

# NORWAY

## General principles

The Norwegian health care system is a universal system; all persons resident in Norway are covered (insured). The principle of free, equal access to healthcare means that all residents in Norway have access to the services provided by the healthcare system independent of the person's socioeconomic background. The basic principle for long term care is that services should be arranged in ways that enable care in people's home communities.

There is no legal definition of long term care in Norway. Although some may seem to believe that long term care only includes care for the elderly (eldreomsorg) (Sosial- og helsedirektoratet 2004:9), this is not by any means the case; long term care includes services to people of all ages, in need of care and assistance and with the following problems: drug addicts, mental and psychiatric problems, physical problems, retarded or physically handicapped (Sosial- og helsedirektoratet 2004:9).

## Organization and financing

For the most part, the Norwegian system is publicly financed and organized. The state is responsible for policy design and overall capacity and quality of health care through budgeting and legislation, and the services are mainly provided locally. The universal system is highly decentralized to the regions and municipalities based on the principle of subsidiarity.

The municipalities are responsible for most of the welfare services in Norway, especially after responsibility for the hospitals was transferred from the counties to the national level in 2002. This means that primary health care is delivered at a local level, while hospitals and other secondary health care arrangements are a state function. In the area of long term care, mainly two pieces of legislation apply. For treatment given by the municipalities, the provisions of the Municipal Health Service Act (kommunehelsetjenesteloven) and the Social Services Act (sosialtjenesteloven) apply (Sosial- og helsedirektoratet 2005:10). The principle of local government applied in Norway means that, within the framework of national legislation, each individual local authority decides the service level in its own geographical area and allocates the funds required to achieve the service level decided.

Most people receive domiciliary care (163,000), but there is also a large population who receives residential care (41,000) in institutions (St. prp. nr. 208 (2005-2006)). The residents of Norway are guaranteed an adequate service independent of housing facilities. The services are given through many different institutions, ranging from 24/7 care in institutions to help for a couple of hours a week in the home.

The long term care services are financed mainly through the municipal budgets. There should of course be noted that these budgets are funded on state grants. This means that local authorities are responsible for providing the various services in compliance with legislative requirements. The local authorities provide funding for the services through local taxes and block grants from the government. It's the government's responsibility to give the municipalities sufficient means so they can make local priorities.

## **Benefits**

The municipalities are legally obliged to meet the social service and housing needs of those who need long term care, but the level of health services and how it's organized are chosen by the municipalities. In other words, the municipalities have a very high degree of autonomy vis-à-vis the central government. This means that each municipality decides their own level of service and range of services provided within the legislative requirements. The provision of long term care is based on a single entry system; the person in need of help turns to the municipality where he or she lives to demand help. Determination of the need for help takes place through a process of need assessment carried out by a municipal care manager.

Domiciliary care has priority over residential care, in the sense that the aim for the public health care is to ensure that people are able to maintain their day-to-day life (in their own house) as long as possible. This does not mean that residential care is downsized or given less resources compared to domiciliary care.

When it comes to residential care, local authorities must provide help and assistance for personal care and practical tasks at all levels. This includes housing, cleaning, food, medicines etc. of which the person is dependant. The municipalities can charge 75% of income above NOK 6,000 (EUR 731) and up to the Basic Amount (Grunnbeløpet) of NOK 60,699 (EUR 7,391) (per 1 January 2006) and 85% of any exceeding income from each user up to the full cost of a nursing home place (as calculated for the municipality in question).

For provision of domiciliary care, Norwegian legislation allows local authorities only to a very limited extent to demand payment for permanent practical assistance and personal care in people's homes. Local authorities are not allowed to demand payment of expenses related to personal care and practical assistance, but they are allowed to charge for products and materials used. For services that are not included in the services provided by domiciliary care (hjemmetjenester - hjemmehjelp), there is a ceiling for cost-sharing. After this ceiling has been reached, people with an income of less than twice the basic amount (121,398 NOK / EUR 14,782) is given a card entitling them to free treatment and benefits, for the rest of the calendar year (Observatory 2000:23). The ceiling is fixed by the parliament for one year at a time. Health care may be granted irrespective of where the person in question lives: own home, residential care homes or sheltered housing for older people.

In general, the municipalities provide the social services, and the personnel working in the sector are directly employed by the municipalities. Some municipalities have contracted out the provision of services to private sector providers. Some services may be carried out by voluntary or private organizations, often with a degree of municipal funding.

## **Accompanying measures**

Through the Social Service Act § 4-2 litra e), persons who provide care for their husband or wife, mother or father or child in cases of illness, may receive a compensation, called carer's pay (omsorgslønn). This is granted to the service provider. More specifically, each municipality must provide an arrangement for this kind of compensation, and they are not allowed to reject an application for budgetary reasons. Note that as for carer's pay as for other care services provided locally, it's a municipal decision whether compensation is given or not.

Another accompanying measure worth mentioning is an arrangement where the assistance provider is managed by the user personally. This arrangement is called BPA (brukerstyrt personlig assistanse). The care receiver is in charge of her/his assistant(s) as if she/he was an ordinary manager or employer. BPA is mainly given to (young) adults with either physical or mental problems. The basic principle is more control to the user for her/him to become more in charge of her/his own day. Instead of having an assistant when it suits the authorities, they will have an assistant when needed.

### **Quality control of care**

The welfare services carried out by the municipalities must balance between two different (often conflicting) interests. The first factor is *local variation*, which means that the locally elected bodies decide how the services are produced. There are no specific minimum requirements at national level with respect to the services that are provided at municipal level or to the ratio between patients and doctors/nurses. Decentralized decision-making brings about several important challenges and the interest of local independency could be in conflict with another basic principle, namely *equal access* to health services all over the country. This dualism indicates that all residents are entitled to some or a minimum of health services, but that there exists local variation between the municipalities.

Within the limits of legislation and available economic resources the municipalities are formally free to plan and provide public health services and social services as they like. However, in practice, their freedom to act independently is limited by available resources. Because of the high degree of decentralization, standards and quality requirements for the health service provided in the Norwegian health care system are to some extent specified through legislation. This legislation only requires that the municipalities secure adequate and efficient medical treatment to the people who live and stay there.

Even though there aren't any direct command or control lines from the central authorities, there exist both guidelines regarding quality and patient rights, as well as control authorities. In the past decade, more emphasis has been placed on the formal rights of the user, both in planning the services and law making (Observatory 2000:16). The Directorate for Health and Social Affairs and the Norwegian Board of Health administer the control mechanism towards health care, on behalf of the Ministry of Health and Care Services. They are monitoring health and social services in relation to the needs of the population and the demands of society for services, and administer health and social legislation (legal capacity).

The concept of quality can be defined in many ways. Norwegian standard (NS-EN ISO 9000:2000) defines quality in the following way: "the degree to which a set of inherent characteristics fulfils requirements" (Sosial- og helsedirektoratet 2005:11). Key objectives of most health care systems are those of equity, efficiency, choice/responsiveness and quality.

In 2003 the Government made an agreement with the *Association of Norwegian Municipalities* (KS) on quality improvement in nursing and care services (St.prp. nr. 14 (2005-2006)). A major task has been to develop national indicators of quality. The aim is to develop and improve the services through benchmarking. Many of the quality indicators have been tested in

a major learning and benchmarking project called 'Municipality networks for innovation and efficiency' ('Kommunenettverk for fornyelse og effektivisering').

## **Current debate**

While the focus in long term care services for a long time was oriented towards the older part of the population, there has been a development towards a growing number of younger users in the recent years. In the period 1997-2004, the number of users under the age of 67 years increased by 50 percent (St.prp. nr. 209 (2005-2006)). The reasons for this change are found in different reforms entailing transfer of the responsibility for groups of users from the state or county to the municipalities. The primary sector has received new user groups, while there has also been a substantial growth in the "old" user population. This shift means new challenges, not just in relation to numbers but also in relation to the user's needs and demands. With increasing and more complex needs among the users, demands for more resources and competence has followed.

Another factor in this discussion is the coordination of care provided by hospitals and care provided by the primary health care sector. The hospitals are trying to reduce the average length of stay for in-patients to cope with their waiting lists. The average length of stay in hospitals has been gradually reduced and the patient returns home faster than before. Due to this, more of the recovery services have to take place in the primary health care sector and may have been straining the municipalities' resources.

The overall need for nursing and care services is expected to increase. This is due to the age structure of the population, and especially to expected increase in the number of persons over the age of 80. This number is expected to rise quite steeply, especially after the decade 2020-2029. This entails new challenges towards residential capacity, number of staff and quality of the services. There is a common belief that the new generations will demand more towards quality and diversity of services than today's older generations. Although the demographic challenges will first manifest themselves 20 years or more from now, the future care system is already an important topic of debate.

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