ESPN Thematic Report on Challenges in long-term care

Norway

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Summary

Long-term care (LTC) in Norway is the responsibility of municipalities, and the right to receive care is regulated by the Municipal Health Services Act. The municipalities finance these services out of their general tax revenue and block grants from the state and through user payments for some services. The state influences through legislation, standards, regulations and guidelines, and through 'soft power' such as recommendations, education, surveillance and targeted grants. Within this national framework, approaches and priorities can vary between municipalities. In 2016, it was estimated that about NOK 106 billion (EUR 10.6 billion) was spent on LTC in municipalities.

Long-term care is typically associated with 'care for the elderly', but long-term care needs can materialise at any age. Care services in Norway target the entire population above the age of 18, and the number of users aged under 67 has increased considerably since the 1990s. Norway thus does not have an 'elder-care sector', but *care services* for all residents in need of long-term care.

Care in the home has been the dominant approach in care services since the early 1990s. *Care homes* (*omsorgsboliger*) – that is, municipally owned houses built for persons (of any age) with caring needs, often with round-the-clock care – have been rapidly expanded since the mid-1990s. Over time, the approach has changed from 'institutions for old people' to 'homes for people with caring needs'.

There are no formal rules for when a person should be able to access care services. Services are offered when 'needed', and need is determined by healthcare personnel in dialogue with the user and their families. How these needs assessments are negotiated is a topic for research, but generally healthcare personnel are committed to offering 'responsible' services.

Statistics Norway has estimated that informal care makes up 90,000 person-years annually. There is a set of benefits that is awarded on the basis of caring needs, either to the person who needs care or to a private carer. These are attendance benefit (*hjelpestønad*), attendance allowance (*pleiepenger*) and carer's support (*omsorgsstønad*). The rights to leave of absence only grant short periods of leave in critical periods, and there is little to suggest that such benefits hamper labour market inclusion among carers. If anything, the statutory right to leave helps carers maintain a foothold in the labour market.

Municipal health and care services are public services, and employment conditions are well regulated – as in Norwegian working life generally. There are, however, concerns related to the availability of qualified staff, the prevalence of part-time work and high levels of sick leave. About 25% of employees in the health and care services have no formal qualifications. And 67% of employees work part time, which is a higher proportion than in any other sector. Rates of sickness absence are also higher than in other sectors.

The *Norwegian Board of Health Supervision* (*Helsetilsynet*) has overarching responsibility for the supervision of health and care services. The Board also handles appeals where users believe their legal rights have not been met. The *Offices of the County Governor* (*Fylkesmannen*) supervise services in their area, and handle complaints from users who think the municipal services offered are insufficient. On top of this, there is a set of national quality indicators that has been considerably expanded recently and an ombudsman for patients and users. Finally, for the past 4 years, the government has issued annual White Papers on 'Quality and security for patients'.

Responsibility for long-term care has now been placed squarely on municipalities. This allows for local variation and limits state influence. Recent developments suggest that we should not expect large-scale national reforms in this area, but rather continuous efforts to influence activity at the local level, for instance through the identification and dissemination of best practices. There is, however, a debate about financing and a trial has been carried out where services were state financed through a ring-fenced grant.

1 Description of the main features of the country's long-term care system(s)

1.1 Main characteristics, governance and financing

Long-term care in Norway is the responsibility of municipalities, and the right to receive care is regulated by the Municipal Health Services Act. The municipalities finance these services out of their general tax revenue and block grants from the state and through user payments for some services (see below). The state influences through legislation, standards, regulations and guidelines, and through 'soft power' such as recommendations, education, surveillance and targeted grants. Within this national framework, approaches and priorities can vary between municipalities.

Long-term care is typically associated with 'care for the elderly', but long-term care needs can materialise at any age. Care services in Norway target the entire population above the age of 18.[1] The elderly are over-represented among the users of such services, but the number of users under the age of 67 has increased considerably since the 1990s (Gautun and Grødem, 2015) (see Figures A1-A3 in the appendix). Norway thus does not have an 'elder-care sector', but *care services* for all residents in need of long-term care. Discrimination or unequal treatment on the basis of age is against the law, but a few age-related distinctions exist: it is very rare to award a person over 67 a support person on the basis of social need (Gautun and Grødem, 2015); unlike older people, those under-67s with extensive care needs have a statutory right to a user-driven personal assistant; and nursing homes are in principle reserved for the old.

The demarcation line between state-owned, specialised healthcare services (hospitals) and municipal health and care services has been altered over time – most recently in the 2012 Coordination Reform. The aim of this reform was to achieve better coordination between primary and secondary health services by strengthening the role of the municipalities in the overall system. For the municipalities, the most important aspect of the reform is that they are given full responsibility for patients who are ready to be discharged from hospital. If municipalities are unable to offer services to 'discharge-ready' patients, they may be required to co-fund the additional nights in hospital. This has incentivised municipalities to expand their services for somatic patients with complicated care needs, and to communicate more systematically with the hospitals (for an introduction to the reform in English, see HOD, 2009).

Users pay for some of the services provided, but not all. User payments are regulated by national guidelines. A general rule is that user payments must not exceed the cost of providing the service, and that ceilings apply for users on low incomes (HOD, 2011). For long-term stays in nursing homes, municipalities can demand up to 75% of the user's annual income up to the National Insurance base amount (currently NOK 93,634, EUR 9,853), and 85% of annual income above this (very low) level. Allowances are made if the user provides for family members or has a very low income. User payments can also be required for practical help in the home (with a ceiling set at the cost of providing the service), while nursing care in the home should be free of charge (HOD, 2011).

About 90% of nursing homes are run by municipalities, and 97% of costs in home-based care go towards services run by municipalities (Sivesind, 2016). Nationally, there are between 70 and 80 nursing homes run by third-sector organisations, and 20 that are commercially run (Sivesind, 2016). Contracting out, particularly to commercial actors, is controversial, and was an important topic in the 2017 election campaign. Parties on the left mobilised against 'welfare profiteers', while parties on the right emphasised that private actors can work more efficiently and provide greater freedom of choice. Services for the elderly have great symbolic value in such discussions (as in the frequently evoked

[1] Services for children and minors are separate, and not dealt with here.

caption 'contracting out grandma'); but in reality, contracting out is far more common in childcare services and asylum centres than in LTC.

1.2 Institutional and home care services

Care in the home has been the dominant approach in care services since the early 1990s. Helping recipients of long-term care and support services to stay in their own homes for as long as possible and to live independent lives became a dominant aim in the wake of the influential Gjærevoll expert committee (NOU, 1992: 1) and the reform for persons with mental disabilities (the HVPU reform, 1991-1995). The Gjærevoll committee emphasised locally based care in the home, while the HVPU reform transferred responsibility for persons with mental disabilities from the state to the municipality, where they should live as independently as possible and be integrated into their local communities. Ambitious action plans for substance users and persons with mental illness in the late 1990s and early 2000s relied on the same principles (Gautun and Grødem, 2015).

Care homes (*omsorgsboliger*) – that is, municipally owned houses built for persons with caring needs, often with round-the-clock care – were rapidly expanded from the mid-1990s onwards. Daatland and Otnes (2014) estimate that in the course of the 1998-2005 action plan for eldercare, about 19,000 new care homes were built, in addition to between 5,000 and 6,000 new places in nursing homes (though the expansion in care homes may be overstated, given the lack of clear definitions). In addition, about 5,000 care homes and between 1,000 and 2,000 nursing home places were established immediately prior to the action plan. In the same period, between 5,000 and 6,000 places in so-called 'old people's homes' (*aldershjem*) were closed down. The net increase in institutional care beds was therefore modest, but there was a transition from 'institutions for old people' to 'homes for people of all ages with caring needs'. At the same time, nursing homes were increasingly made 'homely' through renovations, mainly to ensure that more residents could have private rooms (Daatland and Otnes, 2014).

As can be seen from Appendix Figure A2, services in the private home are now the dominant form of LTC in all age groups – even in the group 90+. As many 67-80-year-olds live in care homes as in nursing homes, but among the over-80s who no longer live in their own home, nursing homes predominate. It is worth noting that no young (under-67) users are placed in nursing homes. This is intentional – nursing homes are targeted at the old, and particularly those with dementia.

1.3 Cash vs. in-kind benefits

Many recipients of long-term care services receive cash benefits from the National Insurance, either as old age pension or disability pension. These are, however, not linked to their caring needs. There is a set of benefits that is awarded on the basis of caring needs, either to the person who needs care or to a private carer (Grødem, 2016; 2017). These are attendance benefit (*hjelpestønad*), attendance allowance (*pleiepenger*) and carer's support (*omsorgsstønad*). Before 2017, this last benefit was known as carer's wage, (*omsorgslønn*). Attendance benefit and attendance allowance are state benefits, mandated by the National Insurance Act and administered by the Norwegian Labour and Welfare Administration (NAV). The two benefits are received by approx. 72,000 and 9,000 people, respectively (source: NAV, administrative statistics). Carer's support is mandated by the Act on Social Services in NAV and is funded and administered by the municipalities. It is received by just under 10,000 people (source: Statistics Norway). Attendance benefit and carer's support can be paid irrespective of the age of the carer or the person with caring needs.

Attendance benefit is paid to the person in need of care. The aim of this benefit is to allow the recipient to establish or maintain private arrangements, i.e. informal care by a family member, friend /neighbour or others. When applying for the benefit, a declaration

from a medical expert must be supplied, stating the extent of the applicant's disability and care needs. The need for assistance must be permanent – that is, it must last 2-3 years (or more) due to the medical condition. The attendance benefit is a flat-rate one, payable at a rate of NOK 14,412 per year (EUR 1,500) (higher for children). It is set to cover approx. 2-2.5 hours of paid care per week, but in many cases is used as a minor compensation for extensive informal (unpaid) care. It is not taxable. Its use is not monitored, and it is not subject to requirements beyond the documented need for lasting care. It can, however, be awarded for limited periods and subject to review. This is done when there is reason to believe that the need for care will change over time.

Attendance allowance (*pleiepenger*) is payable to carers. It can be paid for severely ill children (§§9-10 and 9-11), and to persons caring for a relative or other close person during the terminal phase (§9-12) – in this latter case, the allowance is limited to 60 days. In order to claim the benefit, the patient's doctor must supply a form stating the diagnosis and a declaration that the illness is (presumably) terminal. The allowance can be used flexibly and combined with part-time work. Attendance allowance is paid on the same conditions as sick pay (that is, it only applies to those currently employed), and it offers full wage compensation from day 1. It is taxed as income.

People can apply for *carer's support* if they undertake care work that the municipality would have to do, if the carer did not do it informally. Municipalities, however, decide for themselves what the eligibility and priority criteria should be. In order for carer's support to be paid, the municipality must accept that private informal care is the most desirable way to provide care for the client in question. This understanding should be reached through dialogue with the carer. Municipalities can require the person with care needs to apply for attendance benefit (*hjelpestønad*), and take the amount received into account when determining carer's support. The support can be paid irrespective of whether a statutory obligation to care exists; thus it can be considered for parents caring for special-needs children, as well as for adults caring for ailing parents or spouses. It is not linked to any loss of income, but is available irrespective of the recipient's current employment and work history. The level of the support is typically calculated by using the annual wage of the lowest-paid municipal employees as a starting point. Carer's support is taxed as income. Its use is not monitored, but it is usually awarded for limited periods – typically for a year or less. Most municipalities have limited means and are unwilling to enter into contracts that bind them for more than a single budget year.

Carers have the right to *respite support* (*avlastning*). The aim of respite support is to prevent burn-out among carers and to allow them to go on occasional holidays and have a normal social life. A corresponding arrangement is a 'support person' (*støttekontakt*), a measure targeted at the social needs of the person being cared for. In order to get a 'support person', the applicant must convince the municipality that he or she has social needs that are not being met. Beyond this, there are no formal eligibility criteria, but in practice persons over the age of 67 are very rarely allowed a support person (Gautun and Grødem, 2015). Since 2015, persons younger than 67 in need of assistance have had a statutory right to user-driven personal assistance.

The Norwegian old age pension system offers both a minimum guarantee and earnings-related benefits. Earnings-related pension rights are awarded for certain unpaid activities, among them – on certain conditions – care work.

1.4 Formal and informal care, and quality of jobs in the formal workforce

In the most recent Survey of Level of Living (a population survey, the Norwegian version of EU-SILC), 13% reported that they regularly provide care and/or supervision to a person outside their own household, while 2% provide such care to a person living in the same household (Appendix Table A1). Those who provide care or supervision to a person living outside their own household indicate that they do so for about 5 hours per week.

Persons aged 45-66 provide more such care than do people who are younger or older (Statistics Norway, 2016b); the most common form of care is of one's own parents.

While the proportion of the population regularly providing unpaid care is limited, there is a small section that provides comprehensive and enduring care. Most of these are either the parents of chronically ill children or else elderly people with partners in need of continuous care. Statistics Norway has estimated that such informal care makes up 90,000 person-years annually (Holmøy et al., 2016).

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Access and adequacy challenge

All municipalities are obliged to provide a range of care services. This is a core municipal task, and one that residents in the municipalities demand. Services are thus available across the country, even in rural and remote areas. As described in the previous section, there is a cap on user payments, and there are concessions for users with low incomes and/or with dependants. These limitations apply also when services are provided by private actors working on a contract with the municipality.

A 'long waiting time' is defined as 16 days or more from the date on which an application for care services is lodged with the municipality to the day on which services are offered. Waiting times differ for different services: 77% of applications for healthcare services in the home are processed within 15 days or less; the same is true for just over 60% of applications for practical help in the home, and 50% of applications for long-term institutional care (Statistics Norway, 2017). Waiting times are consistently longer in large municipalities than in small ones.

There are no formal rules for when a person should be able to access care services. Services are offered when 'needed', and need is determined by healthcare personnel in dialogue with the user and their families. How these needs assessments are negotiated is a topic for research (e.g. Gautun and Grødem, 2015), but generally healthcare personnel are committed to offering 'responsible' services. They will not downplay a user's needs because the municipality wishes to save money, but they will act as gatekeepers if users or their families expect services beyond a 'responsible' level. Users who believe that their needs are not being met can complain to the municipality and, if this is unsuccessful, to the county governor (*fylkesmann*).

There is debate on the division of labour between municipal care homes and institutional care. At what point is a person too frail to live in an independent home, even if considerable services are provided? On the one hand, many elderly people prefer to live independently for as long as possible. On the other hand, many reach a point where this is no longer responsible. The Norwegian Directorate of Health recently found that 28% of users in nursing homes died within 6 months of admission, and that the average period between admission and death was 2 years (Helsedirektoratet, 2017c). This indicates that the threshold for admittance is high, although there is variation between municipalities. It has been estimated that about 80% of residents in nursing homes have dementia, and that dementia is the most common reason for nursing home admission (Selbaek et al., 2007, Wergeland et al., 2015). As explained above, for users the cost should not be a problem; but nursing homes are expensive for the municipalities and are therefore typically a last resort.

2.2 Quality challenge

Users of municipal services, be they young or old, are a particularly vulnerable group, and there is a complex infrastructure in place to ensure that their rights are not violated. The *Norwegian Board of Health Supervision* (*Helsetilsynet*) has overarching responsibility for the supervision of health and care services. Supervision applies to all statutory services, irrespective of whether they are provided by municipalities, private businesses, publicly owned hospitals or healthcare personnel who run their own practice. The Board also handles appeals where users believe their legal rights have not been met. Furthermore, it has the task of ensuring that all care service providers have control measures in place to make sure that all patients receive care at a level that is responsible. The *Offices of the County Governor* (*Fylkesmannen*) supervise services in their area, and handle complaints from users who think the municipal services offered are insufficient. The Board of Health Supervision and the County Governors cooperate to ensure that all enterprises work systematically to improve quality and increase the safety of users and patients. On top of this, there is a set of national quality indicators that has been considerably expanded recently (see Section 3) and an ombudsman for patients and users (*Pasient- og brukerombudet*).[2] Finally, for the past 4 years, the government has issued an annual White Paper on 'Quality and security for patients', the most recent being Meld. St. 13 (2016-2017).

The systematic reporting and supervision show that municipal health and care services do face challenges, but these are normally not in the area of long-term care. The ombudsman for patients and users is, however, concerned that the general population is not aware of the right to appeal against a decision made by the care services, and that municipalities deal inadequately with complaints (Meld. St. 13 (2016-2017)). Moreover, the ombudsman is concerned about the lack of efficient cooperation between services.

Municipal health and care services are public services, and employment conditions are well regulated. Informal live-in care is not an issue, but it is well known that there is a black market for services in the home (cleaning, maintenance work, etc.). Persons in need of LTC probably use such unregulated services, but there are no indications that they do so more frequently than the population at large.

There are no indications that working conditions are more poorly regulated in the health and care services than in other sectors of Norwegian working life. Working conditions for staff are a major concern in discussions on competitive tendering in health and care services. Studies indicate, however, that private providers of LTC are being monitored, among other things on employment conditions and staff qualifications, and there is no evidence that working conditions are systematically poorer in private than in publicly run services (Vabø et al., 2013).

About 25% of employees in the health and care services have no formal qualifications for such services (Helsedirektoratet, 2017a). This is an increasingly important topic in the municipalities, as the Coordination Reform requires municipalities to produce health services at a relatively high level. The shortage of qualified nurses in these services is therefore seen as a challenge (Ugreninov et al., 2017). There are, however, few studies on the direct impact on health and safety of having a high proportion of personnel without a relevant health education working in direct patient care (Flodgren et al., 2017).

One recurring concern with regard to working conditions in health and care services is the prevalence of part-time work: 67% of employees in municipal health and care services work part time, which is a higher proportion than in any other sector (KS, 2017). Most part-time work is voluntary, but a certain proportion of part-time workers would prefer full-time employment. Moreover, the prevalence of part-time work is a challenge given the shortage of qualified staff in this sector. Similar reflections apply to sickness absence, which is comparatively high in this sector (KS, 2017). The high rate of

[2] https://helsenorge.no/pasient-og-brukerombudet/health-and-services-ombudsman

sickness absence drives the need for stand-ins – a need that is typically filled by on-call workers. On-call workers are often part-time workers who wish (or are prepared) to work more (Nergaard et al., 2015).

2.3 Employment challenge

There is little debate about the possible adverse employment effects of benefits for carers. The right to leave of absence to care for relatives in need only offers short spells of leave at critical times. If anything, the statutory right to leave helps carers maintain a foothold in the labour market. The right to *attendance allowance* in such cases is dependent on previous employment, and thus the existence of this allowance can act as an incentive to take up employment and win this social right. *Attendance benefit* payable to persons with severe care needs is low and is unlikely to interfere with the decision to seek income from employment. As for *carer's support*, Finnvold (2011) found that mothers in receipt of this benefit were less likely than other mothers with children in the same age group and with the same level of disability to work outside the home. This held true even after controlling for other factors. He also found that mothers who received carer's support had a lower education than average and expressed little interest in paid employment. Given that carer's support is received by fewer than 10,000 people with very heavy caring obligations, and the recipients who use it as an opt-out strategy are anyway typically marginal in the labour market, it is debatable how problematic this is. There are no dedicated strategies to provide formal training to informal carers wishing to become LTC professionals, but the labour market service (NAV) can help all job seekers who lack formal training to obtain the relevant qualifications. These services are also available to former informal carers who aim for a career as a healthcare professional.

A recent article drawing on Norwegian data investigated how having a parent with long-term care needs affects adult children's employment (Gautun and Bratt, 2017). The analysis showed that adult children reduced their work attendance when their elderly parents' health deteriorated, particularly if the parent received care in the home. If the ailing parent was admitted to a nursing home, the effect on children's work attendance was smaller. This indicates that 'home care' leaves more work to the family than institutional care. It should, however, be noted that adult children in this situation are unlikely to leave employment entirely: among the inactive population, only 2.7% of the inactive population said that the reason for inactivity was family/caring responsibilities, while 1.7% gave the reason 'looking after children or incapacitated adults'. These figures are among the lowest in Europe. Among part-time workers, however, 5.8% and 11.9%, respectively, gave these two reasons. These findings suggest that adult children with ailing parents in Norway are more likely to scale down their employment than to give up on the labour market entirely (figures from Eurostat; note that figures for part-time workers are marked with 'low reliability').

2.4 Financial sustainability challenge

Statistics Norway has made projections on the need for care in the long term in Norway (Holmøy et al., 2016). The projections use what is seen as the most realistic demographic projections and maintain the 2014 profiles of service standards, productivity and informal care supplied by family members. The health condition of individuals aged 55 or over is assumed to improve as the expected life time increases. Given these assumptions, the number of users of home-based services increases from 192,000 in 2014 to 330,000 in 2060 – an increase of 72%. The relative increase in institutionalised LTC over the same period is equally strong, but the absolute numbers are smaller: from 43,000 in 2014 to 74,000 in 2060. The study concludes that if these services are to be sustainable in the future, a far higher proportion of the labour force must be willing to work in the services, and taxes must be increased to provide funding.

It is estimated that Norway spent NOK 106 billion (EUR 10.6 billion) on municipal health and care services in 2016. This represents an increase of 19% since 2012 (Statistics

Norway, annual updates). As the proportion of the elderly is expected to increase in the next 30-40 years, there is a continuous effort to identify ways to work more smartly and more efficiently in care services. The government's Action Plan for Care (Omsorg2020, cf. Meld. St. 29 (2012-2013)) highlights five areas in which there should be improvements in order to better face the care policy challenges for the future:

- Cooperation with users, patients and their families (more user involvement)
- Competent health and care services (competent, forward-looking personnel, emphasis on rehabilitation, good leadership)
- Modern locations and housing (variety of housing, rehabilitation of nursing homes)
- New home care services (even stronger expansion of home care services, a wider range of services provided in the home)
- Modernisation and innovation (local innovation and identification of best practices, care technologies).

These measures do not require structural reform, but rather continuous attention, targeted grants, education/training and monitoring. Overall, the plan aims to mobilise underutilised resources (including those of the users themselves), make use of modern technologies and provide services in the home for as long as possible.

2.5 Recent and planned reforms, and how they address the challenges

The government recently (17 January 2018) carried out a symbolic change, in that it appointed a dedicated Minister for the Elderly and Public Health (Åse Michaelsen from the Progress Party). This is seen as essentially symbolic, highlighting the Progress Party's long-term commitment to eldercare.

The most recent structural reform in long-term care services is the Coordination Reform of 2012, which – among other things – drew a new demarcation line between state specialised services (hospitals) and municipal care services. The reform allowed for more comprehensive and cohesive services at the municipal level, but it also created new demand and required municipalities to build healthcare services at a level they never had previously. As noted, the transition from hospitals to municipalities is still not without stumbling blocks. The reform may have solved some problems, but created new challenges. The ombudsman for users and patients has expressed concern that the Coordination Reform requires hospitals to discharge patients after treatment and transfer responsibility to the municipality. The transition phase – when the hospital deems its job done, while municipalities may not have the necessary services in place – is difficult, and often leads to temporary and substandard solutions (Meld. St. 13 (2016-2017)).

There is a reform under way in services for the elderly: 'Living the entire life – a quality reform for the elderly' (*Leve hele livet – en kvalitetsreform for eldre*). A White Paper on the reform is planned for spring 2018. It will address what is described as the four areas where there are often deficiencies in eldercare: food/nutrition, activity and community, healthcare and cohesion in services. It seems – from the information that is available at the time of writing – that a key method of the reform will be to identify and disseminate best practices at the municipal level.

There is a debate about whether municipal health and care services should be financed through a dedicated state grant, rather than out of the block grant. This has been tried out in six municipalities, and the trial is being evaluated (Helsedirektoratet, 2017b).

2.6 Policy recommendations

Responsibility for long-term care has been placed squarely with the municipalities. This allows for local variation and limits state influence. Developments since 2012 suggest that we should not expect any large-scale national reforms in this area, but rather continuous efforts to influence activity at the local level.

The population is ageing, and the number of persons with caring needs will increase relative to the number of potential carers. There are no easy solutions to this challenge. New technologies, better organisation, import of qualified staff (labour migration) and mobilisation of users' own capacities can make the challenge more manageable; but each of these strategies has its limitations.

A core challenge is that the care services have high ambitions on many fronts, and that different aims may conflict. It may not be possible in the future to provide locally based services, of high quality and with well-qualified staff, in the smallest communities, to all persons with needs. The principle most likely to give way is perhaps the principle of decentralisation. Persons with caring needs may increasingly have to choose between limited services in their own home, or higher-quality services in a care home in a nearby city. This will probably require more coordination and division of labour across municipalities, which currently tend to operate as independent entities. It also requires a more efficient division of labour between services, both horizontally (between municipalities and regions) and vertically (between the state, regional and municipal level).

3 Analysis of the indicators available in the country for measuring long-term care

Municipal health and care services are regularly measured on a wide range of quality indicators. Results for each indicator are reported annually as part of the reporting in IPLOS (*individbasert pleie- og omsorgsstatistikk* – individual statistics on care), KOSTRA (*Kommune-Stat-Rapportering* – Municipality–State-reporting) and NOIS (*Norsk overvåkningssystem for antibiotikabruk og helsetjenesteassosierte infeksjoner* – Norwegian Surveillance System for Healthcare-Associated Infections). Municipalities do the reporting, and the Board of Health Supervision emphasises that this should be kept in mind when interpreting the indicators: municipalities have different practices for reporting, and not all municipalities report in detail on every indicator every year.

The current system for reporting has been developed by the Directorate of Health, in an effort that only started in 2012. Some municipalities had local quality indicators earlier, but as a *national* system this was only consolidated in 2013. The number of indicators has grown rapidly in the past 5 years. The following tables indicate when the indicator was implemented in its current form. Some of the new indicators replaced indicators with a slightly longer history. The number of indicators introduced in 2016/2017 thus indicates that this is work in progress, and new indicators will probably be added over time.

The indicators address six dimensions, all related to quality in structure, process and results (Helsenorge, 2018). The six dimensions are:

1. Efficiency
2. Safety and security
3. User involvement
4. Coordination and continuity
5. Resource efficiency
6. Availability and just distribution.

Each indicator addresses a primary and a secondary indicator. This is noted in the column 'dimension' in the table below. The sorting of indicators into main categories 'access and adequacy', 'quality' and 'sustainability' is done by the author for the purposes of this report and has no official standing in Norway.

An overview of the indicators and their precise definitions can be found at https://helsenorge.no/Kvalitetsindikatorer/kvalitetsindikator-pleie-og-omsorg

Area	Indicator (English translation)	Dimen-sion	Reporting	Indicator (Norwegian name)
Access and adequacy	Waiting times for nursing homes	6 2	Annual since 2016	*Ventetid på sykehjemsplass*
	Waiting time for home-based services	6 2	Annual since 2016	*Ventetid på hjemmetjenester*
	Waiting time for support (contact) person	6 2	Annual since 2016	*Ventetid på støttekontakt*
	Waiting time for day-time activities	6 2	Annual since 2016	*Ventetid på dagaktivitetstilbud*
	Daily activities for persons with mental disabilities	6 5	Annual since 2017	*Dagaktivitetstilbud til personer med*

Area	Indicator (English translation)	Dimen-sion	Reporting	Indicator (Norwegian name)
				utviklingshemming
	Daily activities for persons with dementia	6 5	Annual since 2017	*Dagaktivitetstilbud til personer med dementia*
	Help to travel to and from work and education	4 3	Annual since 2016	*Hjelp til å reise til og fra arbeid og utdanning*
	Help to travel to and from organisation activities, cultural events and leisure activities	4 3	Annual since 2016	*Hjelp til å reise til og fra organisasjonsarbeid, kultur og fritidsaktiviteter*
	Help to participate in work and education	4 3	Annual since 2016	*Bistand til å delta i arbeid og utdanning*
	Help to participate in organisation activities, cultural events and leisure activities	4 3	Annual since 2016	*Bistand til å delta i organisasjonsarbeid, kultur og fritidsaktiviteter*
Quality	Residents in nursing homes evaluated by a doctor in the last 12 months	2 6	Annual since 2015	*Beboere på sykehjem vurdert av lege siste 12 måneder*
	Sessions with a doctor per resident in nursing homes	6 4	Annual since 2013	*Legetimer per beboer i sykehjem*
	Residents in nursing homes evaluated by dental health personnel in the last 12 months	6 2	Annual since 2015	*Beboere på sykehjem vurdert av tannhelsepersonell siste 12 måneder*
	Single rooms with private bath and WC in nursing homes	6 4	Annual since 2013	*Enerom med eget bad og WC*
	Readmittance to hospital among the elderly 30 days after discharge	1 4	Annual since 2013	*Reinnleggelse blant eldre 30 dager etter utskrivning per kommune*
	Person-years (municipal) in mental health services	6 2	Annual since 2015	*Kommunale årsverk i psykisk helse- og rusarbeid*
	Proportion of employees with formal skills in health and care services	6 2	Annual since 2013	*Fagutdanning i pleie- og omsorgstjenesten*
Sustainability*	Recipients of habilitation and rehabilitation services with individual plans (institutions)	4 3	Annual since 2016	*Mottakere av habilitering og rehabilitering i institusjon med individuell plan*
	Check-up of nutrition among residents in nursing homes	2 5	Annual since 2017	*Oppfølging av ernæring hos beboere på sykehjem*
	Check-up of medications among residents in nursing homes	2 5	Annual since 2017	*Legemiddelgjennomgang for beboere på sykehjem*
	Occurrences of healthcare-associated infections in	2	Annual	*Forekomst av helsetjenesteassosierte*

Area	Indicator (English translation)	Dimen-sion	Reporting	Indicator (Norwegian name)
	nursing homes	5	since 2017	*infeksjoner i norske sykehjem*
	Check-up of nutrition among recipients of care services living at home	2 5	Annual since 2017	*Oppfølging av ernæring hos hjemmeboende*
	Recipients of habilitation and rehabilitation services with individual plans (home-based)	4 3	Annual since 2016	*Mottakere av habilitering og rehabilitering i hjemmet med individuell plan*
	Rates of sickness absence in municipal health and care services	6 2	Annual since 2014	*Sykefravær i de kommunale helse- og omsorgstjenestene*
	Nursing homes participating in the survey on healthcare-associated infections	2 5	Annual since 2017	*Sykehjem som deltar i undersøkelsen av helsetjenesteassosierte infeksjoner (NOIS-PIAH)*

Website, all indicators: https://helsenorge.no/Kvalitetsindikatorer/kvalitetsindikator-pleie-og-omsorg (in Norwegian only)

* ‘Sustainability’ includes indicators of efficient use of resources and user involvement.

The dimension ‘Impact of caring responsibilities on employment’ receives little attention in Norway, and there are no indicators to monitor this. As indicated above, very few inactive persons list caring responsibilities as a main reason for non-employment.

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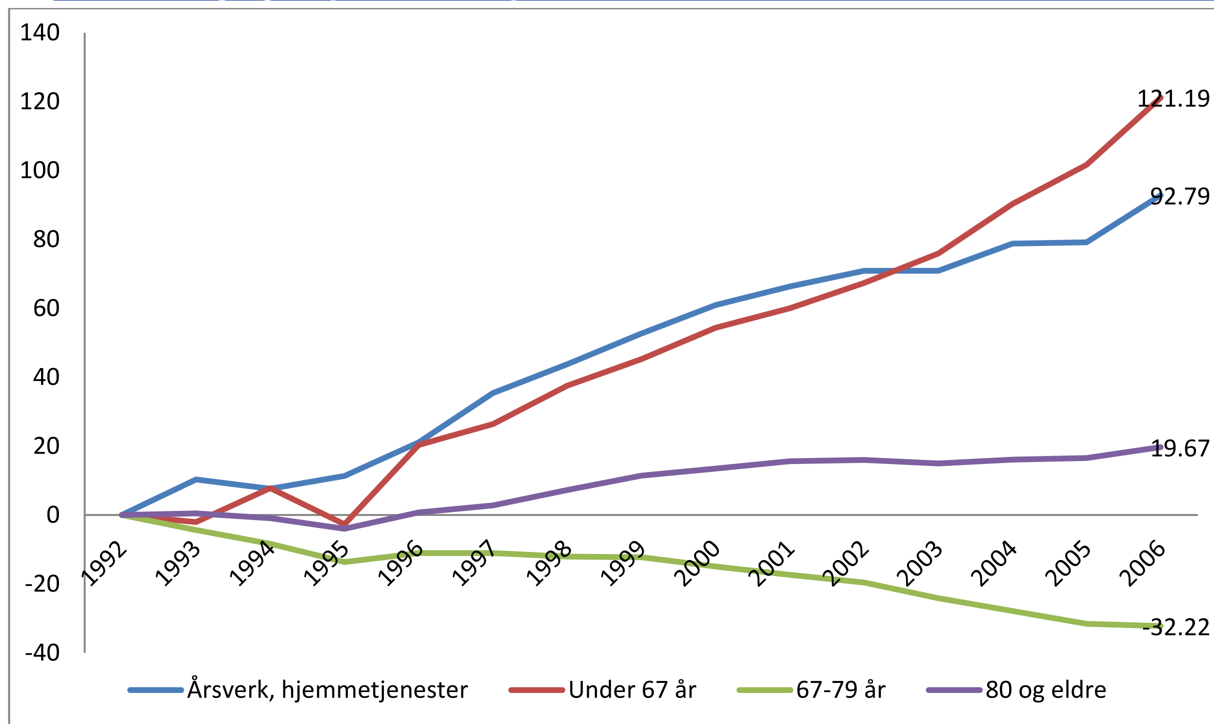
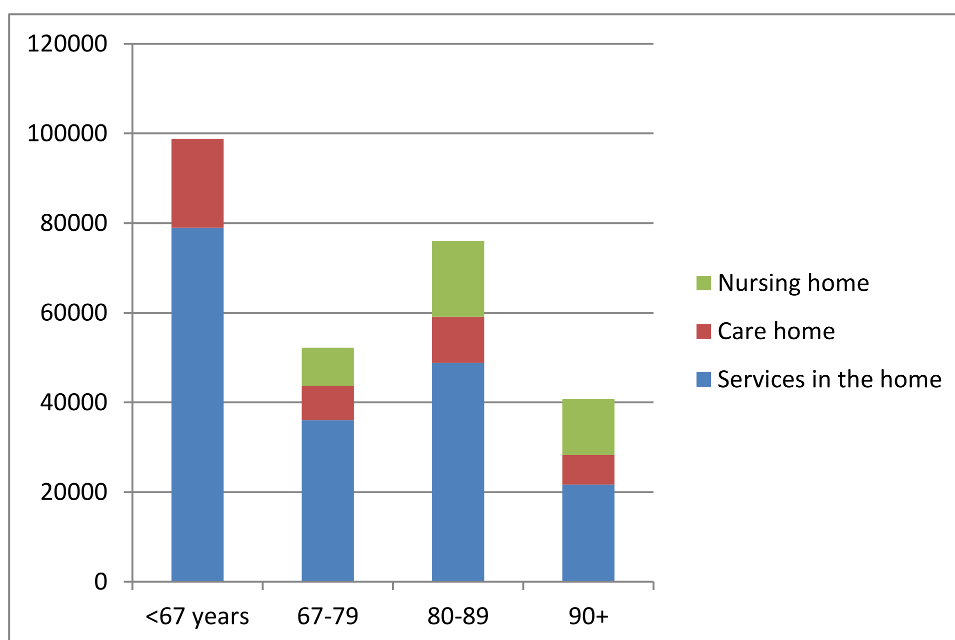
Appendix

Figure A1. Development of work years in home care services, allocated to different age groups in Norway, 1992-2006



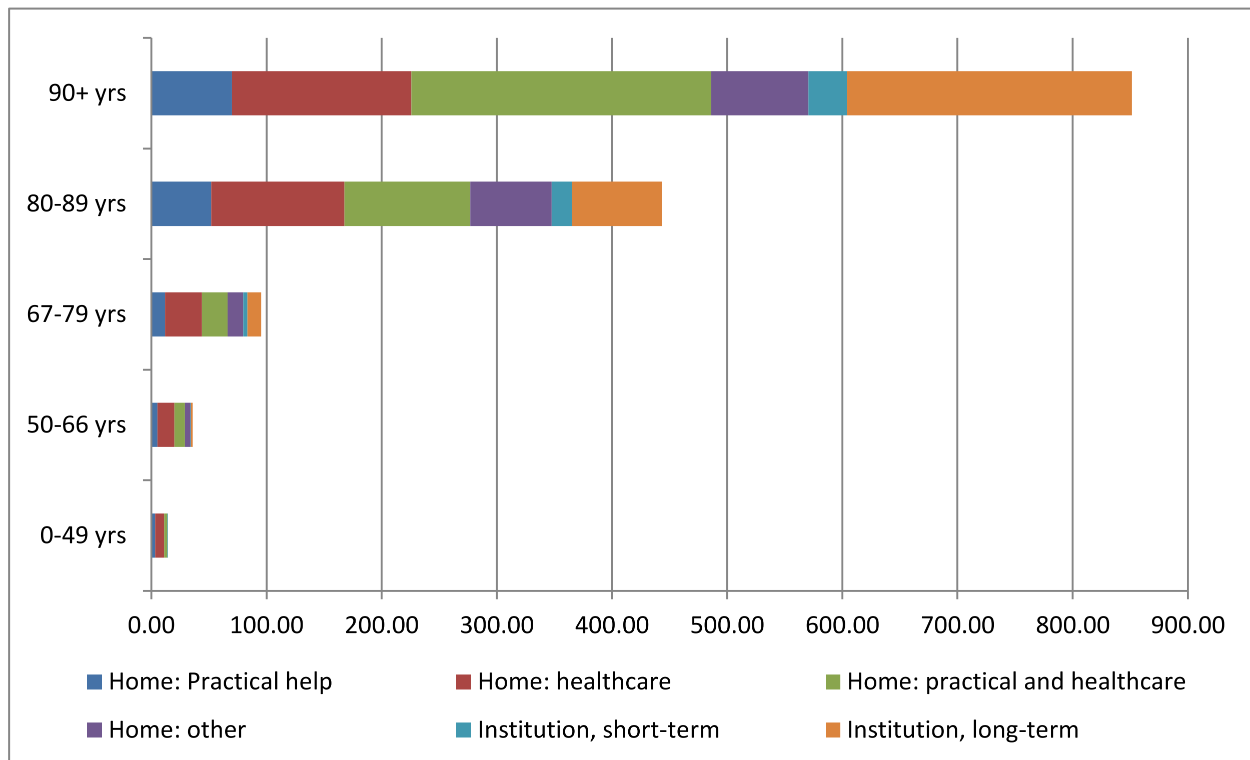
Source: Statistics Norway (2012) og Brevik (2010). Updated data are not available, but see Figure A2.

Figure A2. Numbers receiving long-term care (services in the home, care homes, nursing homes) by age, 2016



Source: Statistics Norway, https://www.ssb.no/helse/statistikker/pleie

Figure A3. The distribution of long-term care forms by age group. Care recipients per 1,000 residents, 2016



Source: Statistics Norway, https://www.ssb.no/helse/statistikker/pleie

Table A1. Proportions undertaking informal care work, Norway, 2015

	% in 2015	Change 2012-2015, percentage points
Belongs to a household with at least one member with care needs	6	0
Regularly provides unpaid care or supervision	15	-1
Regularly provides care or supervision to a person with care needs within the household	2	-1
Regularly provides care or supervision to a person with care needs outside the household	13	-1

Source: Statistics Norway (2016a).