Case study 3. Norway

1. Health system overview

Social demography and population health

Life expectancy at birth of the Norwegian population has grown steadily and reached 82.7 years in 2017. On average, Norwegian women live 3.3 years longer than men, but this gender gap has narrowed by two years since 2000 and is smaller than the EU average of 5.2 years (OECD, 2019).

Organisation and governance

The health care system in Norway is semi-decentralized; the state is responsible for specialist care, which is administered by four regional health authorities. The responsibility for primary health care lies with the 356 municipalities, which are relatively free to organize health care services based on the legislation and budget prepared by the state (OECD/European Observatory on Health Systems and Policies). In this regard, the state has a stronger steering position in specialist care compared to primary health care. Regulation and supervision is carried out by the state (the Ministry of Health) through the Norwegian Directorate of Health (Saunes, Karanikokos, Sagan 2020).

General practitioners act as gatekeepers as referral from primary to specialist health care can only happen through them. Gatekeeping is used to limit the demand for specialized services, as specialist health care is viewed as a limited commodity and is more costly in cases were primary health care can handle the problem equally effective (Larsen, Klausen, Højgaard, 2020).

Health care workers in public health care are salaried public employees. The majority of general practitioners (GPs) are self-employed, but they are fully embedded in the public system through contracts with the municipalities (OECD, 2019).

Financing

In 2017, Norway spent 10.4 % of its GDP on health, which is above the EU average of 9.8 %, but in line with other Scandinavian countries. Health spending per capita in 2017 was the highest in Europe at EUR 4 459, compared with the EUR 2 884 EU average (OECD, 2019).

The Norwegian health system has three main sources of revenue: general taxation revenues (accounting for 74 % of the total), insurance contributions to the national insurance scheme (11 %) and private expenditure (15 %), which in Norway consists mainly of out-of-pocket spending by households. Private health insurance only plays a marginal role. Taken together, the two public sources account for 85 % of health spending, a higher share than in any EU country (OECD, 2019).

Norwegian residents pay a personal contribution of up to NOK 2,460 (EUR 250) annually. Amounts above the threshold are covered by the State (HELFO, 2019).

Human resources

The numbers of both doctors (4.9) and nurses (18) per 1 000 population in Norway are well above the EU average. Nevertheless, health workforce projections indicate that a shortage could emerge by 2035 due to growing health and long-term care needs from population ageing, combined with the retirement of many doctors and nurses. This shortage could be mitigated by for example strengthening the education and training of new nurses, and reducing dropout rates both from nursing studies and the nursing profession. The dropout rate of nurses and auxiliary nurses is particularly high for those working in long-term care (OECD, 2019).

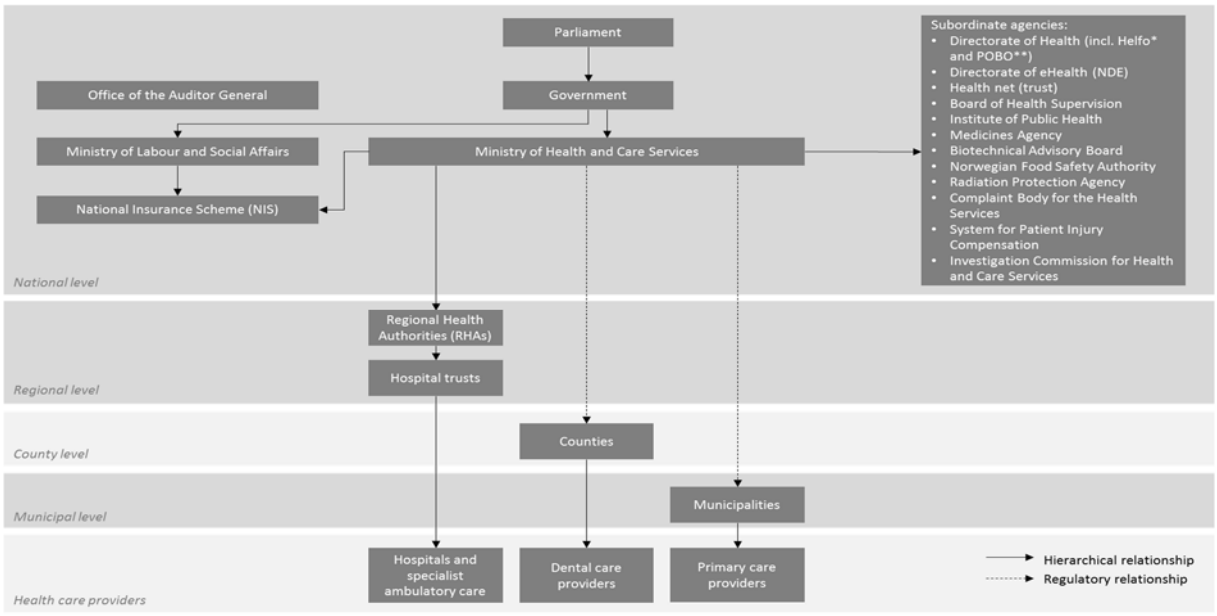
Services delivery

Health coverage among Norwegian residents is universal, covering the whole population. While the benefit basket covers a broad range of services, all services except inpatient care and home-based nursing care require some level of cost-sharing. As most adults are largely excluded from dental care coverage, dental care accounted for the largest share of cost-sharing, corresponding to 26 % of total out of pocket spending in 2017. Outpatient pharmaceuticals absorbed the second largest share, with 24 % of out of pocket spending in 2017. Children under the age of 16, people receiving low pensions and those injured in occupational accidents are exempted from co-payments (OECD, 2019).

Health information systems

Most health providers and clinics use electronic patient record systems. The sector consists of many independent actors who are responsible for their own HIS-systems. This has led to many stand-alone solutions (Regjeringen, 2016).

Overview of the Norwegian health system



Health indicators

A list of health indicators is provided in the annex.

2. System enablers of community care

Legislative framework

In 1972, legislation was introduced according to which health centres became a municipal responsibility and a statutory service. Health centres must comply with many laws, regulations and guidelines. These range from national laws which set out overarching guidelines for the service, such as the Health and Care Services Act (Ministry of Health and Care Services, 2011), to guidelines which provide professional guidance regarding the actual provision of services. Guidelines for prenatal care (Directorate of Health, 2018) and for the health centre and school health service (Directorate of Health, 2020) expand on the legislation and provide professional advice and recommendations for the service. For example, they provide guidance on the health information that health centres should provide, the services that are to be provided for children with weight abnormalities, and how eye and hearing tests

are to be performed. The list is long and the topics wide-ranging and varied. The guidelines are intended to help ensure that the service is based on the right priorities, prevent unwanted variations and ensure high-quality in the provision of the service. The guidelines are regularly evaluated and updated as new legislation is introduced and new knowledge becomes available.#

The municipalities are responsible for the provision of health services to residents, and must ensure that persons who are resident in the municipality receive the health care services they need. The municipalities are obliged to plan, implement and correct service provision, to ensure that the scope and content of the services comply with requirements laid down in applicable regulations (Ministry of Health and Care Services, 2016).

Community care organisation at national, regional and local level

Health centres form part of the municipal health service which carries out planned health promotion and preventive health work. The municipalities are able to formulate the services they provide in an appropriate manner based on local circumstances and needs. In most municipalities, health centres are organised under the municipal health service together with the school health service and youth health centres, which collectively form the health service for pregnant women and children and adolescents 0-24 years. The health service is part of a broader context of services provided at municipal level. The health service is generally organised collectively with other services such as domiciliary nursing or schools/kindergartens, with a different organisational structure from one municipality to the next. The health service has its own director and a specific budget.

Family Centres (*Familiens Hus*) is an organisational model for coordinating municipal services which collectively provide families with integrated and readily accessible support services. The model comprises health care, child welfare and special pedological ervices, and is organised into three levels based on needs (Adolfsen et al. ed., 2019). Health centres are the universal service that meets the needs of all families at the lowest level. As and when necessary, health centres can refer families to other services at the second level.

The Directorate of Health is the service's competent authority at national level. The Directorate is responsible for advising on matters which impact on the health of the population and developments in the service. It is also responsible for developing national standards in selected areas, possessing specialist expertise regarding Norwegian health legislation and developing integrated national health preparedness. The Directorate also has authority to apply and interpret laws and regulations within the health and care sector. Furthermore, the Directorate is responsible for implementing national policies within the health sector (Directorate of Health, 2021a).

Funding sources for community care

The health centres are funded through appropriations which the municipalities receive from the State as determined through the annual National Budget. The municipalities decide for themselves how the appropriations should be spent, and how much should be allocated to cover specific health care services, but they must cover all expenses attributable to the health centre and school health service. Municipalities can also apply for financial support through various grant schemes, which are then earmarked directly for various political initiatives. Grants for strengthening and developing the health centre service are one such political priority.

3. Service delivery

Target needs and groups

The health centre service in Norway is a statutory, universal and readily available low-threshold service for all pregnant women, children and their parents, regardless of their social status. The health centre service is a free service available to residents, and residents cannot purchase any additional services other than those that are provided. It is the needs of the family and their health literacy, as determined by the health professionals concerned, which determine the follow-up and any additional service provision. Almost the entire target group uses services provided by health centres, and the service is trusted by residents.

The origin of health centres dates back a long way. Florence Nightingale realised the importance of a preventive approach and established a network of public health nurses to reach out to women and children in their homes. This formed the basis for the establishment of the health service. The first initiatives aimed at improving children's health took place in the 1890s, due to high infant mortality rates in Norway at the time. There were two precursors to the modern health centre: children's care centres run by the church and health centres run by the Norwegian Women's Public Health Association. The first health centre for mother and child in Norway was opened in 1911. During the early days, the twin aims were to improve hygiene and nutrition and prevent infection. As living standards improved, the focus shifted to health promotion and prevention (Sykepleien, 2012).

The purpose of today's health service is to promote good mental and physical health and good social and environmental conditions, and to prevent disease and injury. The aim of health centres is to contribute to good and secure living conditions for children and adolescents, good health and everyday life skills, and to offer services providing guidance, advice and support. Health centres have a particular focus on groups with special needs and play a central role in identifying signs of neglect, stress and developmental abnormalities at an early stage. As and when necessary, health centres must provide support services, implement special measures, refer patients for treatment and/or provide the necessary information concerning support measures from other bodies.

Health centres must be a place where parents meet professionals who can assess their child's health from a broad perspective, act as a discussion partner and help parents to navigate the health information that is available. Everyone must be met with respect and openness. A vital function is to help eliminate social health differences.

The aims are to:

- **ensure that parents strengthen their parenting skills**
- **ensure good interaction between parent and child**
- **promote physical, mental and social development amongst children and infants**
- **prevent, avert and detect violence, abuse and neglect**
- **identify physical and mental developmental abnormalities at an early stage**
- **help ensure that children receive the necessary follow-up and referrals as and when necessary**
- **provide parents with individual and necessary information, support and guidance based on need**
- **establish contact at an early stage, preferably with both parents present**
- **provide the basis for further follow-up of the child and cooperation with the family**

Source: Norwegian Directorate of Health, 2020

Scope of services

All professionals at health centres are responsible for providing advice and guidance and ensuring that the services they provide are holistic, multidisciplinary, appropriate and of high-quality, regardless of cultural or ethnic background, language and experience. The aim is to provide parents with health-based information tailored to their health literacy, and to improve their ability to make their own appropriate choices.

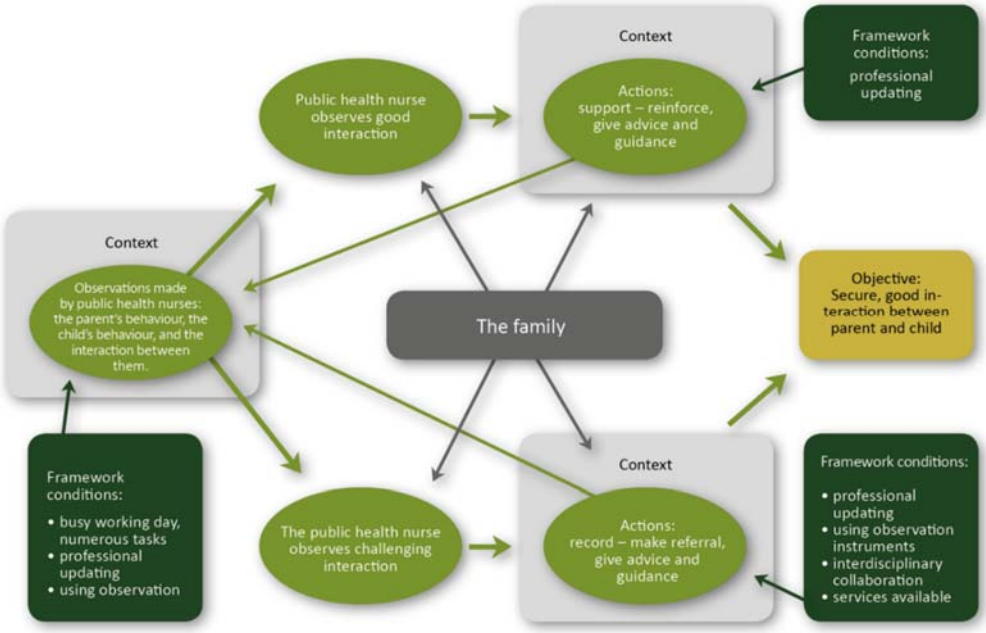
A family's first encounter with a health centre is normally in connection with pregnancy. Midwives are then responsible for following up the pregnant woman in cooperation with the woman's general practitioner (GP). In Norway, pregnant women are entitled to monitoring and support throughout their pregnancy in the form of nine scheduled consultations, as well as home visits and a six-week check-up after birth. The midwives focus on women's health, and the aim is to reduce morbidity and mortality, promote health and offer contraception after pregnancy (Directorate of Health, 2018).

Children in Norway have a statutory right to medical check-ups. Public health nurses are responsible for the majority of the follow-up concerning the child and the family, and the family will normally meet a designated public health nurse at each consultation. Public health nurses are authorised nurses with further education and/or a master's degree in health promotion and prevention specifically aimed at children and adolescents. The health centre service consists of 14 scheduled consultations and additional consultations as and when necessary, as well as referral to other services when necessary. Group activities such as birth preparation courses and postnatal groups are also offered at health centres, and are one way of promoting networking, in combination with health information.

A home visit by a public health nurse is the first consultation and a vital aspect of the health care service. The aim of home visits is to help establish contact and build up trust with the family, and to observe skills and interaction between the child and its siblings and parents in its normal surroundings. Home visits give the public health nurse an opportunity to get to know the family in its own environment, and often facilitate subsequent cooperation. The family can gets answers to any questions they may have, as well as advice and guidance at home. A key aim is to improve the parenting skills of the parents, with a particular focus on interaction between the parents and the child.

The consultations cover health information, health checks, vaccination, advice and guidance to guardians according to a standard basic programme (Directorate of Health, 2020). The parent's resources, challenges and needs are all assessed during the health screening. Every consultation at newborn and infant age includes observations and monitoring of the child's growth and development, as well as the provision of parental guidance. This guidance is based on the needs of the parents and professional assessments, and is a key part of the services provided by the health centre. Some parents sometimes need additional help and advice in relation to common difficulties encountered in everyday life.

The public health nurse's assessments of the child consist of a complexity of various factors, as shown by the figure entitled "The complexity of assessing early interaction" (Berg-Olstad and Klette 2019):



Protection against infection and immunisation are important tasks of the health centre and a high immunisation rate helps prevent serious infectious diseases. Although all immunisations are voluntary, Norwegian children have the right to be immunised and receive the protection that the immunisation programme can provide. Basic immunisation is carried out by the health centres at newborn or infant age, with booster doses given at primary school. Public health nurses must offer immunisation to all children resident in Norway in accordance with the Norwegian Childhood Immunisation Programme (Norwegian Institute of Public Health, 2021) (Ministry of Health and Care Services, 2009).
The public health nurse performs certain screening tests, including the measurement of weight, height, head circumference, eyesight and hearing tests, and an assessment of language development. At four predetermined ages (six weeks, six months, one and two years), a standard medical examination is also carried out. The aim is to identify developmental abnormalities, medical conditions or signs of illness as early as possible, and to refer the child to a general practitioner, hospital or other specialist as and when necessary. The doctor at a health centre will not normally be the child's general practitioner, but will assess all children at the health centre to identify medical conditions at an early stage. Children with chronic conditions, for example, will be followed up by their general practitioner.
The physiotherapist is an important and integral part of a health centre. If the public health nurse identifies factors relating to motor development or asymmetry, there is a low threshold for instigating follow-up by the physiotherapist. Wherever possible, the physiotherapist will work with individual children who are in need of assessment and follow-up. The aim is to identify motor-related challenges and contribute to health-promoting physical health. Early support by a physiotherapist can prevent unnecessary health problems for the child at a later date. The physiotherapist also follows up children with chronic conditions.

Community care providers

The staff at a health centre will consist of a midwife, public health nurse and doctor. In addition, a physiotherapist and secretary can be added to perform tasks which the health centre is required to carry out. The level of staffing will depend on the size of the municipality and the number of children being born. The staff are mostly part- or full-time permanent employees of the municipal authority.

Community care centres

In many municipalities, health centres are located in the municipality in close proximity to other services such as libraries and open kindergartens. Health centres consist of offices which are tailored to meet the needs of the various professional groups. These offices often have a shared waiting room where there is room for children to play. In particularly vulnerable areas outside central locations, health centres can be set up to provide services which are physically close to vulnerable families.

The staffing level required at a health centre is determined using a staffing tool developed by the competent authority (Directorate of Health, 2021b). This tool is used to determine the number of days per week that the health centre should be open, the professional groups that should be present and the number of employees. An administrator/secretary, public health nurse and midwife will normally be present whenever possible, while a doctor and physiotherapist will be present on certain fixed days.

Managing services and performance monitoring

In Norway, the Norwegian Board of Health Supervision and the County Governor are responsible for supervision and control. The staff are covered by many obligations, including a duty of confidentiality, duty of disclosure and duty of documentation. Although health professionals are subject to a strict duty of confidentiality, they also have a duty of disclosure to the child welfare service if they have any concerns about a child who may be experiencing neglect or abuse in any way. All health care, such as observations, immunisations and medical checks are covered by the duty of documentation. The documentation requirements are intended to ensure that the service undergoes quality assurance, and methods for using the data that is produced are being developed to improve our knowledge and understanding of the health status of the population. Residents have a right to complain about the services they receive and a right to see documentation. Cases where the service makes a mistake, fails to provide a statutory service or does not follow procedures must be reported through the municipality's non-conformity system. Health professionals are authorised personnel and may lose their authorisation in the worst case scenario if they make a gross error.

Collaboration with other community actors

Health centres work closely with many other professionals and services, within both the municipality and the specialist health service. For example, the municipality may have municipal psychologists, kindergarten staff, family therapists, child welfare officers, educational-psychological service (PPT), healthy life centres and voluntary organisations, depending on demand. The *Familiens Hus* (Family Centres) cooperation model describes the cooperation between different services within the municipality.

All families encounter the health centre on the first level, which will assess and review whether the family is in need of other municipal services. Health centres are a universal service for all children and their parents, regardless of whether or not they have special needs. Those with individual needs may also encounter the second level, while a few with special needs will require services provided at the

third level. The aim of this model is to ensure that the collaboration works better and more efficiently, so that families receive the help and support they need quickly (Adolfsen et al. ed. 2019).
In today's complex society, it is vital that there is good cooperation between the various professional groups. Children, adolescents and their parents are entitled to a health service which, through multidisciplinary cooperation, is able to offer contact between the professionals that each family will benefit most from. In some families, both the children and parents face major, sometimes enormous, challenges as a consequence of circumstances relating to the child, the parents or life events. The problems are often of such a nature that a wide range of measures is necessary, including parental relief, help in the home, financial assistance and health care. The role of the health centre often becomes that of coordinator.

4. Challenges and reforms needed

As a statutory municipal service, health centres have firm foundations on which to build for the future, and the service has developed enormously since its inception. In recent years, its funding has also been strengthened by the authorities. Nevertheless, the service still faces many challenges.

In 2020, a report on the challenges faced by the service was prepared based on questionnaires distributed to public health nurses and managers within the service. According to the report, more public health nurses are needed amongst the municipalities, recruiting qualified staff is difficult, and not enough staff are being trained to meet the needs of the population (Lassemo and Melby 2020). Health professionals in the service are under considerable pressure at work, perform a wide range of duties and encounter families with diverse needs. In addition to the fact that two few professionals are being trained, there is some concern within the service over the number of public health nurses relative to the likely future demand for services.

As each municipality determines its own priorities based on demand, there is a high probability that the framework for each health centre will vary from municipality to municipality. This is despite the fact that normative figures were established for the service some years ago, and that a tool was launched in 2021 to determine appropriate staffing levels at health centres (Directorate of Health, 2021b).

As regards the demands placed on the service and national guidelines, the conditions are in place for the staff at health centres to identify abnormalities and difficult care situations for children. Nevertheless, there are still children who fall through the net. There are many reasons why this is the case, but time, tools and cooperation all play a role in the work. A study which looked at assessments of early interaction between parents and children under six months of age found that the framework impacted on the work of the public health nurse. Professional updating is afforded a low priority due to a lack of time, and interdisciplinary cooperation is challenging (Berg-Olstad and Klette 2019).

The health centre and school health service during the COVID-19 pandemic

The Norwegian Government has decided that children and adolescents should be shielded as much as possible during the pandemic, and that services should be maintained in line with infection control measures.

The Directorate of Health has therefore recommended that municipal services such as health centres, the school health service and child and youth health centres should continue to operate normally while following applicable infection control measures. The service has been specifically asked to be aware that children and adolescents who would not be vulnerable under normal circumstances could now be experiencing problems as a result of the pandemic.

According to the advice that has been given, those who attend consultations must be healthy. Consultations involving close contact (e.g. medical examinations, weighing, measurement and immunisation, etc.) must be completed within 15 minutes. Health reviews with children, guardians or individual pupils should take place at a distance of at least one metre.

The Norwegian Government has also appointed a coordination group for services to vulnerable children and adolescents with the participation of the Directorate, which is responsible for the provision of services to children and young people. The coordination group collects data and submits a report on the status of the services each month (Norwegian government, 2020). The Directorate of Health is responsible for collecting data from the country's health centres and school health services.

Attachments

Boxes featuring local cases

The health centres are generally relatively similar, regardless of whether they are situated in an urban or rural area in Norway. Office facilities, staffing, opening hours and service provision are relatively similar across the country.

Maria's first encounter with a health centre

A person's first encounter with a health centre often occurs early during pregnancy. During her pregnancy, Maria can decide whether she wishes to be supported by her general practitioner or the midwife at the health centre. Several consultations take place during pregnancy, during which both Maria's health and the baby in her tummy are the centre of attention. The father-to-be is also encouraged to attend the appointment with the midwife. Little use is made of advanced equipment. The mother's tummy is measured, the midwife takes a blood sample for some basic blood tests and the midwife listens to the heartbeat of Maria's baby using a doppler fetal monitor. In the event of any abnormalities, Maria will be referred to a hospital. The consultations last around 30 minutes.

Illustration: Lev Dolgachov / Mostphotos. HelseNorge

Home visit
Anna and Jesper have just become the proud parents of Emilia. She is their first child. A few days after returning home from hospital, they were visited by the midwife. After a week, they are visited by their regular public health nurse at home. The nurse has brought her weighing scales to weigh Emilia, some written information and an iPad on which she will show the parents an informational video. The nurse can carry all the equipment she needs in a small bag or backpack.

The aim of the home visit is to get to know the family and identify any abnormalities or challenges. The nurse will also examine Emilia and provide the family with health information. The information that is provided depends on the family's needs and can cover a wide range of topics. The most common topics are breastfeeding, weight and interaction.

It is important to weigh Emilia and monitor her weight development. If she is gaining weight, it is a good sign that Emilia is doing well, receiving the nutrition she needs and is healthy. After the nurse has got to know the family a little and weighed Emilia, the nurse will show the family an informational video called "In safe hands". She also has a discussion with the parents based around the topic of violence. The aim of this is to prevent physical and mental violence against children, and the nurse can show the video in the language that the parents are most comfortable with. The video is shown to all parents at as early a stage as possible. The nurse will then provide brief information on a wide range of topics which are relevant at this age.

The home visit lasts one to two hours, sometimes longer time if it is a long way for the nurse to drive to see the family. If the baby's weight gain is not satisfactory or the family is facing other challenges, an extra appointment at the health centre may be arranged before the next consultation, which will be at 3-4 weeks of age.


Illustration: Landsgruppen av helsesykepleiere NSF: In Safe hands
Illustration: Jojo studio

Child consultation at the health centre

Anders is at the health centre with his mother for his six-month check-up. The nurse has measured his weight, height and head circumference and will then show Anders' developmental curve to his mother. His motor development is observed on the floor, and the nurse talks to the mother about normal development in children. There are many other things that Anders can reveal about his development while he is lying on the floor, such as how he plays and studies the toys on the floor.

The nurse will also check that Anders has been immunised and will ask Anders' mother whether he experienced any side effects afterwards. The nurse will provide health information on various topics, such as sleep, nutrition, interaction and how to prevent potential accidents. The mother can ask any questions she may have about her child, parenthood or other challenges she is facing. The nurse may involve other collaboration partners, provide information about other services that are available or arrange an additional consultation with her. The nurse will document the observations and the information which emerged during the health screening. The mother and father can both see the health record if they wish. Another appointment will be arranged before the mother and Anders go home.

After the nurse has finished, the doctor will perform a somatic examination of Anders. During this examination, the doctor will listen to Anders' heart and lungs and check his ears, eyes, bones and joints. The mother can ask about anything she has noticed about Anders or anything else she is wondering about. If any abnormalities with respect to normal development are identified, the doctor will refer Anders for further assessment. The consultation lasts around 45-60 minutes in total.

Ilustration: Rebecca Ravneberg/Directorate of Heal, Landsgruppen av helsesykepleiere NSF and Jojo Studio.

Last regular consultation at the health centre

Lisa is attending her last regular consultation at the health centre. She has just turned 4 years old. She goes to kindergarten, and at the end of the day she has an appointment with the public health nurse at the health centre. She goes with her mother.

A lot will be asked of Lisa during this appointment. She will have to undergo a lot of medical tests and checks! The nurse will measure her weight and height, perform eyesight, hearing and language tests, and check whether Lisa is developing normally as regards her motor skills and mental and social development. They will talk about topics concerning everyday life, such as food, sleep and play. The nurse will provide health information about a wide range of topics, and the mother can ask about things she is wondering about and explain what it is like to be a mother.

The consultation lasts 45-60 minutes.

Illustration: Helsedirektoratet.no

Country indicators

Norway	Country indicator	Year
Population size (thousands)	5277	2017
Share of population over 65 (%)	16.6	2017
Fertility rate	1.6	2017
GDP per capita (EUR PPP)	43990	2017
Relative poverty rate (%)	12.3	2017
Unemployment rate (%)	4.2	2017
Life expectancy at birth	82.7	2017
Smoking	11 %	2017
Obesity	14 %	2017
Repeated drunkeness		
Per capita spending (EUR PPP)	4459	2017
Health expenditure (% GDP)	10.4%	2017
Public health funding (%)	85 %	2017
Out-of-pocket expenditure (%)	14.5%	2017
Voluntary health insurance (%)	marginal	2017
Avoidable hospital admission (CHF)	164	2017
Avoidable hospital admission (COPD and asthma)	244	2017
Avoidable hospital admission (diabetes)	77	2017
% reporting unmet medical needs	1 %	2017
Practising doctors per 1000 population	4.9	2019
Practising nurses per 1000 population	18	2019
Number of doctor consultations per individual	4.4	2019
Discharges per 1000 population	163	2019
Preventable causes of mortality	145	2019
Prevention	3 %	2017
Outpatient care	29 %	2017
Inpatient care	29%0	2017
Long-term care	28 %	2017
Pharmaceuticals and medical devices	11 %	2017

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