HealthManagement
Promoting Management and Leadership

# Volume 5 / Issue 1 2003 (English) - Country Focus: Scandanavia

## Collaboration Between Hospitals and Primary Health Care in Norway


**Author**

**Bjørn Guldvog**, *MD PhD, Director General, Berit Eivi Nilsen, MSc, Deputy Director General, Christine Furuholmen, MSc, Senior Advisor; Division of Health Care and Social Services - Norwegian Directorate for Health and Social Affairs*

Because of long distances and a dispersed population, Norway needs a flexible health care organisation taking local conditions into account. Reforms were implemented between June 2001 and January 2002 to improve efficiency and quality of care within the levels of government responsible for that care. In addition to the reforms, coordination of care and collaboration of professions are seen a crucial elements in providing continuity of care based on individual needs. The role of general practitioners (RGP), the role of hospitals and financial incentives all contribute to the discussed.

Norway's 4.5 million people inhabit close to 400,000 square kilometres, i.e. 14 inhabitants per square kilometre. The air distance from north to south is 1752 km. Because of mountains and glaciers, large areas of the country cannot be cultivated. Most people live along the coastline.

The administration of health care is divided between three levels of government. The central government is responsible for the formulation of general policy goals and legislation, and for the financial allocations. The 434 municipalities, ranging in population size from about 240 to 513,000, are responsible for provision of primary health care, including long term care for the elderly and people with disabilities. The 19 counties were previously responsible for delivering specialised health care. In 2002 central government took over responsibility and ownership for all public hospitals.

Although Norway is an affluent country, the health care sector often reports shortage of resources. Professionals have expressed increasing concern that the focus on cost control and technical effectiveness makes rational medical priorities more difficult. Until about 1990 Norway spent less on health care (% of GDP) than its Western European counterparts. During the past ten years the expenditure has paralleled that of many Western European countries (table 1). Because of long distances, transportation costs and costs of offering decentralised delivery are considerable.

Tabelle 1. Gesamtausgaben für Gesundheit, % BIP ausgewählter Länder:

| | 1960 | 1970 | 1980 | 1990 | 1998 | 1999 | 2000 |
|---|---|---|---|---|---|---|---|
| Dänemark | | | 9,1 | 8,5 | 8,4 | 8,5 | 8,3 |
| Finnland | 3,9 | 5,6 | 6,4 | 7,9 | 6,9 | 6,9 | 6,6 |
| Frankreich | | | | 8,6 | 9,3 | 9,4 | 9,5 |
| Deutschland | 4,8 | 6,3 | 8,8 | 8,7 | 10,6 | 10,7 | 10,6 |
| Island | 3,3 | 4,9 | 6,1 | 7,9 | 8,3 | 8,7 | 8,9 |
| Norwegen | 2,9 | 4,4 | 7 | 7,8 | 8,6 | 8,8 | 7,8 |
| Schweden | 4,5 | 6,9 | 9,1 | 8,5 | 7,9 | | |
| Schweiz | 4,9 | 5,6 | 7,6 | 8,5 | 10,6 | 10,7 | 10,7 |
| Großbritannien | 3,9 | 4,5 | 5,6 | 6 | 6,8 | 7,1 | 7,3 |
| USA | 5,1 | 6,9 | 8,7 | 11,9 | 12,9 | 13 | 13 |

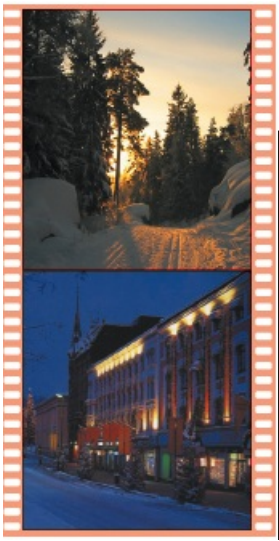
**Reforms in Norwegian Health Care**

In the past 20 years, reforms in health care have attempted to improve accountability among the state, the county and the municipalities. Establishing services at the same administrative level has been a presupposition for optimal coordination of services. In the 1980s and 90s there

was a trend to moving service delivery in the direction of the municipalities. During these years, primary health care, nursing homes, services for people with disabilities and part of mental health, were all organised within the municipalities, as is still the case.

During the past few years there has been increasing interest in the role of the state. Since 2001, three important reforms were implemented. In June 2001 the first of these reforms was implemented. The general medical services were organised as a regular general practitioner (RGP) scheme, or a kind of list system. The GPs have agreed on a certain maximum list size within the local authorities. The objectives of the reform were to give more security through better access to general medical services, continuity in doctor-patient relationships, and a more rational utilisation of the total resources of doctors. The local authorities are responsible for organising the scheme, and the National Insurance Services (state) administers the payment scheme. Patients can change their choice of GP twice a year, provided there is available capacity on the requested list. The main model of remuneration of the GPs is based on self-employment.

Secondly, in January 2002, the Hospital Reform was implemented. The state took over the hospitals which are now operated as five regional health enterprises, covering populations from 460 000 to 1,6 million inhabitants. In previous years, there was rising concern about differences in access to specialised health care as expressed by inequalities in waiting times. There was growing concern that county borders constituted a barrier to achieve a rational division of functions among hospitals. The opponents of the reform argued that the county, with its elective body responsible for that specific population, was the most competent to assess which services that was needed.



| Institutionen unter dem Gesundheitsministerium | Verantwortlichkeiten |
|---|---|
| Direktorat für Gesundheit und soziale Angelegenheiten | • Professionelle Beratung des Ministers über Gesundheit und Sozialpolitik<br>• Implementierung der Gesundheits- und Sozialpolitik<br>• Entwicklung von Richtlinien |
| Gesundheitsausschuss | • Supervision der Gesundheits- und Sozialdienste<br>• Definition der Grenzen gesetzlich vertretbarer Krankenversorgung |
| Institut für Gesundheitswesen | • Supervision des Gesundheitsstatus der Bevölkerung<br>• Epidemiologische, umweltmedizinische, toxikologische und infektiologische Überwachung |

The reform was accomplished in remarkably high speed, mainly due to a strong alliance between central government and professionals. Within each health enterprise, hospitals are organised either alone or in groups as single enterprises. Every regional health enterprise has its administrative management and a board. The enterprise is responsible for planning, development and delivery of specialised health care within the framework set by the owners.

A third important reform took place in central government. Twelve different directorates, institutes and boards previously organised under the Ministry of Health, were reorganised in January 2002 into three major institutions: The Directorate of Health and Social Affairs, The Board of Health and the Institute of Public Health (table 2)

It is too early to assess the effectiveness of the reforms. Our main impression isthat the three reforms have been successful. Evaluations of both the RGP and the hospital reforms are being carried through, and the primary results will be presented this year.

#### The Case for Change

These three reforms were designed to improve the effectiveness and quality of care within each level of care, not primarily to improve the coordination between levels of care. There still seem to exist a considerable loss of effectiveness in the delivery of health care due to suboptimal coordination between primary health care and hospitals in particular.

Health care is a complex service delivery characterised by division of labour, specialization and professionalism. Under such conditions there is great risk of disruption of knowledge between professions and disciplines, and the need for coordination, simplification and assessing the system as a whole becomes crucial. Coordination indicates collaboration to achieve a common goal.

From an organisational point of view, the argument for coordination is improved cost-utility. The gains from coordination may be avoidance of double labour and waste, as well as the clarification of accountability. Coordination and collaboration promote delivery of care that is adapted to patients' needs and to treatment based upon complete information regarding the individual's situation and diagnosis.

Several barriers exist which make collaboration a challenge. In a divided care chain, there is often a tendency within each level for concentrating on the most pressing local issues, without attention to the impact on the whole. Providers at different levels may have very different perspectives and values. There may be important cultural differences and competence imbalance, which may lead to disruption in service delivery. One may also experience existing financial disincentives to coordination. Of course, professional interests may also contribute to the climate of collaboration.

These are some of the concerns of sub optimal coordination:

• Insufficient attendance of patients with chronic disorders and disabilities

• Inexpedient waiting times for treatment in hospitals

• Placement of patients in the hall-way of hospitals before they are discharged to care in the municipalities

• Insufficient clarification of division of functions and labour between levels of care

• Over utilization of procedures and examinations

• Lack of accountability and patients falling between levels of care, creating anxiety among patients who feel that no one is taking responsibility for them. It is difficult to quantify the loss in productivity due to sub optimal coordination. We do feel, however, that there is still a great need to intensify the efforts to improve collaboration between primary health care and hospitals.

**Tools for Improved Coordination**

Collaboration Agreements: Between municipalities and regional enterprises collaboration agreements should be developed. It is up to the parties to establish an agreement that is relevant to their particular situation. In general, there is a need for clarification of values, and the fundamental assumptions/agreements for collaboration which may include:

• Coordination of patient handling and treatment

• Development of competence and professionalism

• Carrying out plans and schemes

• Administrative coordination

• Collaboration with patient and user organizations.

Collaborative Agreements on the Level of the Patient: when dealing with patients in need of complex service delivery, individual collaboration agreements may be prepared. The aim for collaboration, participation, accountability and follow-up should be described.

Responsibility-Sharing Groups: These are meetings where the development of service delivery and specific measures are planned and coordinated, where professionals from hospitals and primary health care meet with the patient or in the case of a child, their guardian.

Individual plans: Individuals with a need for durable, complex and coordinated services have the right to have an individual plan developed. This right is regulated through the Patients Rights Act.

Joint Knowledge Development: It is of crucial importance to work jointly along the chain of care with culture and knowledge development. Professionals and health care workers at different administrative levels should pursue common goals for evidence base and patient treatment. We suggest that hospitals and health enterprises carry a substantial responsibility to achieve this goal. Hospitals are knowledge-based arenas, often with strong professional interests. Especially when collaborating with a dispersed primary health care, we suggest that hospitals make an extra effort to understand their point of view.

Cottage hospitals, community medical centres and community mental health centres provide examples of collaboration. Remote parts of the country have a tradition of Cottage Hospitals, as the distance to the ordinary local hospital is long.

Often a nurse runs the hospital, and the district GP has the medical responsibility. Some cottage hospitals also have a small delivery room and a midwife. The total number of in-patient beds for the country as a whole has dropped from 1600 in 1970 to approximately 1000 today. A total of 18 Cottage hospitals remain, and all but one are situated in the Northern health region. Most cottage hospitals in district Norway consist of both primary and secondary health care. The part of the cottage hospitals delivering specialised health care, are run as a department under a hospital. The cottage hospital at Hallingdal is an example of the latter. This cottage hospital serves a population of 21 000 inhabitants, and has 21 somatic beds. It includes a delivery room, and 12 beds for psychiatric patients. It runs an extensive outpatient clinic with 11 specialities served by specialists working in larger hospitals in the region. The cottage hospital is organised as a department under the larger hospital at Ringerike.

In the past years, there have been attempts to modernise the concept of cottage hospitals. The rapid development in technology and telemedicine enables procedures to be performed on an ambulatory basis. There is also a need for offering day surgery, dialyses, chemotherapy etc.

The outpatient clinic at Ørlandet medical centre is an example of a community medical centre. Patients are treated that otherwise would have to travel 2 hours to Trondheim. Specialists from the University clinic in Trondheim spend one day a month at the clinic. It is likely that patients in the community of Ørlandet get improved access to specialised health care by this model. The outpatient clinic has been extensively evaluated in terms of patient satisfaction, potential health benefits, and profitability for the community. Despite the alternative costs, the number of ordinary patients at the clinic is so high, that the cost savings in terms of and time for these patients is greater than the total costs of the clinic. This is a reminder that travel costs and time in a country like Norway, with a dispersed population, are of considerable importance.

To insure provision of treatment at the right level crucial factors include the role of the RGP as a gatekeeper is important and restrictions as to when hospitals receive fee for service. As long as primary and secondary health care is organised and financed by two different levels of governments this represents a challenge for cooperation between the two.

Two factors contribute to this challenge:

• Because of continuous development in technology, there is a dynamic shift of services from secondary to primary care.

• In order to minimise costs, the two separate financing systems have incentives to move the patients to the other level of care. It is mainly specialised health care that is in a position to decide where the line is to be drawn.

An alternative to a divided financing system would be a single health care, fully integrated both in terms of organisation and financially. So far, this has not been a major issue on the political agenda, since primary health care is a major responsibility for the municipalities with close links to other welfare services. The municipalities are too small to run hospitals and specialised services. Before pursuing this issue further, we suggest that more experience and evaluation of various coordination strategies is necessary.

Asecond alternative discussed briefly by a Royal Commission on the financing of specialised health care (2002) is to introduce a provider/purchaser split. The municipality would have to play the role of the purchaser if such a split were to be proposed. Most municipalities are not believed to have the size or competence to accomplish this. The commission recommends local initiatives and projects to

promote different models of collaboration, included integrated models.

In general, our experience is that the technological and organisational development is moving much faster than the financial systems, and we believe that the lack of rational financing is slowing down the process of collaboration and coordination. This implies that the financial systems support health care delivery that is more costly than necessary, and give suboptimal incentives as to which level treatment is provided. The way healthcare is financed is therefore of crucial importance for the coordination of services.

**Conclusions**

Because of long distances and a dispersed population, Norway needs a flexible health care organisation, taking local conditions into account. Several reforms have been implemented within the past couple of years, leaving the municipalities and the central government as responsible for delivery of health care. Health care is almost free of charge for the population. Patients have a right to choose GP and hospital. The low costs contribute to a high demand for services. The gatekeeper role of the GP, and restrictions as to when hospitals receive fee for service therefore are important tools to prevent over utilisation. The reforms have not sufficiently contributed to a seamless chain of care. There is a strong case for improved coordination of delivery between hospitals and primary health care. Coordination strategies should involve collaboration agreements on both system levels and patient levels, development of individual plans, establishment of arenas where professional knowledge may be developed as a joint venture, utilisation of organisational collaboration exemplified by cottage hospitals, community medical centres and community mental health centres, as well as financial incentives.

Published on : Wed, 2 Feb 2005