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FROM EQUALITY TO EQUIVALENCE?
Norwegian health policies towards immigrants and the Sámi, 1970–2009

Abstract
This article investigates a shift in the justifying ideas in Norwegian public health and immigrant policies. Between 1970 and 2009, equality was gradually supplanted with equivalence as the main principle evoked in policy formulation. Potentially, this opened for more differentiated public health policies for immigrants and the indigenous Sámi. The specific needs of minorities were acknowledged, and the need for linguistic and cultural competence in health services was emphasized. However, only a few specific measures were introduced to meet the needs and challenges of ethnic minorities, and the concrete measures implemented largely mirrored the services aimed at the majority.

Keywords
Migration • health policies • Norway 1970–2009 • equality • equivalence

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1 Introduction

Since the Second World War, Norwegian state policies have aimed at providing all citizens, regardless of their social class or place of abode, the same chances of being included as functional citizens of the welfare state (Seip 1994: 357–359; Slagstad 1998: 210). Universal benefit systems and public provision of health services have been the central means to achieve this objective. The objective to secure universal services has also embraced health policies, and the provision of equal access to health services has been a crucial policy goal (Schiøtz 2003: 319; Seip 1994: 313–314, 355). During the last decade, public debate, government reports and research have pointed to new challenges facing the future welfare state, in particular related to the inclusion of immigrants into the welfare system. Recent analyses also see a shift in the formulation of the main principles of welfare policy over the last decades – reinterpreting the ideal of "equality [*likhetsidealet*]" towards "equivalence [*likeverd*]" – and point out that "equal opportunities for different groups to maintain their identity became the new credo" (Brochmann & Hagelund 2010: 220). However, in their empirical analysis, these authors do not explicitly trace this alleged shift of ideals from equality to equivalence. In this article, we investigate whether and how such a shift has taken place within public health policies regarding the immigrant population and the indigenous Sámi in Norway from 1970 to 2009. In particular, the analysis deals with the shifting use of the concepts of equality (*likhet*) and equivalence (*likeverdighet*) in the formulation of health and immigrant policies.

It has been pointed out that ideas of equivalence often seem to accord with ideas of equality in Nordic countries (Gullestad 2002; Aarvik 2009). There is, however, a subtle but important difference between these ideals. In principle, in relation to the forming of public policy, the ideal of equality implies the need to give different groups the same or identical rights, duties or services, while the ideal of equivalence may imply that the rights, duties or services of different groups need not be identical, as long as they are of equal worth. Thus, while equality implies a common standard against which, for instance, access to or content of health services may be compared, equivalence implies that differing standards – or services – may be appropriate for different population groups; equivalent health services need not be uniform services for all (Hutmacher, Cochrane & Bottani 2001: 307–308; Lindensjö 2002: 57–69). In this way, the principle of equivalence may be seen as an alternative to, or a move away from the principle of equality. A recent study shows a change in the content and relationships between the concepts over time (Aarvik 2009). The concept of equivalence can relate to different ideas of equality, and thus imply different measures. In Norwegian educational policy, a normative idea of equality, with the aim of securing just distribution between population groups to conquer inequality, shifted to an idea of equality in results, based on taking into account individual variations in needs and experiences. Others have more directly linked the concept of equivalence to the concept of equality in results (Haukelien, Møller & Vike 2011), and state that equivalence policies in this sense will tend to be based on decentralization and strengthened local responsibilities.

Inspired by the literature on framing policy ideas (Campbell 2002; Ervik, Kildahl & Nilsen 2009), we are concerned with the concepts of equality and equivalence in the health policies aimed at the immigrant population, and contrast this with an analysis of health policies aimed

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at the indigenous Sámi population, in order to clarify the impact of the categorization of different minority groups on health policy formulation. Here, the concepts of equality and equivalence may be regarded as justifying ideas that legitimate and frame policies. We study how these frames were transformed, creating possibilities for new policy plans and measures to be suggested. The analysis is based on a selection of central public policy documents regarding health and immigration policies from 1970 to 2009, consisting mainly of government white papers (Stortingsmeldinger), propositions and parliamentary reports (NOU), in addition to governmental guidelines for child public health services, sources that are particularly fruitful for an analysis of the ideals underlying the formulation of state welfare policy (cf. Brochmann & Hagelund 2010: 35). We ask the following questions: How have health policy goals, aims and objectives pertaining to immigrants and the Sámi been formulated in these documents, particularly in relation to ideals of equality and equivalence? Which health problems are identified, and which solutions are presented? In addition to the study of political rhetoric and classifications of needs embedded in national public policy documents, we investigate how and to what extent the conceptual changes have been reflected in policies in one specific health policy area: the municipal health care measures aimed at young children and their families. To what extent do shifting concepts of equality and equivalence justify shifting measures aimed at promoting immigrant and ethnic minority health?

2 Public health policy and "foreign workers" in the 1970s: the goal of full equality

Overseas labour migration to Norway grew from the 1960s and the early 1970s (Tjelmeland 2003: 79–118). The migration policy documents of the early 1970s categorized the immigrants chiefly as "foreign workers", indicating that their stay was temporary and related to their contribution to the labour force. The approach of public health and social services towards foreign workers was nevertheless guided by a principle of equality, implying that they were to receive the same social and health services as Norwegian citizens in general. The social policy objective was expressed as "full equality" between foreigners and other municipal residents (St.meld.nr. 39 (1973–74): 48–49, 51–52). In the 1970s, this principle was widely supported across the political spectrum (cf. Brochmann & Hagelund 2010: 227, 241).

Unequal living conditions for immigrants could pose a potential challenge for social services, but the predominantly male foreign workers of the mid-1970s were deemed to be in good physical and mental health, and thus not considered to be a particular challenge for the health services (St.meld.nr. 107 (1975–76): 33). No special health measures were aimed at foreign workers, except for detection of under-nourishment and infectious diseases, and a system of health control for newly arrived immigrants. Such measures were taken in order to provide them with health services equal to the majority population, which was still subject to national monitoring programmes such as tuberculosis.

After free labour immigration to Norway was suspended in 1975, the composition of immigrants shifted. The immigration of women and children increased as a result of a family reunification policy (Brochmann 2003: 139–144, 151; Tjelmeland 2003: 118–134), and the government saw new challenges for the health services, in particular pertaining to mental health problems and immigrant women's need for information on prevention, maternity control, as well as infant and toddler care (St.meld.nr. 107 (1975–76): 38–39).

In this period, immigration was largely concentrated in the capital region (Tjelmeland 2003: 118–119), and in practice, the issue of immigrant access to health services was mainly seen as a local problem. A specific measure aimed at immigrants was established in Oslo in the autumn of 1975, when a municipal but state-funded "Guest workers' office" (*Fremmedarbeiderkontor*) opened. The service included a separate unit providing health services for immigrant families and the teaching of health service staff (Ahlberg, Aambø & Gihle 2007). The office was to serve as a point of entry to general health services for guest workers and their families and operated until 1988.

During the early 1970s, a comprehensive municipal primary health care system for children, with a universal scope and easy access was established (Elvbakken & Kjærnes 1994; Solberg 1995). The objective was to strengthen the prevention of health problems through the principle of securing the weakest by reaching everyone (Bogen *et al*. 1972; Hauge *et al*. 1982). From 1975, the immigrant health centre in Oslo offered services in line with the regular municipal Mother and Child Health Centres (MCHCs), focusing on pregnancy and infant health control and parent education. In line with general policies, the intention was *not* to provide a separate system of health services for immigrant families, but rather to provide a doorway to the ordinary health services, making immigrants capable of using the services in line with the majority of citizens.

The health policies of the mid-1970s defined access to services as the main immigrant health challenge. A 1975–76 white paper on immigration pointed to cultural differences and a lack of language skills and experience in consulting health services as challenges for the newcomers. Language and culture were not regarded as creating health problems as such, but merely as posing obstacles to efficient communication and access to health services. As the immigrants were to be offered the same – or equal – health services as the general populace, the remedy consisted of small-scale linguistic adaptation (translation of health information to the immigrant population) and some organizational adaptation of services. This implied that the simple understanding of equality as same services for all was substituted with an understanding of equality as equal possibilities of access, expressed as: "Immigrants must be given real possibilities of obtaining equivalent conditions [*likeverdige kår*] to those for Norwegians" (St.meld.nr. 107 (1975–76): 73). In this context, "equivalent conditions" implied that equality was the main goal, but in order to attain this, some specific adaptive measures were necessary. This concurs with other analyses pointing out the strong connections between the concepts of equivalence and equality in Norwegian policies during this period (Gullestad 2002; Aarvik 2009).

Linguistic adaptation of health services to ethnic minorities in the name of equality represented a well-established policy in Norway, in particular, one that had been developed to deal with service provision towards the indigenous Sámi. Since the late 1950s, medical professionals have paid attention to the linguistic and cultural background of Sámi patients in order to realize universal health service provision (Ryymin & Andresen 2010). Within the overarching frame of equal health services to all, some specific measures were undertaken during the 1960s, including health care staff initiatives to use the Sámi language in local health services in Finnmark, and the establishment of small educational quotas for Sámi-speaking health profession students. Similar policies for adjusting public services to specific local community conditions and different population groups were also prevalent in the educational policies of the 1970s, when the fundamental aim was still to maintain a common school

system for all groups of pupils (Aarvik 2009: 66–68). Sámi-speaking lower-grade pupils were offered additional education in their first language in order to ensure equality with Norwegian-speaking pupils. Equivalence in schools was thus understood in the 1970s as securing the possibility of equal outcome for all through adaptive and additive measures aimed at certain categories of pupils, the same strategy that informed health policy towards foreign workers and their families.

3 Migration and health policies of the 1980s: immigrants, class and culture

In the 1980s, it became clear that the foreign workers were in Norway to stay, and the term denoting them in policy documents changed to "immigrants" (Brochmann 2003: 163). During this decade, class, culture and migration emerged as the main explanations of health problems among immigrants. In 1979–80, a government white paper stated that many immigrants were marginalized due to low social position (class) and prejudices among the majority population. In terms of health, poor social conditions and problems of adaptation to the Norwegian diet were emphasized, as well as "psychosomatic" problems related to the migration experience. In addition, culture was now seen as an explanation of immigrant health problems: the immigrants were used to different service systems, and experience of health and illness and ways of coping with ill health were seen as culturally determined (St.meld.nr. 74 (1979–80): 80–81). Linguistic and cultural barriers, a lack of information and fear of conflict with authorities were among the factors seen as obstacles to contact between immigrants and the health services.

In the early 1980s, the main objective of health and social policy pertaining to immigrants was still to achieve equality (Brochmann & Hagelund 2010: 241). A white paper on immigration stated: "conditions must be altered so that immigrants are able to strengthen their position in Norwegian society, and thus can function as equals with the rest of the population in Norway."[1] This functional equality implied adjustments of services, not different standards for immigrants.[2]

In accordance with the now-recognized specific health-related problems among migrants, some more permanent targeted measures were seen as necessary in order to attain the goal of equality. A lack of competence in Norwegian language, particularly among immigrant women standing outside the labour market, was defined as a health-related challenge to be overcome through language courses. The need for education applied also to Norwegian health personnel, as more knowledge about their culture and experience of illness among immigrants would make it easier for the health services "to meet the attitudes and reactions of immigrants with understanding" (St.meld. nr. 74 (1979–80): 81–82). This applied not least for the municipal MCHCs, which were highlighted as a crucial health measure for immigrants, providing health control and parental education (St.meld. nr. 74 (1979–80): 81–82).

Equality, in the sense of providing equal access to health services regardless of geography or social differences, was still defined as the main goal of public health policy. The state was to guarantee equal treatment and equal possibilities for all citizens, according to the first Norwegian *National Health Plan* published in 1987 (St.meld.nr. 41 (1987–88)), which was intended to govern the overarching state health policy and to guide the municipal health services. This plan explicitly differentiated between immigrants from countries "culturally closely related" to Norway and from "countries culturally further apart from us". The first were in the country voluntarily, and no special measures were considered necessary to deal with their health problems (St.meld.nr. 41 (1987–88): 228). The other group – refugees and asylum seekers in particular – were "in a totally different situation":

> In addition to cultural differences, religious customs, social structure, health status and notions of disease, diet, ways of living and ethnic norms and values will be different. The climate in Norway is also totally different than that where most of them come from. For refugees and asylum seekers this is amplified as they have been forced to leave their place of origin after long-term strain. To discuss specific measures is of particular interest for this latter group. (St.meld.nr. 41 (1987–88): 228–229).

This differentiation reflected the growing influx of refugees and asylum seekers to Norway in the 1980s. In 1987 alone, Norway received approximately 1000 quota refugees and the number of asylum seekers peaked at approximately 8600 (Brochmann 2003: 194). According to the 1987 *National Health Plan*, only some immigrants needed special measures in order to achieve equal services, and in effect, the plan reserved the adaptation of health services for the latter group of "culturally more distant" immigrants, advocating interpreters and the education of health personnel to avoid "unnecessary cultural barriers" for immigrant access to health services, and psycho-social teams to deal with specific health problems among immigrants and refugees (St.meld.nr. 41 (1987–88): 229).

From the late 1980s, policy goals were increasingly formulated in terms of equivalence rather than equality. Immigration policy documents, also pertaining to health services, put a heavier emphasis on equivalence, and an increased weight on heterogeneity and the differing needs among the population can be observed. Immigrant policy stated that special measures had to be taken, among other fields in health and social policy, in order to provide truly equivalent opportunities of participation for immigrants (St.meld.nr. 39 (1987–88): 48). The fundamental objective here was defined as "real equality [*reell likestilling*] between immigrants and Norwegians, meaning that immigrants as far as possible shall have the same possibilities, duties and rights as the rest of the population" (St.meld. nr. 39 (1987–88): 9). Selective measures were needed in order to equalise difference between population groups, and equivalence was introduced as a characteristic of this kind of policy: "The goal of equality [*likestillingsmålet*] implies that immigrants are to be given an equivalent [*likeverdig*] offer, compared with the population at large" (St.meld.nr. 39 (1987–88): 9). Since public institutions such as health services were formed to accommodate the needs of the Norwegian population, it was necessary to provide immigrants with "health and social services that take the conditions of immigrants into consideration."[3] In this context, equivalence meant that the services offered could be different in order to achieve real equality, a principle that could imply differentiated health and social services for immigrants and for Norwegians. The government did not, however, suggest that special administrative arrangements for immigrants should be established in general, as this could potentially lead to stigmatizing and social isolation. In practice, the adaptation of health services to the special conditions of immigrants was limited only to some particularly vulnerable immigrant groups, such as asylum seekers and refugees. The increased preoccupation with psychosocial problems by the health authorities during this period was reflected in the strong weight put on the psychosocial problems of these groups. Accordingly, new measures were introduced to deal with mental health problems among refugees and asylum seekers. In Oslo, a team specialized in psychosocial work for refugees

(*Psykososialt team for flyktninger i Norge*, cf. Dahl 2005: 67–68) had been established in 1986, and several others were set up in the following years, to meet the needs of immigrants now increasingly settling outside the Oslo region. The proposed differentiation of health services in the name of equivalence thus led to the establishment of an additional psychosocial service for "foreign" migrants.

4 The 1990s: increasing differentiation in migrant health policies

During the 1990s, the Norwegian health authorities continued to distinguish between "settled" immigrants and new arrivals, that is, refugees and asylum seekers. Settled immigrants were seen as particularly prone to diseases such as diabetes type 2, coronary heart disease and obesity, as well as health problems related to lack of adaptation to the Norwegian diet (St.meld.nr. 37 (1992–93): 135; NOU 1998:18). In 1998, it was clearly stated that immigrants, particularly those from "non-Western countries", represented a particular challenge for health policy, being as they were worse off than others in socio-economic terms (NOU 1998:18: 261–264). The health problems of the "settled" immigrants were seen as a fundamentally *social* problem, arising from their exclusion from the society at large, evident in the loss of social networks, poor working conditions and unemployment (St.meld.nr. 37 (1992–93): 55).

The influx of refugees from the conflict-ridden Balkans contributed to the increased governmental emphasis on mental health problems in the formulation of public health policy. The expanding system of psychosocial teams, resulting in a centre in Oslo and four regional units in 1991, also reflected a general increased weight upon municipal responsibility for mental health issues. In 1992, the health problems related to psychosocial conditions were listed among the most important challenges for the primary child health care (Larsen *et al*. 1992: 299). Based on new research, immigrant families and children were defined as vulnerable pertaining to a range of psychosocial problems, and both migration in itself and the immigrant living conditions were mentioned as risk factors. Parent education, an increasingly important tool to cope with risks related to family life among the general population, was explicitly aimed also at immigrant families (Ludvigsen & Danielsen 2009).

A national mental health reform policy launched in 1997 gave municipal health authorities, including the MCHC services, a crucial role in service provision and prevention of health problems (St. meld.nr. 25 (1996–97): 67–79; St.prp.nr. 63 (1997–98)). The policy documents included plans regarding population groups with special needs, among which immigrants, refugees and asylum seekers were the first mentioned. The mental health of refugees had now surfaced as an important challenge for mental health policy. Responsibility for health services towards immigrants was to be based on the general health service acts, but the government underlined that their special needs had to be considered.

Despite the differentiation of immigrants and their health problems in health policies, the main health policy goal towards immigrants and refugees was still defined as uniform in a government white paper on refugee policies: "The public health services shall provide a health service to settled immigrants and refugees on the same level [*på lik linje*] with the services for the population in general" (St.meld.nr. 17 (1994–95): 111–112). In general, immigrants were to receive health services within the usual structure of the public health system, albeit with some specific targeted measures.

The 1990s brought change in the hitherto prevalent understanding of equivalence as necessitating minor adjustments to the ordinary health services for ethnic minority groups. During the previous decade, it had been increasingly recognized that to attain equality in results, health and welfare services had to be offered in Sámi language by professionals who knew Sámi culture. In 1988, the Norwegian state officially recognized the Sámi as an indigenous population and the Norwegian Constitution was amended in order to acknowledge this. From the 1990s, the authorities emphasized that medical professionals who intended to work among the Sámi should learn the Sámi language, indigenous culture and history (Andresen 2011). A specific plan for the provision of public health and social services to the Sámi population, published in 1995, defined the creating of *equivalent* health services for the Sámi as an overarching goal, paying due respect to Sámi culture. This meant that, for instance, traditional Sámi knowledge should be incorporated into health policies, and recent health policy documents consider maintaining a strong Sámi identity as fundamental to good health. After 1995, institutional arrangements provided specialist services, research and competence development particularly aimed at the Sámi (Andresen 2011). However, these developments were not necessarily because of specific health problems among the Sámi. Unlike the indigenous population in, for example, New Zealand and other parts of the world, Sámi health is generally on a par with that of the majority population (Andresen 2008: 75–76), and empirical studies show no overall ethnic differences in the frequency of health service use between Sámi youth and others (Turi *et al.* 2009).

Looking at the policies for immigrants, other conceptual understandings appear. According to the 1996–97 governmental white paper on immigration, equivalence in health services for immigrants still implied adjustment, not specific services, for different groups (St.meld.nr. 17 (1996–97)). This white paper states that the "main principle is that the ordinary system of treatment and care should be applied to all population groups. Adaption to a manifold society implies that the services must be adjusted, [*legges til rette*] in order to provide an equivalent offer to a more diverse user group" (St.meld. nr. 17 (1996–97): 79). In this adjustment policy, translation of health information to various immigrant languages, particularly about diet-related health problems, continued to play a key part, together with the recruitment of health personnel from immigrant backgrounds, in particular to psychiatry, nursing and child welfare services. A specific competence unit for somatic and mental health for immigrants was established to heighten the knowledge level among health personnel. The government also highlighted the need to integrate immigrant health issues to the "ordinary" fields of health policy, such as HIV/AIDS policy, school health services and mental health services.

The difference in the understanding of equivalence regarding health services for the Sámi and immigrants in the context of governmental policy papers might best be explained by looking at the differing understandings of what actually promoted or hindered better health among these groups. The policies indicated that Sámi culture protects against certain illnesses but that acculturation may be harmful to health. Such a view of Sámi culture, however understood as a crucial factor in *promoting* health in the Sámi population, implied that equivalent health services for them meant specific, culturally sensitive health services for the Sámi. For the heterogeneous category of immigrants, however, "culture" – meaning non-Norwegian culture – was more often understood in both immigration and health policy documents as one among many factors *creating* health problems and obstacles to the interaction between the health services and the immigrant population.

5 The early 2000s: a new diversity policy?

In 2003–2004, a more radical approach to equivalence was announced by the centre-right Bondevik II government, emphasizing the need to adjust public services to an increasingly diverse population; growing globalization and an increasingly multicultural society necessitated a new public health policy (St.meld.nr. 16 (2002–2003): 6). To achieve "a healthier Norway", it was necessary to reduce health differentials, not only between socio-economic strata but also between ethnic groups and between men and women. According to the government white paper, the immigrant population was deemed to be vulnerable, and thus, a sharper focus on their particular health problems was needed (St.meld.nr. 16 (2002–2003): 8). This applied in particular to non-Western immigrants, who were worse off in socio-economic and health terms. Epidemiological studies showed that diabetes was more common among non-Western immigrants in Oslo (Folkehelserapporten 2002): their subjective health was reported as worse, and vitamin D deficiency was four to five times more prevalent among those of Pakistani origin than of ethnic Norwegians. Women with "non-Western" names were also over-represented in abortion statistics (St.meld.nr. 16 (2002–2003): 143–146).

The 2003 white paper was critical of earlier universal health policy measures: "Public health policy has until now had average conditions as its starting point rather than reflecting the diversity of the population. This may have had an impact on the effect of the measures implemented" (St.meld.nr. 16 (2002–2003): 2). This was to be countered through a stronger gender perspective: female health was designated a specific focus area, with the particular challenges of Sámi and immigrant women included, and with an explicit stance on ethnic groups. Popular education and health promotion were to cover the needs of all ethnic groups (St.meld.nr. 16 (2002–2003): 123–124). To achieve this, more research, knowledge and health surveys were required, as well as the recruitment of immigrants to the health services.

On a more general level, the Bondevik II government stated that the factual, cultural and religious diversity of Norway had to be acknowledged and respected, and that public services must also reflect this. To offer "equivalent services" could thus necessitate *differentiation of services*, and, importantly, public services might be delivered by other than public actors (St.meld.nr. 16 (2002–2003): 112). This new "diversity policy" explicitly referred to policies for Sámi and national minorities. The government argued that "adaptation of services based on cultural and linguistic preconditions" was necessary to provide "equivalent services for all" (St.meld.nr. 49 (2003–2004): 50; cf. Brochmann & Hagelund 2010: 262–264). For health policy, this implied that "strategies for prevention, treatment and care must be formed and practised differently in order to reach those intended" (St. meld.nr. 49 (2003–2004): 180). This meant that equivalent services might differ between population groups, even though the government somewhat paradoxically also emphasized that an adaptation of services did not automatically mean the introduction of new, different practices, rules and routines for different groups.

Nevertheless, it is reasonable to claim that in 2003–2004, the Norwegian authorities for the first time explicitly stated that it might be necessary to create specific prevention, treatment and health care strategies for different population groups, ethnic groups included. Even though this proposal was criticized as vague in the Parliament, the principle of adjusting public services to a differentiated population was accepted across the political field, with the exception of the right-wing Progress Party (*Fremskrittspartiet*) who demanded that no "special measures" for immigrants should be established at all (Innst.S.nr. 185 (2004–2005): 2, 34). There was, however, disagreement on how to proceed, as representatives of the centre-left opposition claimed that the important task was to raise immigrants as a group "on every level: social, political, economic and cultural". This was important, as Norway was "about to get a class division on ethnic grounds" (Stortingsforhandlinger 2005: 2476).

In practice, the Bondevik II government initiated several new health service measures aimed at immigrants and refugees during 2003: A state-funded National Competence Unit for Minority Health (NAKMI) was established in Oslo to build competence and disseminate knowledge about minority health in Norway. In addition, a new National Competence Centre for Violence and Traumatic Stress (NKVTS) was created, incorporating the older Psychosocial Centres for Refugees. In the following years, five regional competence centres were established. Expert teams on refugee health were attached to these centres, providing supervision of staff at migration centres and health services. In addition, the screening of refugees not only for infectious diseases, but also for mental health problems was proposed (St.meld.nr. 49 (2003–2004): 76). It was suggested that health service staff should be specially assigned to work on refugees and asylum seekers, and to strengthen the mental health education of staff at asylum seeker centres, police and health services. The risks regarding trauma and potentially violent behaviour among refugees were pointed out, and the co-ordination of services through individual plans and co-operation between the school system, child welfare and health care systems were seen as tools for meeting the needs not only of the general population but also of immigrants with particular needs.

In 2003, the government also launched new guidelines for primary child and youth health care as well as new plans to improve child mental health services, with the main approach to strengthen the local community preventive work (Helse- og omsorgsdepartementet 2003; Sosial- og helsedirektoratet 2004). In line with the general governmental argumentation pertaining to the national minorities and the indigenous Sámi, the strategy plan stressed particular mental health problems related to specific child groups. Among these, children belonging to ethnic minority groups such as refugees, the Sámi and the national minorities were particularly mentioned (Helse- og omsorgsdepartementet 2003: 9–10). Several measures aimed at ethnic minority children and families were suggested, and language education and the testing of language skills were regarded in particular as prerequisites for the inclusion and preparation for school of minority children. Kindergartens and the MCHCs were given a crucial role in this respect because of the ease of access to and universality of their services (Viljugrein 2004). The government also wanted to strengthen the parent education programme initiated in 1995, which was carried out by local MCHCs. A pilot project targeting ethnic minority parents was established in 2003 by the Ministry of Children and Family Affairs, aiming at making parents aware of their own cultural values regarding child rearing in a Norwegian context. In 2006, this was established as an ordinary service in several municipalities. Parent education was also a measure included in governmental action against violence in close relationships, arranged marriages and genital mutilation.[4]

The 2003 strategy plan also involved several measures aimed at the Sámi. The need for more knowledge on the living conditions and mental health of Sámi children was emphasized, with references to the UN child committee engagement in children of indigenous people. Services and treatment based on Sámi language and culture were seen as a premise for confidence in the service apparatus (Helse- og omsorgsdepartementet 2003: 41). A national competence centre for

the mental health of Sámi children in the municipality of Karasjok was to be financed through the mental health plan. The main tasks were therapy, education of staff, research and supervision. A main objective was to develop and communicate knowledge on the general mental health of Sámi children (Helse- og omsorgsdepartementet 2003: 52).

Easy access to and increased competence of the interpretation services were two of the measures that were suggested as prerequisites for improving encounters between users and service providers. To secure the same access to services, adapted information was of great importance. Thus, the proclaimed governmental diversity policy did not lead to fundamental, principal changes in the public health service structure: in practice, the understanding of equivalence as adjustment and addition, rather than differentiation of services, endured as the main policy principle. However, the gradual introduction of more targeted measures towards refugees and asylum seekers, the emphasis on the need to adjust the work of MCHCs towards ethnic minority children and families, and the specific measures for the Sámi population from 2003 onwards demonstrate that a practical differentiation of health services was underway, first and foremost at the municipal but to a somewhat lesser extent also at the national level.

6 2005–2009: back to basics? Social inequality and migrant-friendly services

The centre-left opposition entered into government after the parliamentary elections in 2005. Their approach regarding health and minorities was to get back to basics. Rather than the differentiation of public services, their main goal was to avoid the emergence of an ethnic underclass in Norway; that is to say, the goal was to attain social equality in a manifold society (St.prp.nr. 1 (2006–2007): 6). Even though the new government acknowledged the need for adjusted public services as a precondition for equivalence of services and possibilities, the main focus was squarely on the differences in living standards for certain population groups (St.prp.nr. 1 (2006–2007): 8).

In terms of health policy, the goal was defined as a reduction of health differentials between ethnic groups, to be achieved through the prevention of lifestyle-related diseases among immigrants and by offering low-threshold services to enhance physical activity and good nutritional habits (St.prp.nr. 1 (2006–2007): 24, 37). In the *National Health Plan for 2007–2010*, the concepts of equality and equivalence were used almost interchangeably. As the fundamental point of departure, the plan stated that "all inhabitants shall have equal access to good services financed through public funding", and pointed in particular to geographical and social differences in the provision and use of health services, and health status. Ethnicity was not highlighted, although it was briefly mentioned when central challenges in specialist health services, that is, hospitals, were discussed: "People shall have equivalent access to services regardless of place of abode, income, gender, age and ethnic background" (St.prp.nr. 1 (2006–2007): 243, 268, 307). When discussing health personnel and their competence, the plan underlined that "equivalent health services" presupposed good communication between users and providers of services, demanding "knowledge in language, culture and multicultural understanding" (St.prp.nr. 1 (2006–2007): 290).

The principle of equivalence regarding health services for the Sámi, seen as a "democratic right", was specified in this document in a less committed manner than earlier. Rather than treatment and services based on Sámi culture, the Sámi right "to equivalent services (…) implies that health services must develop knowledge of Sámi language and culture in order to communicate well and to offer good services. In situations where this is not possible, the necessary interpretation service must be established" (St.prp.nr. 1 (2006–2007): 244).[5] Regarding immigrants, the plan identified better linguistic and cultural skills in health services as important for "equivalent services" (St.prp.nr. 1 (2006–2007): 290–291). Thus, the earlier differentiation of the meaning of equivalence for the Sámi and immigrants, respectively, was now discontinued in the policy documents.

The *National Health Plan* identified growing social inequality in health as the main problem. To counteract this, it was important to pay close attention to specific population groups such as "refugees, asylum seekers, prison inmates, substance and betting addicts" (St.prp.nr. 1 (2006–2007): 280). The differentiation of immigrants as culturally "close" or "distant" was now disregarded and a clearer definition of immigrants as a risk group appeared, grounded in epidemiological surveys showing a higher prevalence of certain health problems among some immigrant groups (St.prp.nr. 1 (2006–2007): 248).

The renewed emphasis on universal measures in public health policy that was evident in the *National Health Plan* concurs with the findings of a study that point to a shift from measures targeted at particular risk groups and individuals during the 1990s, to a revival of structural and universal measures with the Red–Green government from 2005 (Fosse 2009). However, even though equality, in the meaning of social equality, has been re-established in recent years as the key goal in public health and immigration policy, equivalence in the sense of adjustment of health services for immigrants has not been abandoned. In 2009, a report on migration and health by the Norwegian Directorate of Health introduced the concept of "migrant-friendly health services", inspired by international EU- and WHO-funded projects (Helsedirektoratet 2009). The concept of equivalent services for all, based on the diversity of needs, played a central part in this report, implying that the specific needs of the migrant population should be met through particular concerns and priorities. Mental health problems were identified as some of the most important, based on the considerably higher frequency of such problems among the non-Western immigrants, and child refugees were deemed as particularly vulnerable. The main measures proposed were in line with the general policies, again putting the development of competence at the forefront (Helsedirektoratet 2009: 52–53).

The 2009 report also summed up efforts to adjust health services to new demands of a diverse population in hospitals, general practitioner service and primary health care for children and youth (Helsedirektoratet 2009). Securing better communication between service providers and foreign-language users through information and high-quality interpretation services was emphasized. Certain health centres had organized their work around ethnicity, by dedicating personnel to work with new migrants and refugees (cf. Helse- og omsorgsdepartementet 2010), and a knowledge base on the relationships between ethnicity and migration and psychosocial development and mental health in young people was established. The project provided advice on public mental health work to public services, immigrant populations and NGOs (Folkehelseinstituttet, rapport 2008:14), emphasizing user participation, learning and empowerment also in migrant health work. In 2009, health policies and practices towards immigrants were thus embraced by concepts of diversity, participation and co-operation, reflecting general health policies but also acknowledging the need to supply specific measures for specific groups of population.

7 Concluding remarks

Between the mid-1970s and mid-2010s, the guiding principles in Norwegian health policy towards ethnic minorities, immigrants, refugees and asylum seekers changed at the level of political rhetoric from equality to equivalence, as stated by Brochmann and Hagelund (2010) on a general level regarding the ideals of welfare policy in Norway. In the field of public health policy, equivalence was introduced in the late 1980s as a way of *enhancing* equality, particularly regarding access to health services. From the mid-1990s, equivalence was increasingly seen as a goal in itself, leading to suggestions of a differentiation of health services for specific population groups, culminating in the 2004 formulation of a "diversity policy" by the Norwegian government. However, from 2005, equality – in the sense of stressing the need for universal measures – has regained a stronger position in the formulation of national health policy. Changes in concrete policies seem less visible. From the mid-1990s, the needs and culture of the Sámi have at least in principle played a role in the forming of equivalent health services for them, even though the practical significance of this is debatable. For immigrants, refugees and asylum seekers, there has been no similar turn in health policy, despite the political acknowledgement of the necessity of equivalent health services. In particular, the health policy formulated by the centre-left government from 2005, strongly oriented towards reduction of health differentials between population groups, suggests that non-Western immigrants and refugees were specifically considered eligible for adjusted health services not as the outcome of concerns for ethnic or cultural diversity, but as a consequence of a risk-group definition. This is in line with studies of both general public health policies and educational policies that emphasize a return to ideas of equality and universal and structural measures after 2005 (Aarvik 2009: 92–94; Fosse 2009: 296–98).

However, growing attention to the specific needs of ethnic minority groups can be seen during the period studied. The need for knowledge on the distribution of health problems among migrants, and the need to increase the linguistic and cultural competence of health services have been persistently emphasized. In particular, the focus on immigrant mental health has steadily strengthened during these past four decades, in line with general primary health policy. The municipal Mother and Child Health services have increasingly been directed to focus upon the needs of migrant children, refugee children and children belonging to ethnic and national minorities and their parents, and some specific measures to deal with the specific needs of migrants and minority children have been introduced at the national and the municipal levels, particularly after 2003.

We may conclude that for the last decade, a growing range of governmental policies has advised that specific measures should be established to take care of the migrant populations' particular needs. However, still only a few specific measures have been introduced to meet the specific needs and challenges of a diverse ethnic population. Moreover, when specific measures are suggested or taken, they are designed to mirror the services aimed at the majority population. These policies seem to have been strengthened over the last five years, even if a new tendency can be glimpsed of applying measures labelled "migrant friendly".

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Notes

1. 'Forholdene må legges slik til rette at innvandrerne styrker sin posisjon i det norske samfunn, og på den måten kan fungere som likeverdige med resten av befolkningen i Norge.' St.meld. nr. 74 (1979–80): 77.
2. 'Helsetjenestenes utgangspunkt har vært at innvandrerne så snart som mulig etter ankomsten til landet får de samme tilbud som nordmenn når det gjelder forebyggende helsearbeid og andre helsetjenester. Men man bør ha en spesiell ordning som sikrer at alle som kommer til landet får gjennomgå en første helseundersøkelse.' St.meld.nr. 74 (1979–80): 81.
3. '[…] helse- og sosialtjenester som tar hensyn til innvandrernes forutsetninger.' St.meld.nr. 39 (1987–88): 48.
4. http://www.bufetat.no/foreldrerettleiing/tilbod/
5. See also St.prp.nr. 1 (2006–2007): 257 for the responsibility of municipal health services on this issue.

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