

# Long-term Residential Care: Perspectives from Norway

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# Norway

- 4.7 million inhabitants
- Less urbanized than most European countries
- Three levels of governance:
  - State, county, municipality
- 430 municipalities, ranging from around 250 (Utsira) to 700.000 inhabitants
  - “I can see all the inhabitants from my office window”
- Most municipalities are rather small
- Strong position of local (municipal) authorities
  - Reforms through “the back door”



Kvam kommune



evuk







Tysnes kommune

evuk





Austevoll kommune

evuk





Lindås kommune

evuk

# The welfare state context in Norway

- An example of the “Nordic model”
  - Comprehensive social policy and social rights and legislation of a universal and relatively generous nature. Mainly tax paid, and not politically debated as a model (only details discussed)

# Historical and present features:

- Feudalism: never evolved due to lack of arable land
  - Strong egalitarianism, “passion for equality”
  - strong political and juridical position of peasants (who mostly owned their land)
  - General poverty throughout most of our history (Gurevich 1978; Gullestad 1992; etc.)
- Strong “civil society”: where state and voluntary organization have been closely interlinked (Selle 1992)
- Late industrialization: industrial enterprises were immediately put under democratic and state control (e.g. around 80 % state revenues from petroleum industry)



# Coverage of health staff:

- Around 3.9 physician pr. 1000 inhabitants in Norway (USA and OECD being respectively 2.4 and 3.1).
- RNs approx. 31.9 pr. 1000 inhabitants in Norway and respectively 10.6 and 9.6 for USA and OECD (OECD 2009).
- Highest density of formal care workers in Sweden and Norway: 40 pr.100 inh. 80+ (OECD 2011)

# Elderly and demographic trends

- About 14.8% of the Norwegian population is 65+ while 4.6% population is 80+ (OECD 2009)
- The proportion of 65+ peaked at 16% in 1990 and has since decreased steadily, a trend different from most other OECD countries
- A relatively high fertility rate, 1,84 (OECD average 1,63)
- Hence Norway may be said to experience a golden opportunity (a quiet phase) to rethink its elderly care before 2030
- Later: Population 80+ expected to double by 2040 (OECD Social and Labor Demographics, 2010)

# Elderly in LTC

- Home care and institutional care: nr. 3 (users as share of the population), after Austria and Sweden (OECD 2011)
- NH coverage: Top of the list of OECD countries (OECD 2009). Still political agreement on need for more NHs (recently launched 1 bill. NOK for municipal LTC)
- Patients in NHs:
  - Around 80% with dementia
  - 4.7 diagnoses
  - Approx. 43% pop. dies in NHs (less in hospitals than some other OECD countries)
  - Increase of younger residents (less than 67 years)



# LTC: Some numbers

- In 2008, Norway spent 2.2% GDP on long-term care with additional 2% GDP spent publicly for health related LTC (OECD Health Data, 2010)
- Number 3, after Sweden and the Netherlands
- In 2008, approximately 5.5% of the population over the age of 65 received long-term care in an institution setting with 12.4% of this population receiving long-term care at home.

# Approaches to care

- The coordination reform (White paper 47)
  - Based on need for more preventive health care in municipalities (increase of life style related diseases). Right now it is cheapest for the municipalities to send the patients to state financed hospitals. Too many treated at a specialized level
  - More treatment and care outside the specialized medical facilities
  - More funding flow toward the municipalities
- Care plan 2015: Long term care – future challenges (White paper 25)
  - Cooperation with voluntary organizations and family
  - Competence development
  - More workers in the sector
  - Research and development
  - Dementia care

# Approaches, cont.

- Four levels of care:
  - home nursing: steepest increase of younger users
  - supported (sheltered) housing
  - residential care (care homes)
  - nursing homes
- Increasing weight on home-based care
  - In Scandinavia lagging behind Denmark, but still a growth in home-based care services
- Institutions and housing standards:
  - Norwegian State Housing Bank, from 1946
  - the ideal of home ownership



# Lille Tøyen nursing home: Pre WWII



# Storetveit nursing home: The great expansion phase (60ies and 70ies)



# Kvednatunet nursing home: Typical of the 90ies and to present time





# Kalfaret nursing home: Old buildings for new purposes



# Approaches cont.

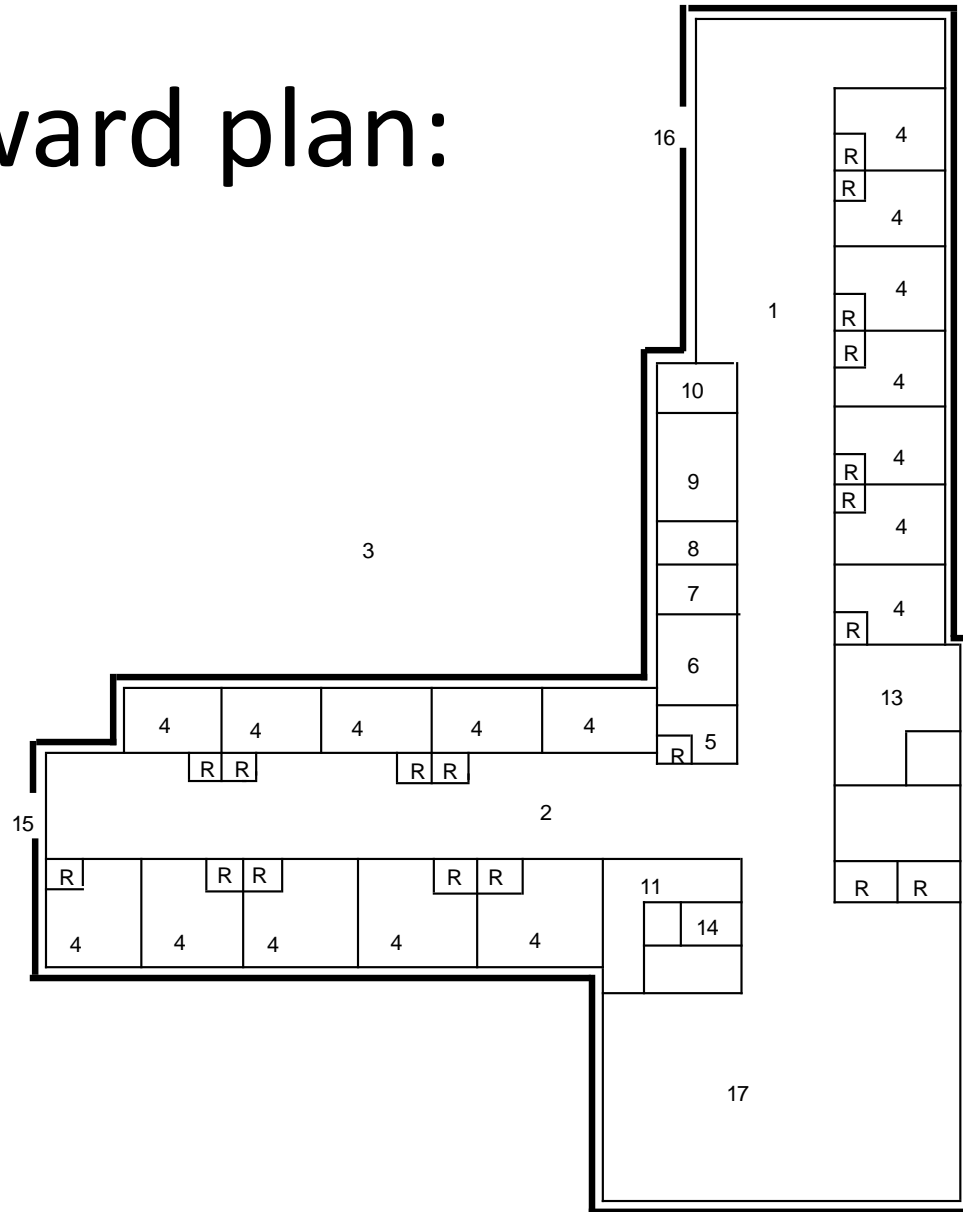
- Centers for care research
  - 5 centers, one for each of the health regions of Norway
- Development centers for nursing homes and home-based care (prev. Teaching nursing homes and teaching home based care)
  - Two development centers in each of the 19 counties, one for nursing homes and another for home nursing
    - Exceptions: an extra development center for the Saami population in the northernmost county; the two centers joined in 4 counties; one county has three centers
  - Educational function with regard to other care units; Facilitating research; Occasionally conducting own research
  - Close interaction with the centers for care research (part of national strategy from 2010), new structure, national grant

# Work organization

- Staff composition
  - Some recent changes
- Needs related to culture, ethnicity and religion
  - History and present
- Models for physical space creating quality conditions for residents and staff
  - Inside
    - Toward smaller wards (“dementia friendly”, from around year 2000)
    - Single occupancies reform (1998)-> more than 90%: politically and not professionally driven reform
    - Common areas?
  - Outside
    - Close and less close surroundings



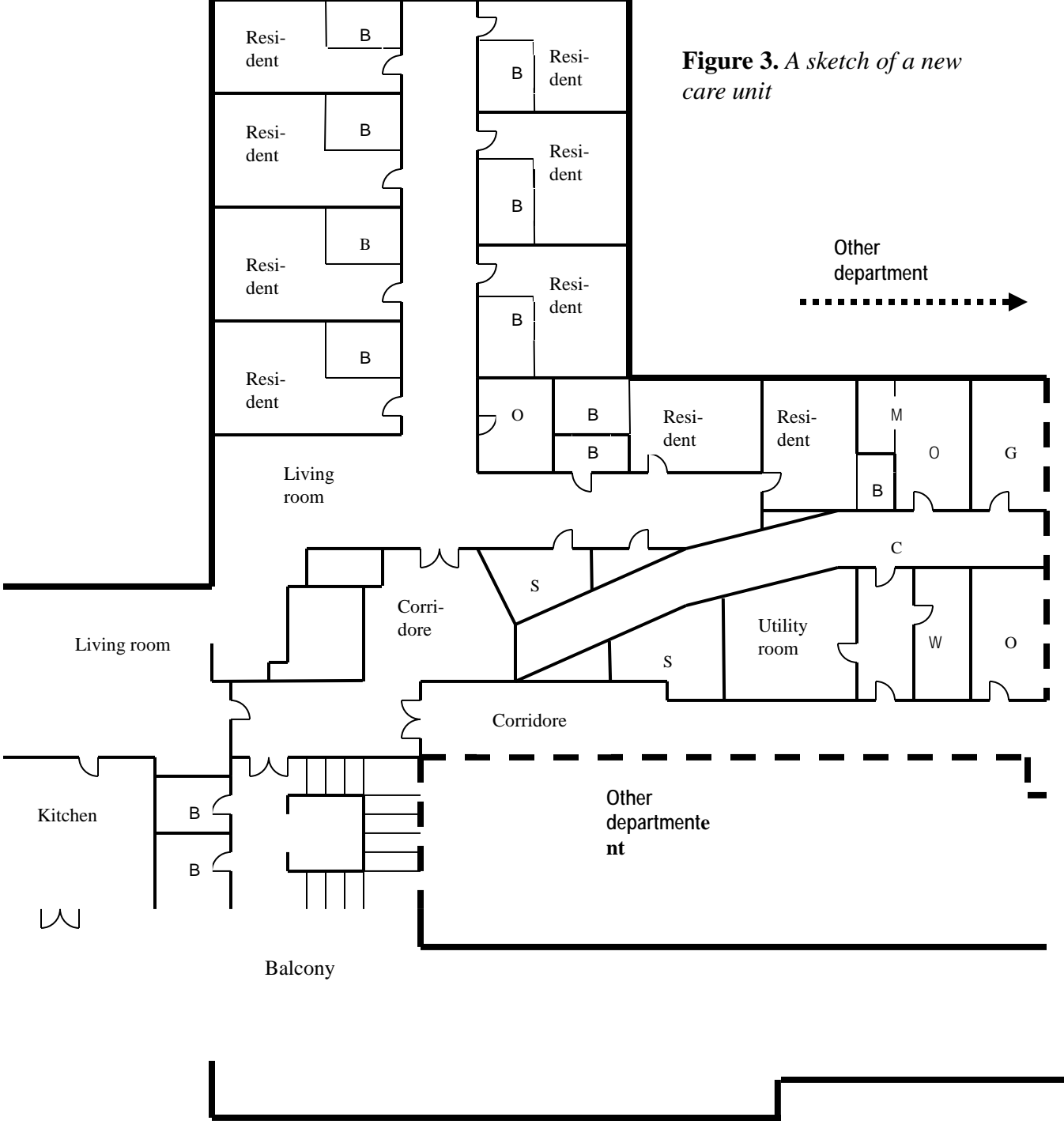
# "Old" NH ward plan:



# “Old” NH corridors



**Figure 3.** *A sketch of a new care unit*



# The new NH facilities:

- Good for the residents?
- Good for the staff?
- Costs and alternative uses of money
- Focus on the near surroundings?

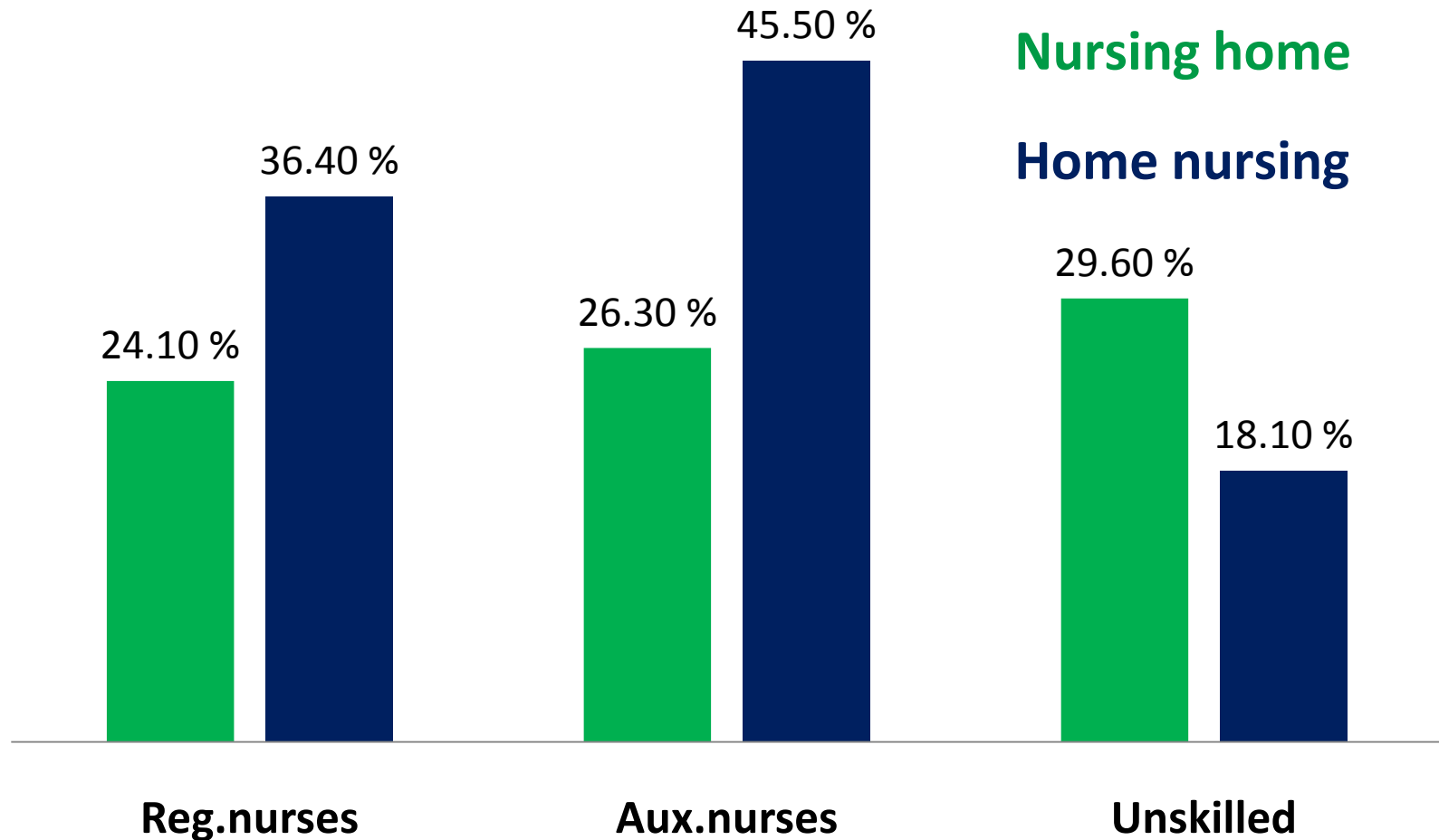
# Staff competence

- Formal competence:
  - The percentage of skilled workers in LTC increased from 65,5 in 2003 to 69,4 in 2006 (Statistics Norway 2008)
- More formal competence in advanced care facilities like nursing homes?



# LTC staffing, dayshifts

(Econ Pöyry 2009)



# Accountability

- Most care-providing organizations are affiliated with the municipality
- Quality regulations:
  - No legal requirements related to staff to patient ratios
  - No specification of the qualifications required for workers
  - Quality regulations exist regarding (the mass media important!):
    - Buildings
    - Medical and care standards
    - Reported violations
    - Workers condition

# Accountability, cont.

- Measurements: 1. user surveys; 2. evaluation by public agencies; and, 3. measurements based on “objective” quality indicators (only in the municipality of Oslo).
- The mass media:
  - Very important in a country with a relatively tiny population!
  - The Adecco scandal (Oslo; Swiss based comp., dealing with other things than LTC): largest for-profit, moving out of Norway (regard.LTC)

# Financing and ownership: spending

- United States the OECD country spending most of its GDP on health, 16.0 % in 2006, Norway is number 15 (8.9% of its GDP, same as the OECD average, OECD 2009).
- With regard to health expenditure pr. capita, Norway is nr.2 of OECD countries with a spending of 4,673 USD, following the United States with a spending of 7,290 USD (ibid.).
- Spending on LTC in institutions, as part of GDP: Norway nr.3, after Switzerland and Iceland (OECD 2011)

# Financing and ownership, cont.

- In Norway, 84.1% of health spending derived from public sources in 2007
  - more than the other Scandinavian countries
  - 10% above OECD average and
  - comparative figure for the United States is 45.4% and for Mexico 45.2 % (OECD 2009).
- With regard to the funding outside public sources in Norway, an increased share of private and corporate insurance play a significant part (Kuhnle 1996; Kildal & Kuhnle 2005).

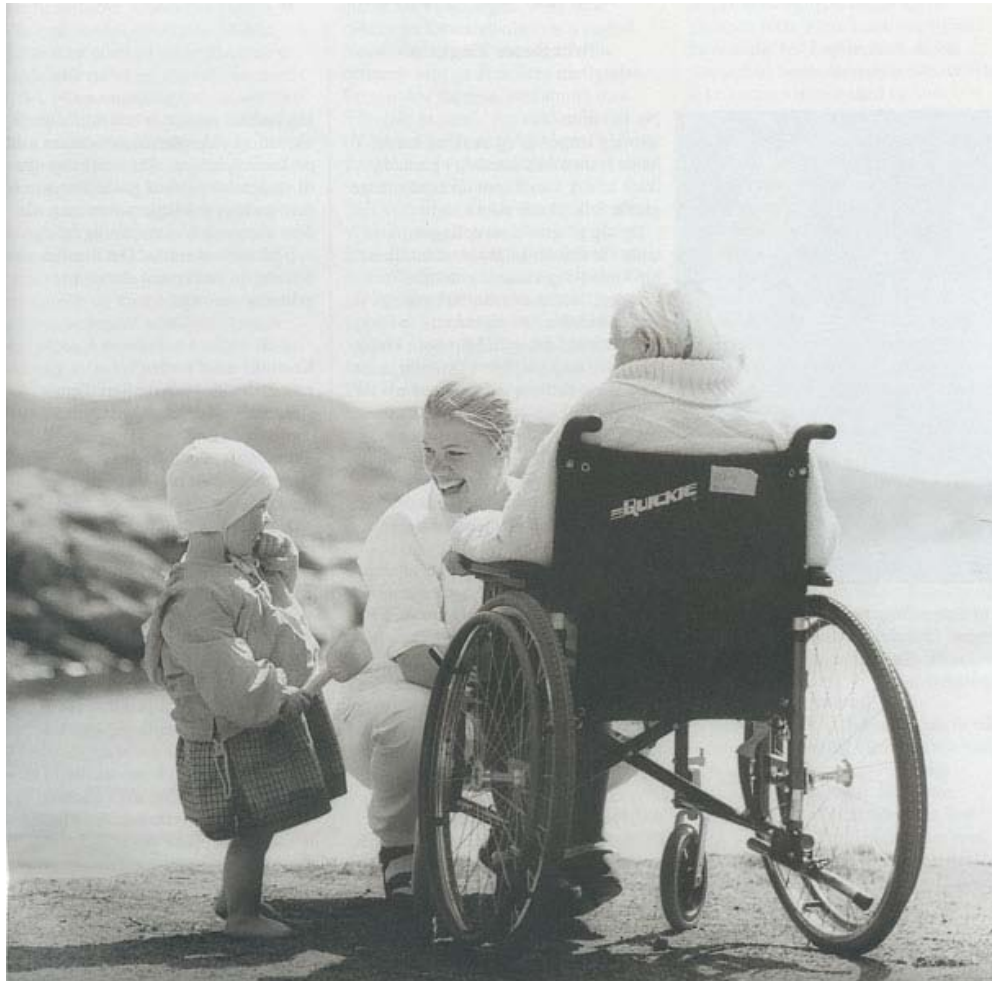


# Ownership and management, NHs

- At least 90 % publicly owned
- Around 5 % run by NGOs
  - NGOs frequently precursors of public adm.
- Less than 5 % run by for-profits
  - Mostly not owning the facilities
  - Operating largely based on public funding
- The future?
  - Privatization and “model privatization” (NPM)

# Concluding thoughts: promising practices?

- Coordination reform: good for whom?
- Increase of supported (sheltered) housing: good and viable?
- Residential care: no longer need for it?
- Development centers: going where?
- Relatively high formal competence, but what is the work content for educated staff? And where will the competent go in the future?
- Small wards and single occupancies: just promising?



Thanks for your attention!