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Hospital Services in Norway

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Norwegian hospitals have traditionally been owned and operated by the 19 different county councils. Most of the funding was provided by the national government in the form of block grants based on the size of the population as well as demographic and social characteristics. Since 1997, the block funding has been gradually replaced by a matching grant depending on the number of treatments (DRG-based), from 30% of gross budget in 1997, to 60% in 2001, and in 2006 reduced to 40%. Outpatient activities are reimbursed based on the number of patients and type of consultations. Furthermore, because of the problems within the Norwegian National Health Service (NHS), long waiting lists, and huge budget deficits, a reform was passed where the central government took over the ownership of all hospitals which were organised into five regional hospital enterprises, active from January 2002. The regions are: Health Region East in the southeast part of the country; Health Region South in the south part of the country; Health Region West on the southwest coast; Health Region Middle Norway in the middle of the country; and Health Region North in the north.

All health regions include a university hospital equipped and staffed to take care of most patients with diagnostic and therapeutic needs above what the smaller hospitals in the region can deliver. Some highly specialised services with a small patient volume are, however, organised in national monopolies or duopolies at selected university hospitals (see below).

To some extent, hospital reform has not met expectations. This has particularly been evident in the area in and around the capital of Oslo with several hospitals and almost one third of the national population, where Health Region East and Health Region South have not succeeded in co-operation in patient treatment.

The Minister of Health has therefore, effective from July 1st 2007, merged these two health regions into one regional enterprise covering almost two thirds of the population, markedly greater and different from the remaining other three regions. This move has been described by many observers as a continuation of a process where hospitals finally will be organised as one national enterprise under government administration and leadership in the near future.

Hospital Size

Somatic hospitals in Norway are rather small. Only four university hospitals have more than 800 beds.

No hospital can be found with a size between 601 and 800 beds. Usually at least one hospital in each county and thus several in each health region have between 201 and 600 beds and can deliver most services within general and orthopaedic surgery, emergency medicine and critical care, paefocus diatrics including neonatology, obstetrics and gynaecology, internal medicine and oncology, neurology, otorhinolaryngology and ophthalmology. The majority of the hospitals are however small, with less than 100 beds, and with services only in general internal medicine, general and orthopaedic surgery as well as obstetrics and gynaecology.

As a part of the mentioned reform, several smaller hospitals within a health region were merged under one administration with the intention of increasing productivity, reducing costs and increasing quality by collaboration through better organisation of services between the different hospitals. So far, this has resulted in only minor practical changes, partly because of political and local opposition. Thus, until now the present government has guaranteed that present services will remain at all (small) hospitals and no hospital will be closed, awaiting the evaluation of a committee on the future of smaller local hospitals.

Hospital Resources and Activity in Somatic Medicine

As a consequence of regional differences between resources and productivity, some regions, particularly Health Region West and Health Region Middle Norway, seem to get less funding compared to other regions. This has stimulated a debate on principles for government funding of the health regions.

As can be seen from the table, the increase in activity from 2005 to 2006 almost parallels the increase in personnel. There is however, a shift to more day-care treatment and outpatient consultations and less overnight admissions.

Private Hospitals

Private healthcare has never had a large volume in Norway. This may partly be related to the fact that private health insurance also is rare. Private hospitals are few and usually specialise in simple surgical procedures within general and orthopaedic surgery, otorhinolaryngology, ophthalmology and cosmetic surgery.

In the 1990's as a result of an increased focus on the need for competition and private enterprises also in healthcare, several small private hospitals were started. The NHS also contracted out specific treatments to several of these hospitals. These private hospitals mainly relied upon the interest of doctors employed within the NHS to work in these hospitals in their off-hours from their regular jobs, while most nurses were fulltime employees.

This has now changed. Firstly, the present government has placed restrictions on the possibility for the hospitals within the NHS to outsource patients and treatments to private institutions.

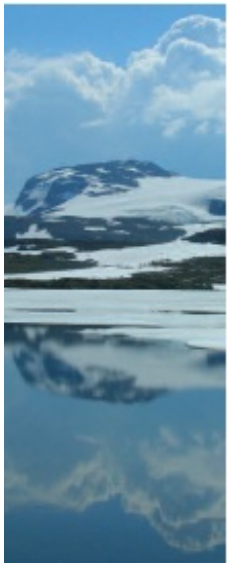
Secondly, hospital managers have restricted and actually banned doctors employed in their institutions from working part-time in private institutions which can be considered to compete within the same market. Private hospitals in Norway are therefore increasingly more dependent on patients who are willing to pay for treatment themselves, and mostly for treatments not covered by the NHS, such as cosmetic surgery.

Centralisation of Highly Specialised Medicine

The presence of many small hospitals in Norway has raised concerns regarding the ability of many hospitals to maintain quality and efficiency of procedures regarded as the most difficult, costly and critical. A monopoly system was therefore established in 1990, defining a number of highly-specialised and costly medical services in which there was both a duty for county hospitals to refer patients to, as well as an obligation for the designated university hospital to admit patients in these defined services.

By means of control of purchasing of expensive equipment as well as establishment of special laboratory services and personnel at selected university hospitals, the government ascertained that treatment of patients with rare and complicated diseases was not split between several hospitals, when each of those would not reach a sufficient patient volume to secure adequate quality of treatment.

By 2001, there were 31 such monopoly functions, 24 of which were located at the two university hospitals in Health Region East and Health Region South in the capital of Oslo, four were located at the university hospital of Health Region West in Bergen, and three were located at the university hospital of Health Region



Middle Norway in Trondheim. Seven duopolies were split between the same hospitals. None of the services were located in Northern Norway. Monopolies admitted from 0 to 431 new patients every year, duopolies from 0 to 200 new patients at each hospital. Altogether these services include approximately 2,700 new patients every year.

Data show however, that fulfilling the original objects of quality and efficiency has been achieved at the expense of a loss of equal access for all patients. Despite the fact that the performance of these services has been monitored, highly significant differences in access to the services for patients from different parts of the country has been disclosed in a recent study (2). The general tendency is that people living in the north and in “district Norway” have a substantially reduced chance of being admitted to these highly specialised services.

Thus, the regionalised organisation of hospital medicine seems to be adequate for maintaining the balance between quality and equality for the majority of patients and health services in general, including the peripheral parts of the country. In a regionalised system, quality may not always be perfect, but the loss in this aspect is for most patients probably more than compensated by a gain in accessibility.

Psychiatric Hospital Medicine

During the last few years, there has been an increased focus on funding of psychiatry versus funding of somatic medicine within the health regions. This is partly because psychiatry has fallen behind the development in somatic medicine and partly due to the recognition of mental illness as an important and increasing health problem in the population.

While community healthcare is responsible for services for everyday mental problems and follow-up of some patients under stable treatment, treatment of defined psychiatric disorders and hospitalisation of patients with mental illnesses is the responsibility of the hospitals in the different health regions. Some of these patients are treated not only in the regional hospitals, but also in smaller so-called district psychiatric centres. These centres are mainly for outpatient visits but also have beds for sicker patients.

Working Conditions of Healthcare Professionals

Also in Norway, during the last few years there has been a focus on working conditions for healthcare professionals, particularly nurses and doctors. Nurses work a three-shift schedule with a 35.5-hour

work week in a full-time position. Most full-time positions usually include day, evening and night shifts. However, in order to fill all shifts, many nurses have to work in reduced positions, and a complete schedule usually includes shifts on every third weekend. The starting salary for nurses is approximately Ú37,500. Many nurses specialise in surgery, anaesthesiology and critical care, paediatrics and others. Such specialisations are also better paid. Nursing organisations have worked hard to reduce the number of nurses with reduced positions as well to reduce the number of weekend shifts within the schedule.

Unlike nurses, doctors are principally considered day-time workers but with the obligation to cover a 24- hour service when needed. This means that doctors in most hospitals departments take part in call systems. Some of the extended work hours are also compensated by days and weeks free from work, for instance every eighth week in an eight-week schedule.

In the last few years there has been an increased focus on the fact that many doctors in call systems often work continuously for up to nineteen hours, considered a possible hazard both for the doctor and the patients. The Norwegian Medical Society has, however, opposed the idea of a regular shift schedule (like the nurses) as an alternative, partly because this would reduce continuity in patient care.

Hospital Management System

Hospitals in Norway are theoretically managed by the principle of one leader on all levels. All leaders are appointed, either by the board of the regional enterprise, the board of each hospital, or by the hospital director. Every position as a leader, particularly on a higher level such as head of department and head of clinic is in principle also neutral to professional background, although a reasonable knowledge of healthcare and medical issues is needed. This implies that in principle any healthcare professional could be a leader on these levels. So far however, most department heads and clinic directors are still medical doctors with some additional administrative training. Also, in some instances nurses and medical laboratory technologists who have been appointed to such positions have been met by strong opposition, particularly by the Norwegian Medical Association, who strongly argue that such positions should be filled by doctors only. In contrast, hospital directors are more often recruited from non-medical professions.

References available at english@hospital.be

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