

# Policies and practices of home based care services - the case of Norway

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# The presentation

- 1) The international image of Scandinavian elder care
  - Point of departure
- 2) Characteristics of the Norwegian elder care system
- 3) The case of home based care services in Norway
  - Policies and practices
- 4) Concluding discussion – lessons to learn from a Scandinavian country



# The image of Scandinavian elder care

## The Nordic model

### A Social democratic welfare regime

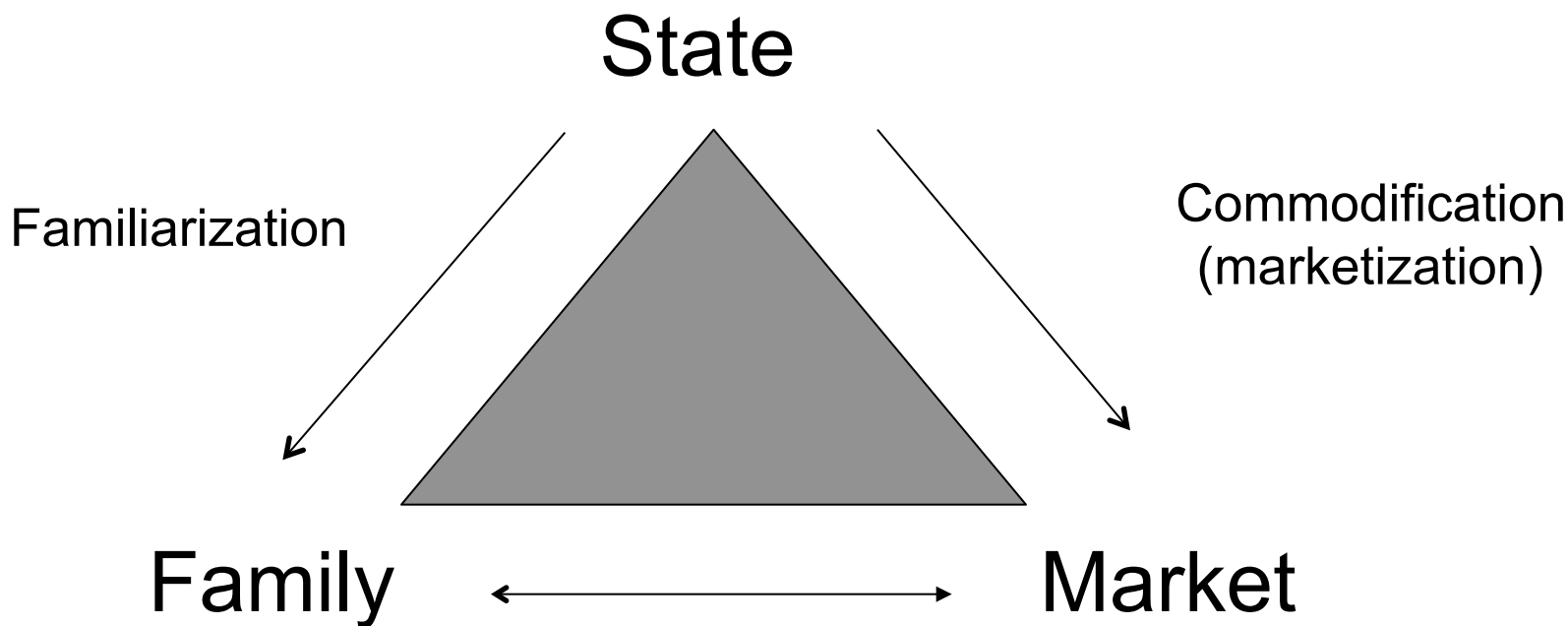
(Esping-Andersen, 1999)

- Generosity (high coverage)
  - Universalism (all citizens' access regardless of income)
  - Formalism (limited informal care)
- 
- **How have home based care services developed?**
  - **What policies have been driving forces?**
  - **What practices have been developed?**
  - **Which lessons are there to learn from Norway?**



# The Nordic model explained by the welfare triangle

(Esping-Andersen, 1999)

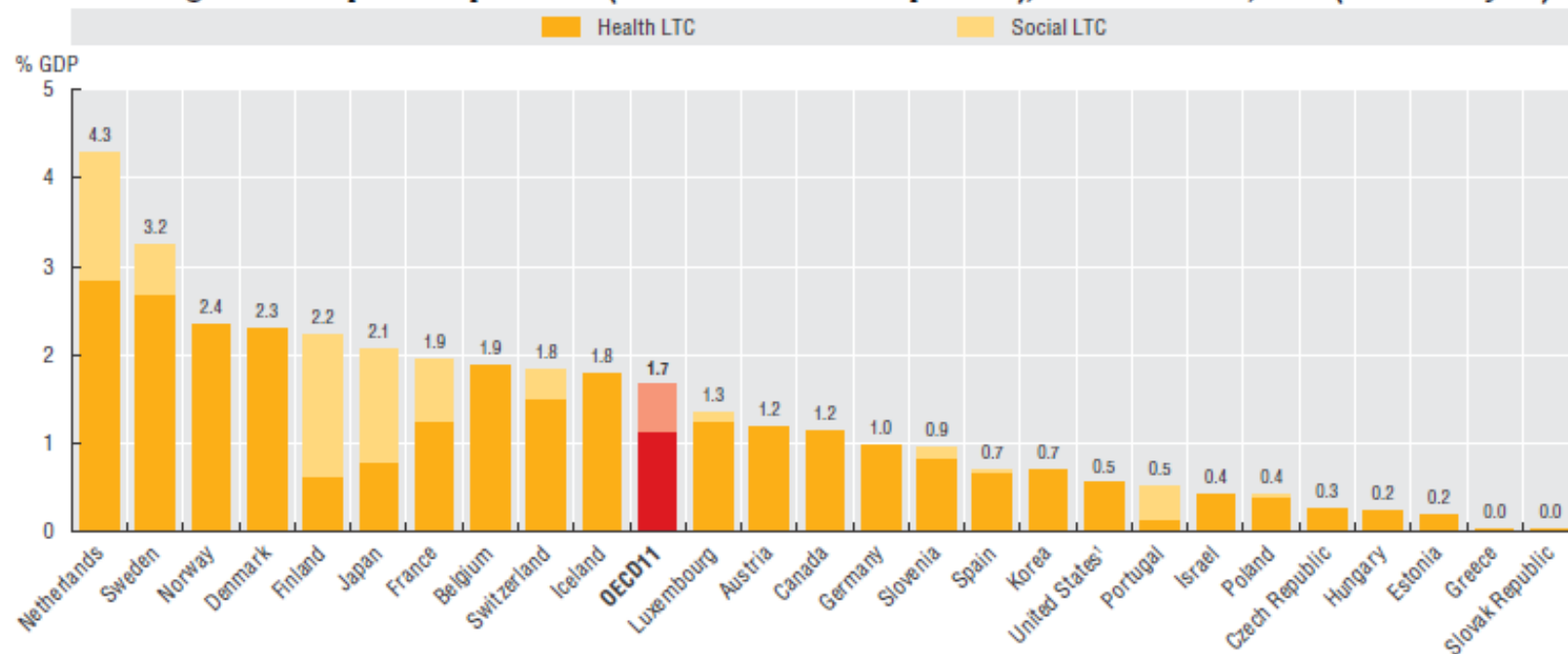


A fourth actor:  
voluntary  
organizations

Nordic social democratic model:  
de-commodification and de-familiarization

# Figures 'documenting' the image of Scandinavian long-term care service


11.21. Long-term care public expenditure (health and social components), as share of GDP, 2013 (or nearest year)



Note: The OECD average only includes the eleven countries that report health and social LTC.

1. Figures for the United States refer only to institutional care.

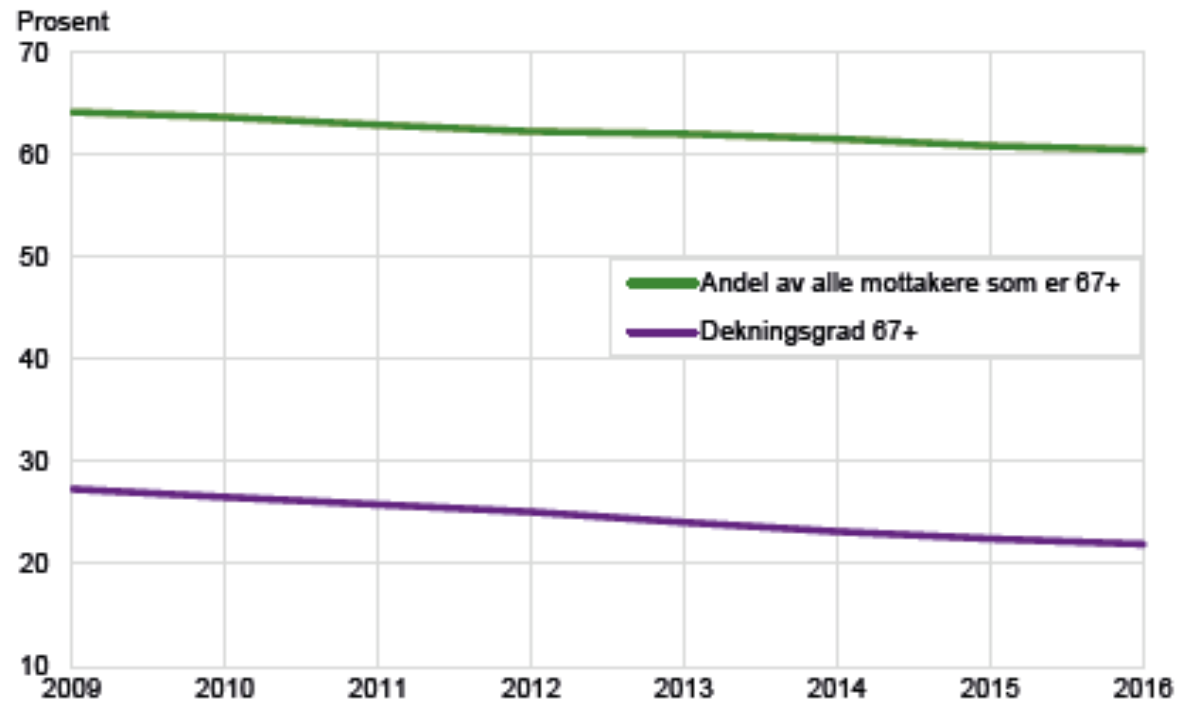
Source: OECD Health Statistics 2015, <http://dx.doi.org/10.1787/health-data-en>.

StatLink  <http://dx.doi.org/10.1787/888933281455>

# Cover level for those 67+ decreasing

## Percentage of all LTC service recipients 67+ and population 67+

Figur 3.1 Eldre mottakere (67 år +) som andel av alle tjenestemottakere



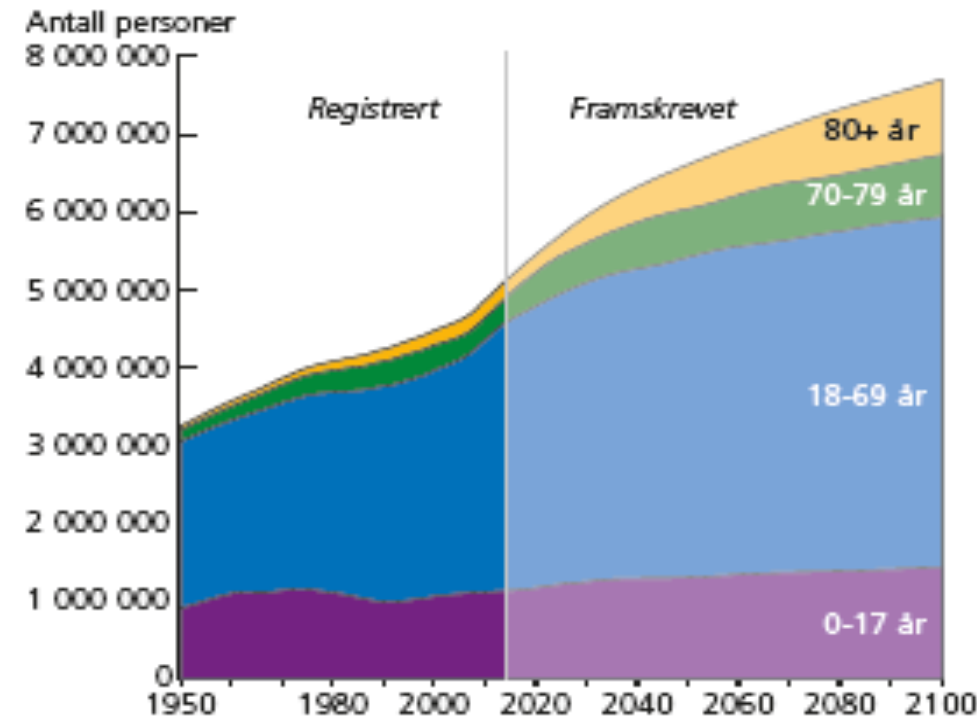
Kilde: IPLOS

Source: Mørk, Beyrer, Haugstveit et al., 2017 . *Kommunale helse- og omsorgstjenster 2016*. SSB report 2017/26.



# Ageing in Norway

Figur 6. Folkemengde i fire aldersgrupper, registrert og framskrevet i mellomalternativet (MMMM)



Kilde: Statistisk sentralbyrå.

Økonomiske analyser 4/2014, Statistics Norway

In 2060: 19% of population 70 or above (14% in 2011)

Dependency ratio: people 65 or above in relation to those 20-64:  $1/4=0,25$  (2011),  $1/2=ca.0,5$  (2060)

[Øk. analyser 2/2012]

# At what age does one get long-term care services in Norway?

Age	Services	No services
0-49	2 %	98 %
50-66	4 %	96 %
67-79	10 %	90 %
80-89	45 %	55 %
90 and above	86 %	14 %

Source: Førland og Folkestad, 2016. *Hjemmetjenestene i Norge i et befolknings- og brukerperspektiv*. SFO rapport 1/2016.





# Norway



5.2 million people  
Large country - sparsely populated

426 municipalities (2017)

Oslo: 600.000 inhabitants  
Half of the municipalities < than  
5.000 inhabitants

One third of municipal budgets  
spent on LTC-services

349 000 LTC-users (2015) – 6% of  
total population  
134.000 work years 2014 (from  
20.000 in 1970)



# Long-term care sector in Norway

State responsibility: medical health services in hospitals

Local/municipal responsibility

Primary health care  
(general practice)

The long-term care sector



# Long-term care sector in Norway

## **Residential care:**

Nursing homes  
Old people's homes

## **Home based care:**

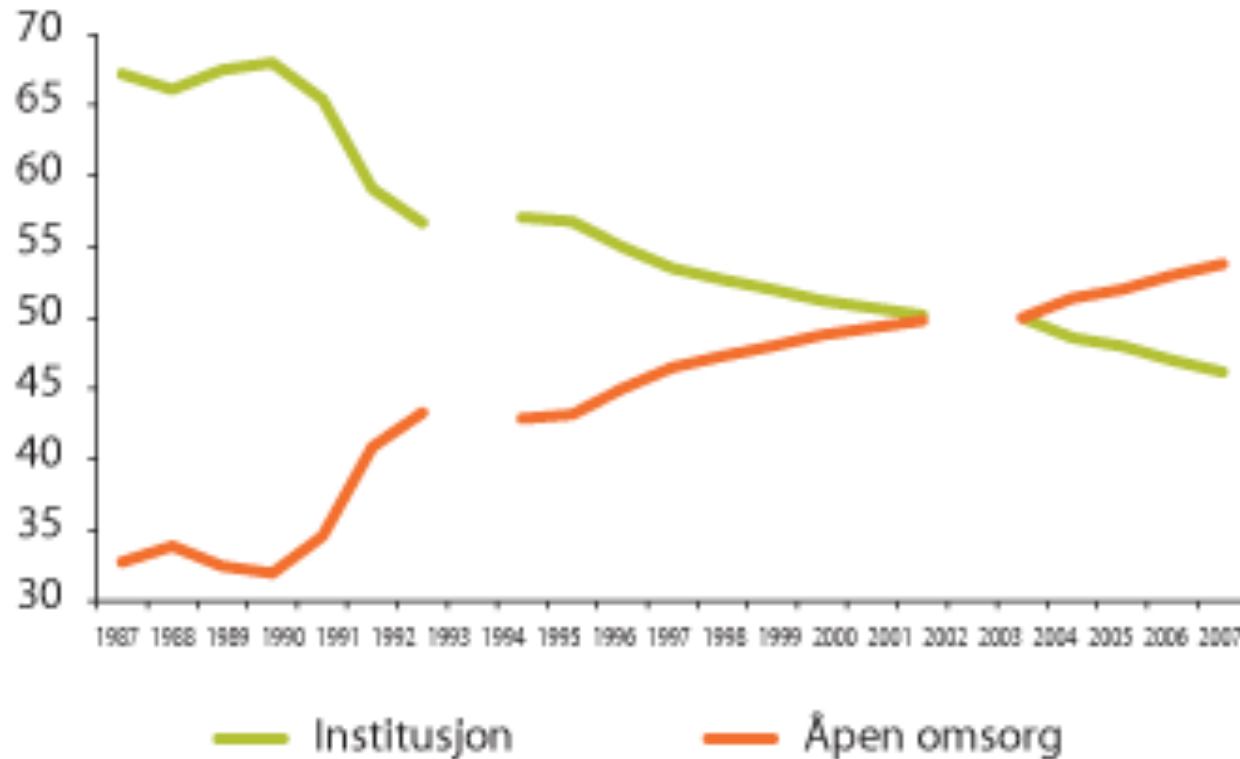
Home nursing (personal care, bathing etc.)  
  
Home help (cleaning, shopping, doing laundry etc.)

## **New care services:**

Preventive services such as meals on wheels, safety alarm etc.



# The overall picture: from residential care to home based services (deinstitutionalization)



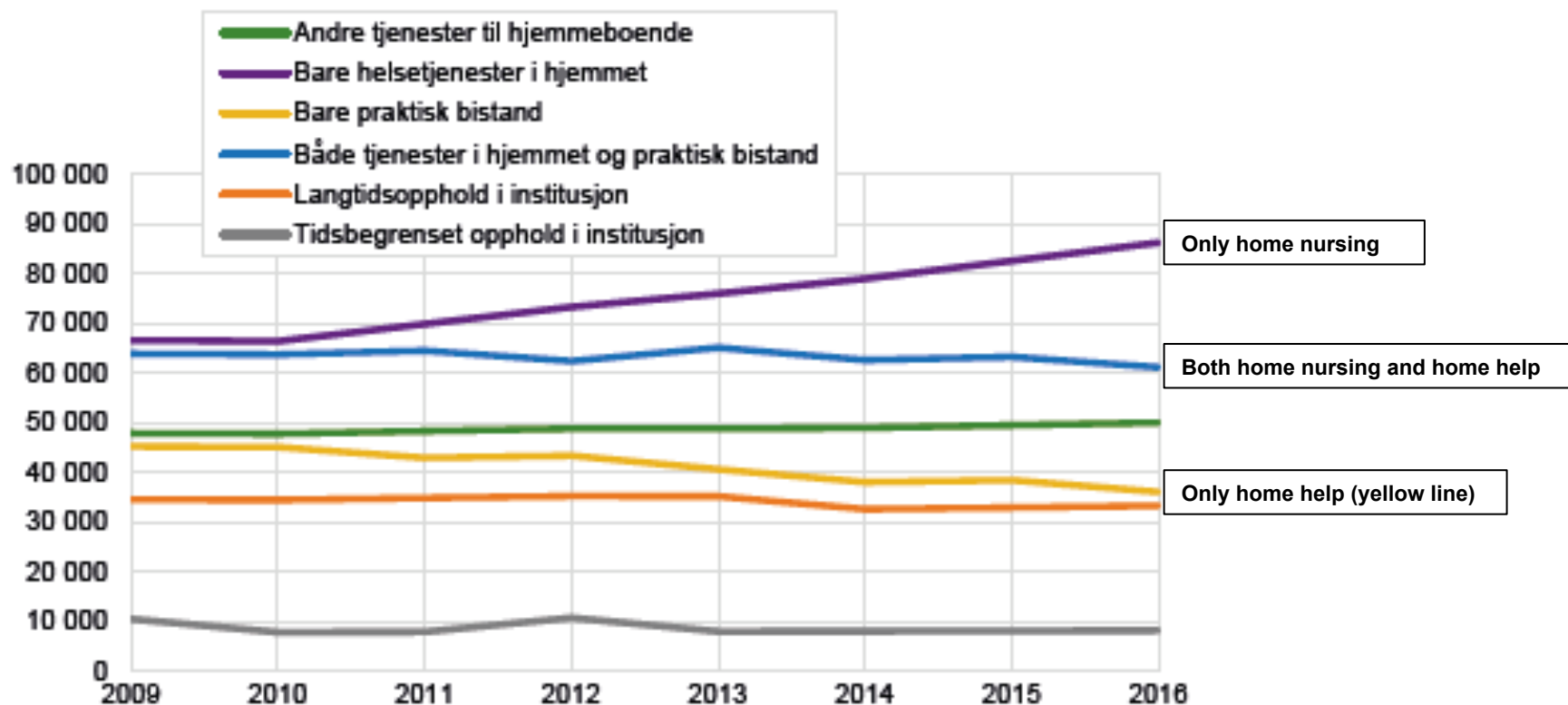
**Work years in LTC, percentage residential and home based care 1987-2007**

**Reference:** Brevik 2010, Norsk institutt for by- og regionforskning.



# Recipients of home based services

Figur 4.2 Mottakere av ulike tjenester per 31.12. 2009-2016. Antall



Kilde: IPLOS

Source: Mørk, Beyrer, Haugstveit et al., 2017. *Kommunale helse- og omsorgstjenster 2016*. SSB rapport 2017/26.



# The development of elder care services – three phases

Phase I (1965-1980): The public revolution  
Home base care: *Traditional care*

Phase II (1980-1995): Consolidation and reorganization  
Home based care: *Modern services*

Phase III (1995-2010): Innovation and efficiency  
Home based care: *Late modern outputs*



# Expansion – Ageing-in-place-policies – Traditional care

Until the **Social Care Act of 1964**: duty to care for one's older parents if they needed care

The public then takes on more responsibility for work carried out by family and voluntary organizations

## **The late 1960s and 1970s**

Main policy direction: living-at-home-as-long-as-possible

Home help becomes very popular and expands (more so than home nursing)

Home help develops through the housewife substitute occupation

Closely related to and inspired by family care and the work of the housewife

Home helpers being female middle-aged part time workers

Few 'clients' – enough time

Altruism and closeness in the care relationship

Generous grants from the state: 50% of costs for home help and 75% of costs for nursing care were reimbursed



# Reorganization – Bureaucratization policies – modern services

## The 1980's and into the 1990s

Main policy direction: bureaucratization of the services – reablement principle regarding the users (limiting services, encouraging self care)

Reimbursement replaced by block grants – decentralization strategy

**The Municipal Health Care Act of 1982** giving municipalities responsibility for providing all LTC services

Professionalization of home helpers – from housewife to employee with more and 'rotating' clients

Home care *clients* and home nursing *patients* become **users**

More professional relationships (more distance – 'contracts')

A process starts of more standardized services, more documentation, more reporting, more determined/fixed and limited tasks

However: ideas, some practice of 'small' and 'big' integrations integration  
E.g. home helpers and home nurses working in teams in certain geographical areas (but under separated laws)





# Efficiency – New Public Management policies – Late modern outputs

**Social Services Act 1991**: regulating the services – contracts and agreements between user and municipality

## During the 1990s and into the 2000s

Main policy direction: New Public Management inspired policies

Purchaser-provider split model introduced in some municipalities – splitting assessment from providing services

Specialised care assessors in stead of care staff – supposed to make more professional assessments

Opening up the sector to for-profit actors – creating a care market

Introducing free-choice-of-provider model in some municipalities (in the beginning only for home help – later also home nursing, in some municipalities)



# Trends today

The separate laws are merged, but home care services are very fragmented ([The Municipal Health and Care Service Act of 2011](#))

Ageing in place now combined with policies of active ageing (strengthening the idea of reablement)

Marketization still very limited in Norway, but the facilitation is there



# Home based care – limited and increasingly for younger people

Provided hours/week	Below 2 hours/week	2 – 5 hours/week
Home help standard services	77 %	11 %
Home nursing services	55 %	23 %

Age	Below 67
Home help standard services	24 %
Home nursing services	39 %

Source: Mørk et al., 2016. Kommunale helse- og omsorgstjenester 2016. SSB 2017/26, p.41 and 14.



# Conclusion – lessons to learn

- ❖ Strong Nordic tradition
  - creating barriers for widespread marketization
- ❖ However, easily inspired by non-Nordic policies
  - when financial circumstances encourage efficiency thinking and cost-efficient solutions
- ❖ Users of home based care services: stronger individual rights
  - but services increasingly limited and fragmented
- ❖ Unintended consequences to the forefront today
  - with services increasingly predefined and fixed rather than adapting to flexible and context based care needs of everyday life

