



# ESPN Thematic Report on Inequalities in access to healthcare

## Norway

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Anne Skevik Grødem  
Axel West Pedersen  
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*Contact:* Giulia Pagliani

*E-mail:* [Giulia.PAGLIANI@ec.europa.eu](mailto:Giulia.PAGLIANI@ec.europa.eu)

*European Commission  
B-1049 Brussels*

**European Social Policy Network (ESPN)**

**ESPN Thematic Report on  
Inequalities in access to  
healthcare**

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*Anne Skevik Grødem*

*Axel West Pedersen*

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## Summary/Highlights

The comprehensive tax-financed system of public healthcare in Norway ensures formal universal access among the population with legal and permanent residence in the country.

An important characteristic of the Norwegian healthcare system is that several key functions are delegated to the municipalities and to regional health enterprises, albeit within a strict national regulatory framework. This ensures that even remote, rural areas have decent primary healthcare, and residents in such communities also have access to high-quality (regional, state-organised) specialised care.

The funding system implies that out-of-pocket payments are limited, with an annual ceiling on accumulated expenditures. The system combines modest user fees with exemption cards for patients if expenditures exceed a certain threshold amount within a calendar year. It is meant to achieve a mild rationing of tax-financed healthcare services, while at the same time avoiding situations in which financial difficulties and/or very high expenditures prevent people from seeking necessary help, or situations where expenditures on necessary healthcare threaten economic wellbeing. Overall there is reason to believe that this works reasonably well, although it could be argued that more targeting of the subsidies needs to be considered.

Data on self-reported unmet need for healthcare confirm that this is a relatively marginal phenomenon, and that factors such as geographical distance and financial inability appear to play a minor role as reasons for not receiving adequate help. However, both the data from EU-SILC and the national data on unmet need for healthcare show a consistent gradient in the answers, with groups on low income and with low educational attainment most likely to report unmet need. Although the causal mechanisms behind this are unclear, the pattern is a cause for concern.

Another concern is related to healthcare queues and waiting times. The present government is committed to decreasing waiting times, and has set clear targets for average and maximum waiting times. Data from the most recent years indicate at least partial success in this area, but the statistics on waiting times are not always fully comparable over time and can be subject to strategic manipulation.

The Norwegian health authorities are also concerned about new evidence on variations in treatment procedures for the same medical conditions, as between regions and hospitals within regions. This is an aspect of equal access to (equally effective) services that is not captured by indicators of unmet need or waiting time data.

An apparent problematic feature of the Norwegian system is the exclusion of adult dental services from the public, tax-based funding system, which implies that adults with dental problems typically shoulder the entire costs themselves and are exposed to prices for dental treatment that are allowed to fluctuate across time and space according to market forces. A possible reform could be to include dental care for adults in the system of price regulations and limited user fees that applies to other healthcare services.

The existence and growth of a private healthcare sector side-by-side with the public system, without a principled debate on the division of labour between the two, is a potential cause for concern, but cannot as of now be said to threaten the foundations of the system.

There is debate on the exclusion of undocumented migrants from the healthcare system, but at present there are no signals that this is going to change.

## 1 Description of the functioning of the country's healthcare system for access

In line with Scandinavian traditions, the provision of health services is in Norway predominantly a public responsibility. Public healthcare is financed out of general taxation (supplemented by a strictly regulated system of modest user fees) and provided on the basis of the principle of universal access for all legal residents in the country.

The administrative responsibility for delivering healthcare services is divided between the municipalities and the state. Primary healthcare is the responsibility of the municipalities. Under the 'Municipal health services act' (Lov om helsetjenesten i kommunene). The municipalities in addition have the obligation to deliver a range of preventive activities and services. The responsibility for providing specialised health services (and here most importantly hospital services) transferred from the counties to the state in a major healthcare reform in 2002. The country is divided into four 'health regions', each with a public health enterprise that is responsible for secondary health services and is the owner of the public hospitals in the region. The regional health enterprises are state-owned, non-profit organisations that have wide autonomy to run their business under supervision from the Norwegian Directorate of Health and the Ministry of Health. The activities of the regional health enterprises, and of the hospitals they run, are financed by a combination of block grants and activity-based reimbursements. According to OECD figures, total health expenditure amounted to 10.5 per cent of GDP in 2017, divided into 8.9 per cent financed by general taxation and 1.5 per cent financed by voluntary out-of-pocket payments (OECD 2017). In terms of absolute per capita expenditure levels, Norway ranks among the highest spenders in the OECD.

A number of laws regulate the rights of citizens to receive adequate healthcare and the terms under which these services are delivered.

All legal, permanent residents in Norway are allotted a dedicated general practitioner (fastlege), who provides primary healthcare and performs a gate-keeping function to public secondary healthcare services. The general practitioner is self-employed but operates under a contract with the municipality. A patient can change general practitioner up to two times a year. This system was introduced in 2001 with the aim of achieving a more effective regulation of access to expensive specialised services. Another aim was to secure more continuity in the patient-doctor relationship. Patients are required to go first to their general practitioner with their medical concerns, but are offered the right to have a second opinion by another doctor if a conflict arises with their current general practitioner.

In the public healthcare services, the principle of 'free patient choice' applies. Patients who have been declared in need of a certain treatment by their general practitioner have a right to choose any public hospital in the country that offers the relevant treatment. Recently this free patient choice has been expanded to include private health service providers that are recognised by, and receive reimbursements from, the state agency 'Helfo'. Hospitals and other health providers that are covered by this regulation have an obligation to receive and prioritise patients on equal terms, regardless of where in the country they live.

The Law on Patients' rights (Pasient- og brukerrettighetsloven) regulates the right to secondary healthcare services. According to the law, patients have a right to receive a binding promise about the start of treatment once the need for care has been established. As of today, health providers are expected to operate with an average waiting time below 56 days; and it has been announced that this requirement will be tightened to 50 days for all branches of the secondary health service by 2021.

The so-called 'coordination reform' that was introduced in 2012 strengthened the role of the municipalities in the overall provision of healthcare, in particular to old and frail patients in need of both healthcare and long-term care. The municipalities were given

responsibility for patients who are ready to be discharged from hospital treatment, and the reform introduced co-financing of secondary healthcare services by the municipalities in order to give the municipalities economic incentives to invest more in prevention and to seek alternatives to referring patients to hospital care. The co-financing arrangement is restricted to include medical treatment of hospital patients only and excludes any type of surgical treatment. Other important aspects of the reform are an attempt to clarify the responsibilities of the municipalities and the (state) health enterprises vis-à-vis different groups of patients, and making legal responsibility for providing services more neutral in terms of the professions that are involved in the provision.

Despite the emphasis of universal access and financing by general taxation, a system of modest user charges is applied to a range of public healthcare services. Both in primary healthcare and in specialised care and outpatient treatment, patients older than 16 years are charged modest user fees for consultations and for various types of tests and examinations. Fees are regulated by the government and the regulations both specify the size of patient fees and a reimbursement tariff for the provider (the general practitioner, the specialist or the hospital or clinic performing medical tests). Public healthcare providers cannot claim higher fees than specified within the regulations, with the exception of dentists who are free to determine their own prices. Patients also have to pay for their consumption of pharmaceutical products, but prices of drugs prescribed by a doctor to treat a chronic illness (so-called 'blue prescriptions') are heavily subsidised by the state.

When a patient's expenditure on user fees and prescribed drugs exceeds a particular amount within one calendar year (€236 or €209 depending on type of service), patients automatically receive an exemption card that secures free access (no further payment of user fees) for the remainder of the year. There are two types of exemption cards, which apply to different health services. The exemption card for 'user fee group one' covers fees for a general practitioner, psychologist, outpatient clinic, laboratory test, radiology, patient travel and subsidised medicine and equipment (so-called 'blue prescription'). The exemption card for 'user fee group two' covers fees for examination and treatment by a physiotherapist, specific dental treatments, rehabilitation centre stays, and travel for treatment abroad arranged by Oslo University Hospital. Only two types of dental treatments are included in the scheme; dental or jaw disease and anomalies, and some gum diseases.

Healthcare – both primary and specialist care – is free of charge for children under the age of 16. Dental care is free for children under 18. Specialist services, too, are free for children. Special benefits and services are available for families with chronically ill or disabled children (Grødem 2016). In addition, people with workplace injuries are exempted from paying user fees, dependent on approval by the Norwegian public welfare agency (NAV).

As for inpatient treatment in hospital, there are no user charges in the Norwegian system.

This system, combining modest user fees with exemption cards if expenditures exceed a certain threshold amount within a calendar year, is meant to achieve a mild rationing of tax-financed healthcare services while at the same time avoiding situations in which financial difficulties and/or very high expenditures prevent people from seeking necessary help, or situations where expenditures on necessary healthcare threaten economic wellbeing. The system is universal in the sense that there is no targeting towards special groups (like pensioners) or people with low incomes.

So far, private health insurance is a relatively marginal phenomenon in Norway and commercially provided health services are mostly found in the area of specialised outpatient treatment and simple surgical procedures. By the mid-1990s, practically no-one had private health insurance in Norway. By 2016, 481 000 residents were covered by such schemes. 90 per cent of those covered were covered through their employer. In the majority of cases, the aim of private insurance schemes is to secure treatment in a



private hospital, so that the insured person would not have to be on a waiting list and could get back to work quickly. In addition, a few schemes cover treatments that are not offered in Norwegian public hospitals – such as alternative medicine or experimental treatments.

Despite universal access, there is one group suffering from formal barriers to healthcare services in Norway: persons without the right to residence (undocumented migrants).

Statistics Norway estimated in 2006 that there were about 18 000 undocumented migrants in Norway (Zhang 2008). The figure has most likely increased in recent years. Undocumented migrants do not have the right to healthcare beyond emergency help. How 'emergency help' is to be interpreted is not entirely clear. Children of undocumented migrants have more extensive rights, but undocumented migrants are generally reluctant to seek healthcare services, as they fear arrest and deportation. In principle, as undocumented migrants are not covered by the reimbursement system, they would pay for any healthcare they receive out of their own pockets. There is a healthcare centre for undocumented migrants in Oslo, run on a pro bono basis by the Red Cross and the Church City Mission, which is currently open for four hours, two days a week. There have been no recent reforms to improve access for this group, nor are any such reforms planned at the moment.

One major concern is the potential mismatch between supply and demand; that is, the waiting lists that occur when demand outstrips supply. The current ambition is that average waiting times for specialist health services shall be less than 65 days (Helsedirektoratet 2016). Providers of healthcare services report monthly on expected waiting periods, and these reports are published on a dedicated website ([www.helsenorge.no](http://www.helsenorge.no)). The waiting times presented relate to the patients with the lowest priority, that is, maximum waiting periods. Waiting periods have decreased in recent years. Average waiting periods are presently 58 days for somatic services, 46/49 days for psychiatric services for adults/children and youth, and 34 days for care services for substance addiction (Helsedirektoratet 2017a). There is, however, substantial variation between hospitals.

As for the municipal care services, 50 per cent of all applications for a bed in a care home are met within 15 days (Statistics Norway 2017). There are, however, considerable differences between large and small municipalities: in small municipalities (under 5000 inhabitants), 80 per cent of applications are met within 15 days. 77 per cent of applications for nursing care in the home are met within this timeframe: 90 per cent in small municipalities and 70 per cent in large ones. For practical help in the home, 76 per cent of applications in small municipalities, and 54 per cent in large municipalities, are met within 15 days.

One very important reason for concern is the large variation that has recently been documented in the types and quality of treatment offered in the different health regions and in different hospitals within the same regions (Helsedirektoratet 2017b). This is a more subtle aspect of inequality in access (to adequate treatment of equally high quality) that is not captured by the indicators of 'unmet need', nor by register data on waiting times. One possible remedy for these inequalities is free patient choice, which allows patients to decide where they want to be treated and to seek out the regional hospital that offers the best treatment – hence the best prospects for a fast and complete recovery. However, as already suggested, this solution is highly unsatisfactory since it is likely to work only for a privileged minority. Another solution is to achieve a higher degree of national standardisation of treatment procedures, and this is the idea behind the package treatment procedures that have been developed for cancer treatment, and that are also about to be developed for other somatic and psychiatric conditions.

Due to rapid technological developments in diagnosis and treatment, and growing expenditures related to new health technologies such as pharmaceutical products, the Norwegian government in 2013 established a national system for the managed introduction of new health technologies within the specialist health service. The system

prioritises and decides on the use of new health technologies within Norwegian hospitals based on systematic health technology assessments. The intention is to ensure rational and cost-effective use of healthcare resources while providing equal access to effective and safe treatment.

The system is owned by the Ministry of Health and Care Services, and is based on broad cooperation between the regional health authorities and government agencies such as the Norwegian Institute of Public Health and the Norwegian Medicines Agency. Any member of the public can submit proposals for health technology assessments. The medical directors of the four regional health enterprises are responsible for the final decisions, and the technologies they approve immediately become universally available.

Presently there is no similar system for the primary healthcare services, though a working group appointed by the government is considering criteria and processes for prioritisation within primary care and dental healthcare services.

The system has been subject to public debate, as some treatments have not been approved due to high costs, challenging the public perception of universal healthcare coverage and the principles of equity and equal access regardless of income.

With respect to depth of access, it should be emphasised that most categories of dental treatment are not covered by the public healthcare system and are simply left to the private market, where patients pay for services out of their own pockets and are confronted with unregulated prices. The exceptions are that children under the age of 18 receive dental services for free, and that certain types of condition such as jaw and gum diseases are covered by the system of user fees and exemption cards as mentioned above. Surprisingly, a market for private insurance against dental treatment costs among the adult population has not developed.

## **2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled**

The universal coverage and (overall) high quality of the Norwegian healthcare system would lead one to expect that there is little concern over inequality in access to healthcare related to formal and financial barriers.

There are, however, some concerns regarding the healthcare needs of ethnic and linguistic minorities, to the effect that these may not get services of equal quality due to language difficulties or cultural beliefs. Equal access to services is covered by the Anti-discrimination Act, and complaints in this area can be directed to the equality and anti-discrimination ombudsman. Persons from a minority background may need an interpreter, and/or extra time with the healthcare provider. Such customisation, to the extent it is possible, is mandated by law. There are some concerns with regard to cultural sensitivity, for instance when facing members of the indigenous Sami community: Sami culture prescribes that one should keep one's problems to oneself, and Sami may prefer to talk about illness in indirect and allegorical ways – or not at all (Bongo 2012). There was an action plan for healthcare services to the Sami population for the period 2001-2005 (Sosial- og helsedepartementet, 2001), and a dedicated Centre for Sami Healthcare Research at the University of Tromsø. As for Roma, these are also a (very small) national minority in Norway, but there have been no recent initiatives on their access to healthcare services. There is no evidence to suggest discrimination against national minorities in healthcare services, thus any concerns relate to possible culturally based miscommunications.

Another group that might suffer from informal (and financial) barriers are some categories of European Economic Area (EEA) migrants. Migrants from the EEA are protected under EEA law, but particular concerns arise regarding very poor migrants, who often sleep rough and make money by begging. Concerns for their health and standard of life are raised by NGOs, which argue that these migrants live in a very

precarious situation, that they are typically unaware of their rights and that the out-of-pocket payments (user fees) demanded create an impenetrable barrier. The authorities are still unwilling to make provisions beyond what is mandated by EEA law.

It has also been found that EEA labour migrants typically use healthcare services in their country of origin, where they know the language and understand how the system works (Czapka 2010), and this could suggest that they face linguistic and cultural barriers in their interaction with the Norwegian healthcare system.

## 2.1 Inequality in access: evidence from survey data

One way to get an empirical grasp on inequalities in access to healthcare is to look at survey data on self-reported unmet need for healthcare. Unmet need for healthcare appears to be a relatively marginal problem in Norway, as evidenced by answers in the EU-SILC survey. According to the statistical annex provided for this thematic report, only 1.1 per cent of the Norwegian population reported unmet health needs in 2016. Among those who do, the most common explanation is that there is a waiting list for services (0.7 per cent). Only 0.4 per cent reported that services were too expensive, while no respondents in 2016 said it was too far to travel to access them.

However, a slightly more worrisome picture is painted in the national survey of level of living, which is a separate, cross-sectional, study with about 14 000 respondents (Lunde et al. 2017). In 2015, 8 per cent of the respondents reported that there had been an occasion in the previous 12 months where they needed a doctor or medical specialist but did not seek one. The difference from EU-SILC may be accounted for by the wording of the question: EU-SILC asks about occasions where someone 'really needed examination or treatment', while in the survey of level of living, the word 'really' is omitted. The single most common reason (4 per cent) for not seeking medical help was 'other reasons', which is not very informative, but which included factors such as fear of pain, fear of what the doctor might find, and 'waiting-and-seeing' behaviour (Lunde et al. 2017:45). The second most common reasons were 'did not have the time because of work or caring obligations' and 'too long waiting times to get an appointment' (both 3 per cent). Those aged 16-45 were far more likely to report unmet health needs than the over-45s (12 as against 5 per cent), mainly due to long waiting periods, not having the time, and 'other reasons'. Those on the lowest incomes, and those with the lowest education level, more often had unmet health needs than others, and were more likely than others to report not being able to afford it as a reason (4 per cent). However, even among those on the lowest incomes and those with the lowest level of education, 'other reasons' were the most prevalent (both 6 per cent). Predictably, the unemployed and those on a disability pension were more likely to have unmet health needs (15 and 16 per cent respectively). Even among these groups, however, 'other reasons' are most prevalent as an explanation (Lunde et al. 2017:44). We find no evidence that high costs or long distances significantly limit the use of doctors or medical specialists among these vulnerable groups.

According to a recent report, 3 per cent of the population in Norway report that they have an unmet need for services provided by psychologists or psychiatrists – 4 per cent of women and 1 per cent of men. Among those with a reported unmet need, 40 per cent say it takes too long to get an appointment, while 25 per cent say it is too expensive (Lunde et al. 2017:51). Commenting on these responses, the authors point out that they did not distinguish between private psychologists and practitioners with a municipal contract. Private psychologists are expensive, but can often see clients at short notice, while the opposite is true for psychologists with a contract. Moreover, the latter requires a referral from a general practitioner.

Unmet needs for dental services are most likely to arise because clients cannot afford such services. 7 per cent of the population in 2015 said they had unmet needs for dentistry. Almost half of these said this was because the costs were too high, almost as many gave 'other reasons' (which the authors suggest may mainly be "fear of the

dentist”, cf. Lunde et al. 2017:47). There is a clear social gradient in the use of dentistry services, with those with the lowest incomes least likely to have been to a dentist in the previous 12 months (Lunde et al. 2017:29). As described in section 1, dentistry is in the vast majority of cases not covered by the public system, but is paid for solely out of the patient’s own pocket. This is a very plausible driver for these results.

Both the Eurostat data and data from the national survey of level of living show that there is a clear and consistent social gradient in self-reported unmet need for healthcare services among the Norwegian population – both in terms of education and income. This suggests that financial considerations and informational barriers are indeed creating inequalities in access to services.

## **2.2 Coordination and package treatment processes in specialised healthcare**

Transitions between various kinds of healthcare service can be a challenge (Meld. St. 13 (2016-2017)). In the wake of the coordination reform, the transition from specialised (state) healthcare to municipal care has been a particular concern, as outlined in the ESPN country report on long-term care (Grødem 2018).

The national strategy against cancer 2013-2017 made it a clear aim that Norway should be a leading example of good patient care (Helse- og omsorgsdepartementet 2013). As of 2018, 28 different ‘package processes’ are in place for cancer patients. The ambition of these processes is that patients should experience well organised, coordinated and predictable treatment processes, where both patients and their families are well informed and involved throughout the treatment period (Helsedirektoratet 2018). Similar package processes have been designed, and are about to be implemented, in care for patients with brain stroke, psychiatric illnesses and substance-related illnesses.

## **2.3 Drivers of inequality in health and the role of inequalities in access to care**

The centre-left think tank Agenda released a discussion paper in November 2016 about inequality in specialised healthcare (Agenda 2016). The think tank points out that there are considerable social inequalities in health in Norway, but maintain that these differences occur prior to contact with healthcare services, as a result of differences in life stressors, resources and constraints, and in lifestyle (cf. Dahl et al. 2014). There is very little evidence to suggest that healthcare services in themselves create or deepen social inequalities. Some worrying trends can, however, be noted: in particular, the growth in private health insurance and privatised healthcare, and also the complexity of the system, which requires considerable skills to navigate. Such skills, obviously, are not evenly distributed.

A possible further growth in private healthcare services is problematic for three reasons (Agenda 2016:13): first, the insured patient may be examined by a private healthcare provider, but will typically be referred back to the public services for treatment. These patients ‘jump the queue’ in the sense that they are ready for treatment much sooner than their uninsured peers. Second, doctors and nurses are in scarce supply in many places in Norway, and private institutions compete with the public sector for the same personnel. Third, a growing private health sector may undermine support for public services, if a growing number of people feel they pay twice for the services (both through insurance and through taxation). A growth in private health services is, over time, likely to undermine equal access to healthcare.

The second potential driver for inequality in access is the emphasis on patient choice in a very complex health system. Patients have varying capabilities to exercise choice, and these capabilities are not evenly distributed. There is a risk that the most resourceful and capable patients will receive the best treatment, because they are better equipped to make optimal choices (Agenda 2016:21).

The principle of **free patient choice**, which has been generalised in recent years to cover almost all branches of secondary health services (see section 1 above), might be expected to work best for the most highly educated and resourceful segments of the population, since it is very demanding to gain the necessary information to make qualified decisions about the choice of provider.

## 2.4 Best practices – and challenges

Inequality of access to healthcare is an issue of minor concern in Norway, for reasons outlined here. The main concern is related to healthcare queues and waiting times. The present government is committed to reducing waiting periods, and has set clear targets for average and maximum waiting times. Evidence presented above indicates at least partial success in this area.

An important characteristic of the Norwegian healthcare system is that several key functions are delegated to the municipalities and to regional health enterprises, albeit within a strict national regulatory framework. This ensures that even remote, rural areas have decent primary healthcare, and residents in such communities also have access to high-quality (regional, state-organised) specialised care. The funding system implies that out-of-pocket payments are limited, typically with an annual ceiling on accumulated costs. It might be worth considering the introduction of more targeting and means-testing into this system, in order to make sure that financial considerations do not constitute a barrier against seeking necessary help among less privileged strata of the population.

One feature of the Norwegian system that does not merit the label 'best practice' is the exclusion of dental services from the overall funding system, which implies that patients with dental problems typically shoulder the entire costs themselves.

The growth of a private healthcare sector side-by-side with the public system, without a principled debate on the division of labour between the two, is also a potential cause for concern, but cannot as of now be said to threaten the foundations of the system. In the coming years there is reason to expect a growth in the demand for privately funded healthcare, unless the public system can keep pace with the growth in demand in terms of quantity and quality.

There is debate on the exclusion of undocumented migrants from the healthcare system, but at present there are no signals that this is going to change.

## 3 Discussion of the measurement of inequalities in access to healthcare in the country

The survey data on unmet need for healthcare are a valuable source of information, and there is good reason to believe that the rather undramatic picture they give for Norway is largely valid – although it can be discussed whether the wording of the EU-SILC survey question is to be preferred over the wording found in the national survey, or vice versa.

The official data on waiting times are another valuable source: but there is a discussion as to whether they can be manipulated to underestimate true waiting times, by postponing the starting point of the measurement (the time when a decision is made concerning the need for a specific treatment).

What is not captured in these measures is a potential variation in the nature and quality of treatment offered to otherwise identical cases and conditions. Here there is reason for concern, as has been documented in recent official reports (Helsedirektoratet 2017b).

We conclude that in terms of providing a valid picture of the availability of healthcare in Norway in a comparative perspective, the EU-SILC indicator of unmet need for healthcare is a good indicator. In order to monitor remaining challenges and more subtle changes over time in Norway, other indicators are needed.

## References

- Agenda (2016), Helse for alle uansett? Om ulikhet i spesialisthelsetjenesten. Oslo: Agenda.
- Bongo, B.A. (2012), 'Samer snakker ikke om helse og sykdom': samisk forståelsehorisont og kommunikasjon om helse og sykdom: en kvalitativ undersøkelse i samisk kultur. PhD-thesis, University of Troms.
- Czapka, E.A. (2010), The Health of Polish labour immigrants in Norway: A research review. Oslo: NAKMI - Norwegian Centre for Minority Health Research (NAKMI), report 3:2010.
- Dahl, E., Bergsli, H. & van der Wel, K.A. (2014), Sosial ulikhet i helse. En norsk kunnskapsoversikt. Oslo: Høgskolen i Oslo og Akershus,
- Grødem, A.S. (2018), ESPN Thematic Report on Challenges in long-term care. Norway, 2018. Prepared for the European Social Policy Network in February 2018.
- Helsedirektoratet (2016), Ventetid til spesialisthelsetjenester i Norge. Available at <https://helsedirektoratet.no/nyheter/ventetid-til-spesialisthelsetjenester-i-norge>.
- Helsedirektoratet (2017a), Ventetider og pasientrettigheter 1. tertial 2017. Available at <https://helsedirektoratet.no/Documents/Norsk%20pasientregister/Ventetider-pasientrettigheter-1-tert-2017.pdf>.
- Helsedirektoratet (2017b) Hovedresultater SAMDATA spesialisthelsetjenesten 2012-2016. Available at [https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Samdata/Filer%20til%20WEB\\_Dundas/2017%20Analysenotater/16-2017%20Hovedresultater%20Samdata2012-%202016.pdf](https://helsedirektoratet.no/Documents/Statistikk%20og%20analyse/Samdata/Filer%20til%20WEB_Dundas/2017%20Analysenotater/16-2017%20Hovedresultater%20Samdata2012-%202016.pdf).
- Helsedirektoratet (2018), Pakkeforløp for kreft. Available at <https://helsedirektoratet.no/kreft/pakkeforlop-for-kreft#implementering-av-pakkeforl%C3%B8p-for-kreft>.
- Helse- og omsorgsdepartementet (2013) Sammen - mot kreft. Nasjonal kreftstrategi 2013-2017
- Hjelde, K.H. (2010), 'Jeg er alltid bekymret': Om udokumenterte migranter og deres forhold til helsetjenestene i Oslo. Oslo: NAKMI - Nasjonal kompetanseenhet for minoritetshelse, working paper 1:2010.
- Lunde, E.S., Otnes, B. & Ramm, J. (2017), Sosial ulikhet i bruk av helsetjenester. En kartlegging. Oslo / Kongsvinger: Statistics Norway, report 2017/16.
- Meld. St. 13 (2016-2017) Kvalitet og pasientsikkerhet 2015
- OECD (2017), Health at a glance 2017. Available at <https://data.oecd.org/healthres/health-spending.htm>.
- Sosial og helsedepartementet (2001) Mangfold og likeverd Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkningen i Norge 2002–2005.
- Statistics Norway (2017), Innbyggerne i store kommuner venter lengst på omsorgstjenester. Published 28 August 2017. Available at <http://www.ssb.no/helse/artikler-og-publikasjoner/innbyggerne-i-store-kommuner-venter-lengst-pa-omsorgstjenester>.
- Zhang, Li-Chun (2008), *Developing methods for determining the number of unauthorized foreigners in Norway*. Oslo / Kongsvinger: Statistics Norway, report 2008/11.

