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Healthcare in Norway

Challenges, Plans and Solutions

Norway faces the same dilemma of many western European countries, as the standard of living improves and people's life expectancy increases, there are new challenges with an ageing population and a growing number of people with chronic diseases. An ageing society will be a challenge for the Norwegian healthcare system. To make further progress in the health of the population, it will be necessary to focus on the challenges of health promotion and illness prevention. From the end of the 1990s several reforms have been launched, designed to meet the main challenges that the Norwegian healthcare system will face in the next century. An overall challenge is to combine a decentralised system with a regulatory environment that ensures equal access.

Health Services in Norway: Organisation and Financing

The system of healthcare provision in Norway is based on a decentralised model. The state is responsible for policy design and overall capacity and quality of healthcare through budgeting and legislation. The state is also responsible for hospital services through state ownership of regional health authorities. Within the regional health authorities, somatic and psychiatric hospitals and some hospital pharmacies are organised as health trusts.

The Norwegian healthcare system is taxbased and is formed around the principles of equal access to healthcare services, political decentralisation to local governments, and free choice of provider. Public expenditures consist of more than 80 percent of total health expenditure.

Special reforms in the late 1980s and early 1990s have contributed to the expansion of the range of services provided to meet the specific needs of the elderly, the handicapped and the mentally ill. In addition, an activitybased system of hospital financing, based on the DRG system, has been in place since 1997. The system has the aim of decreasing waiting lists through the expected expansion of capacity and utilisation. For inpatient stays, hospitals are paid by a combination of cost per case and global budgets.

Norway's 430 municipalities have responsibility for primary healthcare, including both preventive and curative treatment.

There are about 23,000 physicians in Norway. There are currently 230 citizens per physician under 67 years of age in Norway, or 4.34 physicians per 1,000 citizens, more than in the other Nordic countries (source: Physicians in the Nordic Countries 2008). Within the OECD, only Greece has clearly more physicians per head of population than Norway, while it is about equally high in Belgium, Italy, Spain and Switzerland (source: OECD Health Data 2010).

The Coordination Reform

The Government has introduced a Coordination Reform to ensure sustainable, integrated and coordinated health and care services that are of high quality, maintain a high degree of patient safety, and are tailored to the individual user. Greater emphasis will be placed on measures to promote health and prevent disease, on habilitation and rehabilitation, on increased user influence and on binding agreements between municipalities and hospitals. The municipal health and care services will be strengthened and the specialist healthcare services will be expanded.

Medical investigation and treatment of frequently occurring diseases and conditions will be decentralised when possible. Medical investigation and treatment of less frequently occurring diseases and conditions will be centralised when this is necessary to ensure a high quality of service and effective utilisation of resources.

If the Coordination Reform is to succeed, better balance and reciprocity between the specialist and municipal healthcare services must be achieved. The reform will be implemented over a period from January 2012. To achieve the reform's objectives, a wide array of instruments is required:

- Legal instruments, including the entry into force of the Act relating to public health efforts (Public Health Act) and the Act relating to municipal health and care services (Health and Care Services Act). The Public Health Act lays the foundation for long-term, systematic public health activities at all administrative levels: National, county and municipal. The Health and Care Services Act is designed to improve coordination within the municipalities and between the specialist and municipal health and care services. The municipalities' overall responsibility for the services offered is clarified, and the municipalities are given greater freedom to organise the services in accordance with

local conditions and needs. The municipalities and regional health authorities/hospital trusts are required to enter into agreements at the local level.

- Financial instruments A scheme for limited municipal co-financing of somatic treatments within specialist healthcare services has been introduced. The ministry has stipulated that the regional health authorities, in conjunction with the municipalities, must chart the potential for cost-effective, local collaborative projects. The municipalities will be given financial responsibility for patients released from hospital. The municipalities must be able to provide 24 hour in-patient care for patients who require immediate assistance and monitoring from the health and care services, when the municipality has the capacity to investigate, treat or provide care. The municipalities have been given the opportunity to seek state investment funding to develop services in cooperation with other municipalities and hospital trusts. - Profession-oriented instruments are designed to bring about a change in the practices used within the services, in keeping with the intentions of the Coordination Reform. Instruction material, guidelines and procedures and the introduction of national quality indicators are examples of profession-oriented instruments. New requirements on expertise will be needed. Education and training of personnel must be adapted to the objectives of the Coordination Reform. The municipalities must participate in and create a viable foundation for research on the municipal health and care services. - Organisational instruments Appropriate arenas must be established for cooperation between various services and administrative levels. One example of this is the organisation of community medical centres as a collaborative effort between the specialist healthcare services and one or more municipalities. The services offered at a community medical centre may be designed on the basis of local needs, and may include a daytime clinic and possibly 24-hour care. Ownership and responsibility for the operation of such clinics should be regulated through agreements at the local level.

Patient Safety

In Safe Hands: The Norwegian Patient Safety Campaign 2011 – 2013

The Norwegian health and care system holds in general high standards. However, OECD and Commonwealth fund publications tell us that this picture is nuanced:

- Variation in clinical practice;
- Waiting time is unacceptable;
- Variation in health personnel qualification;
- Variation in user involvement; and
- Adverse events.

Financial Incentives

Today, there are no financial incentives for quality and patient safety. But in this context it is relevant to discuss how pay for performance (P4P) mechanisms can be considered as complementary tools for creating further incentives for achieving quality improvement and efficiency gains in the Norwegian health sector.

The Norwegian patient safety campaign, In Safe Hands, was launched in January 2011 by the Norwegian Ministry of Health. The threeyear campaign aims to reduce patient harm and involves both specialist and primary healthcare services. The campaign aims to reduce patient harm, build pervasive structures and systems for patient safety and improve patient safety culture in the health services. In Safe Hands marks the beginning of lasting improvements in patient safety in Norway.

The campaign will introduce specific measures in several focus areas.

As of now, three focus areas are ready to be implemented nationwide:
• Safe Surgery, with focus on post operative infections;

- Medication Reconciliation; and
- Drug Review. In addition, the following areas are under preparation:
- Stroke Treatment;
- Mental Health;
- Central Line Infection;
- Fall;
- Pressure Ulcer; and
- Urinary tract infection.

Further areas will be developed in the course of the campaign. Measurements will be carried out within each priority area.

All focus areas are considered areas with great potential for improvement. They have been recommended by a special advisory board and have been considered by expert groups with expertise in the areas concerned. Because patient safety is a management responsibility, the campaign also promotes relevant leadership interventions. The interventions are piloted locally to ensure that the measures work in practice. Two of the five pilots concern leadership, such as Leadership WalkRounds.

Organisation

In Safe Hands was commissioned by the Ministry of Health. A steering group, led by the CEO of the National Health Directorate, is responsible for all key decisions in the campaign. The campaign secretariat forms part of the National Unit for Patient Safety, positioned in the National Knowledge Centre for the Health Services.

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