwegian Board of Health Supervision's central office directs its regional units set up at the province level. The county medical officer, who reports to the provincial governor, directs the unit as one of his or her responsibilities. These supervisory authorities

[222] J. R. Johnsen, *Health Systems in Transition: Norway in the European Observatory on Health Systems and Policies [Online]*, 2006, p.22. available at: http://www.euro.who.int/__data/assets/pdf_file/0005/95144/E88821.pdf. Accessed 26 December 2015.

are concerned with quality, legal aspects, complaints, and ensuring adequate and equitable health services.

The Norwegian Institute of Public Health (NIPH) is the main source of medical information and advice. It ensures the good use, high quality of, and easy access to data in the registries. It also ensures that health information is treated in accordance with privacy protection rules. The NIPH is responsible for six of the seven national health registries.

Government health care expenditure in the year 2003 alone was estimated at 10.3% of the GDP.[223] The Norwegian health-care system is funded through taxes and supplemented by state grants, other sources, and a few user charges. For example, Norway introduced an activity-based funding system called the Diagnose Regulated Groups (DRG) system for the somatic hospital in June of 1997. The Norwegian system is revenue and tax funded, financed by the government, and administered by the different Norwegian municipalities. The universal public health-care system is also funded by the National Insurance Scheme (NIS), created in 1967. The NIS is one of the largest employers in the country. The NIS offers public insurance against individual medical expenses (fees for service) for ambulatory care provided by hospitals and private practitioners. Although the health care policy is controlled centrally, the responsibility for the provision of health care is decentralized. The government is responsible for making annual budget allocations for the five regional health enterprises.

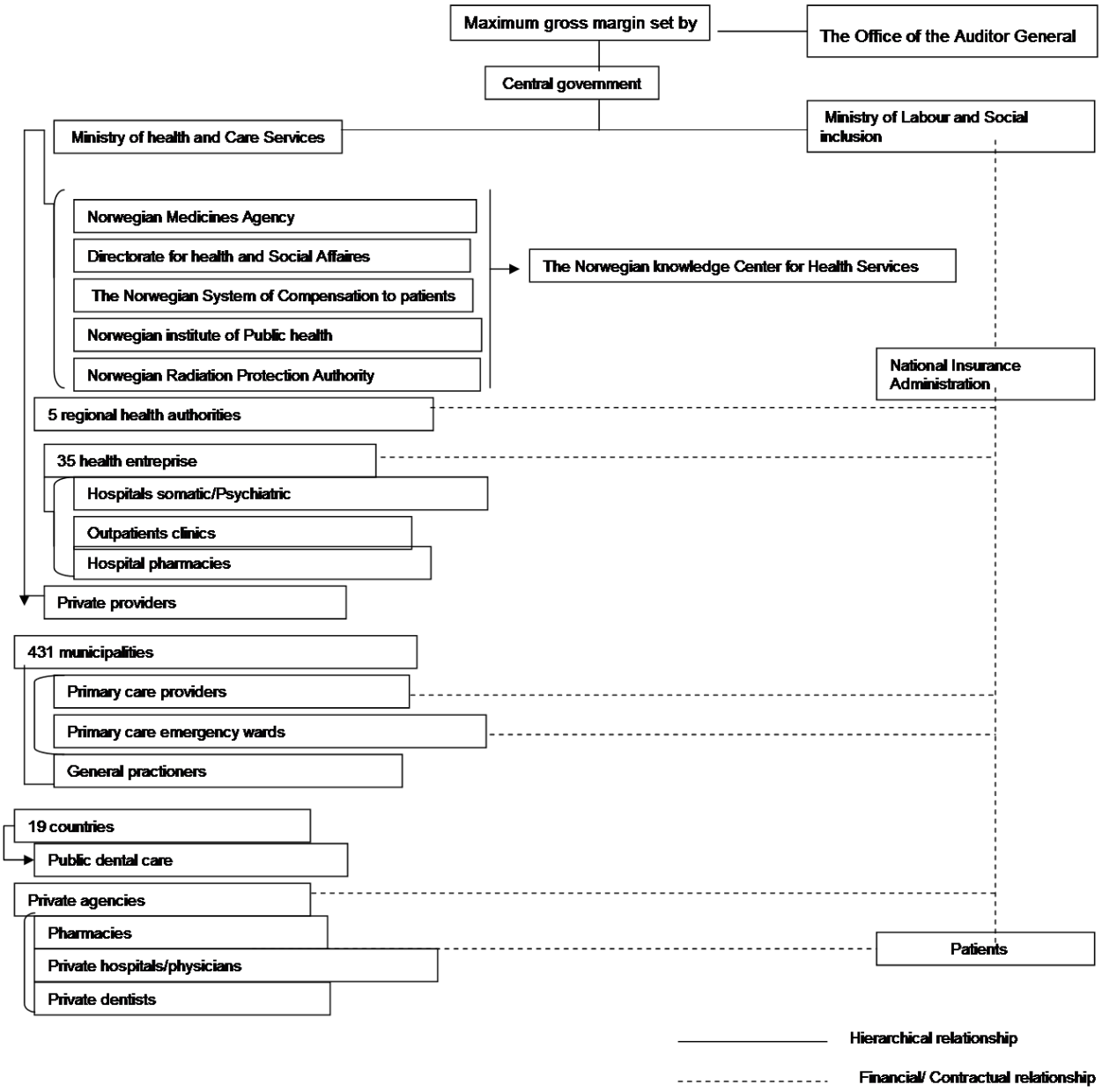
The Ministry of Health and Care Services issues operational directives on the general goals to be achieved with the approved budgets. Figure 5.5 shows Norway's five regional health authorities responsible for the provision of specialized care institutions, as well as other specialized medical services, such as laboratory, radiology, and ambulatory services, and special care for people with drug and alcohol addictions. Each regional health enterprise, in consultation with the regional boards, determines how funds will be distributed among the regions' health enterprises. Operational directives on the health goals to be reached accompany allocations from regional health authorities. Johnsen (2006) notes that resource allocation for both the municipalities and regional health authorities follows the same financial scheme with the addition of activity-based funding.[224] The authorities have the freedom to set up their own financing arrangements; however, in reality, the same arrangements are implemented throughout the country. A policy—Municipalities Health

[223] J. R. Johnsen, *Health Systems in Transition: Norway in the European Observatory on Health Systems and Policies [Online]*, Op.cit.,p.xiii

[224] J. R. Johnsen, *Health Systems in Transition: Norway in the European Observatory on Health Systems and Policies*, 2006. available at: http://www.euro.who.int/__data/assets/pdf_file/0005/95144/E88821.pdf. Accessed 08.02.2016.

Services Act (1982)—was passed on in order to improve the existing health conditions and strengthen social care services and to provide better allocation of health-care workers. In 1999, a Patients' Rights Act was passed to guarantee equal quality health care among all patients.[225] Several reforms have been implemented since that safeguard the right of the patients, prioritize cost containment, and integrate responsibility of health-care services.

Figure 5.6. Overview of the Norwegian health-care system



Source: Adapted from J. R. Johnsen, *Health Systems in Transition: Norway in the European Observatory on Health Systems and Policies*, 2006.

[225] Ibid

Figure 5.6 shows an overview of the Norwegian health-care system[226] . The health-care system is very complex. Knowing more about the structure, relationships, and the dynamics of those relationships allows to better access health-care systems.

Norway introduced a universal and public health-care system accessible to all its residents during the 1990s. All Norwegian citizens and residents have the right to free health care and have access to free medical treatment. Foreigners working or studying in Norway can also access the social security system. The health service is organized into primary care, outpatient specialist care, hospitals, and long-term care.

Primary health care is the responsibility of the Norwegian municipalities, which deal with general medical care, emergencies, and personal care outside of hospital facilities. The municipalities also implement campaigns in schools and other public facilities to raise awareness about common health issues.

Local authorities at the municipal level organize and finance primary health-care services according to local demand. The municipalities receive grants from the central authorities and largely fund the primary health-care system. Unbalanced growth in specialist services and secondary care has been reported in the last ten years due to an increase in the number of physicians in the general practitioner (GP) and hospital sectors, indicating that there was a financial incentive to be a certified GP and see more patients every day. Since 2001, patients have been encouraged to register with regular GPs for better health consultation. The 2001 reform established the current model of GP financing, which was set nationally. Pursuant to this reform, the municipalities contract private GPs, who in turn are provided with capitation combined with the service fees from the Norwegian Health Economics Administration, and also out-of-pocket payments from the patients.[227]

Specialists who are hospital based are salaried, while ambulatory specialists are generally self-employed and are paid an annual lump sum based on their practice and the number of patients that they have treated with service-fee payments. Hence, patients may choose the specialist that they want to see, but specialist availability varies by geographical location.[228]

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[226] J. R. Johnsen, *Health Systems in Transition: Norway in the European Observatory on Health Systems and Policies*, 2006, p.2. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/95144/E88821.pdf. Accessed 08.02.2016.

[227] A. K. Lindahl, *The Norwegian Healthcare System*, The Commonwealth Fund [Online]. 2012. Available at: http://www.commonwealthfund.org/Topics/International-Health-Policy/Countries/~/media/Files/Topics/Country%20Profiles/New%20Folder/Norway_profile_2012.pdf Accessed: 26 December 2013.

[228] Ibid

The emergency services numbers (110 – Fire department, 112 – Police, 911 – Police [but only from a mobile phone], 113 – Emergency, 120 – Sea rescue) are operated by both state-financed and private organizations. In most cases, the ambulance service is managed by the health trust.

The Norwegian state owns most of the hospitals and health facilities, which are managed by region. Most hospitals are publicly funded; the central government provides grants to those counties that redirect finances to the hospital sector. A small number of hospitals are privately owned. However, most private hospitals are also publicly funded. Some private commercial hospitals are financed only by patient co-payments: the state-run National Insurance Scheme (NIS) reimbursements and contract-based grants from the counties.

Regional hospitals and medical facilities are generally free to budget their time and money, but they are subject to the resources assigned to them by the central government. These health institutions are registered as legal entities with executive boards approved by the Ministry of Health and governed as publicly owned corporations. The 2002 hospital payment reform established centralized responsibility for inpatients and specialist care under the four Regional Health Authorities (RHAs). RHAs are organized as corporations fully owned by the state and are funded through capitation, activity-based payments, and out-of-pocket payments. Hospital services are organized to offer ambulatory services through contractual agreements with the RHAs. If hospital treatments for patients go over their allocated budget, they will only receive 40% of the Diagnosis-Related Group (DRG), and, according to the 2012 reform, municipalities will be required to pay 20% of the hospital cost of their residents.[229]

Providing long-term care for the citizens of Norway is one of the responsibilities of the municipalities. Municipal institutions include nursing homes, long-term psychiatric homes, and homes for severely disabled children and youth. The municipalities also reserve the right to provide end-of-life care for the terminally ill patients within the nursing homes, but it is up to each institution to decide if it will offer this option.[230]

All Norwegian citizens have a unique personal call ID number. This number is given at birth, and it is used in various official records, including The Norwegian Health Economics Administration (HELFO), and allows for linking such records on an individual level. An ID number is also given to foreigners who stay in Norway for more than six months. Norway also issues a dummy number (D-number) for foreign nationals staying in the country for less

[229] A. K. Lindahl, op.cit..
[230] Ibid

than six months. All medical services are registered by a patient's ID number or D number. The ID number is used to identify patients enlisted with a Regular General Practitioner (RGP) and also by Statistics Norway as a tool to keep track of immigrants' statuses, countries of origin, reasons for immigration, length of stays in Norway (years), citizenships, and annual work incomes (NOK).

Norway is a country facing a health-care crisis, as its population is increasingly dominated by elderly people. The aging population requires more and more health and care services.

In addition, the number of immigrants is growing due to the acceleration of immigration driven by income differentials, social networks, and Norwegian policies to recruit skilled and unskilled labor and replenish population. Norway is facing the challenge of a smaller percentage of the population working to finance increasing health-care costs.

The generous Norwegian welfare and strong social protection system, together with major demographic changes and a marked increase in cases of diabetes, cancer, obesity, ulcers, skeletal injuries, and mental disorders, are pushing Norway to spend more than ever on health care per person. Norway is organizing its health systems in order to maximize health and give better value for its residents' money.

Immigrants with health problems and living with scarce ressources often face insurmountable barriers to accessing diagnoses and treatment. Introduction courses offered by the Norwegian government to children in school and for adult migrants are important expenditures items that are directly integration-related. Economic burdens associated with the housing and care of immigrants push Norway to look for ways to stop immigration and to contain health-care costs. The increasing demand for health services for the entire Norwegian population and immigrants also puts pressure on Norwegian economies. All of these are obvious issues for the Norwegian government to focus on. The poor and challenging socio-economic status of immigrants makes them even more prone to exclusion from health care. Undocumented immigrants struggle to access health care at all. The rising unemployment makes immigrants' lives difficult, and they often face social exclusion; rising unemployment increases anti-immigrant behavior.

To address the changing demographics and new disease patterns, the Norwegian government focuses on prevention, strong primary care, increased coordination, and stopping the flow of illegal migrants to Norway.

3. Overview of Fees for Accessing Health Care in Norway

In Norway, the tax burden is 45% of the GDP, and people are insured by the National Insurance Scheme, a universal, tax-funded, single-payer health system.[231] There are two exemption card schemes[232] in Norway: one for user-fee group 1 and one for user-fee group 2. These schemes apply to different services,[233] and users may use just one exemption card scheme. User-fee group 1 includes user fees for doctors, psychologists, outpatient clinics (hospitals), X-ray institutes, patient travel, and medication and equipment on the "blue prescription."[234] The blue prescription ensures that a patient is covered for parts or any state medical expenses if severe and prolonged illness occur.

The user fee for group 1 is $267.33. The exemption card is automatically sent by mail within three weeks after a patient has paid more than $267.33 in user fees during 2016.

User-fee group 2 includes user fees for examinations and treatment by physiotherapists, treatment for certain forms of dental diseases**,** stays at approved rehabilitation centers that have agreements with regional health authorities, and travel for treatment abroad arranged by Oslo University Hospital - Rikshospitalet HF**.** However, the user fee group 2 scheme is not automatic—when a person has paid more than $326.67 in approved user fees in 2016, the person then has to apply directly to HELFO for an exemption card.

In addition, for prescriptions, certain people qualify for medication on a so-called *blue prescription,* which allows them to only pay an excess of $63.62 per year.

The deductible depends on the form of treatment. If the treatment received triggers an approved deductible under under tax exemption card 2 scheme's ceiling, an itemized receipt can be obtained from the treating provider.

In Norway, the health system requires everyone to have a referral from a medical professional in order to consult with and be attended to by the specialist health service, and Norwegian citizens have to pay for every doctor's appointment. A doctor's appointment, as shown in Table 3, costs around $17.25 during the day and $29.11 at night, a specialist costs

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[231] J. Shafrin, *Health care around the world: Norway. Health Care Economist,* Health care-economist. 2016. vailable at: http://health care-economist.com/2008/04/18/health-care-around-the-world-norway/. Accessed 27 May 2016.
[232] K. Evang, *Health services in Norway*, Oslo: Universitetsforl. 1976.
[233] A. Stokke, B. Rosted, T. Funderud, *Forenkle og forbedre samhandlingen mellom pasienter og helsevesenet*, 2014, p.1-64.
[234] I. Teslo, *Finasieringsystemenes betydning for prioriteringer i helsevesenet. Virker det som vi ønsker?: Gjennomgang og diskusjon på grunnlag av erfaringer fra Norsk helstjeneste,* (Master's thesis). 2010, p-1-69.

$27.50, and a gynecological appointment for a general Pap smear costs around $73.41 because of all the lab tests involved. The cost for private psychological and counseling services can be $200–$250 for an initial visit and $100–$150 for follow-up visits. In addition, there are also some costs associated with clinicians' time spent explaining and assessing health-care eligibility, as well as administrative costs for checking documents, etc. Even if a patient has to go to the doctor just to get a doctor's certificate for proof of sickness to give to an employer, the patient has to pay for the appointment.

Finally, patients pay additional costs for various travel purposes. The Norwegian Health Economics Administration (HELFO) only covers travel expenses in connection with therapy riding, electrolysis and wax treatment, and some training and rehabilitation.[235, **236**] Only after paying $263.92, which are the high fees demanded by the Norwegian government, can one receive their exemption card, which then allows the person to receive his or her remaining health care free for the rest of that year.

An average day in the hospital costs roughly $4,994.82. For each hospital stay, there may be variations from this cost. For example, a hip operation costs about $19,576.05, a normal birth is about $2,691.70, and a birth by Caesarean section runs about $6,729.26.[237]

Financial problems and health problems create a vicious circle for immigrant patients; a lack of money leads to worse health, which in turn leads to even less spending power and difficulty for immigrants trying to access health services. Socio-economic issues are important factors that complicate the delivery of health education. Individuals who struggle with poverty and fight to meet needs such as housing, food, and transportation often do not place a high priority on health education or health care. In addition, many immigrants send money to their home countries, and they do not have enough money left to pay for health services.

Economic barriers like unemployment, low incomes, and low levels of education have negative impacts on immigrants' health. Conversely, a higher income or educational level leads to a lower probability of encountering economic barriers to health services. Education is a key principle for immigrants who want to have a positive impact on the Norwegian economy. Low-skilled immigrants with little income depend heavily on the

[235] HELFO, *Tjenester og priser forfritt behandlingsvalg [Services and prices included in the free choice of treatment scheem]*. Available at: www.helfo.no. Accessed 24.02.2017

[236] A. Ringard, A. Sagan, I.S. Saunes, A.K. Lindahl *Norway: health system review Health Systems in Transition,* 15,2013, p. 1-162

[237] Regjeringen. *Ofte stilte spørsmål. Her finner du svarene på noen vanlige spørsmål for tema sykehus*. Avalable at: https://www.regjeringen.no/no/tema/helse-og-omsorg/sykehus/innsikt/nokkeltall-og-fakta---ny/ofte-stilte-sporsmal/id534086/. Accessed 24.02.2017.

government for assistance; their contributions are low compared to their needs and their impact.

Another type of barrier to access to health care is related to geographical difficulties. Living far from health centers poses an economic challenge for immigrants. Some immigrants do not have enough money to pay for the travel necessary to visit health services when health problems occur. The nonmedical costs associated with immigrants' health problems can include a range of different expenses incurred in the process of accessing health care (e.g., cost of travel, meals, and accommodations; cost of childcare). The level of cost incurred can depend upon the type of care accessed, as well as other factors such as the locations traveled to and from, and additional fees such as parking charges and tickets. These are some of the reasons immigrants living far from a hospital face significantly higher costs when accessing care than those living close to a hospital. Low-income immigrants are specifically more likely to face increased difficulties in access to health-care services if their economy is not strong.

When immigrants are admitted to a hospital but are not members of the NIS, they may show valid proof of insurance issued by a legitimate and accepted insurance company to avoid having to make a personal payment for medical attention. If they do not have proof of insurance, they must pay for any treatments, medications, and hospital accommodations. There are some exceptions, however. If an expectant mother is a documented immigrant, she does not have to pay for any pregnancy check-ups. Children under the age of 12 do not pay any medical user fees, and anyone under the age of 18 who requires psychological help does not have to pay any treatment fees. Also, fees required for children under the age of 16 may be added to the fees of the parent. If the total amount of fees exceeds the annual upper limit, the child and parent are entitled to a fee exemption card (*frikort* in Norwegian).

Norway utilizes a list-based system for offering primary health care. The RGPs act as gatekeepers to secondary health care. During office hours, patients with urgent needs can consult their RGPs, but during out-of-office hours, patients can consult emergency primary health-care services (EPHC). Many immigrants tend to use EPHC for non-urgent cases as a result of poor knowledge of the health-care system, lack of a regular general practitioner, or dissatisfaction with the RPGs. According to a study by Sandvik, Hunskaar, and Diaz (2012), compared to native Norwegians, immigrants from Germany and Poland had lower rates of EPHC contacts, while Iraqis and Somalis had higher rates of EPHC contacts.[238] In addition,

[238] H. Sandvik, S. Hunskaar, E. Diaz, *Immigrants' use of emergency primary health care in Norway: A registry-based observational study,* BMC Health Services Research, 12(1), 2012, p.308.

all EPHC contacts from Somali and Iraqi immigrants were for nonspecific pains, and most of their visits occurred during the night, demonstrating the extensive demand by immigrants for health-care services.

The costs for health services can be affected by the immigrants' reasons for coming to Norway as well. In addition, different groups of immigrants came to Norway for different reasons. Poles and Germans mainly migrated to Norway for employment; therefore, they have high employment rates and earn well, which enables them to afford most of the health services. These groups of immigrants, consequently, have low contacts with EPHC. These groups also represent the healthier immigrants and contribute to the general health-care revenue of the country, which impacts the economy positively.[239]

The Somalis and Iraqis came to Norway for protection. This group comprises low-income employees who are mostly unable to pay for their medical bills. As a result, this group has high levels of contact with EPHC. The lack of national insurance for immigrants, coupled with other factors like communication barriers, renders immigrants less likely to utilize primary and preventive medical services, emergency medical services, hospital services, and dental care.

According to a study by Leighton Ku and Sheetal Matani (2001), low-income immigrants are twice as likely to report a lack of regular health care compared to low-income native Norwegians.[240] In addition, there is a four-fold possibility that a low-income immigrant child will lack regular health care compared to low-income native Norwegian children. Furthermore, some public health facilities require immigrants to show their immigration status before receiving health-care services. This results in most of the immigrants resorting to black market health-care services and illicit drugs.[241]

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[240] L. Ku, S. Matani, *Left out: immigrants' access to health care and insurance*, Health Affairs, 20(1), 2001, p. 247-256.

[241] J. Shafrin, *Health care around the world: Norway. Health Care Economist*, Health care-economist.com. 2016. Available at: http://health care-economist.com/2008/04/18/health-care-around-the-world-norway/. Accessed 27 May 2016.

CHAPTER VI: UNDERSTANDING THE SOCIAL CATEGORY OF IMMIGRANTS

The focus of this chapter is to provide clarification of the term *immigrant* and other issues that have a relation to this term. The chapter describes and explains the legal aspects of being an immigrant; economic factors affecting immigrants, including employment among immigrants, differences in employment, and labor immigration; differences in access to health-care systems among immigrants; and information and communication barriers.

1. General Understanding of Immigrants

Globalization allows for better travel and communication and more international experiences and opportunities for people all over the world. It has also increased job opportunities in different parts of the globe. Many people take advantage of this opportunity by either working in or migrating to another country.

Immigrants are persons who have citizenship in one country and enter a different country to set up a permanent residence. Immigration has deeply transformed the socio-economic composition of many countries and is a contentious issue in the industrialized countries. Immigrants, according to Waldinger (2003), are people "that slowly give up the attachments that rooted them to their earlier lives. At the outset, immigrants begin with a dual frame of references, judging conditions 'here' in light of the standards that prevail back 'home,' to which they often expect to return. Over time, however, 'here' replaces 'there' as the standard for judging success, the perspective changes."[242]

Table 6.1. Number of international migrants in the world, 2000

[242] R. Waldinger, *Foreigners transformed: International migration and the remaking of a divided people, Diaspora:* A Journal of Transnational Studies, 12(2), 2003, p.247-272.

EVOLUTION OF THE NUMBER OF INTERNATIONAL MIGRANTS IN THE WORLD AND MAJOR AREAS, AND SELECTED INDICATORS REGARDING THE STOCK OF INTERNATIONAL MIGRANTS, 1970-2000

Major area	Number of international migrants (millions)				Average annual rate of growth of the number of international migrants (percentage)			International migrants as a percentage of the population		Percentage distribution of international migrants by region	
	1970	1980	1990	2000	1970-1980	1980-1990	1990-2000	1970	2000	1970	2000
World	81,5	99,8	154,0	174,9	2,0	4,3	1,3	2,2	2,9	100,0	100,0
Developed countries	38,3	47,7	89,7	110,3	2,2	6,3	2,1	3,6	8,7	47,0	63,1
Developed countries excluding USSR	35,2	44,5	59,3	80,8	2,3	2,9	3,0	4,3	8,3	43,2	46,2
Developing countries	43,2	52,1	64,3	64,6	1,8	2,1	0,0	1,6	1,3	53,0	36,9
Africa	9,9	14,1	16,2	16,3	3,6	1,4	0,0	2,8	2,0	12,1	9,3
Asia[a]	28,1	32,3	41,8	43,8	1,4	2,6	0,5	1,3	1,2	34,5	25,0
Latin America and the Caribbean	5,8	6,1	7,0	5,9	0,7	1,3	-1,7	2,0	1,1	7,1	3,4
Northern America	13,0	18,1	27,6	40,8	3,3	4,2	3,9	5,6	12,9	15,9	23,3
Oceania	3,0	3,8	4,8	5,8	2,1	2,3	2,1	15,6	18,8	3,7	3,3
Europe[b]	18,7	22,2	26,3	32,8	1,7	1,7	2,2	4,1	6,4	22,9	18,7
USSR (former)	3,1	3,3	30,3	29,5	0,5	22,3	-0,3	1,3	10,2	3,8	16,8

a. Excluding Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.
b. Excluding Belarus, Estonia, Latvia, Lithuania, the Republic of Moldova, the Russian Federation and Ukraine.

Source: United Nations, *Trends in Total Migrant Stock*: The 2003 Revision (POP/DB/MIG/2003/1 and ESA/P/WP.188), data in digital form.

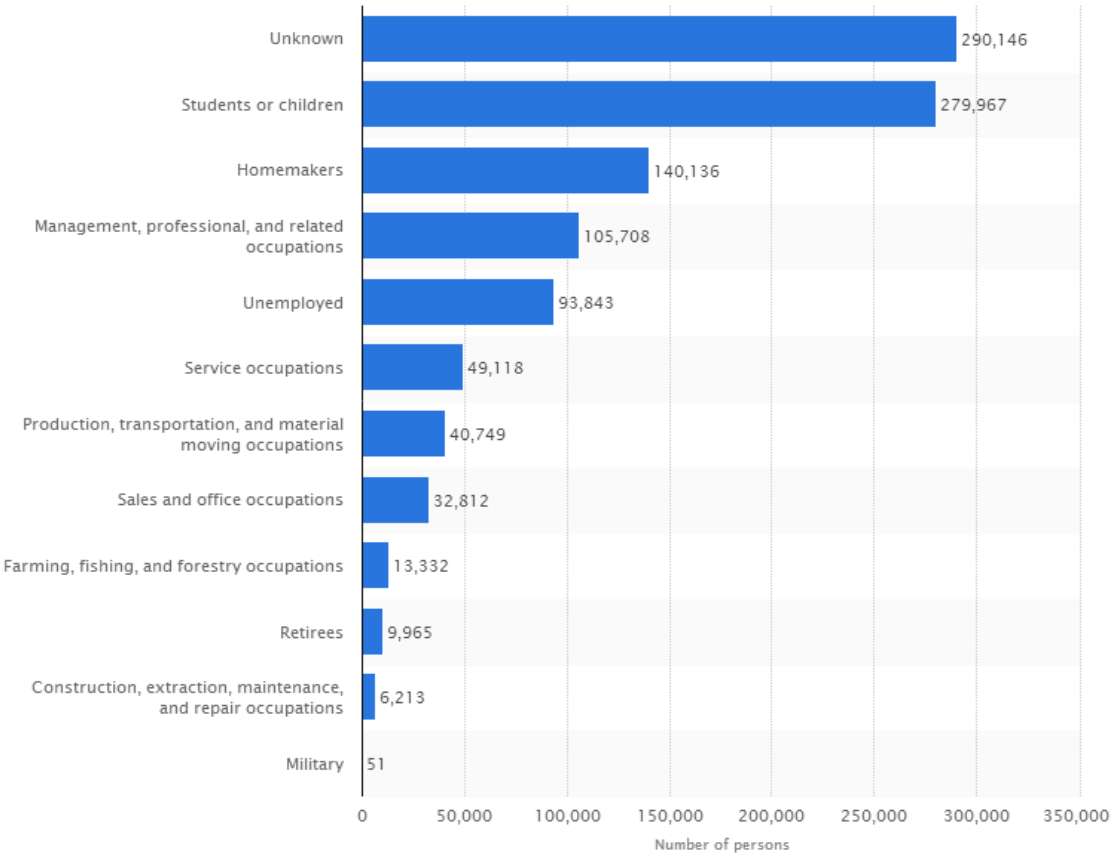
Source: Adapted from International Organization for Migration, *World Migration 2005 Costs and Benefits of International Migration*. *Vol. 3,* Academic Foundation. 2006, p.396

Table 6.1 shows the growth in the number of international migrants during the period of 1970 to 2000. [243] The movement of people across international borders has important economic, social, and political implications. Migration is one of the more cited, also more contested, areas of the new security agenda in many countries. It is preventing or slowing down population decline in a number of developed countries, including Norway, and is expected to continue to play that role in the future.

There are two types of immigrants: legal and illegal. A legal immigrant has received a proper visa or clearance prior to living in the host country. An illegal immigrant sets up residency in another country without proper legal documents and clearance. Immigrants normally emigrate from low and middle-income countries in an attempt to have better lives.

Figure 6.1. Number of persons obtaining green cards in the U.S. in 2011

[243] International Organization for Migration, *World Migration 2005 Costs and Benefits of International Migration*. *Vol. 3,* Academic Foundation. 2006, p.396.



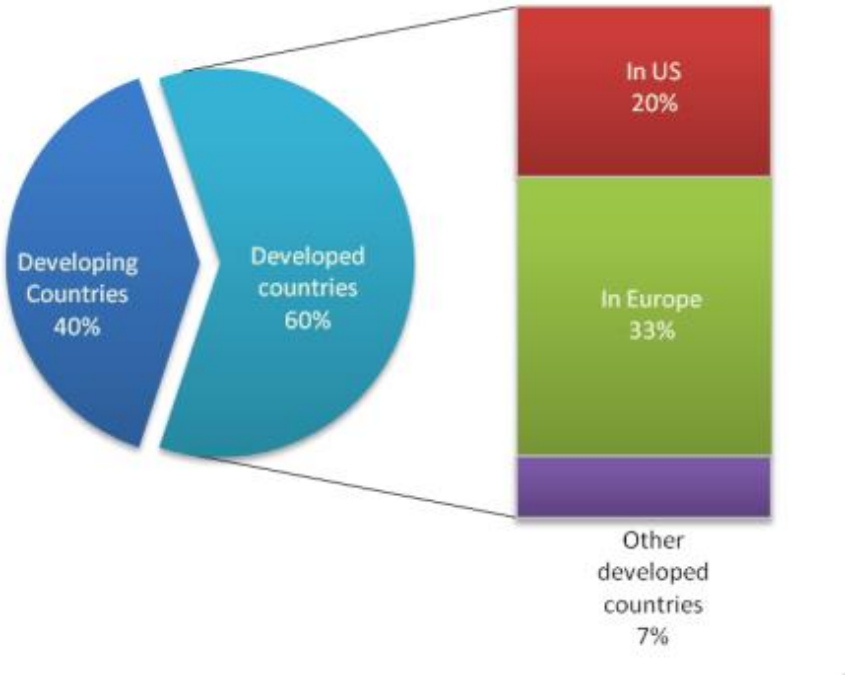
Source: Statista, *Number of persons obtaining legal permanent resident status (green card) in the U.S. in 2011, by occupation.*

The Figure 6.1. shows the number of persons obtaining green cards in the U.S. in 2011. [244] Students, children, homemakers are overrepresented.

Immigration has become a popular topic in recent years. Due to the belief that there are better job opportunities in the rich countries, the number of both legal and illegal immigrants is increasing, particularly in rich countries. Illegal immigrants especially are confronting serious problems such as enduring racism and dehumanizing working and living conditions. In addition, they live in constant fear of being deported by immigration authorities.

[244] Statista, *Number of persons obtaining legal permanent resident status (green card) in the U.S. in 2011, by occupation.* 2014. Available at: http://www.statista.com/statistics/247052/legal-immigrants-in-the-united-states-by-occupation/. Accessed 23.11.2016.

Figure 6.2. Approximate spread of immigrants in past 50 years (total 191 million), 2008.



Source: Shah, *Global Immigration Statistics*, Available at http://www.globalissues.org/article/537/immigration. Accessed 03.16.2016

The increase in migration across the globe (Figure 6.2) can also be attributed to globalization. Desai (2008) asserted that "globalization is a sham, designed to benefit the powerful; it lures desperate people from the South with false promises of a better life, but when they arrive in the west, they are treated like slaves."[245] Moreover, the same author argued that, by extension, if the West embraced migrants in the spirit of globalization, perhaps the latter would not feel the need to hold onto their original national identities. Migrants who feel embraced by their adoptive countries are not likely to feel the enormous anxiety of being a foreigner—that unbearable arrogance and shame of the immigrant.

People migrate to other countries for varied reasons, making the concept of immigration very complex. Immigration can either have a positive or negative impact on both the country of origin and the host country.[246] Some potential benefits of immigration to the host country are[247]:

[245] K. Desai, *The Inheritance of Loss*, London: Penguin. 2008, p.1-306.
[246] A. Shah, *Immigration*, Global Issues. 26 May. 2008. Available at: http://www.globalissues.org/article/537/immigration. Accessed 08.08.2017.
[247] Ibid

- Immigrants are versatile and can do whatever jobs are thrown at them, particularly those jobs that citizens won't or can't do.
- Immigrants can work for longer periods and hours for minimum wages.
- Immigrants can contribute to the diversity of that society.[248]
- "For the host country's economy, immigrants offer an increased talent pool, if they have been well educated in their original country." [249]

Shah also identified potential disadvantages and/or drawbacks[250]:

- Immigrants can be exploited for cheap labor.
- "Developing countries may suffer 'brain drain' as the limited resources they spend in educating their students, amounts to very little if that talent is enticed to another country."[251]
- Immigration is linked to criminal activities such as drug and human trafficking.
- Social and political issues are relative, such that racism can be used to manipulate the behaviors of others.
- Illegal migration/immigrants have problems being integrated.

Frears (2002) said that unfavorable events demonstrate that despite immigrants' unfavorable situation, migrants retain a level of decency that outshines that of their tormentors.[252] In a way, the solidarity exhibited by immigrants suggests that they realize their security (no matter how precarious) largely depends on their sticking together.

2. History of Immigrants in Norway

Immigrants are, according to the Norwegian law, persons born abroad with two foreign-born parents and four foreign-born grandparents, in addition to persons born in Norway with two foreign-born parents and four foreign-born grandparents.

Immigration law serves as the gatekeeper for nations' borders. It determines who may enter, how long they may stay, and when they must leave. As discussed above, legal immigrants are persons who enter a country different from the country where they have citizenship with the purpose of setting up a permanent residence after first receiving a proper

[248] A. Shah, *Immigration*, Op.cit.107.
[249] Ibid
[250] Ibid
[251] Ibid
[252] S. Frears, Dirty Pretty Things. 2002.

visa and clearance to enter the new country and settle. Legal immigrants are not required to show proof that they have the intention of returning to their country of citizenship.

Some immigrants are drawn by the prospect of jobs that could provide money to send home to their families.[253] However, some people are religious or political—not economic—immigrants. Such people can gain legal refugee status by seeking refuge (from outside the country) or asylum (from inside the country) if they are able to prove that they are in a specific danger if they return to their country of origin.

A Brief History of Norwegian Migration[254]:

- In 1905, Norway received its independence from Sweden and was not known as a destination country for immigrants.
- In 1946, the Norwegian Refugee Council was established.
- In the 1950s, a common labor market between Norway, Sweden, Denmark, and Finland was established. Iceland joined in 1982.[255]
- In the late 1950s, a common passport-control area was added.
- From 1957, Norway had a fairly liberal set of regulations on immigration, established by a new legislation ("Fremmedloven").[256]
- In the late 1960s, the combination of a booming economy and a population shortage led Norway to accept a number of labor migrants from Morocco, Yugoslavia, Turkey, and particularly Pakistan.
- In 1975, the government applied the "immigration halt" rule to stop entrance of immigrants in Norway.
- In the 1980s, there was a policy shift, and the public reaffirmed its support for curbing immigration.
- In 1981, a number of minor changes to immigration rules were introduced that generally made it easier for immigrants to enter and stay.
- In 1988, the Immigration Act was passed, which treated immigrants and native Norwegians equally.

[253] W. A. Clark, *Immigrants and the American dream: Remaking the middle class*, Guilford Press. 2003, p.14
[254] G. Brochmann , A. Hagelund, *Immigration policy and the Scandinavian welfare state 1945-2010,* Palgrave Macmillan. 2012.
[255] International Monetary Fund, *Norway: Selected Issues,* International Monetary Fund, 2001, p.1-59.
[256] Å. Cappelen, J. Ouren, T. Skjerpen, *Effects of immigration policies on immigration to Norway 1969-2010.* Statistics Norway, Oslo–Kongsvinger. 2011, p.4.

- In 1988, changes in the regulations allowed Polish migrants to work while on a tourist visa, and an act regulated the adjudication of applications, permanent expulsion, and subsequent deportation. The legislation instituted a settlement permit for individuals with three continuous years of residency.
- In 1990, The Aliens Decree slightly liberalized the provisions for obtaining asylum and work permits.
- In 1991, minor changes affected immigration practices. Family reunion was made easier, and immigrants without a residence permit were granted a residence permit while their application was being considered.
- In 1993, there was a liberalization related to refugees from Bosnia Herzegovina.
- In 1994, Norway joined the European Economic Area (EEA). Citizens of the EU gained free access to work in Norway for three months or to stay for six months as job-seekers with the same social benefits as Norwegian citizens. Although the length of residency was limited, there were in practice unlimited possibilities for extension.
- In 1997, a liberalization took place regarding how refugees fleeing armed conflict were to be handled by immigration authorities.
- In 1998, another liberalization in refugee law took place, affecting people persecuted in their home countries.
- In 1999, UN conventions on children's and women's rights were made part of Norwegian legislation. In addition, work permits were provided for different lengths of time and did not expire automatically after two years.
- In 2000, a liberalization took place relating to work permits for specialists with competences in excess demand in the Norwegian labor market. Iraqis were also granted easier access to Norway.
- In 2001, Norway joined the Schengen Agreement, which created a common policy for short-term visitors' visas. The Agreement also extended the number of countries in which citizens of member countries did not need a passport to enter. The Schengen Agreement included most members of the EU as well as all EFTA countries, but not all state parties joined in 2001.
- In 2003, an act was introduced requiring target refugees' (between the ages of 18 and 55) active participation in settlement municipalities' integration programs.

- In May 2004, transitional rules for the countries of the European Union were established.
- In 2007, changes in regulations affecting potential immigrants from EEA and other countries were made. New 2004 EU members were included in the Schengen area.
- In 2008, rules were tightened for family reunion. Authorities made it more difficult for family members to enter if an ability to provide for the family was not shown.
- In 2009, transitional restrictions were added affecting countries that joined EU in 2004.
- A 2013–2016 action plan called "We Need Immigrants' Competence" aimed to facilitate the recognition of non-EU qualifications (e.g., health sector) and bridge programs. For example, the Norwegian Agency for Quality Assurance in Education (NOKUT), the body responsible to recognizing foreign degrees, started a 2013 trial with refugees missing documentation.

Since the beginning of the 1970s, the Norwegian authorities have implemented several measures to regulate immigration. Like many countries, Norway focuses on border enforcement and some array of interior enforcement policies aimed at identifying unauthorized immigrants for removal, including worksite enforcement, employment verification, jail-house screening, and state and local law enforcement activity.

Based on current immigration legislation or agreements, arrest and detention of foreigners can be done under several circumstances[257]:

- They do not cooperate in establishing their identities, or there is specific evidence to show they have willfully provided false identities.
- There is specific evidence showing they will evade leaving the country when obliged. This also applies when they are to be deported for having committed a crime or there is a danger they will commit another crime.
- They do not do what is required to obtain valid travel documents when obliged.
- They are "in transit at a Norwegian airport" and they are to be deported.
- It has been decided they are a threat to basic national interests and must be deported.

From January 1, 2015, the police can hold a foreigner longer than one day when the arrest occurs under the Immigration Act.

[257] Regjeringen, *Immigration Act, Act of 15 May 2008. On the entry of foreign nationals into the kingdom of Norway and their stay in the realm (Immigration Act).* Available at: https://www.regjeringen.no/en/dokumenter/immigration-act/id585772/. Accessed 27.12.2016.

With the increasing importance of immigrants in various economic fields, more efforts are being made to improve the immigration process and ensure that it is in accordance with Norwegian legal requirements. The main rule for becoming a Norwegian citizen by application is set out in the Norwegian Nationality Act, Section 7, first paragraph. The conditions that must be met are as follows[258]:

- "The applicant's identity must be clarified.
- The applicant must have turned 12.
- The applicant must be resident in Norway and intend to continue residing in Norway after the decision has been made.
- The applicant must meet the conditions for being granted a permanent residence permit.
- The applicant must have spent a total of seven years in Norway during the past ten years.
- Pursuant to the Norwegian Nationality Act, you cannot hold other citizenships when you become a Norwegian citizen.

There are some exemptions concerning the requirement relating to the total period of residence:

- For spouses, registered partners or cohabitants of Norwegian citizens, the required period of residence is a total of three years during the past ten years. In addition, the sum of the period of residence in Norway and the period of marriage to a Norwegian citizen must be at least seven years.
- For children who have turned two at the time the application is submitted and who apply for Norwegian citizenship as secondary applicants, a requirement normally applies that they must have held residence permits of at least one year's duration in Norway during the past two years. That a child applies as a secondary applicant means that his/her mother or father is a Norwegian citizen or becomes a Norwegian citizen at the same time.
- Exemptions also apply to certain other groups of applicants, for example, stateless persons and persons who arrived in Norway before the age of 18."

[258] Utlendingsnemnda, *Citizenship by application* . Available at: http://www.une.no/en/Cases/Citizenship/. Accessed 26.04.2017.

3. Health Problems of Immigrants in Norway

The problems being faced by immigrants in Norway must be understood and their effective resolutions promoted—these issues can affect the living conditions of the nation as a whole.

In Norway, understanding immigrants' health problems and their choices and actions related to health, which are based on their socio-economic backgrounds, is of crucial interest to policy planners and service providers (e.g., health-care personnel, social workers, and teachers) to provide satisfactory services for the country's immigrant population.[259]

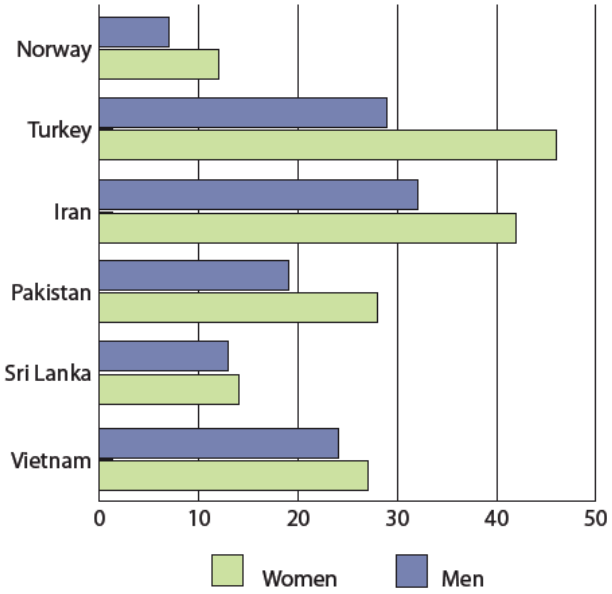
Negative effects of migration, such as stress, depression, and social differences are likely associated with health problems[260]. This by itself is one of the major problems related to immigrants in Norway. However, different immigrants may have different migration experiences; therefore, the consequences may vary by per person or, potentially, according to gender. Major health issues commonly faced by the immigrants in Norway include "lifestyle and diet-related health problems, infectious diseases, reproductive health, and access to and use of health-care services" (p. 7). "Disability, harmful cultural practices and gender-based violence, and care for elderly immigrants" are also among the major issues affecting the health status of the immigrants (p. 7).

Furthermore, according to Kumar et al. (2008), immigrants are the population in Norway that most experiences and reports health problems such as obesity and chronic diseases and, therefore, require more medical attention.[261] The following are some risk factors affecting immigrants in Norway:[262]

- *Dietary Habits*—Immigrants show a higher consumption of soft drinks and full-fat milk and a minimal consumption of fruits and vegetables. This promotes a high risk of obesity, vitamin deficiency, and chronic diseases such as diabetes.
- *Lack of Physical Activities*—Immigrants normally do not engage in physical activities, which puts them more at risk of cardiovascular diseases.
- *Alcohol and Smoking Habits*—Immigrants are the greatest proportion of smokers and alcohol drinkers in Norway.

[259] C. T. Attanapola, *Migration and Health*, Norwegian University of Science and Technology. 2013, p.2.
[260] Ibid.
[261] B. N. Kumar, H. Grotvedt, E. Meyer, A.J. Sogaard, B. J. Strand, B.J. *The Oslo Immigrant Health Profile*, Norwegian Institute of Public Health, 2008, p.22-29.
[262] Ibid

Figure 6.3. Mental distress proportions



Source: Adapted from B. N. Kumar, H. Grotvedt, E. Meyer, A.J. Sogaard, B. J. Strand, B.J. *The Oslo Immigrant Health Profile,* Norwegian Institute of Public Health, 2008, p-22-23.

Figure 6.3. shows subjective health problems. Immigrants have been recognized to have high levels of mental distress, particularly Turkish and Iranians, as shown in Figure 6.3.

According to Farah, Mohamed G., et al., two-thirds of the tuberculosis (TB) cases in Norway are among immigrants. Some cases were discovered on arrival, but many immigrants developed the disease several years later. Knowledge about how long after migration to Norway TB was discovered enables better targeting of preventive measures, including preventive therapy. For immigrants from Africa and Asia, the TB rates were 190 and 80 per 100,000 person-years (PY), respectively, at seven years post-migration. For immigrants from Somalia, Pakistan, Vietnam, and the former Yugoslavia, the rates were 520, 160, 210, and 40 per 100,000 PY, respectively, at seven years post-migration. These rates were 7 to 90 times higher than the crude TB incidence for Norway. This increased risk applied to both genders' pulmonary and extra-pulmonary sites. These results indicate the need for health personnel to be aware that immigrants remain at high risk for TB many years post-migration.[263]

Some immigrants encounter difficulties or stressors after arriving in their host country—they have limited education, are in a poor financial situation, are unemployed, lack

[263] M. G. Farah, H. E. Meyer, R. Selmer, E. Heldal, G. Bjune, *Long-term risk of tuberculosis among immigrants in Norway,* International journal of epidemiology 34.5, 2005, p.1005-1011.

adequate shelter, have no social networks, have different standards of religion and socio-economic backgrounds, must comply with new laws to deal with possible racism, have a different perspective on health or treatment of disease, and don't know the host country's health system.

A study conducted by Oppedal and Røysamb showed that immigrant adolescents reported higher levels of psychological distress and lower social support than host students. Of the four gender groups, immigrant boys reported the highest level of problems, with a 28% prevalence of anxiety/depression. There were no significant differences in prevalence among immigrant and host girls. Specific patterns of relationships between life stress, support, and health problems were found across genders.[264]

4. Immigrants' Access to Health-Care Systems and Factors that Likely Influence Their Access to Health Care

Immigrant access to health-care systems is still problematic in most countries. Immigrants are generally granted equal treatment only when they receive a work and/or residence permit. One of the main characteristics of equity in health is equal access to health care for those in equal need of health care. The right to receive help, the ability to come into contact with caregivers, and the effectiveness of the help are components of "access."

In Norway, immigrants are entitled to the same basket of heath treatments as Norwegians. However, illegal immigrants have no rights to use health-care services in Norway except for emergency services.

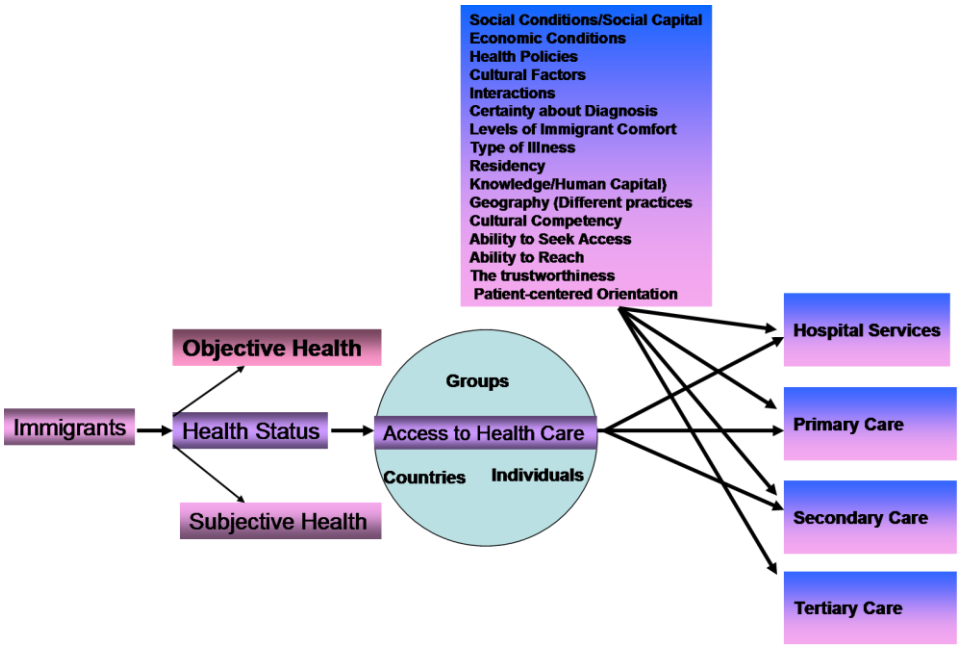
As discussed above, most immigrants in Norway are labor immigrants. This group is usually employed as manual workers, and they have lower health statuses compared to Norwegians. Manual workers also have more care needs than the rest of the society. Many of these immigrants have low education levels and low communication skills, making access to medical services quite difficult for them.

The barriers to accessing health-care services by immigrants are: 1) stringent requirements for obtaining permanent status; 2) literacy and social differences; and 3) administrative and bureaucratic factors, including lack of knowledge of the system. Others barriers are patient-related (e.g., lack of communication competence, beliefs concerning health and treatment, mistrust of the health-care system) and system-related (e.g., legislative,

[264] B. Oppedal, E. Røysamb, *Mental health, life stress and social support among young Norwegian adolescents with immigrant and host national background*, Scandinavian Journal of Psychology 45.2, 2004, p.131-144.

lack of information). Of these, the lack of information, lack of communication competency, and economic factors are the main barriers to new labor migrants accessing health-care services in Norway.

Figure 6.4. Factors that likely influence immigrants' access to health care**.**



Source: Made for this study

As shown in Figure 6.4, access to health care and health-care services varies across countries, groups, and individuals and is largely influenced by social factors, certainty about diagnoses and economic conditions, and the health policies in place.

Figure 6.4 shows that geography (various practices among communes), the economic situations of immigrants, knowledge about navigation of the healthcare system, human capital, immigrant residency, and the trustworthiness, patient-centered orientation, and competency of doctors and the health-care system can affect access to care.

The high costs of health care and the erosion of health insurance coverage are among the main challenges affecting many nations and people all round the world. These challenges are even worse and acute for immigrants, specifically immigrants to Norway, who have extremely low rates of health insurance coverage and poor access to health-care services. While most governments have special insurance coverage and policies to protect the health of their citizens, immigrants often have none, and very minimal policies are developed and enacted for them. All over the world, immigrants are a vulnerable population, especially in the

matters of health and access to health-care services. There has, however, been heterogeneity in the degree to which they are vulnerable to inadequate health care.

Particular social groups, immigrants for example, can be marginalized when their host country does not provide them adequate information and its people interact with them poorly or negatively. All people in Norway have equal rights to get the information they need, and state authorities are obliged to use all the possible resources to provide and support equality in social, political, and economic spheres between minority and majority groups.

Table 6.2. Potential negative impacts of communication barriers in health care

Immigrants

- Less adherence to the healthcare services
- Misunderstanding the side effects of medication
- Lack of explanations regarding potential side effects
- Difficulties in uncovering misunderstandings
- Inadequate comprehension of diagnoses and treatment
- Lack of access or underuse or overuse of health-care services by immigrants
- Lack of a thorough understanding of medication regimen
- Delay in treatment and reduction in the amount of time available to deliver effective care

Care providers

- Challenges and problems with giving preventive health information and in getting informed consent
- Difficulties with involving patients with immigrant backgrounds in their treatment and decision-making
- Increased risk of misdiagnosis—both over-or under-diagnosis
- Lack of treatment or inappropriate treatment
- Increased use of unnecessary diagnostic resources
- Frustrations and less satisfaction on both sides

Source: E., Kale, B. N. Kumar, *Challenges in Health care in Multi-ethnic societies: Communication as a barrier to achieving health equity.* In Public Health-Social and Behavioral Health. InTech 2012.

Table 6.2 shows that communication barriers between immigrants and physicians, nurses, and so on have an adverse effect on the initial access to health services.

Immigrants must have information on the kinds of medical help to which they are entitled, including which health-care services are available and how to get the help they need. However, it is reported that immigrants lack sufficient digital skills and social competence to access *fastlege* (GP), the online gatekeeper to the Norwegian health-care system. All registered newcomers receive written information about Norwegian *fastlege ordning*, but it is not easy to understand, as it is written in Norwegian. Immigrants who speak neither English nor Norwegian may have basic practical problems accessing health-care services (making appointments, communicating with doctors). Linguistic issues present significant barriers for many immigrants. Today, Norway offers immigrants professional translators, and migrants are informed about their rights.

CHAPTER VII: Economic Approach to Immigrant Access to Health Care in Norway

This chapter addresses the economic aspects of and impacts on immigrants' access to health care. It also focuses on the economic circumstances of immigrants with uncertain future access to the Norwegian health-care services. Access to health care is an important factor that significantly affects immigrants' health statuses and the economy of the country.

This chapter sheds light on the relationship between immigrants' access to health services and their incomes. The relationship between Norway's human capital and economy is measured by how greatly its government is invested in the education and health of its citizens. Human capital is directly related to economy. Labor immigrants are presented as important contributors to economy.

1. The Relationship between the Economy and Immigrants' Access to Health Care

Immigration is considered a complex and dynamic process that can affect a country in many ways. It adds to the budget of a country and thus affects the country's economy. Health is as important as income when the focus is on development and human welfare, so for policy purposes, health is linked with income. Good health plays a substantial role in economy.[265] In general, immigration can affect the economy of a country by increasing the number of people who are unemployed; this increased unemployment adds to the government's budget due to services offered to people without work. In addition, immigration affects the health-care system in a number of ways. Immigrants' health problems and needs are associated with their economic backgrounds, expectations, and unfamiliarity with the health-care system compared to those in their countries of origin. An immigrant's health depends on the individual's country of origin, reason for the migration, income, and objective

[265] R. W. Fogel, *Economic growth, population theory, and physiology: the bearing of long-term processes on the making of economic policy,* American Economic Review,1994, p.369–395.
Robert William Fogel (July 1, 1926 – June 11, 2013) was an American economic historian and scientist, and winner (with Douglass North) of the 1993 Nobel Memorial Prize in Economic Sciences.
His writings on the effect of health on economic growth:

- *Economic Growth, Population Theory and Physiology: The Bearings of Long-Term Processes on the Making of Economic Policy*, 1994.
- *Explaining Long-Term Trends in Health and Longevity*, 2012.

and subjective health.[266] Immigrants' incomes vary not only by country of origin (Table 7.1) but also with respect to how long they have lived in Norway.

Table 7.1. Persons with low income. Total population, immigrants, and Norwegians born to immigrant parents, by age.

	2012	2013	2014
	Proportion of persons with low income, EU-scale 50 percent	**Proportion of persons with low income, EU-scale 50 percent**	**Proportion of persons with low income, EU-scale 50 percent**
Immigrants from the Nordic countries, Western Europe, North-America, or Oceania			
All ages	11.4	11.2	10.9
People born in Norway that have immigrant parents from the Nordic countries, Western Europe, No...			
All ages	5.3	5.3	5.6
Immigrants from Eastern Europe, Asia, Africa, or Latin-America			
All ages	22.4	23.1	23.4
People born in Norway that have immigrant parents from Eastern Europe, Asia, Africa, or Latin-America			
All ages	12.9	12.1	11.9

Source: Income and wealth statistics for households, *Statistics Norway*. Available at: https://www.ssb.no/statistikkbanken/SelectVarVal/saveselections.asp. Accessed 16.07.2017.

Immigrants who have stayed many years in Norway have higher incomes than those with short periods of residence (Table 7.2 and Figure 7.1). This chapter also presents the relationships among age, place of birth, education, income, gender, and access to health services.

Figure 7.1. Median income after tax per consumer unit (EU scale), by reason for immigration and length of residence, 2013.

[266] L. Ku, *Why immigrants lack adequate access to health care and health insurance*. *migrationpolicy.org*. 2006. Available at: http://www.migrationpolicy.org/article/why-immigrants-lack-adequate-access-health-care-and-health-insurance. Accessed 17.08.2016.

Source: Statistics Norway. *lavere-inntekt-blant-innvandrere*, Available at: https://www.ssb.no/inntekt-og-forbruk/artikler-og-publikasjoner/lavere-inntekt-blant-innvandrere. Accessed 02.05.2017.

Figure 7.1 shows that immigrants who have been in Norway for more than 5 years have better incomes than those who have been in Norway fewer than 5.

Table 7.2. Immigrants' after-tax incomes per consumption unit by group, reason for immigration, residence, time, and statistics variables.

			2013	**2014**
			Median income (EU-scale)	**Median income (EU-scale)**
All Immigrants	**Work**	**0-2 years**	224500	233700
		3-5 years	281200	279200
		6-9 years	309000	313200
		10 years and over	370900	371300
	Family	**0-2 years**	210000	212200

		3-5 years	254000	255400
		6-9 years	271200	275500
		10 years and over	270400	279200
	Refugee	**0-2 years**	132600	139900
		3-5 years	192400	192700
		6-9 years	213500	216700
		10 years and over	247500	251600
	Education	**0-2 years**	24500	30100
		3-5 years	259700	261900
		6-9 years	322400	329500
		10 years and over	351200	362400

Source: Statistics Norway. *Income and wealth statistics for households,* Available at: https://www.ssb.no/statistikkbanken/SelectVarVal/saveselections.asp. Accessed 05.11.2017.

As presented in Table 7.2, immigrants' after-tax incomes vary according to their time in Norway, residence, and reason for immigration.

This paper investigates how immigrants' access to health care affects the economy of Norway and how those economic factors, in turn, affect immigrants' health.

Health care is currently seen immigrants as a fundamental human right.[267] Equity in health requires that, ideally, all individuals and groups have fair opportunities to attain their full potentials. This requires equal access to health services of good quality and the provision of those services according to individual needs. Immigrant health is considered a public health challenge in Norway[268] because immigrants constitute 10.6% of its total population. The number of immigrants in Norway has steadily increased since the 1960s and includes a higher percentage of young adults than the percentage in the entire population. Norway faces health challenges due to the high number of immigrants with varied educational backgrounds. Immigrants undergo many lifestyle, psychosocial, and biological challenges that contribute to their health problems. These challenges include inequalities in socio-economic and health

[267] World Health Organization, *The Right to Health Fact Sheet No. 31.* Geneva: WHO. 2008, p.9. Available at: http://www. who. int/hhr/activities/Right_to_Health_factsheet31. pdf. Accessed 07.03.2017.
[268] E. Diaz, A. Calderon-Larranaga, A. Prado-Torres, B. Poblador-Plou, L. Gimeno-Feliu, *How do immigrants use primary health care services? A register-based study in Norway,* The European Journal of Public Health, 25(1), 2014, p.72-78.

status, homesickness, and job insecurities.[269] In addition, the cost of providing health care to immigrants is a contentious issue to health-care policy makers.

The Norwegian legal framework contributes to securing equal access to good quality medical treatment by giving patients health service rights. For a patient to be treated at a hospital, the hospital admission must be approved by a doctor. Everyone who resides in a Norwegian municipality is entitled to registration as a patient with a primary doctor (GP). The Norwegian health service has been performed primarily through a Regular General Practitioners (RGPs) scheme (Norwegian: *fastlege ordning*) since 2001, in which individuals who are legal residents (i.e., all people who are registered in the Population Register as residents in Norwegian municipalities) have the right to have their own doctors. This system, however, does not include immigrants; therefore, they have to pay for their health-care expenses from their own pockets. The majority of immigrants in Norway face financial barriers to accessing health-care services; not only do they lack health insurance, but they also are not entitled to be registered with a GP. The public social security system in Norway is called the Norwegian National Insurance Scheme (*folketrygden*). Only members of the Norwegian National Insurance Scheme are entitled to benefits from NAV (the Norwegian Labor and Welfare Administration) health services (treatment by a doctor or psychologist or expenditure on medicines of major importance in long-term use). All personslegally residing in Norway are generally members of the Norwegian National Insurance Scheme. Persons with legal employment in Norway can become a member of the National Insurance Scheme from their first working day, even if they are not deemed to be a resident. Membership to Norwegian National Insurance is automatic for pesons with legal documents.

Employees pay a national insurance contribution of 7.8 percent of their gross incomes. The contribution is deducted together with tax. Some employees may be exempt from the Norwegian National Insurance Scheme because they belong to a social security scheme in their home country. In this case, they must document this with a certificate from the national insurance authorities in the country they come from.

Undocumented immigrants underutilize health care compared to the general population. Immigrants often use emergency rooms rather than GPs, because hospitals are mandated to provide care regardless of immigrants' residency status or ability to pay. Norway's National Insurance Scheme (NIS) is funded by general tax revenue, and the tax burden of Norway stands at 45% of the GDP. The government sets an overall budget that

[269] Ibid, Diaz, et al.

limits health expenditures, and with the addition of immigrants to the health-care system, the expenditures of the government are set to increase. This can affect the economy of the country. In addition, the expenditures increase because most immigrants are jobless,[270] and so they depend on the health-care system offered by the government.[271] Immigrants who are not members of the NIS do not have certain rights to health services. "Free hospital choice", however, does not allow immigrants to choose the hospitals in which they wish to be treated; undocumented immigrants are only entitled to immediate and necessary medical help. They are personally responsible for paying the hospital for medical attention received.

2. The Impacts of Refugees and Immigrants on the Economy

Norway is an attractive destination for migrants from many backgrounds because of its wealth, safety, stability, and welfare. It is estimated that there were 23,000 asylum seekers in 2015 and that there will be 33,000 asylum seekers in 2016. This involves huge costs. It has already been announced that several estimates must be adjusted upward. There will be additional costs of several billion kroner in 2016. Should 40,000–50,000 asylum seekers be granted residence, the expenses will be 40–50 billion over the next five years,"[272] according to Erna Solberg, the Norwegian prime minister. It is also estimated that every non-Western immigrant costs Norway around 4.1 million NOK, on average, during their lifetime.[273] Many of those who come to Norway stay or are still staying at a reception center, and this costs money. The average number of reception center residents in 2010 was 17,911, according to Anne Siri Rustad, director of the Norwegian Directorate of Immigration. That means an average cost per asylum seeker of 136,000 NOK. Despite the high cost, asylum seekers and refugees are granted residence based on their need for protection—not their impact on public finances in Norway.

Immigrants from Asia and Africa have children with complex health problems and life histories. They are more dependent than other groups on government welfare schemes. The effects of increased immigration on public finances never fade away, since most of the immigrants have children and other health challenges. Many immigrants earn low wages and

[270] P. Longva, O. Raaum, *Unemployment and earnings assimilation of immigrants,* Labour, 16(3), 2002. p.469-489.
[271] L. Ku, *Why immigrants lack adequate access to health care and health insurance*, migrationpolicy.org. 2006.
[272] G. Ringheim, K Karlsen, P. Ottosen, *Asylsøkerne kan koste 40-50 milliarder de neste fem årene*, Dagbladet, 2015. Available at: http://www.dagbladet.no/2015/10/13/nyheter/innenriks/samfunn/politikk/flyktninger/41470688/. Accessed 27.12.2015.
[273] H. Storhaug, *Hvorfor forteller ikke mediene hva en ikke-vestlig innvandrer koster?* Aftenposten 19 May. 2013

receive relatively extensive assistance from the Norwegian government in the form of benefits and services. Public welfare needs to be developed because of the increase in the number of children and young people. In Norway, the net spending has increased markedly because the capacity in kindergartens, schools, infrastructures, and other public sectors have been expanded in order to meet the demand from new citizens.

Norway's fiscal policies are tighter than those of other countries, which makes both immigrants and non-immigrants more "profitable" for the state. The Norwegian health-care system requires patients to pay a fee for using health-care services unless they are granted an exemption card (*frikort*) [274] for user-fee groups 1 and 2.[275] Although the patient fee or patient charge is rather symbolic for Norwegian citizens, it can be a problem for some categories of immigrants. Therefore, some immigrants, such as undocumented immigrants, underutilize the health-care system, as they are not covered by health-care insurance. The cost of providing health care to undocumented immigrants is a contentious issue. Immigrants are, therefore, subjected to differential treatment based on their legal status. Municipalitieswith a certain limitations pay to provide the necessary health services for their inhabitants, including educational and health-care services to undocumented immigrants, but those costs represent a small percentage of their local budgets. Some refugees and poor labor migrants cannot afford or do not want to spend money on health-care services: they want to send money home.

3. Immigrants as Important Contributors to Economy

Education, income, and jobs are important for economy and access to health services. A healthy population contributes to economy because they provide human capital, a labor force, and entrepreneurship. Immigration supplies workers, which increases the GDP and helps avoid economic stagnation created by purely demographic forces—in particular, an aging workforce. Human capital has a noteworthy impact upon the utilization of general practitioner (GP) services. The contribution of immigrants to human and physical capital formation, entrepreneurship, and innovation are essential to sustained economy. The contribution to the labor supply made by the infusion of highly skilled immigrants (i.e., human capital) boosts Norway's capacity for innovation and technological change. The more knowledge, competences, experiences, and skills immigrants acquire, the more they can enhance their cognitive abilities, leading to efficient productive activity in the workplace.

[274] Å. Ringard, *Choice of Hospital* (Doctoral dissertation, University of Oslo). 2001, p.30.
[275] K. Stig, *Financing of Health Care in the Nordic Countries*. Nordic Medico-Statistical Committee. 2013, p.45.

Integrating immigrants into the labor market is important for reducing socioeconomic inequality and raising the GDP per capita through healthier labor force participation.

Involving immigrants as employees and entrepreneurs creates economic development and opportunities. Access to health-care for immigrants frees up human capital by facilitating earlier diagnoses and treatment of conditions. Healthy immigrants can use their knowledge, abilities, qualifications, and skills in the activities that stimulate economy and development. Economic inequalities, however, impair immigrants' well-being and limit economic activities. Employment provides income to immigrants and has an impact on immigrants' health and health-care equity. Immigrants contribute to the human capital development of Norway; they tend to contribute even more to the economy once they have learned Norwegian, can speak English, and become citizens. Highly educated immigrants are a huge asset for the Norwegian economy, which attracts scientists and engineers from all over the world. Immigrants with good educations bolster the workforce and add to the nation's overall economic activity. Some immigrants even create jobs and bring more customers into the supply chain, which in turn generates more revenue and resources. They also pay higher taxes than the costs they create for the Norwegian government.

Immigrants' access to health services can contribute to economy, and addressing immigrants' access can free up money, increase human capital, promote education, spawn innovation, and achieve sustained growth. There is a vital relationship between access to health services for immigrants, improving health and well-being, and making immigrants more productive.

Human capital is the collection of skills, education, experience, and talents being reinforced in the workforce to sustain and develop business practices and operations. Immigrants' contributions to human capital have various positive effects on economy and technological progress due to the knowledge and abilities that they can offer to further and develop the global economy.[276] Thus, the impact of human capital on economic development has been a very popular topic for several researchers around the globe. According to Ogunade (2011), "The intensive use of human capital accounts for increased productivity and technological growth that stimulates economic growth in terms of growth of GDP." Human capital is one of the key drivers for technological progress and economy.

[276] Organisation for Economic Cooperation and Development (OECD), *Development Co-operation Report 2013, Ending Poverty,* 2013, p.286. Available at: http://www.oecd-ilibrary.org/development/development-co-operation-report-2013_dcr-2013-en. Accessed 25.08.2017.

Immigrants are one source of human capital. An investment in human capital and in immigrants' health can provide a subsequent increase in productivity, which then leads to economic development. In order for the corporate world to succeed and promote technological progress and economy, an evaluation of immigrants' access to health care and an investment in human capital are required. These could enable businesses to acquire competent and qualified employees to complement the needs of the market and the organization.

In order to aid workforce development projects and human capital assessment, a "needs assessment approach" is required to overcome human resource issues such as skill deficiencies, untrained workers, lack of education, and other barriers. As asserted by Ogunade (2011), "needs assessment involves taking an inventory of skills, knowledge and competencies of a given workforce to determine if they can effectively fulfill organizational goals."[277] In other words, the needs assessment is an approach to determining whether there should be investment in the human capital and, if so, to what extent.

The impact of education on human capital is critical; workers must attain a certain level of skills, competencies, and talents to become effective contributors to technological progress and economy. Workers must be capable of a high percentage of productivity and efficiency in an effort to increase growth and development.

Investment in immigrants' health is a key part of investing in human capital; the non-utilization of immigrants' talents (human capital) and immigrant unemployment create huge costs for the economy as a whole. Unemployed immigrants suffer a loss of income and low living standards, and they are subject to low labor productivity. Many of them do not participate in paying taxes due to their lack of jobs. Further, unhealthy immigrants contribute less to the economy because they spend less; moreover, their excessive consumption of resources also affects the economy. The effects of immigrants' unemployment and lack of access to health services include recession, high government expenditure, and wasted resources.

There is a lack of research that assesses the contributions of immigrant human capital to national economy at the micro and macroeconomic levels.

The growth of the immigrant population in Norway could be explained by the open border policies across Europe, primarily associated with labor migration. Norway was favored by immigrants to work and live in for many years. This fact is indicated by the upward

[277] A. O. Ogunade, *Human capital investment in the developing world: an analysis of praxis.* 2011, p.6.

immigrant population trend. Vatne Pettersen and Østby (2013) argued that immigration to the Scandinavian region could be a manifestation of the gradual opening of countries' borders, initially within the Nordic countries—including Norway—and then throughout the European Union. Historically, Norway and other Nordic countries—including Denmark, Finland, Iceland, and Sweden—have had a common labor market since the mid-1950s.

Moreover, Nordic countries have been part of the open European labor market due to their memberships in the European Economic Area (EEA). Because of such open-border agreements in the EU and the EEA, "citizens have been able to freely live and work in another Nordic country, and that this right has largely been extended to all EU/EEA citizens."[278] The open-border policies in the EU/EEA regions are a vital driving aspect for the large population of immigrants in Norway coming from these regions.

Aside from the open-border policies, another likely justification for the growing immigrant population in Norway is the opportunity for employment in the country. This is evidenced by the country's current labor shortage. The Norwegian Employers' Confederation (NHO) stated that Norway faces a shortage of labor due to the positive and continuous development of the country's economy.[279] Labor demands increase in parallel with economy, and meeting such labor demands of the various economic sectors could pose a challenge in a country. If labor demands are not satisfied by the native-born labor force, then it could result in an influx of immigrants to the country to meet the demands. Simply put, immigrants coming to Norway contribute considerably to the labor market in the country, but the economic policies related to immigrants' access to health care and keeping them healthy enough to contribute to society differs within the health-care institutions and the hospitals.

The contribution of immigrants to a country's labor market varies and can also be influenced by the immigrants' demographic backgrounds. One such demographic-related variable is their educational level. Norway has an immigrant workforce that is highly educated. For example, around 30 percent of the immigrant population are graduates of tertiary education (four years and over).[280] This implies that a huge fraction of the immigrant population in Norway is highly skilled; thus, they have a higher likelihood of landing high-wage jobs in the various sectors where high levels of competencies are required. It might also

[278] S. V. Pettersen, L. Østby, *Skandinavisk komparativ statistikk om integrering. Innvandrere i Norge, Sverige og Danmark.([Scandinavian comparative statistics on integration. Immigrants in Norway, Sweden and Denmark]),* Samfunnsspeilet, 5(7). 2013, p.77. Available at: https://www.ssb.no/en/befolkning/artikler-og-publikasjoner/immigrants-in-norway-sweden-and-denmark. Accessed 14 october 2017.
[279] R. Solholm, *Norway Faces Shortage of Labour,* 2016 [Online]
Available at: http://www.norwaypost.no/business/general-business/11864-. Accessed 14 January 2017].
[280] OECD , *Education at a Glance 2011: OECD Indicators*, OECD Publishing, Paris, 2011, p.183

explain why a majority in the immigrant labor force landed in the top sectors, where educational attainment and competencies are of utmost consideration, including the health-care industry, administrative and support service sectors, and other fields. However, about 24 percent of the immigrants still had unreported education after a 2011/2012 survey, and for some immigrant groups, the labor participation rates are still quite low.[281]

Immigrants' income is taxed in Norway, and the immigrant population has since a certain period had high levels of after-tax income. Immigrants can be found working in most sectors of the economy. Therefore, it could be suggested that the importance of immigrants to the economy of Norway lies in their tax and social contributions. This supports the recurring arguments that highlight the positive fiscal impact of immigrants to a country. A 2013 report by the Organization for Economic Co-operation and Development (OECD) indicated that in some countries in Europe, including Norway and Switzerland, the influxes of immigrants to these countries have been estimated to contribute a net benefit of around 2% of the GDP to the country's wealth.[282] Increasing the labor-market integration of existing resident immigrants offers potentially higher fiscal gains than increasing the influx of new immigrants. It is important to stress, however, that immigrants' contributions in the form of taxes to finance national expenditures are most likely less than those of their native-born counterparts in the labor force.[283]

Regarding the health-care utilization, immigrants use emergency health-care services neither less nor more than the native-born Norwegians. Immigrants as a group go to the GP and emergency care less often than the general population. Health-related consultations, especially those concerning urgent matters, could translate to expenses for the household, and those expenses could impact the level of income one earns during a certain period.

Briefly, healthy and employed immigrants contribute significantly to the labor market in the form of offsetting the labor shortages in the country. Additionally, immigrants effect a positive economic impact through their tax and social contributions, which add to the public purse. Immigrants' human capital, additional labor force, and entrepreneurship are identified as important economic production factors.

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[281] B. Dapi, H. M. Gjefsen, V. Sparrman, N. M. Stølen, *Education-specific labour force and demand in Norway in times of transition.* 2016, p.26.

[282] OECD, *"The fiscal impact of immigration in OECD countries"*, in International Migration Outlook 2013, OECD Publishing, Paris, 2013, p.128.

[283] OECD (2008), "The labour market: supply constraints and immigration", in *OECD Economic Surveys: Norway 2008*, OECD Publishing, Paris. 2008, p.74.
available at: http://dx.doi.org/10.1787/eco_surveys-nor-2008-5-en. Accessed 10 november 2017.

4. Origin and Employment of Immigrants

The total registered population living in Norway as of October 1, 2014 was 5,156,451. In January 2016, the total registered population living in Norway was 5,252,166 (Figure 6.3). This is a growth of 48,183. According to Statistics Norway's Information Center, as of January 1, 2017, around 725,000 persons residing in Norway were immigrants, and around 159,000 were persons born in Norway to two immigrant parents. These people are included as immigrants. Compared to Sweden and Denmark, Norway's labor immigration from the EU has been relatively high. There were increasing numbers of immigrants moving to Norway for work after 2005, particularly because of the expansion of the EU in 2004.

In the last two years, the numbers of immigrants from various parts of the world have increased. Immigrants are mostly from Western and Asian countries, though there are also immigrants from other parts of the world, such as African and South and Central American countries.[284] In Norway, there are immigrants from:

- South Asia (mostly Pakistan and Sri Lanka),
- East Asia (mostly China),
- Southeast Asia (e.g., the Philippines),
- Eastern Europe (mostly Russia and Poland, but since the 2004 EU expansion, there has also been a substantial influx from Estonia, Latvia, and Lithuania),
- Southern Europe (Greece, Albania, and the former Yugoslavian states),
- Turkey,
- the Middle East (especially Iraq and Palestine),
- Africa (Somali and Morocco), and
- Latin America.

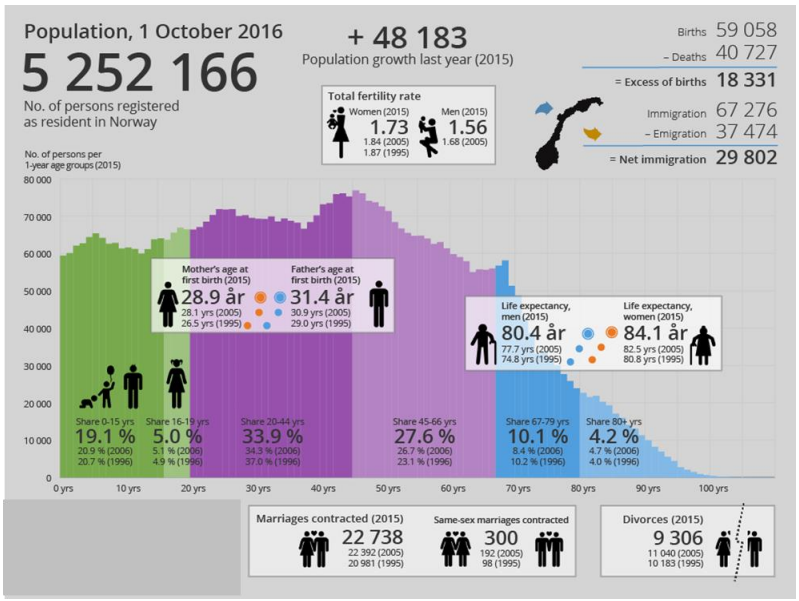
As of 2012, 86.2 percent of the total Norwegian population had at least one parent who is born in Norway. More than 660,000 individuals (13.2%) were migrants and their descendants, including 110,000 second-generation migrants born in Norway. Of these immigrants and their descendants:

- 335,000 (51%) have a Western origin (Australia, North America, elsewhere in Europe), and
- 325,000 (49%) have a non-Western origin (Morocco, Iraq, Somalia, Pakistan, Iran).

[284] Utlendingsnemnda,Op.Cit. p.112

In 2012, of the 660,000 persons with immigrant backgrounds, 407,262 had Norwegian citizenship (62.2%). Immigrants were represented in all Norwegian municipalities. In 2012, the cities or municipalities with the highest share of immigrants were Oslo (26%), Drammen (18%), and Stavanger (16%). Today, Oslo is the fastest growing city in Europe because of its increased immigration. In recent years, immigration has accounted for most of Norway's population growth. In 2011, 16% of newborn children were of immigrant background.[285] Norway has a youth unemployment rate of approximately 7% and a general rate of unemployment of about 2.8%, which is particularly low compared to other countries.[286] There are many employment opportunities, and the government is trying to attract able men and women to work in the country. Table 7.3 shows that the number of employed people in Norway increased by 30,000 from the fourth quarter of 2012 to the fourth quarter of 2013. Of these, 24,450 were immigrants. Hence, immigrants contributed to more than 80% of the employment growth. Immigrants from the EEA countries contributed to most of this growth.[287]

Figure 7.2. Key figures for the population size, composition, and development.



Source: Statistics Norway, *befolkning.* Available at: http://www.ssb.no/befolkning. Accessed 02.22.2017.

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[285] Statistics Norway, *Three categories of immigration background, country of birth and citizenship by country background and sex. 1 January 2012*, Statistics Norway, 2012.
[286] United Nations Regional Information Centre for Western Europe, *Mass Immigration to Norway*, Unric.org. 2015. Available at: http://www.unric.org/en/youth-unemployment/27413-mass-immigration-to-norway. Accessed 29 December 2015.
[287] Statistics Norway, *How different are youth with background from Eastern-Europe outside the EU, Asia, Africa and South- and Central-America compared to the majority?* Available at: http://www.ssb.no/arbeid-og-lonn/artikler-og-publikasjoner/employment-and-education-among-young-immigrants-and-norwegian-born-to-immigrant-parents. Accessed 17.07.2017

Figure 7.2 provides some information about Norway's population size, composition, and development. This information is an important basis for policy, planning, and decision-making in various areas of society. The age distribution in Figure 7.2 affects the demand for education and study places, the share of the working population, and the need for health and social services. Figure 7.2 also shows the regional distribution of the population. This regional distribution provides an important framework for counties and municipalities.

The factors that determine population growth are deaths, births, and people moving into and away from Norway.

Table 7.3. Employed total population and employed immigrants by world region. Absolute figures and percent of persons aged 15—74 years in each group, 4th quarter

	2013		Change last twelve months	
			2012–2013	
	Absolute figures	Percent	Absolute figures	Percentage points
Population in total	2,619,000	68.6	30,000	-0.1
Non-immigrant population	2,260,579	69.5	5,551	-0.2
Immigrants, total	358,421	63.1	24,449	0.3
The Nordic Countries	47,824	76.3	1,145	0.2
Western Europe except the Nordic Countries and Turkey	41,390	70.7	2,101	0.7
EU members in Eastern Europe	102,846	72.9	11,550	0.1
Eastern Europe outside of EU	30,079	62.8	1,607	0.7
North America and Oceania	6,621	66.0	120	-0.4
Asia	91,173	55.2	5,255	0.6
Africa	26,794	41.9	2,091	-0.6
South and Central America	11,694	63.1	580	-0.1

Source: Statistics Norway. *Arbeid og lønn*. Available at: https://www.ssb.no/183599/employed-total-population-and-employed-immigrants-by-world-region.absolute-figures-and-in-per-cent-of-persons-aged-15-74-years-in-each-group.4th-quarter. Accessed 04.22.2017.

As shown in Table 7.3, the number of employed immigrants from EU countries in Eastern Europe increased by 11,550, and many of those persons were settled in Norway in 2013. If we add immigrants from other EEA countries, there was a total growth of almost

14,800 employed among these groups. Among other immigrant groups, Asians had the highest increase, with 5,255 employed.

In spite of the strong growth in the number of employed immigrants during the last year reported, the employment rate among immigrants only increased by 0.3 percentage points, from 62.8 percent in 2012 to 63.1 in 2013 (employed immigrants as a percentage of the immigrant population aged 15–74 years). This is due to growth in the immigrant population. Within the Norwegian population (same age), including migrants as a whole, the employment rate was 68.6 percent, which was 0.1 percentage point below the level of 2012. This small decrease is due to growth in the population aged 67–74 years.

5. Differences in Employment and Differences among Immigrants

There is a disparity of 5.5 percentage points in the employment rate between immigrants and the whole Norwegian population within the age group 15–74 years. Looking at the more occupationally active age groups, larger differences emerge: 11.6 percentage points (25–39 years) and 13.3 percentage points (40–54 years). The majority of the population has a much higher share than immigrants of people aged 67–74 years. This age group has a very low employment rate and, thus, reduces the average within the whole population aged 15–74 years.

Among immigrants (15–74 years), 67.9 percent of the men and 57.7 percent of the women were employed in the fourth quarter, a difference of 10.2 percentage points. In the whole population, the gender difference was smaller. A total of 71.4 percent of the men and 65.6 percent of the women were employed, a difference of 5.8 percentage points. It also follows that there is a larger employment gap among immigrant women than among immigrant men.

Immigrants from the EEA countries, who mainly consist of labor immigrants, have considerably higher employment rates than other immigrants. Employment rates among these groups in the fourth quarter of 2013 were as follows: 76.3 percent (the Nordic countries), 72.9 percent (EU countries in Eastern Europe), and 70.7 percent (Western Europe). Next, immigrants from North America and Oceania had a 66 percent share of the employment rate, while immigrants from South and Central America and Eastern Europe outside the EU both had rates of about 63 percent. The rate for the Asian group was somewhat lower, at 55.2 percent, while immigrants from Africa were lower still, at 41.9 percent employed. These disparities have been stable irrespective of economic cycles. Immigrants from Asia and

especially Africa include a larger share of persons who have had a shorter residence in Norway than other groups. With a longer time of residence, employment levels ascend within most immigrant groups, but differences among groups do not level out. Even among those with ten years or more of residence in Norway, African immigrants have the lowest employment rate, far below the immigrant average.

In addition, there are low employment rates among many African and Asian women (irrespective of time of residence), which pulls down the average within these groups. This phenomenon applies both to established groups, such as the Pakistanis and the Turkish, and to more recently arrived immigrants from Afghanistan, Somalia, and Iraq.

6. Labor Immigration

Immigrants increase economic efficiency by reducing labor shortages in low- and high-skilled markets because their educational backgrounds fill holes in the native-born labor market.[288]

Table 7.4. Immigrants by reason for immigration

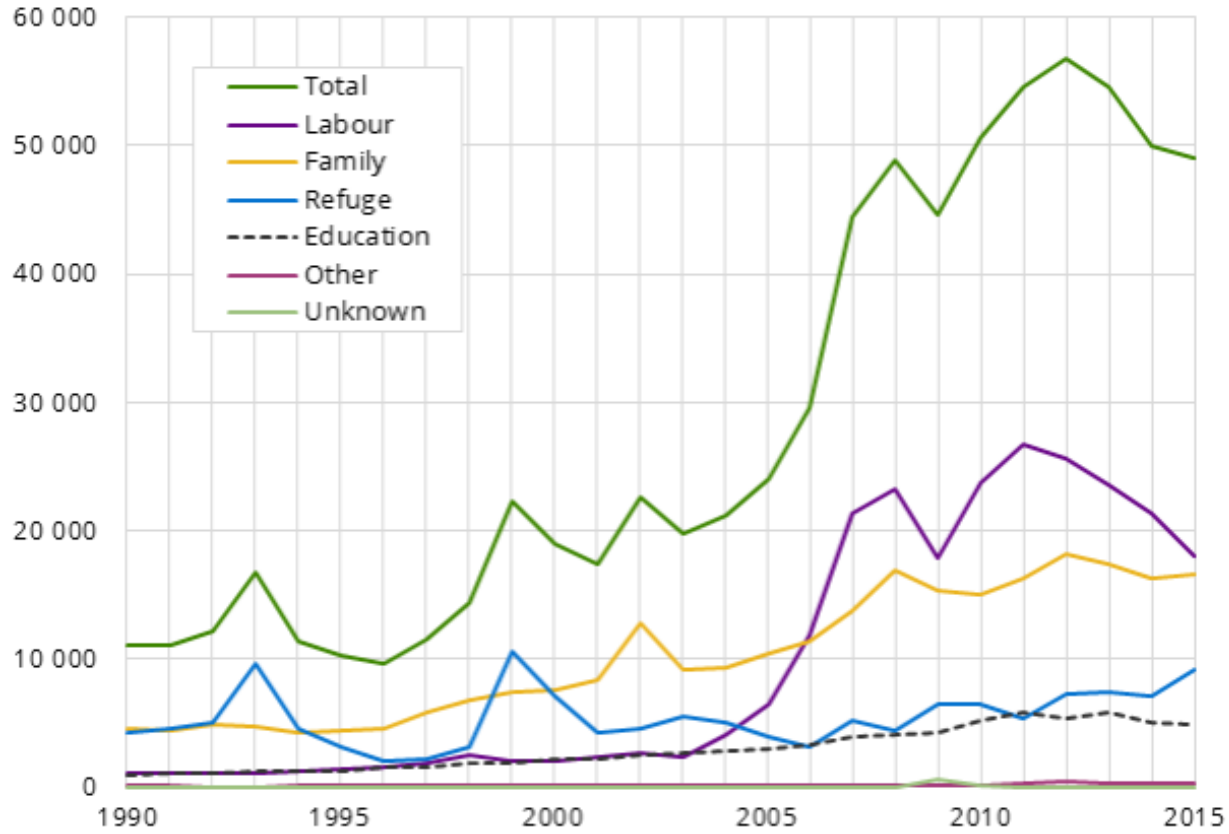
	2013	Change by percent		Total immigration since 1990
		2012–2013	2003–2013	
Total	54,394	3.9	174.8	635,943
Labor	23,517	-7.9	888.5	206,979
Family	17,400	-3.8	88.8	231,769
Refugee	7,326	3.3	33.0	123,998
Education	5,852	7.85	124.6	66,646
Other	299	-34.7	243.7	3,212

Source: Statistics Norway. *Immigrants by Reason.* Available at: https://www.ssb.no/en/befolkning/statistikker/innvgrunn/aar/2014-09-04. Accessed 11.09.2016.

As shown in Table 7.4, over 54,500 persons with non-Nordic citizenship immigrated to Norway in 2013.[289] This is a decrease of 2,200 persons compared with the record year, 2012. People come to Norway when they have work permits, including seasonal workers, specialist workers, *au pairs*, and trainees. The largest decrease was among labor migrants, but the numbers were still high.

[288] Rickard, V. A. *International Influences on United States Domestic Policy*.
[289] Statistics Norway. Available at: http://ssb.no/. Accessed 10.11.2016

Figure 7.3. Immigrants by reason for immigration**.**

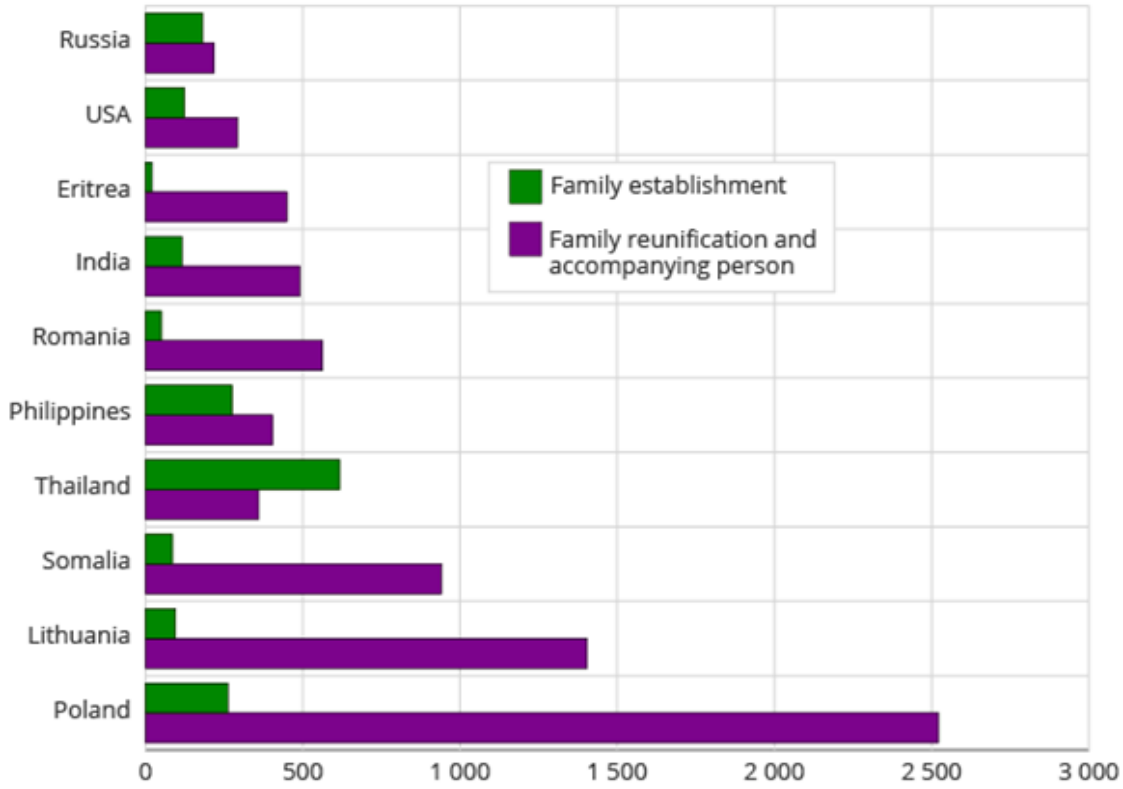


Source: Statistics Norway.

Source: Statistics Norway. *Befolkning.* Retrieved 03.15.2017 from https://www.ssb.no/en/befolkning/statistikker/innvgrunn/aar/2014-09-04

Figure 7.3 shows the largest increase of immigrants in Norway from 1990 to 2015. Labor immigration showed the largest decrease. The number of refugees and the number of immigrants moving for family reasons show a significant increase compared with the previous year.

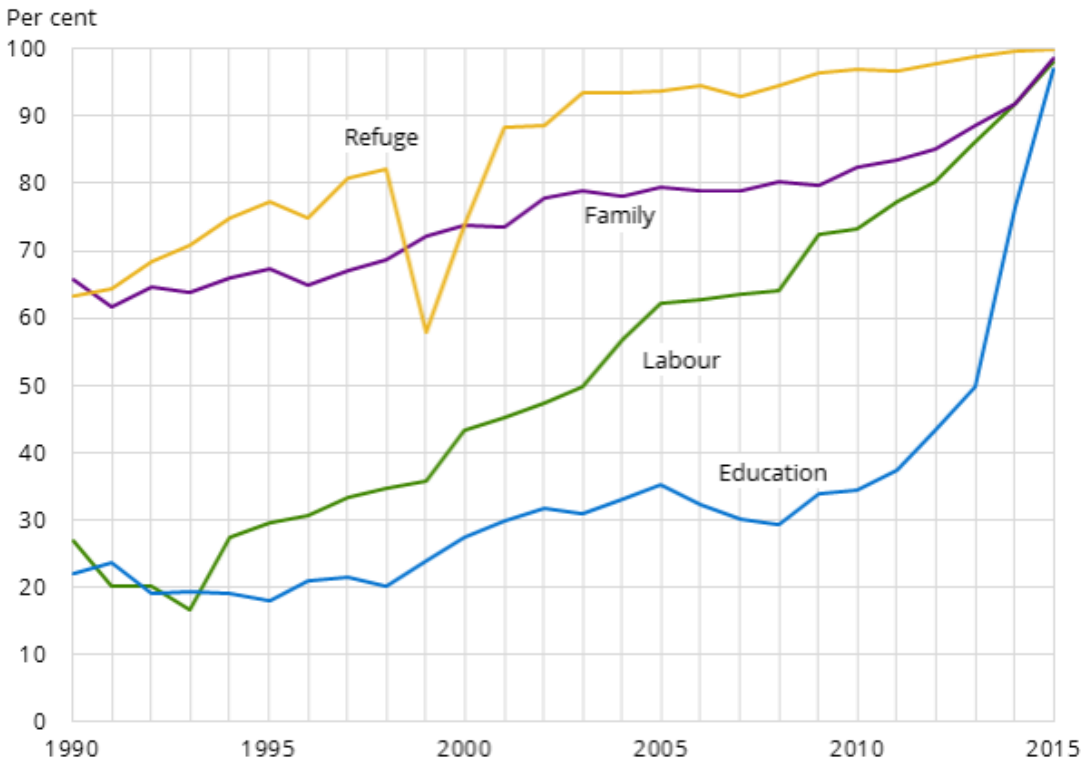
Figure 7.4. Family immigration, the 10 largest groups in 2013**.**



Source: Statistics Norway. *Befolkning*. Available at: https://www.ssb.no/en/befolkning/statistikker/innvgrunn/aar/2014-09-04. Accessed 06.06.2017.

Figure 7.4 shows that Poland had the largest immigrant group in Norway, followed by Lithuania, Somalia, and Thailand. Their reasons were family reunification and to accompany someone. Persons from Thailand were the largest group to immigrate through family establishment.

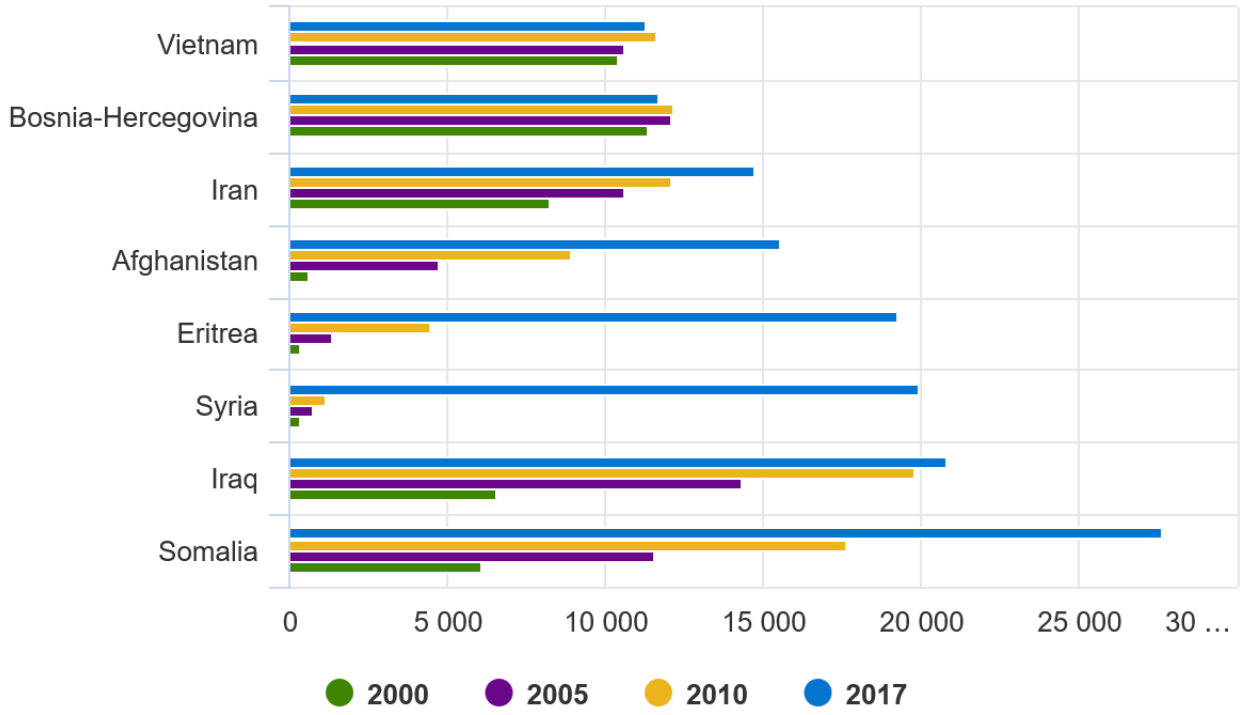
Figure 7.5. Resident Immigrants, by reason for and year of immigration**.**



Source: Statistics Norway. *Befolkning,* Available at: https://www.ssb.no/en/befolkning/statistikker/innvgrunn/aar/2014-09-04. Accessed 07.14.2017.

Figure 7.5. represents a view of resident immigrants by reason for and year of immigration. We can see that the number of refugees saw a significant increase compared with the previous year, especially from Syria; 2,200 more persons were registered as refugees in 2015 than in 2014. Labor immigration was still high in 2015.

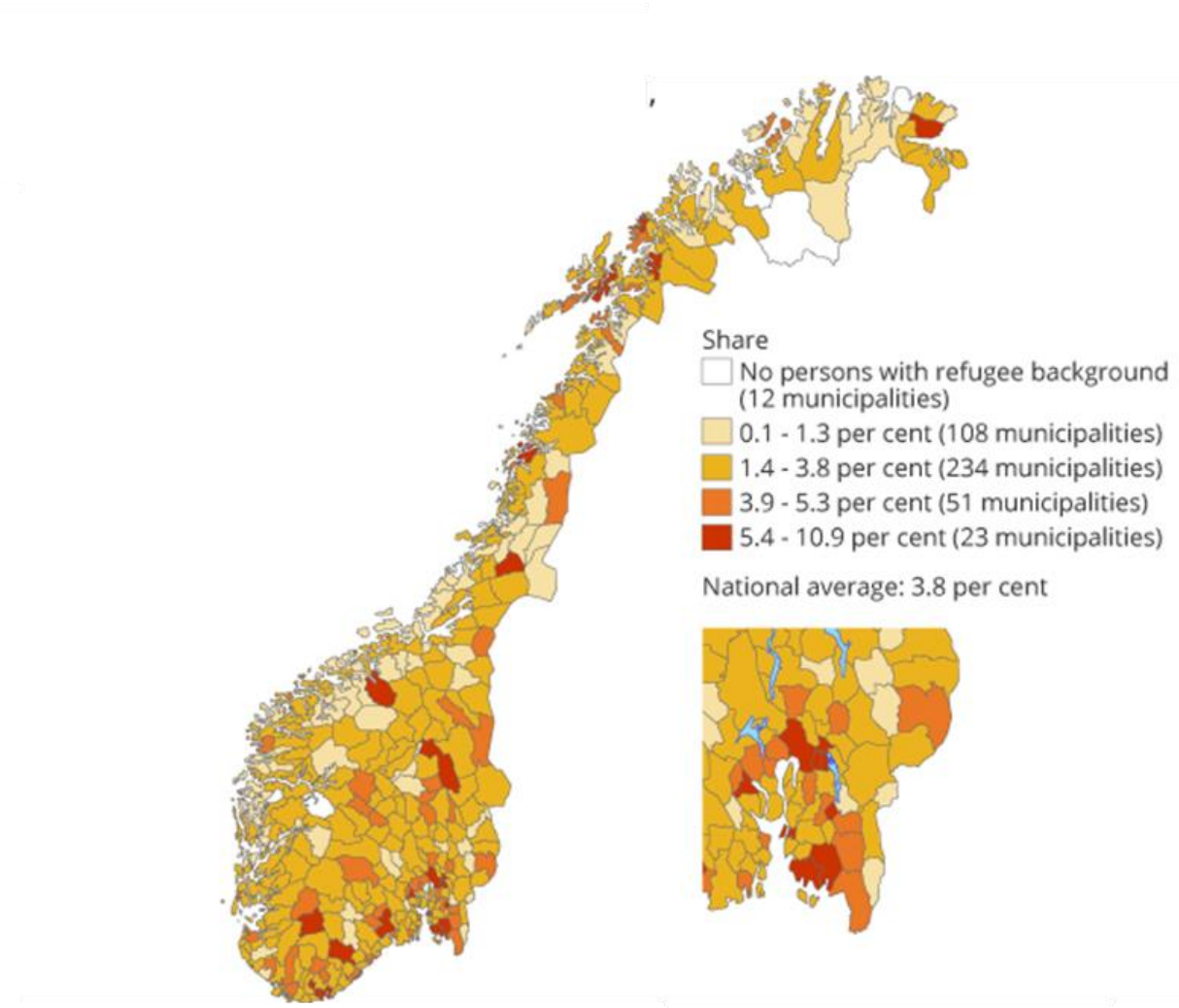
Figure 7.6 Persons with refugee background as presented September 4, 2014.



Source: Statistics Norway. *Befolkning,* Available at: http://www.ssb.no/en/befolkning/statistikker/innvgrunn/aar/2014-09-04. Accessed. 10.10.2016.

Figure 7.6 presents persons with refugee backgrounds. According to Statistics Norway, a total of 217,200 persons with refugee backgrounds were living in Norway on January 1, 2017, corresponding to 30 percent of immigrants in Norway and 4 percent of the total population. Somalia, Iraq, Syria, and Eritrea are still the largest group with the highest proportion of family immigrants.

Figure 7.7. Persons with refugee backgrounds—Portion of total population in the municipality**.**



Source: Statistics Norway, *befolkning.* Available at: https://www.ssb.no/en/befolkning/statistikker/flyktninger/aar/2016-06-17. Accessed 06.25.2017.

Figure 7.7 shows persons with refugee backgrounds living municipalities in Norway on January 1, 2016. In 416 of the country's 428 municipalities, there were persons with refugee backgrounds. In 34 of these municipalities, more than 1,000 persons had refugee backgrounds. Oslo had the most residents with refugee backgrounds, with 46 600, followed by Bergen (10,300) and Trondheim (6,800). According to Statistics Norway, persons with refugee backgrounds constituted 7 percent of the capital's entire population, but the highest share of persons with refugee backgrounds as of January 1, 2016, was in Vadsø municipality, where this group made up 11 percent of the population.

Table 7.5. Persons with refugee backgrounds by citizenship, sex, country background, and time.

Persons with refugee background, by citizenship, sex, country background, and time					
	2013	**2014**	**2015**	**2016**	**2017**
	Refugees	**Refugees**	**Refugees**	**Refugees**	**Refugees**
Refugees with Norwegian citizenship					
Males					
Western Europe	108	115	116	119	129
Eastern Europe	11,951	12,139	12,379	12,499	12,534
Africa	11,851	12,733	13,703	14,446	15,817
Asia including Turkey	30,772	32,561	34,663	36,026	37,226
North-America and Oceania	28	30	29	32	32
South and Central America	2,221	2,222	2,243	2,242	2,240
Unknown and other	0	0	0	0	0
Females					
Western Europe	100	102	109	112	125
Eastern Europe	11,868	12,080	12,316	12,430	12,509
Africa	10,621	11,575	12,622	13,395	14,720
Asia including Turkey	26,623	28,239	30,089	30,976	32,094
North-America and Oceania	26	25	23	20	18
South and Central America	2,164	2,168	2,191	2,191	2,204
Unknown and other	0	0	0	0	0

Source: Statistics Norway. *Statistikkbanken.* Available at: https://www.ssb.no/statistikkbanken/SelectVarVal/saveselections.asp. Accessed 06.05.2017.

Table 7.5 provides information about persons with refugee backgrounds by sex and citizenship in 2014. The total number of refugees with Norwegian citizenship in 2014 was 113,989. Asia, including Turkey, was overrepresented, with 60,800 persons with refugee backgrounds and citizenship, compared to other groups of refugees from Western Europe, Eastern Europe, Africa, North-America, and Oceania and South and Central America. The total number of persons with refugee backgrounds and Norwegian citizenship increased in 2017. They were granted Norwegian citizenship when their identities were verified. The reasons for immigration were conflict in the home country, a need for work, and to have better lives in Norway. In general, work opportunities are viewed as the major reason for the non-Nordic immigration to Norway from 2012 to 2017. According to Statistics Norway, labor

was the reason for immigration for 43% of immigrants in 2013, while one-third came because of family.[290] Flight and studies were responsible for 13 percent and 10 percent, respectively.

Labor immigration in 2013 decreased by about 8 percent from 2012 but was still one of the highest levels ever recorded. A total of 23,500 persons from non-Nordic countries immigrated due to labor in 2013. Seven out of ten of these came from the new EU countries. Labor immigrants from Poland made up the largest group in 2013, with 7,000 persons. Lithuanian labor immigrants followed with 3,900 persons.

There were fewer family immigrants reported. Family immigration in 2013 decreased by about 4 percent compared with 2012. A total of 17,400 persons immigrated for family reasons. Family immigration includes persons who immigrate through family reunification and those who immigrate through family establishment. The two largest groups of family immigrants were Poles (2,800) and Lithuanians (1,500). Out of the 17,400 persons who came to Norway due to family reasons in 2013, 13,200 came for family reunification and 4,200 for family establishment through marriage. Of those who came to Norway due to marriage, 54 percent had a spouse with an immigrant background.[291]

Compared with 2012, 200 more persons came to Norway due to refugee flight, with a total of 7,300. Despite the increase, this group made up only 13 percent of non-Nordic immigrants in 2013. Most of this group was from Eritrea (2,100) and Somalia (1,500). The number of refugees from Syria saw a significant increase, from 300 persons in 2012 to 700 persons in 2013.

A total of 5,900 persons immigrated in 2013 for educational or social exchange. This was a slight increase compared with the previous year. There were many immigrants from the Philippines in this group (1,900 persons, or 33%). The number of registered persons from the Philippines was so high because the *au pair* permit is considered to be a type of education permit. One-third of the immigrants with education permits came from the Philippines.

Not everyone who immigrates to Norway stays for the rest of his or her life. A total of 636,000 persons with non-Nordic citizenship immigrated to Norway between 1990 and 2013, but only 7 percent were still living there at the beginning of 2014. People's reasons for immigration have a bearing on whether they stay. Of those who immigrated due to flight, 85 percent were still living in the country on January 1, 2014. The corresponding percentage for those who immigrated for education was just 42 percent. A total of 179,500 persons with

[290] Statistisk Norway, *Persons with refugee background by sex and citizenship.* Available at: https://www.ssb.no/195071/persons-with-refugee-background-by-sex-and-citizenship. Accessed 13.03.2016.
[291] Statistisk Norway, *Persons with refugee background by sex and citizenship.*

refugee backgrounds were living in Norway on January 1, 2014. This made up 3.5 percent of the total population and 28.4 percent of all immigrants in Norway. In 2013, the number of persons with refugee backgrounds increased by 7,900. The largest increase was among persons from Eritrea, Somalia, and Syria (2,300, 2,000, and 1,000, respectively). Somalis are the largest group of refugees, with a total of 25,000 persons, followed by persons from Iraq and Iran (20,500 and 13,600, respectively). Persons with refugee backgrounds are present in 409 of 428 the Norwegian municipalities. As of 2014, in 32 of these municipalities, more than 1,000 persons had refugee backgrounds. Oslo had the most (44,600), followed by Bergen (9,600), and Trondheim (6,000).

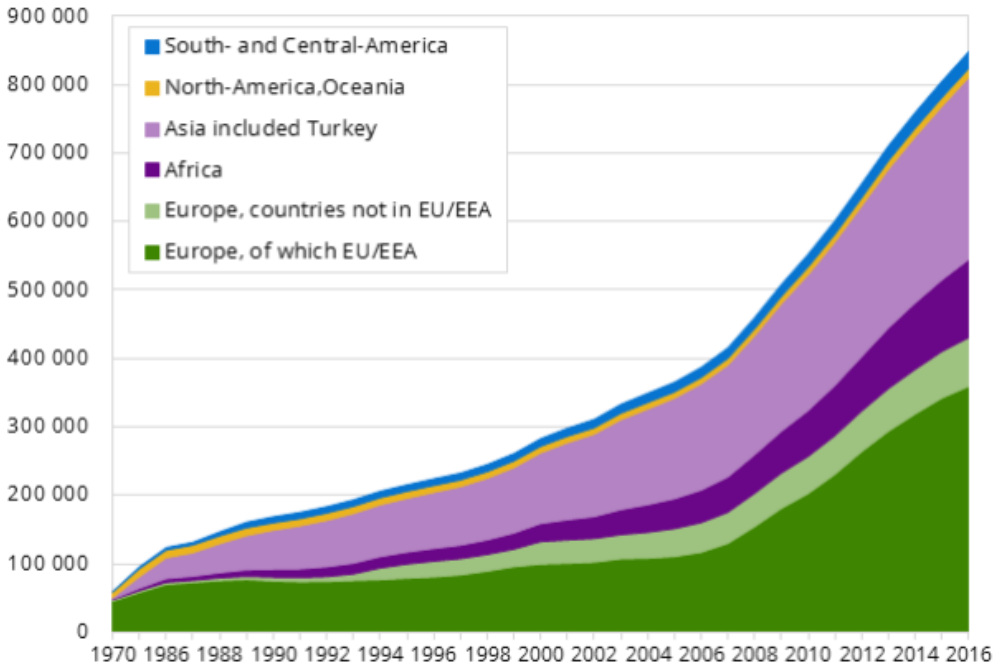
Table 7.6. Immigrants and Norwegians born to immigrant parents, by country background. January 1, 2014.

	Immigrants and Norwegians born to immigrant parents, total	**Immigrants**	**Norwegians born to immigrant parents**	**Immigrants and Norwegians born to immigrant parents in % of total population**
Total	759,185	633,110	126,075	14.9
The EU/EEA, USA, Canada, Australia, and New Zealand	331,590	307,188	24,402	6.5
Asia, Africa, Latin America, Oceania except Australia and New Zealand, and Europe except the EU/EEA	427,595	325,922	101,673	8.4
Nordic countries	75,315	70,282	5,033	1.5
Western Europe except Nordic countries	72,309	67,098	5,211	1.4
EU-countries in Eastern Europe	171,406	157,728	13,678	3.4
EU except Eastern Europe	65,160	52,071	13,089	1.3
Africa	97,152	74,283	22,869	1.9
Asia including Turkey	242,699	179,785	62,914	4.8
North America	10,438	10,018	420	0.2
South and Central America	22,656	19,853	2,803	0.4
Oceania	2,050	1,992	58	0.0

Source*:* Statistics Norway. *Befolkning*. Available at: https://www.ssb.no/en/befolkning/statistikker/innvbef/aar/2014-04-24. Accessed 05.05.2017.

Tables 7.5 and 7.6 show that at the beginning of 2014, there were 633,100 immigrants and 126,100 Norwegians born to immigrant parents in Norway. These two groups come from 221 different countries and independent regions. Immigrants from Poland make up the largest immigrant group in Norway.

Figure 7.8. Norwegians born to immigrant parents and immigrants, by country background.



Source: Statistics Norway. *Beforlkning,* Available at: https://www.ssb.no/en/befolkning/statistikker/innvbef/aar/2016-03-03. Accessed 04.04.2017.

Figure 7.8 illustrates how the number of immigrants and Norwegians born to immigrant parents grew by 48,700 in 2013, which is the lowest percentage of growth since 2006. Immigrants accounted for 12 percent of the total population in Norway as of January 1, 2014, while Norwegians born to immigrant parents accounted for 2 percent. The growth in the Polish immigrant group during 2013 was 7,300. With a total of 84,000 persons, immigrants from Poland made up the largest immigrant group. The second largest immigrant group was persons with Swedish backgrounds (36,400). The third largest immigrant group was Lithuanians (33,000).[292] In 2013, the number of Norwegians born to immigrant parents

[292] Statistics Norway, *Norwegians Born to Immigrant Parents and Immigrants, by Country Background*, Available at: https://www.ssb.no/en/befolkning/statistikker/innvbef/aar/2016-03-03 http://ssb.no/. Accessed 15.03.2017.

increased by 9,000, from 117,100 to 126,100. Norwegians with Pakistani parents made up the largest group of all Norwegians born to immigrant parents, with 15,600. Norwegians born to Somali parents were the second largest group (9,800), followed by those with parents from Iraq (8,200).[293] The number of immigrants and Norwegians born to immigrant parents was still increasing in 2016 (Figure 7.8).

Table 7.7. Number of immigrants in Norway in 2014

Rank	Country of origin	Population (2014)
1.	Poland	91,179
2.	Sweden	38,414
3.	Somalia	35,912
4.	Lithuania	35,546
5.	Pakistan	34,447
6.	Iraq	30,144
7	Germany	26,683
8.	Vietnam	21,721
9.	Denmark	20,897
10.	Philippines	19,886
11.	Iran	19,793
12.	Russia	18,770
13.	Turkey	18,770
14.	Bosnia-Herzegovina	16,845
15.	Thailand	16,559

Source: *Statistics Norway*, Retrieved from https://www.ssb.no/statistikkbanken/selectvarval/saveselections.asp. Accessed 04.20.2017

The largest groups of immigrants in Norway in 2014 were from Poland, Sweden, Somalia, and Lithuania (Table 7.7).

[293] Wikipedia, *Demographics of Norway*. Available at: http://en.wikipedia.org/wiki/Demographics_of_Norway#cite_note-10. Accessed 3.01.2016.

CHAPTER VIII: METHODOLOGY

This chapter provides the methodological approach used to address the research questions.

1. Research Questions

Taking into consideration all the aspects of immigrants' health concerns and the barriers to ensuring their quality care in Norway, this thesis seeks to answer these main questions: Are health-care services and health-care facilities accessible to immigrants in Norway? Is the Norwegian health-care system responsive to immigrants' needs?
Additional questions include:

- What is the health status of immigrants in Norway?
- What is the quality of the care services for immigrants in Norway?
- What are the experiences and challenges in regard to immigrants' access to health care?
- How do documented and undocumented immigrants access access to health care in Norway?
- Do undocumented immigrants contribute to the Norwegian health-care crisis?
- Are there correlations among immigrants' incomes, educations, and health?
- Are immigrants important to economy?

2. Research Hypothesis

There are differences in the access to health services between Norwegian citizens and immigrants, as well as among immigrants themselves. The differences among immigrants depend on their origins, sexes, incomes, and educations and there is a relationship between the state of health and the availability of health services.

3. Research Approach

The main objective of the study was to examine the health statuses of immigrants in Norway and their access to the health-care system in order to address how immigrants' access to health-care services impacts economy for Norway. I used interdisciplinary research methods because different knowledge sectors were needed to contribute to the understanding of the complex area of immigrants' health. Diciplines included are: epidemiology, demography, medical geography, social policy, public health, political sciences. My motivation for choosing interdisciplinary research includes a desire to engage with "real world" problems, tackle socially relevant issues, and contribute to the advancement of academic disciplines. Interdisciplinarity analyzes, synthesizes, and harmonizes links between disciplines into a coordinated and coherent whole.[294] The interdisciplinary health research approach is a mechanism for answering complex health questions more completely. This integration involved collecting supplemental qualitative data and using information from interviews with participants about immigrants' health statuses and their access to health care. These interviews were unstructured and structured and lasted 15 to 20 minutes with survey questionnaires, the interviews included the observation method and also literature. The participant observation method was used to gain a deeper understanding of and familiarity with immigrants and their economic activity, beliefs, values, and ways of life. This dissertation also employed a quantitative approach.

The aim of using these methods was to thoroughly "get inside" the way immigrants perceive their access to the health-care system in Norway. Interdisciplinary research allowed me to become immersed in the economic setting of Norway, thereby generating rich insights into social policy and health policy, immigrants' health statuses in relation to their access to health services, and how immigrants' health, incomes, and educations are linked.

The dissertation collected secondary data from key archives and statistics databases, including the data repositories from the National Statistics Bureau of Norway (Statistics Norway) and OECD Statistics. Statistics Norway is the official statistics agency of Norway and carries the overall responsibility of research and analysis activities, primarily for official statistics in the country. Statistics Norway produces statistics on population and living conditions, resources and the environment, the economy and national accounts, and government-related activities.

[294] B. C. Choi, A. W. Pak, *Multidisciplinarity, interdisciplinarity, and transdisciplinarity in health research, services, education and policy: 2. Promotors, barriers, and strategies of enhancement,* Clinical & Investigative Medicine, 30(6), 2007, p.224-232.

4. Setting and Sample Population

The study population comprised 60 participants from three groups (Africans, Norwegians, and other Europeans) in Bergen, Norway. Convenience sampling was employed, which allowed the selection of any person available to participate based on proximity, accessibility, and possession of qualifications matching the study criteria.[295] Because of the personal data protection regulation for minorities in Norway, immigrant studies must recruit participants based on their availability.

Inclusion Criteria

The sample consisted of 20 people from Africa, 20 from Europe, and 20 from Norway. Of the 60 individuals interviewed, 45 were male and 15 were female. The age range for respondents was between 18 and 56 years old. The interviews took place in a local coffeehouse, hospital, and other public places (reception centers for immigrants) in Bergen, Norway, between September 2015 and January 2016. It took five to eight minutes to persuade them and have a conversation.

Exclusion criteria

People under 18 years old, those with criminal records, and those currently under criminal investigation were excluded from this study with regard to protections from risks in research.

5. Access to the Research Field

The methodology was divided into four segments of equal importance. In the first segment, I used a pilot study to identify potential practical problems in following the research procedure, uncover local politics or problems that may affect the research process, and assess the feasibility of my study. In the pilot study, I asked people for feedback to identify ambiguities and difficult questions. The results of the pilot study showed that some questions were ambiguous in meaning and required changes to enhance clarity and conciseness. Extra words were added to the questions or the questions were entirely reframed to ensure that

[295] A. Crossman, *Convenience Sample*, 2013. Available at: http://sociology.about.com/od/Types-of-Samples/a/Convenience-Sample.htm. Accessed 08.12.2016.

questions were unambiguous. The results also showed that the research questions had been framed correctly to be understood by the respondents in the manner in which they were intended. There was one question in the questionnaire that sought the respondents' financial information to determine whether financial status affected access to health-care services. However, the respondents were uncomfortable revealing their families' financial information, and most of them left the question blank. As a result of the participants being uncomfortable with this question, it was changed so that the respondents provided only basic information regarding their families' incomes. Interviewees (respondents) also provided the interviewer with general information but not specifics about their earnings. Although the information received was not precise, it enabled estimates of family earnings.

The second segment consisted of personal interviews with select respondents (with prior notice, information sheets, and consent) that addressed personal areas such as names, addresses, ages, genders, number of years in Norway, current health conditions, use of public or private health-care systems, and differences between the perceived and actual quality of care (QoC). The participants were asked to attend individual, tape-recorded, structured interviews. The results gained from the interviews were analyzed to determine the statuses of the immigrants (documented or undocumented) and their QoCs, medical attention gained from the health-care systems in Norway, etc.

Structured and unstructured interviews were conducted to understand the immigrants' health statuses, access to health services in Norway, and the economic value of their access to health services. Research interviews (cf. appendix B interviews) were used to determine the perceptions and experiences of the immigrants. Since it was also through research interviews on various aspects of immigrant health care among the private/public health-care systems in vogue in Norway that pursuit of and immersion into this topic was possible, this methodology was employed as the study's primary means of research inquiry. Everything that was seen and heard in the interviews was carefully recorded. The interviews offered answers to critical care issues, such as the treatment meted out to immigrants as compared to naturalized citizens, any differentiation due to the statuses of immigrants and why, characteristics and health profiling of immigrants who seek health-care treatment and medical interventions in Norway, how residency status impacts the quality and convenience of health care delivery, economic facts related to access to health services, and so on.

This research method involved collecting open-ended and emerging data and developing themes from that data. The focus was on those elements of health that would seem to have the greatest relevance for understanding the status of immigrants in Norway.

The third segment was based on a literature review, which established a more solid foundation for this research by backing up the discussions and results with previous research. The literature included scholastic books, articles, academic journals, and credible websites. Publications from organizations such as the World Health Organization and *helsenorge* were good sources of academically rich materials useful for the research. The electronic databases searched were Medline, CINAHL, ProQuest, and the Google Scholar search engine. The literature review involved a search of the main keywords for the research: *health*, *health status*, *wealth*, *immigrant income*, *immigrant education*, *immigrant*, and *economy*. Other keywords used in the search were terms such as *migrant*, *emigrant*, *refugee*, *well-being*, *health experience, immigrants' socio-economic challenges, health issue,* and *health problem*.

The fourth was to use data from Statistics Norway, the central body responsible for collecting, analyzing, and disseminating official statistics. Statistics Norway manages information on health services activities and health status and provides vital information to central, local, and regional authorities, other public authorities, researchers, media, and the public.

A total of 60 questionnaires were distributed to the respondents who accepted and signed the informed consent forms, which provided full information about the research and what was expected of the respondents.

6. Data Description and Analysis

The goals of the data description and analysis were to make some type of sense out of the collected data, to look for patterns and relationships both within the collected data and also across collections, and to make general discoveries about the phenomena I was researching. The data collection focused on immigrants' access to health care and the impact of these immigrants on economy in Norway. The analysis divided the responses into subtopics, labeled subthemes. The results of these subthemes collectively form the research results. I compared and contrasted each of the findings in order to discover similarities and differences, build typologies, or find sequences and patterns.

One of the more significant challenges I experienced in analyzing the research data was that the data were not readily accessible or aligned with the research questions. No section in this paper specifically details the procedures used for the data analysis; however, the procedures can be inferred from the paper overall. For instance, one way in which key data were analyzed was by separately analyzing the respondents' responses.

The study used a multi-method approach in which the qualitative data were examined to gain insights into the research topic. This approach provided a stronger set of findings and conclusions by validating the information retrieved from each data source. This approach provided higher-quality evidence to evaluate the effects of immigrants on the country. However, because there were limited discussions of the logistics of the study, validation of its findings would be difficult to replicate in future studies. For the security of those who have taken part in my interviews, I disclosed only the manner of data collection without discussing exactly how the collection took place, including the selection of participants in the evaluation of the theoretical discoveries and the verification of existing knowledge.

The views of different groups of people—Africans, Europeans, and Norwegians—were considered to ensure that different perspectives were taken into account and that no bias would significantly affect the research results. The study participants spoke French, English, Norwegian, or other expressions. Using scientific questioning, the interviewees were actively and methodically listened to during the interviews so that their thoughts, ideas, and feelings would be properly understood. Any kind of distortion (distorted questions and facts) was avoided to prevent it from becoming embedded in the structure of the research relationship.[296] Through interaction, the respondents and researcher were actively engaged in constructing meaning. This required continuous reflection regarding one's role in the interview.

Research responses were divided into subthemes from the questionnaires and from interviews:

- Status of immigrant health,
- Immigrant awareness of the Norwegian health-care system,
- Quality of health-care services offered to immigrants at Norwegian health-care facilities,
- Experiences of immigrants at Norwegian health-care facilities,
- Ease of access to health-care services by legal immigrants,
- Ease of access to health-care services by undocumented immigrants,
- Undocumented immigrants' contribution to the health-care crisis in Norway
- Immigrant Remittances in Relation to Access to Health-Care Services and Economy in Norway
- The Interplay of Income, Education, and Health

[296] P. Bourdieu, *Understanding. Theory, Culture and Society*, *13*(2), 1996, p.17-37.

Statistical techniques were used to analyze the secondary data gathered. Visual analyses were used to summarize and collate the different statistical data collected, followed by a descriptive analysis of the presented data. Various visual elements were used, including bar and line graphs. Besides the visual representations of the statistical data about immigration in Norway, correlation analyses were conducted in order to understand how health-related variables and employment are correlated with the incomes of immigrants. This allowed an interpretation of the current health status of immigrants in Norway and how it contributes to or influences the socio-economic conditions of immigrants.

7. Limitations and Delimitations

This study mainly focused on immigrants' health statuses and the health-care services in Norway and their accessibility and responsiveness to immigrants' needs. As such, it is limited to the collection of data in Norway and delimited by the information acquired from groups of immigrants and from Norwegians.

Moreover, because there are limited discussions on the logistics of the study, it will be difficult to validate its findings by replicating them in future studies. For the security of those who took part in the interviews, I will only disclose the manner of the data collection without discussing exactly how the collection took place, including the selection of participants in the evaluation of the theoretical discoveries and the verification of existing knowledge.

8. Ethical Considerations

Confidentiality was guaranteed by ensuring the non-disclosure of any details or circumstances that could contribute to the identification of the participants. Further, ethical considerations to safeguard the participants' dignity were honored during discussions with the participants throughout the project and in the presentation of the findings. Due to the requirement that participant information remain confidential, the names and other personal information of the respondents are not referred to in the study. Respondents' identifiers were removed from data to ensure confidentiality.

The interview participants signed informed consent forms that provided all the relevant information about the research and what was expected of the respondents. Personal

interviews with selected immigrants were conducted with prior notice and consent. The use of a tape recorder was discussed with each participant, and they were able to decline being taped if they found it intimidating. The participants also provided informed consent to use notes and recordings from the sessions and their own written materials for research purposes.

CHAPTER IX: ANALYSIS AND RESULTS

Economists have long well-understood that economy and development are generated by people's health, access to health care, and education. The increase of the gross national product (GNP) and gross domestic product (GDP) in a country are based on the investments in education, health, health access, and training that enable the production of goods that have value. This chapter describes the health statuses of the respondents and addresses and answers the research questions by analyzing and presenting the results. The analysis is comprised of subtopics labeled subthemes. The results of these subthemes collectively form the research results. This chapter also presents the states of health and access to health services among the immigrant respondents in Norway. It addresses the impacts of the immigrant respondents' access to health services and the role of immigrants on economy in Norway.

1. Composition and General Health Statuses of Respondents in the Study

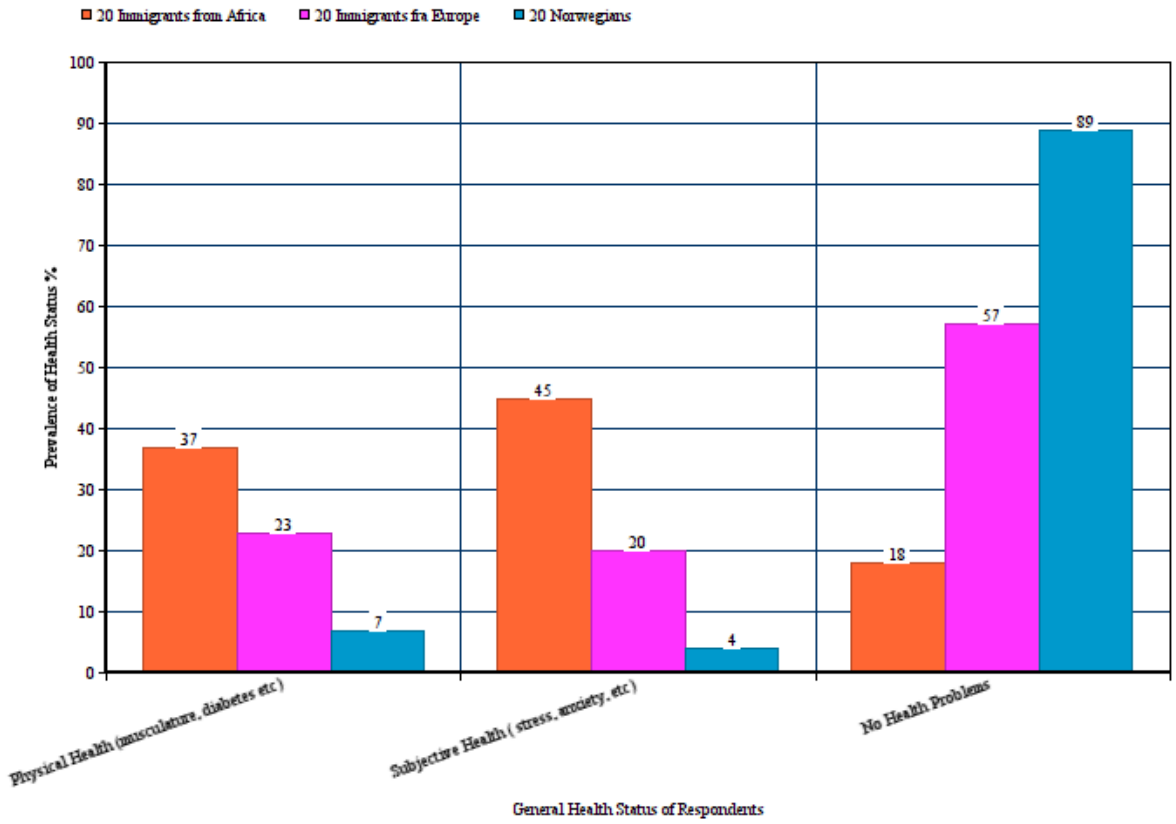
Table 9.1. Respondents in the study

Respondents by age and sex					
	Respondents	**Sex**		**Percentage**	
	All	**Males**	**Females**	**Males**	**Females**
Total	**60**	45	15	75%	25%
18–25 years	16	10	6	16.66%	10%
26–35 years	21	18	3	30%	5 %
36–45 years	11	8	3	13.33%	5 %
46–55 years	7	5	2	8.33%	3.33%
56 years or older	5	4	1	6.66%	1.66%

Source: Fieldwork data collected for this study.

Table 9.1 indicates that of the 60 respondents to the questionnaires, 15 (25%) were female adults, and 45 (75%) were male adults. Table 9.1 shows that most respondents were aged between 26–35 years (as many as 21 respondents, or 35%), and the smallest age group was over 56 years (as many as five people, or 8.32%).

Figure 9.1. General health status of respondents**.**



Source: Fieldwork data collected for this study.

The immigrant respondent populations, specifically respondents from Africa, had a higher prevalence of physical and subjective health problems compared to respondents from Europe and Norway. Figure 9.1 shows the prevalence (82%) of health problems from immigrants from Africa compared to 43% from European immigrants and 11% from Norwegians.

The prevalence of physical health and subjective health problems was higher among 45–50-year-old respondents from Africa compared to Norwegian respondents of the same age. The health problems of the respondents from Africa and Europe could influence their

quality of life and productivity. The high prevalence of the health problems of the respondents from Africa is due to their socio-economic background.

The first question in the questionnaire required the participants to describe their health statuses. The aim of the question was to understand how immigrants to Norway viewed their health and to gauge the actual statuses of their health. Based on their answers, the respondents' perceived that they had lower rates of health insurance, less regular use of health-care services, and often lower quality health-care services than those received by citizens. They saw themselves as foreigners.

When I asked a health-care provider about what he knows about the health status of immigrants in Norway, he said "Immigrants in Norway have a higher burden and higher risk of lifestyle- and dietary-related disorders, health problems, infectious diseases, and complications from reproductive infections as compared to the native Norwegian majority population" (Respondent 33).

The immigrants described their health conditions in varied manners. Most of the them explained that most of their health challenges were the result of harsh living environments and a lack of resources for their health-care needs. Over 82 percent of the respondents attributed their health challenges to a lack of resources and the environment in which they lived. Most participants explained that it was difficult for them to find employment in permanent and secure jobs, which in turn hampered their ability to earn the resources needed for health-care services. The remaining 18 percent of the questionnaire respondents and 10 percent of the interviewees explained that they had been receiving medical treatment in their countries of origin before they immigrated to Norway, and the lack of resources had worsened their conditions since they had been in Norway. One respondent stated:

> I am constantly worried about my health. I am really suffering and struggling with health anxiety regarding my heart and my blood glucose. My health anxiety makes me [think I] have a heart condition when I don't. I'm deeply afraid of becoming seriously ill and failing in life. (Respondent 16)

Two other respondents also discussed their lack of resources:

> [I lack] money to access health care, to improve health, to eliminate wants in my life . . . I don't have [a] job . . . many situations make me worry. (Respondent 17)

> If I think about our lifestyle diseases and health enough, I. . . feel a sense of uncertainty. (Respondent 18)

These answers provide examples of the main categories of health challenges among participants: lifestyle diseases and disorders, dietary disorders, general health issues, reproductive diseases, and infectious diseases.

Immigrants may have poor health conditions and many risk factors related to pre- or post-immigration experiences, social conditions, economic conditions, and, in some instances, higher housing prices because of a higher demand for housing or individual backgrounds. Higher levels of depressive problems are reported among illegal immigrants.

Table 9.2. Data sets reporting on depression: Mean-median

African Respondents
1, 1, 0, 1, 1, 0, 1, 1, 0, 1, 1, 0,1, 1, 0, 1, 1, 0, 1, 1
Count: 20, Sum: 14, Mean: 0.7, Median:1
European Respondents
0, 1, 0, 0, 0, 1, 1, 1, 0, 1, 1, 1, 1, 0, 0, 1, 0, 0, 0, 1
Count: 20, Sum: 10, Mean: 0.5, Median: 0.5
Norwegian Respondents
1, 1, 0, 0, 1, 0, 1, 0, 0, 1, 1, 0,1, 1, 0, 1, 0, 0, 0, 0
Count: 20, Sum: 9, Mean: 0.45 Median: 0

Source: Data from the study

Table 9.2 shows that respondents from both high- and low-income countries in Africa reported significantly more depressive symptoms than their European and Norwegian peers, with a mean score of 0.70 compared to their mean scores of 0.5 and 0.45, respectively. The prevalence of depression appears to be higher among African immigrants between 36 and 56 years of age compared to respondents in that age range who are originally from Norway and from Europe.

Some immigrants from Africa who may need health-care services do not seek them out because of health-care service expenses and because they have little knowledge about the their availability. One respondent said,

> I am not from Norway. I treat myself with traditional herbs [and] medicine from my country . . .. I have them, and I know [how] to deal

with my health. I don't know how to get to the hospital if I get sick. (Respondent 19)

This response shows how some immigrants try to cope with disease on their own or deny that they are ill. They are unaware of the availability of the services.

The increasing share of costs to pay for health care (i.e., *egenandel*) also reduces the opportunities for immigrants to use health care. One interviewee said,

> I heard about *egenandel*. It seems too expensive for me. I am a graduate, but I don't have a job. Where can I get that money? I am alone here. I have no family members here to support me. (Respondent 15)

This answer shows that social capital, family networks, and human capital may be key determinants of the access to and use of health services among immigrants.

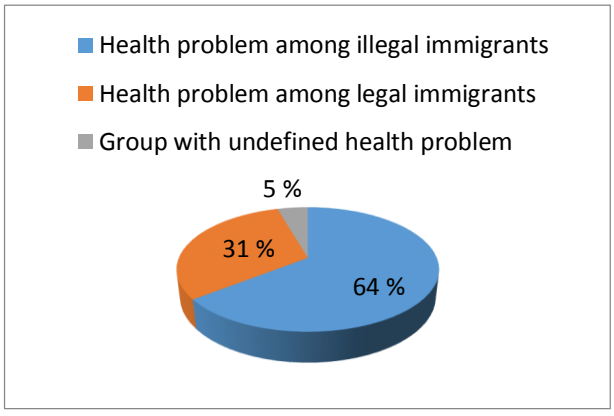
The burden of serious public health problems among the immigrants and their relatives is higher than that among the native Norwegians and the general European population.

A respondent stated:

> I use paracetamol and other medicines when I get sick. I get drugs from my immigrant [neighbors] when I have trouble with my health. Some of these drugs may be expired or not safe for me, as they don't work. I think . . . they lose some or all of their effectiveness. No, I can't throw away [an] expired drug. (Respondent 3)

This response suggests that some immigrants use medications in an unregulated manner, which may lead to harmful effects.

Figure 9.2. Rate of health problems among legal and illegal immigrants.



Source: Data from the study.

Figure 9.2 shows results similar to those in most studies: health problems are worse for illegal and undocumented immigrants and are even worse when there are small children involved. Illegal immigrants toil day and night, doing thankless jobs that leave them too exhausted to have meaningful lives. The illegal immigrants who live underground are the unacknowledged engines of the world above them; if they stopped performing their usual duties, the world above them would grind to a halt. Yet, they are not accorded the respect they deserve. Immigrants are less likely to use health-care services than native Norwegians due to low socio-economic statuses and their lack of health coverage. Illegal immigrants suffer worse physical health than non-immigrants and use health-care services at a significantly lower rate and frequency.

While globalization has increased the movement of people to and from different countries, very little is being done to care for immigrants' health. Norway is one place where immigrants' health concerns have not been considered by many governmental and non-governmental organizations.

2. Overview and Interplay of Education, Income, Health, and Access to Health-Care services

These tables show an overview of the education levels, incomes, and access to health-care services of the respondents.

Table 9.3. Respondents from Africa by educational levels, incomes, employment, and health care

Group A 20 people from Africa		Men # (%)	Health care Access # (%)	Women # (%)	Health care Access # (%)
Education Relative to Age Range	18–25 years	4 (26.67)	2 (13.33)	3 (60.00)	1 (20.00)
	26–35 years	4 (26.67)	1 (6.66)	1 (20.00)	0 (0.00)
	36–45 years	3 (20.00)	1 (6.66)	1 (20.00)	0 (0.00)
	46–55 years	2 (13.33)	0 (0.00)	0 (0.00)	N/A
	56 + years	2 (13.33)	1 (6.66)	0 (0.00)	N/A
Approximate Income (per month)	< 15,000 kr	8 (53.33)	2 (13.33)	4 (80.00)	1 (20.00)
	15,000 kr	5 (33.33)	1 (6.66)	0 (0.00)	N/A
	15,000–35,000 kr	2 (13.33)	1 (6.66)	1 (20.00)	0 (0.00)
	35,000–50,000 kr	0 (0.00)	N/A	0 (0.00)	N/A
	> 51,000 kr	0 (0.00)	N/A	0 (0.00)	N/A
Employment	Employed	4 (26.66)	1 (6.66)	1 (40.00)	N/A
	Unemployed	11 (73.33)	N/A	4 (60.00)	N/A

Status					

Note. # = Number of persons out of *n* = 20; % = Percentage of persons (*n* = 20); kr =Norwegian kroner; N/A = not applicable.

Source: Fieldwork data collected for this study.

Table 9.4. Respondents from Europe by educational levels, incomes, employment, and health care

Group B 20 people from Europe		Men # (%)	Health care Access # (%)	Women # (%)	Health care Access # (%)
Education Relative to Age Range	18–25 years	4 (26.66)	4 (26.66)	0 (0.00)	N/A
	26–35 years	6 (40.00)	6 (40.00)	1 (20.00)	1 (20.00)
	36–45 years	2 (13.33)	2 (13.33)	1 (20.00)	1 (20.00)
	46–55 years	2 (13.33)	2 (13.33)	2 (40.00)	2 (40.00)
	56 + years	1 (6.66)	1 (6.66)	1 (20.00)	1 (20.00)
Approximate Income (per month)	< 15,000 kr	1 (6.66)	1 (6.66)	1 (20.00)	1 (20.00)
	15,000 kr	0 (0.00)	N/A	0 (0.00)	N/A
	15,000–35,000 kr	10 (66.66)	10 (66.66)	3 (60.00)	2 (40.00)
	35,000–50,000 kr	3 (20.00)	3 (20.00)	1 (20.00)	1 (20.00)
	> 51,000 kr	2 (13.33)	2 (13.33)	0 (0.00)	N/A
Employment Status	Employed	13 (86.66)	9 (67.00)	4 (80.00)	4 (80.00)
	Unemployed	2 (13.33)	1 (6.66)	1 (20.00)	1 (20.00)

Note. # = Number of persons out of *n* = 20; % = Percentage of persons (*n* = 20); kr = Norwegian kroner; N/A = not applicable.

Source: Fieldwork data collected for this study.

Table 9.5. Respondents from Norway by educational levels, incomes, employment, and health care

Group C 20 people from Norway		Men # (%)	Health care Access # (%)	Women # (%)	Health care Access # (%)
Education Relative to Age Range	18–25 years	2 (13.33)	2 (13.33)	3 (60.00)	3 (60.00)
	26–35 years	8 (53.33)	8 (53.33)	1 (20.00)	1 (20.00)
	36–45 years	3 (20.00)	3 (20.00)	1 (20.00)	1 (20.00)
	46–55 years	1 (6.66)	1 (6.66)	0 (0.00)	N/A
	56 + years	1 (6.66)	1 (6.66)	0 (0.00)	N/A
	< 15,000 kr	0 (0.00)	N/A	0 (0.00)	N/A

Approximate Income (per month)	15,000 kr	0 (0.00)	N/A	0 (0.00)	N/A
	15,000–35,000 kr	12 (80.00)	12 (80.00)	3 (60.00)	3 (60.00)
	35,000–50,000 kr	2 (13.33)	2 (13.33)	1 (20.00)	1 (20.00)
	> 51,000 kr	1 (6.66)	1 (6.66)	1 (20.00)	1 (20.00)
Employment Status	Employed	15 (100.00)	15 (100.00)	5 (100.00)	5 (100.00)
	Unemployed	0 (0.00)	N/A	0 (0.00)	N/A

Note. # = Number of persons out of *n* = 20; % = Percentage of persons (*n* = 20); kr = Norwegian kroner; N/A = not applicable.

Source: Fieldwork data collected for this study.

Table 9.6. Distribution of educational attainment of the respondents by place of origin

		African Respondents		European Respondents		Norwegian Respondents	
	Education	#	%	#	%	#	%
1	High school	7	35	0	0	0	0
2	Bachelor's degrees	3	15	16	80	14	70
3	Master's degrees	1	5	2	10	4	20
4	Doctoral degrees (PhDs)	0	0	2	10	2	10
Total		11	55%	20	100%	20	100%

Note. # = Number of persons out of *n* = 20; % = Percentage of persons (*n* = 20). The remaining nine respondents from Africa attended primary and secondary school.

Source: Fieldwork data collected for this study.

Tables 9.3, 9.4, 9.5, and 9.6 show the distribution of respondents from Norway, Europe, and Africa. The dataset focuses on the educations, ages, sexes, approximate incomes, and occupations of the respondents. The distribution illustrates the immigrants' levels of education, the share of working immigrants, and their need for health services.

Income. Table 9.3 shows that large numbers of respondents from Africa have monthly incomes between 15,000 and 30,000 NOK. Tables 9.4 and 9.5 show that people from Europe and Norway have higher incomes than immigrants from Africa (Table 9.4). The immigrants' incomes vary not only by country of origin but also by how long they have lived in Norway (Table 9.7). Fifty-five percent of the immigrants who have been in Norway more than three years have monthly incomes over 20,000 NOK. Fewer African immigrants have incomes over 32,000 NOK than either people from Norway or immigrants from Europe.

Table 9.7. Immigrants' median incomes by years of residence

	2016	
	Number of persons	Median income (per year)
Immigrants in total	*N* (40)	
0–2 years	10	225,000
3–5 years	8	249,000
6–9 years	2	320,000
10 years or more	20	385,000

Source: Fieldwork data collected for this study.

Occupation. Immigrants who have been in Norway for longer than three years have higher incomes than those who have lived in the country for fewer than two years (Table 9.7). They contribute to the Norwegian budget and pay taxes. As shown in Table 9.3, respondents from Africa have a higher rate of unemployment than people from either Norway or Europe. There is a higher unemployment rate among immigrant women from Africa than among immigrant women from Europe. Within the immigrant groups, women have higher unemployment rates than men. Close to 7 percent of the employed immigrants from Africa reported having access to health-care services. Fourteen out of 20 (70%) African respondents were not employed, and three out of 40 (7.5%) respondents from Norway and Europe did not have jobs. The immigrants' employment statuses varied by country of origin. The unemployment data shows that African immigrants have the highest unemployment rate among all immigrants from other world regions.

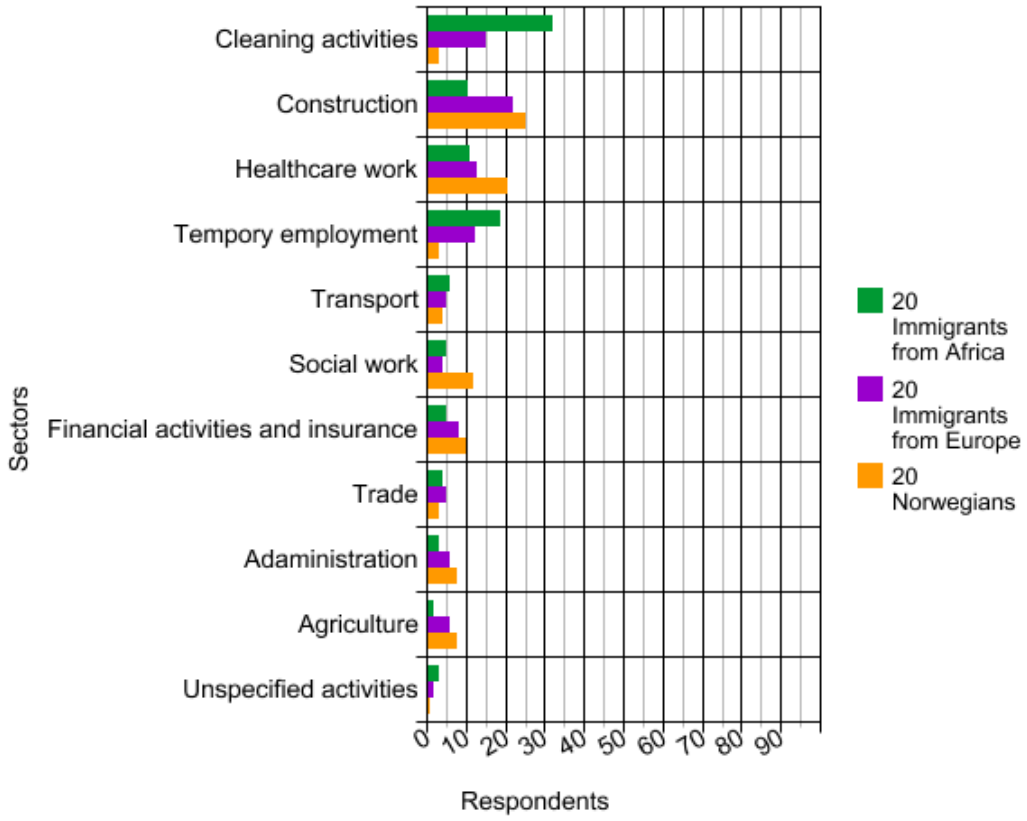
Education. As shown in Table 9.3, there were many respondents aged 18 to 36 years. This indicates that there were many young respondents with grade school or elementary school educations. Tables 9.4 and 9.5 indicate that respondents aged 18 to 36 were in the majority of those represented. Table 9.6 shows the distribution of educational levels by groups of respondents from Africa, Europe, and Norway; most respondents (i.e., 33 people, 55%) had

earned a bachelor's degree, but only four respondents (6.66%) had completed a doctoral program (i.e., PhD). The respondents from Norway and Europe had higher levels of education than the respondents from Africa. The presence of educated people in these three groups represents human capital. With their valuable talent, ingenuity, and skills, immigrants bolster the workforce and participate in economic activity. They create businesses.

Access to Health Services. Table 9.3 shows that access to health services for respondents from Africa is lower than that for respondents from Europe. There are complex interactions between employment, education, health coverage, financial access to care, and health outcomes (activities contributing to good health or improving health). Lack of employment, low-wage jobs, economic downturns, and high insurance costs keep immigrants from Africa from seeking health-care services as often as immigrants from Europe. According to Statistics Norway, only 58 percent of immigrants in Norway visited their GP in 2015. Compared to the general population in Norway, immigrants as a group go to the GP and seek emergency care less often.

Employment and Health Utilization.

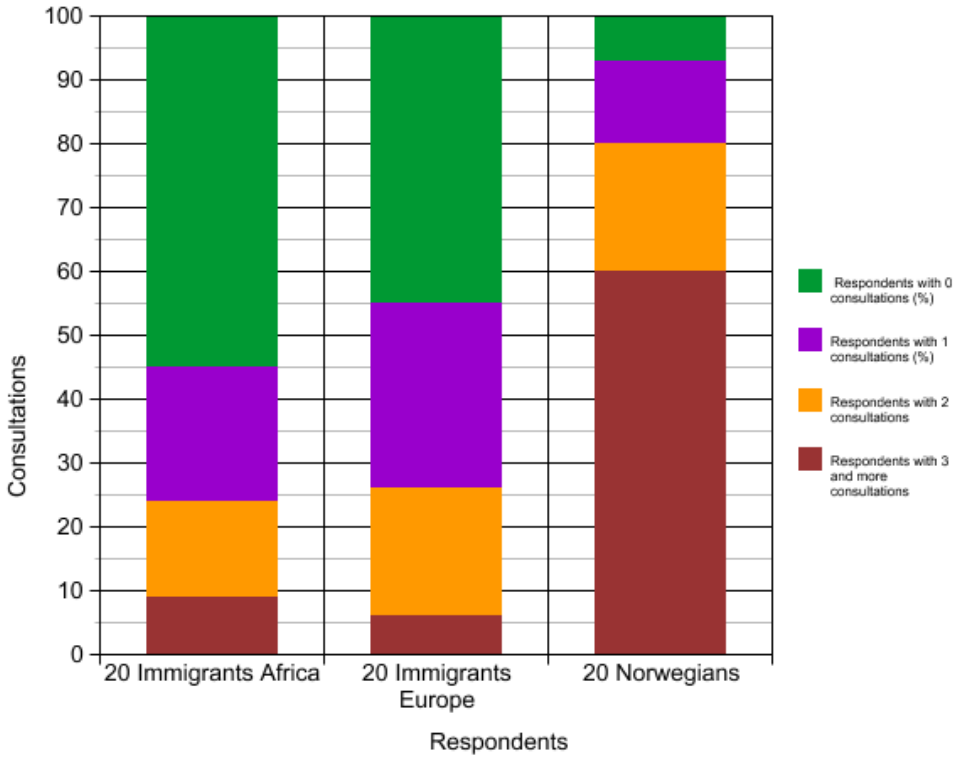
Figure 9.3. Respondents employment by sector (%).



Source: Fieldwork data collected for this study.

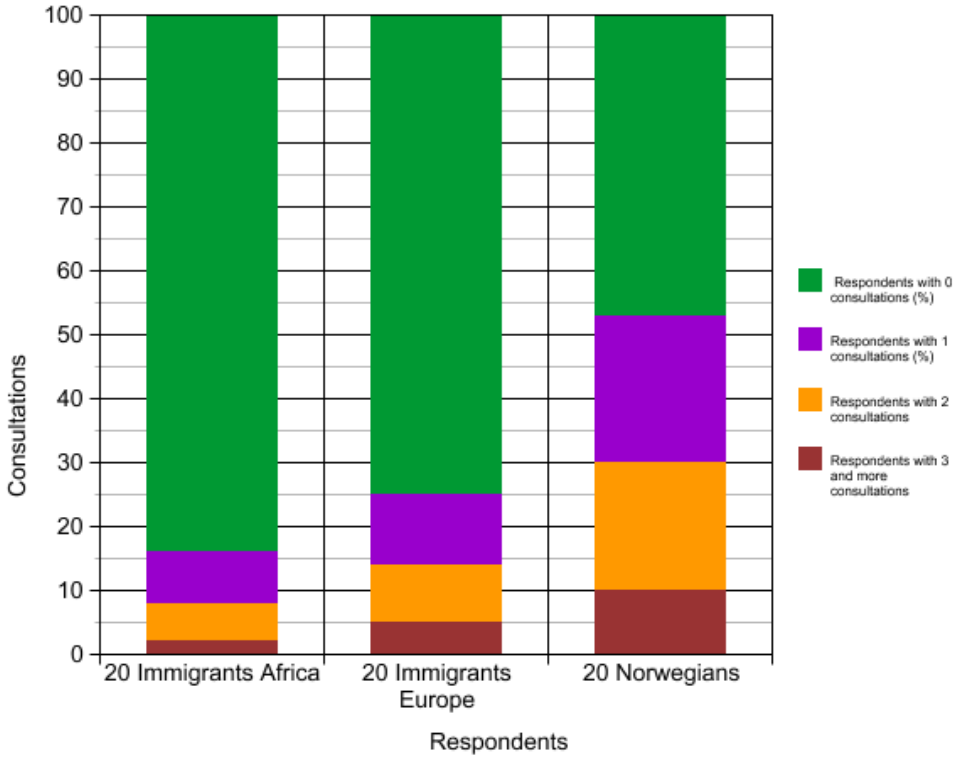
Figure 9.3 shows the number of employed respondents by sectors. Based on the data, a majority of the immigrants work in occupations related to cleaning and construction. The construction and cleaning sectors employ around 32.7 percent of the immigrants from Africa, 15.4 percent of the immigrants from Europe. Immigrants from Africa and immigrants from Europe are 10.8 percent and 22.2 percent of the total number of employed immigrants, respectively. Another 11 percent of the respondents from Africa and 13 percent of the respondents from European groups worked in the health-care sector, while 19.1 percent of the respondents from Africa and 12.3 percent of the respondents from Europe had temporary employment. The sectors where immigrants from Africa and Europe were the most underrepresented and had the smallest percentages were the financial and insurance activities and administration. Other sectors with small percentages of employed respondents from Africa and Europe included accommodations, information and communication, agriculture, and fishing,

Figure 9.4. Respondents' consultations at emergency primary health care facilitiese, 2016**.**



Source: Fieldwork data collected for this study.

Figure 9.5. Respondents' consultations with general practitioners (GPs), (%). 2016.



Source: Fieldwork data collected for this study.

Figures 9.4 and 9.5 show the respondents' health-care utilization based on consultations at emergency primary health-care facilities and GPs, respectively. Immigrant respondents from Africa and from Europe (8% and 11% of the total immigrant respondents, respectively) had only one consultation at emergency primary health care facilities in 2016. Less than 2 percent of the respondents from Africa and 5 percent of the respondents from Europe had multiple consultations at emergency primary health care facilities.

Conversely, the majority of the respondents had *no* consultations with GPs in 2016. Only 21 percent of the respondents from Africa and 29 percent of the respondents from Europe had one consultation with GPs; 11 percent of the respondents from Africa and 23 percent of the respondents from Europe had two consultations; and 6 percent of the respondents from Africa and 9 percent of the respondents from Europe had three or more

consultations with GPs. The respondents from Norway had more consultations with GPs than the total consultations of respondents from Africa and Europe.

Figure 9.5 shows the respondents' consultations with general practitioners (GPs) (%) in 2016. The respondents from Africa and Europe had fewer consultations than the respondents from Norway.

3. Quality of Health-Care Services Offered to Immigrants in Norway

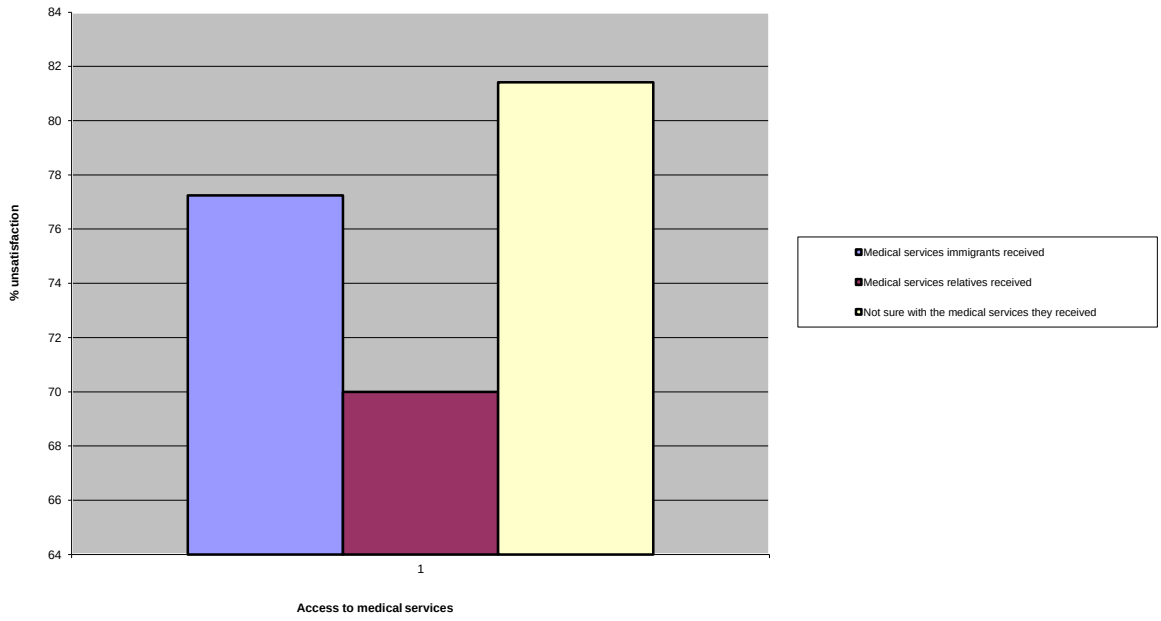
The quality of health care that people receive is a main concern for both native citizens and foreign residents of a country. The third question of the questionnaire required the respondents to describe the quality of treatment and health care that they receive from the Norwegian health-care facilities.

In Norway, the government has taken major steps to ensure quality health care for all (see social and health policy of Norway). No major health risks are excluded from public insurance coverage, and most health-care costs are subsidized. All kinds of treatments are scientifically documented to provide effective results. Expatriates and individuals from other countries who work in Norway for one year or more are also entitled to public insurance coverage. Different rules and regulations apply to employees who have worked in Norway for less than one year.

Health-care quality refers to the degree to which health services increase the likelihood of meeting the desired health-care outcomes and are consistent with the current professional service standards.[297] The provision of quality health care is an important component of the maintenance of a healthy population. The quality of the health of immigrants, like that of other populations, can be evaluated based on the structures, processes, and outcomes of their health care (Chapter IV). *Structure* refers to the characteristics and attributes of the health-care providers; *process* refers to the components of the encounters between the providers and recipients of health-care services.[298] However, most of the emphasis on process is placed on technical components, such as the appropriateness of the service and the technical skills of the providers. Finally, *outcomes* refers to the effect or the impact of the care on the patients' health.

[297] E. Kelley, and Hurst J., *"Health Care Quality Indicators Project: Conceptual Framework Paper"*, OECD Health Working Papers, No. 23, OECD Publishing, Paris, 2006, p.10.
[298] J. Escarce, K. Kapur, *Racial and ethnic differences in public and private medical care expenditures among aged Medicare beneficiaries*, Milbank Quarterly. 81 (1), 2003, p.249–275.

Figure 9.6. Chart on the quality of health-care services offered to immigrants in Norway.



Source: Data from the study.

The respondents' responses indicate that immigrants receive a lower quality of health-care services compared to others in Norway. This result was clearly shown in Figure 9.6 by the fact that most questionnaire respondents—77.24 percent—were not satisfied with the services they had received from medical facilities, and 70 percent of the interviewees explained that they were not satisfied with the services that they or their relatives had received. Moreover, 70 percent of the interviewees and 81.41 percent of the questionnaire respondents explained that they still had questions about how they had been treated and what medication had been given to them. From the responses, it may be deduced that the immigrants in Norway receive very low-quality services for treatment. It is also possible that they receive good services but do not realize it because they do not understand the services.

The low quality of health-care services provided to the immigrants can be attributed, in part, to their levels of poverty. As discussed previously, most immigrants are not well-educated, and many live in poverty. The prevalence of poverty among the immigrants in Norway is at an alarming level.[299] Due to this poverty, immigrants may seek cheap, low-quality services because they are not covered by insurance or financial social assistance and do not have social capital.

There are variations in access to health care services experiences among respondents. Differences on experiences of the quality of health cares services is connected to different socio-economic bakgrounds among respondents and different expectations of quality health care services.

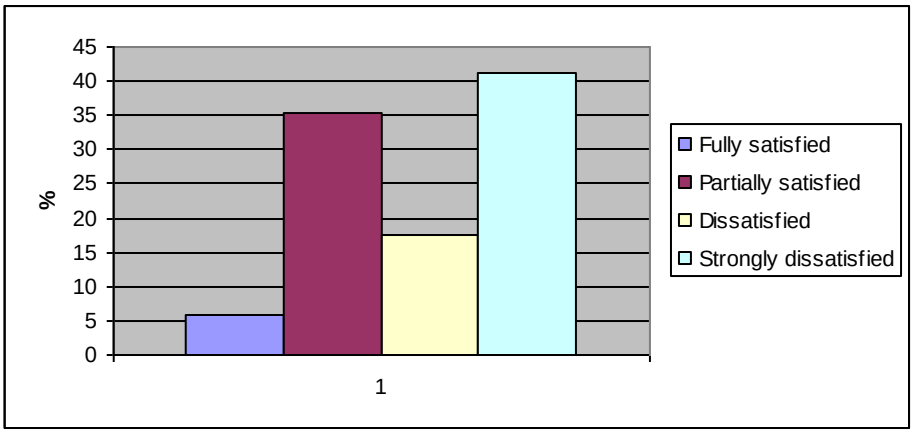
4. Experiences and Challenges in Regard to Immigrants' Access to Health-Care Centers

There are some major variations in access to health care, the quality of the care, and the outcomes of the health-care practices between native Norwegians and immigrants, with immigrants receiving health care that is of lower quality and, consequently, having poorer health. Socio-economic factors and levels of health literacy play major roles in determining how well an individual understands health-care information and makes appropriate health decisions.

The fourth question in the questionnaire and the interview guide was aimed at understanding the experiences of the immigrants in the health-care facilities. Many health practitioners in the Norwegian health-care system have very poor attitudes toward the immigrants in the country, which leads to negative experiences by immigrants. The responses of the respondents demonstrate this; many did not like their experiences at medical facilities and only go there because they have no other option.

Figure 9. 7. Respondents' satisfaction with medical staff.

[299] T.A. Galloway, *Do immigrants integrate out of poverty in Norway*, 2006, p.3.



Source: Data from the study.

According to the responses (Figure 9.7), a significant proportion of the respondents felt that they were not treated appropriately at medical facilities. When they compared the manners in which health-care services are offered to them and to native Norwegians, they saw that a major gap exists. The questionnaire offered five possible answers about the immigrants' experiences with hospital staff: fully satisfied, partially satisfied, dissatisfied, strongly dissatisfied, or don't know. According to the respondents, 5.9 percent were fully satisfied, 35.3 percent were partially satisfied, 17.6 percent were dissatisfied, and 41.2 percent were strongly dissatisfied. One dissatisfied respondent said,

> They couldn't operate on me at that time because there was no interpreter to give the preoperative information . . .. They postponed my operation to the next day because of that. (Respondent 17)

Some health-care providers described the challenges associated with restricted access to interpreting services:

> There is often a lack of translation services. We [try] many times to find a translator. We don't ask family members to come to translate . . .. They might only say what the patient wants to hear, and they might translate incorrectly. Family members may be selective in what they translate. We can't ask personal, intimate things. We do not use them. (Respondent 4)

Confidentiality is an important issue when providing health care. There is often a lack of the professional interpreters or qualitative interpreting services needed to protect confidentiality and interpreters who know the medical terminology and understand the importance of professional discretion.

The interview guide required the interviewees to explain some of their worst experiences with Norwegian medical facilities. Most respondents explained that their lack of Norwegian fluency made many health practitioners turn away from serving them and instead serve those who understood the language. Numerous instances were reported in which practitioners and medical staff members expressed hatred toward the immigrants. Stigma and marginalization were the result of the immigrants' vulnerability.

An interviewee said:

> You know, I was lucky. I met a doctor who spoke my language today. He understood what I told him about my health . . . He is also from Ghana . . .. I told him all about my health . . . I was . . . given the opportunity to tell my story . . .. He recommended treatment, and I understood what I am supposed to do before I can follow the medical recommendations. (Respondent 58)

This answer shows that patients experience greater satisfaction when they are treated by doctors with the same backgrounds. Health care improves when patients and providers share values and backgrounds. This answer also shows that socio-economic similarities between patients and providers is associated with greater patient participation, higher satisfaction, and greater adherence to treatment. Immigrant patients' health literacy is central to their ability to adhere to treatment recommendations. *Health literacy* refers to the degree to which immigrants have the capacity to obtain, process, and understand the basic health information and services needed to make appropriate health decisions. Quality health-care outcomes depend upon patients' adherence to the recommended treatment regimens. The nonadherence to treatment recommendations by patients with immigrant backgrounds can be a pervasive threat to their health, wealth, and well-being and can carry an appreciable economic burden as well.

Most of the interviewees reported having better experiences with doctors and nurses who were also immigrants to Norway than with native doctors and nurses. One of the interviewees explained that he had been denied treatment at a hospital after the nurses noticed that he was an immigrant.

Most of the health-care challenges that the immigrants go through are well-documented and recognized around the world. The steps taken in the past were based on the increasing need for competency among interpreters and health-care workers. Interpreters took a more active role as mediators in consultations and learned to inform health-care providers about relevant socio-economic factors, such as housing, occupations, environment, education,

hygienic standards, and physical activity.[300] Immigrants in Norway have a right and obligation to complete a minimum of 300 hours of Norwegian communications training, free of charge. While the government in Norway has invested substantial time and resources to ensure that these challenges are eliminated, native Norwegians still seem to have major difficulties in accepting immigrants. Spilker, Anne, and Storste (2012) explained that, despite a solid body of evidence on immigrants' health statuses and the recognition of the challenges they face in various reports by governmental and parliamentary committees, attempts to meet and incorporate the health needs of immigrants and ethnic minorities into the Norwegian health-care services have remained fragmented and uncoordinated.[301] St.meld. no.9 (2006–2007), St.meld. no.16 (2006–2007), and report no.47 (2008-2009) to the Norwegian Parliament have aimed to reduce socio-economic inequalities in health. There is no comprehensive strategy from the national government or the national health authorities for protecting the immigrants from discrimination in the health-care facilities and elsewhere in the country.

As pointed out by the research respondents, socio-economic factors affect the health and the willingness of immigrants to access health-care services. Self-reported socio-economic treatment differences have been associated with many outcomes of health-care services. The low socio-economic statuses of some immigrants from African countries have had significant impacts and effects on a wide range of health outcomes. This research shows the importance of the government working to ensure that immigrants have equal access to health-care services.

5. Ease of Access to Norwegian Health-Care Services for Immigrants

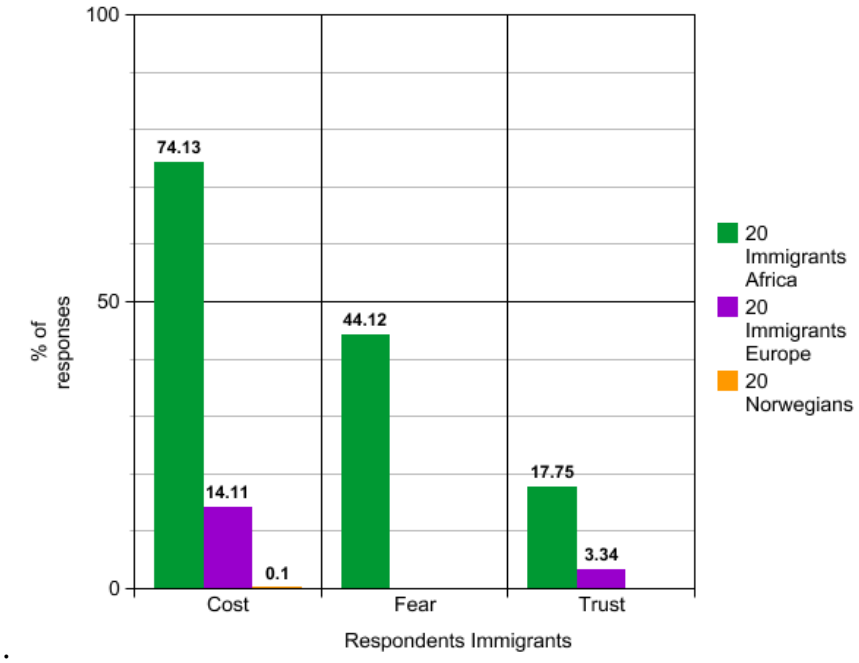
Inadequate access to health care for immigrants could have serious consequences for not only their health but also the health of the entire population of Norway. *Access to health care* refers to the degree to which people can obtain appropriate care from the health-care system in a timely and efficient manner. The literature has divided access to health care into two main categories: potential access and realized access.[302] *Potential access* refers to the presence or the absence of barriers to obtaining appropriate and timely care. *Realized access*

[300] C. V. Angelelli, *The role of the interpreter in the health care setting. Crossing borders in community interpreting: Definitions and dilemmas,* 2008, p.147-164.
[301] R. A. C. S. Spilker, *Public health challenges among immigrants in Norway: A content analysis of health policy documents,* 2012
[302] J. F. Levesque, M. F. Harris, G. Russell, *Patient-centred access to health care: conceptualising access at the interface of health systems and populations,* International journal for equity in health, 12(1), 2013, p.18

refers to the quantity of health care actually received. For the immigrants in many countries, both potential access and realized access are very low.[303]

This study focused on understanding the major challenges and barriers that prevent immigrants from easily accessing Norwegian health-care services. The questionnaire respondents were asked to pick from a list some of the barriers that prevent them from accessing health-care services. The major categories identified by prior research, and from which the respondents were required to choose, included financial barriers, status of immigration, and socio-economic differences between the immigrants and other Norwegians.

Figure 9.8. Challenges and barriers to access health-care services faced by respondents



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Source: Data from the study.

Figure 9.8 shows that, of the questionnaire respondents, 88.24 percent explained that the costs of the health insurance policies and hospital costs are too high for them. Based on their employment statuses, it is difficult for immigrants to afford the high costs of hospital bills, let alone to pay for the national health insurance policy. Additionally, 44.12 percent of the respondents feared seeking hospital treatment, especially at government hospitals, due to their immigration statuses (i.e., not legally documented). One respondent said,

[303] J. F. Levesque, M. F. Harris, G. Russell, *Patient-centred access to health care: conceptualising access at the interface of health systems and populations,* Op.cit., p.164

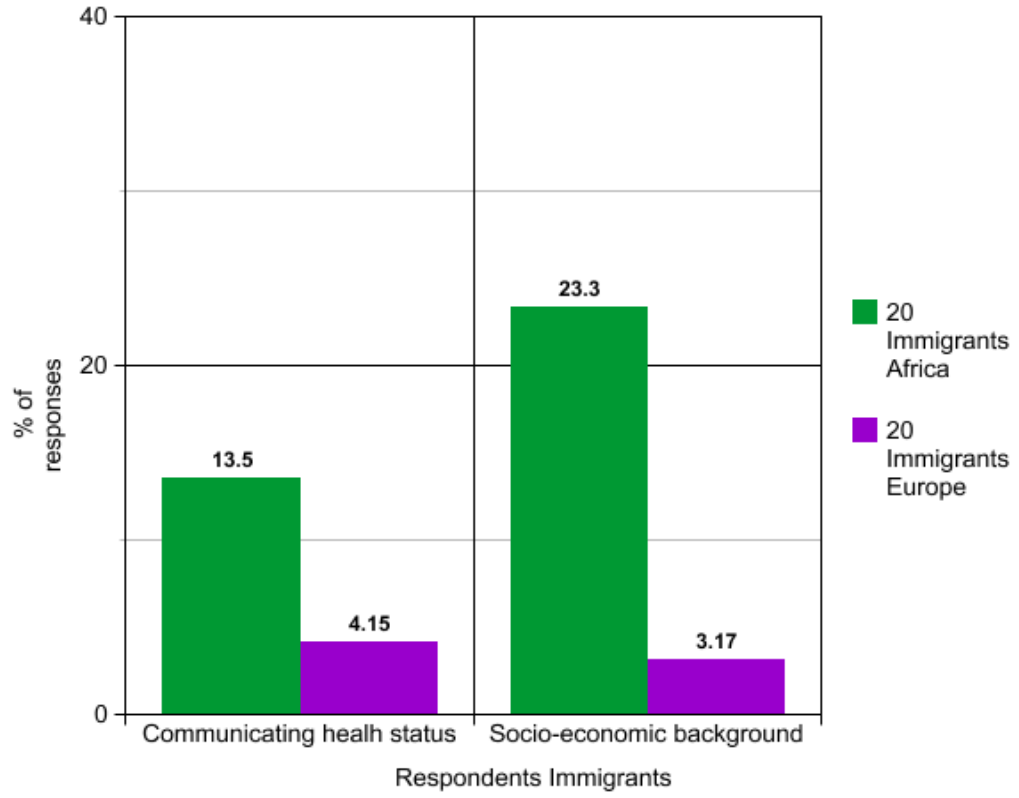
> I am afraid to go to the hospital . . .. The police can come there and find me. They can deport me back . . . no . . . no . . . I am afraid. (Respondents 11)

This answer shows that some immigrants fear that going to the hospital may lead to government notice and the risk of being deported back to their countries of origin.

Figure 9.8 also shows that, of the immigrants interviewed, 20.59 percent had challenges adapting to and trusting the Norwegian health-care system. This meant that they had greater trust in using traditional methods of treatment than in seeking hospital treatment and using modern drugs. Based on the interviewees' responses, the level of socio-economic difference largely affected the level of trust that the immigrants had in the Norwegian health-care system. The more time immigrants had spent in Norway, the more they had adapted to the health-care system. Immigrants who had been in the country for fewer than 6 months had a very poor perception of the Norwegian health-care system. However, immigrants' perceptions became more positive as the duration of their residence in Norway increased.

Absences of interpretation services and socio-economic differences are another challenge.

Figure 9.9. Communication and socio-economic barriers faced by respondents**.**



Source: Data from the study.

Figure 9.9 shows that, of the questionnaire respondents, 17.65 percent explained that they had experienced major challenges in communicating their health statuses to the doctors and other medical practitioners. Additionally, 26.47 percent reported that their differences in socio-economic background from the nurses and doctors had led to very negative experiences at hospitals. They, therefore, preferred purchasing medicines themselves instead of seeking advice from medical facilities.

The lack of interpretation services can result in serious detrimental effects on the outcomes of the treatment of a disease or symptom. It can also have a major effect on the quality of care provided to the patient and on that patient's health status. The presence of interpretation services is of special importance for undocumented immigrants due to the complexity of the social and health-care systems.[304] Their social and health statuses are also multifaceted and, thus, require a comprehensive communication strategy. Patients who are able to communicate in the language spoken by the caregivers are in a better position to receive attention and quality care than are patients whose communication is different from that of the caregivers.[305, 306] They are also more likely to establish a rapport with their health professionals, participate in the decision-making process, and receive sufficient information about their health statuses. Communication barriers prevent the health practitioners from fully understanding the needs of the patients, which leads to lower-quality treatment and fewer appropriate referrals to secondary care. As a result of communication barriers and the consequent inability to explain their health conditions, the patients are unable to provide the health practitioners with information about their health statuses. In the absence of socio-economically accessible care for immigrants, it is difficult for them to develop trust in the Norwegian health-care system.

We don't have health insurance; what if we get sick? (Respondent 13)

This response shows that the lack of insurance coverage for immigrants has been a challenge. Moreover, while most native Norwegians receive insurance packages as benefits from their employers, most of the immigrants are unemployed and have no health-insurance coverage benefits. Some of the immigrants are employed, but with employers who do not

[304] C.A. O'Donnell, et al., *They think we're OK and we know we're not. A qualitative study of asylum seekers' access, knowledge and views to health care in the UK,* BMC Health Services Research.7(1), 2007, p.75.
[305] A. MacFarlane, et al., *Responses to language barriers in consultations with refugees and asylum seekers: a telephone survey of Irish general practitioners,* BMC Family Practice. 9(1), 2008, p.67-69.
[306] A. MacFarlane, et al., *Arranging and negotiating the use of informal interpreters in general practice consultations: experiences of refugees and asylum seekers in the west of Ireland,* Social Science & Medicine. 69(2), 2009, p.210-214.

offer health benefits to them. Uninsured rates are higher for individuals from foreign countries than for the Norwegian citizens and are even higher for undocumented immigrants.

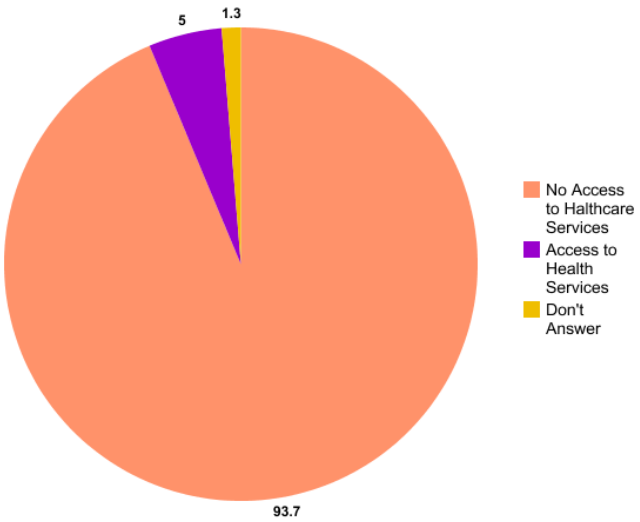
The immigrants' lack of insurance is due both to their employers not offering them health benefits and to the immigrants' unwillingness to pay for such services. Siddiqi et al. (2010) explained that having health insurance greatly reduces, although does not entirely eliminate, inequalities in immigrants' health-care access.[307]

Some newer immigrants are likely to know relatively few long-term immigrants to whom they could turn for assistance and knowledge about the health-care system. A lack of assistance from long-term residents and a lack of knowledge may cause newer immigrants to delay care until a problem becomes unbearable, or they may encounter frustration if they do seek access to health care. The ability for immigrants to access health-care services seems to be related to the capacity of a locality's safety net and social and human capital.

6. Ease of Access to Norwegian Health-Care Services for Undocumented Immigrants

Documented immigrants have easier access to health-care services than undocumented immigrants.

Figure 9.10. Access to Norwegian health-care services by undocumented immigrants**.**



Source: Data from the study.

[307] A. Siddiqi, Q. C. Nguyen, *A cross-national comparative perspective on racial inequities in health: The USA versus Canada. J. Epidemiol,* Community Health 64(1), 2010, p.29-35.

Figure 9.10 shows that 93.7 percent of undocumented immigrants do not have access to health-care services and 5 percent of undocumented immigrants do have access. While most of the challenges and barriers that affect documented immigrants also affect undocumented immigrants, undocumented immigrants have numerous additional challenges.

Immigrants may be undocumented for two main reasons: they never had legal status or they previously had legal status but lost it. *Non-status immigrants* refers to the group of immigrants whose claim for refugee status was denied or who are in the country illegally. *Undocumented immigrants* are those who had temporary employment or are visitors or students who have overstayed their visas. When they stay in Norway after their visas have expired, their stay is considered illegal.

One illegal immigrant interviewee said,

> I am often afraid to go to doctors; I fear that I may be detained or reported to immigration authorities and then deported . . .. I live here illegally. (Respondent 21)

Illegal immigrants like this interviewee are afraid to go to doctors out of fear that they will be detained or reported to authorities and then deported. Fear of arrest and deportation may lead undocumented and illegal immigrants to be constantly on the move in order to evade authorities, a situation which does not promote economic stability or stable relationships with health-care services and health care professionals.

Apart from the known challenges of documented immigrants, another challenge identified from the participants' responses is intimate partner violence (IPV), which was reported by 41.18 percent of the participants. There is a higher frequency of IPV among immigrants than among native Norwegians, a fact which is attributed to their greater level of social vulnerability. Social vulnerability has long been associated with economic difficulties, low levels of education, and high degrees of divorce and separation.[308]

Immigrant women in Norway who experience IPV have higher rates of major depressive disorders than other women in the country. In addition to this, physical and emotional IPV is associated with very low levels of self-reported health status and higher

[308] C. Vives-Cases, D. Gil-González, I. Ruiz-Pérez, V. Escribà-Agüir, J. Plazaola-Castaño, M.. I. Montero-Piñar, J. Torrubiano-Domínguez, *Identifying sociodemographic differences in Intimate Partner Violence among immigrant and native women in Spain: a cross-sectional study,* Preventive medicine, 51(1), 2010, p.85-87.

rates of disability, sexual and reproductive health problems, and chronic pain. Many immigrants who are in Norway illegally are affected by post-traumatic stress disorders.[309]

Immigrants are also subject to more police control than native Norwegians. Police brutality is a form of political violence and can inflict severe health problems (whether physical or psychological). Societally biased conduct such as discrimination, segregation, and racism against immigrants in Norway has also been reported. Consequently, immigrants are at a higher risk for health problems. Significant numbers of immigrant patients are diagnosed with major depression or post-traumatic stress disorder.[310]

Immigrants, especially women, may experience economic challenges:

> Oh, my goodness! I feel so bad . . . access to health needs? I don't have a bank account, a credit card, or any money. How If I feel sick… how can I get access to health services and pay for for that? I want to take care of my health, to be healthy and happy, and to work. (Respondent 7)

This response shows that some African women immigrants do not know anything about what to do to finance access to health services. Most undocumented immigrants in Norway have undergone economic difficulties (the periods of living described by immigrants as isolation, passivity, and waiting because of the lack of money and jobs) that destroy the self—the very foundations of a person's stability and values.

A female respondent from Europe stated:

> I have good education. I wish to take . . . better care of my health and spend more quality time with friends. Working 24 hours a week is enough for me. (Respondent 41)

A male respondent from Europe stated:

> I just want to work. I've applied for many jobs in the last six months. I have only received few calls for interviews. I've been passed up for lack of working experience...I want to have a full time work. (Respondent 42)

This response is one example of how immigrant women—especially educated immigrant women from Europe—are more focused on taking care of their health than are

[309] T. Myhrvold, F. Eick, *Undocumentedness, human rights and nurses' obligations: an appeal, Oslo:* Health Centre for Undocumented Migrants. 2010, p.6.
[310] R. P. Foster, *When immigration is trauma: guidelines for the individual and family clinician,* American Journal of Orthopsychiatry, 71(2), 2001, p.153.

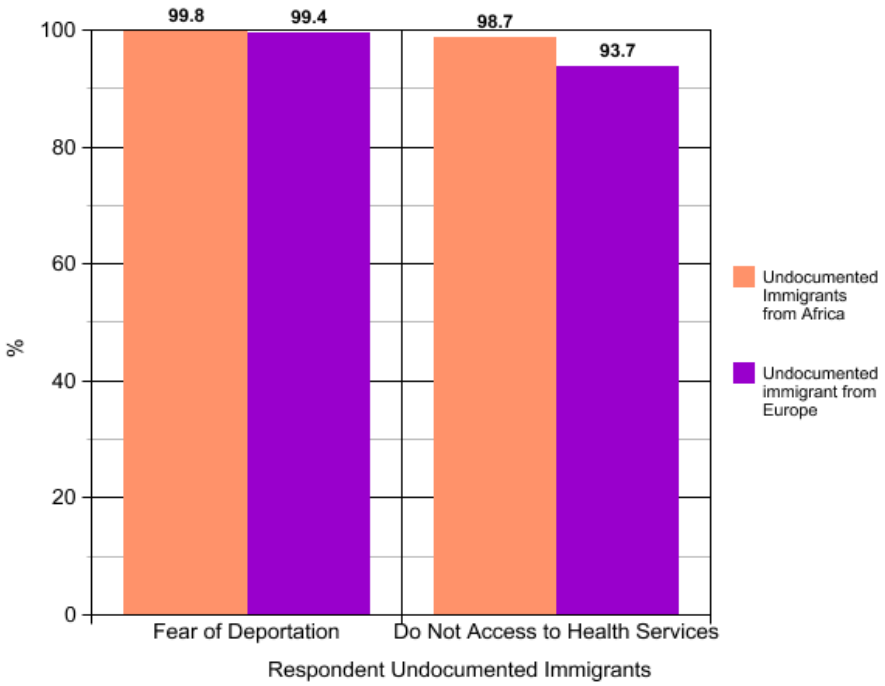
men. They tend to take on more caring responsibilities than men by working fewer hours and, thus, taking home less pay.

7. Undocumented Immigrants' Contributions to the Norwegian Health-Care Crisis

Illegal immigration is a social problem not only in Norway but also in a growing number of countries worldwide. A health-care provider states:

> We do not [arrest or deport] people just because they are seeking health care…. We offer access to health services, "emergency care," without thinking or asking about patients' legal statuses. The legal statuses of immigrants, for the most part, do not affect how we care and what we do for people…. Our awareness of the legal situation of an immigrant may put us into a dilemma when the service the patients are going to receive is expensive. It's a big problem if immigrants are not covered by the National Insurance Scheme. Uninsured patients should cover the costs of their treatment by themselves. [There] may be some delay in treatment when we do not know who will pay for it. All this [puts] us in a challenging situation. Ethically, we must provide treatment, but from a legal point of view—we must not. (Respondent 52)

Figure 9.11. Reported fear of deportation and access health-care services for undocumented Immigrants.



Source: Data from the study.

Figure 9.11 shows that in general, the undocumented immigrant respondents from Africa and Europe feared exposure to deportation. Consequently, they did not have access to health care. An undocumented immigrant with fear of the unknown declared:

> I just think, What will happen with me tomorrow? The police will come and take me away and send me to an unknown country. An order of deportation means a death sentence for me. I am between yes and no . . .. I am backed against the wall, waiting. I am really not motivated to learn, to get information about health issues. I have no rights, no right to [a] job, to education, to get income, [and] no right to access to health-care service. (Respondent 21)

Undocumented immigrants do not benefit from assistance programs because the fear of deportation keeps them away and because of past experiences that have greatly influenced their health-seeking behaviors. The fear of arrest and deportation lead undocumented immigrants to be constantly on the move in order to evade authorities, a situation which does not promote economic stability or relationships with health-care services and health care professionals. This has become a subject of debate among experts in the field of public health. The World Health Organization has reported that illegal immigrants comprise one of the most

at-risk groups for health problems.[311] This fact is directly connected to their irregular legal statuses and economic and social marginalization. It is also worth noting, however, that the Article 25 of the 1948 Universal Declaration of Human Rights recognize illegal immigrants' right to health care[312].

The increase in the number of undocumented immigrants in Norway has largely contributed to a challenging health crisis. Most undocumented immigrants in Norway do not have any medical insurance coverage, and for most of them, the costs of health care are beyond their capacity to pay. As explained earlier, 88.24 percent of this study's respondents explained that their financial incomes and abilities do not cover their health needs. Although undocumented immigrants have to pay out of pocket to emergency health-care services from specialized and municipal health-care services, according to Aschehoug (2010), the definition of *emergency health-care services* is strictly interpreted concerning the limits of care that may be provided.[313] Furthermore, researchers have noted that the restrictions on "necessary care" may violate core human rights to essential primary care.[314]

Some special and non-governmental organizations such as Frivillighet Norge, Red Cross, and Norwegian Refugee Council (NRC) have expanded the health care they provide for documented and undocumented immigrants. For instance, undocumented women have the right to prenatal care, care during birth, and postnatal care from the hospitals. They also have the right to induced abortions. Children of undocumented immigrants under the age of 18 have similar rights to those of legal residents of Norway. Sinding and Kjellevold (2012) and Søvig[315] (2011) explained that undocumented immigrants have the right to health care for infectious diseases and psychiatric care for mental illness.

These benefits result in increased populations at the hospitals and medical facilities. However, as noted earlier, Norway has very few natives who are unemployed; thus, it mainly depends on immigrants from other countries as a workforce. The result is that the number of immigrant patients requiring hospital care is greater than hospital and medical practitioners can handle, which further contributes to the existing health care crisis.

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[311] M. Stanhope, J. Lancaster, *Public health nursing: Population-centered health care in the community*, Elsevier Health Sciences. 2015, p.62-66.
[312] U. G. Assembly, *Universal declaration of human rights.* UN General Assembly, 1948.
[313] S. Aschehoug, *HELSE OG JUS-Retttilhelsehjelp for papirløsemigranter [Right to health care for undocumented migrants]*, Tidsskrift for Den norskelegeforening, 130(7), 2010, p.765.
[314] H. Sinding, A. Kjellevold, *Welfare and human rights: "Illegal residence" as the basis for limiting the health and welfare services?* Tidsskrift for velferdsforskning, 15(2), 2012. p.93–108.
[315] K.H. Søvig, *Provision of health services to irregular migrants with a special focus on children*, European Journal of Health Law, 18(1), 2011, p.43–54.

Since undocumented immigrants are not members of the Norwegian National Insurance Scheme (see Chapter 8), they do not have the right to assigned GPs. A health-care provider said this:

> All [foreigners] without a residence permit in Norway must pay for the treatment they receive. If they have travel insurance, or if their home country has an agreement with the Norwegian health service, some or all of the bill may be covered. For those who have applied for asylum and are staying at a center for asylum seekers, [they] are entitled to receive health care while their case is being processed. (Respondent 8)

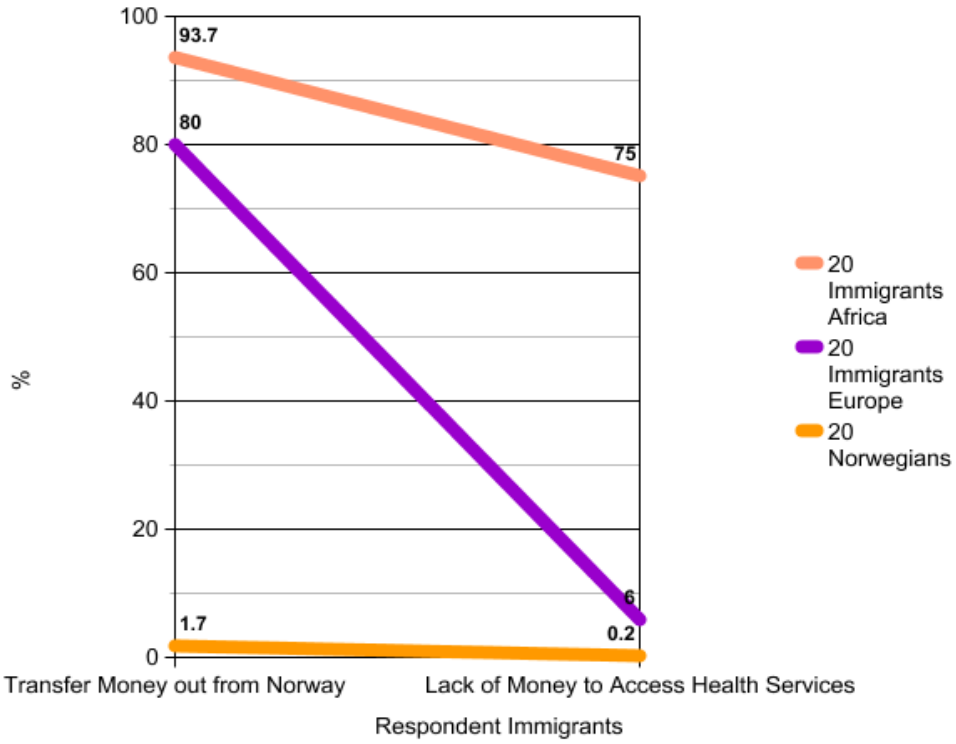
Having a right to care does not mean the care is free. Undocumented immigrants have the obligation to pay the full cost of their treatment. Exceptions are made, however, for prenatal care, involuntary admissions to psychiatric treatment and care, treatment of contagious diseases, and infections and vaccinations—all of which are free for all people regardless of legal status. While in some countries health professionals may face criminal charges for treating undocumented immigrants, the case is very different in Norway. The health professionals are mandated to ensure the confidentiality of all information pertaining to patients, and it is illegal for them to share the patients' information.[316]

8. Immigrant Remittances in Relation to Access to Health-care Services and Economy in Norway

Remittances are private, unrequited transfers of money from immigrants to the family members they leave behind; they represent a great challenge to access to health services and have an adverse effect on immigrants' health.

Figure 9.12. Facts about respondents' remittances and access to health-care services.

[316] H. Castañeda, *Illegality as risk factor: A survey of unauthorized migrant patients in a Berlin clinic.* Social Science & Medicine, 68(8), 2009, p.1552–1560.



Source: Data from the study.

Figure 9.12 shows that the respondents from Arica were an overrepresented group regarding transferring money out of Norway. Of the respondents from Africa, 93.7 percent sent money out of Norway, compared to those from Europe (80%) and Norway (1.7%). We note that 75 percent of the respondents from Africa lacked the money to access health services, versus 6 percent of the respondents from Europe and 0.2 percent of the respondents from Norway.

In response to the questions about how immigrants manage their lives and economies and whether they sent money to their home countries, an immigrant said:

> I [used] to send money by Western Union to my father for shopping for new clothes and paying for health-care needs. My family in Africa needs my help. Here in Norway, I only have enough money to survive . . .. Going to the hospital when I am sick? No . . . it's expensive . . .. I prefer to [treat] myself with my traditional medicine. (Respondent 25)

This answer shows that some immigrants send their money to their countries of origin. Immigrant remittances are truly a force to be reckoned with in the global economy and make up one of the major international flows of financial resources. Immigrants send funds back home during hard times, which influences the immigrant economy by reducing the money available to use for their own health, as well as their economic activity in their host

countries. Many immigrants' primary goal is earning as much money as possible in the shortest time possible to send it to their home countries; caring for their health is not on their priority list.

9. The Interplay of Income, Education, and Health

Immigrants, both documented and undocumented, make major and significant contributions to the economy of Norway. However, those contributions are both positive and negative. The increased rate of immigration has gradually affected the rate of unemployment.

One of the major impacts of the increased rate of immigration in Norway is a reduction in the wages of employees. Immigration lowers the wages of relatively low-skilled native Norwegian employees in those sectors and organizations of the economy that hire larger shares of foreign workers. The reduction in the cost of wages that the employers enjoy is mostly passed on to consumers. Inflation is much higher for services with no changes in immigrant employment than for those services in which the rate of immigrant employment is on the rise. The research also shows that low-skilled and semi-skilled workers have increasingly faced competitive pressures on wages, salaries, and employment, while consumers enjoyed more and better-quality services at lower prices.

In response to questions about whether getting a job is important for health and whether they see themselves as an economic burden on Norway, some participants said "yes." One answered,

> I spend all my time by watching TV; I really need a work permit to make money. I want to work; it's good for my well-being, and I can contribute in this society by working and paying taxes . . .. You know, . . .if I get sick, I will not have money to pay. I am alone here, with no family members to help me. (Respondent 11)

This response can be understood to mean that staying home and watching TV may lead to health problems. Social isolation and lack of physical activity, exercise, and physical fitness affects both mental and physical health (see Chapter 2). Transportation to and from health services is a challenge for many immigrants. Some immigrants rely on a social network (family, friends, and neighbors) for visiting health services.

Unemployment has devastating health effects. Unemployment is highest amongst immigrants with low educational levels. Immigrants with good educations have more opportunities for job and income security than those without solid educations. Immigrants'

abilities to access health services, to understand the information related to access to health services, and to keep themselves healthy is subject to their levels of education. Income from employment is the most important source of income in enabling immigrants to get access to health services. Factors such as their durations of stay, reasons for immigration, employment or status as refugee, actual time of immigration, and homeless influence the income situations of immigrants. Immigrants from Western Europe have higher incomes than immigrants from developing countries. Undocumented and unemployed immigrants have even less capacity to pay for health-care costs. Health-care service in Norway is expensive, and paying for it is difficult for some immigrants.

Another immigrant stated:

> I do not have money, no job. I am nervous most of the time. I feel pain, some physical ailments. I am stressed and depressed. My days are too long and too much. I'm not working. I can't [easily] afford medical care. (Respondent 19)

A health-care provider stated:

> When [patients] have no place to go to, no activities to spend time with, no job to do, and no money to feed, protect, and send their relatives to school, their days become chaotic. They stress because of their financial situation. We could do more than just prescribe medication. (Respondent 33)

Another health-care provider said this:

> Many of [the immigrants] do not come to the hospital to get help; some of them do not take the prescribed medication because they can't afford to buy it . . .. They say they can't afford to buy medicine. They just buy paracetamol to relieve pain and . . . paracetamol for anything. (Respondent 9)

These responses show that having a job or other income and a social network are very important for immigrants' well-being. Many immigrants are unaware of the medical assistance available for them. There are some immigrants who need medical assistance, but, due to different reasons, they do not seek out professional medical help. The reasons for this include everything from socio-economically contingent differences in the experience of illness to levels of income and education to a lack of familiarity with the Norwegian health services. Financial burdens (unemployment, lack of insurance, and low income), the

organizational structure of the health-care system in Norway, poor social networks, and human capital factors also serve as barriers to immigrants' access to health-care services.

Income levels and financial hardships and difficulties can ultimately affect both objective and subjective health. Income directly affects health because healthier immigrants can afford the resources needed to protect and improve their health. Economic difficulties are described as one of the main reasons immigrants do not seek medical services. Health-care services in Norway are expensive, and many immigrants are not aware that, regardless of their immigration status, they may qualify for financial assistance for hospital medical services under the Social Welfare System/National Insurance Scheme. Much welfare information is, unfortunately, available only in Norwegian. An immigrant said this:

> When I [came] to Norway, I had no education; I couldn't read Norwegian. I just wanted to stay home. I didn't know and understand how to find information about access to health care. I began to learn Norwegian. Over the past 5 months, I began getting health information. A lot of the information that I got, I found on the Internet. I was able to find information that [was] important to working and health (e.g., transportation to health care facilities, stable housing, insurance, healthy food, health care, and access to health care). (Respondent 26)

This statement shows that immigrants with education have significant advantages in gaining access to health-care services, securing employment, and finding information about jobs. Education helps develop one's ability to get information and to solve problems on many levels; it increases one's potential to have and to understand information related to accessing health-care services.

Many immigrants do not know that being an inclusive and equitable society is an important goal for the Norwegian government.[317] In Norway, it is important that everyone feels like a part of Norwegian society, regardless of socio-economic background. An equitable health-care system is a part of, and a prerequisite for, achieving this goal. Asylum seekers and immigrants for family reunification purposes have automatic rights to national insurance on arrival but must register for tax registration. As members of the national insurance plan, patients pay only a portion of the expenses for public health services—the so-

[317] Regjeringen, *NOU 2011:7, Welfare and Migration : Perspective and summary*, 2011. Aailable at: https://www.regjeringen.no/globalassets/upload/BLD/IMA/nou_2011_7_perspective_andsummary.pdf . Accessed 01.02.2017.

called deductible. The lack of health insurance or national health schemes and unaffordable health care costs make access to health care very difficult for some immigrants.

The respondents' responses explained that they make substantial contributions to the economy of Norway. Most of the documented immigrants who had been employed by the government or by the international organizations have records of paying taxes to the government; thus, they participate in the overall growth of the country. Moreover, they provide services and products to the residents of the country, enabling residents to obtain cheaper goods and services.

However, countries hosting immigrants also experience difficulties in their economies due to the need to provide for them. According to Lindahl (2013), the increased number of immigrants in Norway costs the government approximately 4.1 million Norwegian kroner per year.[318] The business daily *Finansavisen* computed that by 2100, Norway would pay approximately 4,000 billion kroner for immigrant services, which is more than the entire oil fund and the state's share in the oil company Statoil combined.

With the increased integration of European and global labor, goods, capital, and services markets, evidence of how international migration affects the receiving and sending economies is now among the more interesting subjects of economic research.[319] While some researchers have found that immigration causes unemployment, other researchers have found that unemployment actually causes emigration. Withers and Pope (1993) found in their research in Australia that the higher the rate of unemployment in a country, the higher the rate of emigration was.[320] Feridun (2004) conducted research in Sweden investigating the impact of the increased rate of immigration on the two most popular indicators of macroeconomics: gross domestic product (GDP) per capita and unemployment.[321] His research showed that there is a direct relationship between immigration of a foreign population and GDP per capita. When the level of immigration increases, GDP per capita also increases.

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[318] B. Lindahl, *OECD: Economic worries fuel immigration debate — Nordic Labour Journal,* Nordiclabourjournal.org. 2015. Available at: http://www.nordiclabourjournal.org/nyheter/news-2013/article.2013-06-18.6621190769. Accessed 30 December 2015.

[319] M. Mussa, *Factors driving global economic integration. Global economic integration: Opportunities and challenges,* 2000, p.9-55.

[320] G. Withers, G. D. Pope, *Immigration and Unemployment,* Economic Record. 61(1), 1993, p.11-13.

[321] M. Feridun, *Does Immigration Have an Impact on Economic Development and Unemployment? Empirical Evidence from Finland (1981 – 2001),* International Journal of Applied Econometrics and Quantitative Studies. 1 (3), 2004, p.39-60.

The relationships between immigrants'health, their access to health services and economy are complex but significant. Immigrants'access to health services affects their health status by weelbeing, which in turn affects economy by productivity.

CONCLUSIONS

Health is a wealth of society guaranteeing its social and economic development, because only a healthy society is able to create material goods, develop and achieve the right length of life. In this approach, it is believed that health should be the basic resource of the individual and society as a whole and it must be supported by investing in living conditions, because a sick, impoverished society does not guarantee or secure social and economic development. Understanding health as the fundamental right of every human being gives the basis for taking action to improve the health of society and its development.

Health is a state that allows an individual to adequately cope with the demands of daily life. Health is also a significant determinant of economy, the basis for job productivity, and the basic capabilities giving value to human life. Health is a means that bring the capacity for individual development and economic security in the future. Physical health refers to the physical functions of the body that prevent certain diseases or other negative elements from impairing bodily functions. Objective health and subjective health are fundamentally linked. Interdisciplinary health research helps to completely answer complex health questions. Health depends on income and income is a means to improve health, and hence to reduce health inequalities. Immigrants' health problems are associated with their socio-economic backgrounds, expectations, and unfamiliarity with the health-care system compared to those in their countries of origin. Ill, health and lack of access to health services may affect employment opportunities in ways that affect subsequent health.

Immigrants are persons who have citizenship in one country and enter a different country to set up a permanent residence. Immigrants are, according to the Norwegian law, persons born abroad with two foreign-born parents and four foreign-born grandparents, in addition to persons born in Norway with two foreign-born parents and four foreign-born grandparents. There are two types of immigrants: legal and illegal. A legal immigrant has received a proper visa or clearance prior to living in the host country. An illegal immigrant sets up residency in another country without proper legal documents and clearance. Understanding immigrants' health problems is of crucial interest to policy planners and service providers to provide satisfactory services for the country's immigrant population. Some immigrants have limited education, are in a poor financial situation, are unemployed, lack adequate shelter, have no social networks, have different standards of religion and socio-economic backgrounds, must comply with new laws to deal with possible racism, have a

different perspective on health or treatment of disease, and don't know the host country's health system. Immigrant access to health-care systems is still problematic. The high costs of health care and the erosion of health insurance coverage are among the main challenges affecting many nations and people all round the world.

Social and health policy play fundamental roles in advocating for health and well-being of all the citizens. They are also instruments used to improve immigrants' health, to expand access to health and reduce socio-economic inequalities.

It is the basis for understanding the health status of immigrants in Norway with regard to the accessibility and responsiveness of the health-care system. Norway is presented as a diverse and complex society because of immigrants who come to Norway for various reasons, including education, jobs, refuge, and family. Immigrant health care in Norway is distinct from Norwegian citizen health care due to various political, social, and economic factors. Immigration status has a significant connection to access to health care. The challenges that hinder or prevent immigrants from accessing health services are economic, educational, structural, and social. Scarcity negatively impacts immigrants' health. Unhealthy immigrants may negatively impact the economy in Norway because they cannot bring their human capital to technological progress and innovation.

In Norway, the government is responsible for developing and implementing effective health policies and social policies to promote its citizens' well-being. The quality health care services, the right to be a patient, patients' rights, and procedural rights are important.

The empirical analyses of my work reveal a disparity in the ease of access to health services between Norwegian citizens and immigrants. There is also variation among the respondents' immigrants themselves, depending on their origins, sexes, incomes and educations. Socioeconomic background and immigration status influence immigrants' access to health care services. Living in a limited space is challenging for respondents and makes access to health services very complex.

The diverse levels in the ability to access health services are caused by socio-economic factors including education, income, and health literacy levels; inability to pay for healthcare services and lack of health insurance; lack of understanding of the Norwegian health-care system; communication barriers; social isolation; remittances; fear of deportation, and stereotypes. The Norwegian health-care delivery system is fragmented and very difficult to navigate.

For proper social development, it is important to take care of the health of all citizens. The Norwegian government must work to improve the health of immigrants as an important

factor for accelerating their integration in the society and for economy. In the work of this dissertation, I found some clarity about the importance for immigrants to have access to health services. Health and access to health services are fundamental to human happiness and well-being. Access to health-care for immigrants frees up human capital—which is an integral part of the economy. The use of knowledge, abilities, qualifications, and skills of all citizens can stimulate economy. Involving immigrants as employees and entrepreneurs creates opportunities and impacts the economy.

The respondents' answers reveals a disparity in the ease of access to health services between Norwegian citizens and immigrants. There is also variation among the respondents immigrants themselves, depending on their origins, sexes, incomes, and educations. Living in this liminal space is challenging for respondents and makes access to health services very complex. The diverse levels in the ability to access health services are caused by several factors. The socio-economics factors include education, income, and health literacy levels; inability to pay for healthcare services; lack of understanding of the Norwegian health-care system; communication barriers; social isolation; remittances; fear of deportation, and stereotypes.

The Norwegian health-care delivery system for immigrants is fragmented and very difficult to navigate, and its use depends on affordability, physical accessibility, acceptability of services, and the adequacy of supply. Many respondents have little knowledge about health, health services, how and where to seek help, what is being referred to, who can direct them, and where it is possible to get help. Further, many respondents simply do not know what their rights to health are. Socio-economic factors are viewed as major influencers in the link between respondents' health and incomes, because there is a social gradient in health—an increase in socio-economic standing improves immigrants' access to health services by the same degree.

Generally, it is not possible to fully answer all of the research questions posed in empirical research. Further research is required to answer of some the questions posed in this study.

RECOMMENDATIONS

This section presents the recommendations for social and health policy makers to focus their efforts on immigrants' health issues and their access to health-care services in Norway. Expanding immigrants' access to health-care services may contribute to the economy in the country. The social, economic, and political integration of migrants; the existence of local health-care services and education; the use of mediators from immigrant communities, and the recognition of individual needs are key factors for immigrants with different backgrounds, origins, and sexes for enabling their access to health services and economy. The focus is on immigrants' access to health-care services and the effects of the impact on economy of this access.

The presence of immigrants in the country contributes to its human-capital diversity through their new thinking, innovation, and creativity. Migration also puts Norwegian society on trial, regardless of cause as it challenges health policy makers to translate their policy to action and to appropriately support these immigrants in the society on improved access to health-care services. Not least, this applies to the Norwegian welfare state's sustainability. Therefore, the regulation of immigration is necessary for the purposes of keeping society dynamic, improving immigrants' access to health services, and giving greater attention to immigrants' health.

It is important to develop immigrants' health literacy skills and to increase their awareness of the use of health services. Educational institutions and school systems must provide the health professionals with the skills, attitudes, and knowledge to provide competent care, better education about access to health care, and education to improve health literacy in order to create a migrant-friendly health system. Health-care providers must be trained to educate and teach immigrant patients to navigate the Norwegian health system through easily accessible health services and multilingual information. Training immigrants in Norwegian and training professionals in other communication skills is fundamental to building rapport with health-care providers and improving access to health-care services. Further, increasing immigrants' access to high-quality medical interpretation services is required. Through early communication training, practical training (the ability to help immigrants and their families ease themselves into daily life in Norway.), and organization work, the Norwegian people can help immigrants to easily access health-care services.

There is a need to create a properly structured health delivery system that can reach immigrants. The highest priority is to create a service delivery system at the local level. A

medical system based on building trusting relationships between immigrants and their general practitioners may lead to positive personal experiences and willingness to use the health-care services. Health professionals and the Norwegian government need more understanding of the different population groups' specific health challenges. At the same time, it is important that immigrants are received and treated as individuals regardless of their socio-economic backgrounds or status. Additionally, information about access to health-care must be made available in multiple languages and in social media, newspapers, and so on.

Many immigrants have lower levels of trust in the health-care community because of past discrimination in health services. Accordingly, access to health services for immigrants must be based on the development and maintenance of trustworthiness, patient-centered orientation, and social competency of the doctor and health-care system. Norwegian immigration, social, and health policies should not foster discrimination against a category of patients in the provision of health care.

The presence of different religions also poses challenges for the access for health services. Health care must have policies such as allowing immigrants the possibility to choose their preferred food in the hospital and allowing Muslim women to choose to be examined by female doctors.

Greater investments in specific health services by the Norwegian government would enable easier access for immigrants. The best way to create a migrant-friendly health system is to remove barriers to accessing health care. Therefore, the Norwegian government should invest in immigrants' health by conceptualizing some dimensions of accessibility:

- Approachability
- Acceptability
- Availability and accommodation
- Affordability
- Appropriateness

Immigrants themselves must also manage the differences in access to health-care by addressing their own willingness to adapt to life in a different socio-economical setting. Self-orientation, others-orientation, socio-economical toughness, and perceptual ability can make health-care service accessibility easy. *Self-orientation* refers to the ability to strengthen immigrants' self-esteem, self-confidence, and mental well-being. Immigrants with solid self-esteem and self-confidence may have more interest in and be better able to access to health-care services. *Others-orientation* helps immigrants to interact effectively with Norwegians.

The more interaction there is, the more likely immigrants can easily get access to health services. Relationship development and communication help build friendships with Norwegians, and having a Norwegian as a friend may help in case of health problems. A well-developed social network can help them get information about health care services.

Perceptual ability refers to the ability to understand why Norwegians behave the way they do. This will help immigrants be more flexible to the Norwegians' style, to adjust to it as social conditions warrant. *Socio-economic toughness* refers to how well immigrants adjust to particular health-care information and costs.

Immigrants must learn to tolerate their anxiety and learn that access to health-care services will become easier the longer they live in their host country. The fear of deportation puts stress on undocumented immigrants and make them sick. Having more knowledge about the health-care system and developing the courage to meet and face detection by authorities are factors that would strengthen the ability of immigrants to access health care.

Immigrants' abilities to generate health access and to contribute to economy must include:

- Ability to perceive one's own health
- Ability to seek health services
- Ability to reach health services
- Ability to pay for health services
- Ability to engage for getting access to health services

A direct-access health-care program should be in place to provide immigrants with coordinated primary and preventive health-care services. In addition, Norway needs to expand the capacity of its health-care system to provide competent primary and preventive health-care services to immigrants.

The quality of life of immigrants can be improved if, on a regular basis, the Norwegian government conducts community public education and outreach about health care and coverage options for immigrants and the organizations that serve them. Norway must continue to work to ensure that immigrant status is never a barrier to the provision of health care.

All immigrants must have access to appropriate care and emergency services, and the country's immigration policy must not interfere with the ethical obligation to provide care for all. Health care must have guidelines that include common ethical values emphasizing how health-care workers should carry out their work. These guidelines should be based on treating

everyone with respect, irrespective of gender, age, ethnicity, sexual orientation, religion, social background, physical or psychological functioning, and organizational/political orientation. The Directorate of Immigration must continue to improve the adaptation of public health services to immigrants' needs by providing support for health projects, training, information, advice, and guidance. When the government fails to optimally help immigrants' get access to care, individuals and charities must step in to make health services for immigrant accessible.

Access to health services for immigrants is a national issue and must be addressed through social and national health policy. Diversifying the health-care workforce to include more socially competent immigrant care providers should be a national priority. The Norwegian government has to develop new and innovative strategies and health policies able to support safety-net health-care facilities (community health centers, health centers, public health agencies, and hospitals), ensuring access to health care for immigrants. The Norwegian government must do more by investing and offering health access and higher education to immigrants at no cost. Political regulation of remittances may also give immigrants more economic power to invest in their own health.

Good health will open the door for job training, which is important for fostering an appreciation for Norwegian socio-economic systems. An understanding of the Norwegian society will help immigrants empathize with the socio-economic aspects, which will enhance their access to health-care services. Improving the health of immigrants with good social and health polices can result in economy, because there will be more people to work, create jobs, produce goods. It is socio-economically profitable for Norway to work for better access to health care for immigrants. Enhancing immigrants' integration by making health services more accessible can boost GDP per capita and promote entrepreneurship, the allocation of human capital, and productivity.

By establishing policies that positively influence social and economic conditions and that support changes in immigrants' behavior, the conditions in which immigrants live, learn, work, and search access to health services can be improved. The quality of immigrants' relationships with the Norwegian people can create a healthier population, society, and workforce contributing to economy.

Assessing immigrants' health statuses and integration into the labor market is vital to reducing social inequality and raising the GDP per capita through healthier labor force participation. Labor market integration is necessary for the total utilization of their "human capital." Educational institutions have to properly assess immigrants' credentials and cater to

the needs of skilled migrants in terms of their acquiring the skills needed in the Norwegian labor market. Continuous work in assessing immigrants' health and contributions of human capital is important to national economy at the micro and macroeconomic levels.

Greater financial investments in making specific health services accessible to immigrants must be a priority. Health investments lead to higher individual immigrant productivity and economic economy. Health is an important component of human capital and a crucial determinant of economic development. All efforts toward improving information about access to health services and investing in immigrants' health must take place.

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APPENDICES

APPENDIX A

INFORMATION SHEET
AND
INFORMED CONSENT FORM

INFORMATION SHEET FOR PARTICIPANTS

PROJECT TITLE:

Immigrant Health Status and Access to Healthcare. The Case of Norway

INVITATION

My name is Emmanuel Aoudi Chance, and I am a student at The Institute of Economic Sciences of the Polish Academy of Sciences, Pałac Kultury i Nauki, Warszawa. You are invited to participate in a research study exploring *Immigrant Health Status and Access to Healthcare. The Case of Norway*. Through this proposed study, I intend to address the current lack of research evidence on this topic. This study has been designed to discover your perspective and experiences with regard to the accessibility to healthcare services and healthcare facilities in Norway, to understand if the healthcare system is responsive to immigrants'needs. Therefore, it is very important to understand your perspective on this issue, as this will provide valuable information that can help sustain and improve immigrants access to health service.

Should you agree to take part, I will ask you to answer some questions. There are no right or wrong answers—I just want to know your opinion. This study will involve an audiotaped interview. The discussion should take about 30 minutes at most. The interview will be conducted at a time and place nominated by you. Please note that some of the questions will relate to your personal history and experiences in norway

Participation is voluntary. If you do not want to take part, you do not have to give a reason and there will be no pressure to change your mind. You can also withdraw from the discussion at any time. Please note, if you choose not to participate or withdraw during the discussion, this will not affect you.

RISKS AND BENEFITS

This study may not pose any benefits or risks for you. Its findings will only provide important information to nurses, relatives, local health authorities, and healthcare administrators on how to improve patient care. If you feel distressed during the interview, I will stop the process and refrain from further queries, proceeding only if you wish to do so.

CONFIDENTIALITY

All the information you provide will be confidential and will be used for the purposes of this study only. To ensure anonymity, once the study is complete, all collected data will be securely destroyed. During the project also, the information will be used such that participants cannot be individually identified. No one will be able to link any information you provide back to you. Thus, your anonymity will be safeguarded at all times.

WITHDRAWING FROM THE STUDY

You may decide to withdraw from the study at any time without explanation. You have the right to omit or to refuse to respond to questions asked of you. You are free to withdraw consent. You are free to discontinue participation at any time.

CONTACT

If you have any queries or concerns with any aspect of this study, please contact me by phone on 00 47 476 30 433 or by email at chaemao@yahoo.no

You may also contact my Supervisor:

dr hab. Violetta Korporowicz
Profesor nadzwyczajny SGH
Szkoła Główna Handlowa w Warszawie
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ul. Wiśniowa 41 p. 66
02-520 Warszawa
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THANK YOU VERY MUCH FOR YOUR HELP!

INFORMED CONSENT FORM

PARTICIPANT

PROJECT TITLE

Immigrant Health Status and Access to Healthcare. The Case of Norway

By signing below, you agree that: (a) you have read and understood the Participant Information Sheet; (b) any questions you have about your participation in this study have been answered satisfactorily; (c) you are aware of the potential risks (if any); and (d) you are taking part in this research study voluntarily and without coercion.

_____ _____

Participant's signature Date

INTERVIEWER

I have fully explained to the respondent _____ the nature, aim, and procedure of this study, as presented above. All respondents will have a copy of the Information Sheet.

_____ _____

Signature of Interviewer Date

_____ _____

Print Name Position

APPENDIX B
INTERVIEW PROTOCOL

INTERVIEW QUESTIONS

SECTIONS A, B, C, D, E, F

Interested in speaking with you about health and access to health services in Norway, Is it OK? I have some questions about your background, education, income, and health., and health care services.

SECTION A: Demographics

I'd like to start out by asking you to please verify the spelling of your name. Could you please give me your full name starting with your family name.

Sex ☐ Woman ☐ Man ☐ Refused ☐ Don't know	**What is your name?** My name is _____ Refused _____ Don't know _____
In what year and month were you born? Year _____ Refused to answer _____ Don't Know _____	**In what country were you born?** Other specify _____ Refused _____ Don't know _____
How much longer will you be where you are now? Number _____ Refused _____ Don't know _____	**Are you currently living by yourself or with other people in your current residence?** Family members ☐ Housemates ☐ Roommates ☐ Foster children ☐ Roomers ☐ Boarders ☐
Including yourself, how many people are currently living in your household? Enter the number _____ Refused _____ Don't know _____	**What is this person's relationship to you?** Name _____ Kind of relatioship _____ Refused _____ Don't answer _____ **In what country was he/she born?** Country _____ Refused _____ Don't know _____
Where are you living in Norway? Live far from health facilities _____ Live close from health facilities _____ Don't know _____ Refused _____	**What is your profession** Profession _____ Refused _____ Don't know _____

SECTION B: Education

Can you read Norwegian? Yes _____ No _____ Refused _____ Don't know _____	**Do you speak Norwegian** Yes _____ No _____ Refused _____ Don't know _____
How many years of schooling in total have you Completed? Number _____ Refused _____ Don't know _____	**Have you received any degrees, diplomas or certificates from your schooling?** Yes _____ No _____ Refused _____ Don't know _____
In what country did you receive this degree, diploma or certificate? Country _____ Refused _____ Don't know _____	**What is your parents' educational level?** Education _____ Refused _____ Don't know _____ **What is your parents'occupation?** Occupation _____ Refused _____ Don't know _____
Can you contribute to society? Yes _____ No _____ Don't know _____	

SECTION C: Health

Would you say your health is: Excellent _____ Very good _____ Good _____ Fair _____ Poor _____	**Compared with your health right before you most recently came to Norway to live, would you say that your health is:** Better now _____ About the same _____ Worse _____ Don't know _____
How much does this condition limit your normal daily activities? A lot _____ Somewhat _____ Just a little _____ Not at all _____ Refused _____ Don't know _____	**How do you communicate with your doctors or nurse?** A lot _____ Somewhat _____ just a little _____ Not at all _____ Refused _____ Don't know _____
How do you do when you are sick? Hospital _____ Stay home _____ Traditional medicine _____ Other _____	**Do you get assistence when you have health problem?** Yes _____ No _____ Don't know _____ Refused _____ **Explain**
	Do you thing the doctors understand you? Yes _____ No _____ Don't know _____

SECTION D: Health Care Utilization

In the last 6 months, have you been a patient in a hospital overnight? Yes _____ No _____ Refused _____ Don't know _____	**How many different times were you a patient in a hospital overnight in the last 6 months?** Number _____ Refused _____ Don't know ___ _____
In the last 6 months, have you been a patient overnight in a nursing home, convalescent home, or other long-term health care facility? Yes _____ No _____ Refused _____ Don't know _____	**Aside from any hospital stays, have you seen or talked to a medical doctor about your health, including emergency room or clinic visits in the last 6 months?** Yes _____ No _____ Refused _____ Don't know _____
Aside from any hospital stays, how many times have you seen or talked to a medical doctor about your health, including emergency room or clinic visits in the last 6 months? Number _____ Don't know _____ Refused _____	**Were the costs for your doctor Completely covered by public or private health insurance, partly covered by insurance, or not covered at all by insurance?** Fully covered _____ Partly covered _____ Not covered don't know _____ Refused _____
Can you communicate to doctors, nurses in Norwegian? Yes _____ No _____ Don't know _____ Refused _____	**How is it for you access norwegian health care services (Describe please)** Good _____ Bad _____ Worse _____ Refuse _____ Don't know _____
In the last 6 months have you seen a dentist for dental care, including dentures or general practioner? Yes _____ No _____ Don't know _____ Refused _____	**Were your dental or medical traitement expenses completely covered by health insurance, partly covered by insurance, or not covered at all by insurance?** Fully covered _____ Partly covered _____ Not covered _____ Don't know _____ Refused _____
How are you treated in Norwegian health care. **(**Experiences with hospital staff if any) • Fully satisfied • Partially satisfied • Dissatisfied • Strongly dissatisfied • Don't know	**Your experiences with the norwegian healthcare system (Experiences with hospital staff if any). Are you:** Fully satisfied? _____ Partly satisfied? _____ Dissatisfied? _____ Strongly dissatisfied? _____ Don't know? _____ Refused? _____ **Describe your experiences** Yes _____ No _____ Refused _____
Do you know the norwegian healthcare services? No _____ Yes _____ Don't Know _____ Refused _____ **Do you have health insurance?** No _____ Yes _____ Don't Know _____ Refused _____	**Describes your experience with meeting a Norwegian emergency unit**

What are your experiences when seeking healthcare?	**Do the norwegian health sytem differ from the health care system you come from?** Yes _____ No _____ Don't know _____ Refused _____ **If possible, describe**
Do you know the phone of the norwegian Ambulatory services The number _____ Refused _____	

SECTION E: Income

How do you manage your life, your economy?	**Did any of your earnings from work in the last 6 months come from self-employment?** **No** _____ **Yes** _____
Do you sent money to your home country? No _____ Yes _____ Refused _____	**Do you pay for health care services?** No _____ Yes _____ Refused _____ **What do you think about health fees in Norway?** **How much do you pay for medicines to treat your illness?**
Which one of you worked for pay during the last 6 months?	**Do you have health insurance** Yes _____ No _____

SECTION F: QUESTIONS

- Are you norwegian?
- What does access to health care mean?
- How do you interact with immigrants?
- How do you care for immigrant patients?
- Describes how you give information to pasients with immigrants background?
- Are immigrants contributing to the health care crisis?
- Do immigrants pay for health services?
- What are the experiences you have about immigrants in hospitals?
- What do you know about the health of undocumented or documented immigrants?
- How can undocumented immigrants access healthcare?