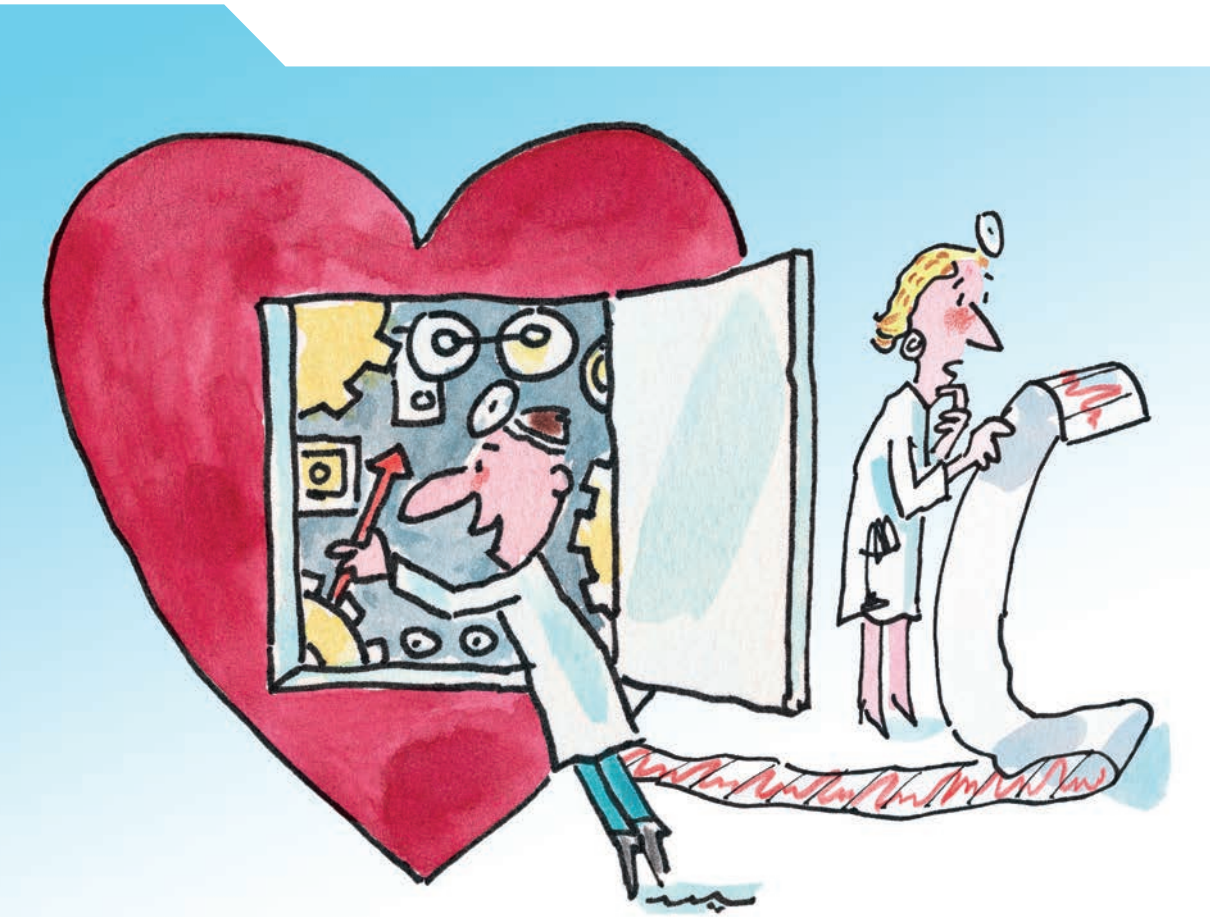
OECD Reviews of Health Care Quality

NORWAY

RAISING STANDARDS



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Foreword

This report is the sixth of a new series of publications reviewing the quality of health care across selected OECD countries. As health costs continue to climb, policy makers increasingly face the challenge of ensuring that substantial spending on health is delivering value for money. At the same time, concerns about patients occasionally receiving poor quality health care have led to demands for greater transparency and accountability. Despite this, there is still considerable uncertainty over which policies work best in delivering health care that is safe, effective and provides a good patient experience, and which quality-improvement strategies can help deliver the best care at the least cost. *OECD Reviews of Health Care Quality* seek to highlight and support the development of better policies to improve quality in health care, to help ensure that the substantial resources devoted to health are being used effectively in supporting people to live healthier lives.

This report reviews the quality of health care in Norway, and seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care. Norway has an impressive and comprehensive health system, which is the result of sustained commitment to providing health care for the whole Norwegian population, investment in the health system, and readiness to make changes to drive improvements. Despite this positive story, challenges do lie ahead for Norway. As in all OECD countries, changing demographics are putting increased pressure on health services, and with hospital lengths of stay dropping and discharges increasing, many of these pressures will be felt by community and primary care services. Norway is putting in place measures to respond to these challenges, notably with the 2012 Coordination Reform, but still has some way to go before the fruits of such labour are truly felt across the health system. Norway's ambitious reform agenda must now be balanced by structured efforts "on the ground". Attention should now turn to putting in place appropriate data infrastructures, promoting meaningful engagement between key stakeholders, and by balancing a generous health budget that allows for important investments in developing new structures and services with attention to getting the most out of existing services.

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Acronyms and abbreviations

ACT	Assertive Community Treatment
AF	*Allmennlegeforeningen* (Association of General Practitioners)
AMI	Acute myocardial infarction
CBT	Cognitive Behavioural Therapy
CME	Continuous medical education
CMHC	Community Mental Health Care
CPD	Continuous professional development
DCPs	District Psychiatric Centres
DRGs	Diagnosis Related Groups
DSB	Norwegian Directorate for Civil Protection
EEA	European Economic Area
EPSO	European Partnership of Supervisory Organisations
EQUALIS	External Quality Assurance in Laboratory Medicine in Sweden
F-ACT	Flexible Assertive Community Treatment
FEST	Norwegian Electronic Prescription Support System
FFS	Fee for service
GP	General Practitioner
GTT	Global Trigger Tool
HCQI	Health Care Quality Indicator
HELFO	Norwegian Health Economics Administration
HoNOS	Health of the Nation Outcomes Scale
HTA	Health Technology Assessment

IAPT	Improving Access to Psychological Therapies programme
ICD-10	International Statistical Classification of Diseases and Related Health Problems 10th Revision
ICP	Individual Care Plan
IHD	Ischemic heart disease
KOSTRA	*Kommune-Stat Rapportering*
KS	Norwegian Association of Local and Regional Authorities
KUP	*Allmennmedisinsk utvalg for kvalitet og pasientsikkerhe*t (Quality and Safety Indicators in General Practice Project)
MSIS	Norwegian Surveillance System for Communicable Diseases
NCD	Non-Communicable Disease
NFA	*Norsk forening for allmennmedisin* (College of General Practitioners)
NGO	Non-Governmental-Organisation
NMA	Norwegian Medical Association
NOIS	Norwegian Surveillance System for Healthcare associated Infection
NOKC	*Nasjonalt kunnskapssenter for helsetjenesten* (National Knowledge Centre for Health Services)
NOKLUS	Norwegian Center for External Quality Assurance in Primary Health Care
NOMA	Norwegian Medicines Agency
NRLS	National Reporting and Learning System
OCD	Obsessive Compulsive Disorder
OMT	Opioid Maintenance Treatment
OOP	Out of pocket
PKO	Practice Consultant Scheme
P4P	Pay for performance

QOF	Quality and Outcomes Framework
RELIS	Regional Drug Information Centers
RHA	Regional Health Authorities
SAK	*Senter for allmennmedisinsk kvalitet* (Centre for General Practice Quality)
SKUP	Scandinavian Evaluation of Laboratory Equipment for Primary Health Care
SSB	Statistics Norway

Executive summary

This report reviews the quality of health care in Norway. It begins by providing an overview of policies and practices aimed at supporting quality of care in Norway (Chapter 1). The report then focuses on three areas that are of particular importance for Norway's health system at present: the role of primary care physicians (Chapter 2), the shifting of care towards primary care settings and away from the hospital sector (Chapter 3), and mental health care (Chapter 4). In examining these areas, this report examines the quality of care currently provided, seeks to highlight best practices, and provides a series of targeted assessments and recommendations for further improvements to quality of care.

Norway's health system appears to be high performing, and squarely turned towards delivering high-quality care. A range of indicators – for example life expectancy, mortality rates from ischemic heart disease, or breast cancer five-year relative survival rate – suggest that Norway's health system is performing well not just when compared to the OECD average but also when benchmarked against countries that would be considered peers, such as Denmark and Sweden. In many respects Norway is facing the same challenges as other OECD countries; an aging population, falling length of stay in hospitals and rising discharge rate will all stretch the Norwegian health system in the years and decades to come, and Norway will need to develop stronger primary care systems and better co-ordination across care settings to cope with changing demands. Norway is, however, making impressive steps towards addressing these challenges, and through reforms such as the recent Coordination Reform has been defining an overarching strategic vision for the future of the health system, something lacking in many OECD systems.

Norway has an impressive number of ***policies and practices to promote quality of care***, and Norway is performing well on most available quality indicators. Quality assurance mechanisms in Norway are extensive and through legal requirements, they secure high quality of health care services. Quality policies traditionally focus on nurturing a culture of quality improvement, but it should be complemented by additional assurance mechanisms. National authorities might look to extend the formal

requirement toward continuous medical education to all medical doctors, and consider setting-up a comprehensive accreditation programme for doctors. Policies around the patient safety agenda, and the use of national guidelines and health technology assessment are generally strong, but could in some cases be expanded to cover more care settings. Increasing incentive structures through quality contracting and targeted reimbursement would further enhance performance of health providers in the years to come. Finally, ambitious recent reforms demand for a coherent governance approach that is fuelled by good information systems; specific attention should be given to performance measurement for local, county and national health care system governance and with information made publicly available.

Norway appears to have a high performing primary care sector, in which ***primary care physicians*** play a central role. Norway benefits from a strategic vision of how primary care and health care more broadly should develop over the short to medium term, as set out in the Coordination Reform, as well as from having several engaged and competent institutions which are ambitious to improve primary care quality. Quality measures that exist suggest that Norway has a high performing primary care sector. However, to cope with the new demands that demographic changes and increased pressure on primary and community care services will bring, there are several steps that should be taken. The information infrastructure underpinning primary care needs to be developed, to make primary care activities and outcomes more visible. Smarter payment systems are a closely related priority. There is scope to include a stronger emphasis on preventive and co-ordination activities within the fee-for-service schedule, and more strategic decisions could be made around determining which activities should be prioritised within the schedule. Initiatives to bring GPs more closely into the design and implementation of new models of local care will also be vital going forward.

To respond to the challenges of an aging population, falling lengths of hospital stay, a rising rate of discharge and the resulting pressures on primary care settings, Norway has begun concerted efforts to ***shift care away from the hospital sector and towards primary care settings***. This shift includes the establishment of supplemented primary health care units, which will have a key responsibility in taking care of patients upon discharge from hospital, or where there is a risk of admission to hospitals when the condition could be appropriately managed at a lower intensity care setting. The introduction of the economic incentives under the Coordination Reform – the municipality co-funding of hospital care, and financial penalties for municipalities if discharge is delayed – is an excellent drivers for the setting up of supplemented primary health care units. Whilst it is too early to fully

assess the impact of these municipal units, their success will likely depend upon the improvement of care co-ordination between hospitals and municipalities, the development of information infrastructure, the setting up of standards, and the enhancement of municipal capacity. Additionally, going forward it is important to ensure that quality and safety are built into the system, and that workforce capacity and skills are assured. Looking beyond these units there is a broader need to improve co-ordination between care settings, and strategies such as the development of co-ordination indicators, the appointment of care co-ordinators, and ensuring that health records are portable across providers will help facilitate this.

Finally, ***mental health care*** in Norway appears to broadly offer good, appropriate care to the whole population. Norway has committed significant efforts and resources to improving mental health care across recent decades: strengthening care delivered by municipalities, increasing specialist services, increasing resources going into the system and making mental health a policy priority. In terms of collecting indicators of mental health care quality Norway is also making impressive progress in many respects. There are some key opportunities for further improvements to be made to mental health in Norway. As a foundation for improvements, better data availability for mental health will help policy makers and service providers better understand shortcomings in quality, and can guide appropriate changes. There is a need to ensure high-quality care for mild-to-moderate mental disorders through supporting GPs and mental health professionals working in primary care, and assess the availability of appropriate evidence-based treatments such as psychological therapies. The care pathway for severe disorders should also be improved, and Individual Care Plans could help with this. Addiction care, which has historically sat slightly outside of the mental health system, must be a priority, with greater integration being one important avenue for consideration. After a long period of change in the Norwegian mental health system, continued commitment and attention – supported by good information, data, and stakeholder input – will help secure further improvements in quality and outcomes in the years to come.

Overall, whilst the overarching vision for Norway's health system is in place, some of the details are left underdeveloped, and Norway must now turn attention to the detail of health care quality improvements. Attention needs to be given to ensuring that basic structures to support reforms are in place, including a good data infrastructure, appropriate payment systems that incentivise high quality and efficiency, and meaningful engagement between key stakeholders.

Assessment and recommendations

Norway has an impressive and comprehensive health system, which is the result of sustained commitment to providing health care for the whole Norwegian population, investment in the health system, and readiness to make changes to drive improvements. Despite this positive story, challenges do lie ahead for Norway. As in all OECD countries, changing demographics are putting increased pressure on health services, and with hospital lengths of stay dropping and discharges increasing, many of these pressures will be felt by community and primary care services. Norway is putting in place measures to respond to these challenges, notably with the 2012 Coordination Reform, but still has some way to go before the fruits of such labour are truly felt across the health system. Norway's ambitious reform agenda must now be balanced by structured efforts "on the ground". Attention should now turn to putting in place appropriate data infrastructures, promoting meaningful engagement between key stakeholders, and by balancing a generous health budget that allows for important investments in developing new structures and services with attention to getting the most out of existing services.

Health care in Norway is organised nationally (the Ministry of Health and Care Services), regionally through four hospital regions which oversee the provision of specialist services, and at the local level, by 428 municipalities of varying sizes, which are responsible for primary and community care. As a percentage of GDP Norway's total health care expenditure is 9.4%, slightly higher than the average 9% across other European OECD countries but lower than the expenditure in Denmark (11%) or Sweden (9.6%). Spending on inpatient care accounts for the largest proportion of Norway's health expenditure. Over the past ten years, the number of hospital discharges in Norway has increased, whilst average length of stay has fallen. On most indicators Norway's health system appears to be performing well. Norway's life expectancy at birth of 81.4 years in 2011 is higher than the OECD average of 80.1 years, and also higher than the other Nordic countries (79.9 for Denmark and 80.6 for Finland). As in Denmark, mortality rates from ischemic heart disease (IHD) in Norway are well below the OECD average. Breast cancer five-year relative survival rate is higher than the OECD average, and breast cancer

mortality rates is below the OECD average or the average across Nordic countries (OECD, 2013). Advances in improved treatments, well organised screening programmes, and delivery of evidence-based best practice have contributed to reduce mortality rates and are associated with improved survival rates in Norway. Hospital case-fatalities within 30 days after admission for acute myocardial infarction (AMI) rates are relatively low, at 4.5 in Norway, compared to a 7.9% on average among other OECD countries in 2011, clearly indicating good quality of acute care in Norwegian hospitals.

There have been a number of significant health care reforms in Norway over the last decade, including reforms to primary health and GP services in 2001, a National plan for mental health 1999-2008, hospital sector and specialist health care service reforms in 2002, and most recently the Coordination Reform, which took effect in January 2012. The Coordination Reform focuses on prevention, integrating care in the community and strengthening health care in the municipalities, and improving co-ordination between different levels of care, and has the overriding aim of directing more investment towards primary care in order to curb the growth of expenditure in hospitals. The Coordination Reform introduces substantial economic and organisational changes within the health care system. In particular, the reform relies on a percentage of co-financing of hospital care by municipalities, and a financial penalty for municipalities for any delay in discharge for a patient in the event that the municipality is unable to provide appropriate community care. This reform, which is well-placed to turn the Norwegian health system towards facing many of the approaching pressures – an aging population, falling length of stay in hospitals and rising discharge rate – does, nonetheless, require further attention in some areas. There are a number of key challenges which run across the health system, and with which Norway ought to engage fully:

- There appears to be broad consensus across stakeholders over the direction of the health system, even when this entails significant challenges or adjustments, for example there has generally been agreement over the direction taken by the Coordination Reform. However, beyond this broad consensus there is a lack of consistent meaningful engagement between key stakeholders (for example, discussion and negotiation between GPs, municipalities, hospitals, mental health services) which is an obstacle to the successful implementation of some impressive aspirations for improvement, particularly around increasing co-ordination.
- Norway's information infrastructure is weak, which means that good information about the health system is not available to inform

decision making. Whilst promising steps have been made, Norway's information infrastructure is markedly poorer than in other comparable countries, for example in Denmark, and efforts needs to be made to strengthening the data infrastructure, and make good use of information that is available.

- In a number of areas – most notably the Coordination Reform – Norway has launching into ambitious, and often impressive, reforms without a full basic structure. A structure to facilitate negotiation between stakeholders, to collect and use good information, in some cases to define the basic expectations of service delivery – for example, national standards and workforce requirements for supplemented primary health care units – need to be put in place to support such change.

- In recent years Norway has made some significant investments in improving care, both in direct investments to areas where care has been judged to be weak – mental health care, low-threshold care – and in reforms to the health care system as a whole. Whilst these investments have likely brought positive changes in some areas, going forward Norway ought also to focus on maximising quality using existing resources, looking for example at efficiency in the health system and incentive structures for providers, rather than scaling-up investments where weaknesses appear.

- Whilst Norway may not at this stage be facing the kind of health budget contractions that other OECD countries are facing, efforts to ensure that health care represents good value-for-money, and that services are performing efficiently and effectively, will stand Norway in good stead in the medium to long term.

Responding to these challenges will require careful attention and application, and some further reform. This review makes recommendations for how Norway can maximise the positive impacts for quality of recent reforms, and ensure that there is a robust quality architecture to help guide decision making and responses to the needs of an ageing population, and with the shift in the locus of care provision from hospitals to municipalities. In particular, Norway needs to develop richer information systems, to work to define a clearer role for all of the stakeholders in the health system, and encourage stakeholders to consistently work together to drive improvement, and to shift incentive structures to make quality and efficiency health system priorities. The rest of this part of the report makes a more detailed assessment and set recommendations for three areas of care particularly relevant to the Norwegian context: primary care, the shifting of care away from hospitals and towards the primary care sector, and mental health care.

Complementing a quality improvement culture with quality assurance mechanisms

A more robust inspectorate, assurance for professional performance, and the introduction of an accreditation system

Norway has a long history of quality improvement work and an impressive number of quality initiatives, which help to secure high-quality health care services. At the same time, Norwegian quality policies traditionally focus on nurturing a culture of quality improvement. Such an approach is undoubtedly an excellent basis for system improvement, but it should now be complemented by more robust quality assurance mechanisms. These mechanisms, for example around individual professional performance or accreditation, could be both strengthened to further enhance quality of care and increase performance of health providers in the years to come.

The inspectorate role and activities of the Norwegian Board of Health Supervision ("Helsetilsynet") in primary care could be increased to more systematically ensure that standards are kept high, and to help promote a culture of learning from shortcomings and adverse events. Already deemed by the European Partnership of Supervisory Organisations to be functioning well, the Board's existing role is in ensuring that services are run in accordance with professional standards, developing proposals to maintain and improve quality standards, as well as to oversee social and children's care. At present, the Board responds to specific incidents or complaint reports, and conducts quality reviews of primary and specialised health care institutions. However, primary care services are excluded from the National Reporting and Learning System, meaning that there is no formal system by which primary care services can learn from serious adverse events.

At present, Norway has not introduced an accreditation system in the hospital sector. Some hospitals however are certified according to ISO 9001 and the Norwegian regulation for internal quality assurance of health services assures the quality of health care providers and facilities. Given Norway's highly devolved health care system, the introduction of an accreditation system for health care services should be considered to help assure continuous quality improvement. Strengthening of the quality assurance mechanisms for individual professional performance is desirable. Given the relatively large proportion of the workforce that has been trained abroad, robust quality assurance for professionals could help ensure that professional practice is in line with desired standards across the workforce. Strengthening re-certification based on continuous performance assessment of health professionals, might be a key

component to fully assure and improve the quality of care. Such an approach could include, or could be complemented by, stronger Continuing Medical Development protocols.

Strengthening the information infrastructure and putting greater focus on performance measurement and public reporting

With on-going reforms to strengthen primary care and devolve responsibilities for health and social care to the local level, information-based leadership is needed to assure that Norwegian health care is effective, safe and patient-centered for individual Norwegians, contributes to population health, and makes optimal use of the available resources. The Coordination Reform requires that information systems be strengthened, and the Norwegian Health Network was required to develop and operate information technology infrastructure for the health care sector. Good information systems are needed both for promoting openness about quality in the health system and providing good information for patients, and as a tool for policy makers and politicians in evaluating services and prioritising investments.

There are some good reporting and data gathering systems already in place in Norway, but these could be made stronger. A national quality indicator system for the health sector has been implemented by the Norwegian Directorate of Health, which gathers hospital care and primary care indicators that measure the quality in structure, process and result within the health sector. Quality indicators regarding municipalities' health care services are collected from the IPLOS registry. IPLOS is a national anonymous registry containing detailed information about all applicants and recipients of health care services at home or in nursing homes in Norwegian municipalities, which provides a basis for monitoring, planning, development and overall management of health and social services. Some national quality indicators for municipality health care services are also published on the internet (www.bedrekommune.no/bk/hjem/), and the KOSTRA system provides information on the use of health resources both at the municipal and county levels. At a national level there are several registries covering different diseases, health outcomes and professional areas. Finally, some initiatives are in place to collect data on health care and other social care areas, and there are a number of public reporting platforms, most notably a Norwegian official web-based portal (helsenorge.no) which has started a reporting cycle for health professional and patient.

However, the overall data and reporting infrastructure in Norway is weak compared to other Nordic countries (such as Denmark), and could be strengthened. The data and reporting infrastructure should be extended

further towards primary care and might also give greater attention to performance measurement. Of particular importance is the establishment of a good data and reporting structure for supplemented primary health care units, which will benefit greatly from good information about successes and weaknesses, both across Norway and between different providers.

Broadening of the patient safety agenda to primary care

Several patient safety initiatives are in place in Norway, including under the Patient's Rights Act legislation, through the National Agency for Patient Safety, and the patient safety campaign "In Safe Hands" launched in 2011. However, whilst Norway has well developed initiatives to support patient safety improvement in hospital care, existing initiatives in the primary care sector are relatively weak. For example, In Safe Hands which aims to reduce patient harm, to build sustainable structures for patient safety and to improve patient safety culture, targets the hospital sector and some primary care facilities. Suicide prevention, infection prevention, the correct use of medicines and fall prevention are identified as key areas of concern. Although nearly 40% of municipalities were involved in the patient safety campaign by the end of 2013, there is a need to increase its coverage to more primary care services. More explicit inclusion of primary care in the patient safety agenda is also called for, including through the National Reporting and Learning System within the National Agency for Patient Safety.

Assuring alignment of national patient organisation activities with local community involvement in health care

In Norway, several mechanisms are being developed to ensure and strengthen the position of the patient in the health care system. These mechanisms include the Patients' Rights Act, the Norwegian information service "Fritt sykehusvalg Norge" (Free Hospital Choice Norway), the Norwegian official portal (helsenorge.no), and national surveys conducted on patient experience by the Norwegian Knowledge Centre for the Health Services. Several user and carer organisations are also operating in Norway, which are central bodies in the oversight of health care, and involve with national authorities to improve quality of care to guarantee that the population and patients have the best possible conditions and access to high-quality health care services. A positive trend that is apparent in Norway, as well as in other countries, is the growing role of patient organisations at a local level. Patient organisations, for example for mental health, have been providing support, networks, and in some cases services, to local communities which are highly beneficial. Efforts should be made to support patient groups in carrying out such activities, and in continuing to

represent the interests of service users. Some areas where patient groups are less developed, for example for addiction service users, may benefit from support from national or local governments, or from support by other more established patient groups.

Strengthening performance management on quality in the contracting relations between national, regional and local level and assuring alignment with payment mechanisms

Norway has the opportunity to encourage performance management on quality through the contractual arrangements made between the various levels of the health system. At present, in contracting between the national and local level, quality agreements and quality indicators play a limited role in Norway, and could be strengthened. Performance data could be used, as it is in Denmark and Sweden, as part of annual contractual agreements. These performance criteria could be linked to specific payment mechanisms or budgets, but the most important dimension would not – initially – be the financing mechanism, but would be to make quality of care an integrated part of the local and national governance arrangements, and to use performance data more actively. Then, any further health services-based initiatives on pay-for-performance (P4P) should be aligned with these local and national system goals.

Norway's Coordination Reform has set out a clear and ambitious vision for pivoting the provision of health care services toward primary health care sector. Yet, the information and payments structures that one would expect to see underpin continuous quality improvement are not as well established in the Norwegian primary care sector as in other countries. Norwegian GPs have few external incentives to deliver the objectives of the Coordination Reform or, indeed, to deliver better quality primary care more broadly. Whilst hard incentives have been placed around municipalities to encourage them to operationalise the Coordination Reform, GPs are disconnected from these mechanisms. Norway needs to develop a richer information system that captures activity and outcomes in primary care, design smarter payment systems that reward quality as well as activity and develop mechanisms to bring GPs in more closely to the design and implementation of new models of care at the municipality level.

Norway appears to have a high performing primary care sector, but faces challenges brought by demographic changes and increased pressure on primary and community care services

As in other Scandinavian countries, Norway's GPs are a central figure in the health care system. Independent contractors paid through a mix of a

capitation fee, fee-for-service payments, and patient co-payments, there are around 4 700 GPs in Norway; generalist doctors comprise a slightly smaller part of the medical workforce in Norway (27%) compared to other OECD countries. List sizes for GPs, however, are small – on average 1 160 patients per GP (the maximum allowed is 2 500) and access to GPs is reportedly good. GPs are obliged to spend at maximum 7.5 hours per week, if so wished by the municipality, working in activities for the municipalities, for example in school health or in a nursing home. Rural Norway has fewer doctors than urban centres but figures compare well internationally. Indeed, even though the urban/rural gap in Norway is large by international standard, rural areas still have a greater density of doctors than seen in other Scandinavian countries.

Norway faces two significant challenges which will place increased pressure on primary care sector, in particular in relation to the provision of continuous and well co-ordinated care for patients with long-term conditions. First, the proportion of the population aged over 80 years is projected to rise to 9% by 2050, in line with the OECD average, and a concurrent rise in adults with at least one chronic health condition, such as diabetes, heart disease or cancer, is to be anticipated. Second, there have been shifts in the way health care is provided. Average length of stay in hospitals (ALOS) has dropped from 8.9 days to 6.8 days over the past decade in Norway, in line with a trend seen across OECD countries. Indeed, for some conditions, Norway has some of the shortest hospital stays observed in the OECD. At the same time, hospital activity has been increasing: over the past ten years, the discharge rate has increased from around 16 000 discharges per 100 000 population per year in Norway to around 17 500 per 100 000 population per year. Particular specialties in Norway have seen even larger increases – in orthopaedic surgery (which typically makes heavy use of community health care services after discharge), volumes increased by 57% between 1999 and 2007. This combination of increasing numbers of hospital discharges and shorter lengths of stay implies increasing pressure on the community and primary care sector to take over the care of increasing numbers of patients earlier in the course of their recovery.

Norway needs to develop a richer information system that captures activity and outcomes in primary care

There is a significant deficit of information on the patterns of care and outcomes in primary care. There are some broad measures of primary care in Norway – prescribing patterns, hospital admissions for chronic conditions – but little is known about the quality of care at a more local level. There is virtually a complete absence of information at local level regarding the quality

of primary care services. Norway has no information infrastructure at local or at national level to systematically collect a dataset that would allow GPs, patients and authorities to benchmark quality and performance against peers or against national guidelines. Of even greater concern, perhaps, is the fact that the dearth of information is profound – most Norwegian GPs would not be able to quickly produce an up to date register of patients with diabetes. Without this fundamental ability to identify a base population, it is hard to see how any other quality initiatives, around patterns of care or clinical outcomes, could work. In this respect, Norway compares unfavourably with other countries which would normally be considered peers – Israel or Denmark, for example – several of whom have developed comprehensive and actionable indicators to support quality improvement in primary care.

Developing the information infrastructure underpinning primary care, so that a fuller and more detailed picture of the effectiveness, safety and patient centredness of primary care can be built, is a priority. At this particular moment in Norway's reform history, however, it is especially needed as part of the assessment of the impacts of the Coordination Reform, particularly as increased expectations are placed on the primary care sector to maintain current service levels, engage in more preventive work and deliver a wider and more complex range of acute care. Norway could be better using some existing sources of data. Opportunities within the HELFO database could be explored as a first step – it may be possible, for example, to construct primary care quality indicators detailing how often key preventive checks are offered for chronic conditions. Similar opportunities may exist within the KOSTRA database, particularly given that this database contains measures of patient experiences (such as waiting times) and satisfaction. HELFO and KOSTRA do not contain clinical outcomes, hence new data sources are also needed. A necessary first step is to build a legal framework which will allow the collection of more comprehensive primary care data.

High-quality care and better co-ordination could be better encouraged using smarter payment systems which reward quality as well as activity

At present, Norwegian GPs have few strong external incentives to deliver the objectives of the Coordination Reform or, indeed, to deliver better quality primary care more broadly. Available indicators, for example data on prescribing patterns and admission rates for chronic conditions, do suggest that Norwegian primary care is functioning well in the absence of much central guidance, monitoring or accountability, and this is in no small measure due to high levels of trust between those paying for and those delivering primary care. However, this trust and consensus need not conflict, with more concerted efforts to incentivise high quality and

cost-effectiveness as part of Norway's generous health spending on primary care and reform process. At the same time as developing a richer information infrastructure, Norway should also consider ways in which payment systems in primary care could be reformed to better reward high-quality care.

Currently there are few strong incentives for GPs to deliver the Coordination Reform's vision of integrated, proactive and community-focused care. The only incentives built in to the reform were municipalities' 20% co-financing of hospital activity and the additional daily penalty if patients who were ready for discharge remained in hospital. These incentive mechanisms, however, do not directly connect through to GPs given that municipalities have relatively weak influence over GPs' practice. Furthermore, the new government from September 2013 intends to scale back the 20% co-financing element. Hence, GPs remain "behind the firewall" in terms of feeling direct pressure or incentives to change their ways of working to realise the vision of the Coordination Reform. This need not imply a wholesale move toward a system of financial incentives, given that existing payment systems show ample opportunity for more smart design. Indeed, reforms in this area are likely to be simpler to introduce than a national primary care indicator set and have significant positive benefits. Future fee-for-service (FFS) negotiations should make more explicit links to national priorities and standards of care. Representation from the National Knowledge Centre in these negotiations should be considered. It is particularly important to note that a FFS payment system may be a poor design to support integrated and continuous care. Specific attention should be directed toward identifying activities within the FFS that could support better co-ordinated care (such as creating detailed Individual Care Plans for patients with complex conditions with joint sign-off by the services involved and by the patient).

The FFS schedule could also be adapted to reward a greater set of activities undertaken by nurses and wider clinical staff. In many OECD countries, however, nurses with additional training are undertaking an increasingly wide range of primary care tasks, particularly around chronic disease management, including clinical assessment, ordering investigations, referring for onward care, clinical management and, in some settings, prescribing. The evidence is that this has not led to any lapses in quality and can be associated with higher rates of patient satisfaction.

Mechanisms to bring GPs in more closely to the design and implementation of new models of care should be developed

The Coordination Reform sets out ambitions for Norway to achieve more closely co-ordinated and integrated care most clearly, yet the impression remains widespread that co-ordination across multiple providers or across a complex pathway of care is poor – something particularly relevant to patients with one or more long-term conditions. It is reported that Individual Care Plans (ICPs) for patients with complex needs, for example, are variably implemented. The development of the *Praksiskonsulentordningen* (PKO – Practice consultant) role (GPs who are employed part-time by a hospital to support the co-ordinated management of complex patients, at the same time as developing local reforms to support co-ordination across pathways involving primary and secondary care more generally) has been poor, although a model has recently been introduced to strengthen their role. Perhaps most crucially, negotiations between municipalities and hospital managers – which have great potential value given that these two parties rarely interacted with each other previously – are reported to have a low and inconsistent level of participation from GPs.

GPs' involvement in negotiations between municipalities and hospitals is important: GPs will have a clear idea of local health needs and weaknesses in local service delivery and so are ideally placed to steer the focus of municipality-hospital negotiations; second, GPs will inevitably feel the impact of whatever is decided with regards to hospital service levels or processes around admission/discharge. As independent contractors, GPs expect that any time spent at such meetings is adequately compensated – a financial stipulation which some municipalities may be reluctant to underwrite. One easy and fair solution would be to include local planning and implementation of the Coordination Reform as work that counts towards the maximum 7.5 hours/week that GPs have already agreed to spend on municipality-level activity. At the same time, thought needs to be given to varying the content of contract between municipalities and GPs themselves. Furthermore, contracts between municipalities and GPs offer a rich opportunity to specify additional activities and reimbursement that reflect local needs or service ambitions. Examples would be service agreements to find new cases of undiagnosed diabetes or hypertension and start appropriate treatment, or to take on an expanded role in the diagnosis and management of patients with mental health or substance abuse problems.

More consistent application of Individual Care Plans (ICPs) for patients with one or more long-term conditions is another way to encourage GPs, and health and social care providers more generally, to more fully implement the ambitions of the Coordination Reform. Developing a

monitoring framework to ensure that these patients who could benefit from an ICP are offered one, and standardising their content would be ways in which the use and application of ICPs could be made more consistent. Specifying a requirement to proactively review of the functional status and medication regime of patients with multimorbidity, including when they fail to attend for a booked appointment, would be one example of how content could be standardised in a way that does not overburden primary care staff.

Shifting care away from the hospital sector and towards primary care settings

To respond to the challenges of an aging population, falling lengths of hospital stay, a rising rate of discharge, and the resulting pressures on primary care settings, Norway has begun to establish supplemented primary health care units (also called "Distriktsmedisinsk senter" or "Sykestue" in Norwegian), which will have a key responsibility in taking care of patients upon discharge from hospital, or where there is a risk of admission to hospitals when the condition could be appropriately managed at a lower intensity care setting. These units are service models for integrated care, financed jointly by hospitals and municipalities, for patients with intermediate care needs. By providing a mix of post-acute, rehabilitation and nursing care, these supplemented primary health care units are intended to curb hospital care costs through reducing hospital admission, length of hospital stay, and preventing readmission.

The introduction of the economic incentives under the Coordination Reform – the municipality co-funding of hospital care, and financial penalties for municipalities if discharge is delayed – are excellent drivers for the setting up of supplemented primary health care units. Although these financial incentives aim at increasing co-operation between primary care and specialised health care services, the reform also gives more emphasis to the effective management of long-term or chronic conditions through better care co-ordination between the health and other social sectors. Whilst it is too early to fully assess the impact of these municipal units, its success will likely depend upon the improvement of care co-ordination between hospitals and municipalities, the development of information infrastructure, the setting up of standards, and the enhancement of municipal capacity.

Co-ordination across health services and providers should be improved

Poor co-ordination of care between hospitals and primary care is too often reported in Norway, which suggests that patients may face particular difficulties at transitions between different care settings. The poor

transmission of information between providers is one of the foremost causes of a weak co-ordination, and often means that information coming from hospitals does not reach primary care levels. Physicians within supplemented primary health care units do not consistently have access to critical health information such as patient's medical histories, previous hospital treatment and follow-up requirement upon discharge. Improving information sharing between hospitals and supplemented primary health care units would help to deliver care of a consistently high quality, and more efforts should be made to ensure that appropriate information and medical records are shared between all parties involved in care. Co-ordination would be better facilitated by electronic clinical records that are portable across primary care settings and hospitals.

Information sharing might also be improved by assigning a care co-ordinator, who would act as a navigator between different health care settings in order to ensure that discharge leads into appropriate follow-up care. The Practice Consultant Scheme which has been introduced in most hospitals and the initiative developed by the municipality of Oslo for hiring GPs or discharge nurses as care co-ordinators should be rolled out throughout Norwegian supplemented primary health care units. At the same time, it would be advisable to monitor care co-ordination in these units by collecting specific indicators such as the share of discharge information that reaches these facilities or the waiting times to receive municipal services.

Establishing workforce requirements and increasing mutual learning processes

An important challenge in Norway is related to the number of health professionals in supplemented primary health care units and its capacity for developing adequate skills levels. As part of the Coordination Reform, municipalities are required to establish municipal emergency beds with adequately trained health professionals. While good efforts to promote further training programmes for municipal care services have been made recently as part of the Competency Plan (included in the National Care Plan 2015), the government might look to ensure that the workforce in supplemented primary health care unit (including nurses and home care staff) have the right level of skills to provide care for patients who likely have a higher complexity of needs than in many long-term care settings. Setting up mandatory requirements on continuous professional development, including for example continuous medical education or establishing specific training opportunities would facilitate such a process. Examples of requirements can be found in other OECD countries such as Denmark, which has a national curriculum for social and health care helpers which includes both formal and practical training.

Norway might also want to consider the development of a framework document in order to provide guidance to support the establishment of supplemented primary health care unit. It would for example identify the main challenges municipalities or health professionals will need to address, present the quality assurance model for these facilities and fixe specific workforce requirements.

Finally, it is essential to ensure that municipalities share experience around the establishment of supplemented primary health care unit, by developing for example a mutual learning process toward successful and unsuccessful experiences of service models. Beyond this, in the longer term, Norwegian health authorities should be encouraged to develop a culture of open comparison around performance for supplemented primary health care units. The experience in other OECD countries such as Sweden, with its system of Open Comparisons, suggests that comparing performance across municipalities is a useful force in driving quality improvement.

Further attention needs to be paid to quality measurement, monitoring and contracting for supplemented primary health care units

Another important challenge for Norway is to increase the collection of data around processes and outcomes of care within supplemented primary health care units. The current lack of data suggests that it is currently impossible for policy makers to assess the quality of care being delivered, which prevents them from appropriately exploring any shortcomings, and identifying areas that may require improvement. Collecting information around the management of chronic conditions, the assessment and measurement of pain or the patient's experience with these facilities is of paramount importance to monitor the quality of care. At the same time, the process of collecting data might be accompanied by a strengthening of the wider information infrastructure. Developing uniform health records that are portable across primary care settings and hospitals ought to be a priority in Norway. This would allow authorities and providers to get a richer picture of patient's experience across different care settings.

Beyond this, it is recommended that Norway ensure that supplemented primary health care units comply with Norwegian regulations for internal quality assurance of health services to guarantee that care is continuously monitored. Developing minimum quality standards, which is the cornerstone for building consistent and adequate quality of care, might be one avenue for consideration to better standardise care processes and to avert undesirable outcomes. To move forward, Norway ought to develop minimum quality standards focussing on, for example, an accreditation programme or on

disease-specific guidelines that include supplemented primary health care units. Finally, Norway should take advantage of the Norwegian Board of Health Supervision that carries audits in the primary and specialised health care sector. The frequency of inspection in supplemented primary health care units might increase through choosing particular issues, such as how the follow-up upon discharge, or how care for patients with chronic conditions is organised within these units. A major strength of the Coordination Reform in Norway is the contractual agreement which requires municipal decision makers and hospital managers to meet to discuss about various issues ranging from the follow-up organisation upon discharge to the distribution of duties and responsibilities between municipalities and hospitals. There is much that can be done to take advantage of these agreements to direct improvements in the quality of supplemented primary health care units, through achieving greater co-ordination. It would, for example, be consistent for municipal decision makers and hospital managers to organise joint care planning or joint assessments of care needs in order to improve both the quality of care and the patient's experience with care. The effectiveness of the referral system between primary care and hospital should also be considered during these meetings.

Securing high-quality mental health care

Mental health care in Norway appears to broadly offer good, appropriate care to the whole population. Norway has committed significant efforts and resources to improving mental health care across recent decades and these efforts – strengthening care delivered by municipalities, increasing specialist services, increasing resources going into the system and making mental health a policy priority – suggest that Norway is moving towards having a strong and comprehensive mental health system. In terms of collecting indicators of mental health care quality Norway is also making impressive progress in many respects.

However, shortcomings in Norway's mental health system remain, and Norway can do more to secure high-quality mental health care for the whole population. There are opportunities for Norway to further strengthen data collection and to use data to help drive improvements in outcomes, to ensure that all mental disorders are appropriately treated, to make sure that responsibilities amongst health authorities for service delivery are clearly established and followed through, to promote better co-ordination, and to assure high quality of mental health care across the country.

Although good indicators for quality are hard to come by, Norway could do more to help the assessment of its mental health system

In a difficult area such as mental health Norway has already made good progress in establishing and publishing relevant data on quality of care. Norway is able to report on almost all of the OECD Health Care Quality Indicator mental health indicators, and is reporting on a number of other relevant indicators of mental health care quality. However, continued attention to building good indicators of quality of care for mental health should be a priority for Norway. Many of the indicators that Norway is collecting at present are, though useful, primarily process indicators, or measures of service capacity, for example, registration of diagnoses, or staffing numbers. Other examples of existing indicators are inpatient suicides, readmission rates and waiting times.

Developing indicators on primary care and municipality level is an essential step towards capturing the quality of care, and has been a significant challenge for most OECD countries, due to a lack of administrative data sets at the primary care level. However, a number of OECD countries are attempting to measure the quality of mental health care in primary care settings using a range of indicators, for example in Sweden, Finland and the United Kingdom. Quality assurance for addiction services is a further priority. Norway does have some quality measures for addiction services, but the need for quality assurance is particularly acute given that addiction services are frequently provided by non-state providers, and again there is potential to learn from other international examples.

Norway should also be building better indicators to help assure patient safety. Well-conceived targeted data collection instruments can assist care providers and patients in charting outcomes, and be used to give an indication of the need to adjust care where necessary. Equally, to secure the safety of often-vulnerable patients, good data collection on adverse events can help direct the attention of providers and clinical staff towards areas of risk in delivering mental health care. To further promote patient safety, good adverse event reporting should also be a priority for Norway. Good adverse event reporting – for example reporting on self-harm or adverse drug events – would both protect patients and has the potential to be used by individual providers to identify gaps in practice.

Filling the gaps in service delivery and availability of mental health care

Mental health needs are being included in the policy agenda addressing the whole health system, and rightly so, but it is possible to identify three key shortcomings in service delivery and availability for mental health care

in Norway: weaknesses in care provision for mild-to-moderate disorders; shortcomings in the co-ordination of individual's care pathways; and inadequate care for drug addiction. Each of these shortcomings will likely need targeted efforts to bring meaningful improvements in the quality of care provided, in parallel with reflection over priorities across mental health.

- Greater attention to quality of care is needed for services targeted at mild-to-moderate disorders. As in many countries, mild-to-moderate mental health problems are too often excluded from mental health care in Norway. Given the important central role that primary care providers – particularly GPs, but also nurses and other community mental health personnel – are expected to play in the provision of services for mild-to-moderate mental disorders, there is a need to ensure that service provision at a primary care level is sufficient, and of high quality, and GP competency should be supported through training and support from municipalities and specialists. Appropriate specialised services for mild-to-moderate disorders – for example psychological therapies – also deserve closer attention, and minimum service provision guidelines for municipalities could improve access to such specialised services for mild-to-moderate disorders across the country.

- Individual Care Plans should be better used to secure appropriate and effective care over time for individuals with severe and enduring mental disorders. Good co-ordination of care, good follow-up in the community following hospitalisations, appropriate long-term support, and sensitivity to patient requests and treatment needs are important parts of securing high-quality care. The better and more consistent use of care plans could help support individuals with severe and enduring mental disorders, and their care providers, to secure the care package that they need over time.

- There is a clear need to better address addiction care in Norway, as indicated by the relatively high numbers of drug-related deaths. A co-ordinated and concerted efforts is needed, with closer integration of historically separate mental health and addiction fields, and a stronger voice for individuals with addiction disorders, highly desirable.

Improving co-ordination and defining responsibilities for mental health across different levels of governance

Amid some significant changes to the mental health system, including the shift towards care outside of hospitals, the increased role of municipalities, and the impact of the Coordination Reform, there is a need

to for health authorities – on a national, regional and local level – to strengthen co-ordination between different levels of care, and to define responsibilities for services. There is a combined problem of the expectation of increased responsibility of the municipalities – both due to the shifts caused by the Coordination Reform, and the move towards community care under the Escalation Plan, and under the National Plan for Mental Health 1998-2008 – some lack of clarity on the obligations of hospitals with regards to community care. Norway's high level of readmissions might indicate too short inpatient stays in some cases, or to poor co-ordination with care after discharge leading to readmission, or a combination of the two. There should be a focus on closing gaps in service delivery, as well as preventing duplications.

Furthermore, there are clearly excellent examples of good quality of care provided in municipalities, where community services are working well, and in co-ordination with specialist services, and where access to care is timely, but there are no real mechanisms to ensure that this excellence is in place across Norway. Although the Health and Care Services Act states that the municipalities are responsible for primary care also to people with mental problems and addiction problems, standards for community care provision are not in place, and service availability is not consistent across municipalities. Priority setting at a municipal level is also not clearly established, nor are good mechanisms for information sharing between services. As a consequence, whilst one municipality can decide that mental health is a priority area, and invest in excellent service provision and care co-ordination, another municipality may make (far fewer) much less investments in mental health services. Whilst community-level quality measures are under-developed, and available indicators are not sufficiently granular so as to assess service provision at a municipal level, the absence of national minimum standards for care provisions very likely to be leading to uneven quality of care between municipalities. Given Norway's large number of small municipalities, provision of high-quality mental services by each is an impossibility, which makes co-operation between smaller municipalities for the provision of mental health services advisable. Financial incentives, wherein ring-fenced funding is given to groups of municipalities for service provision, or where minimum service provision contracts with associated ring-fenced funding are given to collectives of municipalities, could be explored as possibilities.

Policies for improving quality of care in Norway

Having already started an ambitious and largely appropriate programme of reform, which should help confront the challenges that await the health system, Norway now needs to work to ensure that the underlying structures that will help secure high-quality care are in place, and remain alert to gaps in quality across the health system. In particular, Norway must:

Put in place quality policies to help implement a double reform shift, with triple aims

- Introduce more robust quality assurance mechanisms: increase the inspectorate function; a stronger quality assurance mechanisms for individual professional performance, for example re-certification based on continuous performance assessment of health professionals; and an accreditation system for health care services, especially given Norway's highly devolved health care system.
- Strengthen the information infrastructure and bringing greater focus on performance measurement and public reporting. Good information systems are needed both for promoting openness about quality in the health system and providing good information for patients, and as a tool for policy makers and politicians in evaluating services and prioritising investments.
- Broaden the patient safety agenda to more primary care services. More explicit inclusion of primary care in the patient safety agenda is called for, including addressing this sector through the National Reporting and Learning System within the National Agency for Patient Safety.
- Continue promote more fruitful alignment of national patient organisation activities with local community involvement in health care.
- Strengthen performance management on quality across national and local level and assuring alignment with payment mechanisms, and strengthen the importance of quality agreements and quality indicators in contracting between governance levels.

Supporting primary care physicians to improve health care quality

- Develop a richer information system that captures activity and outcomes in primary care, to give a fuller and more detailed picture of the effectiveness, safety and patient centredness of primary care, and as part of the assessment of the impacts of the Coordination Reform.
- Design smarter payment systems that reward quality as well as activity, particularly in contract negotiations and in the fee-for-service schedule. Specific attention should be directed toward identifying activities within the FFS that could support better co-ordinated care, and to the potential for adapting the FFS schedule to reward a greater set of activities undertaken by nurses and wider clinical staff.
- Better promote co-ordinated and integrated care from primary care, and across providers. More consistent use of Individual Care Plans (ICPs) for person with complex needs should be considered.

Policies for improving quality of care in Norway *(cont.)*

- Introduce mechanisms to bring GPs in more closely to the design and implementation of new models of care at the municipality level. There is a bigger role for GPs to play in supporting the co-ordinated management of patients with complex needs, developing local reforms to support integration, and taking part in negotiations with municipalities and hospitals.

Make quality a priority for supplemented primary health care units

- Put in place a good basic structure for high quality: increased data collection, developing national standards and establishing additional workforce requirements. At present, there are too few quality indicators on outcomes or even processes indicators for supplemented primary health care units, no minimum national standards for the setting up of municipal emergency beds, and explicit guidance for expected skills for workforce. Norway needs to work to put these fundamental elements in place in a timely manner.

- Consider the development of a framework document in order to provide guidance to support the establishment of supplemented primary health care units, which would identify the main challenges municipalities or health professionals will need to address, present the quality assurance model for these facilities and fix specific workforce requirements.

- Improve co-ordination across health services and providers, especially the poor transmission of information between providers. Co-ordination would be better facilitated by portable electronic clinical records, and might also be improved by assigning for each patient with long-term conditions a pathway co-ordinator (as done with the Practice Consultant Scheme) who would act as a navigator between different care settings in order to ensure that discharge leads into appropriate follow-up care.

- Give further attention to contracting between municipalities and national government, and to mutual learning processes. Much more could be done to take advantage of the contracting process that require agreement between municipalities and hospital managers to achieving greater co-ordination for supplemented primary health care units, for example organising joint care planning or joint assessments of care needs. To help promote mutual learning about successful and unsuccessful experiences of supplemented primary health care units. Norwegian authorities should develop a culture of information sharing and open comparison around supplemented primary health care units performance.

Work to secure high-quality mental health care

- Do more to help the assessment of its mental health system through further developing appropriate indicators of quality of care. Although a difficult area for which to develop indicators, good information on mental health care is very important, and developing indicators on primary care and municipality level care, and comparable information on patient safety, should be a priority.

Policies for improving quality of care in Norway *(cont.)*

- Fill the gaps in service delivery and availability of mental health care, including for mild-to-moderate disorders, on the co-ordination of care for severe mental disorders, and for addiction care.
- Give greater attention to quality of care is needed for services targeted at mild-to-moderate disorders, including to the role of primary care – in particular GPs, but also nurses and other community mental health personnel –, to available support for primary care providers, and to the availability of appropriate specialist services for example psychological therapies.
- Promote the wider use of Individual Care Plans to secure appropriate and effective care over time for individuals with severe and enduring mental disorders, as part of a push to ensure that patients, and their carers, can access the care package they need over time.
- Better address addiction care in Norway, through a co-ordinated and concerted effort, likely leading to closer integration of mental health and addiction fields.
- Improve co-ordination and defining responsibilities for mental health across different levels of governance, and ensure that the positive impact of the Coordination Reform is fully felt for mental health. The roles of different service providers should be clarified, and minimum service expectations for mental health should be defined.

Chapter 1

Quality of health care in Norway

This chapter provides an overview of policies and strategies to assure and improve the quality of health care in Norway. After describing the organisation of the Norwegian health care system and the roles of the central government, the county and local level, the chapter focuses on the assurance of the quality of professionals, medical devices, pharmaceuticals and health care institutions. Policies to monitor and improve quality of care are then described, including the Norwegian patient safety agenda, the information infrastructure, and the use of national guidelines and health technology assessment. Specific attention is finally given to policies aimed at strengthening the role and perspective of the patient, as well as contracting and paying for quality.

This chapter concludes that Norway has an impressive number of quality initiatives, but challenges remain to complete a quality improvement culture with robust assurance mechanisms. Individual professional performance could be made mandatory for all medical doctors, accreditation programme might be set-up for health care facilities and patient safety could be strengthened to more primary care services. The implementation of incentive structures through quality contracting and targeted reimbursement would further enhance performance.

1.1. Introduction

Norway, with 5 million inhabitants, is among the top performing countries in terms of its universal health care system which guarantees extensive health coverage, secures high quality of health care services and contributes to an overall excellent health status of the Norwegian population. In Norway, the health care system is semi-decentralised, with municipalities responsible for the primary health care sector and the central government responsible for the specialised health care sector.

Norway has a long history of quality improvement work and indicators on quality of care overall paint a favourable picture. Nevertheless, there are areas that can be strengthened given its recent health reforms. A main finding is that many initiatives have been taken to nurture a quality improvement and patient safety culture but that several quality assurance mechanisms might be more robust, especially related to primary care. The on-going reforms to strengthen primary care makes knowledge-based leadership essential to assure that the Norwegian health care system is effective, safe and patient-centered in order to enhance public health and to make optimal use of the available resources.

This chapter seeks to profile the key policies and strategies that Norway has used to encourage improvements in the quality of health care. The description of quality of care policy in this chapter is structured according to a framework that is detailed in Table 1.1 below.

Table 1.1. A typology of health care policies that influence health care quality

Policy	Examples
Health system design	Accountability of actors, allocation of responsibilities, legislation
Health system input (professionals, organisations, technologies)	Professional licensing, accreditation of health care organisations, quality assurance of drugs and medical devices
Health system monitoring and standardisation of practice	Measurement of quality of care, national standards and guidelines, national audit studies and reports on performance
Improvement (national programmes, hospital programmes and incentives)	National programmes on quality and safety, pay for performance in hospital care, examples of improvement programmes within institutions

After providing some general context information, the chapter presents the following:

- the governance and legislative framework for quality of care in Norway
- whether inputs into health care system are appropriately equipped to deliver high quality of care
- key policies to monitor and standardise the quality of care
- whether policies support the health system in driving continuing improvements in the quality of care.

A short description of the Norwegian health care system is provided in Box 1.1. For detailed information on the Norwegian health care system, the European Observatory's Health Systems in Transition report on Norway offers a useful source of information (Ringard et al., 2013).

Box 1.1. Overview of the Norwegian health system

The Norwegian health care system is organised along three different levels (national, county and local levels), each playing different roles in the delivery of health care services. Overall responsibility for the health care sector rests at the national level, with the Ministry of Health and Care Services which determines national health policy, prepares legislation and allocates funds. The Ministry of Health and Care Services owns four Regional Health Authorities which are responsible for the provision of specialised somatic and mental health care. The 19 Norwegian counties are responsible for the provision of statutory dental health services while the 428 municipalities have responsibility for primary somatic and mental health care as well as nursing care.

In the last ten years, several health care reforms have been undertaken in Norway. A first reform led to the 1999-2008 National plan for mental health which brought substantial improvement in mental health services, both at the primary and specialised health care settings. Then, the Regular General Practitioners scheme was instituted in 2001 to improve the quality and the access to primary health care services. A GP is normally responsible for a patient list size of up to 1 500 persons. Furthermore, the reform permitted the local authorities to hire GPs in private practice on contract, rather than offering them employment in publically owned facilities. Further, the provision of specialist care was reorganised in 2002 by the Norwegian Health Authorities and Health Trusts Act, which led to the establishment and operation of regional and local health enterprises. Five Regional Health Authorities (later reduced to four through a merger) were set up to own health trusts in each region normally running several hospitals, with appointed boards responsible for governance and results. Finally, the Coordination Reform was introduced in January 2012 in order to achieve higher level of prevention, more co-ordinated services and more comprehensive primary health and care services. The overriding aim of the reform is to direct more investment towards primary care in

order to curb the growth of hospitals expenditure (see Box 1.2).This reform is supported by the changes introduced by the Health and Care Services Act (2011), the Public Health Act (2011) and the National Health Plan (2011-15).

As an integral component of the Norwegian welfare model, the Norwegian health coverage is universal, covering a set of services including primary and specialised health care, selected dental services, ambulatory care, emergency service and prescription drugs entitled in the approved list. The Norwegian health care system is financed through general taxation collected by the central government, counties and local authorities. Although there is no specific health tax, the sources of financing mainly include direct taxes at the state level (progressive income tax) and indirect taxes (income and property tax) at the lower levels of public administration.

Total health care expenditure in Norway is 9.3% of GDP, slightly higher than the OECD average of 9% but lower than the expenditure in Denmark (10.9%) or Sweden (9.5%). Public expenditure account for 85% of total health expenditure, compared to an average of 72% across other OECD countries. Out-of-pocket payments (OOP) account for 15% of total expenditure, compared to a 20% on average among other OECD countries. The share of OOP spending has decreased by 1.6% during the past decade, which is close to the OECD average decrease of 1.2%. Although voluntary health insurance does not play any significant role in Norway, a market for private health insurance is emerging.

Since the hospital reform of 2002, the physical and organisational infrastructures of the hospital sector have undergone a series of changes. Between 2000 and 2011, the number of hospital beds has decreased by 23%, falling from 4.3 per 1 000 population in 2000 to 3.3 in 2011.In Norway, the reduction in the number of hospital beds has been accompanied, as in many OECD countries, by a reduction in hospital discharges and the average length of stay.

Source: Ringard, A. et al. (2013), "Norway Health System Review", *Health System in Transition*, Vol. 15, No. 8, pp. 1-195; OECD (2013, *Health at a Glance 2013 – OECD Indicators*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264183896-en.

Box 1.2. The Coordination Reform

The Coordination Reform, introduced in January 2012, was designed to meet several challenges faced by the Norwegian health care system. Among the most significant are: i) an insufficient care co-ordination across health services; ii) a general lack of incentives regarding disease prevention and health promotion; and iii) an increase of an ageing population having complex health and social needs. Improvement of co-operation and co-ordination between the primary and specialised health services is considered to be the best way to meet these challenges and to reduce hospitalisation. The general intention is to shift care toward primary and community care settings away from the hospital sector, with a greater emphasis on prevention.

The Coordination Reform introduces substantial economic and organisational changes within the health care system. In particular, it relies on economic incentives and it alters the governance structure so as to delegate a greater responsibility to the primary health care sector.

Since the implementation of the Coordination Reform, the allocation system has been changed. At present, local authorities are required to co-finance some somatic specialised health care services and are also financially responsible for patients ready for discharge from hospital. Economic incentives involve a co-financing wherein municipalities are required to pay a 20% of the hospital cost when their residents are admitted to hospital for certain diagnoses. A financial penalty is further charged for local authorities when they fail to provide local care to a patient ready for discharge from general hospital, uselessly prolonging length of hospital stay.

The modification of responsibilities required by the reform compels municipalities and hospitals to enter into binding agreements in order to specify the distribution of duties and responsibilities.

These economic and organisational changes have had an impact in motivating municipalities to set up supplemented primary health care unit; by 2016 all municipalities are required to set up municipal emergency beds (see Chapter 3).

Other key measures are contained in the Coordination Reform. Consistent clinical pathways will be established to achieve better co-ordinated health services. Local authorities are thereby required to assign one person as a care co-ordinator for every patient who needs long-term care from more than one branch of the health services. Electronic information systems are strengthened to share relevant patient information. To this end, the Norwegian Health Network (see Section 1.6) develops and operates information technology infrastructure for the health care sector across health care institutional levels.

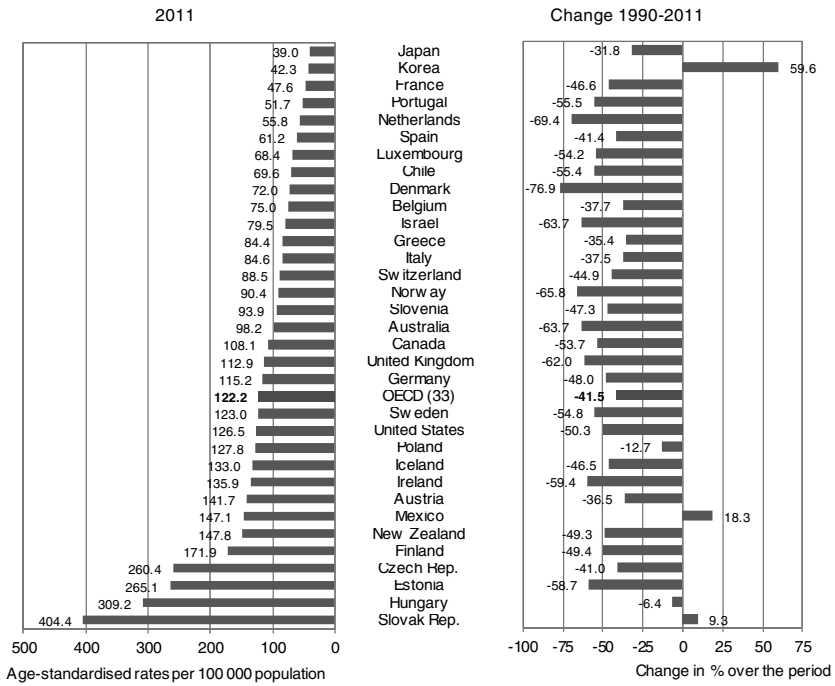
Source: Norwegian Ministry of Health and Care Services (2009), "The Coordination Reform, Proper treatment – At the Right Place and Right Time", *Report No. 47 to the Storting (2008-2009)*.

1.2. Context

Norway performs well on most quality indicators but has high levels of health care spending

Norway's life expectancy at birth of 81.4 years in 2011 is higher than the OECD average of 80.1 years. The Norwegian's life expectancy at birth is also higher than in Denmark (79.9) and Finland (80.6) but is below the Sweden and Iceland average (81.9 and 82.4 respectively). As in Denmark, mortality rates from ischemic heart disease (IHD) in Norway are well below the OECD average. As shown in Figure 1.1 below, IHD mortality rates have declined in nearly all OECD countries but more sharply in Norway. Apart from improvements in medical care, the reduction of mortality rates is explained in large part by the decline in tobacco consumption which has reduced by 47% between 2000 and 2011.

Figure 1.1. Ischemic heart disease mortality, 2011 and change 1990-2011 (or nearest year)

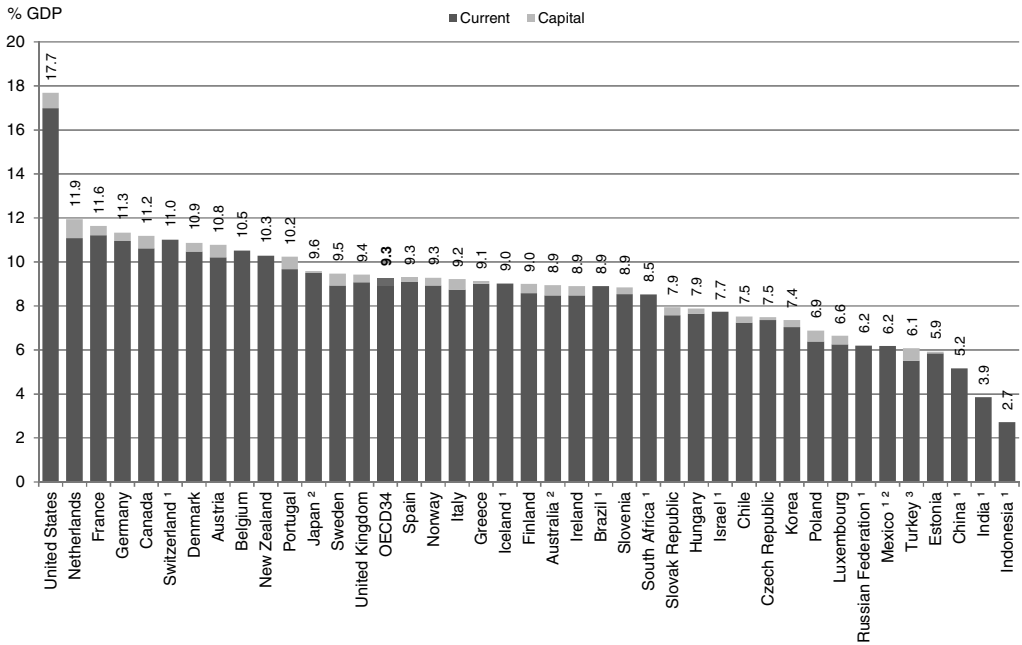


Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Breast cancer five-year relative survival rate is higher in Norway than the OECD average, and breast cancer mortality rates is below the OECD average or the Nordic countries average (OECD, 2013a). Advances in improved treatments, well organised screening programmes as well as provision of evidence-based best practice have contributed to reduce mortality rates and are associated with improved survival rates in Norway.

Norway is the European country that spent the most on health in 2013, with spending of over USD PPP 5 669 per person (OECD, 2013a). It largely exceeds the OECD countries average of USD 3 322 per person. Although Norwegian health spending is more than one-and-a-half times the average of all OECD countries, it experienced a much slower growth in health spending on the period 2000-01 than the other OECD or Nordic countries (OECD, 2013a). In devoting 9.3% of its GDP on health in 2011, Norway is close to the OECD average (Figure 1.2).

Figure 1.2. Health expenditure as a share of GDP, 2011 (or nearest year)



1. Total expenditure only.

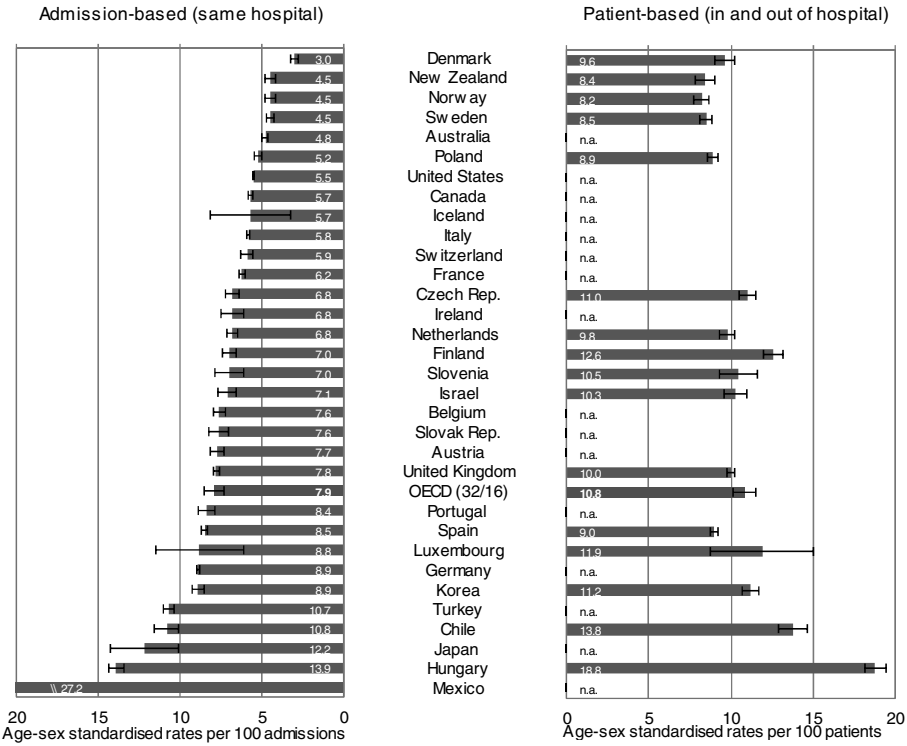
2. Data refers to 2010.

3. Data refers to 2008.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en*;* WHO Global Health Expenditure Database.

Norway's hospital-case mortality rate for acute myocardial infarction (AMI) within 30 days after admission is 4.5%, which is relatively low compared to a 7.9% on average among other OECD countries in 2011 (left-hand-side panel of Figure 1.3). This figure clearly indicates good quality of acute care in Norwegian hospitals, which is also confirmed by the right-hand-side panel of Figure 1.3.

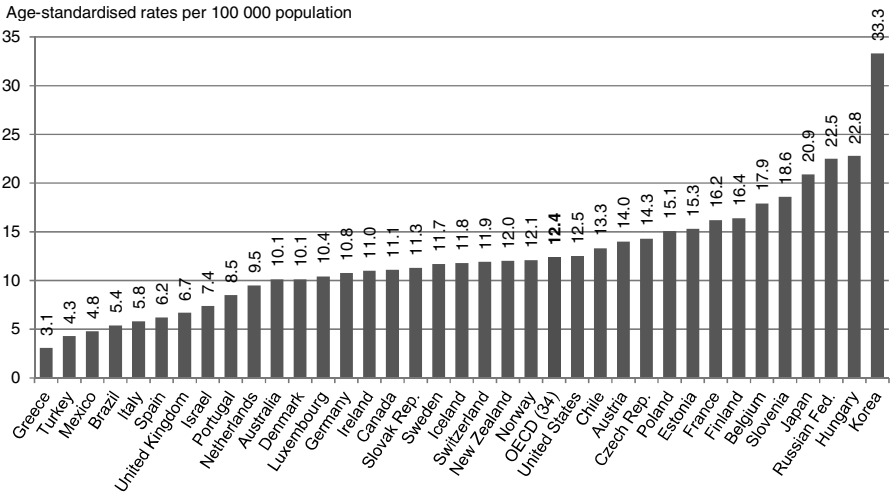
Figure 1.3. Case fatality in adults aged 45 and over within 30 days after admission for AMI, 2011 (or nearest year)



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

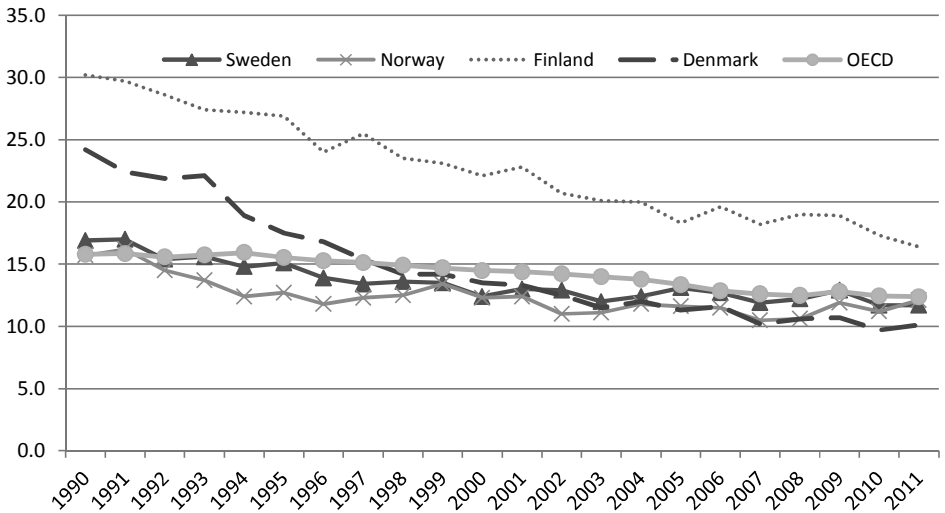
Finally, as shown by Figure 1.4, suicide mortality rates in Norway are close to the OECD average with nearly 12 deaths per 100 000 population. This figure is still high and indicates that mental health challenges remain in Norway. However, some progresses have been made as shown by the fall of suicides rates since 1990 (see Figure 1.5). Spending on mental health, improvements in the numbers of facilities or services as well as an increase in workforce are likely to have contributed to reducing suicide mortality rates.

Figure 1.4. Suicide mortality rates, 2011 (or nearest year)



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Figure 1.5. Trends in suicides rates, selected OECD countries, 1990-2011



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

1.3. Health system design

The Ministry of Health and Care Services is the main actor responsible for health care quality policy in Norway

At the national level, the main actor responsible for health care quality policy is the Ministry of Health and Care Services (*Helse- og omsorgsdepartementet*). On behalf of the government, the ministry is responsible for the national health policy through legislative and funding mechanisms and by setting priorities. Through direct ownership, the ministry is responsible for specialised health care services. Primary health care services are the responsibility of the municipalities. Mental health and medical rehabilitation is run both on primary and secondary health service levels. There is national, regional and local responsibility for public health. Pharmacies are run as part of health trusts and as private enterprises by special legislation. Dental services are partly a county responsibility and a task for private practitioner dentists.

The Ministry of Health and Care Services has direct administrative responsibility for the following subordinate bodies: the Norwegian Directorate of Health, the Norwegian Board of Health Supervision, the Norwegian Institute of Public Health, the Norwegian Medicines Agency, the Norwegian Radiation Protection Authority, the Norwegian Biotechnical Advisory Board, the Norwegian System for Patient Injury Compensation, the Norwegian Registration Authority for Health Personnel and the Norwegian Knowledge Centre for the Health Services (Ringard et al., 2013).

The role of Norwegian Regional Health Authorities

The four Regional Health Authorities (RHAs) were established as part of the Health Authorities and Health Trusts Act of 2001. They are subordinated to the Ministry of Health and Care Services and are therefore under national governmental control. The Ministry of Health and Care Services regulates their budget through national government transfer and clarifies the framework and priorities in an annual governing document where population needs and the demography of the regions are taken into account.

Regional Health Authorities are responsible for providing specialist care services including somatic, psychiatric, laboratory, radiology, ambulatory services and other specialties related for example to addiction. The Regional Health Authority plans, sets up and runs the specialist health services of the region assigned to it. The actual service provision is performed by its subordinate units known as health trust. At present there are 22 health trusts in Norway consisting of one or more hospitals. This system is financed by

national government grants and DRG-based reimbursement. The proportion of the budget raised from DRG reimbursement is decided by the Parliament in the annual budget. In 2013 the rate is 40% DRG reimbursement of the total budget.

Each Regional Health Authority is run by a board of management appointed by the Ministry of Health and Care Services. The board of management of a Regional Health Authority is responsible for the quality of the service it provides. While their strategy on quality enhancement must take into account the local conditions, it might nevertheless follow the requirements of the National Strategy for Quality Improvement in Health and Social Services. Both strategies should be consistent with the Norwegian Health Authority and Health Trust Act, the Specialised Health Services Act and the Patients' Rights Act.

The role of local authorities and the county councils

Local authorities – municipality level

In Norway the local authorities, represented by 428 municipalities, are fully responsible for the provision of all primary health care services. Parliament can only regulate local authorities by law, although financial instruments, technical guidance and various action plans are used to influence the quality of services provided. Primary health care services include GP services, midwifery, pre-hospital emergency help, a first-line mental health service, convalescent care, pre- and post-natal clinics, rehabilitation, school and district nurses, public health and preventive medicine, and health promotion.

As mentioned in Box 1.2., a local authority is required to co-finance a part of the specialised somatic health services and is also financially responsible when municipalities are unable to provide care in the community for patients ready for discharge from hospital.

To organise the provision of primary health care services, local authorities are financed through local taxes it levies, national grants, out-of-pocket payments and additional activity-based national funding from the Norwegian Health Economics Administration (HELFO – *Helseøkonomiforvaltningen*).

In providing primary care, the municipality is required by law (the Health and Care Services Act) to plan, establish and run services in full accordance with the national regulations and standards to assure the high quality of services. To this end, a municipality is required to plan and implement an appropriate strategy to enhance quality of primary care services.

The Ministry of Health and Care Services and the Norwegian Directorate of Health are responsible for the planning of health care professional regarding skill needs. Municipalities have, similar to the health trusts and hospitals, a responsibility to ensure sound professional practice in their services. They are required to ensure that health workforce has adequate and relevant competence and to facilitate clinical practice training programmes for health professionals and students, including for example nurses and nursing assistants. In addition, they have an obligation to organise internship programmes for graduated medical doctors and physiotherapists.

Counties

Norway´s 19 counties are politically and administratively independent and can only be regulated or instructed by law. The county, which represent a geographical area, is governed by a county council elected every four year.

The county council has primarily the responsibility of regional development, including for example the development of transport and the expansion of the labour market by stimulating creativity and innovation. The county council is delivering those welfare services (such as public health initiatives, upper secondary schools and public dental health service), that are too large for an individual municipality to deliver on its own.

The county council role in statutory dental care is regulated by the Act related to dental health services of 1983. Dental health services are directed by the chief dental officer of a county council. This service is required to have certain capacity, so that dental care will be available to people living in areas where private dentists are scarce.

Most dental health service is based on OPP for the majority of the population. Public dental service of a county is free of charge for certain age groups, persons with municipal long-term care services and mentally disabled persons. In some cities, dental service provides a subsidised emergency dental service. A county finances its dental service by taxes it levies and grants from the government. People who are not entitled to free dental care have to pay the price demanded by private dentists, which is not regulated.

In addition to the county council, each county has a national government representative, the County Governor who has a crucial regional role within crises and preparedness, environment, education and health care. As part of this organisation, a County Medical Officer supervises the health and care services in the county, both on primary and specialised levels and within the dental health sector to ensure that they meet the legal and professional standards. Serious cases of patient harm or malpractice will be submitted to the National Board of Health Supervision for further investigation.

Norway has a comprehensive legislative framework to support the quality of care policy

The Norwegian health system is regulated through a large number of acts and legislations that contains a number of quality requirements. The Patients' Rights Act of 1999 (*Pasientrettighetsloven*), the Health Personnel Act of 1999 (*Helsepersonelloven*), the Specialised Health Services Act of 1999 (*Spesialisthelsetjenesteloven*) and the Health and Care Services Act of 2011 (H*else- og omsorgstjenesteloven*) are the most relevant among them.

The Patients' Rights Act, which has been amended several times, is intended to ensure that the population has equal access to high quality of care. Its provisions are designed to promote trust between patients and health services. It upholds respect of patient's life, integrity and human dignity. The Act further guarantees the patient's right to access to necessary health care, to the assessment of the medical need when referred from primary to specialised health care within 30 days, to a second opinion within specialised health care, to choose a hospital, to be involved in the treatment decision, to consent to health care, to access to medical record as well as the right to complain and to achieve assistance from the Health and Social Services Ombudsman.[1]

The scope of the Health Personnel Act is the safety and quality of care provided by the health services. It requires health professionals (29 registered professions) to serve in a manner that guarantees the patient's safety, the quality of health services and to create public confidence in the health system and in health professionals. It also requires that the work of health professionals must fall within their qualifications. When necessary, patients should be referred to the appropriate health professional whose specialty and training requirements are described in the relevant acts and ordinances. The registration authority system of health professionals, requirements for the organisation of health facilities or the patient records are also laid down in this Act.

The Specialised Health Services Act defines the tasks and responsibilities of the hospitals and other specialised services. Health care institutions and services are required to work systematically with quality improvement and patient safety. This also applies to the provision of services at municipality level according to the Health and Care Services Act. To this end, all specialised health care institutions are required to establish local quality and patient safety committees. The Specialised Health Services Act regulates two separate reporting systems following adverse events. All incidents which have caused patient harm, or could potentially have caused serious harm, during health care in the specialised health services should by obligation be reported to the Norwegian Knowledge Centre for the Health

Services. Serious and unexpected incidents that have caused death or serious harm to patients must, in addition, be reported to the Norwegian Board of Health Supervision for supervisory follow up.

The 2011 Health and Care Services Act regulates primary health and care services. It makes the municipalities responsible for the organisation and the provision of all primary health and care services in a co-ordinated manner. The national government has no direct control over the organisation of primary health and care services, but the act specifies that the services must comply with sound professional standards ("forsvarlighet") and it describes, to this end, specific requirements. The national government provides funding, regulations and national clinical guidelines. Patients or services can complain to the County Medical Officer at the County Governor, the regional branch of the Norwegian Board of Health Supervision. The County Medical Officer will investigate health care service and assess whether it has the required standards or whether individual professionals comply with requirements to practice medicine or nursing care.

All health care service providers, such as municipalities or health trusts, are required by the Health and Care Services Act and the Specialised Health Services Act, to establish quality systems. This is specified in the Norwegian regulation for internal quality assurance of health (*Internkontrollforskriften*) which requires that all health professionals have relevant and adequate competence, that services are continuously monitored and that adverse events with potential or actual consequence for patient safety are reported to management. The latter must ensure medical practice according to the standards specified by law.

There are additional acts, such as the Act related to dental health services of 1983 (for the regulation of dental care), the Mental Health Care Act of 1999 (for the regulation of mental care) and the Public Health Act of 2011 (for the promotion of public health and the reduction of social inequalities in health).

Main institutions responsible for quality of care

The Norwegian Board of Health Supervision

The Norwegian Board of Health Supervision (*Statens helsetilsyn*) is the national authority with responsibility for supervision of all health, social and child care services. County Governors, through their County Medical Officers, are, with a few exceptions, the actual supervisory body (under the instruction of the Board of Health Supervision) of all health services and health professionals. Supervision is a regular activity to ensure that services are run in accordance with the professional quality standards required by the

national Acts and Regulations. When health services or health professionals do not comply with the latter, the supervisory authority can impose sanctions to enforce compliance. The Norwegian Board of Health Supervision has approximately 120 staff members at its main office in Oslo and a total of approximately 250 staffs in the 18 County Governors' Offices. All supervision is performed by medical, nursing and legal professionals.

The Board receives complaints about possible deficiencies in the health services from many sources including patients, relatives, employers, the police or the mass media. The County Governors investigate specific complaints (there are approximately 4 000 complaints a year in Norway) and about 10% of cases are referred to the Norwegian Board of Health Supervision when the cases are serious enough to lead to sanctions. The decision of the Norwegian Board of Health Supervision may lead to a warning, practice restriction, or a health professional being stricken-off from the list of authorised practitioners.

Beyond this, the County Governors perform between 300 and 400 health services quality audits each year, of which approximately two thirds are in primary care services. These planned supervisory quality activities are risk-based, some part of a yearly national strategy under the leadership of the Board of Health Supervision and some based on local risk assessment. So far, no clinical service has been suspended or closed in Norway, but some hospitals and service units have been fined for contravention of required practice norms. In addition, the Norwegian Board of Health Supervision receives notifications from all specialised health services regarding unexpected and serious adverse events (see Section 1.6). These notifications are all assessed and given a supervisory follow up, either by the Board itself or by the County Governors. To facilitate learning processes, all reports from supervisory activities are made publicly available.

The Norwegian Board of Health Supervision has recently been evaluated by the European Partnership of Supervisory Organisations (EPSO).[2] Although the latter has recommended that the former take steps to expand its dissemination of information, and to increase its transparency, the peer evaluation concludes that the current procedures makes it possible to maintain high-quality supervision and professional standards.

The Norwegian Directorate of Health

The Norwegian Directorate of Health serves three main functions: an executive, administrative and an advisory function.

In its executive and administrative roles, it is concerned with the implementation of national health policy and with the interpretation of legal statutes and regulations. The Norwegian Directorate of Health is responsible

for the development and the provision of national clinical guidelines. Its other duties involve training and licensing the health workforce, the management of certain international projects, allocating grants to local service projects or research, and the maintenance of the Norwegian Patient Register. Finally, it executes diverse projects to both promote public health and strengthen preventive activities.

In its advisory role, the Norwegian Directorate of Health is consulted by the national and local authorities, Regional Health Enterprises and voluntary organisations. The Ministry of Health seeks its technical help in health policy and strategy development, global health issues, the composition of parliamentary white papers and health law.

Finally, the Norwegian Directorate of Health is required to be well informed on the current national and international developments in health. Areas of its greatest interest include health policy and strategy, financing, information technology and medical developments.

The Norwegian Knowledge Centre for the Health Services

The Norwegian Knowledge Centre for the Health Services ("Nasjonalt kunnskapssenter for helsetjenesten") supports the development of quality in the health services by summarising research, promoting the use of research results, contributing to quality improvement, measuring the quality of health services, and working to improve patient safety. The centre is financed by the government and subordinated under the Norwegian Directorate of Health, but is scientifically and professionally independent. The Knowledge Centre has no authority to develop health policy or responsibility to implement policies.

The Knowledge Centre hosts the secretariat for the National Council for Priority Setting in Health Care as well as the Secretariat for the Patient Safety Programme. The Safety Programme is a five-years prolongation of the national patient safety campaign *In Safe Hands*. Since July 2012, the Knowledge Centre has run the National Reporting and Learning System, which addresses adverse events in health care. The Centre also hosts The Norwegian Electronic Health Library – providing useful information for health professionals, students, and patients. In addition to health technology assessment and health economic evaluations, the Centre supports the introduction of mini HTA in hospitals.

The Norwegian Medicines Agency

The Norwegian Medicines Agency (NOMA – *Statens legemiddelverk*), which was established the 1st January 2001, is responsible for the supervision of pharmaceuticals production, clinical trials and marketing of

pharmaceuticals. The Agency is also in charge of general reimbursement and it provides drug information for prescribers and patient. By approving medicines and monitoring their use, the Norwegian Medicines Agency fulfils important responsibilities to ensure the safety and effectiveness of care.

The Norwegian Medicines Agency has about 250 employees and is organised around seven departments: the Department for Medicinal Product Assessment, the Regulatory Department, the Laboratory Department, the Department for Inspection and Narcotic Drugs Control, the Department of Pharmaco-economics, the Department of Medical Information and the Department of Administrative Affairs.

The Norwegian Council for Quality Improvement and Prioritisation

The National Council for Priority Setting in Health Care was established in 2007 by the Ministry of Health and Care Services to develop a comprehensive national approach for the work on quality and priority setting. The Council has 26 members, representing top leaders of the central health administration, health services, on various levels and patients' organisations.

It plays an advisory role regarding principles and processes for prioritisation, and gives advice in specific cases such as the introduction of new technology or treatment, the development of national official guidelines and the assessment of medical measures.

The Norwegian Association of Local and Regional Authorities

The Norwegian Association of Local and Regional Authorities (KS – *Kommunesektorens organisasjon*) is a national interest association for municipalities, counties and public enterprises. All 428 Norwegian municipalities and 19 counties among others are members of KS.

KS have regular contacts with central authorities to advocate the interest of its members. The government and KS have entered into several agreements. The 2012-15 agreement, for example, aims at promoting quality initiatives in the primary health care services. The agreement puts great emphasis on patient participation, prevention, rehabilitation and the use of new technologies. KS actively communicates with the members, disseminates information and facilitates the exchange of experience.

The regular consultations between the central government and the Norwegian Association of Local and Regional Authorities also focus on financial issues depending on the duties and responsibilities of local authorities. KS plays an important role in the salary negotiations of public

health care professionals. For GPs, for example, KS negotiates with the Norwegian Medical Association the per capita reimbursement (while the capitation rate is negotiated centrally and is the same throughout the country).

Specific national strategies were established from 1995 to achieve better quality of care

The first Norwegian initiative in developing a framework toward quality improvement was launched in 1995 with the "National Strategy for Quality Development in the Health Service 1995-2001" and the plan of action "Evidence and Bridge-Building 1997-2001 for Social Services" (Helsedirektoratet, 2005). The overriding aim of those strategies was to develop a quality improvement culture and a continuous improvement of health services.

These initiatives were co-ordinated and brought forward in the "National Strategy for Quality Improvement in Health and Social Services 2005-2015". The latter was instituted in 2005 in order to promote further quality development work in health and social services. The responsibility for provision of quality rests with service providers and the individual professionals. It underpins the patients' right to receive high-quality services and to ensure that quality improvement initiatives are implemented within each health and social services. In this respect, the Norwegian health policy is patient-centered and a great emphasis is given to the quality of care the system is intended to deliver (Helsedirektoratet, 2005).

Specifically, the aims of the 2005-15 strategy are to make sure that:

- health services are effective, safe and secure
- health servicesinvolve users by incorporating their views in the treatment decision
- health servicesare co-ordinated and integrated
- health services utilise resources appropriately
- health servicesare available and equally distributed.

To this end, five target areas were highlighted: greater user involvement, strengthened role of provider, better leadership and organisation, enhanced role of education, and regular monitoring and evaluation of services.

The on-going strategy toward quality of care is contained in the White Paper (2012-13) entitled "High Quality – Safe Services" (Norwegian Ministry of Health and Care Services, 2012). It provides key

recommendations for developing a comprehensive approach to quality and patient safety issues with more emphasis on patient-centered care, quality improvement and prevention. Several measures were proposed to the parliament including:

- establishing a five-year national patient safety programme
- consider the enlargement of the existing National Reporting and Learning System to include municipal health services
- the setting up of a permanent unit within the Norwegian Board of Health Supervision to follow-up serious adverse events
- the introduction of a national pilot project on pay-for-performance in hospitals
- the development of more quality indicators and the establishment of among others a national health registry for municipal health and care services
- establishing a new national system for the introduction of new health technologies.

1.4. Assuring the quality of inputs to the Norwegian health care system

Professional certification and continuous medical education for health professionals

Health care professionals are licensed and authorised according to the Health Personnel Act (Chapters 9 and 10). There are 29 registered health professions. Under the Act, the Norwegian Registration Authority for Health Personnel (SAK) is responsible for granting health professional authorisation. To be granted, applicants must fulfil different criteria according to the country in which they have obtained their professional qualifications. They must have passed the relevant professional training, included in some cases practical skills during internship, be less than 75 years old, and not be considered as unsuited for the profession. The Norwegian Directorate of Health is responsible for specialty recognition, and is the competent authority for issuing certificates of specialist training for certain groups (at present medical doctors, dentists and opticians). In 2011, this task was taken over from professional bodies such as the Norwegian Medical Association.

Medical education is delivered by four Norwegian public universities (Oslo, Bergen, Trondheim and Tromsø) and it consists of a six-year education programme. Three universities offer studies in dentistry (Oslo,

Bergen, Tromsø). Basic education in dentistry is a five-year programme and dental specialisation lasts between three and five years.

Nursing education is on bachelor level and is given at a number of university colleges. In addition, there are master degrees and PhD programmes in nursing. There are a considerable number of special training programmes in nursing to obtain the status of "special trained nurse" to be started after minimum two years of practice in general nursing (referred to as ABIOK; anaesthesia, children, intensive care, surgery, cancer).

Authorisation, license and certificate of completion of specialist training and other health professionals expire when the holder turns 75 years of age. The professional title may however still be used, and under certain conditions health personnel over 75 years of age may be granted a license or achieve a certificate of completion for specialist training.

The Norwegian Board of Health Supervision assesses individual cases against health professionals based on technical quality of performance and some cases relating to the fitness to practice due to substance abuse, mental illness or criminal activity. In 2011, the Board assessed 366 cases, of which 283 cases lead to reactions, warnings or revocations of license to practice.

Continuous medical education (CME) is not formally compulsory, except as the requirement to always practice according to sound professional standards, which includes the obligation to continuously be updated within their profession and speciality. The law also requires that the health trust or the municipality ensures that their staffs have relevant and updated competence. This system is now under assessment by the national health authorities and there is an ongoing process of revising the Regulation on internal quality assurance.

Recertification is only required for specialist GPs who want to maintain their specialist status (Garattini et al., 2010). To get recertification, specialist GPs must attend every five years, a number of CME courses which can take the form of congresses, reading medical journals or textbooks, own research and systematic self-evaluation of practice. There is financial incentive to enhance CME participation in giving specialist GPs the right to receive higher fees for each consultation than regular GPs (Garattini et al., 2010).

According to Norwegian authorities, 42% of health professionals authorised or licensed in 2013 are trained outside Norway. The majority of the foreign-trained health professionals are Norwegian citizens studying in EEA countries. Approximately 18% are trained outside the Nordic countries, while about 10% are trained outside the EEA area. As evidenced by Kutzsche (2006), the variation in the skill mix among internationally

trained medical doctors might be a key area of concern for quality of care. With this respect, inadequate language (Ref. EF 36/2005 Directive) and communication skills might be identified as potential safety hazards for the Norwegian health care system. Several training activities are already in place to address this issue. By regulation, training programmes and exams are compulsory for health professionals (such as nurses, nursing assistants, pharmacists, medical doctors, dentists) having qualifications from outside EEA countries.

Given the structural feature of the Norwegian health system to rely on foreign-trained human resources in health and the weak formal requirement for continuous medical education, it seems advisable for Norway to strengthen the quality assurance mechanisms related to individual professional performance. Such an approach could be based on continuous performance assessment and on stronger continuous medical education programme, which are key components to assure that health professionals are still fit to practice.

Norway makes efforts to ensure the safety of pharmaceuticals and medical devices

The Norwegian Directorate of Health is the competent authority for medical devices in Norway. Medical devices have to fulfil the requirements given by the European Directives, implemented through Act of 12 January 1995 (No. 6) and Regulation of 15 December 2005 (No. 1690). As competent authority for medical devices, the Norwegian Directorate of Health is responsible for market surveillance of devices and manufacturers on the Norwegian market as well as surveillance of the Norwegian Notified Bodies designated to certify medical devices. This responsibility also includes follow-up of medical devices and vigilance reports.

A new national system for Health Technology Assessment (HTA) is implemented in the specialist health care sector in Norway as a broad collaboration between the Regional Health Authorities, the Norwegian Medicines Agency, the Norwegian Knowledge Centre for the Health Services and the Norwegian Directorate of Health. The main objective is to perform HTA to provide evidence for the introduction of new health technologies including medical devices, medical and surgical procedures and pharmaceuticals. The Norwegian Directorate of Health is responsible for the co-ordinating function in the new system. The implementation of decisions concerning the use of new health technologies is crucial, and national guidelines for prevention and treatment of disease provide important tools in order to support high quality of the health care system.

The Norwegian Board of Health Supervision is responsible for the surveillance of health services in Norway, including the use of medical devices. A proposal for a regulation providing rules on how health care professionals should handle medical devices in a safe way has been developed both by the Norwegian Directorate of Health and the Norwegian Directorate for Civil Protection (DSB) which has a special responsibility for electro-medical devices. The proposal has been adopted and is in the process of implementation since the1st of January 2014.

Similar policies are undertaken by the Norwegian Medicines Agency (NOMA – *Statens legemiddelverk*) for pharmaceuticals. The Agency, which is in charge of marketing authorisation, pharmaco-vigilance and clinical trials, further maintains the Norwegian Electronic Prescription Support System (FEST). Fest is a database with core information on clinical decision and drugs used in Norway. It is universally used by electronic medical record systems in Norway. The system enables to alert prescribers when they prescribe a drug on new developments, when there is a new adverse reaction or in case of drug withdrawal.

Finally, the Regional Drug Information Centers (RELIS) supports independent information for health professions, as well as the "Legemiddelhåndboken" which is a publicly financed handbook of drug treatment and pharmacology distributed to all physicians in Norway.

The quality of health care facilities is assured through the Norwegian regulation for internal quality assurance of health services

The Norwegian regulation for internal quality assurance of health services ("Internkontroll") specifies that quality assurance system must be established in all health care facilities. In particular, the regulation on internal control contains requirements to ensure that health care services are continuously monitored and that adverse events with potential or actual consequence for patient safety are reported to specific management systems. Norwegian hospitals are, for example, required to have an Infection control programme, an infection control committee and to dedicate infection control nurse. Altogether, management systems must ensure that medical practices within health care facilities are run according to the standards specified by law. One should note that some hospitals have chosen to be certified according to ISO 9001 to meet the requirements specified in the regulation.

In addition, Norwegian hospitals are obliged by law to participate in the Norwegian Surveillance System for Healthcare Associated Infection (NOIS). The NOIS system is national and mandatory. It consists of on-going surveillance of surgical site infections after five given surgical

procedures and also relies on two cross-sectional surveys. Both modules are nationally standardised. The surveillance system of surgical site infections is also standardised to European surveillance. At the same time, a national strategy for prevention of infections in the health service and antibiotic resistance (2008-12) has also been developed but the strategy has not been yet fully evaluated.

Beyond this programme, the Norwegian Government has set up a voluntary system of certification for laboratory equipment outside the hospital. The Scandinavian Evaluation of Laboratory Equipment for Primary Health Care (SKUP), which was set up in 1997, assures the quality of laboratory equipment. SKUP constitutes collaboration between the three Scandinavian countries and it includes the Norwegian Center for External Quality Assurance in Primary Health Care (NOKLUS), the External Quality Assurance in Laboratory Medicine in Sweden (EQUALIS) and the laboratory medicine and the primary health care in Denmark. In Norway, NOKLUS aims at producing objective and independent information concerning the quality of laboratory equipment for physician's offices. More specifically, it provides procedures and schemes for the use of internal quality controls, it offers external quality assessment, and also provides advice about the use of control material methods. Its management committee consists of representatives from the Norwegian Government, the Norwegian Association of Local and Regional Authorities and from the Norwegian Medical Association. Participants to NOKLUS initiatives include all Norwegian GP offices, nursing homes and other health institutions. Since 2007, NOKLUS is certified according to NS-EN ISO 9001:2002 and it seeks accreditation according to ISO/IEC 17043:2010. The Norwegian Government actively supports the NOKLUS programme. In 2007, the government initiated a project offering two years free participation to all nursing homes in Norway. This project was a success and at present, most nursing homes have chosen to continue as paying participants.

The existing regulation and programmes are valuable mechanisms to assure high quality of health care facilities. However, it is fair to note that the Norwegian Government has not yet established an accreditation model for hospitals or other health care facilities, while it is internationally considered as a key policy for assuring the quality of care. The experience of other OECD countries could guide national authorities to establish a comprehensive accreditation programme as it exists in the United States, England, Australia, Denmark or France. These countries are relying on increasingly sophisticated forms of accreditation to reassure payers and the users.

1.5. Patient safety policies and reports about medical malpractice

Many legislations and initiatives have been implemented to ensure patient safety in Norway. These activities share similarities with the patient safety policies in Denmark such as the Danish Safer Hospital Programme and the Danish national reporting system for adverse events (OECD, 2013b). It started through the adoption of the Patient's Right Act in 1999 and is further developed and governed through the National Unit for Patient Safety, a key player in the Norwegian patient safety agenda. The continuous and legally required supervision of all health services based on risk assessment and publicly reported is a crucial part of the national system to ensure patient safety.

Norway has a comprehensive patient safety agenda

The Patients' Right Act stipulates that every county must establish a Health and Social Services Ombudsman to respect patient's legal right regarding health care services. The Ombudsman assists users of health services as advisors, mediators and arbitrators. The institution has an obligation to protect patients' interests and needs. It is independent of the health authorities and it provides guidance, advice and information to patients regarding safety within the primary and specialised health care sector.

Beyond the Patients' Right Act, the National Agency for Patient Safety has been established in 2007 under the Norwegian Knowledge Centre for the Health Services in order to promote patient safety in Norway. It has been the secretary for the Norwegian patient safety campaign "In Safe Hands". The three-year campaign from 2011 to the end of 2013 intends to reduce patient harm and to nurture a patient safety culture. The work from the campaign continues in a five-year patient safety programme from 2014. By putting a great emphasise on suicide and strain prevention, the campaign clearly identified mental health as a key area of concern. Other specific avenues for consideration are infection prevention and correct use of medicines in nursing homes and home care services. In order to spread interventions in the primary health care services, the Centres for Development of Institutional and Home Care Services co-operate in each county through two development centres (one for nursing home and another for home care services). Both centres are responsible for organising local collaborative activities with the nursing homes and home care institutions to ensure high quality of health services. Nearly 40% of municipalities were involved in the campaign by the end of 2013.

Overall, three objectives are defined to improve patient safety in Norway. First, preventable patient harm shall decrease by 20% by the end of 2013; the results will be disclosed during the summer of 2014. The long-term goal for the programme will be set thereafter. Second, structures to support improvement must be established in covering, for example, the development of competence and routine for patient safety. Last, the patient safety culture in health and care services should be strengthened. To this end, a survey is conducted to measure the professional working environment and to highlight the routines that prevent adverse events or patient harm. To identify areas for improvement and to ensure the following-up of results, hospitals are strongly encouraged to discuss the results with employees and to establish routines. Health care services are required to measure patient harm and quantify adverse events in using the Global Trigger Tool (GTT), an internationally recognised and standardised method.

Malpractice and adverse events in the specialised health services are addressed to the Norwegian Board of Health Supervision

As part of the Specialised Health Services Act of 1999, all Norwegian specialised health care providers are obliged to report serious unexpected adverse events with death or serious bodily harm to the Norwegian Board of Health Supervision. A specific unit within the Norwegian Board of Health Supervision follows up these events and investigates when deemed necessary. Since 2010, there have been a total of 857 notifications. All have been assessed by the Board of Health Supervision and 43% were referred to County Governors for supervisory follow-up. Of the total number of notifications, 40% merited no additional supervisory investigation, 5% were investigated by the Norwegian Board of Health Supervision, and the remainders were followed up by the responsible units in the service. A National Reporting and Learning System (NRLS) has been set up at the Norwegian Knowledge Centre for the Health Services to provide advice to hospitals in their process of reporting adverse events. The NRLS also carries out national analyses of adverse events to make warning and recommendations. This system results in the dissemination of regular reports and learning briefs.

Although the NRLS is a performing tool to promote and support patient safety in Norway, providers of primary care are currently excluded from the existing system. For primary care services, there are only legal requirements for local authorities to monitor adverse events or incidents, and for County Medical Officer at the County Governors to investigate reports from patients and health care providers.

Overall, Norway has well developed initiatives to improve patient safety but existing initiatives, although covering the primary care sector, mostly target the specialised health care services. One recommendation would be to increase the coverage of the Norwegian patient safety agenda to more primary care services. The current proposal to include municipalities to the National Reporting and Learning System (contained in the White Paper No. 10, 2012-2013) is an excellent initiative to fill the existing gaps.

1.6. Health system monitoring and standardisation of practice

Strengthening the information system with greater focus on performance measurement

A national quality indicator system for the health care sector has been gradually developed and implemented by the Norwegian Directorate of Health. At present, the Norwegian quality indicator system includes specialised and primary health care indicators. Some of these indicators are made publicly available on the following website: www.helsenorge.no. The system allows benchmarking and enables the population to take more informed choices regarding the specialised health care services. Openness about the quality in health care services is a necessary condition for patients to have a true choice about their own health care. At the same time, openness about the results will provide an incentive for health providers to continuously improve the quality and safety for patients. The set of indicators might serve as a tool for policy makers and politicians in their evaluation and prioritising of investments in health. In Norway, existing indicators are under continuous evaluation and revision, and new indicators are discussed and developed in expert groups.

The Norwegian Directorate of Health makes decisions regarding indicators that should be included in the system such as, for example, 30 days survival after coronary infarction, stroke, hip fractures and overall survival after hospital stay. Surveys of patients' experiences performed by the Norwegian Knowledge Centre for the Health Services are also part of the quality indicator system.

Quality indicators for specialised health care services were developed in order to improve the patient basis for decision of where to be treated. In 2003, the "Free Hospital Choice Norway" system (*Fritt sykehusvalg Norge* – www.frittsykehusvalg.no/start/) was launched in order to provide quality information regarding public and private hospitals in Norway. It covers indicators for various medical interventions in specific regions and individual hospitals and gives average waiting time for medical evaluation, outpatient treatment and admission. The central tasks of the information

system are to empower Norwegian citizens, to contribute to a better utilisation of the health system and to give health professionals and leaders an improved base of information. This is likely to contribute to the improvement in quality of care through increased competition among hospitals.

Quality indicators for primary care services are collected from the IPLOS registry. IPLOS is an anonymous registry, containing detailed information about all applicants and recipients of health care services at home or in nursing homes in Norwegian municipalities. It provides a basis for monitoring and planning primary health care and social services. Beyond this, the national KOSTRA system gathers individual data that are reported regularly by local authorities. Information focuses on the use of health resources at local level and for oral and dental health at county level. These data are aggregated to present activities and resources to the different governance levels. Some national indicators for local authorities are also published on the following website: www.bedrekommune.no/bk/hjem/.

At the same time, there are several registries covering different diseases, health outcomes and professional areas. The Norwegian Institute for Public Health run most of the Norwegian registries. The institute is, for instance, responsible for:

- cause of death registry
- medical birth registry of Norway
- Norwegian Surveillance System for Communicable Diseases (MSIS)
- Norwegian prescription database
- food allergy registry.

The Cancer Registry of Norway, which is part of the South-Eastern Regional Health Authority and organised as an independent institution under Oslo University Hospital Trust, also provides important information on specific treatment or disease. The National patient registry is another central registry run by the Norwegian Directorate of Health. Altogether, Norway has 45 national clinical registries covering specific patient groups. One should note that a National Health Registry Project was launched in 2011 by the Ministry of Health and Care Services in order to modernise the existing registries and to secure comprehensive information.

Some other initiatives are in place in Norway to collect data on health care and other social areas. Amongst other are the Statistics Norway (SSB) surveys of living conditions, the Norwegian Prescription Database and the

HUNT study which is a longitudinal population health study in Nord-Trøndelag County in Norway (www.ntnu.edu/hunt).

Altogether, these evidence show that Norway has a large number of information systems and health registries to collect indicators on quality of care. They gather broad measures such as waiting times in specialised health services, avoidable hospitalisations, and survival rates after specific treatment and other health services received at home or in nursing homes. Although all health care services are required by national regulation (through the "Internkontroll") to monitor the quality of care, the current information systems however do not allow health providers and authorities to benchmark quality and performance against peers or national standards (see Chapter 2 for the primary care sector). As a result, it seems advisable for Norway to develop more quality indicators around performance and to extend the information infrastructure to more primary care settings.

Public reporting about health care can be improved

Public reporting in Norway appears weaker than in some other countries such as Denmark which has, for example, established an impressive e-health portal called "*Sundhed.dk*" (OECD, 2013b). However, Norway makes significant inroad in this direction. First, a Norwegian official web-based portal (helsenorge.no) has started a reporting cycle for health professionals and patients. The overarching goal of the portal is to assist the Norwegian population in finding information and to encourage more co-operation between health services providers. The Norwegian portal includes information and documentation regarding the current legislation, specific diseases or treatments (see Box 1.3).

The annual "Samdata Report" (no English summary) is published by the Norwegian Directorate of Health. The report contains steering data, comparative statistics and analyses of the specialised health service in general. It includes both structural and process indicators to illustrate the functioning of health institutions. It provides to health institutions and national health authorities a basis for improvement in governance and planning.

Further, there is an established website where private dentists register their prices for treatment (www.hvakostertannlegen.no), which provides guidance for patients around price level in dental care.

Box 1.3. The Norwegian official portal "helsenorge"

Helsenorge.no, the Norwegian official portal, is the e-health portal for the Norwegian health care services. It is a web-based portal containing information on health, illness, treatment, health services, prevention, screening programme and legal rights. Helsenorge's goal is to assist people in taking better care of their own health while encouraging more active co-operation between health services. Helsenorge.no is primarily geared toward the general population, but over time it will introduce services and content for health care professionals.* Information found on the helsenorge.no portal comes from various organisations within the health sector. Each organisation that delivers information to the portal is responsible for the content being up-to-date, knowledge-based and of high quality. At present, only quality indicators around hospital services are being published on the portal, covering areas such as cancer treatment, delivery and psychiatric care.

A secure online service is offered on the portal. Patients have access to their prescriptions, can ask for prescription renewals and obtain online consultation with GPs or other health professionals. Several other e-services are available including booking an appointment, having information on reimbursement status, locating health care providers and getting feedback to the health care services.

* For health professionals, the Electronic Health Library (www.helsedirektoratet.no) provides free access to guidelines, systematic reviews, scientific journals and other evidence based information.

Source: http://helsenorge.no/Sider/default.aspx.

Exchange of patient information is facilitated by the Norwegian Health Network

The Norwegian Health Network[3] (*Norsk Helsenett*) was established by the Ministry of Health in 2004 and is, since 2009, a ministerial-owned company. The Norwegian Health Network is a health communication network to provide electronic exchange of patient information between all relevant health and social services.

It includes information regarding patient trajectory and patient medical needs, so as health professionals access to the most comprehensive and updated information. The Norwegian Health Network has been put in place to guarantee that care delivered to patient is of consistent and adequate quality. At the same time, it enables to improve co-operation within and across health sector and is an important policy instrument to achieve efficient use of health resources.

At present, all specialised health services and pharmacies use the Norwegian Health Network, along with 99% of municipalities and more than 500 dental health units.

Large efforts have been made to produce national guidelines and develop health technology assessment

The Norwegian Directorate of Health started to produce national clinical guidelines following the two main public reports [Lonning I (1987) and Lonning II (1997)] which introduced core principles for priority setting in health care services in the 1980s (Morland et al., 2010). At first, the guidelines did not take into account the cost-effectiveness evaluations. From1997, the priority criteria have been the severity of the condition, the expected outcome of the health intervention and the cost-effectiveness of the intervention. At national level, the Norwegian Directorate of Health is the only responsible body devoted to develop and disseminate national clinical guidelines. Professionals are invited to take part in the developments of such guidelines. Local authorities and Regional Health Authorities facilitate the implementation of national clinical guidelines, and ensure their effective use. At present, there are approximately 400 national clinical guidelines for health care providers that are distributed in paper version or available on Internet through the Electronic Health Library (Ringard et al., 2013).

In line with this strategy, Norway started from 1998 to set up a system to develop Health Technology Assessment (HTA) as a tool to avoid unintended variations in clinical practice and to optimise the use of health resources (Morland et al., 2010).

At present, HTA are performed by the Norwegian Knowledge Centre for the Health Services. It gathers and disseminates evidence about the effect and quality of health intervention through systematic reviews, health economic evaluations, assessments and other quality measurements.

The new national system for the introduction of new health technologies is in the process of implementation in the specialised health care service (see Section 1.5). The new system aims at promoting safer patient treatment in using systematic assessment of health technologies to investigate the effects, safety and consequences of a service. HTA will be used as a tool for supporting priorities setting and decisions regarding new technologies to ensure that they are safe and effective. It will consist of rapid HTA reports carried out at the level of local hospitals. This will make possible to use rapidly new and effective hospitals treatments and to quickly remove inefficient or dangerous treatments. The new system will also consist of national HTA reports conducted by the Norwegian Knowledge Centre for the Health Services and the Norwegian Medicines Agency. Transparent processes and a good co-ordination between the specialised health care services and the health authorities will be key components for the success of the system.

1.7. Policies to drive improvement in the quality of care

Strengthening the role and perspective of the patient

In Norway, several mechanisms are being developed to ensure and strengthen the position of the patient in the health system.

The Patients' Rights Act gives patients the right to complain to the County Governor if they are not satisfied with the delivered health care services. The County Governor will investigate and decide, or refer to the Norwegian Board of Health.

Beyond the Patients' Rights Act that ensures to all citizens an equal access to good quality of care, the Norwegian Free Hospital Choice (*Fritt sykehusvalg Norge*) promotes the patients' rights to choose where to receive treatment. It provides hospitals information to empower Norwegian citizens. It gives patients the opportunity to make better-informed decision and to better use health care resources. The Helsenorge.no official portal (presented in Box 1.3) also gathers information for patients, covering areas such as prevention, health, wellness, illness and treatment.

Another key initiative to strengthen the role of the patient consists of conducting surveys on patient experiences. The Norwegian Knowledge Centre for the Health Services has undertaken several surveys on patient experience regarding inpatient and outpatient health care services (Kunnskapssenteret, 2008), giving valuable information and feedbacks to stakeholders that can be used to direct improvements in care. Reports presenting survey results are produced for the national health authorities, the Regional Health Authorities, health trusts and hospitals and are also made publicly available to the population.

As part of the 2011 Health and Care Services Act, municipalities are required to organise a system to collect information about patient experiences. Municipalities are now obliged to take into account patient opinions when planning and organising the provision of primary health and care services.

Several non-governmental organisations (NGOs) are in place in Norway to strengthen the position of the patient within the health care system. The Mental Health Association, the Norwegian Diabetes Association and the Norwegian Federation of Organisations for Disabled People are, for example, central bodies for disabled people in Norway (see Box 1.4). They aim at giving patients the best possible conditions in the health care system and they push national authorities to improve quality of care. The patient organisations focus on influencing policies through national and local stakeholders. With this respect, the Mental Health Association has provided

support, networks and services to local communities, which have proved to be highly beneficial for patients. Efforts should be made to support these organisations in carrying out such activities.

Box 1.4. Examples of Norwegian patient associations

The Mental Health Association

The Mental Health Association (*Mental helse*) comprises 9 000 members across 260 local associations and 19 county associations that receive national grants. The user organisation focuses on reducing stigma, improving mental health services and enhancing support for patients with mental health issues. It works as a political organisation and is considered as the users' voice for mental health issue.

To improve health condition of patient with mental health problem, the organisation is working on services that enhance prevention and that provide treatment or rehabilitation. It focuses also on information campaign and puts great emphasis on patient involvement in mental health services. At the same time, the Mental Health Association has developed local support groups and a 24/7 helpline. The 24/7 helpline receives nearly 70 000 phone calls every year. It mostly deals with suicide and workplace problem from both employers and employees.

The association is very proactive in being responsible for many initiatives and events. It is, for example, responsible for the World Mental Health Day which is an international event to provide information and achieve openness about mental health. Smaller events in local authorities are also carried out in school for improving knowledge and sharing experiences with teacher, parent and young. A summer camp, as well as a youth organisation with 14 local divisions is organised under the Mental Health Association for those aged under 30 years old.

Although the Mental Health Association is well financed and advanced on user involvement, it suffers however from a weak co-operation between primary and specialised health services. Mental health was left out of the co-payment mechanisms of the Coordination Reform (see Chapter 4). As a result, local authorities do not have the same financial incentives to limit mental health-related extended hospitalisations, or to provide fully appropriate follow on community care, as they do for other areas of health care.

The Norwegian Diabetes Association

The Diabetes Association (*Diabetesforbundet*) in Norway comprises 40 000 registered members (of whom 3 500 health care providers) and has 150 offices across Norway. The voluntary and independent organisation was created in 1948 and is at present member of the International Diabetes Federation.

The overriding goal of the association is to improve quality of life for diabetic people in stimulating medical research and in disseminating learning and information programme. It works in close co-operation with health care providers and public authorities to improve care in primary and specialised health services.

The association plays a significant role in Norway because of a weak national strategy to guarantee and monitor the quality of diabetes care. At present, it is far from easy to provide a

full picture of diabetes in Norway due to a lack of registry. At the same time, national prevention programme to prevent diabetes are not implemented in Norway and there are too few national guidelines to encourage good practice. Overall, these shortcomings have led to an inappropriate quality level of diabetes care in the primary health care sector. Secondary complications from diabetes (such as amputation rates) are found to be important in Norway compared to other OECD countries. The existing guidelines are currently under revision, and will be digitalised to enhance distribution and use. At present, only 60% of GP use and rely on the existing guidelines.

To fill the existing national gaps, the Diabetes Association publishes patient guidelines covering areas such as the treatment to request or education programme to manage diabetes. It also organises conferences or develop treatment guidelines for health professional.

The Norwegian Federation of Organisations for Disabled People

The Norwegian Federation of Organisations for Disabled People (*Funksjonshemmedes fellesorganisasjon*) was set up in 1950 to ensure right of disabled people. It comprised 71 organisations across Norway and it officially constitutes the largest umbrella organisation for disabled people.

The main goal of the federation is to influence policy decisions through documentation, information and visibility. The organisation disseminates information to its member but also to county or municipality, it organises seminars and meetings for health professionals and finally, it is involved in problems or injustices experienced by disabled people. At present, the association is more specifically involved with the development of guidelines; it works on privacy issues related to national registry and is also included in the patient safety campaign. Through these activities, the federation is a recognised consultation body for many public agencies and authorities.

Note : Information on patient Association also comes from interviews undertaken by the OECD.

Source: www.mentalhelse.no/om-oss; www.diabetes.no/; www.ffo.no/no/.

Contracting and paying for quality

The recent Coordination Reform in Norway has introduced economic incentives for municipalities to place more emphasis on rehabilitation interventions and on prevention. Local authorities have an obligation from 2016 to set up municipal emergency beds. Local authorities also have since 2012 a financial stake in the co-funding of somatic hospital services to their population (Norwegian Ministry of Health and Care Services, 2009). These financial mechanisms will drive more efforts to reduce avoidable hospitalisations through prevention and rehabilitation, and might also have a positive impact on the quality of care. These incentive mechanisms represent a first step towards improving the quality of care through contractual agreements between different governance levels.

At present however, quality indicators and performance play a limited role in contractual contracts between the national and local levels. With this

respect, there is a potential to strengthen governance by including quality and performance indicators to discuss annual contractual agreements. These performance criteria could be linked to specific payment mechanisms or budgets but the main thing seems to make quality of care an integrated part of the local, county and national governance arrangements.

Health service-based initiatives on pay-for-performance should be aligned with local, county and national system goals. Examples of initiatives to introduce pay-for-performance approaches can be found in others Scandinavian countries. In Sweden for example, a pay-for-performance agreement was set up to promote patient safety in specialised health care service. A set of indicators was defined (such as pressure ulcer prevalence or compliance to basic hygiene routines) and when hospitals met the defined targets, additional funds from the national government were allocated to the region. In Denmark, financial engagement has been set up in primary care to drive improvements in integrated care and to encourage the co-ordinating role of the GP. GPs are offered financial incentives when they participate in a chronic care model for diabetes.

The national pilot scheme with quality-based funding that is going to be introduced in 2014 in the specialised health care services would certainly facilitate the process of improving the quality and the efficiency of the health care services in Norway. Approximately NOK 0.5 million is allocated to the four Regional Health Authorities depending on the results of the 29 defined indicators.

1.8. Conclusions

Norway has an impressive health care system that performs well on most quality indicators. Nevertheless, the system is challenged by the same factors as other OECD countries such as the need to align its policies with the needs of an ageing multi-morbid population that forces system re-design through decisions to strengthen primary care. The present health care system though comes at a price and like other countries; Norway is required to assess the overall efficiency, the appropriateness and timeliness of the many services it provides.

The three administrative levels governance model has great potential to marry patient-based health service performance with population-based health system performance on local, county and national level. In essence reforms in Norway try to shift care away from hospital to primary care settings. The goals of strengthening care in primary care setting are threefold: achieving more effective, safe and patient-centered health care services, improving population health status and reducing hospitals expenditure. Achieving these objectives asks for a coherent governance

approach that is fuelled by good performance information systems. Norway is one of the countries capable to tackle these challenges if it masters to optimise its information infrastructure. Specific attention should be given to performance measurement for local, county and national health care system governance and with information made publicly available.

At the same time, quality assurance mechanisms in Norway are extensive and through legal requirement, they secure high quality of health care services. Quality policies traditionally focus on nurturing a culture of quality improvement, but it should be complemented by additional assurance mechanisms. There are some key opportunities to be made to increase the quality of health care in Norway. First, national authorities might extend the formal requirement toward continuous medical education to all medical doctors and they also might want to set-up a comprehensive accreditation programme as it is done in the Unites States, England, Australia, Denmark or France. Given the current trend to shift care toward primary care settings away from the hospital sector, it seems critical to broaden the safety policy agenda in covering more significantly the primary health care sector. Finally, increasing incentive structures through quality contracting and targeted reimbursement would further enhance performance of health providers in the years to come.

Notes

1. See for more details: www.pasientombudet.no/informasjon/english.
2. See for more details: www.helsetilsynet.no/upload/om_helsetilsynet/EPSO_report_engl2012.pdf.
3. See for more details : www.nhn.no/english-1.

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Chapter 2

Primary care physicians in Norway

Norway benefits from a strategic vision of how primary care and health care more broadly should develop over the short to medium term, as set out in the Coordination Reform. It also benefits from having several engaged and competent institutions that are ambitious to improve primary care quality. The few broad quality measures that exist suggest that Norway has a high performing primary care sector. In the absence of much central guidance, monitoring or accountability, this is in no small measure due to high levels of trust between those paying for and those delivering primary care and a reform process founded on consensus rather than confrontation.

The chapter opens with a description of how primary care is organised in Norway, followed by a discussion of key quality initiatives in the sector. It presents some indicators of the quality of Norwegian primary care alongside international benchmarks, describes the challenges facing the sector and closes by discussing recommendations for how primary care can be strengthened and its contribution to continuous quality improvement secured.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

2.1. Introduction

Primary care is an important central element of Norwegian health care and in many respects delivers excellent, high-quality care. At the same time, the Norwegian sector is facing same pressures of increasing long-term conditions and multi-morbidity, shifting patterns of hospital activity with an emphasis on shorter stays, and increasing public expectations of patient-centered care, as seen in many other countries. Norway's Coordination Reform has set out a clear and ambitious vision for pivoting the provision of health care decisively toward primary and community health care sectors.

The information and payments structures that one would expect to underpin continuous quality improvement, however, do not exist in the primary care sector. As a result, there is a risk that Norwegian GPs have relatively few external incentives to deliver the objectives of the Coordination Reform, or to deliver better quality primary care more broadly, compared to primary care systems elsewhere. Whilst hard incentives have been placed around municipalities to encourage them to operationalise the Coordination Reform, GPs are disconnected from these mechanisms.

How can the primary care physicians best be supported to deliver the reform's aims around proactive, integrated and community-focused care? This chapter argues that Norway should consider developing a richer information system that captures activity and outcomes in primary care, design smarter payment systems that reward quality as well as activity and develop mechanisms to bring GPs in more closely to the design and implementation of new models of care at the municipality level.

The chapter opens with a description of how primary care is organised in Norway, followed by a discussion of key quality initiatives in the sector (Section 2.3). Section 2.4 presents some indicators of the quality of Norwegian primary care alongside international benchmarks. Section 2.5 describes the challenges facing the sector. Section 2.6 closes by discussing recommendations for how primary care can be strengthened and its contribution to continuous quality improvement secured.

2.2. The provision of primary care in Norway

Primary care is a central and positively rated element of Norwegian health care

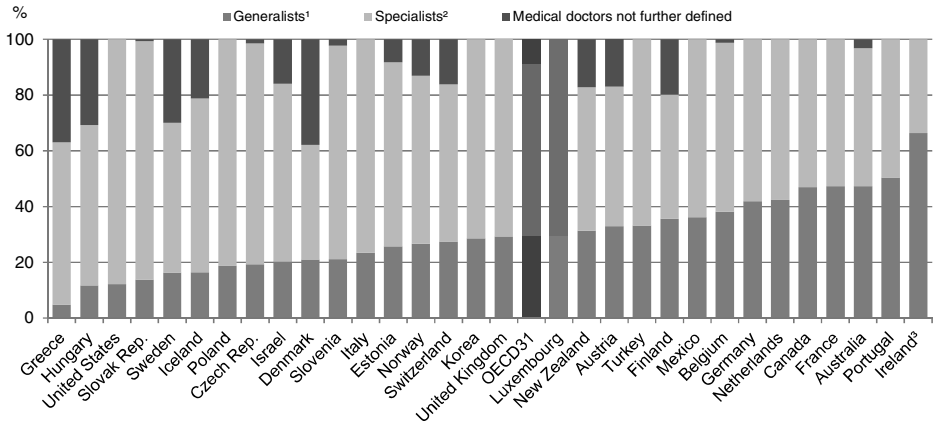
As in other Scandinavian countries, Norway's GPs are a central figure in the health care system. There are around 4 700 GPs in Norway; generalist doctors[1] comprise a slightly smaller part of the medical workforce in Norway (27%) compared to other OECD countries, as shown in Figure 2.1.

List sizes for GPs, however, are small – on average 1 160 patients per GP (the maximum allowed is 2 500). Access to GPs is reportedly good, with an average consultation rate of 4 625 consultations per 1 000 inhabitants per year (Deraas et al., 2013).

Significant diversity exists in how local primary care services are organised and delivered across the country, perhaps unsurprisingly given its geographic diversity. The number of single-handed GPs is declining, and now stands at around 10-15% of all practices. A more common model is for two or more GPs to provide care in a partnership. Nurses and other staff such as psychologists may form part of the extended primary care team. Practices offer a traditional set of primary care services focused on maternal and child health, management of long-term conditions and assessment of new health needs.

Box 2.1 describes some primary care innovations undertaken by Oslo municipality over recent years.

Figure 2.1. Generalists and specialists as a share of all doctors, 2011 (or nearest year)



1. Generalists include general practitioners/family doctors and other generalist (non-specialist) medical practitioners.

2. Specialists include paediatricians, obstetricians/gynaecologists, psychiatrists, medical, surgical and other specialists.

3. In Ireland, most generalists are not GPs ("family doctors"), but rather non-specialist doctors working in hospitals or other settings.

Source: *OECD Health Statistics 2013,* http://dx.doi.org/10.1787/health-data-en.

Box 2.1. Primary care innovation in Oslo

Oslo is the largest municipality in Norway with over 620 000 residents. Although it differs in important ways to the majority of other municipalities in Norway, Oslo's policy response to the challenge of meeting evolving primary care needs is informative. Several initiatives are underway, some pre-dating the Coordination Reform:

- In response to quicker discharges from the hospital sector, Oslo gave its districts NOK 100 million in anticipation of increased pressure. Most used this to provide more home care and employ one or two officers to go into hospitals and meet patients during their treatment phase to plan their discharge.
- Oslo also has a GP-run, 32-bed, urgent care unit with the aim of avoiding admission for patients with known diagnosis. This has existed for many years, although there are new plans to expand to 73 beds. The aim of the unit is to reduce admissions, but patients can stay for a few days.
- The urgent care unit runs in parallel to a primary care emergency services (PCES) that runs a Clinical Decision Unit (CDU). Here, patients can stay up to 24 hours before decision to admit or to send home must be taken. Around 20% are admitted; Oslo municipality estimates that this figure would be around 80% without the CDU.
- Oslo's emergency primary care unit has social services embedded; they offer emergency social services such as arranging accommodation for homeless individuals or counseling for victims of assault. Around 23 000 contacts per year are made, signaling a huge demand (although some are telephone contacts, and the figure includes extended courses of counseling).
- Oslo also has an innovative unit where elderly can self-refer for nursing care. Patients often self-refer for social care and occasionally for clinical care as well (for example when they have flu-like symptoms). The unit is nurse run and patients can be referred onward for specialist clinical care if needed. Has proved popular and anecdotal evidence states that patients who have been once are reassured by its presence and tend not to overuse.

All medical undergraduates undergo a fixed period of training in primary care, of three to six months. After graduating and being licensed, junior doctors have a compulsory internship of six months in general practice and one year in hospital. Of the established GP workforce, around 60% have undergone further specialist training in general practice. There is no difference in the services offered, or employment conditions, of those who have or have not undertaken specialist training in general practice. There are no plans to make specialist training compulsory for GPs.

Of note, the proportion of Norwegian GPs with specialist training has decreased by around 1% a year over recent years. It appears that GP in

Norway is a less attractive option than hospital practice for many medical graduates, to whom the social and professional network offered by hospital medicine is of particular value. Around 25% of Norwegian GPs are qualified abroad, most often in neighbouring and Scandinavian countries.

Nearly all Norwegian GPs are independent contractors. Notional terms and conditions are drawn-up on a national basis. Individual contracts, however, are signed with one of the 428 municipalities and include a standard clause requiring all GPs to devote up to 7.5 hours/week to municipality activities, such as school health and nursing homes. In theory, the municipality has a mechanism to adjust an individual GP's contract according to local needs; very few do so, however. A small number of GPs (around 6%) are salaried employees of the municipality, and this number is decreasing.

The wider primary care system comprises nurses, public health nurses, youth clinics and school health services

Beyond GPs, nurses form an important part of the primary care workforce. Nurses in Norway are graduates, with a bachelor degree. Further special training programmes are available in 20 to 30 thematic areas, some of which are supported by master degree programmes at university colleges or university level. There is some geographic inconsistency, however, in the extent to which nurses are required to self-fund special training programmes and the extent to which specialist qualifications are recognised or rewarded by employers. The Norwegian Nurses Association (founded in 1912 and one of the largest trade unions in Norway) is working to standardise both these points. The association is also working to develop a programme of continuous professional development (CPD) for nurses and, possibly, a five-yearly recertification scheme, similar to that for GPs as discussed further below.

Recent educational reforms have underlined the importance of extended practical experience in local health and social care services. This applies to the education and training of upper secondary school students, students of higher education and professionals engaged in on-going career development. In particular, the Ministry of Higher Education's recent report to the Parliament on welfare educational programmes (*velferdsutdanningene)* emphasizes that interaction between education, research and the labour market needs, between levels of education and between different professions should be continuous throughout health and social care training, and would be a key to improving the quality of services.

A network of clinics covering antenatal health, children's and youth health (up to 20 years) covers the country, focused on preventive health

care. Such clinics are run by public health nurses, with a primary care physician at hand for consultation when needed. Midwives, physiotherapists, psychologists and other health care professionals may also be engaged at these clinics. The services provided include assessment, follow-up, referral, vaccination, counselling, home visit and co-operation with other social services for more comprehensive services.

School health services, for school children and youth under 20 years of age, provide vaccination, health promotion, sexual health and social and psychological support in the school environment. In addition, youth clinics provide integrated individual prevention services, covering physical and mental health assessment and advice, nutrition, physical fitness, sexual and reproductive health, contraception, problems of adolescence, family problems, and rehabilitation of the disabled and chronically ill. The clinics for school children are usually located at schools, while the youth clinics are strategically located elsewhere in the municipality, with flexible hours of consultation.

A recent innovation has been the development of *Frisklivssentralene*, or Health Living Centres, in around 150 municipalities. These support people to quit smoking, exercise more, deal with depression or meet other similar needs through a range of clinical and social activities, including structured follow-up and specialist referral as needed. GPs refer to and collaborate with these centres.

All citizens are registered with a named GP who takes responsibility for ensuring that their health care needs are met

The regular GP reform (*Fastlegeforskriften*) of the early 2000s required, for the first time, all citizens to register with a named GP. This GP would be primarily responsible for providing or co-ordinating each individual's prevention, investigation and treatment of health care needs, including decisions on the need for referral for secondary care. Responsibility for appropriate liaison with social security and social services was also specified. The maximum number of patients a GP could have on his or her list was set at 1 500 (reduced pro rata for those working less than full time). The reform also specified that GPs should maintain a balanced portfolio of work and engage in public health activities, emergency care, out-of-hours care and the supervision of students and doctors in training.

Prior to this reform, Norwegian citizens were able to consult one (or several) GPs without restriction. Discussions from the mid-1980s onward, however, increasingly centered on the possibility that lack of a one-to-one arrangement might encourage over-activity and jeopardise the co-ordination of care, especially for those with complex needs or those less able

to state their needs. The reform was intended to improve the quality of care by strengthening the relationship between and patient and their GP, bringing new rights and opportunities to both parties.

Piloting of a named-GP system was undertaken in four municipalities in 1993, prior to national implementation. Despite anticipated difficulties in implementing *Fastlegeforskriften* across the diversity of Norway's geographical and social settings, national implementation was a success. Close to 100% Norwegians are now registered with a GP, signaling the popularity of the reform. In a recent survey of public attitudes to state funded services, GPs were the second most popular institution after public libraries (DIFI, 2013). The reform also served to strengthen links between municipal authorities and local doctors, since municipalities were required to sign contracts with a sufficient number of local GPs to meet their populations' needs.

The GP payment system is a mix of capitation, service fees and patient co-payments – quality and outcomes, however, do not feature prominently

In Norway, GPs income comes from three roughly equally sources: a capitation fee (which is not adjusted for local socio-demographic factors), fee-for-service (FFS) payments and a patient co-payment of NOK 140 (EUR 16.8, USD 23.0; higher if specialist services are also used), with an annual ceiling for those making frequent use of health services. Although somewhat unusual, Norway's flat capitation rate is recognised as having been a social choice, made in order to avoid stigmatising certain needy groups.

In contrast, the FFS element is quite sophisticated and it is here that the provision of different levels of care for different levels of need (i.e. an equity rather than equality principle) is enabled. Some 200-odd items of service are included in the FFS schedule, and items are renegotiated annually. It could be argued that some rudimentary quality elements are incentivised through the FFS schedule. More is paid for spending 20 minutes with more complex patients, for example, or for establishing peer-support and self-management education for patients with chronic diseases. Relatively few preventive activities, however, are included – although there are items for annual diabetic checks and for giving individual, structured diet and exercise counselling to patients with hypertension, diabetes or obesity. Beyond these items, the nationally specified contract does not contain any detailed payments or incentives linked to clinical outcomes or other quality measures. More importantly,

there is no monitoring, benchmarking or feedback to GPs, even for the limited set of quality-related process measures outlined above.

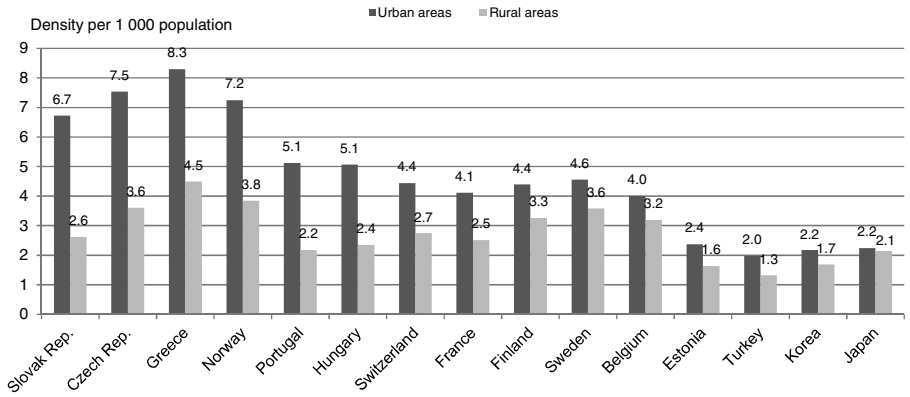
Despite being independent contractors, and the theoretical possibility of specialists in Family Medicine charging more for their services, there is no price competition amongst Norwegian GPs. There is also the theoretical possibility of competition based on quality. Again, however, this hardly applies in practice. The lack of any real competition between GPs is driven by two factors. First, the supply of primary care services is regulated and in many areas the low number of GPs in a geographically accessible area effectively eliminates choice. More importantly however, patients have virtually no quality-related information on which to base a choice. Very little is published officially (apart from basic descriptive facts such as opening hours, physical access or whether the practice is a group practice). Of interest, a source emerged recently from the private sector – www.legesliste.no, similar to the "rate your doctor" websites seen in the United States and United Kingdom. These sites provide a platform for patients to rate, and post comments about, their experience with local doctors. The popularity of the Norwegian version (passing a million visits within a year of its operation) perhaps indicates the level of interest in having more quality related information about local primary care services.

Rural Norway has fewer doctors than urban centres but figures compare well internationally

The uneven distribution of physicians is an important concern in most OECD countries, especially in countries such as Norway with remote and sparsely populated areas. Doctors may be reluctant to practice in remote regions because of concerns working hours, opportunities for career development and isolation from peers, as well as concerns about social, professional and educational opportunities for their families.

There is a perception in Norway that rural and remote areas are underserved compared to urban centres. The density of doctors (all doctors, not just GPs) is indeed significantly higher in predominantly urban areas of the country, at 7.2 doctors per 1 000 population compared to 3.8 per 1 000 population in predominantly rural areas. This is a pattern seen across all OECD countries, which reflects the concentration of specialised services such as surgery and physicians' preferences to practice in urban settings for the reasons set out above. Even though the urban/rural gap in Norway is large by international standard (see Figure 2.2), rural areas still have a greater density of doctors than seen in other Scandinavian countries. Indeed, the density of rural doctors is higher in Norway that for any other country for which data is available, with the exception of Greece.

Figure 2.2. Physician density in predominantly rural and urban regions, 2011 (or nearest year)



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

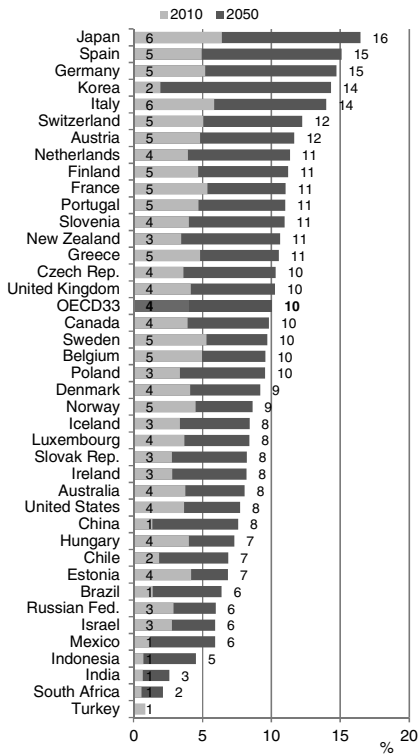
Norway plays an important role in contributing to international knowledge around the provision of health care in remote areas. One example of this is the Norwegian Centre for Telemedicine based in Tromsø in the far north of the country, which has been a WHO Collaborating Centre for Telemedicine since 2002. The centre aims to research and promote the safe and effective integration of telemedicine services into health care more broadly. Tromsø is also home to the National Centre of Rural Medicine (NCRM). NCRM aims to promote education, research and networking amongst physicians and health personnel in rural and remote areas, to contribute to quality improvement and the recruitment and retention of health professionals in rural areas. The University of Bergen also hosts a National Centre for Emergency Primary Health Care. Its focus is on developing the quality of emergency and out-of-hours primary care, by undertaking research and training, setting out standards and maintaining registers that monitor the activity of the out-of-hours services in Norway.

There is, additionally, a pro-poor gradient in GP use: Hansen et al. (2012), using data from the cross-sectional Tromsø Study of 2007-08, found that lower income groups were significantly more likely to visit a GP – a pattern that contrasted with use of specialist services.

Socio-demographic shifts as well as recent reforms are increasing the prominence of primary care

Norway faces a set of socio-demographic challenges which will place increased pressure on primary care sector, in particular in relation to the provision of continuous and well co-ordinated care for patients with long-term conditions. First, the proportion of the population aged over 80 years is projected to rise to 9% by 2050, in line with the OECD average (Figure 2.3). Although the majority of these elderly individuals are fit and independent, many will have one or more chronic health conditions, such as diabetes, heart disease or cancer. The Nord-Trøndelag health study (www.ntnu.edu/hunt) found that 90% of people aged over 80 were affected by at least one significant health condition. Hence, increased pressure on the primary care system, particularly to ensure good secondary prevention and avoid unnecessary hospitalisation, must be anticipated.

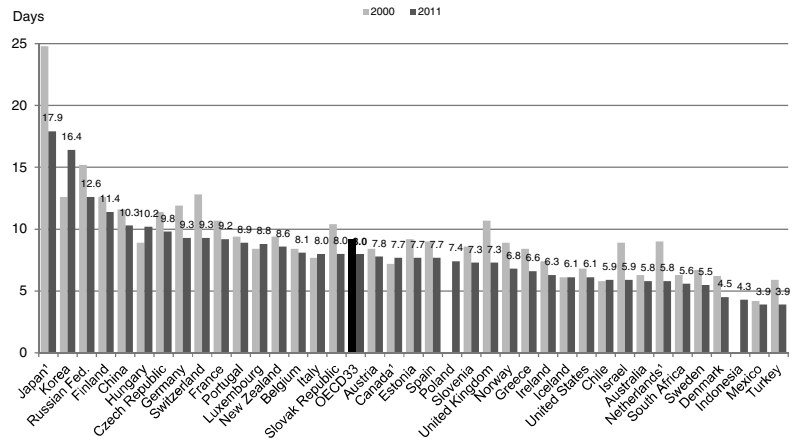
Figure 2.3. Share of the population aged over 80 years, 2010 and 2050



Source: OECD Historical Population Data and Projections Database, 2013.

Parallel to this demographic trend, there have been shifts in the way health care is provided. Average length of stay in hospitals (ALOS) has dropped from 8.9 days to 6.8 days over the past decade in Norway, in line with a trend seen across OECD countries (Figure 2.4). Indeed, for some conditions, Norway has some of the shortest hospital stays observed in the OECD. ALOS after a heart attack, for example, is 4.0 days in Norway, compared to an OECD average of 6.9 days. Only Denmark has a shorter stay, at 3.9 days on average for this condition.

Figure 2.4. Average length of stay in hospital, 2000 and 2011 (or nearest year)



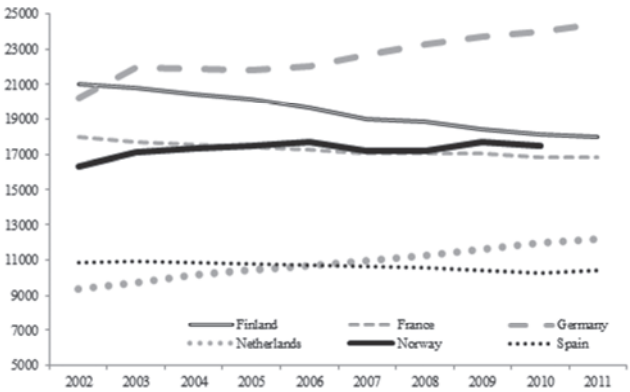
1. Data refer to average length of stay for curative (acute) care (resulting in an under-estimation).

Source: OECD Historical Population Data and Projections Database, 2013.

At the same time, hospital activity has been increasing: over the past ten years, the discharge rate has increased from around 16 000 discharges per 100 000 population per year in Norway to around 17 500 per 100 000 population per year. This is not a pattern seen uniformly across OECD countries – Finland, France and Spain, for example, have shown stable or falling discharge rates from various baselines in 2000 (Figure 2.5), and the reasons underlying divergent cross-national trends have not been explored. Particular specialties in Norway have seen even larger increases – in orthopaedic surgery (which typically makes heavy use of community health care services after discharge), volumes increased by 57% between 1999 and 2007 (Norwegian Patient Registry, 2013).

This combination of increasing numbers of hospital discharges and shorter lengths of stay imply increasing pressure on the community and primary care sector to take over the care of increasing numbers of patients earlier in the course of their recovery.

Figure 2.5. Trends in average length of stay in hospital, selected countries



Source: OECD Health Data 2013, www.oecd.org/health/health-systems/oecdhealthdata.htm.

Recognition of the need to manage the effects of these socio-demographic shifts, as well as the success of the regular GP scheme, led to the introduction of the Coordination Reform. As described in Chapter 1, the reform sets out the intention that Norwegian health care pivot decisively toward primary and community settings away from the hospital sector, with an emphasis on prevention. The Coordination Reform has a strongly proactive element as well – the reform heralds a decisive shift towards avoiding and shortening hospitalisation wherever possible, largely through developing a new "third space" of intermediate care facilities (an innovation that is described in detail in Chapter 4).

All stakeholders – including professional and patient groups – agree with the motivation behind the Coordination Reform and support it broad ambitions. Thus, in contrast to many other OECD countries, the Norwegian primary care sector benefits from a clear vision of what it should be doing over the next five to ten years, particularly in relation to other parts of the health care system. Without doubt, this involves primary care and the wider community health sector taking on new tasks and responsibilities. Avoiding hospitalisation and discharging hospitalised patients sooner are explicit intentions of the reform and, indeed, municipalities have received additional funding in anticipation of this. Much of this chapter will be taken up with assessing how well the primary and community care sectors, as well as broader surrounding infrastructure, are set up to meet these expectations.

2.3. Quality initiatives in Norwegian primary care

Municipalities are principally responsible for delivering high-quality health and social care

In Norway, the local municipality is responsible for providing both health and social care. As discussed in Chapter 1, the Municipal Health Services Act states that municipalities should provide necessary health care to all who live or temporarily staying in the community, including medical services, physiotherapy services, nursing and midwifery services. Likewise, the Social Services Act specifies that the municipality provide preventive care, housing for the disadvantaged, practical assistance with the activities of daily living for those unable to live independently, relief for carers as well as treatment and support for drug addicts.

In providing primary care services, a local authority is required to assure a high quality of service and to meet national regulations and standards, including regular surveys of outcomes and patient experiences. The range and depth of municipalities' responsibilities for health and social care have increased as a result of the Coordination Reform, and are centered on co-operation, prevention, self-management, treatment and rehabilitation. Some of the key activities expected of municipalities include:

- increased co-operation and collaboration within and between services, through co-location of services (including through expanded local medical centres), multidisciplinary mobile teams and shared training activities;
- increased competence and expertise, through better understanding of local health and social care needs, use of new technologies, research on local service models and outcomes;
- better prevention and patient self-management, through renewed efforts to promote good social and environmental conditions, reduce inequalities, promote independent living and citizen participation in the design and operation of local services.

An important actor in these efforts is the Norwegian Association of Local and Regional Authorities (KS). KS functions as an interest organisation for municipalities, counties and local public enterprises in Norway – all of the 429 municipalities and 19 counties, as well as around 500 public enterprises, are members. KS advocates to central government on local government issues and facilitates exchange of ideas and good practice between members on issues of regional development and good governance. As discussed in Chapter 1, the government and KS have entered into an agreement for 2012-15 to promote quality initiatives in the municipal health

services, with particular emphasis on patient's participation, prevention, rehabilitation and the use of new technology.

In addition, County Medical Officers and the Norwegian Board of Health Supervision ensure that health and social services are provided in accordance with national acts and regulations. The Board's assessment of GPs, and health care providers more generally, is reactive and opportunistic. It is triggered by high rates of patient complaints or adverse events, or by a serious patient complaint or adverse event. Assessment of other primary care services, such as municipal health and welfare services for children and the elderly is more systematic and continuous, involving regular risk assessments. In 2013, 101 municipalities were assessed.

Professional groups and national authorities such as the Norwegian Knowledge Centre for Health Services have developed a range of quality initiatives around primary care

Norway's *Allmennlegeforeningen* (AF – Association of General Practitioners) was founded in 1938 and functions primarily as a trade union. Members of the AF, who number around 4 400, are also members of the *Norsk forening for allmennmedisin* (NFA – College of General Practitioners, founded in 2007). This latter organisation has a mission focused on quality improvement and professional development. In its 2009 report, the Association noted that general practice was "invisible" in many national quality initiatives and that many GPs are relatively uninformed about quality initiatives and quality improvement work. The following year, the Association initiated its *Senter for allmennmedisinsk kvalitet* (SAK – Centre for General Practice Quality) project. This sought to develop and implement a suite of tools to support GPs at a local level to improve the quality of their practice (by measuring waiting times, conduction patient surveys etc.) as well as encourage more systemic changes around electronic medical records, for example.

The *Nasjonalt kunnskapssenter for helsetjenesten* (NOKC – Norwegian Knowledge Centre for Health Services), described in detail in Chapter 1, has a section dedicated to quality improvement in primary care and has carried out a number of projects of a more strategic or academic nature, seeking to set out the evidence base for quality improvement work, or collate international experience with particular initiatives. Four reports are of particular interest, given their focus on health care quality measurement and improvement:

- *Norwegian and international approaches to quality improvement work in general practice* (Lindahl et al., 2010a) sought to establish the theoretical basis for quality improvement work in primary care,

emphasizing the importance of integrated and co-ordinated care in conceptualising primary care, and an effective information infrastructure capable of monitoring outcomes across a pathway of care.

- *Evaluation of elements that could be part of a national quality system for primary health care* (Lindahl et al., 2010b) sought to identify elements that could be included in a system to monitor the quality of primary care at practitioner, service, municipal and national level. It emphasized the need for easy comprehension by professionals as well as patients, local benchmarking and national leadership. The lack of an adequate information infrastructure in Norway was identified as a significant impediment to the imminent introduction of any such system.

- *A framework for quality indicators* (Rygh et al., 2010) made 18 recommendations around possible future quality indicators for Norwegian health care. Recommendations were all high level and generic, covering concepts such as validity, utility, transparency and timeliness, rather than specific suggestions of what could be measured.

- *A report on readmission rates* (Lindman et al., 2012) looked at unplanned readmission in patients aged 67 or older for 11 conditions (such as fractures, urinary tract infection or stroke) between 2005 and 2009 in 20 public and four private hospitals. Significant differences in the readmission rate across hospitals were found. The report proposed that this measure could be used as an indicator of the quality of local health services, particularly with respect to the degree of co-ordination and integration between levels of care.

In its *Allmennmedisinsk utvalg for kvalitet og pasientsikkerhet* (KUP – Quality and Safety Indicators in General Practice Project), the NFA looked at international experience in using quality indicators in primary care and identified many that would be suitable for Norway across several areas of practice, including acute care, care for chronic disease, preventive health care and practice organisation (NFA, 2012).

Despite these initiatives, use of standards, indicators and clinical guidelines in primary care is low

Much of the content of the reports outlined above did not progress beyond the stage of being a set of proposals and was never operationalised. At present, the penetration of standards and clinical guidelines into primary care in Norway is low. This is due both to a relative lack of guidelines as

well as poor uptake of those that exist. Few national primary care guidelines exist and work at sub-national level is also scant. Only the mid-Norway region, for example, has developed a diabetes strategy that included clinical guidelines to support clinicians in managing and reducing disease burden.

Surveys suggest that only 60% of GPs use and rely on the guidelines that exist. To some extent, this is likely to be related to the fact that there are no incentives or requirements for GPs to provide a standard level of care, as discussed later in the chapter. Surveys suggest, for example, that only about 80% diabetic patients have an annual HbA1c check, 50% an annual albuminuria check, an only 30% an annual foot check (retinal examination, on the other hand, is well taken care of and provided by ophthalmologists). Other possibilities for low use may relate to the large number of guidelines in existence, a perceived lack of local relevance or utility, or lack of a strategy to promote use and uptake. Of note, a new initiative from the Directorate of Health aims to increase the accessibility and uptake of primary care clinical guidelines, through an internet-based platform.

Continuing professional development, regular recertification and voluntary adverse event reporting are in place, but it is unclear how formative these are in practice

Supporting doctors in their on-going professional education and development was previously the responsibility of the Norwegian Medical Association but was adopted by the national Directorate of Health, acting in its regulatory/administrative role, two years ago. Norway encourages its GPs to participate in small peer-teaching groups, mutual practice visits and conference attendance. Linked to the objectives of CPD, the Norwegian Medical Association has organised a system of five-yearly recertification for GPs, approved by the Directorate of Health. Around 60% of GPs voluntarily participate. They are required to submit a portfolio of courses attended and other educational activities to the Directorate of Health in order to demonstrate that they have engaged in CPD. Although valuable in reassuring the public that GPs have kept themselves up to date, there has been no evaluation of the scheme to identify ways in which it could be improved. Anecdotally, all GPs pass this recertification, somewhat automatically. This, plus the submission of a portfolio without any formative discussion with a peer or a mentor (as occurs in the recertification process in the Netherlands, for example) raises questions as to the true extent of its benefit. Revisions to current CPD arrangements in Norway, including recertification, are currently under discussion. Proposals for modified CPD requirements expected towards the end of 2014 (Box 2.2).

Box 2.2. International experience with CPD schemes for medical professionals

There is general consensus that medical professionals should regularly attend some sort of continuing medical education (CME) or professional development (CPD). The latter is a broader concept which includes the development of personal, social and managerial skills alongside CME (Merkur et al., 2008). The objectives of both are to deepen clinicians' skills and knowledge base, to keep abreast of developments in their area of practice and, in some countries, to demonstrate this systematically to public authorities.

In reviews of CME policies across countries such as that published by Garattini et al. (2010) or Maisonneuve et al. (2009), substantial heterogeneity in how national CPD programmes are organised and governed is evident. Although CPD is formally compulsory in Austria, France, Italy and the United Kingdom, this is often a formality since no sanctions are enforced against non-compliant physicians. Norway is somewhat unusual in having a voluntary scheme (Belgium and Spain do as well), although participation is incentivised to the extent that specialist GPs must demonstrate on-going CPD to retain their specialist status. Norway is also distinct in two other respects: it is the only country of those reviewed not to permit commercial sponsorship of CPD events and in monitoring clinicians' CPD prospectively. Other countries monitor CPD retrospectively – typically through a points system – accompanied by reflection, demonstration of impact, peer discussion and prospective planning to varying extents.

Demonstrating and increasing the value of CPD is a challenge for all countries. In a review of 26 systematic reviews of the effectiveness of different CME techniques, Bloom (2005) found that interactive techniques (such as an audit and feedback) were more effective at changing practice and outcomes than didactic techniques (such as distributing printed information). Marinopoulos et al. (2007) suggest that multiple techniques be combined. It is increasingly recognised that demonstration of CPD must move on from counting points to measuring the impact of continued learning, through more demanding methods of CPD incorporating personal reflection and analysis of learning needs, peer review, external evaluation, and practice inspection (Miller et al., 2008; Parboosingh, 2000).

The link between demonstration of CPD and revalidation is variable, although is becoming formalised in an increasing number of countries, with the aim of consistently assuring the public of a clinician's fitness to practice. In Holland, for example, physicians have to undergo a peer review by a team of three other doctors every five years to revalidate their entry on the medical register. The review includes discussion of CPD activities, including analysis and reflection on how the doctor's practice has changed as a result. In the United Kingdom, a similar system of five-yearly revalidation has recently been introduced. Doctors are required to submit an annual portfolio of evidence showing how they meet professional standards, have changed their practice through CPD activities and have reflected upon feedback from patients and colleagues. The portfolio is appraised by a peer; five successful appraisals lead to revalidation of a doctor's entry on the medical register.

It is also unclear how formative adverse event reporting is within primary care. First, only specialist health care services are legally mandated to report all adverse events to the Norwegian Knowledge Centre for Health Services. Second, although a voluntary system exists for primary care

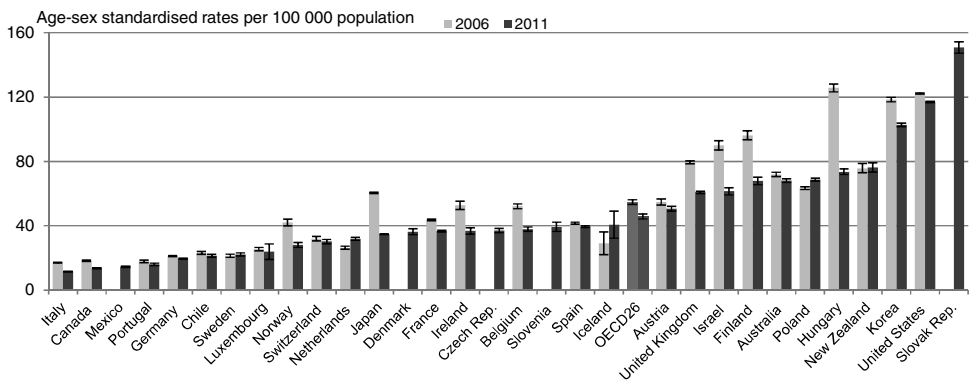
services, there is no system in place to look at patterns, trends or outliers and derive learning from these incidents. An opportunity to give feedback to individual practices as well as implement system-wide quality improvement actions is therefore lost. This stands in contrast to other health systems which have shifted quality improvement activities on from merely completing tasks towards reflection and learning. In England, for example, a National Reporting and Learning System has been developed. Clinicians and safety experts analyse individual reports to identify common risks and opportunities to improve patient safety, providing alerts to address specific safety risks, national campaigns on specific topics such as hand hygiene and other resources.

2.4. Outcomes associated with primary care in Norway

At aggregate national level the quality of care provided by Norwegian GPs appears good

Data submitted to the OECD's Health Care Quality Indicator project show that hospital admission rates for chronic conditions – an indirect measure of the quality of primary care – are lower in Norway than for the majority of OECD countries for all conditions expect COPD, as shown in Figures 2.6 to 2.8. Furthermore, age-sex standardised admission rates have been decreasing over recent years suggesting improvements in primary care (although rates are not standardised for background prevalence of the condition, or other factors which are likely to influence admission rates).

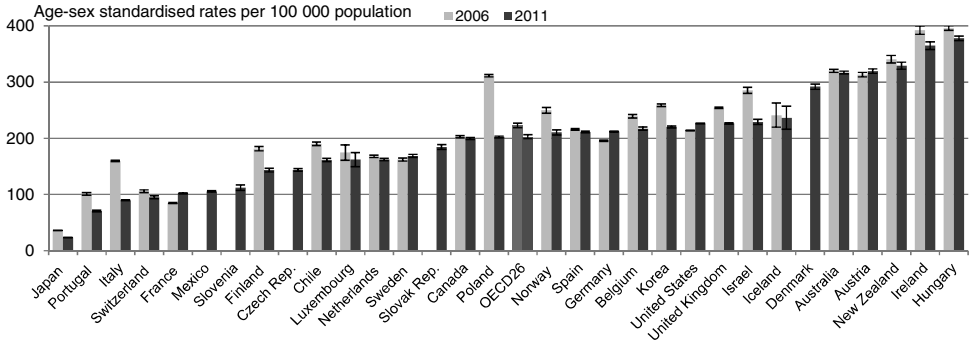
Figure 2.6. Asthma hospital admission in adults, 2006 and 2011 (or nearest year)



Note: 95% confidence intervals represented by H.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

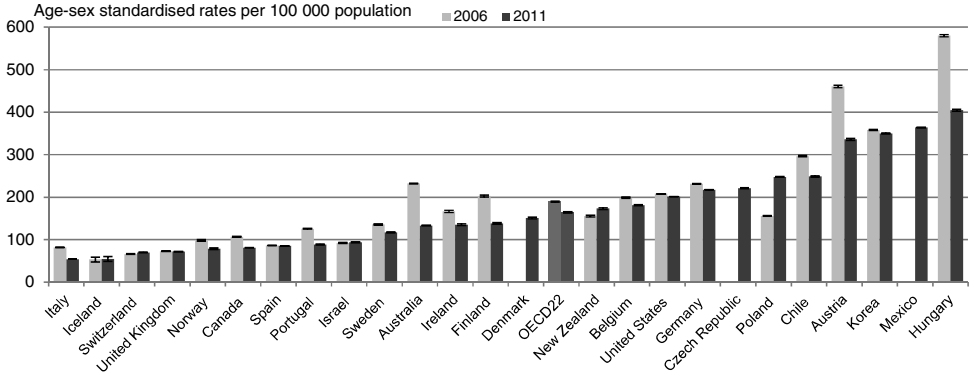
Figure 2.7. COPD hospital admission in adults, 2006 and 2011 (or nearest year)



Note: 95% confidence intervals represented by H.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Figure 2.8. Diabetes hospital admission in adults, 2006 and 2011 (or nearest year)

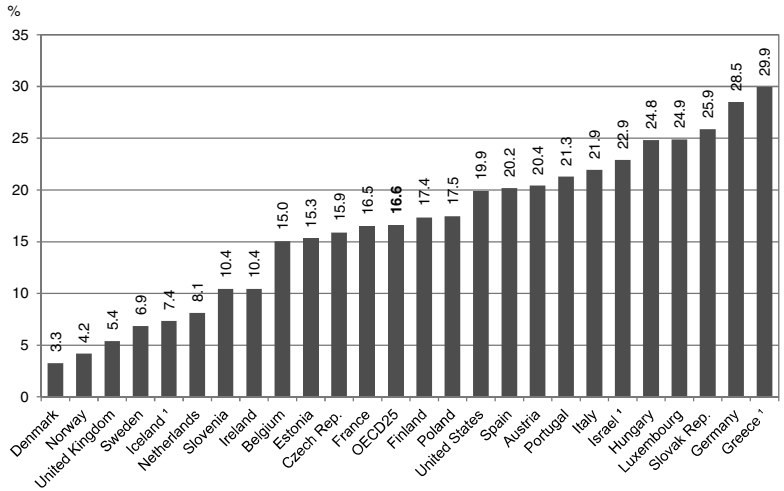


Note: 95% confidence intervals represented by H.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Prescribing patterns can also be used as indicators of the quality of primary care. Quinolones and cephalosporins, for example, are considered second-line antibiotics in most prescribing guidelines whose use should be restricted. Their volume as a proportion of the total volume of antibiotics prescribed has been validated as a marker of quality in the primary care setting (Adriaenssens et al., 2011). Norway reports one of the lowest proportions across OECD countries, suggesting a high quality of prescribing in primary care (Figure 2.9).

Figure 2.9. Cephalosporins and quinolones as a proportion of all antibiotics prescribed, 2010 (or nearest year)



1. Data refer to all sectors (not only primary care).

Source: European Centre for Disease Prevention and Control 2013 and IMS for United States.

Patient surveys demonstrate high levels of satisfaction with primary care services in Norway, with over 85% reporting that they "completely agree" with the statement that "the GP took me and my problems seriously" when surveyed in 2000 (Statistics Norway, 2013).[2]

Little is known about the quality of care at a more local level

Beyond these broad measures though, there are no further measures of the quality of primary care at a national aggregate level. Furthermore, there is virtually a complete absence of information at local level regarding the quality of primary care services – whether general practice or community services more broadly, such as physiotherapy or nursing home care. There are some rudimentary local statistics on child preventive health checks gathered by KOSTRA, but nothing that would constitute a full suite of indicators of primary care quality.

Even those statistics gathered by KOSTRA, however, are of limited use. A search on the "percentage of children who have completed a medical examination when they start school" reveals proportions varying from 0% in nine municipalities, to over 100% in dozens of municipalities, with proportions over 200% in six municipalities and over 1 000% in two

(www.ssb.no/statistikkbanken, accessed 30 September 2013). Whilst it is clear that movement of families across municipalities between a child's birth and starting school could cause difficulty in accurately specifying numerators and denominator populations, it is hard to see how data such as these could be informative or actionable for administrators, professionals or the public.

2.5. Challenges faced by primary care in Norway

In addition to the extrinsic challenges of ageing, shorter hospitalisation and the increased expectations established by the Coordination Reform, primary care in Norway is characterised by a number of intrinsic shortcomings which have implications for the degree to which it will be able to adapt to meet the new demands being made of it. These include a deficit of information on the patterns of care and outcomes in primary care and on-going problems in the co-ordination of care.

Another fundamental challenge relates to the relatively fragmented leadership around primary care and primary care quality. A number of stakeholders, including the Ministry of Health, the Norwegian Association of Local and Regional Authorities, the Norwegian Directorate of Health, the Association of General Practitioners, the College of General Practitioners and the Norwegian Knowledge Centre for Health Services, occupy this ground in Norway. While this plurality has yielded some advantages (particularly around a shared vision, trust and consensus) it seems to have held up the design and implementation of practical action to improve quality. This is seen clearly in the lack of a national information system on primary care activities and outcomes. Most critically, however, it is seen in the fact that, while the Coordination Reform sets out a clear vision for primary care, its operationalisation remains vague. There are no strong incentives for GPs to deliver the vision of integrated, proactive and community-focused care.

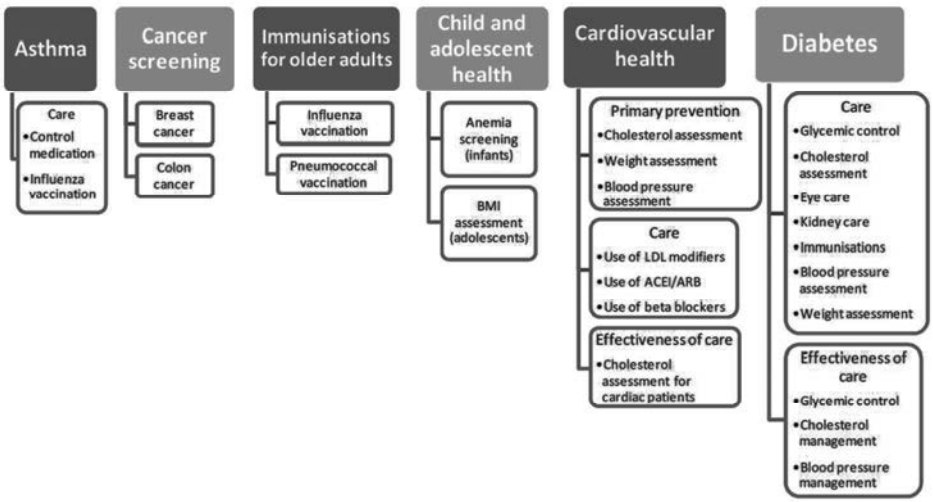
A striking information deficit marks out Norwegian primary care in comparison to peers

One area in which Norwegian primary care appears particularly weak is the near-complete absence of data around activity and clinical outcomes in the sector. As mentioned in Section 2.4, there is no information infrastructure at local or at national level to systematically collect a dataset that would allow GPs, patients and authorities to benchmark quality and performance against peers or against national guidelines. Of even greater concern, perhaps, is the fact that the dearth of information is profound – it was reported, for example, that most Norwegian GPs would not be able to quickly produce an up to date register of their patients with diabetes.

Without this fundamental ability to identify a base population, it is hard to see how any other quality initiatives, around patterns of care or clinical outcomes, could work.

In this respect, Norway compares unfavourably with other countries which would normally be considered peers. Several of these have developed comprehensive and actionable indicators to support quality improvement in primary care. The Quality Indicators in Community Healthcare (QICH) programme in Israel, for example, covers six areas of primary care activity (as shown in Figure 2.10) and reports performance at individual provider level, after adjustment for health need and socio-demographic factors. Managers report that the data fed back to them is instrumental in quality improvement work. One of Israel's health funds, Maccabi, reports that amongst diabetic patients between 2004 and 2009, poor HbA1c control fell by 29% and adequate cholesterol control increased by 96.2% for example (OECD, 2012). Of note, QICH is neither mandated nor reliant on financial incentives. Instead, its success is thought to be due to its robust scientific basis, consensual development of the indicator set involving GP and health insurance companies early on, clear patient-oriented objectives and, crucially, systematic and continuous feedback of comparative data to both professionals and the public.

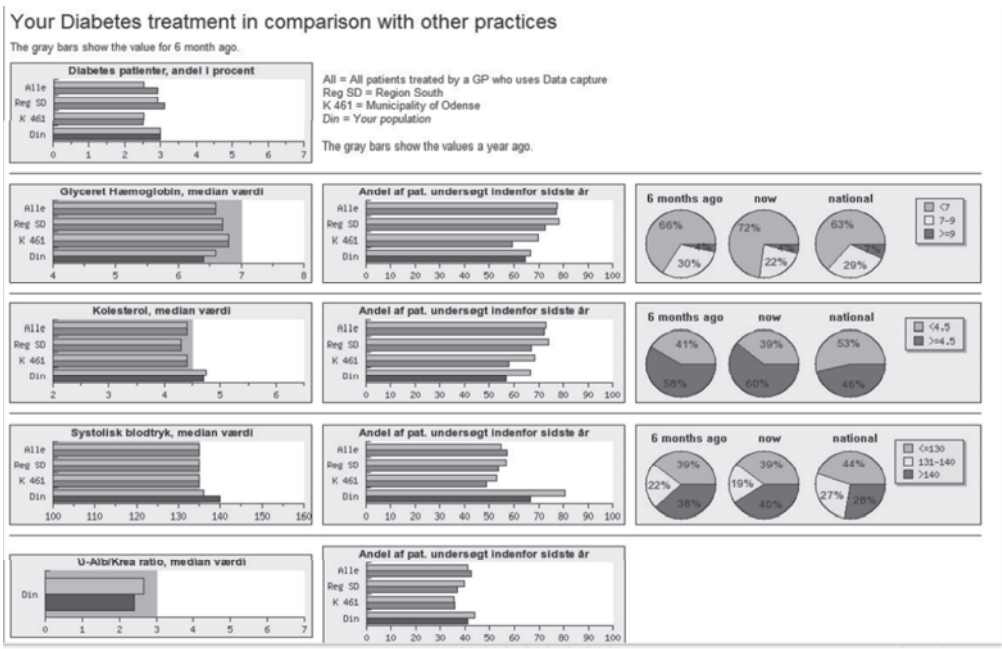
Figure 2.10. Structure of the Quality Indicators in Community Healthcare (QICH) programme, Israel



Source: OECD (2012), *OECD Reviews of Health Care Quality: Israel 2012 – Raising Standards*, OECD Publishing, http://dx.doi.org/10.1787/9789264029941-en.

In a similar vein, Denmark has developed a system of automatic data capture from primary care records, which allows GPs to access quality reports from their own practice for over 30 areas. These include management of chronic diseases such as depression, COPD, diabetes or heart failure; routine care such as childhood vaccination and provision of contraception and aspects of effective practice administration. As well as being able to identify individual patients that are sub-optimally treated, the system allows them to benchmark their practice against other practices at municipal, regional, and national levels (see Figure 2.11 for an example relating to diabetes management). Patients can also monitor their own clinical data. Analyses using the data collected have reported significant improvements in the proportion of diabetics on appropriate antidiabetic, antihypertensive and lipid-lowering medications (OECD, 2013a).

Figure 2.11. DAMD output allowing GPs to compare the quality of their practice with peers



Glossary: *Median værdi*: median value; *andel af pat. undersøgt indenfor sidste år*: proportion of patients with an annual check in the last 15 months.

Source: Danish Quality Unit of General Practice, www.dak-e.dk.

In Norway, whilst care for diabetic patients treated in Norwegian General Practice has improved over recent years, as measured by appropriate reductions in HbA1c, blood pressure and cholesterol levels (Cooper et al., 2009), there is still substantial room for improvement. A study by Jenssen et al. (2008) demonstrated poor attainment of HbA1c, blood pressure and cholesterol targets in patients with type 2 diabetes. Forty-five percent of those with blood pressure >140/85 mmHg were treated with only one or no antihypertensive agents at all, for example, despite the fact that patients with type 2 diabetes most often need two or three antihypertensive agents to achieve the blood pressure, as recommended in guidelines issued by the NFA.

The only systematised window into primary care activity is the HELFO database, which reimburses GPs for items of activity (see Box 2.3). In theory, this could be used to monitor activity and benchmark patterns of care. The database is rarely, however, exploited in this way: at present, this type of work is only carried out by university researchers rather than being developed as a constituent part of primary care practice. This is in large part due to the fact that HELFO was developed as a reimbursement system and not as a quality improvement platform – in particular, no clinical outcomes are captured, which significantly limits its utility for quality monitoring. Nevertheless, the potential held within the data that currently exists is demonstrated in a study by Kjome et al. (2012). Looking at the patterns of care for patients with a recorded diagnosis of diabetes, the researchers found significant differences in the consumption of medications and blood glucose monitoring equipment across Norwegian counties, which they suggested could be related to a poor implementation of national guidelines on these aspects of diabetes management.

Box 2.3. Information sources in Norwegian primary care

KOSTRA is an accounting system used by Norwegian municipalities to report to central government. It provides information on most of municipal and county municipal activities, including the local economy, schools, health, culture, the environment, social services, public housing, technical services and transport and communication. Although a detailed source of information, KOSTRA mainly contains data on inputs and activity. In addition to workforce and expenditure, its primary care-related content consists of the number of maternal and child health checks by municipality, users of home nursing help or institutional care for the elderly, waiting times and some patient experience measures.

IPLOS is a register with individual encrypted information about applicants and recipients of health and care in Norwegian municipalities. Since 2007 this has been the main data source for Norwegian health and care statistics. Detailed information on service needs and use is collected, including an individual's ability to perform activities of daily living (ADL), housing conditions, diagnoses, admissions to hospital and use of home health services, day centres, respite care or rehabilitation. The register also collects information about individual co-ordinated care plans.

Box 2.3. Information sources in Norwegian primary care *(cont.)*

The Norwegian Health Economics Administration, commonly known by its Norwegian acronym HELFO is housed within the Ministry Directorate for Health and Social Affairs. HELFO records information on who is registered with a particular GP, administers the fee-for-service scheme which underpins around a third of GP income and arranges reimbursement to patients for certain medicines, dental services and health services abroad. HELFO publishes regular statistics, but these are mainly concerned with reimbursement patterns and are not quality related.

The Norwegian Directorate of Health also produces a *Key Figures for the Health Sector* publication annually, which includes statistics on population health status, health needs, service performance and quality. The Directorate also produces thematic publications on an *ad hoc* basis, such as its report on implementation of the Coordination Reform.

The co-ordination and integration of care remains poor

Achieving more closely co-ordinated and integrated care is a priority for all OECD countries at the moment, with primary care typically identified as the "hub". All countries are, however, struggling to operationalise the concept and deliver perceptible benefits to patients and families. Norway is no different in this regard. The Coordination Reform set out ambitions clearly yet the impression remains widespread that co-ordination across multiple providers or across a complex pathway of care is poor –something particularly relevant to patients with one or more long-term conditions. It has been reported, for example, that individualised care plans (ICPs) for patients with complex needs are variably implemented. Whilst there are reports from patients and professionals that some have found ICPs useful, a number of problems in their use and application remain. First, there is no standard model of what an ICP should contain, meaning that they vary in utility across patients with similar needs. In particular, ICPs are typically used in a limited number of clinical areas such as psychiatry, rehabilitation and cancer care. Other patient groups who could benefit are sometimes not offered one. At the same time, there are reports of a single patient having several ICPs written by different services – which clearly defeats their object. Additionally, IT platforms were not developed to support implementation of ICPs and their introduction and use remain unevaluated.

Another example of poor integration is the poor development of the *Praksiskonsulentordningen* (PKO – Practice consultant) role. Broadly, these are GPs who are employed part-time (between 5% and 40% full-time equivalent) by a hospital, to support the co-ordinated management of patients with multiple health care needs, at the same time as developing local reforms to support co-ordination across pathways involving primary and secondary care more generally (by improving communications and information flows, for example). The role in Norway has existed for around

20 years, but remains somewhat informal and variably implemented across municipalities.

A final issue is that there is no consistent system for primary care electronic record keeping across the country. Norway was one of the first countries to pilot electronic medical records, in a variety of settings. The downside of this early experimentation is that, now, Norway has a multiplicity of electronic medical record systems, developed by different services, few of which are compatible. This is particularly an issue for the provision of care outside of office hours (OOH) – because the OOH doctor cannot see the usual GP record, a more cautious clinical approach ensues. It has been reported that patients may end up at higher levels of care than are needed as a result.

Overall leadership or governance for primary care quality as well as various specific initiatives well established in other countries remain undeveloped in Norway

As noted in Section 2.3, although various quality initiatives are nominally in place in Norwegian primary care, they are relatively underdeveloped in comparison to other countries. As a consequence, opportunities for reflection, analysis and learning are lost, both at individual practitioner level and system level. This applies to current arrangements for CPD, recertification and adverse event reporting for example.

As well as the relative immaturity of specific quality initiatives, national leadership around primary care quality is also lacking. At present, there are no national or regional programmes which systematically bring together quality information or initiatives on primary care. There is, for example, no annual report on the quality of primary care in Norway or a single national centre which leads on primary care quality. Instead, there are several stakeholders with an interest in the field. Within the Ministry of Health, responsibility for quality in primary care is split between several sections (such as the teams working on e-health team or integrated care, in addition to primary care). Beyond the Ministry, the Association of General Practitioners, College of General Practitioners and Norwegian Knowledge Centre for Health Services are all looking to lead the quality agenda.

While this plurality has yielded some advantages it seems to have held up the design and implementation of practical action to improve quality. Most critically, there are few strong incentives for GPs to deliver the Coordination Reform's vision of integrated, proactive and community-focused care. The only incentives built in to the reform were municipalities' 20% co-financing of hospital activity and the additional daily penalty if patients who were ready for discharge remained in hospital. These incentive mechanisms, however, do

not directly connect through to GPs, given that municipalities have relatively weak influence over GPs' practice. Furthermore, the new government elected in September 2013 intends to scale back the 20% co-financing element. Hence, to some extent, GPs remain "behind the firewall" in terms of feeling direct pressure or incentives to change their ways of working to realise the vision of the Coordination Reform.

2.6. Securing a greater quality dividend from primary care in Norway

Going forward, a better information system will be a priority

Developing the information infrastructure underpinning primary care, so that a fuller and more detailed picture of the effectiveness, safety and patient centredness of primary care can be built, is a priority. This is something upon which all groups – government, professionals and patients – agree. It is needed to assure the public of the quality of local services and to support them in choosing between providers, to enable central and local governments get a better picture of the value for money of their public spending, and allow professionals to benchmark their performance and seek continuous quality improvement. At this particular moment in Norway's reform history, however, it is especially needed as part of the assessment of the impacts of the Coordination Reform, particularly as increased expectations are placed on the primary care sector to maintain current service levels, engage in more preventive work and deliver a wider and more complex range of acute care. Professional groups may initially feel some reluctance to open up their practice to more detailed public scrutiny, but international experience suggests that this reluctance can be overcome if the process is handled in a consensual manner and the potential quality-yield made clear.

Developing a richer information system means both using existing data more effectively and developing new sources of data. In terms of the former, opportunities within the HELFO could be explored as a first step – it may be possible, for example, to construct primary care quality indicators detailing how often key preventive checks are offered for chronic conditions. Parallels to the HELFO analysis by Kjome et al. (2012) on patients with a diagnosis of diabetes, could be imagined for COPD and asthma (annual spirometry) or cardiovascular disease (weight, blood pressure and cholesterol checks) for example. Similar opportunities may exist within the KOSTRA database, particularly given that this database contains measures of patient experiences (such as waiting times) and satisfaction.

HEFLO and KOSTRA do not contain clinical outcomes, hence new data sources are also needed. A necessary first step is to build a legal framework which will allow the collection of more comprehensive primary care data. Governments need to balance concerns around data access and privacy, although guidance and country case studies are available to help optimise

this trade-off. In practice, countries across the OECD are moving away from highly restrictive data privacy regimes to realise the benefits of anonymised, secure data sets made more easily accessible for research and audit purposes. Increasing numbers of countries are exploring possibilities to link data from clinical and administrative databases, from health and social care, as well as other public services (OECD, 2013b).

Candidate indicators to measure the quality of primary care in Norway would most likely concentrate around prevention and management of chronic diseases, elderly care, child health and mental health care. Whilst models such as Israel's QICH, England's QOF or Denmark's DAK-E programmes should inform development of candidate indicators, it is particularly important that any indicators align as much as possible with the indicators and quality registers already used in Norwegian secondary care or wider quality improvement work. A suite of indicators for the management of diabetes, spanning both primary and secondary care, would be timely, for example. Considerable thought will need to be given to how data can be made accessible and useful to both professionals and the public. Sweden's approach of open comparison and benchmarking municipal performance offers a model to study here (OECD, 2013c). It is considerably easier to navigate and understand that the Statistics Norway's platform (www.ssb.no) that currently houses equivalent data. One particular use of the data may be to support a system which offers positive incentives to deliver better quality primary care, as discussed next.

Smarter design of payment systems is a closely related priority

At present, Norwegian GPs have few external incentives to deliver the objectives of the Coordination Reform or, indeed, to deliver better quality primary care more broadly. Peer-to-peer benchmarking of quality and outcomes can be a very powerful driver of continuous quality improvement, and is the mechanism discussed earlier in Israel. At the same time as developing a richer information infrastructure, Norway should also consider ways in which payment systems in primary care could be reformed to better reward high-quality care. Although there is increasing international interest in using pay-for-performance schemes in primary care, their impact on quality and outcomes has been mixed (Box 2.4). It is important that the schemes are carefully designed, monitored and seen as one element in a blended payment system, rather than as a silver bullet.

In particular, moving towards smarter payment systems need not imply a wholesale move toward a system of financial incentives. Existing systems show ample opportunity for smarter design. Indeed, reforms in this area constitute "low-hanging fruit" in that they are likely to be simpler to introduce than a national primary care indicator set and have significant positive

benefits. The FFS element of GP payment, for example, does have a few quality-related incentives built in, but they are few and do not systematically reflect national priorities or clinical guidelines. This is demonstrated by the relatively small number of preventive activities included, despite the fact that one of the aims of the Coordination Reform was to encourage more preventive work. One policy option would be to ensure that future FFS negotiations make more explicit links to national priorities and standards of care. Representation from the Norwegian Knowledge Centre for Health Services in these negotiations should be considered. In addition, it is important to note that a FFS payment system may be a poor design to support integrated and continuous care. Specific attention should therefore be directed toward identifying activities that could support better co-ordinated care (such as creating detailed individual plans (IPs) for complex patients with joint sign-off by the services involved and by the patient).

Box 2.4. International experience with pay-for-performance schemes in primary care

Since their inception in the United States, United Kingdom and Australia in the late 1990s and early 2000s, pay-for-performance schemes have become increasingly popular payment mechanisms for primary care across the OECD. Pay-for-performance is, in fact, more widely used in primary care than in secondary care. Primary care schemes operate in around half of countries, focusing mainly on preventive care and care for chronic disease. Design varies widely, ranging from relatively simple schemes in New Zealand (10 indicators) or France (16 indicators) to the complexity of the United Kingdom's Quality and Outcomes Framework (QOF) – the largest scheme currently in operation. QOF covers over 100 indicators in 22 clinical areas and is implemented across the whole country.

Given its scale, and the fact that it was a system-wide reform, much research has focused on the impacts of QOF. Gillam et al. (2012), in a systematic review covering 124 published studies, note that evaluation is complicated by lack of a control group and the difficulty of ascribing changes in clinical practice or outcomes (each with manifold determinants) to a complex intervention such as the QOF. Nevertheless, against a background of improving care generally, they report that quality of care for incentivised conditions during the first year of implementation improved at a faster rate than prior to QOF, although subsequently returned to prior rates of improvement. Given the cost of QOF (an extra GBP 1 billion per year), much debate has focused on its cost-effectiveness. Gillam et al. reported evidence of modest cost-effective reductions in mortality and hospital admissions in some areas, such as epilepsy. Of note, however, work by Walker et al. finds no relationship between the size of payments in a clinical domain (ranging from GBP 0.63 to GBP 40.61 per patient), suggesting substantial efficiency gains by reducing the upper spread of these figures.

In a review of 22 systematic reviews looking at pay-for-performance schemes internationally (not confined to primary care), Eijkenaar et al. (2013) find that P4P seems to have led to a 5% improvement in performance of incentivised aspects of care. Effects were generally stronger in primary care than in secondary care although, given the extent of variation in findings and the paucity of rigorous study designs, the authors conclude that there is insufficient evidence to support or not support the use of pay-for-performance in the quality of preventive and chronic care in primary care.

Box 2.4. International experience with pay-for-performance schemes in primary care *(cont.)*

Beyond clinical effectiveness and efficiency measures, pay-for-performance schemes have been associated with improvements such as narrowing of the quality-gap between deprived and non-deprived areas (Doran et al., 2008); systems strengthening by expanding use of practice-based IT, patient registers, call-recall procedures and audit; and expansion of nursing roles and competencies, including better team working. They may also support better dialogue between purchasers and providers, promote broader public debate and thereby clarify the objectives of primary care services (Cashin et al., 2014). Some evidence of negative effects, such as deprioritisation of non-incentivised activities or a fragmentation of the continuity of care, have also been noted.

Pay-for-performance in primary care should not be seen as the ideal or only payment system, but a potentially useful tool in a blended payment system, particularly where it might spur other activities such as development of quality indicators and better monitoring. As stated in a recent editorial cautioning against over-enthusiastic adoption of the schemes, "the choice should not be P4P or no P4P, but rather which type of P4P should be used and with which other quality improvement interventions" (Roland, 2012). Fundamentally, pay-for-performance should be seen as part of the means to move toward better purchasing (including, in this case, GPs' time), in which quality plays a more prominent role.

The FFS schedule could also be adapted to reward a greater set of activities undertaken by nurses and wider clinical staff. At present, most of the income available through FFS can only be earned by a GP. In many OECD countries, however, nurses with additional specialist training are undertaking an increasingly wide range of primary care tasks, particularly around chronic disease management, including clinical assessment, ordering investigations, referring for onward care, clinical management and, in some settings, prescribing. Evidence suggests that this has not led to any lapses in quality and can be associated with higher rates of patient satisfaction. An RCT with two-year follow up randomising patients with diabetes to protocol-based, nurse-led care or usual physician-led care, for example, found that fewer patients were hospitalised in the intervention group, with fewer side effects from drugs, compared to controls. Nurse-led care was also associated with a modest reduction in costs per quality adjusted life-year gained (Arts et al., 2012). In a systematic review of 31 studies focused on primary care, Keleher et al. (2009) concluded that nurses achieve positive health outcomes similar to those achieved by doctors, achieve good patient compliance and are effective in a more diverse range of roles including chronic disease management, illness prevention and health promotion than physicians.

The Municipality Health Services Act has been careful not to define the professional group that should deliver particular services. Hence a potential legal framework exists for expanding the role of nurses and other groups

such as pharmacists. Given that the demographic and political pressures already outlined imply a greater task load for the primary care sector, it would be sensible to allow Norwegian GPs greater freedom in how tasks are shared. Adapting FFS regulations to allow practice income to be earned from nurse-led preventive health checks, long-term conditions monitoring or care co-ordination activities (amongst others) would be a useful step. Community pharmacists offer another potential development (several already offer cardiovascular health checks in a programme welcomed by the Norwegian Diabetes Association and other patient groups). Modifying primary care reimbursement in this way may be opposed by GPs, hence a consensual, incremental approach – as is characteristic of Norwegian health care reform – should be followed. Furthermore, such changes would need to be accompanied by adequate training, monitoring and governance structures, to assure the quality of services provided by nurses and other new groups.

A new approach to long-term conditions is needed, characterised by proactive, co-ordinated care

As noted earlier, the perception of care for patients with long-term conditions remains one of poor co-ordination. Given that achieving better co-ordinated care is an area which all OECD countries are prioritising, it is worth focusing attention on how care for this group of patients can be improved in Norway. There is strong recognition of the need for a renewed focus on long-term conditions at national level. In response to a global commitment made at the 2013 World Health Assembly to reduce premature mortality due to NCD by 25% by 2025, Norway recently launched a national non-communicable diseases (NCD)[3] strategy – the first country in the world to do so. In considering the role that primary care should play in this, it is important to not to over-burden the sector, but chose a few carefully selected initiatives that are likely to bring significant quality gains.

Encouraging more consistent application of individualised care plans (ICPs) for patients with one or more long-term conditions would be one policy option. As noted earlier, it is reported that these are variably implemented. Issuing guidance on which patients should have an ICP, developing a monitoring framework to ensure that these patients are offered one and standardising their content would be ways in which the use and application of ICPs could be made more consistent. Specifying a requirement to proactively review of the functional status and medication regime of patients with multimorbidity, including when they fail to attend for a booked appointment, is one example of how content could be standardised in a way that does not overburden primary care staff.

ICPs will still need to be based upon a comprehensive set of clinical guidelines for the management and prevention of common long-term conditions, since it is unlikely that generic guidelines for patients with multiple long-term conditions can offer sufficiently tailored care (Roland and Paddison, 2013). The use and penetration of primary care guidelines needs to be improved in Norway. The reasons underlying this need to be understood – whether due to a lack of professional or local involvement in guideline development, guideline overload or a lack of incentives to use them. Clinical guidelines for the management of common long-term conditions should be aligned, cross-referencing each other appropriately and spanning both primary and secondary care. Their use and implementation could be incentivised through open benchmarking of outcomes or adjustments to the FFS schedule, as noted earlier.

A mechanism also needs to be found to bring GPs into negotiations and planning for the wider system of care

Although all parties agree that the direction of travel set out in the Coordination Reform is broadly correct, there is a risk that implementation at local level does not include all the necessary stakeholders at the table. In particular, newly instituted negotiations between municipalities and hospital managers – which have great potential value given that these two parties rarely interacted with each other previously – are reported to have a low and inconsistent level of participation from GPs. GPs' involvement, however, is important for at least two reasons. First, GPs will have a clear idea of local health needs and weaknesses in local service delivery (particularly concerning issues at the interface between primary and secondary care), and so are ideally placed to steer the focus of municipality-hospital negotiations. Second, GPs will inevitably feel the impact of whatever is decided with regards to hospital service levels or processes around admission/discharge, and so should be present when changes to local service configurations are being discussed.

Mechanisms need to be found, then, to ensure consistent and effective participation from GPs at meetings between municipalities and hospitals. As independent contractors, GPs expect that any time spent at such meetings is adequately compensated – a financial stipulation which some municipalities may be reluctant to underwrite. One easy and fair solution would be to include local planning and implementation of the Coordination Reform as work that counts towards the 7.5 hours/week that GPs have already agreed to spend on municipality-level activity.

At the same time, thought needs to be given to varying the content of contract between municipalities and GPs themselves – although the transaction costs of pursuing this line of reform could be high. At present,

municipality-GP contracts replicate the terms and conditions agreed at national level, the only variable element being deciding how the 7.5 hours/week spent on municipality level activities shall be organised. Contracts between municipalities and GPs offer, however, a rich opportunity to specify additional activities and reimbursement that reflect local needs or service ambitions. Examples would be service agreements to find new cases of undiagnosed diabetes or hypertension and start appropriate treatment, or to take on an expanded role in the diagnosis and management of patients with mental health or substance misuse problems, as discussed in Chapter 3. As noted earlier, specific attention should be directed toward identifying activities that support better integration and co-ordination across entire pathways of care for patients with complex needs.

A more unified national approach to primary care quality could offer practical benefits across a range of areas

Norway benefits from a strategic vision of how primary care and health care more broadly should develop over the short to medium term, as set out in the Coordination Reform. It also benefits from having several engaged and competent institutions and actors who are ambitious to improve primary care quality, including the municipalities, the Association of General Practitioners, the College of General Practitioners, the Norwegian Knowledge Centre for Health Services and patient organisations, as well as the Ministry of Health and the Norwegian Directorate of Health. All are broadly supportive of the direction of travel set out in the Coordination Reform. Yet it is not always clear that these actors work together as effectively as they could do to implement practical initiatives that support continuous quality improvement. The relative immaturity of Norway's primary care information infrastructure, clinical guidelines, CPD arrangements and other quality initiatives are evidence of this.

One policy option to achieve a more unified national approach to primary care quality would be to consider establishing a national centre for primary care quality. Several areas of work for a national primary care quality centre could be envisaged, including producing national or international overviews of current knowledge, practice and performance of key quality initiatives (such as recertification arrangements); co-ordinating guidance or setting standards on performance and performance reporting; encouraging innovation, evaluation and dissemination; or developing tools such as evaluation frameworks and IT platforms. It should be noted, however, reorganising elements of the current array of institutions and actors into a single national centre may provoke opposition. The aims and mandate of such a centre would need to be clearly defined and the benefits of a unified approach balanced against the benefits of multiple voices and actors.

Two further areas which would benefit from a more unified national approach would be development of the role of municipality-employed GPs and local evaluation of the effects of the Coordination Reform. In terms of the former, municipality-employed GPs, although few in number, are likely to have a critical and as yet unexplored role to play in achieving many of the Coordination Reform's ambitions. Supporting them better to bring in GPs more widely, for example, into local service negotiations and planning would make good use of their unique position within local health care economies. Likewise, a national toolkit of evidence, guidelines, evaluation strategies and collaborative platforms, could support, extend and standardise the Practice Consultant (PKO) role.

Evaluation of the effects of the Coordination Reform will be critical because, as noted earlier, it could be argued that Norway introduced these reforms without the necessary information and payments systems being in place to support them. Whilst effects, particularly with respect to primary care workload, readmission rates and patient experience, must be measured at a local level, lessons must be brought together at a national level. Likewise, the interpretation of a wide set of stakeholders must be synthesized effectively to ensure that quality of care continuously improves as intended. Current institutional arrangements make this depiction of effective collaborative learning unlikely.

A more unified national approach to primary care quality, with or without establishment of a national primary care quality centre, will require each of the current set of stakeholders to give up some area of competence or influence. Stakeholders will perceive this as a cost, yet it is unlikely that any will lose their distinctive voice. The case for the benefits of a single national approach should be made.

2.7. Conclusions

Norway benefits from a strategic vision of how primary care and health care more broadly should develop over the short to medium term, as well as from having several engaged and competent institutions that are ambitious to improve primary care quality. The few broad quality measures that exist suggest that Norway has a high performing primary care sector. Yet it is not always clear that these different elements work together as effectively as they could do. The relative immaturity of Norway's primary care information infrastructure, clinical guidelines, CPD arrangements and other quality initiatives are evidence of this. This is a particularly pressing issue at the moment because of the recent flagship reforms such as the Coordination Reform, the Health Care and Services Act and the Public Health Act, all of which seek to decisively pivot the provision of health care towards primary and community health care.

Norway has taken a gamble in introducing these major reforms without the basics (particularly payments and information systems) being in place to support the new expectations being demanded of the community and primary care sectors, and to assure the public of the quality of the new services being set up. There are several steps that could be taken to build on the many strengths of Norwegian primary care to ensure that it can continue to play a central role in delivering high-quality, proactive, co-ordinated and community-focused care.

First and foremost, the information infrastructure underpinning primary care needs to be developed, to make primary care activities and outcomes more visible. Candidate indicators should be sought within pre-existing databases (such as HELFO and KOSTRA), at the same time as building up a new set of indicators focused on outcomes of care. More effective interpretation and dissemination of data is also needed. Smarter payment systems are a closely related priority. There is scope to include a stronger emphasis on preventive and co-ordination activities within the fee-for-service schedule, and the Norwegian Knowledge Centre for Health Services should play a greater role in determining which activities should be prioritised within the schedule. Extending FFS payments to other primary care staff, such as nurses and pharmacists, should also be considered by the relevant national authorities.

A new approach to long-term conditions is needed. In particular, more consistent use and application of individual plans (IPs) would be welcome, backed by an aligned set of clinical guidelines and indicators. Greater coherence across quality initiatives, information systems and payment systems is needed for long-term conditions, as well as across all areas of primary care more generally. Initiatives to bring GPs more closely into the design and implementation of new models of local care will be vital going forward. As well as making more inventive use of the 7.5 hours per week that GPs may be contracted to dedicate to municipality-level work, municipalities and GPs should explore other ways in which contracts can be modified to best meet local needs. Fresh thinking and renewed investment in the PKO role would also be beneficial.

Finally, thought should be given to developing an ambitious and unified national approach to primary care quality. The best vehicle for this may be the creation of a national centre for primary care quality. Even in the absence of such an institute, however, clear leadership at national level is needed to steer primary care through the substantial reforms taking place and to ensure that the effects of the Coordination Reform are fully evaluated.

Notes

1. "Generalist doctors" is the term used in compilation of international health statistics, the definition of which may vary slightly from country to country.
2. Although Statistics Norway surveys patient satisfaction regularly through its survey of living conditions, no more recent statistics are available on its website.
3. Long-term conditions (LTC) and non-communicable diseases (NCD) are synonymous. Both refer to conditions such as cancer, heart disease, diabetes or chronic pulmonary disease.

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Chapter 3

Shifting care away from the hospital sector and toward primary care settings in Norway

This chapter describes existing supplemented primary health care units in Norway and it provides advice on how the set-up of these units can contribute to goals of improving quality of care. Supplemented primary health care units are community-based structures created to provide short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital. Whilst comparable units have already existed for several years in a number of Norwegian municipalities, the 2012 Coordination Reform required their development and has given an added impetus to their systematic establishment. The overarching goal is to boost lower-level care, expand primary care services, and reduce unnecessary hospital admissions.

3.1. Introduction

Norway has undergone a series of structural changes in the delivery and organisation of its health care services. The past few years have seen efforts to redefine the division of responsibilities between the local and national authorities. At present, the Norwegian health care system is semi-decentralised, with municipalities – the local authority – responsible for the provision of all primary care services, and Regional Health Authorities – owned by the national government – responsible for the provision of specialised health care services.

In Norway, the growing prevalence of chronic diseases and the population ageing impose high financial burden to the health care system in rising hospital care cost. Given the epidemiological and demographic shifts, the expansion of primary care services has been at the forefront of the Norwegian policy agenda. The objectives are to achieve at local level greater prevention and more effective management of chronic conditions that require complex and co-ordinated response from health professionals. A great emphasis has been placed on improving care co-ordination between primary and specialised health sectors to secure a comprehensive and seamless pathway of care.

To this end, the 2012 Coordination Reform will require municipalities to set up municipal emergency beds from the 1st of January 2016. While these primary care units are not explicitly set up for older people, several potential users would be frail elderly, chronically ill patients, or others needing post-acute care. The Coordination Reform encourages more broadly the experimentation and diffusion of supplemented primary health care units to expand the role of primary health care services. These supplemented primary health care units (also called "*Distriktsmedisinsk senter*" or "*Sykestue*" in Norwegian) are new models for integrated care, financed jointly by hospitals and municipalities, for patients with intermediate needs for institutionalised care. The reform includes economics incentives for municipalities unable to provide care in the community for patients ready for discharge from hospital. This incentive strongly urged municipalities to look for modes of action to take over the responsibility for early discharged patients from hospital.

The thrust is that patients discharged earlier from hospitals or at risk of being admitted and frequently readmitted to hospital could be taken care of in alternative, low-threshold sites of care, improving their experience of care. Also, patients receiving primary health care services would be closer to their homes, and lengthy or unnecessary hospitalisation could be avoided, hopefully reducing hospital costs by more effective services. Overall, the intention of the reform is to promote the optimal utilisation of hospitals by

expanding primary care services with a view of shortening or avoiding unnecessary or unintended hospital stays. This requires a corresponding increase in local medical, nursing and other relevant competencies, as well as capacity. The municipalities and the hospitals are required to establish legal binding agreements to specify the distribution of duties and responsibilities of each health sectors in supplemented primary health care units.

This chapter reviews the status and development of supplemented primary health care units in Norway, also called intermediate care facilities in other OECD countries, and especially offers suggestions for addressing quality and safety as part of this process. It also outlines the contribution these units may make to the enhancement of quality in the Norwegian health care services. The chapter starts (Section 3.2) with presenting policy initiatives aim at expanding primary care services in Norway. In the next section (Section 3.3), the chapter describes these supplemented primary health care units; they can take different forms, ranging from municipal emergency beds, health care services at home to nursing homes. In the following section (Section 3.4), the chapter discusses key elements to assure high quality of care out of hospitals that Norwegian authorities might want to consider as part of their internal quality assurance system, ranging from process to guide municipality in the process of establishing supplemented primary health care units, to mechanisms to improve care co-ordination and secure the qualification of health care professionals. Section 3.5 then considers how monitoring and contracting might need to be strengthened to move towards a quality improvement culture for these units. Section 3.6 concludes with some key suggestions, as well as discussion of possible risks to be averted.

3.2. Policy initiatives to expand primary health care services

Over the past years, Norway has made significant inroad to expand primary health care services through the implementation of policy initiatives such as the National Strategy for Quality Improvement in Health and Social Services, the 2007-2010 National Health Plan and the 2012 Coordination Reform. While the National Strategy for Quality Improvement in Health and Social Services regarded care co-ordination as a fundamental prerequisite for quality of care, the 2007-2012 National Health Plan and the 2012 Coordination Reform gave broader attention to the role of municipalities to take over the responsibilities of patients discharged earlier from hospitals or at risk of being re-admitted to hospitals.

The National Strategy for Quality Improvement in Health and Social Services

The National Strategy for Quality Improvement in Health and Social Services (2005-2015) provides an overall framework supporting leaders and professionals in their work of delivering high quality of health and care services. The strategy states that to be of high quality (Helsedirektoratet, 2005), health and care services must meet the following six elements:

- be effective,
- be safe and secure,
- involve the patients,
- be co-ordinated and integrated,
- utilise resources appropriately,
- be accessible and fairly distributed.

As part of the National Strategy, the Norwegian health care system is patient-centered and information, co-operation and quality improvement are considered as key components to achieve safe and effective health services.

One specific avenue for consideration is good co-ordination between the different levels of health and social services to manage efficiently chronic diseases and to improve the quality of care delivered for patients with long-term affections. As demonstrated by the National Strategy for Quality Improvement in Health and Social Services (Helsedirektoratet, 2005), there is room for improvement in this particular area of concern. In fact, it is argued that Individual Care Plan was not assigned to a patient with addiction disorders and that municipality did not provide any care follow-up. Another patient diagnosed with colorectal cancer reported communication issues between health professionals, moving back and forth between different hospitals and finally transferred to a nursing home. In both examples, the health care services were not efficient, co-ordinated and patient-centered.

Given these deficiencies, the National Strategy for Quality Improvement has the ambition to initiate quality improvement work in achieving, among other things, greater care co-ordination and integration between health and social services. This means that health care services in Norway might be delivered as a continuous and complete chain of services with a clear allocation of responsibility, authority and tasks within and across health sectors. With this respect, the Norwegian Government puts great emphasis on the implementation of Individual Care Plans for patient having needs for long-term and co-ordinated health services. As a result, the Practice

Consultant Scheme (further describes in Section 3.4) would open up new avenues to strengthen co-operation between hospitals, GPs and others municipal care services.

The 2007-2010 National Health Plan and the 2012 Coordination Reform

The Norwegian Government made further steps to expand primary health care services through the 2007-2010 National Health Plan and the Coordination Reform. These strategies focus on prevention and effective patient pathway; and both continuous and comprehensive health care services are considered as a matter of particular importance to achieve high quality of care.

In line with the National Strategy for Quality Improvement in Health and Social Services, the 2007-2010 National Health Plan recognised that patients might experience fragmented health care services for which there is no clear allocation of responsibility within and across health sectors (Norwegian Ministry of Health and Care services, 2006). Two observations are made by Norwegian authorities. There is first a lack of interaction between the primary and the specialised health care sectors and second, there is a lack of interaction between the health sector and the other social sectors while at the same time, there is an increasing number of patient having complex health and social needs. These observations clearly underscore the necessity of increasing care co-ordination and interaction within and between health care and social services. As a result, it is argued that health care services provided by the primary and specialised health services might constitute a network where both health care sectors are partners in delivering high quality of care. Health and social services must also be professionally co-ordinated. To meet these challenges, Norwegian authority has set up co-operation agreements that would be signed between responsible agents at national and local levels. These agreements are designed to guarantee a comprehensive care follow-up by ensuring that systematic interaction procedures, strategies and measures have been established between municipalities and health enterprises for some groups of patient.

In addition to improving care co-ordination and follow-up, the 2007-2010 National Health Plan further describes municipal health services as the main arena for preventive activities in the health service (Norwegian Ministry of Health and Care services, 2006). This means that effective treatment and follow-up might be organised at the lowest level of care to deliver adapted services through proximity, preventive activities and patient involvement. The need to develop high quality of local health services at

municipal level is pointed out as a matter of particular importance. The service provided by local hospitals must be, for example, modified or expanded at primary care level in putting greater emphasis on treatment and rehabilitation close to patient home (Norwegian Ministry of Health and Care services, 2006).

The objectives of achieving greater co-ordination and improving preventive activities are further described in the Coordination Reform (Norwegian Ministry of Health and Care Services, 2009). As noted in Chapter 1, the general intention of the Coordination Reform is to strengthen the role of municipalities in prevention and early detection and to provide health and care services to the public as close as possible to their home.

To this end, three substantial changes are introduced to the Norwegian health care system:

- The co-operation agreements between municipalities and health enterprises are becoming mandatory to specify the distribution of duties and responsibilities of each health sectors.
- The reform also introduces economic incentives and alters the governance structure so as to delegate a greater responsibility to the primary health care sector. Municipalities are required to co-finance some somatic specialised health care services and are also financially responsible for patients ready for discharge from hospital. Economic incentives involve a co-financing wherein municipalities are required to pay a 20% of the hospital cost when their residents are admitted to hospital for certain diagnoses. A financial penalty is further charged for local authorities when they fail to provide local care to a patient ready for discharge from general hospital.
- Finally, all municipalities are required to establish, from 2016, emergency beds as part of the primary health care sector.

These legal requirements have given an additional impetus to improve continuity and comprehensiveness of health care services, to encourage preventive activities and to achieve better cost containment through more effective use of health care resources. The Coordination Reform requires the diffusion of alternatives types of primary care models to be set up in different primary care settings including patient home, municipal facility or outpatient hospitals and clinics. These primary care services, further described in the next section, are provided by the municipality or the State (in case of mental health disorders – see Chapter 4) according to law, regulations and legal binding agreements. The Coordination Reform has led to the implementation of two key laws: the Health and Care Services Act of 2011 and the Public Health Act of 2011.

Finally, it is important to note that the objectives of expanding the role of municipal health care services are further defined in the National Health and Care Services Plan 2011-2015.[1] The current Plan stresses that municipal health and care services will be strengthened and will work in greater co-operation with family members, specialised health care services and local communities in order to achieve high quality of health care services.

3.3. Description of supplemented primary health care units

As mentioned in the previous section, the Coordination Reform gives priority to prevention and early detection in order to achieve better sustainability through cost-containment in hospitals. The result is a shift towards primary care settings, shorter stay in hospitals and more complex health conditions to be treated in the primary health and care services.

While in other OECD countries the term "intermediate care" is largely used, the Norwegian authorities rather encourage the development of "municipal services" or "sustainable, integrated and co-ordinated health and care services" for patient prior to, instead of, or following admission to hospital (Norwegian Ministry of Health and Care Services, 2013). According to the King Funds, these models of primary care services can be defined as any service structure or set-up, established by municipalities, "to provide short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care" (Stevenson and Spencer, 2002, p. 5).

The Coordination Reform did not seek to provide a definitive, unique solution to shift care toward primary care setting; rather it offered a framework of conceptualising care out of hospital and new roles for local governments. Comprehensive health and care services in Norway can be received in many different primary care settings. These supplemented primary health care units (also called "*Distriktsmedisinsk senter*" or "*Sykestue*" in Norwegian) might connect human and other health resources according to patient needs.

The main responsibilities of municipal services are:

- *Municipal emergency beds*. These new facilities provide care for patients for whom it is hoped hospitalisation could be avoided but who are too sick to remain in their homes, as well as patient at risk of exacerbation. An example from a large city is the Emergency Care Service unit in Oslo (Box 3.1). Every municipality are required to set up such services by 2016. Some are already established as pilots.

Box 3.1. The Emergency Care Service unit in Oslo

Oslo has for many years had a very popular primary care emergency unit down-town in Oslo which combines acute primary medical care services with specialised injury services. The unit also offers emergency psychiatric help, an Assault Centre for victims of rape and other forms of violence, as well as acute social care services. These services offer a roof to homeless people and others who may need temporary housing, provide counselling and support to drug addicts and people who are disorientated or have minor mental health disorders.

The unit has a Clinical Decision Unit with 18 beds where patients with an unclear diagnosis can be observed and assessed over a 24-hours period by clinicians before a decision is made on whether they should be admitted to hospital or can be sent at home. This unit has been a great success. For example, it is estimated that only one in five of patients are eventually admitted to hospital, suggesting significant reduction in the number of unnecessary admissions.

An additional unit has been recently established for patients with a known diagnosis who require some days' treatment but do not need hospital admission. The unit has 32 beds but plans are to expand to 73 beds. It is located independently from the emergency care unit and it shares premises with an acute primary care facility run by the municipality. It is staffed by GPs who also provide necessary house calls for patients with acute illness. Patients may be referred from the urgent care unit, individual GPs or even the hospital when patients do not require admission. The main objective is to reduce the number of unnecessary admissions for patients with chronic care needs.

The main feature of the unit is the combination of a wide range of acute medical and social services including acute psychosocial support and the Assault Centre. The main site is supported by acute primary care services with acute beds and house calls at a separate location, and a self-referral unit where elderly persons who become anxious living at home, can stay for some nights. This last unit is located within a nursing home. Altogether these services reduce the risk of unnecessary hospital admissions, though it is hard to quantify the exact effect.

Source: Information provided by the Norwegian authorities.

- *Nursing homes* with rehabilitation or post-acute care units attached to it and beds for short-term medical observation for patients discharged from hospitals. Typically, these facilities are staffed with nurses and nursing assistant. A single nurse is looking after a large number of patients during nights and week-end and with a physician on call. An example is the Søbstad Helsehus unit in Trondheim (Box 3.2).
- *Other types of municipal services* including rehabilitation units, local medical centres or dedicated units for patients with specific care needs (e.g., cardiovascular). To some extent, these services require additional human resources from the specialised health care sector such as medical specialist on consultative basis.

- *Services at home or other municipal health care services at home* defined according to patient needs. These services require nurses in addition to other home-based social services.
- *Emergency services* at home, at accident site or at a unit.

Box 3.2. The SøbstadHelsehus unit in Trondheim

The Søbstad Helsehus unit located in Trondheim is a community hospital with the aim to perform care for older patients initially admitted to the general hospital but without any need for further acute care.

The overriding goal of the unit is to foster recovery before returning home after general hospital care. By providing medical care and rehabilitation in a nursing home setting, the unit offers continuity and a pathway between advanced care and home care. The average length of stay for a patient in the unit is about 18 days.

The unit includes 20 beds and employs a larger number of medical and care staff than in a conventional nursing home. The general hospital has provided training to all employees working at the units. Although laboratory facilities in the community hospital were upgraded, there is an agreement with the general hospital to use the main laboratory for more advanced analysis.

There is evidence supporting the beneficial impact of this unit on patient. According to Garåsen et al. (2007), the Søbstad Helsehus unit has been more efficient than the general hospital in providing care to this group of patient. The supplemented primary health care unit has also resulted in better health outcomes for patients compared to other having received conventional care. Empirical evidence has shown that a quarter of patients gained physical independence after six months of stay, against only 10% of patients treated in the general hospital. Further, mortality rates after one year have been steadily reduced and re-admissions rates fell from 36% to 19%. These better health outcomes have led to a significantly lower cost of stay in the unit for this group of post-acute patients, compared to the general hospital.

Source: Garasen, H. et al. (2007), "Intermediate Care at a Community Hospital as an Alternative to Prolonged General Hospital Care for Elderly Patients: A Randomised Controlled Trial", *BMC Public Health*, Vol. 7:68.

The size, equipment and staff of supplemented primary health care units vary significantly. They can be very small, or look like a hospital in terms of equipment and range of professionals employed (nurses, health care workers, physiotherapists, occupational therapists, nutritionists, general practitioners and physicians with additional qualifications). A common feature is that the municipality is responsible for all units. The human resources are also employed by the municipality or on contract with the local authority. When medically necessary, there are additional services from a hospital including, for example, medical visits from specialists in

rehabilitation medicine, internal medicine, geriatrics or radiologists. These additional services are based on institutional contracts.

Some units are located close to or on the same premises as hospitals, other might be located close to acute care units in municipalities, to long-term and short-term care facilities, while other are set up as new larger independent units.

Beyond this brief description, it is far from easy to provide a full picture of supplemented primary health care units in the Norwegian context. There is not statistics providing a picture of what they look like. The 2012 Coordination Reform and the 2011 Health and Care Services Act, suggests that supplemented primary health care units be vehicles for strengthening the role of municipalities but it, however, does not set in definitive terms how these initiatives should look like.

3.4. Assuring high quality of care in keeping people out of hospitals

A main ambition of the Coordination Reform is to expand primary care services to promote efficient utilisation of health care resources through greater prevention and higher care co-ordination. To this end, municipalities are required since the 2011 Public Health Act to assess local health needs in order to develop and implement appropriate public health measures (Norwegian Ministry of Health and Care services, 2011). At the same time, Norway has established several e-health strategies such as the Norwegian Health Network and the introduction of the Electronic Health Records (EHR) to support the diffusion of information between health providers and to improve their co-operation. Beyond these initiatives, it is recommended to ensure that care delivered in these supplemented primary health care units is of consistent and adequate quality. There are a number of possible mechanisms that might be considered to meet the new demands and roles required for supplemented primary health care units.

Getting a picture of supplemented primary health care units and developing a framework to guide their development

At present, local authority and health enterprise are obliged to enter into agreements before establishing a supplemented primary health care unit. The Norwegian Directorate of Health has established national guidelines stipulating what should be provided at municipal emergency bed, which all municipalities are required to have by the 1st January 2016. More concretely, these guidelines cover things such as the co-operation agreement between local authority and health enterprise, the patient groups for which emergency bed is appropriate and some general requirements in staffing,

qualification and medical equipment (Norwegian Directorate of Health, 2012). Although informative, these guidelines appear however rather broad, giving flexibility to municipalities to make tailored arrangements. As a result, municipalities have developed many different models of organising municipal emergency beds (KS and Deloitte, 2013).

The current legislation makes local authorities responsible for the provision of primary care and for the allocation of resources within the community to provide safe and adequate quality. However, there does not appear to be a framework document identifying the main challenges municipalities will need to address in setting up these units, clarifying the responsibility of the unit vis-a-vis GPs and other primary care services, and setting what quality framework would underline the work of supplemented primary health care units. As a first step, it seems advisable to develop some sort of framework for how these units could look like and what would be expected in terms of quality infrastructure for them.

The Norwegian Association of Local and Regional Authorities (KS) has provided a report of municipal emergency beds last November 2013 (KS and Deloitte, 2013). It investigates the development of emergency beds among 79% of Norwegian municipalities in order to provide recommendations. Beyond this report, no comprehensive inventory of what existed prior to the Coordination Reform, especially local, successful examples, has been developed to guide the reform implementation. Such document and picture could provide inspiration to other municipalities, and could also include a review of experiences with supplemented primary health care units from other countries. For example, the Netherlands has long experiments with these primary care units (called intermediate care facilities), but the experiment turned out to be more complex than originally envisaged (Mur-Veeman and Govers, 2011, Plochg et al., 2005). Learning from other international experiences could be useful as Norway moves ahead with strengthening primary care services (Box 3.3). Table 3.1 provide a summary of desirable and less desirable practices with supplemented primary health care units, based on a review of the experiences in the United Kingdom and the Netherlands.

Box 3.3. International experiences with supplemented primary health care units:* lessons from the United Kingdom and the Netherlands

As in Norway, supplemented primary health care units have been implemented in other OECD countries such as the Netherlands and the United Kingdom. The review of good and bad practices in both countries may serve as a useful model for Norway as part of the process of developing these units.

In both countries, these units were proposed as an alternative to hospital admission in order to maximise recovery and rehabilitation following early discharges. Apart from the promotion of functional independence, the main objectives of this initiative were to minimise unnecessary length of stay and thereby, to reduce system pressures faced in acute hospital sector. In the United Kingdom, these units have been implemented following the National Beds Enquiry report, the National Service Framework (NSF) for Older People and the 2001 NHS Plan (Stevenson and Spencer, 2002). Several services model of supplemented primary health care units exist in the United Kingdom including community hospitals, hospital-at-home schemes, nursing and residential home rehabilitation, day hospitals or nurse-led units (British Geriatrics Society; 2008). In the Netherlands, these facilities have emerged from 1996, mostly in the forms of nursing departments and GP hospitals (with rehabilitation and nursing home beds) (Moll van Charante, 2007).

The development of supplemented primary health care units has been hampered in the United Kingdom and the Netherlands by a lack of co-ordination between services as well as a lack of integration into the whole health care system (Barton et al., 2006; BGS, 2008; Pearson et al., 2013; Stevenson and Spencer, 2002). Isolation from the primary and specialised health care services appeared as a main problem for these units. In the Netherlands, interviews show that co-operation between the hospital, the nursing home and the unit was insufficient (Mur-Veuman and Govers, 2011). The three organisations were considered by staff members as independent to provide care, thus failing to share information regarding patient care or patient flows. In another Dutch unit, the patient transition between services appeared to be poorly organised, increasing the average length of stay in the acute sector (Plochg et al., 2005). Whilst regular clinical governance meeting and the use of single patient record are of relevance to achieve better care co-ordination between health and social services, these practices were often missing in an English facility (Hutchinson et al., 2011). Available evidence shows that insufficient integration and lack of co-ordination are associated with ineffective clinical outcomes and have negative impact upon the ability to deliver patient-centered care (Young et al., 2005; Mur-Veuman and Govers, 2011; Plochg et al., 2005).

Further, because of blurred definitions, there was confusion about what is "intermediate care" among policy makers and health professionals (Stevenson and Spencer, 2002; Plochg et al., 2005; Department of Health, 2002; BGS, 2008). This has resulted in a large expansion of these units through a variety of schemes which has led to fragmentation. At present, there is in the United Kingdom and the Netherlands a wide variation of service models in terms of capacity, content, setting and staffing, meaning that it is difficult to evaluate overall benefits. In the United Kingdom, the uneven spread of these units around county has resulted in some inequalities in access (National Audit Office, 2003).

More importantly, both countries have experienced workforce problems in their process of setting-up supplemented primary health care unit (Veuman and Govers, 2011; Plochg et al., 2005;

Hutchinson et al., 2011). In the Netherlands, the nursing staff mix was unbalanced due to a shortage of skilled nurses. The care was delivered by nursing assistants rather than medical and registered nursing staff, which might be the result of poor improvement in the quality of care (Plochg et al., 2005). With this respect, it appears necessary to develop skilling or education programmes for nurses and care assistants because the latter might have greater involvement in patient care than in acute hospital (Pearson et al., 2013; BGS, 2008; Barton et al., 2006). Health care workforce in supplemented primary health care unit should have appropriate skills that enable to secure high-quality of post-acute care for patients with complex health and social needs.

Finally, policy aims at monitoring supplemented primary health care unit was poorly functioning at its early stage of development. In the United Kingdom, there have not been until recently defined national standards for data collection, nor precise performance indicators to monitor quality of care in these units (Stevenson and Spencer, 2002; Barton et al., 2006). In the Netherlands, the quality assurance model was not functioning because managers and leaders were not involved in setting up the unit and because health professionals did not have the expertise to provide the care needed by patients (see Box 3.5).

Monitoring care in these units has been recently improved in the United Kingdom. Recent initiatives have been conducted to measure quality of care through the development of an Annual National Audit of Intermediate Care (see Box 3.6) and the implementation of inspection in these units. This valuable practice is not unique, since other supportive initiatives have been implemented at the early stages of supplemented primary health care unit development (Stevenson and Spencer, 2002).

A number of policy papers and reports have been issued by the UK Department of Health in order to provide health professionals with general guidance for the establishment of these units (Stevenson and Spencer, 2002). The first detailed guidance published in 2001 contained for example important information about appropriate service models, responsibility and funding as well as community equipment services (Stevenson and Spencer, 2002). These units have also been included in more specific medical guidelines such as disease-specific guidelines to promote good practice.

In addition, authorities in the United Kingdom have provided follow-up guidance to help identifying success factors and thus guide the development of units. An assessment of progress was made in order to explore areas where further actions were required, which in turn led to a new implementation framework (Stevenson and Spencer, 2002; Department of Health, 2002; Department of Health, 2009).

A further prompting element was the large budget that the central government has allocated to foster the development of supplemented primary health care unit. The Department of Health has invested over GBP 800 million between 2001-02 and 2003-04 (National Audit Office, 2003) and additional funding was attributed to some counties to develop new units. Although this financial investment was considered as supportive, it is important to mitigate perverse incentives that might lead to an improper use of these units. This was the case in the Netherlands, where financial incentives have encouraged some units to achieve a full occupancy rate in order to meet the expected volume of care and thus not to suffer budget cuts. As a result, no formal admission criteria were used, diverting these units from their primary objective of delivery transitional care (Plochg et al., 2005; Mur-Veuman and Govers, 2011).

*: In most other OECD countries, supplemented primary health care units are called Intermediate Care Facilities.

Table 3.1. Review of practice with supplemented primary health care units

Good practice	Bad practice
• General or specific guidelines and follow-up guidance	• Lack of clarity about definition
• Implementation strategy with explicit standards	• No precise performance indicators
• Good data infrastructure, single records transfers across settings to help good management of transitions	• Lack of integration and co-operation
• National audits	• Shortage of skilled nurses
• Inspection of units	• Perverse financial structure

Improving care co-ordination and co-operation between hospitals and municipalities

Better co-ordinated care across settings is critical for delivering patient-centered care, particularly for patients with complex health and social needs who are more likely to move between various health care providers, often at different levels of care. As this section examines, there is no one model to achieve greater care co-ordination, but working with multi-professional teams including both primary and social care professionals or appointing care co-ordinators, and developing co-ordination indicators are key components.

The Norwegian Knowledge Centre for Health Services has published a systematic review of integrated care and the management of chronic care after hospital discharge for people needing long-term care (Oxman et al., 2008). The Centre recognised the important role supplemented primary health care units might play to achieve better co-ordinated clinical pathways for patients. The Centre has also provided reports on the types of interventions that could be helpful to reduce unnecessary hospital admissions (Forsetlund et al., 2013). These reports point to supplemented primary health care unit as an alternative to prolonged hospital stay for elderly and to hospital admission for some chronic conditions. The need to transfer some responsibilities from the specialised to the primary health care sector and to provide more treatment or care in the community is also underlined. It is anticipated that the development of supplemented primary health care units would reduce hospital admission because it enables to achieve a better continuity of care across different settings.

Although a main goal of expanding the primary care setting is to improve co-ordination with the specialised health care sector, simply having supplemented primary health care units will not ensure co-ordination in itself. As demonstrated by the evaluation report commissioned by the Norwegian Nurses Organisation (Gautun and Syse, 2013), collaborations between hospitals and municipalities health services have not significantly improved after the implementation of the Coordination Reform in January 2012. Only a quarter of nurses reported that health services have become more co-ordinated and that transfer processes have improved. A number of actions will need to support this reform provision, requiring concerted efforts and investment on the part of different actors in the Norwegian system including local and national authorities.

First, it is recommended to develop indicators and a comprehensive information system to sustain supplemented primary health care units and to deliver co-ordinated care. As demonstrated in the National Strategy for Quality Improvement in Health and Social Services, some Norwegian patients reported communication issues between health professionals. Information produced by hospitals, such as discharge information and care plans for example, do not move swiftly down to primary care levels. As demonstrated by Garasen (2008), there is a need for Norway to develop better communication between primary and specialised health care services. In a similar vein, the Trondheim case has shown that the quality of written communication between health professionals, as measured by referral and discharges letters, was weak because vital health information was missing. This lack of communication between health sectors is a stumbling block to care co-ordination and it might increase the risk of inappropriate care and also lead to inappropriate prescribing in supplemented primary health care unit (Bakken et al., 2012). Information flows from and to primary care facilities needs to be developed also too.

Among the possible indicators that could be used to monitor the quality of care co-ordination are:

- the share of discharge information that reaches supplemented primary health care units within a time span of 24 hours;
- the proportion of discharge information or nursing home information that is shared with these units;
- preventable hospital admissions for chronic conditions that could be dealt within community and supplemented primary health care units;

- the rate of admissions and readmissions from supplemented primary health care units for certain people with chronic conditions; and
- measures of waiting times for "admissions" to supplemented primary health care units.

An important aspect of co-ordination is the extent to which there is professional teamwork, integration between primary health care services, or the attribution of a particular co-ordination role to supplemented primary health care units to guide patients transferred between hospital and primary health care services. While the role of care co-ordinators remains a main task for GPs to perform, other health professionals (often a nurse) can be assigned as care co-ordinator when the GP is incapable to perform this task. One should note that patients with complex health needs have, by legal acts, the right to such care co-ordinator. Both the municipality and the hospital shall have a contact point for services to be co-ordinated.

To meet these challenges, some municipalities have started to hire GPs to respond to the requirements of the Coordination Reform. Some hospitals have also hired PKO consultants (see Box 3.4), or discharge nurses to contact municipalities when patients are ready for discharge from hospital in order to ensure the process of discharge is well co-ordinated. The Practice Consultant Scheme (Praksiskonsulentordningen – PKO) is a useful development to promote and support co-operation between GPs, other primary care services and hospitals. It intends to build networks between GPs and hospitals, it promotes quality referrals and discharge procedures and contributes to the development of electronic communication between health professionals. Overall the scheme is impressive and Norwegian authorities should ensure that supplemented primary health care unit, as other primary care services, are linked to PKO consultants and are included in discussion around the best way to manage the discharge of patients.

At the same time, discussion with Norwegian stakeholder gave the impression that primary care facility – whether municipal emergency bed, or other supplemented primary health care units – might have developed as an "adds-on", but somehow parted from the already pre-existing primary health care infrastructure. This is in part because the respective roles of GP, nurse and other staff in co-ordinating care are not clearly defined or differentiated, neither at central nor at local level.

Box 3.4. The Practice Consultant Scheme

The Practice Consultant Scheme (*Praksiskonsulentordningen* – PKO) has been in place in Norway since 1995, when a corresponding Danish model was adopted. The central feature is that GPs, who are municipality-based, take on part time contracts with the hospital, work in different departments and form a team within each hospital. These PKO consultants work with hospital administrations and clinical departments to promote co-operation between primary and specialised services.

PKO consultants seek to improve co-operation between physicians in clinical work, regarding diagnostic, therapeutic and follow-up activities. The scheme aims at close collaboration with health professional within nursing and rehabilitation services. The principal aim is that patients receive health services that are safe, predicable, co-ordinated and of good quality. The PKO consultants do not deal with individual patients.

In late 2012, all 19 out of 20 public hospital organisations had established this service. The workforce corresponded to 20 full positions, distributed among 140 consultants. Some few hospitals have also employed nurse and physiotherapist in this service.

The scheme seeks to establish local consensus on the distribution of medical responsibility between primary and specialised care. A central task is to improve the quality of referrals and discharge messages by creating professional dialogue, developing routines and follow up. The municipalities have no formal responsibility for the scheme, but systematic contacts with health officers in the communities and with the GP are essential. The scheme includes information work both within the hospital and across health care sectors, which is a substantial element to improve care co-ordination.

Source: Information provided by the Norwegian authorities.

While there is no "one-size-fit-all" solution and municipalities might respond to the challenge in different ways, certain solutions to reduce the risks of care being uncoordinated or fragmented might be desirable. For example, it seems appropriate to ensure that:

- supplemented primary health care units have access to the GP and hospital medical record of the patients;
- they can have access to any GP booking system for a patient seen in these units;
- supplemented primary health care units have access to the list of care co-ordinators, whether PKO consultants, GPs or nurses, and the name of the patients having a care plan;
- care co-ordinators have real-time information on availability of rooms in nursing home settings, and in home care services;

- care co-ordinators are linked to supplemented primary health care units and provide feedback on care improvement – electronically, through meeting or otherwise.

Developing skills and workforce capacity in supplemented primary health care units

Discussion with key stakeholders in Norway and a review of published studies point to two main challenges with the workforce: one in relation to the number of staff, the second in relation to the qualification of health professionals within supplemented primary health care units.

The new reform will require local governments to develop new beds, structures, and to employ health professionals in these units. However, there is some indication that supplemented primary health care units might be under stress to deliver care to a growing number of people discharged from hospitals, and that the policy reform might have come along too quickly for some local governments to adapt. It appears that supplemented primary health care units have not as yet, or not in advance to the reform, built up the infrastructure and capacity to support the new demands of the Coordination Reform. Some nurses, for example, stressed that their work have become more challenging because of a scarcity of medical equipment and information (Gautun and Syse, 2013). Discussion with Norwegian stakeholder also reported that waiting times to access to short-term beds in nursing homes are growing in some areas, an indication that bottlenecks might have emerged at local level. Another example concerns the little capacity, in some municipalities, to deliver physiotherapy for patients discharged earlier from hospital, for example those requiring orthopaedic rehabilitation. This suggests a need for better capacity development, and also that municipalities are struggling to provide the care needed by patients.

There is a further fear that workers at supplemented primary health care units might not have the right level of expertise to address a population with early discharge from hospital and characterised by a high complexity of care needs, such as frail elderly or those with multiple chronic conditions. As demonstrated by the evaluation report commissioned by the Norwegian Nurses Organisation (Gautun and Syse, 2013), mostly all nurses working in nursing homes or home care services reported that the nursing tasks have become more complex and too numerous due to a growing number of patient discharged earlier from hospitals than before. For 74% of nurses, their work load has significantly increased and most importantly, 73% of them reported to have unmet needs for education, which have resulted in more limited health services. Nurses stressed the need to increase the

number of qualified nurses in both nursing homes and home care services (Gautun and Syse, 2013).

At present, there are no formal national standards concerning the skill mix and competences required for staffing supplemented primary health care units. In fact, these units are staffed differently, reflecting a wide range of skills. While some municipalities have started to employ salaried GPs to respond to the new ambitions of the Coordination Reform, this does not seem to be the norm to date, and relatively few units might employ nurses with advanced master training.[2] A good sign is that there is willingness from professionals such as nurses in upskilling. This is demonstrated in the evaluation report in which most nurses asked for educational measures to increase their competency (Gautun and Syse, 2013).

At the same time, several nurses might have special training in care for elderly people, dementia care, palliative care, cancer care or mental care. Finally, it is important to note that the national Competency Plan 2015 (Kompetanseløftet, 2015) has been launched to increase the capacity of municipal services. The overriding aim of the plan is to ensure that primary health care services have knowledgeable and competent health professionals. For 2011-15, the plan focuses on five objectives including the increase in the number of municipal health professionals, the improvement of their educational level, the need to guarantee adequate number of health care workers per year, the enlargement of professional scope and the increase in guidance, internal training and education.[3] To this end, the Norwegian Government provides grants to municipalities to improve both health educational programmes and the number of health care workers, but also to build or renovate municipal health care services. Overall the plan is impressive, during the first six year of the plan (2007-12) nearly 21 000 people have completed qualification either through basic, further or continuous education programmes.

In spite of these valuable initiatives to increase the capacity of municipal health care services and to enhance qualification, Norwegian authorities might want to address the remaining issues:

- *First, it seems important to help local governments survey and quantify staffing levels and shortages better.* With this respect, important steps have been taken with the national Competence Plan 2015 (Kompetanseløftet 2015), which is included in the National Care Plan 2015. In addition to increasing the number of qualified health care worker, the Competence plan has developed an annual special reporting system for the local authorities. It includes data on total health professional in health care services and its annual variations. This system would help Norwegian authorities to

quantify future needs regarding staffing and skill levels for the development of supplemented primary health care units.

- *Second, Norwegian authorities will need to agree on appropriate mechanisms for scaling up staffing and competences.* As noted by the recent KS report, there is a need to strengthen professional competence of nurses through, for example, practical training (KS and Deloitte, 2013). Other OECD countries, such as Japan, Spain, France, the United States, Germany, Denmark and South Korea, set minimum educational and training requirements for personal care workers attending to frail old people, for example (Colombo, 2011; OECD, 2013). Denmark has a national curriculum for social and health care helpers and assistants lasting respectively one year and seven months and one year and eight months, which include both an education model and practical training. Requiring minimum workforce standards (ratios and skills), for example in nursing-homes and municipal emergency beds, might be an appropriate way to assure quality and minimise nursing errors or inadequate care. As mentioned in Box 3.3 and Box 3.5, both the United Kingdom and the Netherlands experienced workforce problems because of a shortage of skilled nurses in their structures. More specifically, in the Netherlands the care was delivered by nursing assistant who did not have the appropriate qualification, underlying the importance of developing education or skilling programmes to ensure that nursing assistant are able to deliver *adequate* quality of care (Plochg et al., 2005).

  Other ways to achieve this goal also ought to be considered, notably by seeking to ensure uniformity in the process of assessing performance of care workers. At present, there does not seem to be a formalised *system of continuous professional education for nursing staff, for example, something that could be encouraged and incentivised.*

- *Third, there seems to be an opportunity for learning from the development of innovative models of care revolving around staff roles and responsibilities.* To take an example, as nurses employed in supplemented primary health care units have increasing responsibility helping to reduce unneeded hospitalisation, there is likely to be a demand for 24-hour service in municipal emergency beds. As an alternative to staffing such units with nurses available round the clock, it would be desirable for municipalities to develop telecare services linked to these supplemented primary health care units , that patients could reach over the phone or be connected to

electronically for advice, assurance, and help. These services could be jointly organised across municipalities. There are already models of telecare services to build upon. Pilot projects were for example set up at the Norwegian Centre for integrated Care and Telemedicine in Tromsø. Another example is in the city of Oslo and Stavanger where pilot projects try to keep seriously ill COPD patients at home with additional resources from hospitals. These projects have a great potential in reducing hospital readmissions and in lowering mortality rates (Jeppesen et al., 2011).

Box 3.5 Learning from the Dutch experience: the importance of skills in supplemented primary health care unit

A supplemented primary health care unit was established at the end of the 1990s in the South-Eastern Amsterdam district in the Netherlands. It was specifically set up within a nursing home (the Henriette Roland Hold House – HRHH), and in collaboration with the Academic Medical Center of the University of Amsterdam (AMC). The main goal is to provide transitional care to patients whose medical treatment had been completed. Concerns about quality of care rapidly emerged within the unit, mainly because the quality assurance strategy was missing.

The unit was found to be poorly functioning by both staff members and patients, and as a result it was unable to deliver good quality of care. While several quality assurance activities were instituted, its implementation was quasi non-existent within the unit. Agreed working processes and practices were not consistently followed by staff members because of a lack of expertise from health professionals. The latter had no experience in providing post-acute care; rather they were used to deliver limited care to elderly patient. Further, managers and leaders were not sufficiently involved in setting up the unit so that supervision was scarce and staff members not adequately prepared. Altogether, lack of knowledge and organisational ability, as well as limited supervision from managers led to defections in the functioning of the quality assurance model.

This experience suggests the importance of developing a detailed implementation strategy to follow quality assurance activities. For this purpose, it is important that all relevant staff members and managers are involved, encouraged to develop continuous communication and supervision, and thereby nurturing a continuous improvement culture.

Source: Plochg, T. et al. (2005), "Intermediate Care: For Better or Worse? Process Evaluation of an Intermediate Care Model Between a University Hospital and a Resident Home", *BMC Health Services Research*, Vol. 5:38.

Building capacity and learning

The Coordination Reform and the linked requirements to set up supplemented primary health care units clearly require municipalities to play a larger and more significant role. Besides the other issues already mentioned in this chapter, it is clear that efforts might be necessary to build

capacity for addressing these new sets of responsibilities fully and successfully, especially in smaller municipalities. There seems still to be concerns shared by several key players that municipalities were not ready or adequately resourced for taking on the new responsibilities. The fact that more than half of the 428 municipalities have less than 5 000 inhabitants, with limited resources, might make it harder to take on these new roles in negotiation with hospitals.

With this in mind, it will be critically important to ensure that a strong internal quality culture is present once municipal emergency beds and others supplemented primary health care units will be established. This is something that does not emerge by itself or overnight. It will be necessary to ensure that supplemented primary health care units comply with the Norwegian regulation for internal quality assurance of health services (described in Chapter 1) and it might also be advisable to develop a broader quality assurance system through, for example, accreditation. Another important point will be to encourage a culture of open comparisons and learning. Although not strictly related to supplemented primary health care unit, a clear example is offered by the system of Open Comparisons of Sweden (OECD, 2013). This consists of indicators of quality of health care in different Swedish counties, presented in an annual publication that is released by the Swedish association of local governments. This has been a very powerful tool for encouraging municipalities and counties appearing at the bottom of the ranking to lift their standards. A condition for this type of approach to work is that an agreed set of quality indicators be collected by all municipalities, on a regular basis.

Norwegian municipalities have different size and capacity. Although governmental grants are allocated to all municipalities to strengthen their capacity, some seed funding might be a good incentive to encourage quality monitoring and collection for the least endowed municipalities. An example is the way Oslo works with its own districts. As the changes implied by the Coordination Reform were likely to lead to earlier patient discharged from hospital, Oslo has distributed the grants to districts to deal with higher demands for patient follow-up. Most districts have spent these resources to scale up home-care capacity. In addition, some districts have employed officers that would directly visit patients in hospitals to facilitate planning of discharge, assessment of whether patient should be going home or be admitted to supplemented primary health care units, and any other follow-up needed in the municipalities.

Another possibility is to establish clear leadership roles, and encouraging municipalities to share successful experiences, through some "contests" or celebration of successful examples. For example, the requirement for 20% co-financing of hospital cost by municipalities has

created interest in municipalities in seeking innovations in shared care models. It is important that such initiatives and the learning it brings, is adequately shared and disseminated across the country.

A final issue concerns opportunities for two or more municipalities to work together. As the scale and complexity of the tasks managed by local governments grow, there is today a need for larger organisational units for supplemented primary health care unit, and therefore many municipalities already have established inter-municipalities units. This process needs to be encouraged to drive improvement in the quality of care. As such, it appears that co-operation between municipalities, as well as the involvement of physicians in the process of setting up the unit, is of paramount importance to achieve more efficient provision of care, especially for small municipalities with limited resources (KS and Deloitte, 2013). Co-operation between municipalities increases the opportunity for dialogue between professionals and allows for more experiences and more available health resources.

Similarly, there appear to be few opportunities for patients to choose supplemented primary health care units offerings from different municipalities. While a clear advantage of these units is closeness and embedness in community care, there could be a scope for municipalities to diversify their offer of supplemented primary health care unit for a particular group of patients. This would require giving patients the opportunity to receive care in unit located across their own municipality boundaries. Linked to this, experiences with joint purchasing of services across regions and municipalities boundaries might offer a greater range of services.

3.5. Moving forward, strengthening monitoring and improving contracting for quality improvement

Measuring quality and outcomes

A strong learning from the example with supplemented primary health care units in other OECD countries such as the Netherlands and the United Kingdom is the importance of carefully monitoring quality (Box 3.5). As noted earlier, Norwegian municipalities are required to set up municipal emergency beds from the 1st January 2016 and from this date quality measurement system will be an obligation. To date, however, there seems to be little if any embedding of quality measurement as part of the process of developing supplemented primary health care units in Norway.

Recognising how critical to the success of municipal services the measurement of quality is, it will be important for Norwegian authorities to strengthen the information infrastructure and measurement system

underpinning these supplemented primary health care units. Specific suggestions include for example:

- *Assess local needs,* especially focusing on frail elderly and people at risk of hospitalisation such as those with chronic conditions. It is important to note that steps have already been made in this direction. The new Public Health Act requires that municipalities collect information around local health needs. Accordingly, municipality might assess population's health and identify its causal determinants using information made available by national or county governments, as well as using knowledge from local health services or community (Norwegian Ministry of Health and Care services, 2011). The Norwegian Institute of Public Health (www.fhi.no/) provides, for example, information about local health needs, disease prevalence, and the use of nursing and other care services.

- *Develop an accurate picture of supplemented primary health care units.* There is an opportunity for the Norwegian Knowledge Centre for the Health Services (see Chapter 1) to deliver some sort of systematic reviews of municipal emergency beds, along the line of what was done, for example, with systematic reviews of integrated care (Oxman et al., 2008; Bjerkan et al., 2011). Currently the nursing association appears to be working on an evaluation of these municipal emergency beds. The evaluation investigates whether municipal health care services are well equipped to provide care for a growing number of patients discharged earlier from hospital. In particular, it studied the experience of municipal nurses working in nursing homes or home care services. Overall the evaluation report demonstrates that nurses are under more pressure since the implementation of the Coordination Reform. Most of them reported having less time for care work, and asked for additional medical equipment, educational measures and information to facilitate the provision of care (Gautun and Syse, 2013). Beyond this, Norwegian authorities should have the ambition to deliver a regular national report on quality or develop a National Audit on these municipal services as in the United Kingdom (see Box 3.6).

Box 3.6. The National Audit of Intermediate Care facility in the United Kingdom

A National Audit of Intermediate Care has been conducted since 2012 to measure service provision and performance against standards in these facilities (see Table 3.2). The NHS Benchmarking Network is in charge of the audit and it works in partnership with various health professional bodies, NHS organisations and local authorities. It was designed to obtain comparative national data at commissioners, provider and patient level, covering bed and community-based intermediate care services.

In 2012, the objectives of the National Audit of Intermediate Care were the following (BGS et al., 2012):

- To develop quality standards for intermediate care,
- To develop a set of patient outcome measures and to determine if the measures could be case mix adjusted
- To assess performance against the agreed quality standards and outcome measures
- To summarise national data and provide results on key performance indicators
- To inform future policy development within the Department of Health and the NHS Commissioning Board.

Participation to the national audit was voluntary and all Primary Care Trusts in the NHS were invited. The Audit management and data collection were organised by the NHS Benchmarking Network. In particular, each registered facility was required to fill the questionnaire through a secure website.

At the organisational level, commissioners were asked about quality standards, commissioning partners and providers, services commissioned, access criteria, funding, bed-based activity and home-based activity (BGS et al., 2012). For each identified service, providers were then asked to complete a questionnaire regarding quality standards, services provided, funding, activity and workforce. Finally, each intermediate care service was required to perform patient level audits for consecutive discharges from the service. Other data sources were used within the audit, such as the Hospital Episodes Data which was specifically used to assess the impact of these services on secondary care utilisation.

The national audit is planned to be carried out annually in order to monitor over time the quality, performance and development of these facilities. The 2013 edition* has developed a Patient Reported Experience Measure and other outcome measures for intermediate care and also tries to develop detailed case studies of high-performing intermediate care services.

* www.nhsbenchmarking.nhs.UK/projects/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php.

Source: British Geriatrics Society et al. (2012), "National Audit of Intermediate Care Report 2012", NHS Benchmarking Network, London.

- *Develop indicators of quality for supplemented primary health care units.* Many of supplemented primary health care units consist of community care beds providing a mix of post-acute, rehabilitation, or nursing care. Norwegian authorities could encourage

supplemented primary health care units to collect some of the measures already used in nursing homes. Some of the possible indicators of quality of care that could be collected, as done in some OECD countries, are pressure ulcers, incidence of falls and fall related fractures, incidence of malnutrition, multi/poly-pharmacy, and the management and assessment of pain.

Other possible indicators would include measures of patient experience in supplemented primary health care units collected through national user experience surveys conducted by the Norwegian Knowledge Centre for the Health Services (see Chapter 1), which could be built as part of the municipality health indicators (KOSTRA). As noted earlier, a candidate area would be co-ordination between hospital care and municipal care. Another area could be around the number of users who have a care co-ordinator and use a care plan within these units. There would also be a need to develop indicators on general medicine (see Chapter 2), along with those existing on hospital care, with a view to monitor the full pathway of care of certain patients. As part of the legal requirement that makes municipalities responsible for collecting indicators, the Ministry of Health and Care Services or its agencies could require municipalities to collect the above mentioned indicators for supplemented primary health care units. Last, the process of developing quality indicators for municipalities that the Norwegian Directorate of Health is setting up should be expanded. With this respect, the Norwegian Directorate of Health has published data on the cost and the use of hospitals for municipalities, enabling them to better plan and organise health services including supplemented primary health care units.

- *Strengthen systems for tracking quality information.* Efforts to develop the data collection infrastructure are also needed. An important first step would be to standardise the way supplemented primary health care units keep their records, with the aim of developing uniform or at least compatible coding systems with those used by hospitals and GPs. At the moment, there does not seem to be a unique system used by municipalities, and it is unclear to what extent these are compatible with the rest of the health care system information infrastructure. Another important issue would be ensuring quick transfer of hospital discharge information and other patient records to municipal primary health units. More broadly, these facilities should be included in the wider national efforts around the modernisation of health systems, the e-health agenda, and the development of patient e-journals. For example, it will be important that all municipal health services are part of efforts to upgrade and standardise the architecture of health information systems and the capacity to collect data.

All these efforts might involve significant investment on the part of municipalities and thought could be given to provide some monetary incentives to help this work kick off. The KS is well positioned to help municipalities identify what quality indicators would work and be the most useful in the Norwegian community care context, and should therefore take the lead in initiating this work. This information would be useful both for providers, and could be set in a format that is understandable to patients as well.

Table 3.2. Example of quality standards used for intermediate care audit in the United Kingdom

Quality standards for commissioners	
Governance and strategy standards	- Is there a multi-agency board for intermediate care? - Is strategic planning for intermediate care undertaken jointly by health and local government? - Is there a local intermediate care strategic plan - Is there a single intermediate care manager coordinating all intermediate care provision?
Pathway standards	-What is the assessment framework used (common assessment framework, single assessment process, other, etc..)?
Participation standards	- Have views of service users been actively sought?
Performance management standards	- Have performance goals been set and measured for the whole health and social care system - Have goals that reflect the quality of the service and the users' experience been set? - Have indicators to monitor the delivery of service performance been developed and reviewed at least annually for each intermediate care service?
Quality standards for providers	
Provider participation standards	- Have views of patients and their carers on current services been actively sought? - Have plans for future service developments been actively sought?
Clinical governance and pathways	- Are multi-disciplinary team meetings held once a week? - Are incident reporting systems set up? - Is an intermediate care plan documented for each individual?
Workforce standards	- Is there mandatory training in risk assessment for all staff? - Have all members of the team received training in mental health and dementia care?
Resource standards	- Is there a shared, electronic patient record? - If not, is there a comprehensive, shared paper patient record?

Settings standards and monitoring

A broad issue concerns to what extent Norwegian authorities might want to better standardise care processes for supplemented primary health care units and strengthen the ability to monitor deviations or undesirable outcomes.

Thus far, there does not seem to be any standards for municipal emergency beds, nor requirements for accreditation of such facilities. The national guidelines for opening emergency beds facilities issued by the Norwegian Directorate of Health are broad and mostly about inputs and the structure of the facilities (such as the patient groups for which the service is appropriate, the need assessment process for patient and other general requirement around staffing and medical equipment), but do not set precise standards for effectiveness or safety of care, or for co-ordination across care pathways. There is a risk, therefore, that units that are involved in the delivery of increasingly complex social and nursing tasks might not know what levels or benchmarks of quality are expected of them. It seems important that central authorities and local governments begin a dialogue about what standards or accreditation procedures might be needed for delivering good care in supplemented primary health care units. Starting with assessing the extent to which there is variation in care outcome or in patient experience at these units might provide a rationale for setting up such standards.

The Norwegian authorities could also consider including supplemented primary health care units in initiatives towards standardisation already underway in other areas. An example is patient safety, around which there seems to be a strong culture supporting its importance and the need for setting clear responsibilities, including at local level. The Norwegian patient safety campaign “In Safe Hands” lasted from 2011 to 2013. From 2013, the programme is further developed as a five-year programme and it includes most municipalities and hospitals. As part of the campaign, suicide prevention, infection prevention, the correct use of medicines and fall prevention are identified as key areas of concern (see Chapter 1). By the end of 2013, nearly 40% of municipalities were involved in the patient safety campaign. There is therefore an opportunity to include all emergency beds or other supplemented primary health care units in this programme, and ensure that patient safety standards are built for this particular setting. An important issue will be to ensure that patient safety standards cut across the whole continuum of care, from hospitals to all primary care services. These initiatives should also link back to any efforts at developing indicators of patient safety for these units, for example around issues of pressure ulcers or patient falls.

Another issue will be to ensure that supplemented primary health care units are included in any initiative to develop medical/nursing guidelines. To date, there is little quality guidance when it comes to these units. A possibility would be to include supplemented primary health care units in disease-specific guidelines already used in Norway, on issues such as dementia, diabetes, or other chronic care issues. In this regards, Norway should follow the English model that develops guidelines or guidance reports to support the effective and safety of care delivered in these units. The National Institute for Clinical Excellence (NICE) has, for example, established a disease-specific guidelines within supplemented primary health care units for the chronic obstructive pulmonary disease (NICE, 2010). For other chronic conditions, such as diabetes, some nursing guidelines have also been developed by experts, which discuss the treatment and clarify the roles of general practitioner, specialist, community nurses or dietician (British Diabetic Association, 2010).

It will be important to improve monitoring of supplemented primary health care units outcomes. For example, as part of efforts to develop quality indicators mentioned before, these units may need to be asked to report data on processes and outcomes of care. There are plans underway to develop community indicators around issues such as the use of care co-ordinators, which could be further enlarged. The ongoing strategy made in this direction focuses on municipal rehabilitation services, pharmaceuticals and nutrition for demented frail elderly. It consists of publishing national guidelines and establishing quality indicators to monitor these services.

There is finally a need for the Norwegian Board of Health Supervision to increase the frequency of its inspection in supplemented primary health care units. In this respect, there is an opportunity to build on the effective supervision model used for hospitals or other primary care settings, where the inspection Board carries out audits on very specific issues (such as single clinical areas or specific patient groups), helping to develop a culture of systematic assessment and quality improvement around areas of particular focus. A possibility would to apply this model to municipal emergency beds or others supplemented primary health care units, choosing for example to audit how care for certain patient groups with chronic care needs or post-acute rehabilitation needs is delivered.

Improving contracting across hospitals and municipalities

A further way to drive quality improvement in supplemented primary health care units would be by leveraging payment and contracting incentives.

As part of the 2012 Coordination Reform, the municipality is by law obliged to make agreements with hospitals. Prior to the reform, these agreements were advisable, on a voluntary basis, based on an agreement in 2007 between the municipalities and the Association of Local and Regional Authorities. The goals of the new measures are to encourage a discussion between hospitals and municipalities about issues such as the management of patient discharged to the community, ways to avoid unnecessary hospitalisation, the organisation of follow-up and post-acute care, and so forth. National health authorities do mandate specific content for such agreements and provide some general guidance regarding the process. These agreements have to cover the distribution of duties and responsibilities between hospitals and municipalities. More especially, an agreement has to describe how the transfer of knowledge and the exchange of information should be established between both health sectors. These contracts are also supposed to assist municipalities in prioritising medical resources and organising the use of GPs and his or her co-operation with specialists and other care staff (Norwegian Ministry of Health and Care Services, 2009).

While it is still too early to evaluate the impact of such agreements, the requirement has had an immediate effect: for the first time, many hospital managers and municipal decision makers have met to deliberate on improving care in the transfer process of patients between hospitals and primary health care. This is an important departure from the previous situation and it might mean a lot for efforts to further improve care co-ordination between municipalities and hospitals. To this end, it seems important that certain actions are undertaken.

With this respect, a critical issue might be the importance of not simply following standardised agreements, but rather for municipalities and hospitals to take real advantage of the opportunity for a dialogue on ways to improve care co-ordination. The agreements could also cover specific quality activities, process or outcomes, moving beyond simply information on "logistics". For example, the agreements could be an occasion for discussing or settings targets for specific groups of patients most at risk of hospitalisations or readmission, or for discussing the effectiveness of referral systems between primary and hospital care.

These efforts are likely to be useful the more they are informed and linked to other key providers of primary care, specifically the GPs. There is clearly a need as well as an opportunity for more effective involvement of GPs as part of the discussion on how to improve care co-ordination between primary care services and hospitals on early discharge, the respective roles and responsibility of GPs within supplemented primary health care units, and how to avoid hospital readmission. These could well take place within

the context of follow-up the agreements, and be tailored to the specific circumstances of each local context. There appears to be an appetite from all various stakeholders for this type of involvement, and it must be considered as a genuine opportunity in driving improvement in care quality. Along the line of what KS has done for the municipal emergency beds (KS and Deloitte, 2013), some demonstration of successful experiences across municipalities might stimulate others to extend beyond the scope of standardised contractual forms.

3.6. Conclusions

As part of the Coordination Reform, Norwegian municipalities are required to set-up municipal emergency beds or other supplemented primary health care units in order to strengthen health care in primary care settings and to promote the efficient utilisation of health resources. The growing complexity of health care needs, rising costs of hospital care and the ageing population, have made the establishment of these units of paramount importance to achieve greater care co-ordination across different health care sectors and levels. Norway is clearly committed to provide high-quality level of care to its population in strengthening the role of municipalities in prevention and early intervention. By 2016, all Norwegian municipalities are required to establish municipal emergency beds.

While it is too early to draw general conclusion about the existing units in Norway, recent studies proved that supplemented primary health care unit might result in better health outcomes for the target groups compared to conventional hospital care (Garasen et al., 2007) and might also reduce avoidable hospitalisation (Lappegard and Hjortdahl, 2013). Available evidence in Norway (KS and Deloitte, 2013) demonstrated that municipalities have developed many different models of supplemented primary health care unit. The co-operation between municipalities seems to be a key characteristic to achieve more efficient provision of care, as well as the involvement of health professionals throughout the whole process of developing the unit.

Norway is making progress in establishing national guidelines and in making recommendations for the setting up of supplemented primary health care unit. Although informative, these guidance materials are broad and should include more information on what would be expected in terms of quality infrastructure and how these supplemented primary health care units could look like to support the reform implementation.

Furthermore, Norway is making significant efforts to improve the information system. The Norwegian Directorate of Health, for example, is in the process of developing new community indicators on municipal

rehabilitation services, the use and the cost of hospital for municipalities. These initiatives ought to continue in Norway to secure high quality of care within supplemented primary health care units in putting greater emphasis on the outcomes or quality of care. This would ensure that health care services in these units are safe, effective, and patient-centered. Collecting information on the management of chronic conditions, the assessment and measurement of pain or the patients' experience are candidate indicators to monitor the quality of these municipal health care services.

At the same time, it will be necessary to ensure that supplemented primary health care units comply with the Norwegian regulation for internal quality assurance of health services to guarantee that care is continuously monitored. As shown in other countries such as the Netherlands, there are important potential risks related to insufficient measurement of quality, while the lack of standards of care might hamper the ability to deliver patient-centered care. To address this issue, a comprehensive implementation strategy with explicit national standards, measurement indicators and a national audit scheme might be desirable. There is example from the United Kingdom to develop an effective model of national audit in these units. In a similar vein, developing an accreditation system could be an important priority to secure high quality of care.

Another important challenge in Norway is related to workforce and its capacity for developing adequate skills levels. As part of the Coordination Reform, municipalities are required to establish supplemented primary health care units with adequate professional staffing. Beyond the Competence Plan aimed at increasing the qualification and the number of health care workforce, the setting up of mandatory requirements on continuous professional development including, for example, continuous medical education or establishing specific practical training programme would help to ensure that health professionals are able to deliver adequate quality of care.

Although one main goal of setting up supplemented primary health care units is to improve care co-ordination between the specialised and primary care settings, a number of strategies might need to be established to achieve this objective. Developing co-ordination indicators, appointing care co-ordinators for each patient with complex health needs in supplemented primary health care unit (as the Norwegian PKO consultants in hospitals), and ensuring that health records are portable across health care providers are possible options. Further, the Coordination Reform requires municipality and hospitals to make agreements to specify the distribution of duties and responsibilities between both levels of governance. Norway should take advantage of these agreements by including more quality or performance indicators, as well as developing more discussion on ways to improve care

co-ordination to ensure high quality and outcomes of care. Lastly, taking into account the difference in population size, in human health resources and considering the dispersion of Norwegian municipalities, efforts should be made to build capacity at local level. Additional funding or supports to the least resourced municipalities might be an effective tool to encourage them to monitor and improve the quality of care delivered in supplemented primary health care unit.

Notes

1. For more information, see www.forskningsradet.no/helseomsorg.
2. All nurses in Norway have a bachelor training.
3. For more details, see www.regjeringen.no/en/dep/hod/documents/regpubl/stmeld/2012-2013/meld-st-29-20122013-3/3/4.html?id=735346.

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Chapter 4

Mental health in Norway

Norway's mental health system appears to broadly offer good, appropriate care to the whole population, with Norway having committed significant efforts and resources to improvements across recent decades. These efforts – strengthening care in the community provided by municipalities, increasing specialist services, increasing resources going into the system and making mental health a policy priority – suggest that Norway is moving towards having a strong and comprehensive mental health system. In terms of collecting indicators of mental health care quality Norway is also making impressive progress in many respects.

However, shortcomings in Norway's mental health system remain, and Norway can do more to secure high-quality mental health care for the whole population. There are opportunities for Norway to further strengthen data collection and to use data to help drive improvements in outcomes, to ensure that all mental disorders are appropriately treated, to make sure that responsibilities for service delivery amongst health authorities are clearly established and followed through, to promote better co-ordination, and to assure high quality of mental health care across the country.

4.1. Introduction

Considerable effort has been invested in improving care for mental disorders in Norway across the past decade, and based on available evidence; Norway's mental health system appears to broadly offer good, appropriate care to the whole population. Mental health systems across the OECD are large, often fragmented, and short of reliable indicators and data through to assess quality of care, and in many respects Norway is no exception. Given these information shortages, and given the challenge of characterising complex and sometimes very divergent models of care, international benchmarking of mental health systems is difficult to do. However, Norway's efforts in recent decades to improve the mental health system – strengthening care delivered in the community by municipalities, increasing specialist services, increasing resources going into the system and making mental health a policy priority – suggest that Norway is moving towards having a strong and comprehensive mental health system. Recent moves to address shortcomings, for example by introducing more psychologists, psychological therapies and internet-based therapies, indicate that Norway is among the countries that are leaders in driving effective and innovative mental health care. In terms of collecting indicators of mental health care quality Norway is also making impressive progress in many respects.

However, shortcomings in Norway's mental health system remain, and Norway can do more to secure high-quality mental health care for the whole population. This chapter explores ways that Norway can build on progress that has been made, and areas of great strength within the system – for example the very impressive service user movement, and a growing data information system – and bring further improvements to the quality of mental health care. There are opportunities for Norway to further strengthen data collection and to use data to help drive improvements in outcomes. Norway can do more to makes sure that quality of mental health care is not uneven across the country, that co-ordination between services is good, and that all mental disorders are appropriately treated. Governance responsibilities for mental health care are an area for attention, and there is a need to ensure that responsibilities for commissioning and delivering services are fulfilled, and that co-ordination between administrative bodies is strong.

The chapter begins by describing the organisation of mental health care in Norway, including recent changes and developments, and service delivery and care availability for different disorders. Section 4.3 then looks at available information on mental health care, and suggests that whilst Norway has a quite impressive array of available indicators, there is the potential to further improve data sources to give better information on quality of care. The chapter then goes on to identify and address three key

service delivery challenges for Norway: provision of care for mild-to-moderate disorders; co-ordination of care for individuals with severe mental disorders, including the use of Care Plans; and the need to improve care for substance abuse and addiction. Finally, the chapter takes a system-level perspective, and addresses the need to improve co-ordination of service provision and care delivery across governance bodies, and to better define service responsibilities, so as to maximise the use of existing resources , to guard against gaps and duplication in care provision, and to promote high-quality care at all levels.

4.2. Organisation of mental health care in Norway

Across the last 30 years Norway has made significant improvements to its mental health system, including shifting care to community settings, increasing service provision, and reducing number of beds in psychiatric hospitals. The organisation of Norway's mental health care system broadly resembles that of many other OECD countries, with care in place for mild-to-moderate disorders, severe disorders, alcohol and substance abuse, and a good degree of cross-sectoral co-operation. This section outlines the way that Norway organises care provision for mental disorders, both within the health system and cross-sectorially, highlighting some strengths and weaknesses.

Development of the Norwegian mental health system

The deinstitutionalisation process, and keen attention to mental health care, came later in Norway than in many other Western countries, with the slow shift to community care only really starting in the late 1970s/early 1980s (Pedersen and Kolstad, 2009). In the 1990s there was a strong feeling in Norway that the provision of mental health care was much weaker than somatic care, and that those with mental health needs were not able to access the services they required. Recommendations from the parliamentary Social Committee for Cooperation and Management addressing goals and measures for better health (Social Committee, 1995) suggested that mental illness was a low priority for both local and regional authorities, and asked that the problems and possible solutions for the mental health system be presented to Parliament as a matter of particular importance, separate to concerns affecting the rest of the health system. The Parliament went on to resolve to draw up an action plan for mental health, following the publication of an expected white paper on the state of mental health and mental health services in Norway. A government white paper, "Openness and Comprehensiveness: Mental Disorders and Service Provision" (Norwegian Ministry of Health and Care Services, 1997), followed, and set out significant weaknesses and gaps in the mental health system.

Addressing the whole population – including children, young people, adults, and the elderly – this white paper on mental health focused particularly on the need to improve services through prevention, treatment, and rehabilitation for individuals with severe and long-term mental disorders. The principles that inpatient and residential care should be short-term and temporary, and that no individual should have permanent residency in a psychiatric institution, were clearly established. Hospitalisation was to provide stabilisation and acute care. After discharge care was still to be assured, a role largely attributed to municipalities. The white paper supported the belief that there was a strong need for improvements, identifying the following key areas of weakness, stressing that there were challenges across the mental health pathway, from prevention through to post-discharge follow-up: preventive work is too weak; services offerings in the municipalities are insufficient; the availability of specialist services is inadequate; inpatient stays are short term, and represent short-termism in treatment; discharge is inadequately planned; follow-up is not good enough. The problems were perceived to be significant, and the report underlined that "Patients do not get all the help they need, staff did not feel that they have done a good enough job, and the authorities are not able to give people a full offer" (Norwegian Ministry of Health and Care Services, 1997, Section 1.3).

As inpatient stays fell, and specialist psychiatric hospital care became less dominant, municipalities were expected to fill the gap in service provision at the community level, but in the 1990s they were not yet sufficiently equipped to meet these new demands. Municipal services were generally, and as reflected in the 1997 white paper, found to be weak, with a lack of funding, a lack of skilled personnel and a lack of competence regarding the planning, organisation and integration of services (Ådnanes and Halsteinli, 2009). Following on from the white paper, a national action plan to improve mental health care was established: the Escalation Plan for Mental Health 1999-2008 (referred henceforth to as the "Escalation Plan"). The Escalation Plan included strategies to strengthen mental health care – broadly service-orientated, focusing on the strengthening of community-based services provided by municipalities, and upon specialist psychiatric services – in line with the priority areas highlighted by the white paper "Openness and Comprehensiveness" (Norwegian Ministry of Health and Care Services, 1997). In addition to improving service provision, the Escalation Plan established that the goal of mental health services should be to promote independence and autonomy for individuals with mental health needs, and service users were central to the crafting of the plan. Strengthening of links across sectors – across sector boundaries and administrative levels – was a further key aim, including strengthening education and research, and labour and employment initiatives. Under the Escalation Plan for Mental Health, there was an investment of

NOK 6.3 billion, and a set increase in mental health expenditure by NOK 4.6 billion through the period 1999-2008.

Improvements following the Escalation Plan are generally seen to be significant, and the Plan in general is seen as a success by policy makers, service providers and service users alike. Far more Norwegians were getting access to mental health services as the Escalation Plan came to an end than had been in 1998 and the preceding years (Pedersen, 2009) (Box 4.1).

Box 4.1. Priorities, targets and results of the National Plan for Mental Health 1999-2008

The National Plan was accompanied by a number of targets, most of which were focused on up-scaling service provision, and were quantitatively defined rather than quality orientated.

In the municipalities, there were to be 3 400 new care homes for people with mental illness, space for 4 500 more users of day centers, 10 000 more individuals being offered personal support, 15 000 more individuals offered cultural and recreational initiatives. Treatment provision was to be strengthened with the addition to the mental health workforce of 184 psychologists, and 125 additional college-educated staff with additional training in psychiatry. A further 260 additional full-time-equivalent staff were to be added to strengthen psychosocial services, personal support offerings, cultural and recreational programmes for children and adolescents with psychosocial disorders in the same relative extent as for adults, and a further 800 full-time staff to strengthen health clinics and school health services. In the specialised services, there were also an additional 160 hospital beds created for (compulsory) inpatient care, and over 1 000 additional spaces created in District Psychiatric Centres (which include outpatient clinics, day-care centres and 24-hour wards). Capacity for a further 220 000 more outpatient treatments or consultations, additional capacity for day visits to psychiatric centres, and increased staffing for outpatient clinics was added.

A range of measures addressed services for children and young people – 250 beds were to be added, 265 more day care places were created, municipal services were to be strengthened – as well as for groups with special needs (e.g. drug addicts with mental illness, refugees and asylum seekers, the mentally disabled and deaf).

Cross-sectoral links were included; there were to be new measures for strengthening employment opportunities, co-operation with NGOs was included, along with support for user and family organisations, and user-orientated measures and informational activates.

The overall picture shows that the targets by and large were fulfilled. Financed by the state earmarked grants, approximately additional 6 000 full-time professionals were employed by the municipalities at the end of the period 1999-2008. Another 6 000 professionals were employed by the municipalities financed with their own means, totally 12 000. More than one third has additional education in mental health. This level is maintained in the years after.

Source: Norwegian Ministry of Health and Care Services (1998), "Om opptrappingsplan for psykisk helse 1999-2006 Endringer i statsbudsjettet for 1998" [About Escalation Plan for Mental Health 1999-2006. Changes in the State Budget for 1998], Proposition No. 63 (1997-98), Oslo, available at www.regjeringen.no.

Mental health has also been clearly identified as a priority in important national-level policy documents, which is a strong point of the Norwegian health care system. The parliamentary propositions for the 2010 budget clearly identify mental health as a key area of concern, even after the end of the Escalation Plan, making links to the challenge of mental health-related sickness absence from work, and the need to strengthen provision for children mental disorders and/or with parents with mental or addictive disorders, and the need to make mental health care in municipalities more accessible, especially for people with lower-threshold disorders such as mild-to-moderate anxiety and depression (Ministry of Labour, 2009, "Proposition No. 1 to the Storting 2009-10").

National-level strategy documents – such as the public health targeted plan "Health Promotion: Achieving Good Health" – have highlighted mental health as a priority, stating "*Mental health problems and disorders are one of our major public health challenges… We therefore need a broad commitment to health promotion and preventive work both within and outside the health service, with priority on prevention, low-threshold measures and early intervention. Mental health is a shared responsibility that cuts across sectors, professions and services*" (Norwegian Directorate of Health, 2010, p. 117). The report includes a chapter discussing on going challenges and strategic approaches to mental health, looking to fill some gaps around prevention and good mental health promotion left unaddressed by the primarily service-orientated Escalation Plan, for example by addressing risk factors for mental disorders and preventative approaches. The Health Promotion plan also discusses online services, low-threshold services and self-help approaches for depression and anxiety.

Care for mild-to-moderate disorders

In Norway, care for mental disorders that have mild-to-moderate symptoms is led by General Practitioners (GPs), as in many other OECD countries. GPs, in collaboration with other community mental health personnel, constitute the most important and wide spread low threshold mental health service in Norway. GPs are expected to treat and manage mild-to-moderate disorders themselves, with support from other community mental health personnel and some more specialised clinics. GPs would then refer to specialised outpatient clinics if sufficient improvement is not achieved within an acceptable time. College-educated health personnel and psychologists based in municipalities also provide services and care (Box 4.2).

Box 4.2. Mild-to-moderate disorders

Mild-to-moderate disorders have less severe and debilitating symptoms than other (for example, psychotic) mental disorders, with severity of the disorder determined by the number of and severity of symptoms, the degree of functional impairment, and the duration of symptoms. Mild-to-moderate disorders are typically frequently occurring disorders such as depression and anxiety as well as disorders such as obsessive compulsive disorder (OCD), or somatoform disorders, which can all also present as "severe" disorders, but are most prevalent in less acute forms. To take an example, following the International Statistical Classification of Diseases and Related Health Problems (10th Revision) (ICD-10) classification system, a mild depressive episode (ICD-10 F32.0) would consist of two or three of the specified symptoms being present (for example, lowering of mood, reduction of energy, reduced capacity for enjoyment and concentration, disturbed sleep, marked tiredness, diminished appetite, reduced self-confidence and self-esteem), and the patient would usually be distressed by able to continue with most activities (WHO, 2010). Moderate depression (ICD-10 F32.1) would usually include four or more symptoms, and the patient would have great difficulty in continuing with ordinary activities. Severe depression (ICD-10 F32.2) or severe depression with psychotic symptoms (ICD-10 F32.3) are not directly addressed by this chapter, but would typically include a large number of marked and highly distressing symptoms, with suicidal thoughts and acts common, and in the case of F32.3 the presence of hallucinations, delusions, psychomotor retardation, or stupor so severe that ordinary social activities are impossible. Severe depression and severe depression with psychotic symptoms would more typically require specialised, high-intensity treatment.

Mild-to-moderate disorders impede the health, daily functioning, and quality of life of affected individuals, and require appropriate diagnosis, treatment and care.

While this chapter makes a distinction between the severities of mental disorders and different levels of care organisation, it is important to note that for patients and practitioners the reality of disorders is frequently more fluid. The mental state of a patient experiencing a moderate depressive episode can worsen and become "severe", just as a severe episode can be stabilised with symptoms lessened or alleviated. Good co-ordination between services and sensitivity to the need for different intensities of treatment are very important. In addition, it is increasingly recognised that sub-threshold mental disorders (where the symptoms fall below the diagnostic criteria for the disorder) can be distressing and disabling, particularly if persistent, and low-intensity treatment for such cases is often appropriate.

Source: WHO (2010), "ICD-10 Version: 2010", available at www.who.int/classifications/icd/en/; OECD (2014), *Making Mental Health Count*, OECD Publishing, Paris.

GPs are trained and supported through their basic education, specialisation and through elective courses, electronic support systems and through co-operation with the specialised health services. GPs can also refer patients to Psychiatric Outpatient Services, which provide more specialist treatments. However, it is not clear to what extent GPs take up the mental health training opportunities on offer to them, or how good their mental health skills are. Furthermore, it is not clear that GPs are given consistently

good support from specialist services in treating mental disorders, or that there are timely referral pathways available to patients who need more specialised care.

Psychological therapies, which are increasingly popular in a number of OECD countries, are also being used to treat mild-to-moderate disorders in Norway. GPs can also receive training to provide Cognitive Behavioural Therapy (CBT), which is then covered in the reimbursement schedule. The Escalation Plan added a large number of psychologists to the mental health workforce (see Box 4.1). Access to psychological therapies is based on assessment of need, and those assessed to have less need for treatment may face long waiting lists or need to find a private provider. For mild-to-moderate depression, Norway has been piloting a community-based service built on the British Improving Access to Psychological Therapies (IAPT) (see also www.iapt.nhs.uk/iapt/). There are also several group treatments that are becoming available to community care services.

Some internet-based models of care for mild-to-moderate disorders are used in Norway. For example, the freely available computerised CBT programme MoodGYM for anxiety and depression, developed in Australia by the Centre for Mental Health Research at the Australian National University (moodgym.anu.edu.au), has been translated into Norwegian by the University of Tromso, Norway.

Care for severe mental illness

In addition to being primary carers for mild-to-moderate disorders, GPs help manage some severe mental illnesses (SMI), such as schizophrenia and bipolar disorder. Generally GPs are the "gate keepers" of specialised services, and are also key personnel when patients are discharged from the specialised services, playing a role in managing the ongoing care of individuals with acute mental health needs living in the community. GPs are also responsible for co-ordination of medical services for patients. A GP will generally, for example, be part of an Individual Care Plan (ICP) panel. A review on community mental health services found that GPs generally are regarded as competent, involved and accessible partners by the community mental health workers (Slettebak et al., 2013).

Whilst GPs fulfil a referral, gatekeeping, and at times care management and co-ordination role, the majority of care for severe mental illness is provided by specialist services in the community, and psychiatric inpatient services. These specialist services would provide care for severe mental illnesses, including severe and/or enduring cases of depression and anxiety, and for individuals with complex multiple mental disorders (multiple morbidity). As with the rest of the health care system, hospitals are governed

by four Regional Health Authorities, whilst municipalities (local authorities) are responsible for primary and community care. This care is of particular importance in the shift away from hospital care, and towards more community service provision. Municipalities are afforded significant freedom in how they choose to organise their services, especially since the end of the Escalation Plan, which dictated a specific set of mental health services with tied funding. At present, there is no ring-fenced funding for mental health services at a municipal level. Municipalities would typically provide low threshold services such as home-based care, early intervention initiatives and health promotion. There is also a legislated duty for primary and specialised health services to co-operate and co-ordinate their services, although there may be some weaknesses in this co-ordination process.

As part of the Escalation Plan municipal services were significantly scaled-up in Norway, including with the establishment of more individualised and personal support (for example cultural and recreational activities), capacity for outpatient treatment and consultation increased, and additional capacity for day visits to District Psychiatric Centres (DCPs) introduced. DCPs include outpatient clinics, day care services, and 24-hour wards.

At the end of the Escalation Plan far more Norwegians appear to be getting access to mental health services as the Escalation Plan came to an end than had been in 1998 and the preceding years (Pedersen, 2009). Patient discharges increased from 29 200 in 1998 to 49 200 in 2008, an increase of 68%, without any corresponding increase in stays per patient. Furthermore, there was a particular increase in discharges from inpatient psychiatric care outside of hospitals (for example District Psychiatric Centres); outpatient consultations also increased significantly, from 476 000 to 1.1 million in 2008 (Pedersen, 2009).

Suicide rates, a very loose proxy measure of the state of a population's mental health,[1] have been falling in Norway across recent decades (see Figure 1.4, Chapter 1). This fall could suggest that there have been some improvements in mental health care, or that Norway's Action plan for suicide has had a positive impact. The reality is likely a complex combination of the two, combined with a range of possible external factors.

However, the suicide rate in Norway remains one of the higher rates of all OECD countries, with a mean suicide rate just below the OECD average at 12 deaths per 100 000 population. The suicide rate in Norway in 2011 was marginally higher that of neighbouring Sweden, and more significantly higher than that of Denmark. Suicide rates in Finland remain higher than in Norway, but have been falling at a far greater rate (see Figure 1.5, Chapter 1). A new Action Plan for suicide in Norway, which will also

encompass efforts to prevent self-harm, is in its final stages of development and includes issues such as awareness and knowledge improvement amongst the public and front-line staff (such as mental health professionals, teachers and GPs), and puts importance on furthering co-ordination of services.

If measured in bed numbers, the use of inpatient care has fallen in Norway across the last decade, in line with trends seen across most OECD countries. The Norwegian mental health service is aiming to avoid long-term inpatient stays, and has taken some steps to reduce admissions.

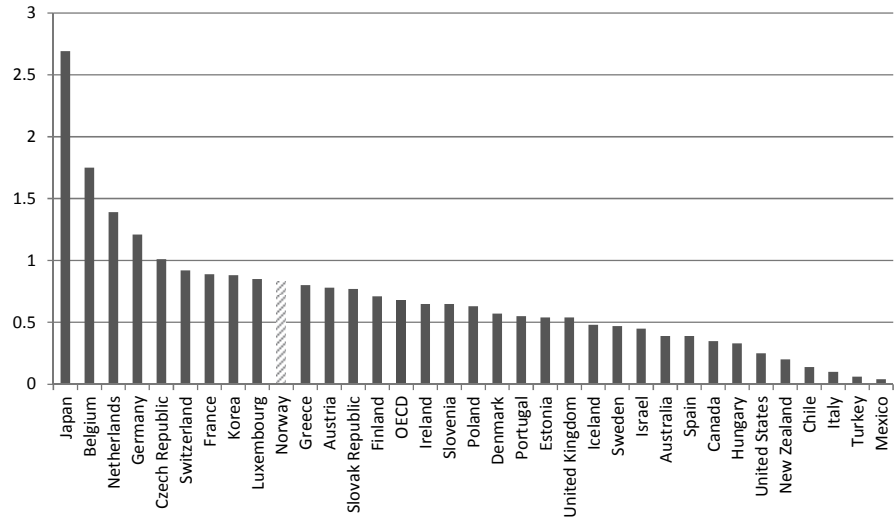
Psychiatric beds per 100 000 population in Norway are above the OECD average, and are based in acute psychiatric wards in hospitals; in-patient wards in DPCs (which are usually not certified for involuntary treatment, and a small number of stand-alone psychiatric hospitals (Hasselberg et al., 2013). Referral to inpatient care can be made by GPs, emergency clinics, Community Mental Health Care teams (CMHC teams) or clinical units.

Under the Escalation Plan inpatient beds fell by 25%, despite the increase in discharges, explained in large part by a fall in long-term care beds (psychiatric nursing homes), which were to be replaced by "active treatment" places in District Psychiatric Centres, for which there would be a shorter stay duration and a move towards treatment and away from passive "housing" of patients. The increase in the number of discharges became possible with a significant shortening of the duration of stay, from an average of 110 days in 1998 to 28 days in 2008 (Pedersen, 2009).

Addressing availability of services, particularly Assertive Community Treatment teams (ACTs) working in the community, is one priority area for the Norwegian Health Services, especially with regards to differences between regions.

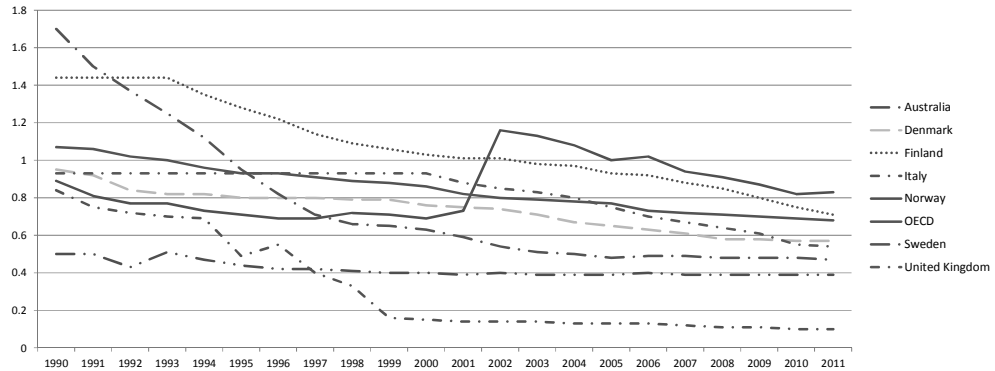
For example, extended hours for the availability of ACT teams (also crisis resolution teams) has been shown to reduce some hospitalisations (Hasselberg et al., 2013). Efforts in this area have already been started by Norway, and 17 ACT teams are now in place in Norway, two of which are Flexible Assertive Community Treatment (F-ACTs) teams. Indeed, an evaluation report on the impact of the implementation of ACT teams in Norway is expected in 2014, and should provide a valuable insight into strengths and weaknesses of this important service.

Figure 4.1. Psychiatric care beds per 100 000 population, 2011



Source: OECD Health Data 2013, www.oecd.org/health/health-systems/oecdhealthdata.htm.

Figure 4.2. Psychiatric care beds per 100 000 population, selected OECD countries, 1991-2011



Note: Break in series: Australia (1993), Finland (2000), Netherlands (1995, 2001, 2006), Norway (2002), Sweden (2001), United Kingdom (2010).

Source: OECD Health Data 2013, www.oecd.org/health/health-systems/oecdhealthdata.htm.

Involuntary admissions – whereby the patient is admitted against their will under the Mental Health Act – are a concern in Norway as in other OECD countries. In 2012 16% of all inpatient admissions were involuntary

(Helsedirektoratet, 2013). This amounts to around 138 involuntary admitted persons per 100 000 adult inhabitants, and about 198 involuntary admissions per 100 000 adult inhabitants. There is also significant variation within and between regions, and for more than one in three involuntary admitted patients, no mental health service was provided the first month after discharge. This is a significant area of concern. Norwegian Health Authorities are working with user organisations and mental health professionals to find a solution, and there may be opportunities for learning from other OECD countries, including Nordic countries such as Finland and Sweden which have worked to reduce involuntary admissions, and reduce disparities in involuntary admissions.

The Norwegian mental health services strives to avoid both long-term voluntary and involuntary inpatient stays. For example through the adoption of the ACT model for outreach and outpatient care, and through assisted living facilities. Furthermore, Norway has establishment some "user controlled" inpatient beds, whereby the user can informally admit themselves for a period in a time of crisis until they become stabilised, a move that is seen as a significant step towards user empowerment and reduction in unnecessary inpatient stays.

The increase in service use by adults across the past decade has been quite significant, but treatment rates for children and young people has not increased as significantly. However, more children and young people were receiving care in 2008 than in 1998, with a 4.8% increase in children and young people receiving care, which can be very positively set against the 2% to 5% expected by the Escalation Plan (Pedersen, 2009).

Care for alcohol and substance abuse disorders

Compared with most other European and OECD countries, Norway has a low consumption of alcohol and drugs (see Table 4.1; OECD, 2013a). Although in recent years Norway has seen an increase in alcohol consumption (OECD, 2013b), Norwegian alcohol consumption remains low compared to most other OECD countries. An important explanation for this low consumption is the long standing emphasis that Norway has put on the regulatory instruments in alcohol policy. However, the number of patients with alcohol related diagnoses has increased in the last decade, both in inpatient units and outpatient consultations. More worrying is the fact that the number of injecting drug users in Norway is rather high: in 2010 it is estimated that there were between 8 300 and 11 800 injecting drug in Norway, mostly heroin users (EMCDDA, 2013). Most recent estimates, from 2008, suggest that there were 6 600 to 12 300 heroin users in Norway (both injecting and smoking), a rate of 2.1 to 3.9 per 1 000 inhabitants aged 15-64 (EMCDDA, 2013). The number of injecting drug users in

Norway increased until 2001, before falling until 2003, since which it has been quite stable. The number of drug-related deaths per year in Norway is high – towards the upper end of the EU range – and is a more significant cause of death than car accidents (Table 4.1).

Table 4.1. The impact of drug use, and treatment rates, in Norway compared to the EU range

Drug/Indicator	Key statistic	Norway	EU range	
			Minimum	Maximum
Opioids	Problem opioid use (rate/1 000)	3	0.26	8.2
	All clients entering treatment (%)	37.5	7	91
Cocaine	Prevalence of drug use - all adults (%)	0.4	0	2
	All clients entering treatment (%)	1	0	41
Amphetamines	Prevalence of drug use - all adults (%)	0.7	0	2
	All clients entering treatment (%)	0	0	65
Prevalence of problem drug use	Injecting drug use (rate/1 000)	3	0.2	5.7
Drug-related infectious diseases/deaths	HIV infections newly diagnosed (rate/million)	2	0	51.5
	HIV prevalence (%)	2.3	0	34
	HCV prevalence (%)	65	18	65
	Drug-related deaths (rate/million)	73.1	1	135.7
Health and social responses	Syringes distributed	2 639 000	0	13 800 000
	Clients in substitution treatment	6 640	188	177 993
Treatment demand	All clients	8 817	224	119 652
	All clients with known primary drug	7 690	224	114 904
Drug law offences	Number of reports of offences	42 101	388	415 354
	Offences for use/possession	22 116	59	391 649

Source: EMCDDA, "Key Statistics on the Drug Situation in Norway", available at www.emcdda.europa.eu/publications/country-overviews/no/data-sheet.

Norway has a range of different treatment and care programmes, classified in four categories: i) outpatient functions and assessment units; ii) detoxification; iii) inpatient treatment of less than six months; and iv) inpatient treatment of more than six months (EMCDDA, 2013). In Norway there has historically been a trend of having separate schools of mental health care and addiction care. Whilst the trend for addiction care is towards integration, the two systems are still frequently separate. By law, mental health services and drug centres have to treat people even with

comorbidities, but reports suggest that some people are still excluded from mental health services because they have problems with substance abuse. Historically, addiction services have been private services, often provided by charities or religious organisations. Many inpatient alcohol and substance abuse treatment centres are still long-term facilities. An estimated 60% of drug user rehabilitation services are run by NGOs, and funded by the government. A significant number are rooted in voluntary organisations and private service providers. Meanwhile, outpatient and community care is frequently provided by dual-purpose mental health care centres. Integration between outpatient and inpatient care, and between public and private-providers, is not always particularly strong.

Historically, drug addiction has been treated with social methods, rather than medicalised approaches, although this is beginning to change. Opioid maintenance using methadone has been available through a nationwide programme since 1998, while buprenorphine has been available since 2001. In 2010 new national guidelines for Opioid Maintenance Treatment (OMT) came into force. These guidelines aim to increase nationwide access to OMT as part of comprehensive treatment and the rehabilitation process. The guidelines support a collaboration model between social security offices, GPs and specialist health care services (which hold the authority to prescribe OMT). GPs are allowed to adjust prescriptions of methadone if a specialist health care service has already started treatment, or if the admission time for treatment is forecast be too long (to a clinic). GPs can come across challenges when seeking to refer patients, due to shortages at the specialist level. At the end of 2011 a total of 6 640 clients were in opioid maintenance treatment, 47% of whom were on methadone, 37% on buprenorphine while 19% received a buprenorphine/naloxone combination, and clients are increasing year-on-year. Norway is also due to start trials of a nasal spray that reverses the effect of a heroin overdose in Oslo and Bergen, an innovative move that could help reduce overdoses from heroin (Lewis, 2014).

People with concurrent mental health problems and alcohol and substance abuse have particular problems accessing mental health care. Given the historical – and ongoing – separation of the mental health and substance abuse systems, there can be a struggle over responsibility for patients, and conflict between addiction treatment and mental health treatment. Across the past 15 years there are some reported improvements, and there has been an emphasis on dual diagnosis, which is a positive step.

Cross-sectoral care: prevention efforts, mental health in education, employment, social care, and the criminal justice system

Mental health promotion, as part of public health efforts, is in place in Norway. The need for effective prevention efforts has been established in a

number of policy documents, including the white paper "Openness and Comprehensiveness: Mental Disorders and Service Provision" (Norwegian Ministry of Health and Care Services, 1997), the strategy document "Health Promotion" (Norwegian Directorate of Health, 2010), and the Coordination Reform (Norwegian Ministry of Health and Care Services, 2009). The report "Better Safe than Sorry" (Major et al., 2011), prepared by the Norwegian Institute of Public Health on behalf of the Ministry of Health and Care Services, also offers 50 recommendations on prevention for mental health, addressing central and local health authorities, as well as local and national authorities outside the health care system. This report offers a number of important points on which municipalities could build, of which the recommendation around the establishment of better preventative measures in senior centres – and also in intermediate care centres – is highly relevant to many of the objectives of the Coordination Reform. There are also a number of targeted prevention programmes already in place in Norwegian schools and workplaces (Box 4.3).

Box 4.3. Programmes for the prevention of mental disorders and promotion of good mental health in schools and workplaces

There are a number of school-based programmes in place in Norway. "Mental Health in Schools", which was implemented from 2004 to 2011, following on from the government's strategic plan for the mental health of children and young people, "Promoting Mental Health Together" (2003), and the "Escalation Plan for Mental Health" (1999-2008), includes six different programmes for children of different ages and for teachers. Developed in England and run by one of Norway's leading children's charities, "Voksne for Barn" (Adults for Children), "Zippy's Friends", targets 5-, 6- and 7-year-olds, helping to develop coping and social skills, often with the participation of both teachers and school nurses. "Mental Health for Everyone", aimed at older children, is designed to fit in with the general curriculum as a three day project, aimed in part at helping students to express their own feelings and become more aware of their own mental health and that of others. The programme "What's Up with Monica?" is a training course designed to help teachers and others working with young people to identify students with mental health problems at an early stage, and improve understanding of mental disorders and their symptoms. This informational programme has been evaluated as having been quite successful at improving teachers' mental health literacy and ability to better identify signs of early psychosis (Joa et al., 2008; Langeveld et al., 2011).

"Better Safe than Sorry" (Major et al., 2011) highlights a need to expand efforts towards "health promotion" in schools, including fostering environments where students are not bullied (bullying is identified as a strong risk factor for psychiatric problems in children and adolescents), and are part of a community of peers, and extend some of the anti-bullying programmes already in place to all primary schools. The report also identifies a range of programmes in Norway, in other Nordic countries, and internationally that address anxiety and depression in schools, and recommends that successful programmes be built upon, and put in place in more Norwegian schools.

Box 4.3. Programmes for the prevention of mental disorders and promotion of good mental health in schools and workplaces *(cont.)*

There are a range of work-based programmes that focus on prevention of ill health, some of which address mental ill health. The Norwegian Labour and Welfare Administration (NAV) offers special services to enterprises signed up to the Working Environment Act in preventing sick leave and in information provision. A similar role is played by occupational health services, and by the labour inspection authority, whose engagement with mental health is usually focused on prevention of exclusion, and promotion of a psychologically healthy environment (OECD, 2013a). A need to better engage mental ill health and workplace conditions is highlighted in "Better Safe than Sorry" (Major et al., 2011), and the mental health of young people, and the unemployed, is identified as a key priority and current shortcoming in both this report, and the OECD (2013a) report *Mental Health and Work: Norway*.

Source: Joa, I. et al. (2008), "Information Campaigns: 10 Years of Experience in the Early Treatment and Intervention in Psychosis (TIPS) Study", *Psychiatric Annal*s, Vol. 37, No. 8, August 2008; Langeveld, J. et al. (2011), "Teachers' Awareness for Psychotic Symptoms in Secondary School: The Effects of an Early Detection Programme and Information Campaign", *Early Intervention in Psychiatry,* Vol. 5, No. 2, pp. 115-121, May; Major, E.F. et al. (2011), *Bedre føre var – Psykisk helse: Helsefremmende og forebyggende tiltak og anbefalinger* [Better safe than sorry: Health promotion and preventive measures and recommendations], Norwegian Institute of Public Health; OECD (2013), *Mental Health and Work: Norway*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264178984-en.

The integration of health services and social care services is facilitated by a specific grant for the development of mutually binding collaboration projects between specialist and primary care services. Although municipalities are showing increasing interest in such integration, the extent to which integration is prioritised and put into practice varies between municipalities, given that they can decide how to organise services independently.

The government supports several initiatives directed at mental health promotion in schools, workplaces and other community settings. The Ministry of Health and Care Services works with the Ministry of Education and the Ministry of Children, Equality and Social Inclusion on improving early intervention and early discovery programmes rooted in kindergartens and schools, and in improving children and adolescents' understanding of mental health concerns. Child and school health services are also key in early intervention, and are in the most part the responsibility of municipalities. The government has been supporting municipalities in recruiting psychologists, including psychologists attached to school health services, which appears to have led to an improvement in the provision of early intervention and low threshold services.

Engaging with another key challenge for most OECD countries, the need to make meaningful links between care for mental disorders, and employment opportunities, the National Strategic Plan for Work and Mental Health 2007-2012 (Norwegian Ministry of Labour and Social Inclusion and Norwegian Ministry of Health and Care Services, 2007), which has been followed by a renewed strategic plan, constituted a national plan to prevent inclusion and provide a more inclusive workplace for people with mental disorders. This type of high-profile national commitment to mental health and to breaking down the barriers between the health, welfare, and labour sectors, is highly commendable (for further discussion of cross-sectoral co-ordination, see Section 4.3).

Good co-ordination with the police and the criminal justice system is a priority in Norway, as in other countries. Given that tackling drug addiction, and dangerous drug use, is a priority for Norwegian health services, good links with the police are needed. For example, contact with the police, and drug use, were both found to be risk factors for involuntary admission in Norway (Hustoft et al., 2013).

4.3. Measures of quality for mental health care can be strengthened further

To effectively address and improve the quality of care delivered for mental health, there is a need for appropriate indicators of quality of care, and whilst Norway has made good progress in establishing and publishing relevant data, there is scope for improvement. Mental health has been a particularly difficult area to establish suitable indicators and to gather data on. Nonetheless, some good measures of quality are available. Norway is already collecting many of these indicators of mental health care, but there are opportunities for Norway to learn from other OECD countries – especially neighbouring Nordic countries – in further strengthening the data infrastructure for mental health. Strengthening the data infrastructure, and using the data collected in decision making, will help Norway identify weaknesses in mental health care quality and can be used to drive and measure improvements.

Although availability of indicators for mental health is generally good, there are some areas where existing data collection could be strengthened

In a difficult are such as mental health Norway has already made good progress in establishing and publishing relevant data on quality of care. Norway is able to report on almost all of the OECD HCQI mental health indicators, and is reporting on a number of other relevant indicators of mental health care quality (Table 4.2).

Mental health has long been a difficult area for which to measure quality, and for which to establish relevant and informative indicators. A range of potential indicators were both by the OECD, and under the Nordic Indicator Project of which Norway was a part. Norway was able to report on most of those quality indicators for mental health collected by the OECD in 2013, which gives Norway a good base from which to start assessing quality of mental health care.

Table 4.2. OECD HCQI mental health indicators

Indicator name	Final unit	Reported by Norway (year)
Any hospital re-admissions within 30 days for patients discharged with schizophrenia	Age(-sex) standardised mean per 100 patients	2011
Same hospital re-admissions within 30 days for patients discharged with schizophrenia	Age(-sex) standardised mean per 100 patients	2011
Any hospital re-admission within 30 days among patients discharged with schizophrenia	Age(-sex) standardised rate per 100 patients	2011
Same hospital re-admission within 30 days among patients discharged with schizophrenia	Age(-sex) standardised rate per 100 patients	2011
Any hospital re-admissions within 30 days for patients discharged with bipolar disorder	Age-(sex) standardised mean per 100 patients	2011
Same hospital re-admissions within 30 days for patients discharged with bipolar disorder	Age(-sex) standardised mean per 100 patients	2011
Any hospital re-admission within 30 days among patients discharged with bipolar disorder	Age(-sex) standardised rate per 100 patients	2011
Same hospital re-admission within 30 days among patients discharged with bipolar disorder	Age(-sex) standardised rate per 100 patients	2011
In-patient suicides among people diagnosed with a mental disorder	Age(-sex) standardised rate per 100 patients	2011
In-patient suicides among people diagnosed with schizophrenia or bipolar disorder	Age(-sex) standardised rate per 100 patients	2011
Deaths after discharge from suicide among people diagnosed with a mental disorder	Age(-sex) standardised rate per 100 patients	Not available
Deaths after discharge from suicide among people diagnosed with schizophrenia or bipolar disorder	Age(-sex) standardised rate per 100 patients	Not available
Excess mortality for patients with schizophrenia	Ratio	Not available
Excess mortality for patients with bipolar disorder	Ratio	Not available

Note: For the next HCQI data collection hospital re-admission will be dropped due to issues of interpretation due to varied national contexts. Collection of excess mortality and suicide after discharges will continue, as will research and development work on inpatient suicide.

Source: OECD Health Data 2013, www.oecd.org/health/health-systems/oecdhealthdata.htm.

A number of indicators have been developed by the Norwegian Directorate of Health which do go beyond those indicators collected in 2013 by the OECD, in part in conjunction with the Nordic Indicator Project, a collaboration between Denmark, Finland, Greenland, Iceland, Norway and Sweden. For those indicators that are being reported publically Norway's data collection appears to be improving year-on-year, which is very promising. However, there are clear shortcomings, as identified in Table 4.3.

Table 4.3. Indicators for mental health currently collected in Norway, reported 2013

Indicator	Measurement	Status
Compulsory admission to psychiatric care (*Tvangsinnleggelse*)	Compulsory referrals or admissions per 1 000 – involuntary admissions under through so-called "compulsory observation" (*tvungen observasjon*) and "forced psychiatric care" (*og tvunget psykisk helsevern*).	Reported for each of the four health regions, and by psychiatric institution. There are major deficiencies in relation to the registration of compulsory admissions, including from Oslo University Hospital and Health Mid-Norway. Therefore, the figures are not complete from all health regions. Tentative interpretation of reporting suggests 2.2 coercive admissions per 1 000 inhabitants in 2012, with significant geographical differences.
Registration of legal status in mental health care for adults	This quality indicator shows whether hospitals and community mental health centres have registered legal status for treating the patient's medical record and reported this to the Norwegian Patient Register. Compulsory treatment, and voluntary treatment, should be reported.	The reporting of legal basis is inadequate, partly due to different definitions of the reference periods. At the national level were registered legal basis of 65.9% of referrals. The North region had the highest percentage of registered legal status at 90.0% in 2012. The region has remained high and stable over the past three years. Central Norway has the lowest with 39.3% in 2012. This is still a marked increase from 3.6% in 2011. The total number remains stable in the three years, but there is a marked improvement in the registration of legal basis.
Percentage of estimated waiting times recorded on frittsykehusvalg.no.	Percentage of estimated waiting times are updated in the preceding four month period the website frittsykehusvalg.no for mental health services for adults, and for mental health services for children and adolescents.	For adults, nationally, 86% of the waiting times at frittsykehusvalg.no updated monthly mental health for adults in the period January to April 2013. This was a marked increase from 78.9% in the corresponding period in 2012. Results vary between regions For children and adolescents, on a national basis, 89.1% of the waiting times at frittsykehusvalg.no updated within the mental health of children and adolescents in the period January to April 2013. This is a significant increase from 77.8% in the corresponding period of 2012. The results vary somewhat between regions.
Waiting time from application received to first consultation	Waiting time (days) before first visit (emergencies not included)	Published at frittsykehusvalg.no. For adults and children and adolescents 0-18 years (by region): • Old-age psychiatry • anxiety, phobias, obsessive compulsive disorders, adjustment disorders • depression • dual diagnosis (mental health) • psychosis • hyperactivity ADHD • personality and behavioural disorders • gambling • eating disorders • unspecified mental illness
Registration of diagnoses in psychiatric care for adults	This indicator shows the percentage of patients for whom the diagnosis has been registered in the patient journal. Registration of diagnoses in patient journal is important for choosing an efficient and quality care, and for communication between clinicians.	At the national level, the main diagnosis recorded for 73.3% of referrals in 2012. It has remained stable over the last three years.
Registration of diagnoses in psychiatric care for children and young people	This indicator shows the percentage of patients for whom the diagnosis has been registered in the patient journal, including diagnostic codes for features of diagnosis (e.g. main diagnosis, somatic diagnosis, psychosocial factors, comprehensive assessment of psychosocial functioning).	At the national level, the main diagnosis recorded for 82.8% of referrals in 2012. This is an increase from 75.9% in 2011.

Source: www.helsenorge.no, accessed 30 September 2013.

Gaps in reporting on key indicators leave Norway with an incomplete picture of quality of care, and may mask some important differences in quality across the country. The incompleteness of registration of compulsory admissions and the legal status of referrals are two particular concerns, especially given that available data suggests that there are significant regional differences in both. The marked increase in reporting of waiting times data is encouraging, and similar improvements for other indicators are most desirous.

Norway should consider a push towards better collection of indicators that are already reported publically, as well as making efforts to build on some partial data collection that is already in place. For example, measurement of restraint (physical and chemical) – potentially a key measure for quality for mental health care – is included in a paper protocol, must be reported to a supervisory board on a monthly basis, and should be reported nationally. At present this national data collection is not operational, and only an estimated 25% of all reports of measures of restraint are collected.

The granularity of the indicators reported is also generally good, with many indicators available at both a provider (hospital) and health region level, including "registration of diagnoses in psychiatric care for children and young people", "registration of diagnoses in psychiatric care for adults", "involuntary admissions" and "registration of legal basis for treatment for adults".

Norway can further increase and diversify the collection of mental health indicators and strive to be a leader in this field

Continued attention to building good indicators of quality of care for mental health should be a priority for Norway. Many of the indicators that Norway is collecting at present are, though useful, primarily process indicators, or measures of service capacity, for example registration of diagnoses or staffing numbers. With other existing indicators, for example inpatient suicides, readmission rates or waiting times for access to services, Norway is making steps towards being able to assess quality of mental health care. However, the fact that psychiatric patients are often very vulnerable, and in a large proportion of instances held involuntarily, makes measuring performance and quality of care vital and more complex (Pincus et al., 2011). There are particular challenges in developing good quality indicators for mental health care, given the heterogeneity of diagnoses and patient pathways and outcomes, and increasingly because of the shift away from hospital-based care towards care in the community, where data infrastructures tend to be weaker. However, Norway is in a position to build

on its existing resources, and its culture of respect and openness towards mental disorders, to build even better indicators to meaningfully strengthen quality of mental health care for its citizens.

Developing primary care- and municipal-level indicators is an essential step towards capturing the quality of care, and has been a significant challenge for most OECD countries, due to a lack of administrative data sets at the primary care level. However, a number of OECD countries are attempting to measure the quality of mental health care in primary care settings using a range of indicators, and Norway should follow their lead. Sweden monitors the use of inpatient somatic care for patients with a mental disorder diagnosis that could have been avoided if primary care and/or primary or secondary prevention was sufficient. Finland tracks total mental health visits to primary care which sometimes include visits to specialists (psychiatric nurse, psychiatrist) who work within primary care as well as mental health related visits to a primary care physician. The Quality and Outcomes Framework (QOF), in use across GP practices in England, includes some indicators on depression, although there have been some challenges in the use of these indicators (NICE, 2011).

Quality assurance for addiction services is a further priority. Norway does have some quality measures for addiction services (including waiting times for treatment, rate of treatment, available beds, consultations, and available spaces on treatment programmes) (www.ssb.no/; frittsykehusvalg.no) and the Norwegian Knowledge Centre also has an on-going project patient Experiences with health care and substance abuse treatment. The need for quality assurance is particularly acute given that addiction services are frequently provided by non-state providers. There is potential for learning from the quality assurance programme put in place in the Netherlands, "Scoring Results" (see www.resultatenscoren.nl/en/).

In strengthening data collection Norway should pay more attention to measuring patient outcomes and assuring patient safety

There is potential for Norway to learn from other OECD countries which have made significant efforts in focusing on measuring patient outcomes to improve care, and using data to help assure patient safety. Well-conceived targeted data collection instruments can assist care providers, and patients, in charting outcomes, and can be used to give an indication of the need to adjust care where necessary. Equally, to secure the safety of often vulnerable patients, good data collection on adverse events can help direct the attention of providers and clinical staff towards areas of risk in delivering mental health care.

One very interesting tool, on which Norway could draw, is the "Health of the Nation Outcomes Scale" (HoNOS), which was developed in the United Kingdom, and is now also used in Australia and New Zealand. A patient-specific outcomes measurement tool, the HoNOS instrument has 12 items measuring four domains of behaviour, impairment, symptoms and social functioning, each of which is scored from 0 (no problem) to 4 (severe problem) yielding a total score in the range of 0 (best) to 48 (worst). HoNOS is a provider-rated instrument with ratings carried out by an individual psychiatrist, nurse, psychologist, or social worker, or by using input from the clinical team (a consensus rating based on a team discussion). The individual patient's outcome is measured by comparing a patient's scores at two points in time. Scores at the second point in time can be more challenging to obtain if there are issues of staff changes or patient access (Jacobs, 2009). HoNOS can track individual patient-level outcomes, and give provider-level and national data.

Good national data collection can help improve the safety of individuals with mental disorders. Mental health service users may be at greater risk, and less able to participate in joint decision making as a result of the problems they are experiencing, and sometimes as a result of staff attitudes and behaviours. This may lead to under reporting of adverse effects. To further promote patient safety, good adverse event reporting should also be a priority for Norway. The MedEvent system, in place in Norway from 1994 to 2012, should have recorded all inpatient suicides. A national reporting system such as this is an important first step in good adverse event reporting in Norway, but further steps could be introduced, potentially building on the Global Trigger Tool reporting system in place (see Chapter 1). In addition to recording inpatient suicides, national recording of suicides after discharge, and suicides of patients in contact with outpatient and community care, will give important information about patient safety post-hospitalisation and can help identify gaps in care and follow-up. National reporting systems for incidents of self-harm – especially in inpatient settings – and adverse drug events would also be important further developments, and could help shed light on two major areas of risk in psychiatric services (Australian Government, 2005). The Safe Hands campaign, launched in January 2011, includes a focus on suicide and overdose prevention, which is a very positive inclusion.

A strong system of data collection has the potential to be used by individual providers to identify gaps in practice. Where providers are falling short in preventing harm, they should be supported to make improvements. Supporting providers in making environmental assessments, for example to reduce self-harm events, ensuring that professionals are educated about risks and warning sign – which is particularly important in an area such as mental

health, where stigma and lack of awareness can be a problem even amongst medical and care staff – and systems of national support, for example clinical guidance, can back up an adverse events reporting framework to support harm reduction (Australian Government, 2005; NICE, 2013).

4.4. Addressing three key shortcomings in service delivery and availability for mental health care

Mental health needs are being included in the policy agenda addressing the whole health system, and rightly so, but it is possible to identify three key shortcomings in service delivery and availability for mental health care in Norway: weaknesses in care provision for mild-to-moderate disorders; shortcomings in the co-ordination of individual's care pathways; and inadequate care for drug addiction. Each of these shortcomings will likely need targeted efforts to bring meaningful improvements in the quality of care provided.

In addition to these three challenges, there may be a need for greater systematic reflection on the priorities for mental health in the years and decades to come. The Escalation Plan 1999-2008 prioritised a movement of services to the community and the closure of hospital beds, following a trend seen in many OECD countries. The building up of services in the community has been quite successful, with impressive strengthening of capacity.

As Norway looks to build on the progress made under the Escalation Plan, quality of care for mild-to-moderate disorders, co-ordination of care for individuals with severe and enduring mental health needs, and addiction care should be prioritised. One possibility is that Norway develop a second action plan for mental health, which reflects upon progress following the Escalation Plan, and establishes new priorities at a national level, leaving scope for municipal independence and interpretation. Other OECD countries have found national plans and strategies, when well conceived and designed – often with targets – have been useful, and the use of mental health strategies or plans is widespread across OECD countries. Of 32 respondents to the 2012 OECD Mental Health Questionnaire, 27 OECD countries reported to have a mental health strategy or plan in place (OECD, forthcoming). Mental health strategies in OECD countries have ranged from a broad-brush establishment of key principles for the mental health system – for example, a need to move towards "deinstitutionalisation" – to strategies that articulate future steps for the mental health system in much greater detail, broadly in line with the outlines set by the WHO. Constructed and employed in a range of ways, mental health strategies have been proved a valuable tool for OECD policy makers at the highest level of government to

drive the direction of the mental health system, and identify common priorities and views to push forward at a national level, and to focus attention on the need to assure a high-performing mental health system.

Greater attention to quality of care is needed for services targeted at mild-to-moderate disorders

Norway needs to continue work towards assuring a good level of care for mild-to-moderate disorders, and promoting quality for these services. As in many countries, mild-to-moderate mental health problems are too often excluded from mental health care in Norway. Across OECD countries concerted efforts to improve mental health care have been focused predominantly on severe mental illnesses, and have been seen as outside of the remit of specialist services. Consequently, a shortage of appropriate treatments for mild-to-moderate disorders is commonplace. Globally, treatment gaps for disorders such as depression and anxiety have been estimated at over 50%[2] (Kohn et al., 2004), and whilst Norway has not made national prevalence estimates, mild-to-moderate disorders are very likely similarly common. Norway has been scaling-up service provision for mild-to-moderate disorders, for example through increasing numbers of psychologists and reimbursing GPs for delivering CBT, which are good steps, but there is a concurrent need to maximise the quality of care using existing services and resources.

Given the central role that GPs are expected to play in the provision of services for mild-to-moderate mental disorders, especially depression and anxiety, there is a need to ensure that service provision at a primary care level is sufficient, and of high quality. In Norway, a review of community mental health services found that GPs generally are regarded as competent, involved and accessible partners by the community mental health workers (Slettebak et al., 2013). This is a good base on which Norway should build. However, given that GPs will likely remain at the forefront of diagnosing and treating mild-to-moderate disorders, there is an on-going need to assure a high quality of care for mental disorders.

Whilst mental health training is a part of GP training, additional incentives for GPs to undertake mental health training as part of continuous professional development (at present CPD for mental health is on a voluntary basis) could be examined as one way of promoting appropriate care for mental disorders. The availability of training for CBT, and reimbursements for GPs delivering CBT, is an interesting development. Clinical guidelines for primary care practitioners can support high-quality services, especially where practitioners are unconfident at providing care, and are another valuable tool. Whilst Norway does have some clinical guidelines for mental disorders they are

organised vertically, by disease, rather than being adapted to care settings. In an area such as mental health, where knowledge gaps and stigma – even amongst the medical community – can be significant, and practitioners' knowledge may not keep pace with developments in diagnosis, treatment and management, clinical guidelines that are specific to primary care can be a valuable tool. Municipal mental health services could also co-operate more systematically with GPs, for example by providing short courses or training for primary carers, or scheduling regular meetings between primary care practitioners and specialist mental health services to discuss individual patients and/or service delivery approaches. Such practices are reported as being in place in some areas, but are not consistently in place across the country.

Good links with specialist services can also help GPs in treating mental disorders. The WHO and Wonca have stated that "collaborative or shared care models, in which joint consultations and interventions are held between primary care workers and mental health specialists, are an especially promising way of providing on-going training and support" (WHO and Wonca, 2008, p. 6). A 2011 survey by the Norwegian Knowledge Centre of GPs' perceptions of specialist community facilities is an excellent starting point for ensuring good collaboration (Helsedirektoratet, 2011). Overall, the survey shows that GPs perceive there to have been positive developments in the country's District Psychiatric Centres since similar surveys in 2008 and 2006. However, centres scored poorly on questions about the guidance and collaboration with GPs. Norway reports that a range of links between primary care and specialist services are used (e.g. outpatient model, consultant-liaison model, facilitation model, multi-disciplinary review meeting) (OECD, 2012). Given the importance of good collaboration and support for GPs, and given the GP responses to this 2011 survey, further investigation into the level of support and support mechanisms for GPs could be appropriate, for example through a further detailed survey of GPs experiences across different regions.

Ultimately, primary care practitioners are limited by the resources and services available to them. Workload pressures, lack of skills and knowledge, poor support from specialist care, economic factors or organisational structures can inhibit or disincentives the provision of high-quality mental health care by primary care practitioners (Telford et al., 2002; Katz et al., 1998). In Norway very positive steps have been taken to increase referral options for GPs, notably through increasingly introducing GP-delivered CBT, increasing psychologist numbers, experiments with the introduction of a vertical IAPT-style programme of psychological therapies, and increasing use of web-based therapies. However, differences in service availability at the municipal level remain, and may limit referral options for

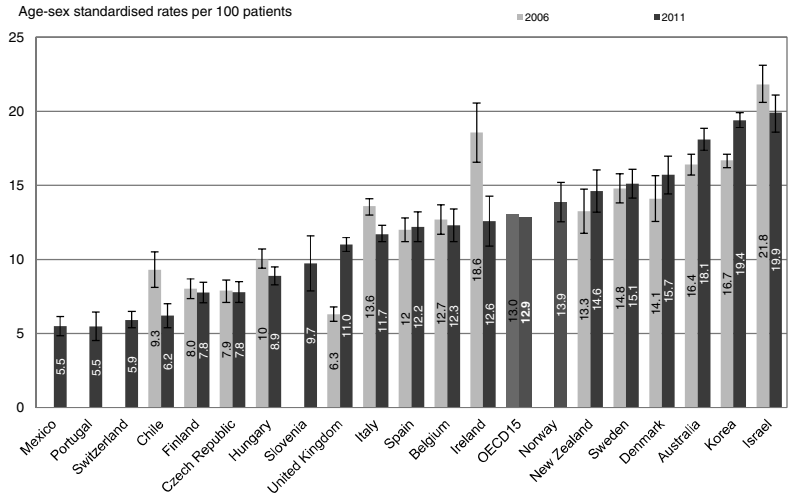
GPs in certain areas. The Norwegian Government is aware of some of the challenges around uneven municipal service availability, and planning steps to address this issue. In addition to steps planned by the Norwegian Government, minimum mental health service provision guidelines for municipalities, as well as established patient pathways from primary care, may strengthen access to appropriate specialist services – such as CBT or other talking therapies – for mild-to-moderate disorders across the country. The systematic recording of waiting times for patients following a referral to psychological therapies, published alongside Norway's existing data on waiting times and referral to depression services, may be a further way of effectively appraising unmet need and disparities across the country.

Individual Care Plans should be better used secure appropriate and effective care over time for individuals with severe and enduring mental disorders

For individuals with severe and enduring mental disorders, the care pathway often involves a number of different service delivery settings, contact with a range of professionals, and periods of both more acute need and greater stability. For these individuals, good co-ordination of care, good follow-up in the community following hospitalisations, appropriate long-term support, and sensitivity to patient requests and treatment needs are important parts of securing high-quality care. The better and more consistent use of Individual Care Plans could help support individuals with severe and enduring mental disorders, and their care providers, to secure the care package that they need over time.

The shift towards community care for severe mental illness is on-going in Norway, and good progress has been made in increasing availability of community services, for example Mental Health Care Teams. However, there are some indications that co-ordination of patients' care between inpatient and community settings could be more effective. Usually, patients are not re-admitted to hospital within 30 days following discharge without any prior plan to do so. Therefore, the proportion of patients re-admitted to hospital within 30 days has been used and collected by the OECD as an indicator of the lack of proper management of mental health conditions outside of hospital (OECD, 2013a). Whilst there are some limitations with regards to this data, including the small number of countries able to distinguish between "planned" and "unplanned" re-admissions to hospital, this can be a useful indicator (OECD, 2013b). Unplanned re-admissions to the same hospital for schizophrenia and bipolar disorder in Norway are quite high. Unfortunately, Norway was unable to report unplanned re-admissions for 2006, so change over time could not be tracked.

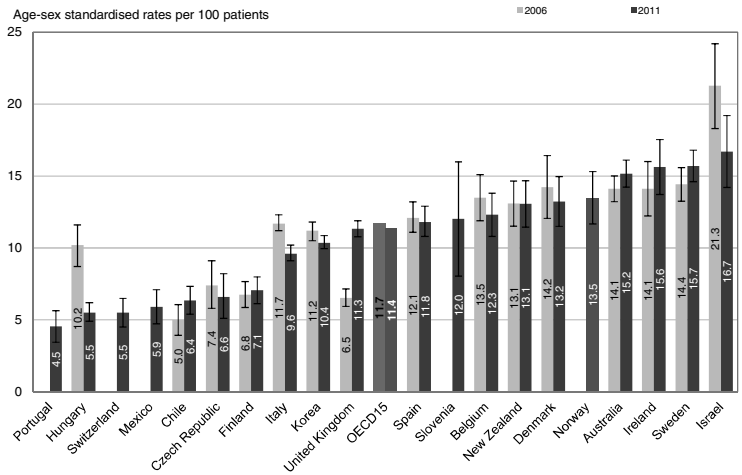
Figure 4.3. Schizophrenia re-admissions to the same hospital, 2006 and 2011 (or nearest year)



Note: 95% confidence intervals represented by H.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787.health-data-en.

Figure 4.4. Bipolar disorder re-admissions to the same hospital, 2006 and 2011 (or nearest year)



Note: 95% confidence intervals represented by H.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787.health-data-en.

ICPs could help improve co-ordination across a patient's treatment pathway, and at present ICPs are not being fully exploited as a tool to promote good co-ordination and good quality of care at an individual patient level. Efforts should be made to promote the use of such plans, give clear guidance about their use, and measure their use. At present, obligations to use ICPs appear not to be in place, and instead the reluctance of professionals to take on the extra work associated with being an ICP co-ordinator acts as a disincentive for the establishment of an ICP. Financial incentives, or clear identification of ICPs as a priority and a responsibility of select practitioners, may be needed. Systematic reporting on the use of ICPs may also both incentivise providers to use them further, and help identify areas – geographical or particular care settings – where ICPs are under-used, and therefore target support and resources appropriately.

Clear guidance about the availability, utility, and establishment of ICPs should target both practitioners and providers, and potential care plan users. Such guidance would include expectations of the scope of the plan, intended patients, key stakeholders, and appropriate timetables for establishment and review. At present, there seems to be little consistency over the way ICPs are used and well-constructed guidance, with buy-in from providers, practitioners and service users, may help make ICPs a more effective tool for promoting co-ordination. Service delivery settings, organisational modes, and decision-making hierarchies – for example in hospital settings – may not be well adapted to taking on board users' views, and efforts should be made to empower users, and educate and encourage practitioners/staff, in facilitating dialogue around treatment, especially when establishing ICPs. A small study in Norway (Gudde et al., 2013) supported the international trend towards user-centered care. The importance of meaningful dialogue as part of treatment was highlighted, and was perceived by surveyed users and related research as contributing to feelings of hope, optimism, and empowerment in the recovery proves (Gudde et al., 2013), and good dialogue when setting ICPs could help support this.

Weak addiction care has to be addressed and improved

The rate of reported drug-related deaths in Norway suggests an urgent need to improve care and treatment for addiction. To help tackle some of the significant problems with substance abuse in Norway a co-ordinated and concerted effort is needed. In Norway there has historically been a trend of having separate schools of mental health care and addiction care. Whilst the trend for addiction care is towards integration, the two systems are still frequently separate. By law, mental health services and drug centres have to treat people even with comorbidities, but reports suggest that some people are still excluded from mental health services because they have a substance

abuse problem. There are variations of between three and 23 weeks for access to a Medically Assisted Treatment scheme for opiate addiction (http://frittsykehusvalg.no); 23 weeks is an unacceptably long time to wait for access to treatment.

Additionally, addiction services have often been private services in Norway, often provided by charities or religious organisations; an estimated 60% of drug user rehabilitation services are run by NGOs, and funded by the government. Addiction services, which are less widespread in Norway than mental health services, likely need support from mental health services. This would require co-ordinated efforts with private addiction services, or more active inclusion of addiction treatment in mental health services. More integrated service provision would also help improve treatment for individuals with dual diagnosis disorders (addiction/substance abuse disorder combined with a diagnosed mental disorder). An integration model, which Norway is moving towards, is one clear possibility, and there are opportunities to learn from the experiences of other countries. For example, service integration in the Netherlands helped to bring down deaths from substance abuse. The experience of the Netherlands also gives some insights into treatment approaches for heroin use, including opioid and methadone treatment use (Box 4.4).

Box 4.4. Integrated care for addiction: a case study from the Netherlands

Addiction care has a special place in the Dutch mental health care system, and is delivered through a specialised combination of mental and somatic health care. Areas of focus are addiction to nicotine, alcohol, drugs, and sedatives and tranquilisers.

In 1998 public opinion on addiction care was low. Politicians questioned the effectiveness of the system and threatened to stop funding. A group of directors of addiction care institutions responded by designing a programme that focused on three goals (Rutten et al., 2009).

- Redesigning addiction care to provide care based on protocols and evidence and which is ordered in a "stepped care" hierarchy;
- A quality system based on permanent measurement of results to come to a system of continuous learning en improvement;
- Creating a supporting system, for example with initial education and extra training.

Through this initiative the knowledge centre "Resultaten Scoren" (translated as "Scoring results" which refers to the "scoring of drugs" as well as a focus on results) was founded. This centre specialises in addiction care and has had a major role in creating a scientific, evidence-based care approach in the sector during the past decade. Currently the Dutch addiction care sector is held in high regard internationally and is well informed on the prevalence of different addictions and on effective treatments (Rutten et al., 2009). There are currently nine categorical and eight integrated providers for addiction care in the Netherlands. The nine categorical

addiction care providers have nearly 5 000 professionals on staff (GGZ Nederland, 2013). It is unknown how many more professionals are employed in the integrated providers that provide addiction care. In 2012 there were 66 094 clients, or 395 per 100 000 citizens (in 2011 this number was 416 per 100 000 citizens), seeking help (78% male, 22% female), with most treatment provided on an ambulatory basis.

Opiates

The number of opiate users in the Netherlands is declining from an estimated 25 700-39 000 in 2002 to 17 300-18 100 in 2011 (Cruts and Van Laar, 2011). From this group, 11 300 persons are enrolled in an addiction care centre or in a regular mental health care provider that also offers addiction care. Almost 10 000 opiate users are enrolled in a methadone programme (Wisselink et al., 2012). A smaller group of 700 people is also being treated with heroin. There are 12 institutions in the Netherlands that offer heroin and/or methadone treatment for long-term addicts. A quarter of opium addicts live in social isolation and has multiple interrelated psychological issues (Loth, 2009). These sustained substance-dependent patients remain a vulnerable group.

Treatment of opiate addiction by medical prescription of heroin is possible since 1998. The Central Committee on the Treatment of Heroin Addicts (Centrale Commissie Behandeling Heroïneverslaafden – CCBH) has been responsible for co-ordinating the supply and treatment of heroin. Since 1998, treatment took place in the context of scientific research. The goal was to provide treatment with heroin in a (regular) pharmacotherapeutic treatment. The necessary adjustments in legislation were passed on 15 October 2009. Currently, heroin can now be prescribed to a selected group of patients who meet the required indication.

The effects of the transition to the medical prescription of heroin have been examined. The study found that clients receiving both methadone and heroin, compared to clients who just received methadone, had higher health benefits, and created less costs for law enforcement and lower damage to victims. The new treatment of combining methadone and heroin reduces costs of law enforcement with EUR 4 129 per patient per year (PPPY) and it reduces the cost of damages to victims with EUR 25 374 PPPY. The combined treatment costs an extra EUR 16 222 PPPY. In total, this leads to a reduction in societal costs of almost EUR 13 000 PPPY and furthermore there are also increased health benefits for the patients (Dijkgraaf et al., 2005).

Source: Rutten, R., M. Stollenga and G. Schippers (2009), "Tien jaar Resultaten Scoren in de Nederlandse verslavingszorg" [Ten years of scoring results in Dutch addiction care], *Verslaving*, Vol. 5, pp. 2-13; GGZ Nederland (2013), *Een visie op verslaving en verslavingszorg: focus op preventie en herstel* [A vision on addiction and addiction care: focus on prevention and recovery], GGZ Nederland; Cruts, A. and M. Van Laar (2011), *Aantal problematische harddrugsgebruikers in Nederland* [Number of problematic hard drug users in the Netherlands], Trimbos Instituut; Wisselink, D., W. Kuijpers and A. Mol (2013), *Kerncijfers verslavingszorg 2012* [Key figures addiction care 2012], Stichting Informatie Voorziening Zorg; Loth, C.A. (2009), "From Cram Care to Professional Care: From Handing Out Methadone to Proper Nursing Care in Methadone Maintenance Treatment: An Action Research into the Development of Nursing Care in Outpatient Methadone Maintenance Clinics in the Netherlands", available at http://dare.uva.nl/document/128571; Dijkgraaf, M.G., B.P. van der Zanden, C.A. de Borgie, P. Blanken, J.M. van Ree and W. van den Brink (2005), "Cost Utility Analysis of Co-prescribed Heroin Compared with Methadone Maintenance Treatment in Heroin Addicts in Two Randomised Trials", *British Medical Journal,* Vol. 330, No. 7503, p. 1297.

It is also the case that the voice of users of addiction services is less obviously represented in Norway; the separation of organisations for the users of mental health services from the users of addiction services reflects the division between services in the health sector. Such a division is not uncommon, but strengthening of links between user groups may be mutually beneficial to both mental health and addiction service users, and may help influence positive change, perhaps towards greater integration, at the service level. Given how common co-morbidities between mental health and addiction are, more co-ordination between user organisations may better represent the often complex needs of their members.

4.5. Improving co-ordination and defining responsibilities across different levels of governance

Amid some significant changes to the mental health system, including the shift towards community care, the increased role of municipalities, and the impact of the Coordination Reform, there is a need to for health authorities – the Ministry of Health and Care Services, regional health boards, and municipalities – to work to strengthen co-ordination between different levels of care, and to define responsibilities for services. Such a process, if carried out with input from all key stakeholders, is a key step towards closing gaps in service coverage, and also making the most efficient use of resources, including preventing duplication of services.

A need for better definition responsibilities for mental health at different levels of health provision (primary, municipal, and specialist care)

There is a combined problem of the expectation of increased responsibility of municipalities – both due to the shifts around the Coordination Reform, and the move towards community care under the Escalation Plan – some lack of clarity on the obligations of hospitals with regards to community care, and the role of GPs in providing and managing care. Norway's high level of readmissions might indicate too short inpatient stays in some cases, or poor co-ordination with community care leading to readmission, or a combination of the two. There is a need for clarity over the distribution of responsibilities between providers, and a prioritisation of co-ordination across this framework.

Pre-2008, increased funding delivered under the Escalation Plan was earmarked for mental health care at the municipal level, but municipal-level funding is no longer earmarked. Whilst the Health and Care Municipal Services Act states that municipalities are responsible for primary care for people with mental health needs and addiction problem, there is no

obligatory portfolio of services or service capacity at the municipal level. Reports from service users suggest that municipalities, especially small municipalities, don't have the capacity to provide high-quality treatment in the community for severe mental illnesses. Similarly, service users report that the wait to get specialist care is too long – as indicated by some particularly long waiting times for services – and that while hospitals are closing wards, but this care is not being sufficiently replaced by care provided by municipalities.

Whilst the Coordination Reforms may have brought challenges for all stakeholders, with payment systems and information systems not yet fully in place to support the new expectations being demanded of the community and primary care sectors, this is even more the case for mental health services. Given the broad aim of the Coordination Reform to shorten hospitalisations, emphasising the responsibilities of the municipalities, services provided by municipalities are going to be under increasing pressure. There is a need to respond to this on two fronts: firstly, but ensuring that mental health services provided by municipalities are safeguarded and not undermined by the squeezing of municipality budgets and capacities; secondly, through a clarification of responsibilities around mental health service provision, co-ordination, and care quality between health enterprises and municipalities, and the promotion of associated mechanisms. If municipalities are to be able to competently provide high-quality primary mental health services, as they are increasingly expected to do, then they will likely need support from and co-operation with specialist mental health services. Skilled professionals concentrated in hospitals and at present information sharing is usually informal and through colleagues. Mechanisms to promote knowledge sharing, the definition of a good patient treatment pathway, and data systems to share patient information could be promoted.

Consultation with service users as municipalities look to fulfil their responsibilities for community care would be highly valuable. The involvement of users of mental health services in policy making and service governance, both due to a legal obligation (Mental Health Act, 1999) and an apparent genuine and quite widespread conviction in the importance of the involvement of service users, is one of Norway's great strengths. Users' views are valuable at all levels of the mental health system, from policy level to the care delivery level. At the care delivery level especially, good mechanisms that ensure that users' views about their own care are fully taken on board will likely increase quality of care, and improve outcomes in terms of quality of life and treatment adherence (Barnes et al., 2006). Whilst there are clear examples of users' views being listened to and taken on board, users' views should be systematically taken on board in a meaningful

way. Gudde et al. (2013) found, for example, that service users expressed a need for low-threshold services to help break a vicious cycle of crisis and recovery, a cycle which is borne out also in Norway's high readmission rates for bipolar disorder and schizophrenia. Municipalities would be the most appropriate body to investigate the delivery of such services. Users' views should be taken on board with regard to care co-ordination; service users indicated that the way that treatment was offered, and the organisation of services did not always meet their needs (Gudde et al., 2013). Furthermore, there is an on-going need to ensure that users' safety and rights are a priority in practice as well as in principle; on this point there may be a need to more closely examine, or at least put in place better recording/monitoring systems, around the use of involuntary detainment (admission), seclusion and restraint in Norway.

GPs are playing an important role in caring for Norwegians with mild8to-moderate and severe mental illness, and also need to be actively included in the articulation of responsibilities for mental health. In strengthening care for mild-to-moderate illnesses, excellent care delivered by GPs will be vital. GPs also have the potential to play an important co-ordinating and managing role in care for severe mental illnesses, including participation putting together of ICPs. As such, the inclusion of GPs in planning for the wider system of mental health care is important.

As set out in Chapter 2, negotiations between municipalities and hospital managers have a very low and inconsistent level of participation from GPs. At present there appear to be far fewer negotiations between municipalities and hospital managers to promote good mental health planning. Alongside the need for better dialogue between specialised services, including in hospitals, and municipalities for mental health, there is a need to include GPs actively in decision making.

A clear articulation of the distribution of responsibilities for service provision, care, and co-ordination for mental health needs to be set out. A mental health plan, similar to the Escalation Plan, is one possibility. The process of establishing a plan would also be an opportunity to bring together diverse stakeholders, and broadly discuss expectations and needs for mental health in Norway. A minimum service requirement package for mental health services at a municipal level is another possibility, although this may not fully define responsibilities at the specialist (and hospital) level and the primary care level. A further possibility is an extended report articulating the application of the principals of the Coordination Reform to mental health, and mental health services.

Differences in availability of care across Norway are a cause for concern

From the quality measures available, it appears that there are some shortcomings and discrepancies in the quality of care for mental disorders in Norway. Attention should be given to these discrepancies, including efforts to trace apparent disparities back to service delivery. There should be a focus on closing gaps in service delivery, as well as preventing duplications.

Disparities in the use of forced admission and in waiting times for services may be indicative of shortcomings in the care quality of some specialist services. There are considerable differences in the use of forced admissions both between counties and between hospitals. This trend is difficult to explain fully, and various explanations have been proposed, including different treatment cultures and different attitudes to the use of compulsory admission among referring physicians, in hospitals and in DPCs; differences in competence, co-operation procedures and personnel resources; differences at a municipal level, and unequal access to hospitals and mental health specialists between geographical areas; and differences in rates of mental ill health across the country. Reduction in involuntary admissions is a priority, but greater co-ordination across regions is likely needed to better understand the root causes of these disparities. A national network for research, led by the south-eastern region, is looking to register involuntary treatment and use of seclusion and restrain nationally, which could be fruitful.

Table 4.4. Involuntary admissions across health regions, 2011 and 2012

Treatment location	2011		2012	
	Number of admissions per 1 000 population	Total involuntary inpatient admissions	Number of admissions per 1 000 population	Total involuntary inpatient admissions
Norway	**2.3**	**9 057**	**2.2**	8 798
Western Regional Health Authority	4	3 086	3	2 774
Northern Regional Health Authority	3	992	3	887
Southern and Eastern Joint Regional Health Authority	2	4 644	2	4 720
Midland Regional Health Authority	1	335	1	417

Source: http://helsenorge.no.

In addition to differences in rates of involuntary admission to inpatient care there are differences in waiting times for services, which again suggests variations in care across regions. Waiting times for outpatient services, for example, differ quite significantly between areas; referral times for depression services vary between four and 30 weeks across service delivery settings (institutions), between one and twelve weeks for psychosis. An appraisal of whether such differences in waiting times translate into differences in access for patients – for example, whether quality of care for psychosis for patients in the city of Tvedestrand, where referral time is 26 weeks, is compromised or whether other appropriate services are available in the vicinity – would be appropriate.

Table 4.5. Variations in waiting times for outpatient mental health services across Norway

Average and median waiting time in days for outpatient mental health services for adults, by health region

Treatment Location	Mean waiting time		Median waiting time	
	2007	2008	2007	2008
Norway	**58**	**53**	**36**	**34**
Western Regional Health Authority	58	44	34	30
Northern Regional Health Authority	61	74	39	43
Southern and Eastern Joint Regional Health Authority	56	49	35	31
Midland Regional Health Authority	64	66	46	49

Source: www.sintef.no/Projectweb/Startsiden/.

Furthermore, there are clearly excellent examples of good quality of care provided in municipalities, where services are working well, and in co-ordination with specialist services, and where access to care is timely, but there are no real mechanisms to ensure that this excellence is in place across Norway. Standards for municipal care provision are not in place, and service availability is not standard across municipalities. Priority setting at a municipal level is also not clearly established, nor are good mechanisms for information sharing between services. As a consequence, whilst one municipality can decide that mental health is a priority area, and invest in excellent service provision and care co-ordination, and another municipality may make far fewer investments in mental health services. Whilst community-level quality measures are under-developed, and available indicators are not sufficiently granular so as to assess service provision at a municipal level, the absence of national minimum standards for care provisions very likely to be leading to uneven quality of care between municipalities.

Co-operation between smaller municipalities for the provision of mental health services is highly desirable. Given Norway's large number of small municipalities, provision of high-quality mental services by each is an impossibility. There are some municipalities that are co-operating around service provision, and these instances could be used as learning examples. Financial incentives, wherein ring-fenced funding is given to groups of municipalities for service provision, or where minimum service provision contracts with associated ring-fenced funding are given to collectives of municipalities, could be explored as possibilities. Such an approach would support smaller municipalities to ensure that they have comprehensive and appropriate care for their population.

Making the Coordination Reform count for mental health

At present, the Coordination Reform is the key policy influencing change, and shifting governance and service delivery roles, in the Norwegian health system. Some of the themes of the Coordination Reform (Ministry of Health and Care Services, 2009) need to be more explicitly applied to mental health. Mental health is included as a priority of the Coordination Reform, but has not as yet been included in the financial mechanisms to assist with the shift in care provision from specialist services to the community. Whilst it is evident that providing similar financial mechanisms and incentives for mental health can be more challenging, there is a need for a concerted effort to safeguard mental health as a priority both on a policy level, and on a service-delivery level, whether through financial incentives or other tools. Furthermore, since the end of the Escalation Plan, there is no longer ring-fenced funding for mental health. With increased pressure on municipalities to provide appropriate care to avoid penalties for extended hospital stays, there is a risk that resources for mental health will be squeezed in the future.

Municipalities should be supported in applying the principals of the Coordination Reform, even ahead of the intended introduction of financial mechanisms for mental health care. Whilst eventually extending the financial mechanisms and incentives for care in the community that have been introduced for somatic health under the Coordination Reform to mental health would seem an appropriate way to safeguard mental health care in the health system, there may be other ways to strengthen mental health services and co-ordination. A national strategy or action plan for mental health, possibly alongside a minimum service provision contract for mental health for municipalities, could help define expectations of different service providers. If municipalities are to be able to competently provide high-quality mental health services, as they are increasingly expected to do, then they will likely need support from specialist mental health services.

Other dimensions, including a focus on prevention and primary care, are also important and may be more immediately and explicitly applied to mental health care. Prevention, one of the three key challenges identified in the Coordination Reform (1. Patients' needs for co-ordinated services are not being sufficiently met; 2. In the services there is too little initiative aimed at limiting and preventing disease; 3. Population development and the changing range of illnesses among the population), is a priority for mental health and addiction as it is for diabetes or COPD. In line with the expectations of the Coordination Reform, municipalities are to take primary responsibility for prevention and early intervention in the course of a disease (Norwegian Ministry of Health and Care Services, 2009). "Prevention" was also included as part of the services that municipalities were expected to deliver in the Escalation Plan. When looking to address mental health, municipalities are in some respects well-placed to lead prevention efforts, given their responsibility for public health, kindergarten and pre-schools, education (up until age 16), for social services, and community services, which are key loci for prevention and early intervention, programmes.

Norway has in place a number of impressive and effective programmes which focus on prevention and promotion of good mental health (see Box 4.2). Given the existence of some good prevention and promotion programmes in Norway, and in Norway's neighbouring countries, the expansion of some of these pre-existing programmes across all municipalities would be a good starting point. In most cases, this responsibility will fall to municipalities. In order to promote the most effective and most appropriate interventions, best practices could be shared between municipalities. Such best-practice sharing could be done on an informal basis, but given the great number of municipalities or varying sizes, some more formal platform may be desirable, for example a platform that focuses on key challenges and ambitions for implementing the Coordination Reform. Specialised services are also expected to participate in educational and consulting work with municipalities, for example in schools, and small municipalities may be better placed to negotiate demands for services with specialised services when part of a consortium of local municipalities. The report *Better Safe than Sorry* (Major et al., 2011), prepared by the Norwegian Institute of Public Health on behalf of the Ministry of Health and Care Services, offers 50 recommendations on prevention for mental health, addressing central and local health authorities, as well as local and national authorities outside the health care system. This report offers a number of important points on which municipalities could build, of which the recommendation around the establishment of better preventative measures in senior centres – and also in intermediate care centres – is highly relevant to many of the objectives of the Coordination Reform.

4.6. Conclusions

Norway is clearly committed to providing good mental health care for its population, having highlighted the importance of mental health in a range of policy documents, having committed significant resources to the mental health system, and having worked to increase system inputs. Norway already collects a good range of indicators for mental health care, and reporting on these indicators appears to be improving year-on-year. Despite the difficulty of assessing quality of care across the mental health system, especially in an empirical or internationally comparable way, provision for mental health in Norway appears to be quite good, and a good base on which to build further efforts to measure and improve care quality. Furthermore, Norway has been committed to reducing inpatient services and increasing community care, to some increases in care for mild-to-moderate disorders, and to bringing care for mental disorders in Norway in line with care provision in many other OECD countries, which are very positive steps. The suicide rate, a very loose proxy indicator for quality of mental health care, has also been falling over the last decade in Norway, and is now a little below the OECD average. The falling-but-still-high suicide rate in Norway suggests, as do other more robust information sources and reports, that there have been improvements in mental health care in Norway, but that there is still scope to strengthen care further.

There are some key opportunities for further improvements to be made to mental health in Norway. As a starting point, stronger data systems will help policy makers and service providers better understand shortcomings in quality, and can guide appropriate changes. In particular, Norway could look to build upon existing data indicators by introducing data structures that help measure and assure patient safety, and that help measure treatment efficacy and patient improvement through a focus on outcome measures. Whilst data collection around mental health is complex and challenging, there are examples both from Norway's Nordic neighbours, and from countries such as England and Australia, of opportunities for effective collection of and use of indicators of mental health care quality.

Some particular challenges do stand out, including the need to ensure high-quality care for mild-to-moderate mental disorders – especially through supporting GPs and an increasing number of psychologists, and other mental health professionals –, the need to improve the care pathway for severe disorders and the potential to better use individual Care Plans to do so, and a need to improve addiction care, with greater integration being one important avenue for consideration. In addition, whilst co-operation and collaboration appear to be guiding principles in the Norwegian mental health service, there is room for further reflection by different levels of health authority – the

ministry, health regions, and municipalities – to better promote co-ordination, and define responsibilities for services. Such reflection, which should ultimately lead to stronger definition of responsibilities for service provision, should include consultation with a range of stakeholders, including service users, carers, mental health specialists, nurses and GPs. After a long period of change in the Norwegian mental health system, continued commitment and attention – supported by good information, data, and stakeholder input – will help secure further improvements in quality and outcomes in the years to come.

Notes

1 Suicide rates can be considered to give a very rough indication of the state of mental health, and to a lesser extent mental health care, of a population. Notably, over 90% of people who have attempted or committed suicide have been diagnosed with severe psychiatric disorders such as severe depression, bipolar disorder and schizophrenia (Nock et al., 2008). However, care should be taken when comparing data between countries – as several factors, both cultural, religious and systematically influence how suicides are reported (OECD, 2013b).

2. Note that this is a treatment gap for *all* depression and anxiety, and therefore includes cases that have more acute symptom severity, as well as mild-to-moderate cases.

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