Proposition to the Storting No. 1 (2006-2007) Chapter 6

National Health Plan for Norway (2007-2010)

6 National Health Plan for Norway (2007–2010)

We have set ambitious goals for the health service in Norway. We want the services to be of a high quality, to be available within acceptable waiting times and distances, and the provision to reach out to everyone regardless of their financial situation, social status, age, gender and ethnic background. These high ambitions have to a great extent been realised, marked by a health service that is among the best in the world. At the same time we acknowledge that there are deficiencies and challenges in a number of areas, which show there is still much that can be improved. There is broad agreement in Norway concerning the central goals of the health policy. The government will work systematically to achieve these. Patient experiences and supervisory activities that uncover errors in the delivery of services shall be followed up.

In the National Health Plan for Norway (2007–2010) the government presents the status of the health service in Norway today, and suggests policy measures that are intended to result in a better health service. A better health service also means prevention and facilitating the participation of patients and their relatives.

The health service faces considerable challenges in the years to come, because there will be more senior citizens, the distribution of diseases will change, and expensive, new medicines and treatment methods are constantly being developed. To meet these challenges the government will in this four-year plan give emphasize to six cornerstones that shall characterise all types of health services:

- cohesion and interaction
- democracy and legitimacy
- proximity and security
- stronger patient role
- professionalism and quality
- work and health

The National Health Plan for Norway shall show how the various parts of the health service depend on each other in order to help patients and their relatives in a satisfactory manner.

The government will provide a status report of the National Health Plan for Norway in its annual national budgets.

6.1 The cornerstones of the health plan

Norway has a well-developed health service from an international perspective. One of its core values is that everyone should have equal access to good health services funded through public schemes. Important reforms have been carried out in recent years within both municipal health services (the regular general practitioner (RGP) scheme) and

specialized health services (hospitals). Experience and evaluations indicate that these reforms have had significant positive effects, but that at the same time not all of the intentions have yet been realised.

Through the National Health Plan for Norway (2007 – 2010) the government wants to strengthen and coordinate the focus on a more equal and fair distribution of good health. The principal task is to prevent illness and harm. This does not just make demands of the health service; it also makes demands of all sectors of society that affect public health.

Patients and their relatives have high expectations of the health services and some deficiencies and distinct challenges have become apparent. Our goal is for health services to be equally and fairly distributed. Nonetheless we can see that there are geographical differences in health provision. There are geographical differences in waiting times and the prioritisation of groups with different diagnoses. Considerable social disparities in health have been documented, and there is much to indicate that such differences also exist in the use of health services. There are still unacceptable waiting times within some medical fields. The number of reported treatment errors is increasing. Many patients and their relatives experience the health service as fragmented without a clear allocation of responsibility for the interaction between the various agents. Tomorrow's challenges also include a rise in the number of senior citizens, a change in the distribution between different diseases, and new knowledge resulting in new and often expensive treatment possibilities. Union organisations report a sense of alienation as language from the business world is increasingly being utilised in the health sector.

People's expectations of the health services will remain high in the years to come. This will require us to organise and manage the health service better and to utilise the knowledge from patients and professionals. Given this, the government would like to highlight six cornerstones that shall be common to the preventive work, municipal health services and specialized health services.

Cohesion and interaction (or integrated care)

One recurrent theme in reports, evaluations and criticisms from patient organisations are that the interaction is too poor and that the services are not cohesive enough. This applies both within the health service and in its interaction with other sectors and professional fields such as schools, child welfare, work and welfare services, the legal sector, etc. Many patients experience that they themselves have to manage the interaction between the agents. This lack of cohesion often comes to light when agents push their area of responsibilities onto others instead of cooperating on good solutions that serve their patients. The need for a cohesive approach is increasing in parallel with hospital services becoming increasingly more specialised. Integrated care has not held a position in the general health service system that commensurate with its importance, changing this will therefore be a central topic during this health plan period. The National Health Plan for Norway emphasises that all staff in the health service should be aware of the patients' need for integrated care in and outside the organisation. Managers in the sector have a special responsibility to organise and implement interaction schemes where this is necessary. Agreements will also be signed between responsible agents at the national

level and the local level. Good interaction must be based on the government having various means of managing the municipalities' services and the specialized health services. In the white paper St.meld.nr 25 (2005 - 2006) *Mestring, muligheter og mening* (Long term care - future challenges – Care plan 2015) the government presented a complete discussion of the development, challenges and measures for municipal care services to the Parliament (Stortinget). The National Health Plan for Norway must be seen in the context of the challenges and measures that have been presented in this whitepaper concerning future care services.

Democracy and legitimacy

The hospitals reform, the RPG reform, the escalation plan for mental health, and the substance abuse reform are important health reforms that have been implemented in recent years. The government wishes to build on the concept that the health service should be politically guided and professionally managed, and be characterised by openness and participation, in many areas this happens best within the framework of municipality autonomy. A good health service must have legitimacy and trust of the general public. Evaluations and feedback indicate that the RGP scheme, the municipalities' health care services and social services, and specialist health services enjoy a high degree of legitimacy among the general public. The general public's expectations with respect to the health service are considerable and increasing in line with medical progress and economic development, this is especially true with respect to specialized health services. The follow-up of the health plan in the annual presentation of the national budget must manifest a realistic level of expectations and clarify limits for the development and operation of the services. Within the politically framework, the administrators and the employees of the health service shall "govern" the allocated resources in a socially beneficial manner. The government takes the democracy challenge seriously and has already appointed new boards for the health enterprises. A majority of the owner appointed board members have been appointed from proposed elected representatives. Further development and appropriate modifications will continue to take place within the enterprise model. The government will emphasise national administration of the specialized health services in selected areas that are of significance with respect to achieving provision of equality and proper national utilisation of resources. The democratic right to provision of equality for the Sámi population means that the health services must develop their knowledge of the Sámi language and culture in order to facilitate good communication and offer good services, in situations where this is not possible the necessary interpretation services must be established.

Proximity and security

We want a decentralised settlement pattern in Norway, and the health service should support this. We want the entire population to have equal access to health services regardless of where they live. Treatment and follow-up shall continue to be organised according to the lowest, effective level of care principle (known in Norway as the LEON principle). Proximity and local knowledge provide the best opportunity to achieve individually adapted service provision with genuine patient influence. We must therefore facilitate good municipality services that follow the patient over time. The municipalities are in a particularly good position to carry out local preventive work.

The medical developments assume access to advanced diagnostics and treatments that often require special competence. This dictates that some fields must be centralized, while others can be decentralized. High quality local health services shall be organised and developed in cooperation with municipal health services and pre-hospital services. The National Health Plan for Norway builds on the government's programme that no local hospital shall be closed down. The services provided by local hospitals must be developed and modified on the basis of good professional services with an emphasis on the major illnesses in which treatment and rehabilitation near to home are important.

Stronger patient role

We want patients to have knowledge about the health services, and that they can participate and influence the services. Greater openness about the health service's content and quality will, among other things, play a central role in the further development of the services. Patients and their relatives are experts concerning their own situations and what they can achieve. This resource can be utilised better in the treatment and rehabilitation of individual patients, but it is also necessary for the planning and development of the health services. A majority of today's patients are active patients who want to receive information about their health in order to make decisions themselves to improve their own health. The patients want to set goals for their treatment themselves – some want to run a marathon after a hip operation, while for others being able to fetch the post is enough. Some will choose life-prolonging treatment regardless of how great the side effects are, while others will decline such treatment. Not all patients are able to advance their own demands and rights; this is particularly true for the seriously ill, a number of people with mental health disorders, people with substance abuse problems, people suffering from dementia, and people with an intellectual disability. Relatives are often important intermediaries with respect to patients' wishes and needs as care givers and supporting agents for the health service. Patient organisations also play an important role. Being taken seriously and feeling that one is respected as a patient is important to everybody – both in the light of human dignity and because we know that patients who participate in their own treatment often achieve a better result. Better utilisation of the free hospital choice scheme (fritt sykehusvalg) will play a central part during the four-year period of the National Health Plan for Norway. We also want the experiences and knowledge that patients accumulate as patients of the services to benefit other patients. Emphasise shall be placed on developing the role the patients' organisations play in the development of the health services.

Professionalism and quality

The professions and the professional agents are the health service's foundation and value creators. The health service is a major knowledge-based organisation and the "knowledge rate is accelerating". In general, Norwegian health services maintain a high level of professionalism. Professional circles have an important responsibility with respect to introducing new knowledge and phasing out old, this is necessary in order to maintain the quality of the services at an international level. Surveys show that errors occur and that many errors have serious consequences for patients, systems shall be established to learn from such mistakes so that they are not repeated, and these systems shall support the

development of the health service as a learning organisation. It is important for the health service legitimacy that there is openness about errors and quality improvements.

Health care professionals are situated in a reality where patients' expectations, possibilities provided by knowledge, fundamental ethical values, and financial and professional priorities are melting together. Priority challenges in the health service are demanding and complicated, and must be resolved with the participation of the professions and patients' organisations. The government will continue to develop organisational systems that better enable patients and national agents to address the big picture vis-à-vis the prioritisation and quality work.

Work and health

Work is vital for health and rehabilitation. Almost 11 per cent of the working age population receive some kind of disability benefit. Reward in the form of wages and recognition means a lot for one's self-respect and health. Unemployment and insecure work situations constitute a health risk. It is important to prevent the social exclusion of groups who fall out of training and work for health-related illnesses or other reasons. The National Health Plan for Norway will emphasise prevention and rehabilitation in which labour – and especially cooperation between work and welfare services, health services, working environment authorities, and the parties involved in work – plays a central role.

Summaries of the chosen direction and concrete measures associated with each of the cornerstones are provided in chapter 6.5.

6.2 Consultation process and follow-up of the National Health Plan for Norway

The National Health Plan for Norway (2007–2010) has been drawn up in line with the following statement in the Soria Moria Declaration: "The Storting shall be presented with a National Health Plan for Norway every four years for its consideration. The county councils shall participate in the drawing up of such plans." In addition to the county councils, the Ministry has also invited patient organisations, professional organisations, the Norwegian Association of Local and Regional Authorities, municipalities, the Sámi Parliament and the regional health authorities to participate in the work.

6.2.1 Consultation

In May 2006, the Ministry of Health and Care Services circulated a consultation paper containing key thematic areas in the National Health Plan for Norway. More than 600 bodies were invited to submit contributions. Prior to this, general contributions were asked for concerning the work on the National Health Plan for Norway. In their initial contributions many county councils pointed out the need for, among other things, a comprehensive National Health Plan for Norway including a presentation of the public health challenges, municipal health services, and specialist health services. These contributions were utilised in the subsequent work.

From the approximately 160 responses to the consultation paper, it is clear that there is agreement about the need for a National Health Plan for Norway. The consultation process demonstrates that there is broad agreement concerning important national goals for the health service, with high quality health services of equal worth as the principal goal. Moreover, there is broad agreement concerning the description of the current situation and the challenges the health service is facing.

The consulted bodies unanimously agree that health policy should clearly stress prevention and public health work. They are asking for a more intersectoral approach to national health work. Institutions in working life such as company health services, the Norwegian Labour and Welfare Organisation (NAV), and institutions associated with the conditions in which children and young people grow up such as child welfare and school health services, should be more strongly tied to the theme of public health. Several of the contributions from the county councils also want the health enterprises to become more involved in the work.

A large majority of the consulted bodies agree that interaction provides great potential for improvement and will be one of the greatest challenges in the years ahead. Interaction with other sectors is also highlighted as being important. The Norwegian Association of Local and Regional Authorities and the municipalities point out that future agreements between health enterprises and municipalities must be based on equal grounds if this interaction is going to succeed, and highlight the *Helsedialog* project ("The Health Dialogue" is a project between the Norwegian Association of Local and Regional Authorities and the Southern Norway Regional Health Authority) as a good example. Many bodies, especially patient and community organisations, point out that interaction initiative must be patient-oriented. Personalised plans and the general practitioners' clinical practice programme are highlighted as good interaction tools.

A majority of the consulted bodies that have commented on the RPG scheme agree that the scheme has several positive aspects. At the same time many municipalities and county councils point out that the access to regular general practitioners is too poor in many areas and that the interaction between the regular general practitioners and other bodies is not satisfactory. Some underline that they face a challenge in relation to recruiting enough physicians to the municipal casualty clinics, community medical positions and nursing homes. One measure suggested by many, in slightly different guises, is that an agreement system be established that results in regular general practitioners being more integrated into the municipal health services. Some bodies suggest that more community physicians should be trained. Several municipalities point out that the challenge of poor physician coverage at casualty clinics could be resolved by facilitating inter-municipality casualty clinics to a greater degree.

Some consulted bodies give the impression that they want stronger political control of the health enterprises. Furthermore, some pointed out that there is a need to clarify the roles of the various agents who administer health at a national level.

Many consulted bodies have commented on the subject of local hospitals. The vast majority are positive to the idea of local hospitals functioning as safety nets for the general public by offering health services to major patient groups such as sick senior citizens and the chronically sick. Many municipalities and county councils point out that local hospital must provide adequate emergency and ante/post-natal services. Several of these want the National Health Plan for Norway to contain guidelines concerning what local hospitals should provide. Others point out that the development of local hospitals should provide room for organisational models that are tailored to the general public's needs and current knowledge, technology and the competence of the personnel.

Many of the consulted bodies highlight the need for clearer priorities and that prioritisation in municipal health services and specialist health services must be seen in this context. Furthermore, several underline the idea that prioritisation must take the patients' situation as its starting point, and not be affected by individual cases that are highlighted in the media. Others suggest that financial means must be considered in order to support prioritisation. Some bodies stress that the subject of social disparities in health should be moved up as a key challenge in relation to the goal of services of equal worth.

Several of the consulted bodies believe that it is very positive that the National Health Plan for Norway will draw up guidelines for the work within mental health after 2008 as well when the Escalation Plan for Mental Health comes to an end. Many bodies, and in this case especially the municipalities, point out that the escalation plan has resulted in institutions being wound down too quickly without municipalities having had time to build up their provision. Several municipalities point out that they lack the competence and resources necessary to treat heavy patients and want clear guidelines concerning the required level of treatment for this group.

Some bodies point out that the challenges associated with privacy protection must be resolved before new information and communications systems (ICT systems) are introduced. It is also pointed out that patients must have a right to be consulted with respect to which information is released. Many municipalities want to be more robustly included in the development of the Norwegian Health Network. Some bodies, especially the Norwegian Labour and Welfare Organisation, also point out that ICT should be utilised to support interaction with other sectors.

Many municipalities want an increased focus on research within the municipal health and social services. Several universities and university colleges believe that the research being carried out in hospitals should be more closely linked to research environments in universities and university colleges. Some bodies also want an increased focus on research vis-à-vis the organisation of health services.

Many responses to the consultation paper stressed that education should be directed more towards current needs for competence and personnel. In association with this several bodies want measures to ensure that more geriatricians are trained. Some bodies point out that specialisation has gone too far within medicine, and this is especially true with respect to surgery. Moreover, it was pointed out that this development is creating major

challenges for the decentralised hospital services. Because of this some bodies want more generalist physicians. Some training institutions point to the goal that patients and their relatives should be more involved in the patient's treatment and want measures that strengthen communications competence within the health service.

All of the responses to the consultation paper are available on the Ministry's website at: http://odin.dep.no/hod/norsk/tema/p30009082/bn.html.

6.2.2 Follow-up of the National Health Plan for Norway

The National Health Plan for Norway shows there is a need for arenas and processes in which the agents can together assess statuses, challenges and how services can be developed to achieve the objectives of the national health policy. The aim is for the National Health Plan for Norway to provide a basis for dialogue between the agents based on the principal goals stipulated by the Storting.

A briefing on the follow-up of the National Health Plan for Norway will be provided in annual national budgets. This will primarily focus on the implementation of the strategies and measures discussed in the National Health Plan for Norway. Prior to the annual feedback on the National Health Plan for Norway to the Storting, processes shall be conducted involving the health service, patients and employees in which developments can be discussed in light of the challenges and goals that are identified and stipulated in the National Health Plan for Norway. An annual conference shall be established in which the agents can together review and discuss significant development trends and challenges, and which shall become an arena for the mutual exchange of points of view and expectations. The dialogue shall as far as possible be based on the ordinary documentation and reporting systems that have been built up: the Directorate for Health and Social Affairs' monitoring report, the Norwegian Board of Health's inspection reports, annual reports from the regional health authorities, KOSTRA, reports from Statistics Norway (SSB) and Samdata, and the Norwegian Institute of Public Health's (FHI) reports on the general public's health status, etc.

6.3 Status and trends in the health service's main areas

6.3.1 Public health work

Public health reflects trends in society, the conditions in which children grow up, and living conditions, and is developed and maintained in municipalities and local communities where people reside and live their lives. The foundation for good health while growing up and throughout one's entire lifetime is laid in the years one spends as a child and adolescent.

Public health work is society's total effort to improve factors that have a positive effect on public health and reduce factors that entail a risk to health. Norway's restrictive policies with respect to drugs, alcohol and tobacco have been an important part of this effort. Public health work is intersectoral and includes initiatives in many sectors of society aimed at creating good conditions to grow up in and living conditions: e.g.

nursery schools and schools that look after the health and development of children and a society that facilitates a healthy lifestyle and promotes a sense of community, safety and meaning for the individual. Society's efforts within public health work affect the need for health services.

Welfare and lifestyle diseases are the major health challenge facing the western world. It is necessary to implement effective preventive measures in many arenas. At the same time measures against known threats to health and preparedness against new threats to health due to the fact that we live in a globalized world have to be maintained at a high level. Infectious disease prevention is important in this context.

Current situation in the area of public health

In general, the Norwegian population enjoys good health. The trend throughout the 1900s was positive with a reduction in infant mortality, higher life expectancy, and less illness. Better living conditions and systematic efforts in several sectors of society have, together with medical developments, made a big contribution to us in our part of the world having overcome a number of epidemics and infectious diseases. However, new diseases and threats to health have arisen. Examples of these include the HIV epidemic, the increase in cases of chlamydia, outbreaks of legionaries' disease, the spreading of methicillin-resistant Staphylococcus aureus (MRSA), the SARS outbreak, avian flu, etc.

Disease trends in the Norwegian population can increasingly be linked to living habits and health behaviour. According to the World Health Report 2002, Reducing Risks, Promoting Healthy Life, the seven most important risk factors vis-à-vis disease in western countries are: the use of tobacco and alcohol, high blood pressure and cholesterol levels, obesity, low consumption of fruit and vegetables, and physical inactivity. All of these factors can be influenced and to a large degree prevented. In its global strategy for diet and physical activity WHO encourages every country to implement measures to reverse the global obesity epidemic, which is also impacting Norway.

WHO forecasts that by 2020 the most important cause of health problems after cardiovascular diseases on a global basis for both genders will be mental health disorders. In western countries depression is expected to account for the greatest burden.

A pleasing reduction in injuries caused by accidents has occurred in several sectors of society thanks to systematic accident and injury prevention work, e.g. with respect to traffic. Injuries due to accidents are still a public health problem, and are still the most frequent cause of death among children and adolescents. Accidents in the home, at school and during leisure time account for the largest proportion of injuries caused by accidents that require treatment in a hospital or casualty clinic.

A summary of current knowledge about children's environments and health (Report 2006:3 The Norwegian Institute of Public Health) concludes that Norwegian children are among the healthiest in the world measured by illness and mortality. Norwegian adolescents are physically healthy and do not use the health services often. However, adolescent years are characterised by a significant increase in the proportion reporting

physical difficulties. There are significant social disparities in health and health behaviour among children and adolescents.

The population's composition and age distribution are also public health challenges. Health behaviour that results in an increased risk of illness is most widespread in groups with short educations and low income. The incidence rates of excess weight and obesity, physical inactivity, type 2 diabetes, high blood pressure and high cholesterol are higher and increasing in the general public as a whole, and in some groups of the immigrant population in particular. The proportion of senior citizens will double in the next few decades. Even though the vast majority of people aged 67 years old and older are physically fit and in good health, an increasing proportion of senior citizens will be of significance vis-à-vis capacity and competence, and also with respect to preventive work. Preventive efforts tailored to an individual's situation are important in order to maintain functional abilities, quality of life and self-sufficiency in old age.

Even though work is in itself a health-increasing factor, we know that some aspects of working conditions constitute a health risk. Lack of work is however a major health risks. More than 10% of Norway's able-bodied population does not participate in the labour market. Furthermore, figures from Statistics Norway from the 1st quarter 2006 show the total sickness absence rate has increased by 5.8% since the 1st quarter 2005. The figures show that the public sector experiences the highest sickness absence rate with the biggest increase in employees in the health and social services. Diagnoses of various types of musculoskeletal disorders together account for a large proportion of sickness absence. This represents challenges for public health work in general and working environments work in particular.

The situation with regards to diseases that can be transmitted via food or water is pretty stable. As far as reported cases are concerned, campylobacteriosis is the most common disease. Norway still experiences few cases of salmonellosis compared with other countries and most people (80%) are infected while abroad. As far as non-reportable diseases are concerned, there is still reason to assume that together these are the cause of many days off sick. The most common risk factors are poor drinking water and the unhygienic handling of food.

The problematic use of drugs, alcohol and other intoxicants represents a major challenge for the public health sector in Norway. Alcohol is the intoxicant that is clearly the biggest threat to public health. It is difficult to estimate the costs of alcohol consumption in Norway accurately. A report in 2006 concerning the alcohol situation in Europe estimates that the measurable costs of alcohol consumption in the EU in 2003 were around NOK 1 000 000 million, which is equivalent to the harm caused by tobacco.

The use of illegal drugs, alcohol and other intoxicants results in serious health disorders for individuals and for their relatives. It is estimated that there are currently between 11,000 –15,000 injecting drug addicts in Norway. A large majority of these have serious health disorders, and are at a clearly increased risk of premature death. Lower prices and increased availability vis-à-vis drugs is resulting in more overdoses and more harm

among people with drug problems. It is therefore important that Norwegian drugs policy continues to work to limit imports and sales of drugs.

Social health disparities
Significant social disparities in health have been documented in Norway with respect to a large number of health targets. The social disparities in health are great, regardless of which variable one takes as one's starting point – education, occupation, income or various combinations of these. Social disparities in health have been documented for both genders and in all age groups. Social disparities in health form a gradient through all education, occupational and income groups in the population. There is a clear correlation between health problems and poverty, even though social disparities in health do not just affect the poorest.

Since the 1970s, that part of the population that is in the middle to high income bracket and is educated has experienced a substantial increase in life expectancy, while life expectancy has changed too little for groups with short education and low incomes.

Several causative mechanisms have been uncovered that lie behind the correlation between social background and health. Differences in material conditions such as physical working environment appear to play a significant role. Health behaviour factors such as drugs, alcohol and other intoxicants, tobacco, diet and physical activity also help to create and maintain social disparities in health. Various psychosocial mechanisms such as loneliness, stress and insecure finances or work situations also constitute important causes.

A fair and well-functioning health service can do a lot to reduce disparities in health, and vice versa: a health service that does not function as it should, can help to reinforce disparities. Some research results indicate that while municipal health services are reasonably distributed over various social groups, groups with long educations (who statistically speaking are relatively healthy) consume more specialist health services than groups with short educations. In the spring of 2007 the government will submit a report to the Storting that presents a strategy to combat social disparities in health.

Public health goals and strategies

The principal goals of public health policy, cf. White paper, St.meld.nr. 16 (2002-2003) Prescriptions for a Healthier Norway (The Public Health Report) (Resept for et sunnere Norge), are more years of good health for the population as a whole, reduced health disparities between different socio-economic groups, ethnic groups, and between men and women.

The Public Health Report emphasises the following four main strategies:

- create the conditions necessary to make it easier to choose a healthy lifestyle
- build alliances to achieve systematic and holistic public health work
- place more emphasis on prevention in the health service
- base public health work on knowledge and experience

The government's political platform includes expressed goals concerning focusing more strongly on work to prevent illness, continuing the work to combat the use of drugs, alcohol, other intoxicants and tobacco, and helping to ensure that the focus on physical activity and diet is increased. The government's policy vis-à-vis prevention also includes a better environment, less exclusion from the labour market, and reduced crime among its goals.

One central theme in public health policy is to strengthen public health work through building alliances and better embedding: politically, administratively, and in the overall primary planning systems in county councils and municipalities. Decisions that have an effect on public health are often taken outside the health sector's primary area of responsibility. Good embedding in county councils and municipalities is a prerequisite with respect to making public health work more systematic, continuous and comprehensive. Good embedding also helps to put the issue of public health on the agenda in places where decisions are taken. The health sector has an important role to play as a professional contributor in the interaction with other sectors in planning and decision-making processes.

For example, pedestrian and cycles paths are important with respect to enabling more people to walk or cycle to work, school and for other reasons. One social measure, of which a new law concerning protection against harm from tobacco is an example, may prove to be as effective and cost-effective vis-à-vis reducing tobacco consumption as measures directed at individuals. The same applies to the regulatory means in alcohol policy that can affect the availability and total consumption of alcohol. Safe local environments (roads, nursery schools, homes) require intersectoral cooperation and will prevent accidents and injuries. Means that affect prices and availability appear to be more effective in reducing the gradient in health behaviour than campaign and health information initiatives. Trials with free fruit and vegetables in schools are one example of these.

The health sector is itself a sector of society with activities that can result in harm to life and health. Protecting patients from suffering unintentional and unnecessary harm to life and health due to examinations, treatment including medication, or follow-up in the health services, is one of society's most important safety challenges. For example, the wrong use of medicines is an area in which the harmful effects are great and where systematic prevention is necessary. There is a lot to indicate that the health services can adopt strategies and tools that have proved to be effective in other sectors of society, for example transport and industry.

The health services, especially municipal health services, are the primary arena for individual and group-oriented preventive efforts. The main themes in public health policy provide a basis for municipal health services and specialist health services placing more emphasize on preventive work in their activities.

The health sector's role in intersectoral public health work

Key factors that influence an individual's health, e.g. air pollution, dust, environmental toxins, accidents, stress, nutrition, physical activity, the consumption of drugs, alcohol and other intoxicants, tobacco consumption, and social networks, are not controlled by the health service directly, although the health service deals with the consequences. It is therefore necessary to emphasise intersectoral public health work. Within the health sector, national and municipalities are responsible for:

- monitoring the health situation and spread of disease, and the factors that influence these
- developing knowledge about causal relationships and contributing to the development of methods and intersectoral tools
- helping to ensure that society as a whole is working effectively to protect and promote health

In order to address these responsibilities it is necessary to strengthen public health work through placing emphasize on the following strategic areas:

- partnership for public health in counties and municipalities
- intersectoral strategies and action plans in the area of public health
- health impact assessments
- embedding in the planning system and in social and land-use planning
- skills upgrading in the health service

Partnership for public health in counties and municipalities

The national government gives grants to counties and municipalities who organise their public health work in partnership. The condition is that the counties or municipalities contribute their own resources and that the public health work is embedded in the municipality and county council planning system. The purpose of this is to contribute to more systematic and comprehensive public health work by ensuring greater administrative and political embedding and strengthening the interaction between the authorities and, among others, work, school and voluntary organisations.

The scheme was established in 2004. As regional development agents and regional planning authorities, the county councils have been assigned the role of prime mover in the regional and local public health work partnership. Regional state-owned entities, including regional health authorities, university colleges and universities are, together with voluntary organisations, important agents in the regional partnerships.

From 2006, 16 of the country's counties and a large number of municipalities in these counties will be involved in these schemes. Emphasis will be placed on developing the partnerships as a method of achieving systematic public health work embedded in social planning with broad participation from the general public.

The Directorate for Health and Social Affairs has a responsibility to contribute to the development of partnerships as a method of working. For example, evaluating work as an arena for prevention and intervention is relevant in a partnership between the authorities and agents involved. Besides following up sickness absence and working for more

inclusive employment, important cooperation areas include preventive measures vis-à-vis tobacco, drugs, alcohol, and other intoxicants, as well as measures that to a greater degree contribute to a health promoting working environment. Furthermore, schools are a key arena because they encompass the entire population of children and adolescents.

The Directorate for Health and Social Affairs shall continue to facilitate professional discussion forums involving the public authorities, professional circles, voluntary organisations and private agents for the mutual exchange of information and experience. Emphasis shall be placed on supporting local involvement and local initiatives.

Intersectoral strategies and action plans in the area of public health

Strategies and action plans are ways of making agents aware and responsible in various sectors. It is therefore important to embed measures in intersectoral strategies and action plans. One example of such an action plan is the Action Plan for Physical Activity 2004-2009, which was developed and is followed up through a collaboration between eight ministries. The vision is better public health through an increase in physical activity in the population. The main goals are to increase the proportion of children and young people who are moderately active for at least 60 minutes every day, as well as increase the proportion of adults and senior citizens who are moderately active for at least 30 minutes every day. The initiatives in the plan initiate cooperation at all administrative levels by, among other things, the physical activity being incorporated as a measure in the partnership for public health. Other examples are the Strategy to Prevent Accidents and Injuries and the National Strategy for Tobacco Prevention Work 2006-2010.

Health impact assessments

Action plans identify measures that are intended to operate for a limited period of time, however there is also a need for routines and methods that will take account of and illustrate, on a continuous and systematic basis, how initiatives and programmes in most sectors have consequences with respect to the population's health. The consequences with respect to health effects and distributional effects are important when national, regional or municipalities make decisions concerning plans, regulations, expansions or other initiatives.

In the case of national initiatives, the health-related consequences of proposals are adequately illuminated through assessments, regulations, reforms and measures, as well as statements and reports to the Storting, cf. the reporting instructions. Local initiatives shall be assessed in relation to the Planning and Building Act. Health became a factor that has to be assessed with respect to planning proposals when the Regulations on Environmental Impact Assessments were amended on 1st April 2005. The consequences for health shall also be assessed in connection with other initiatives in municipalities and county councils, for example in association with a municipality's plan for its district and the county master plan.

A competence unit has been established in the Directorate for Health and Social Affairs in order to strengthen the work on health impact assessments. This unit works on method

development and experience exchange, skills upgrading, networking and guidance for counties and municipalities.

Public health embedded in the planning system and in social and land-use planning

Social and land-use planning are key means in public health work. Local decisions influence child rearing and living conditions, as well as health behaviour. The Planning and Building Act is the municipalities' and county councils' primary tool in social and land-use planning. Public health should be one of the main considerations in all social and land-use planning. The Ministry of Health and Care Services will in the ongoing work on the new Planning and Building Act assess whether consideration of the general public's health should be stipulated in the objects clause.

Pursuant to section 1-4 of the Municipal Health Services Act, municipalities shall, among other things, maintain an overview of the health situation and factors that influence this. A good overview is a prerequisite for placing the question of public health on the agenda in places where decisions are taken and being able to initiate targeted and measurable initiatives. Such an overview or health profile can be based on both national data, which is broken down to a municipality level, and on surveys in municipalities. The Directorate for Health and Social Affairs has, in cooperation with the Norwegian Institute of Public Health and Statistics Norway, set-up an Internet portal for municipality health profiles as a useful management tool for municipalities. Here one can find a range of key data and indicators concerning, among other things, factors that influence public health together with documented facts, scientific papers, examples of local initiatives, and links to other relevant websites. The website will undergo continuous development, and relevant tools will be developed for municipality planning.

A chief administrative officer shall when assessing the social parts of a municipality's plans, municipality's land-use plans, and zoning plans assess whether or not the plans adequately cover public health.

Skills upgrading in the health sector

In order to take advantage of the intersectoral planning arena in public health work, the health service and the sector must also develop its role as a contributor to planning processes in counties and municipalities. In addition to good professional knowledge and competence within health monitoring and about the various public health areas, competence in how this knowledge can be introduced into the ordinary planning and decision-making processes is required. A five-year development and testing project has been initiated in a selection of municipalities vis-à-vis how the Planning and Building Act and planning systems can be utilised to embed and strengthen public health work. This development work also includes increasing the planning and process competence of personnel and professionals who work in the health sector through, among other things, the provision of courses, and how this type of competence can be addressed in relevant basic training and continued and further training provision.

One important social medical task is helping to ensure that the health service participates in public health work with its knowledge; it is naturally included in planning processes.

There is a need for social medical competence at all administrative levels. Work has been started to improve social medical competence in the municipalities and in both regional and national state health administration.

Health monitoring

The Ministry of Health and Care Services is responsible for monitoring health at a sector level. The Norwegian Institute of Public Health shall maintain a good overview of the health situation in the population and all the factors that influence this. Locally it is municipalities that bear the health monitoring responsibility pursuent to section 1-4 of the Municipal Health Services Act. This overview is of great importance vis-à-vis the sector's own work on, among other things, prioritisation, quality, measuring the effect of initiatives in the health services, forecasting health service needs, and prevention strategies. Such an overview is also crucial with respect to ensuring that the responsibilities and importance of sectors with respect to public health is well documented. National systems for health monitoring consist of health registers, health surveys, and data from research projects.

The health registers collect information about diseases, births, deaths and factors that may be of significance vis-à-vis sickliness and mortality rates. The registers provide up-to-date knowledge about various types of cancer, causes of death, birth defects and complications during birth, and about how these are distributed with respect to gender, age, epidemiologically, geographically and over time. The national registers currently include the Norwegian Cause of Death Register, the Cancer Registry of Norway, the Medical Birth Registry of Norway (MFR), the Norwegian Surveillance System for Communicable Diseases (MSIS), the Norwegian Tuberculosis Register, the Norwegian Childhood Vaccination Register (SYSVAK), and the Norwegian Prescription Database.

The establishment of a Norwegian Patient Register (NPR) in which individuals can be identified has been proposed. This is now being considered by the Storting. It has been suggested that the Injury Register be included as part of the Norwegian Patient Register in which individuals can be identified. This would help municipalities target their preventive efforts even more.

Health surveys are based on questionnaires answered by the general public and cover factors that are not caught by the registers such as self-experienced health, degree of social contact, dietary habits, physical activity, etc. Health surveys are conducted in individual counties including, among other things, Hedmark and Oppland (OPPHED), Oslo (HUBRO), Nord Trøndelag (HUNT), Østfold (Østfold Health) and Akershus (Health profiles for Akershus). In 2003, the Centre for Sámi Health Research, in cooperation with the Norwegian Institute of Public Health conducted a health and living conditions survey in areas with Sámi populations. Furthermore, a number of theme-based surveys are conducted which are in part nationwide such as the Norwegian Mother and Child survey and the 40 Years survey.

We are continuously working to develop a comprehensive health monitoring system. In addition to monitoring the health situation, it is important to maintain an overview of the

factors that influence lifestyle, living conditions and environmental conditions. For example, the Directorate for Health and Social Affairs and the Norwegian Food Safety Authority have a joint system for food and diet monitoring. The National Institute of Occupational Health is working on developing a system to monitor working environment and health at work (NOA) on a national basis. Environmental medical health monitoring by the Norwegian Institute of Public Health involves some measurements of environmental factors in communities (water and air quality) as well as environmental factors in human biological materials.

Preventive work in the municipal health services

The municipal health services are the main arena for prevention efforts in the health service. The municipal health services, including preventive health services, shall be integrated into the municipality's principal planning systems such as the municipality plan, action plans and financial plans. Municipalities are charged with important tasks within community-oriented health protection and infection control.

Public health centres and school health services

Public health centres and school health services shall, in addition to being public low threshold services for pregnant women and pre-school children, include public health centres for young people and school health services in primary and secondary schools. These services are low threshold provision that reaches all social groups. The public health centre provision reaches almost all children in their first years of life through, among other means, recommended vaccinations. School health services have the equivalent potential. This provision is important for young people who need a place in their own environment where they can go with their problems without having to make an appointment and without always having to involve their parents/guardians.

Key tasks include health surveys, vaccinations, information work, advice, counselling and measures for improving children and young people's own mastering and parents/guardians' mastering of their role as parents. The provision has a comprehensive perspective with respect to prevention and shall therefore carry out extensive interdisciplinary work. This is, among other things, absolutely central to the work on preventing mental health disorders and handling compound social problems. The provision shall in cooperation with pupils, homes and the school create a health promoting school through promoting good learning and work environments. The equivalent provision is targeted at pre-school children. The Directorate for Health and Social Affairs also prepares a guide for the use of medicines, etc, in nursery schools and schools.

Patient participation is a prerequisite for improving the target groups' insight, knowledge and ability to master small and major challenges. Key themes include the significance of self-care, ties with friends and family, social networks, and children and young people's psychosocial and physical development. The work also includes the topics of sexuality, living together and birth control, infection control, including prevention of HIV and sexually transmitted diseases, diet, dental health, freedom from tobacco, drugs, alcohol and other intoxicants, physical activity, and accident and injury prevention. In order to

meet the challenges associated with, among other things, excess weight in children and young people, specialist guidelines for prevention and treatment shall be drawn up and implemented as a tool in the provision. Work will also be done on the development and implementation of new guidelines for the measurement of weight and height.

The provision shall particularly focus on pregnant women, children and young people with special needs. The provision shall pick up on earlier indications of unhappiness, abnormal development and anti-social behaviour, and shall collaborate on the earlier initiation of measures aimed at preventing problems manifesting themselves. If needed, the provision shall refer people for assessment and treatment, and cooperate on the facilitation of services from other bodies.

The employees in public health centres and school health services include health visitors, physicians, midwives, physiotherapists and other personnel. There is a need to improve the provision from both a capacity and competence perspective in order for the provision to become a vigorous actor in the work on reducing social disparities in health. Some surveys indicate that the utilisation of health services varies according to social group. For example, a higher proportion of girls visit psychologists/psychiatrists in the inner-city west end of Oslo than in the eastern outskirts of Oslo. Better-developed school health services could help to ensure that those who need it most either get help from the municipal health services or are referred to specialist health services, and thus help to reduce social disparities in the use of health services.

Preventive efforts aimed at at-risk groups

Greater emphasis will be placed on preventive measures for at-risk groups. Some groups need personalised counselling in order to move their health behaviour in the direction of a healthier lifestyle. It is also important to equalise social health disparities. Lifestyle factors such as regular physical activity are important as part of, among other things, the prevention and treatment of mental health problems. The continued development of low threshold strategies and low threshold provision shall take place as part of the national strategy to combat social disparities in health. Please also refer to special strategies such as the cancer strategy and diabetes strategy.

Today, regular general practitioners have a special responsibility to identify at-risk people, ensure personalised counselling and follow-up, and to coordinate the follow-up of these patients. This applies, for example, to the follow-up of patients with a high risk of developing cardiovascular diseases. Special pay rates have been introduced in the standard pay scale in order to encourage regular general practitioners to prioritise lifestyle counselling and lifestyle measures. The pay rates for green prescriptions and smoking cessation are examples of these.

Regular general practitioners can also play a more active role in the prevention of problems with drugs, alcohol or other intoxicants. Studies show that interventions by health personnel at the start of problematic drug, alcohol or other intoxicant use are effective. Unfortunately, many physicians and other health personnel neglect their task of identifying and analysing problematic drug, alcohol or other intoxicant use early on.

Drug, alcohol or other intoxicant use is not considered a contributory cause of health disorders often enough. The Directorate for Health and Social Affairs has recently issued a new guide for municipal drugs and alcohol policy action plans (IS-1362). Please refer to the *Opptrappingsplanen for rusfeltet* (Escalation plan for the area of substance abuse) in chapter 6.6.

Municipal health services are an important meeting place for personalised counselling concerning the harm using tobacco does to one's health. Tobacco smoking is the predominant cause of COPD (chronic obstructive pulmonary disease). The most important preventive measure is therefore to help the individual to stop smoking. In the case of patients who have already been diagnosed with COPD, stopping smoking will only help to delay the worsening of the disease. The standard pay scale for doctors includes a pay rate for smoking cessation. There is also a pay rate for dentists in which smoking cessation initiatives are included as part of the treatment for periodontitis (loose tooth disease). Medicinal treatment when stopping smoking increases the stopping rate significantly, but the effect of treatment with medicines is largely dependent on the treatment being combined with counselling. The Directorate for Health and Social Affairs has drawn up guidelines of the work of municipal health services on smoking cessation.

The county council dental health service can be an important partner and play a role in municipal health services. This is especially true with respect to the work aimed at preventing tooth decay, promoting good dietary habits, and preventing a poor nutrition status, especially among children and senior citizens.

The green prescription scheme

The green prescription scheme is an attempt to move the focus away from medicines to self-help and other help with transforming health behaviour in cases where this is medically warranted. In addition to the pay rate for physicians the scheme includes professional counselling materials for use during consultations and for following up patients in the form of personalised programmes vis-à-vis diet and/or physical activity. This professional tool and the prescribing of a green prescription can be used for all patients one's thinks will benefit from lifestyle counselling and a change in his or her health behaviour.

The first part of the evaluation in 2005, which dealt with the physicians' perceptions and experiences from the use of the scheme, uncovered a number of weaknesses. Work has therefore started on developing the professional tool for physicians further and developing skills upgrading measures. It is vital that physicians themselves are involved and actively participate in this development work.

The results from part two of the evaluation will be available during the course of 2007 and will provide a basis for an overall evaluation of, firstly, whether it would be relevant to extend the motivational pay rates to more diagnoses and, secondly, what the follow-up should be like in order to be as good as possible for the patients. As part of the quality assessment of the follow-up, it would be natural to form an opinion about how specialist groups, e.g. physiotherapists and nutritionists, can contribute to the follow-up provision.

The government will assess various aspects of locally-based low threshold provision as part of the work on evaluating and developing the green prescription scheme. The health service, local communities and places of work are relevant arenas for prevention and intervention. In addition to the health service, voluntary organisations and private agents, it would be natural to consider the Norwegian Labour and Welfare Organisation (NAV) and involved parties as contributing agents. Meanwhile, certain criteria for such low threshold provision can already be nailed down: the provision must form part of a prioritised effort embedded in the municipality planning system, and it must build on structures that have already been established for the municipality's or other agents' activities and services.

Prevention in care services

The recipients of municipal care services are primarily senior citizens but also include children, adolescents and adult with functional impairments, including physical disabilities, intellectual disabilities, mental health problems or people with problems involving drugs, alcohol or other intoxicants. Please refer to White paper St.meld.nr 25 (2005-2006) *Mestring, muligheter og mening* (Long term care - future challenges – Care plan 2015).

For example, nutrition is one area in which there are major challenges and potential for prevention. Even though facts concerning the nutritional situation among the patients of care services are scarce, we know that many people experience somewhat large nutritional problems including malnutrition, poor nutrition and/or excess weight/obesity. There is a need to develop systems to pick up people who are at risk of developing poor nutritional habits and malnutrition. The Ministry therefore wishes to focus on food and meals as an important part of the care services' activities, both in nursing homes and with respect to home care services.

The incidence rates of osteoporosis and osteoporositic fractures are higher in Norway and Scandinavia than in most other countries. Preventive measures require a long-term, systematic, intersectoral effort. Along with a varied and healthy diet, daily physical activity helps to strengthen the skeleton, reduce risk and delay the time when osteoporosis sets in. Various preventive measures and anti-falling measures targeted at nursing home residents and senior citizens living at home shall be carried out by the care services and home care services. Specialist guidelines for the prevention and treatment of osteoporosis and osteoporositic fractures, drawn up by the Directorate for Health and Social Affairs, are a useful tool in this work.

Competence requirements and professional development

Work shall be done on improving social medical competence in municipalities.

Access to social medical competence is necessary in order for municipalities to address key tasks within infection control, health preparedness, environmentally-oriented health protection, local health monitoring, planning and the coordination of the health services. The tasks in social medical work also include helping to ensure comprehensive services

with good interaction between various sub-services and levels in the health service, as well as putting the health service in a better position to contribute to the interaction with other sectors. As part of the work on improving social medical competence in municipalities and in the national health administration, regionally and nationally, the Ministry of Health and Care Services is working on stipulating new regulations concerning the implementation of specialist training in social medical work.

The Ministry of Health and Care Services shall conduct a review of environmentally-oriented health protection. This should be viewed in the context of the improvement of social medical work in the municipality, and a review of district or city medical officers' duties.

The main challenges in the work on improving nutritional competence in municipalities are to find good organisational solutions and establish systems for the services' quality management. There is no special competence within today's municipal health services vis-à-vis clinical nutrition that can address diet counselling and the follow-up of patients/users in the various services, and which can perform an advisory function with respect to the services. The provision that does exist in this area is found in the specialist health services. We shall therefore look more closely at how nutritional work and competence can be improved. The emphasis shall be on cooperation between municipal health services and specialist health services within, among other things, malnutrition and the problem of excess weight and diabetes.

Preventive work in the specialist health services

The specialist health services have important duties in secondary and tertiary prevention, and in patient training. The framework conditions for the preventive work are stipulated by the Specialist Health Services Act, in which the objects clause states that the services shall, among other things, promote public health and counteract disease, injuries, disorders and functional impairment, and in the regional health authorities' bylaws. The specialist health services also have a duty to provide guidance to municipal health services.

Section 3-8 of the Specialist Health Services Act stipulates that a hospital's duties include educating patients and their relatives. Training about and insight into one's own illness is an important prerequisite for mastering living with a chronic illness and functional impairments.

The regional health authorities are duty bound to initiate measures to educate patients and their relatives in all health enterprises. There are now more than 35 learning and mastering centres, and more are being planned. The learning and mastering centre at Aker University Hospital HF has been approved as a national learning and mastering competence centre for chronic illnesses. In order to support this work the regional health authorities have been instructed to ensure that satisfactory secondary preventive measures exist for the major groups of diseases such as cardiovascular diseases, diabetes, asthma and allergies. The reimbursement tariff for training patients has been widened to be diagnosis-independent as of 1st January 2004.

The prevention efforts in specialist health services have been surveyed as part of the follow-up of the Public Health Report. The survey included general population-oriented health promoting and preventive activities and individual oriented prevention, including both primary prevention and secondary prevention. The survey shows that individual-oriented secondary prevention represents the predominant prevention effort in the health enterprises. Furthermore, the survey shows that the managerial and organisational embedding of the preventive work varies between the health enterprises. The Ministry of Health and Care Services will follow this up in the governance dialogue with the regional health authorities with a view to improving the embedding.

The Public Health Report suggests that one considers developing quality indicators vis-à-vis the prevention work in the specialist health services. It is also suggested that specialist health services legislation be reviewed to see whether there is a need for amendments to clarify the health enterprises' responsibilities in the field of prevention, and whether or not there is a need for a guide to the Specialist Health Services Act with respect to addressing public health work and guidance for the municipal health services. The measures will be followed up within the framework of the National Health Plan for Norway.

Regarding the municipal health services, it is important to increase confidence and competence with regard to talks about lifestyle changes. Guidelines and communications tools shall be drawn up for the use of various groups of health personnel in hospitals and other health institutions. In order to encourage more work on prevention measures such as, for example, smoking cessation, please refer to the *Nasjonal strategi for det tobakksforebyggende arbeidet 2006–2010* (National Strategy for Tobacco Prevention Work 2006-2010).

Clinical nutrition

Nutrition and diet form a natural part of the treatment and care of sick people within somatic and mental health services. Nutrition is either a component or the only element in the treatment of a number of diagnoses. Satisfactory nutritional follow-up is important for diagnoses such as diabetes, food allergies and food intolerances, coeliac disease (gluten intolerance), cardiovascular diseases and eating disorders. Nutrition plays a key role as a support element in other treatments such as, for example, in the prevention and treatment of malnutrition. Malnutrition in patients in hospitals and care institutions is a particular challenge. Older patients are an especially vulnerable group after being discharged from hospital. A number of mental health disorders involve food intake that is not in line with the body's needs, and many of those who are affected are young people. An inadequate provision of nutritional treatment and personalised programmes can affect the effectiveness of treatment and in a worst case scenario result in serious complications. Among other things, the area of nutrition should be followed up in the further development of hospitals' mobile teams and through the specialist health services' duty to provide guidance to municipal health services.

Specialist knowledge about nutrition in the specialist health services is most commonly possessed by clinical nutritionists. There are 115 positions for clinical nutritionists in the specialist health services on a nationwide basis. In order for the health service to be equipped to meet the challenges that an increase in the incidence rates of diabetes and excess weight in all age groups constitute, and to accommodate an increasing need within the service for clinical nutrition, the health service must have enough well-qualified personnel with specialist competence in clinical nutrition, and other relevant health personnel groups must possess basic knowledge in the area.

Infection control – an important arena for interaction between municipalities and national government

The municipal health services and specialist health services have been assigned a great deal of responsibility and important tasks within the area of infection control, tasks that can often not be satisfactorily resolved without good interaction and good cooperation between the various levels.

Municipalities have been assigned primary responsibility for infection control preparedness. In a time when the danger of an influenza epidemic is greater than for a long time and when serious outbreaks of legionaries' disease and illnesses involving methicillin-resistant yellow staphylococcae are taking place, the preventive work and preparedness work within infection control in the municipal health services and specialist health services will have a high priority. Version 3.0 of the national preparedness plan for pandemic influenza was adopted on 16th February 2006. The plan, which is a dynamic document, is continuously followed up in order to improve preparedness at both a national and a local government level. Work is being done to examine the possibility of Nordic cooperation on the production of influenza vaccines.

The municipal health services are currently responsible for 90% of all prescriptions of antibiotics and reducing this will be a challenge for these services. Preventing resistance to antibiotics and infections in hospitals and nursing homes will be central to the infection control work during the period 2007-2010. The goal is to ensure antibiotics remain good, effective medicines, and reduce the number of infections in hospitals and nursing homes. The effect of the prevention measures in this area will to a large degree depend on good interaction between municipal health services and specialist health services. Good infection control and good infection control preparedness requires competent and adequate laboratory diagnostics. Improving laboratory capacity for reference functions for important agents is key.

Food safety

The goal of the work on food safety is to reduce the risk of illnesses being transferred by infective agents and unwanted foreign bodies in food and drinking water, as well as to ensure honest sales and address consumer interests. The Norwegian Food Safety Authority's activities require interaction between health, farming and fishing authorities.

It is still important to make a big effort to ensure good hygiene in the food production chain so that the incidence rate of illnesses that can be transmitted via food and water is reduced.

Food should be safe when it reaches consumers, regardless of whether it was produced at home or abroad. The supervision shall be designed to ensure that the end products are safe through inspection efforts in every link of the food production chain. It is still necessary to inspect end products in order to ensure and document that the total measures in each link of the food production chain are having the desired effect.

Changing shopping patterns and the complicated flows of products in the modern sale of food make it necessary for enterprises to have good tracking systems that make is easy to withdraw food products from the market that could cause harm. Changes to the food on offer, including the use of new ingredients, increased processing and the increased use of dietary supplements make it necessary to expand the opportunities to conduct diet risk assessments, and stipulate new requirements vis-à-vis the documentation of the composition of diets and food products. Overall assessments of the health promoting and harmful aspects of food products are becoming more relevant. It is important to label food products well in order to allow consumers to make informed choices, including when it comes to choosing healthy and health-giving food.

6.3.2 The municipalities' health and social services

The Nordic welfare model is characterised by well-developed local health and social services. The municipality services are the foundation of overall health provision for the general public. It is therefore very important that the capacity and content of these services are able to meet future assessment, treatment, care and rehabilitation challenges. These include an increasing proportion of inhabitants with immigrant backgrounds, a strongly increasing proportion of senior citizens in the population, and the fact that the strongest growth today within the care sector is taking place in the younger patients group in which many people have compound disorders.

Municipal health and social services perform a total of around 200,000 man-years of work with care services as the largest area with around 110,000 man-years. By way of comparison the total number of man-years within the specialist health services is around 93,000.

Municipal health services include general practitioner services, casualty clinics, physiotherapy services, nursing, including the health visitor service and district nursing, midwife services, nursing homes and housing with 24-hour care, medical emergency services and the transport of medical personnel. The health service's participation in public health work is discussed in chapter 6.3.1.

Social services include home help, relief initiatives, support contacts, places in institutions or 24-hour residential care services, care pay, outreach initiatives, and care and activation initiatives. Most municipalities have organised a number of social services

as part of care services, however they can also be organised such that they are linked to social services offices or form part of the services for drugs and alcohol work and mental health work. It is vital that the cooperation with health and social services develops well in order for the new Norwegian Labour and Welfare Organisation (NAV) to succeed.

As described in chapter 6.3.1, many different services and sectors in municipalities contribute to promoting public health and ensuring good living conditions for their inhabitants. Public health relies on the efforts of many sectors of society. The municipal health services are however responsible for prevention efforts in the health service through, among other things, public health centres and school health services, and are responsible for health monitoring and play an important role in the interaction with other sectors through, among other things, community-oriented health protection and infection control. The challenges faced by municipal health and social services must be seen in the context of other municipality services such as the cultural and leisure sectors, the schools and nursery schools sector, and others.

A number of inhabitants need comprehensive services and assistance from many agents. Provision that improves individual people's health status, functionality and mastering of their everyday lives are embedded in various laws. The Ministry is following up the regulatory framework in this context in the work on NOU 2004: 18 Comprehensiveness and planning in health and social services (The Bernt Committee). The aim is to circulate a consultation paper containing a draft of a new common Act relating to Municipal Health and Social Services in 2007.

In order to make sure that the Sámi people are ensured equal access to health and social services, the necessary competence vis-à-vis language, culture and multicultural understanding must exist in the municipality. This is especially true with respect to personnel who have a treatment and or care function.

Mastering perspective and patient participation

One principal goal of municipal health and social services is to help improve individual person's ability to master their own life for those who need such help. This perspective is based on the view that a person is the foremost expert on his or her own life and knows best what is good, useful and important for him or her.

Patient participation is a right stipulated in legislation and can take place on several levels: at an individual level such as, for example, the right to participate in the design of one's service provision, influence at a system level, and through participating in the shaping of policy through patient organisations NGOs. The systematic collection of patient experiences and learning from the results of supervision and from complaints are important tools in the development of the service provision in municipalities. Municipalities face a number of challenges with respect to ensuring that mastering and patient perspectives characterise the work of employees and the health personnel they have agreements/contracts with.

Cooperation between municipal services and the specialist health services

The boundary between the responsibilities and duties of the municipal services and specialist health services is constantly changing. The aim is to work towards assessments, treatment, rehabilitation and care being able to be provided as close to the patient's home as possible. Previously defined "grey zones" in the system of services must in the future become, to a greater degree, areas for joint solutions between municipalities and health enterprises. Please refer to chapter 6.3.4 Comprehensiveness and interaction.

The provision provided by the municipal services and specialist health services must together constitute a treatment network around the individual patient. This requires municipalities and health enterprises to be equal partners and be very familiar with each other's services and structures.

Local democracy and patient orientation

The decentralisation of tasks and delegation of the authority to the municipalities will facilitate local autonomy and a greater degree of patient orientation in the services. Municipalities, with their closeness to the services and the patients, are assumed to be in a better position to prioritise resources according to local needs and prerequisites than the region or national government is.

The care provided by families and volunteers is almost on a par with that provided by public sector care. The care provided by families and the care provided by the public sector complement and strengthen each other. There is great potential inherent in developing better framework conditions and improving the conditions for those who carry out voluntary care work.

Care services

Care services primarily consist of nursing homes, senior citizens homes, assisted living facilities, home nursing, various forms of home care services that often work closely with the other municipal health and social services, and daytime provision and activity initiatives. The care services provided in 2005 amounted to almost 110,000 man-years for more than 200,000 service recipients. Of these, approximately 40,000 lived in institutions. Financially speaking, care services account for almost 4/5 of municipalities' total expenses vis-à-vis health and social services.

In recent years the development of the services has been characterised by decentralisation, institutionalisation and differentiation of the provision. Municipalities are constantly developing more flexible services based on the patients' needs for assistance and help. This requires more flexible solutions vis-à-vis the organisation of the care services' provision. Municipalities have met these challenges by strongly improving home nursing and home care services, differentiated provision in nursing homes that is being made available to patients who live at home, and a large expansion in the building of assisted living facilities.

Society faces demanding care challenges in the next few decades. These cannot be left to the health and social services alone, but have to be solved with a basis in public sector responsibility that involves most sectors of society, and by supporting and developing the voluntary involvement of families and local communities, organisations and enterprises. As far as we can tell today the challenges will first and foremost be associated with new patient groups, aging, the need for more care providers, for better medical follow-up, and for activities and social contact.

Strategies and future follow-up

The government's principal strategy for meeting the care challenges of tomorrow is to take advantage of the, demographically speaking, stable period we face to gradually build up service provision and to prepare for the rapid growth in the need for care that is expected in 15 years. It is already possible to commence a gradual expansion and invest in preventive measures, competence, new technology, technical aids and general facilitation. The strategies sum up the government's measures for the next few decades aimed at meeting both the care challenges of today and tomorrow. The strategies are presented in their entirety in White paper St.meld.nr. 25 (2005-2006) *Mestring, muligheter og mening* (Long term care - future challenges – Care plan 2015).

The following measures constitute key elements of the government's care plan. These will characterise the future provision of care services and afford the planning direction and content.

Investment grants for nursing homes and residential provision

The government is announcing a new investment grant for nursing homes and assisted living facilities. The target group for the scheme is people who need 24-hour health services and social services. The grant will facilitate long-term planning and investment in municipal care services. The grant will strengthen municipalities' provision of, among other things, short-term beds in nursing homes and residential provision for senior citizens and people with disabilities with a need for comprehensive care services in both nursing homes and assisted living facilities, including people with mental health disorders, intellectual disabilities and problems with drugs, alcohol or other intoxicants. Grants will also be given for the modification of people's homes and access to homes (e.g. lifts). The government will return to the question of investment grants in connection with the national budget for 2008.

Capacity growth and 10,000 man-years

The government has through an increased framework for the municipality sector facilitated the expansion of personnel capacity by 10,000 new man-years in municipal care services by the end of 2009, compared with the level in 2004. Municipalities are first and foremost expected to utilise this growth to expand their provision in nursing homes and home care services based on local needs and priorities. In addition to this the government wants in particular to point out the possibilities that the new personnel man-years afford vis-à-vis contributing to:

- more care in assisted living facilities

- improving physician coverage and medical competence in care services
- placing greater emphasize on culture, activities and social initiatives
- expansion of daytime provision and senior citizen centres
- improving dementia care – preventive measures and the coordination of volunteers

Competence and recruitment plan

The purpose of the Competence Lift 2015 is to secure adequate personnel and the necessary specialist competence for municipal health and social services. The action plan for the first four-year period will emphasise measures that will result in:

- more health professionals
- an increased proportion of employees with health and social work training
- improved management and better working environments
- reduced involuntary part-time work
- increased further education

In addition to this, recruitment campaigns will be carried out with a view to broader recruitment in relation to age, gender and cultural and professional backgrounds.

Escalation plan for research and development

In order to strengthen care research that is closely linked to practices, the government wants to establish separate regional research and development centres (R&D centres). It would be appropriate to establish the centres in key university college environments that provide health and social work education, such that the research activities also contribute to improving the development of the professional knowledge base, methodological development in the health and social work training courses, and ensure proximity to the service providers in municipalities. The locating of the centres will take into account, among other things, needs in the health regions in relation to already established specialist environments and infrastructure, and the fact that the university colleges cooperate with teaching nursing homes in every health region. The organisation and funding of the R&D centres will be discussed with the Research Council of Norway and other involved agents. It is important to preserve the geographical distribution, quality and good cooperation routines, and cooperate with local agents and the national network. The Norwegian Pensioners Association has, through Einar Strand’s Research Fund, contributed to the funding. In addition, the government and the Norwegian Association of Local and Regional Authorities have agreed to strengthen municipality participation in the research and development work vis-à-vis provision taking place close to practices through the new agreement concerning health and social services.

New agreement concerning improving quality

The government and the Norwegian Association of Local and Regional Authorities have reached a new agreement concerning improving the quality of municipal health and social services. The parties have reached agreement concerning the primary strategies that are necessary to meet the care challenges of the future, and are emphasising interdisciplinary skills upgrading, municipality planning, organisational and managerial

development with a view to providing higher quality provision, a more active rehabilitation and care profile, and services tailored to the needs of individual patients.

Ethics project

Employees in municipal health and social services face difficult ethical dilemmas and issues on a daily basis that require ethical awareness and good powers of judgement. The government has as part of the quality agreement invited the Norwegian Association of Local and Regional Authorities and professional organisations to cooperate on developing a system that ensures all employees receive basic training in professional ethics and developing models for embedding ethics work organisationally in a municipality context.

Plan to face the challenge of dementia

Old age dementia is the disorder that results in the most years spent with serious functional impairment at the end of life and requires the most resources from municipal health and social services. Around 66,000 people suffer from this serious disorder today. This diagnosis is the primary cause of admission for almost half of current nursing home patients, and three quarters of those who live in nursing homes suffer from a dementia disorder. In the years ahead there will be an increase of around 10,000 new cases per year. The government will give research and the development of the professional knowledge base within prevention and treatment of dementia disorders a high priority. The Ministry is in the process of drawing up a plan to improve the entire initiative chain in the continuing work on dementia. The planning work is oriented towards research, development initiatives, skills upgrading and recruitment, forms of housing, and cooperation with families. The planning work shall also clarify what sort of provision one expects the specialist health services to be able to provide to this group of patients. The plan shall be designed with a view to implementing it from 2008.

Expanded patient advocate scheme

The cases of patients/services recipients are often complex and require an advocate scheme that covers both administrative levels and the interaction between them. The government will therefore propose amendments to the law such that patients of municipal health and social services will also get advocates.

Measures for relatives

The government has started work on looking more closely at current health and social legislation and the rules concerning work leave in order to better facilitate and ensure the rights of families, relatives and volunteers who take on extensive care responsibilities. A handbook (guide) will also be drawn up for service recipients and families/relatives that describes one’s rights and obligations pursuant to the health and social legislation, and provides practical instructions for how to deal with the health and social services’ administration, e.g. with respect to applications, decisions and the processing of complaints.

Expansion of volunteer centres, senior citizen centres and preventive measures

Volunteer centres, senior citizen centres, daytime provision and other measures that have a preventive function, and trigger and coordinate volunteering, can be strengthened with personnel within the framework of the 10,000 new man-years for care services.

Municipal medical/practitioner services

Municipal medical/practitioner services include general medical/practitioner services, casualty clinics and social medical work. The general practitioner often represents the inhabitants' first encounter with the health service. The general medical/practitioner services include the RGP scheme, general public sector medical work (public health centres, school health services, nursing homes, prisons and refugee reception centres, etc) and 24-hour municipal casualty clinics. One special feature of the Norwegian general medical/practitioner services is that the various types of medical tasks in most municipalities are jointly performed by the physicians within the individual municipality.

The total number of man-years in the municipal health services increased from 3,809 in 2000 to 4,219 in 2005 (Statistics Norway). The number of physician measured in man years increased by 6% from 2004 to 2005 (from 260 to 275 man-years) in institutions for senior citizens and people with disabilities. The number of physicians with RGP contracts has increased from 3 486 in January 2001 to 3 807 as per 30th June 2006. Statistics Norway's figures for physician man-years in municipal health services per 10,000 inhabitants show an increase from 7.5 in 1994 to 9.1 in 2001. The scope of physician man-years in municipalities has remained at the same level since 2001. 100 RGP practice licences are still without regular general practitioners. The lack of regular general practitioners is greatest in Nordland and Finnmark (especially in the eastern part of Finnmark). Since 1998, the Ministry has through the national budget given annual grants to a number of motivational initiatives designed to improve recruitment and the stability of physician coverage in small and outlying municipalities. The number of RGP practice licences without regular general practitioners in Sogn og Fjordane has fallen in recent years. The chief administrative officers' initiative in cooperation with the Norwegian Association of Local and Regional Authorities locally and municipalities appears to have improved the situation. The organisation of casualty clinics at night and during weekends/public holidays and participation in the development of the professional knowledge base locally appears to be of substantial significance vis-à-vis recruitment and stability, especially with respect to recently graduated physicians.

The RGP scheme

General practitioner provision for the general public has been organised as a RGP scheme since 1st June 2001. The purpose of the RGP scheme is to enable all inhabitants who want it to have a regular general practitioner to relate to. Municipalities are obliged to offer their inhabitants an opportunity to be linked to a regular general practitioner or general practitioner practice. Most regular general practitioners practice privately and have an individual RGP contract with the municipality. Pursuant to section 7 of the Regular General Practitioner Regulations, regular general practitioners are responsible for the general practitioner provision to people on his or her list within the limits that apply for the RGP scheme pursuant to the law, regulations and national agreement. The list system involving a list of inhabitants for each regular general practitioner and the arrangement

with contracts between municipalities and regular general practitioners as privately practicing physicians are two core elements of the RGP scheme.

Evaluation of the RGP scheme

The RGP reform is primarily a reform that has been structural in nature that involves a restructuring of the general medical/practitioner services. The Research Council of Norway has had responsibility for coordinating a five-year, research-based evaluation of the RGP scheme from 2001-2005. The final report concludes that the RGP reform has generally been successful. However, some challenges remain for the general medical/practitioner services. The final report emphasises the following challenges:

Access to regular general practitioners

Access to regular general practitioner offices is in many cases perceived as too poor. This applies to both telephone availability, waiting times for appointments, and access to casualty clinics. The inhabitants' opportunities to freely choose a general practitioner are strictly regulated by the RGP scheme. Access to one's own regular general practitioner office therefore largely determines the accessibility of health services. Patients want to be able to bring their most urgent problems to their regular general practitioner when they feel that it is urgent. Regular general practitioners must therefore be able to arrange consultations at short notice.

In the Ministry's opinion this largely has to do with the regular general practitioners' organisation of their own practices. Municipalities, as parties to the contracts with the regular general practitioners, are expected to address the needs of the inhabitants and ensure that their rights are fulfilled. Similarly it is important that municipalities continually monitor the general public's ability to change physician, and that they have, at any given time, established a sufficient number of RGP practice licences. The general public will thus have a genuine right to change in all municipalities.

The evaluation report also points out, among other things, that the size of consultation fees for general practitioner help may be of significance vis-à-vis the accessibility of regular general practitioners.

Recruitment to the RGP scheme

Establishing oneself as a private practicing regular general practitioner can represent a financial boost for newly graduated physicians. Around 35% of newly established regular general practitioners during the period 2001 to 2004 were women. At the same time the proportion of female medical students is well over 50%. It would be desirable to have more women as regular general practitioners. The Ministry will in cooperation with the Norwegian Association of Local and Regional Authorities and the Norwegian Medical Association look more closely at which consequences any changes in prices for medical practices may have vis-à-vis the recruitment to the RGP scheme and for female regular general practitioners especially.

Regular general practitioners cooperation with others

The evaluation of the RGP scheme indicates a potential for better interaction with both other municipal services and with the specialist health services. This especially applies to patients with comprehensive and compound needs for services over a long period of time.

Municipalities, as administrative bodies and parties to the contracts with privately practising regular general practitioners, have a special responsibility to ensure that regular general practitioners fulfil their roles and duties in the interaction vis-à-vis various patients groups. This especially applies in relation to patients/users of municipal care services. It also applies in relation to other physicians and other groups of professionals, both those with and without referral rights. Here municipalities can use both local cooperative committees and the individual RGP contract as their starting point.

District or city medical officer's role

The district or city medical officer is the expert medical advisor to a municipality and thus a key supplier of premises for local health policy decisions, health-related preparedness, and addressing infection control tasks such as drawing up an infection control plan and other community-oriented health protection. The district or city medical officer has one key duty involving planning medical/practitioner services in the municipality through participation in the local cooperative committee for the RGP scheme. Please refer to chapter 6.3.1 Public health work.

The evaluation report concerning the RGP contract points out that the field of social medicine has for many years struggled with poor recruitment and instability. During the period 1994-1999, 50% of social medicine practitioners left their positions. The same thing happened in the period 1999-2002. The number of hours spent on social medical work has also fallen over many years independent of the introduction of the RGP reform. Participation in social medical work cannot be demanded as a criterion for signing a regular general practitioner contract. Many general practitioners, and especially recently graduated physicians, do not possess social medical competence. Social medical work is best served by such work being carried out through voluntary agreements. The district or city medical officer shall contribute a social medical perspective to municipality planning and development work. It is therefore important to recruit physicians with social medical qualifications to municipalities.

Public medical work

The tasks in public medical work are individual-oriented and include work in public health centres, school health services, nursing homes and penal institutions. Pursuant to the Regular General Practitioner Regulations and key agreements, a municipality can stipulate conditions concerning participation in public medical work of up to 7.5 hours per week of fulltime curative activities. Municipalities and physicians can sign agreements involving a higher number of hours. On average, regular general practitioners carry out 4.3 hours of public medical work per week. In some municipalities the physician coverage vis-à-vis nursing homes, school health services, and public health centres, as well as prisons and refugee reception centres in those municipalities with these, is unsatisfactory. The evaluation of the RGP scheme has also indicated that the number of positions in nursing homes is in many areas so small that they border on what

is professionally acceptable. There is an untapped potential within public medical work that municipalities should utilise to a greater extent.

The Government wants to improve public medical work provision for the users of care services: this applies to both patients in nursing homes and recipients of home care services and home nursing care. The focus will first be on increasing the capacity and quality of the medical provision in nursing homes. Thereafter the Ministry will review how regular general practitioners are addressing their responsibilities vis-à-vis medical help for recipients of home care services and home nursing services. The Ministry is basing this on a need to increase the contribution of physician man-years in nursing homes by at least 50% up to 2010. The Directorate for Health and Social Affairs is currently drawing up professional guidelines for medical/practitioner services in nursing homes, embedded in the Quality Regulations. The Norwegian Board of Health will in 2007 focus on medical/practitioner services in nursing homes in particular. In order to improve the quality of the medical provision provided in nursing homes the government will enable municipalities to link their nursing homes to NOKLUS (Norwegian Quality Improvement of Primary Care Laboratories).

Basic education, compulsory practice periods, specialist training, research and the development of the professional knowledge base are of significance vis-à-vis the recruitment of physicians to individual fields. The Ministry will ensure that geriatric medicine in general and nursing home medicine especially is strengthened in the compulsory practice periods for physicians and in the specialist training of physicians.

Casualty clinics

Municipalities shall organise a casualty clinic system that addresses the general public's need for emergency help 24-hours a day. Municipal casualty clinic services form an important part of the emergency medical services outside hospitals. Casualty clinic work can by some physicians be experienced as a major burden. This can lead to difficulty vis-à-vis recruitment in some municipalities with few physicians to share casualty clinic duties between.

Around 30 inter-municipal casualty clinic systems with manned casualty clinic centres at night and during weekends/public holidays have been established on a nationwide basis. This involves a quality upgrade of the municipal casualty clinic. At the same time this structuring helps to ensure that the frequency of duty for the individual regular general practitioner is significantly reduced, which one knows is of major importance for both recruitment to RGP practice licences in small municipalities and the stability of medical/practitioner services. The Ministry knows that more municipalities want or are planning to establish inter-municipal casualty clinic partnerships with manned casualty clinic centres.

Further follow-up

During its consideration of the White paper St.meld nr. 60 (2004-2005) *Om lokaldemokrati, velferd og økonomi i kommunesektoren 2004 (kommuneproposisjonen)* (About local democracy, welfare and economy in the municipalities sector 2004 –

municipalities' proposition), the Storting adopted Request no. 528 concerning inter-municipal casualty clinic cooperation. The resolution asks the government to give an account of how national incentives can be developed that contribute to the development of inter-municipal casualty clinic cooperation where this appears geographically appropriate and of benefit to the general public. The Ministry is currently considering several reports concerning municipal casualty clinics in general and inter-municipal casualty clinic cooperation in particular. In 2002, NOK 306 million was paid out for casualty clinic work and in 2005 NOK 304 million, the extent to which such restructuring has resulted in more use of the "ambulance service" is currently uncertain. The Ministry will, in cooperation with the Norwegian Association of Local and Regional Authorities and Norwegian Medical Association, assess how means can be developed to enable more municipalities to establish inter-municipal casualty clinics.

Research and professional development within general practice

The municipal health services duties have changed much in recent decades, which entails a need for new and research based knowledge. There is therefore a need to strengthen research and the development of the professional knowledge base within general medical/practitioner services on the services own premises. The development of the professional knowledge and research in general practice in both Norway and Sweden is far behind the medical research and development of the professional knowledge base within specialist health services.

In connection with the consideration of the revised national budget for 2006, the Storting has granted NOK 3 million for more detailed planning of general practice research units. The aim is to build up four research units linked to universities that provide basic medical training. The units are expected to work closely with the universities and presuppose general practice research that is close to the practices and patient-oriented. The work and funds will be continued in 2007.

NOK 2 million was set aside in connection with the pay rate negotiations with the Norwegian Medical Association for a general practice research fund. The funds will be spent on reinforcing the development of the research units in a close partnership between the Norwegian Medical Association and the health authorities.

The physiotherapy service

The resources allocated to physiotherapy services in 2005 amounted to a total of 4,148 people distributed as follows: 1,326 employees in municipalities, 2,531 with practice agreements with municipalities, 153 private practices without practice agreements, and 137 compulsory practice candidates.

Physiotherapy services have not been subjected to a systematic review or evaluation in the last 15 years. The Ministry has therefore assigned the Directorate for Health and Social Affairs the task of surveying the service. The survey will be ready in the autumn of 2006. Moreover, a review of the funding schemes for physiotherapist services will be conducted in light of the purpose of the service and its function within municipal health services.

Challenges associated with some special patient groups

Much of the municipality work is characterised by forms of outreach work and network-oriented approach for some special patient groups. Some patients have great difficulties turning up to fixed appointments with regular general practitioners or other public sector offices. Municipal health and social services face a particular challenge with respect to developing good working methods aimed at such patients. The Norwegian Board of Health (2005) has in its report 'Nursing and Care Services Under Strain' in particular pointed out the challenges in working with people with mental health disorders and people who are addicted to drugs, alcohol and other intoxicants. The service and working methods should be tailored to the patients and not vice versa.

The development of competent professional environments that are independent of organisational links and models should be encouraged. In the case of municipalities with few employees in sub-services or who have few specialists with specific competence it would be a good idea to develop professional environments and professional networks across municipality boundaries and in partnership with the specialist health services.

People with drug, alcohol or other intoxicant problems

Access to health services for people with drug, alcohol or other intoxicant problems has improved greatly in recent years. The substance abuse reform gave people who are addicted to drugs, alcohol or other intoxicants patient rights including when it comes to treatment for the abuse of drugs, alcohol or other intoxicants. The substance abuse reform also involved physicians and social services getting the right to refer people to interdisciplinary treatment in the specialist health services. The number of participants in medicine-assisted rehabilitation has increased and a far greater number of people are being offered personalised health services as a low threshold health initiative. At the same time the Norwegian Board of Health and the Office of the Auditor General of Norway have documented in supervision reports that there is a great unmet need for these services. Many people are not receiving the services they are entitled to and the services are not of the necessary quality. It is particularly worrying that young people who are debuting with drug, alcohol or other intoxicant problems are not being caught early enough and receiving personalised help.

Both supervision reports and several evaluations point out that the challenges are particularly great in the municipalities. Even though a steadily increasing number of people are receiving treatment in the specialist health services, the vast majority of people with drug, alcohol or other intoxicant problems are recipients of municipal services or live in municipalities without receiving public sector services. Municipalities have a comprehensive responsibility for the area of drugs, alcohol and other intoxicants, and many patients require long-term follow-up and services from multiple sectors. Those addicted to drugs, alcohol or other intoxicants often live in poor living conditions and have major social and health related problems. In the case of compound needs, professional social work including milieu therapy and housing guidance, is a prerequisite with respect to ensuring that the recipient is able to make practical use of health services and social and work related rehabilitation. There are great variations in the degree of

drug, alcohol or other intoxicant problems and life situation. Municipalities must be able to utilise differentiated measures and be able to provide the individual with a personalised programme. There is a need to strengthen competence with respect to issues related to drugs, alcohol and other intoxicants and care and rehabilitation initiatives, and to raise the level of quality and develop methods of working. There is often a correlation between drug, alcohol or other intoxicant problems and mental health disorders. Coordination is therefore often needed, as is some overlap between these service areas.

Municipalities' and specialist health services' responsibilities vis-à-vis the treatment and follow-up of people with drug, alcohol or other intoxicant problems are practised differently, which results in variations in the sort of provision provided. Municipal and national authorities lack adequate information about the relationship between resource use and service provision because information and documentation about the activities within the field of drugs, alcohol and other intoxicants are not precise enough. This is due, among other things, to the fact that the reporting systems record needs and not diagnoses.

From a prevention perspective, it is important that municipal health services and other municipality services become better at providing help and counselling earlier in a drug, alcohol or other intoxicant career in order to prevent the development of serious addiction to drugs, alcohol or other intoxicants, and the social and health related problems associated with this.

Further follow-up

The government will finalise an escalation plan for the area of drugs, alcohol and other intoxicants in the autumn of 2006. The focus areas for the municipalities will in particular be:

- prevention, early intervention, accessible services, including strengthening low threshold measures and follow-up at home
- quality development in cooperation with the Norwegian Association of Local and Regional Authorities and voluntary sector
- skills upgrading and increases in professionalism, better research and documentation
- interaction with the specialist health services, new Norwegian Labour and Welfare Organisation (NAV), Norwegian Correctional Services and child welfare services, increased patient participation

The efforts in the field of drugs, alcohol and other intoxicants must also be seen in the context of the government's efforts to prevent and eliminate poverty and the organisation of the new Norwegian Labour and Welfare Organisation (NAV).

People with mental health disorders

The background for and status of the Escalation Plan for Mental Health (1999-2008) is described in detail in chapter 6.6. During the escalation period the municipalities will, if one includes the increase in the period 1995-1998, have been allocated resources that provide room for around 6,000 new man-years. Mental health work will thus be assigned more man-years than the other health and social services with the exception of care

services. Mental health work is both a knowledge field and a practical field and includes prevention, information work, treatment, rehabilitation and measures aimed at people with mental health disorders and their families. The goal is to help promote independence and a sense of belonging, and to improve the ability of people with mental health disorders to master their own lives.

So far municipalities have used grants from the Escalation Plan for Mental Health (1999–2008) to focus on treatment and follow-up measures for adults and primary preventive measures for children and young people. In the future there will be a need to develop treatment and follow-up measures for children and young people suffering mental health difficulties. The aim is to strengthen the competence and professional environments in mental health work for children and young people in municipalities. The following areas will receive particular attention during the health plan period:

Further follow-up

- Ensuring measures and services for patients are of good quality and effective by developing competent professional environments within the mental health work in municipalities. Encouraging more interdisciplinary work and the introduction of more psychologist positions in the mental health work for adults and for children in municipalities. Developing appropriate models for professional collaboration between municipality employees who work on drug, alcohol and other intoxicant problems and municipality employees in the mental health work. Developing professional environments and networks across municipality boundaries and in fellowship with district psychiatry centres.
- Increasing the focus on developing assessment, treatment and follow-up provision in primary health services for children and young people with mental health difficulties, including strengthening professional environments within mental health work for children and young people, possibly across municipality boundaries and in cooperation with child and adolescent psychiatric outpatient departments. Developing methods for outreach work that improve encounters with children and young people in their arenas: at home, nursery schools/schools and during their spare time. Closer cooperation with families and teaching personnel vis-à-vis the follow-up of children and young people who have developed mental health difficulties.
- Cooperation between public health centres, school health services and outpatient departments for child and adolescent psychiatry shall be improved with a view to the early identification of mental health problems and disorders in children and young people with a view to the early implementation of measures.
- People with serious mental health disorders shall receive comprehensive and cohesive assistance and follow-up through mutual, binding cooperation agreements between municipalities and health enterprises. It is important that suitable housing with adequate assistance from the municipalities can be provided.
- The focus on mental health shall be incorporated in the new Norwegian Labour and Welfare Organisation (NAV) through, among other things, the Strategy for Work and Mental Health. It will be important to develop permanent cooperative structures between the professional fields of mental health work, specialist health services and NAV.

- Improving the knowledge base for mental health work in municipalities through the establishment of a competence centre for mental health work. Developing statistics and documentation for municipalities' future mental health work.

People with intellectual disabilities

After the withdrawing of special health protection for people with intellectual disabilities, the needs of people with intellectual disabilities for services have been addressed by the ordinary services in municipalities. There has been a substantial increase in the recruitment of auxiliary nurses working with people with intellectual disabilities in the municipalities after education capacity was increased in the last half of the 1990s. Nonetheless, it would appear that services for people with intellectual disabilities are to a large extent still provided by many people without university college qualifications or without formal education. Auxiliary nurses who work in the field often have to carry out the development of the professional knowledge base work alone; this can result in auxiliary nurses working with people with intellectual disabilities to transfer to more attractive professional environments.

The 2005 supervision report from the Norwegian Board of Health calls for a stable personnel situation and good professional competence. The experiences from the supervision show that municipalities are not adequately ensuring that other solutions are tried before force is used. Municipalities often seek dispensation from the competence requirements in chapter 4A of the Act relating to Social Services because the services do not possess the correct or adequate competence.

Further follow-up

The quality of care services for the intellectually disabled will be followed up through the means the government describes in White paper St.meld.nr. 25 (2005-2006) *Mestring, muligheter og mening* (Long term care - future challenges – Care plan 2015).

Challenges faced by future care

The Ministry of Health and Care Services and the Directorate for Health and Social Affairs will also ensure specific follow-up of the provision for people with intellectual disabilities through:

- evaluating practices vis-à-vis the provisions of the Act relating to Social Services vis-à-vis limiting the use of force with respect to people with intellectual disabilities
- the development programme: Aging and the Intellectually Disabled
- developing the national professional environment within the field of intellectual disability, which was established in 2006
- special R&D initiatives

The Directorate for Health and Social Affairs is working on a summary of the knowledge about health and social services for people with intellectual disabilities. The Ministry will in cooperation with the directorate assess any need for more knowledge and initiatives in the field.

Younger people with physical disabilities

This is a heterogeneous group both with respect to the type of disability and the degree of functional impairment. Nonetheless it is generally important that the health and social services be made accessible both with respect to transport, building access, communication and information. Many people need modified housing. The planning of such housing should take place in good time such that it can form an important part of comprehensive habilitation and rehabilitation, and can also lay a good foundation for participation in society and work where this is possible.

For some people with impaired functional abilities a good solution can be to organise practical assistance pursuant to the Act relating to Social Services as patient steered personal assistance. The patient is then himself or herself the supervisor of the assistant(s) and the person who organises the services. Good training and guidance is required in order for this arrangement to work. This applies to caseworkers, supervisors and assistants. For many people with impaired functional abilities such training and the transition to taking on responsibility of supervisor will be an important goal and means in a more comprehensive rehabilitation process. There should be a continuing focus on such training being developed and becoming a permanent service.

The Ministry wants to encourage municipalities to organise service provision in new ways and help to increase freedom of choice and patient influence, as well as greater similarity in how municipalities put the scheme into practice.

Dental health service – future development

Dental health services are organised as county council health services. Dental health services were evaluated in the Royal Commission NOU 2005:11 *Det offentlige engasjementet på tannhelsefeltet – Et godt tilbud til de som trenger det mest* (Public sector involvement in the field of dental health – a good service for those who need it most). This evaluation was universally circulated for comments with a deadline for the submission of comments of 1st November 2005. The Ministry received a total of 104 submissions. 88 contained remarks concerning the evaluation.

The committee is not in favour of the universal public funding of dental health services, but recommends that the public sector involvement be targeted at the groups who are regarded as having a special need for dental health services. In addition it suggests, among other things, strengthening public sector dental health services, regulating prices with maximum rates and introducing establishment control vis-à-vis dentists.

There is broad agreement among the consulted bodies concerning the committee's proposal to strengthen public sector dental health services and improve the interaction between the public and private sectors. These are factors that the government will also emphasise in its future work. Furthermore, the consulted bodies support the committee's proposal to simplify the regulations in the area of social security. The Norwegian Labour and Welfare Organisation has therefore been assigned the task of reviewing the relevant regulations with a view to their simplification.

There was a great deal of disagreement concerning the proposals that entail regulating the private dentist market, which accounts for almost ¾ of dental health services. This is especially true with respect to establishment control and the introduction of national pay rates. Work has therefore begun on a survey, in cooperation with Statistics Norway, the university and the Norwegian Dental Association, aimed at obtaining better information about price and cost levels in this sector.

Further follow-up

Based on the evaluation and the responses to the consultation process, the government has decided that the reform work shall not include the universal public sector funding of dental health services for the entire population at this time. The public sector's involvement shall continue to be targeted at those groups that are regarded as having a special need for dental health services, either through publicly organised services and/or reimbursements from the National Insurance Scheme. For many of these groups, good dental health provision requires close cooperation between dental health services and municipal care services.

The government will present a white paper on dental health services to the Storting in 2007.

6.3.3 The specialist health services

The specialist health services shall provide diagnosis, treatment and follow-up of patients with acute, serious and chronic diseases and health disorders. The services shall also provide guidance to patients and municipal health personnel, and carry out training and medical research. The specialist health services carry out the tasks in the health service that require competence and resources beyond those the municipal health services have at their disposal. The specialist health services include general and psychiatric hospitals, outpatient clinics/departments and treatment centres, training and rehabilitation institutions, institutions for interdisciplinary specialised treatment for drug, alcohol and other intoxicant abuse, pre-hospital services, specialists in private practice, and laboratory and x-ray units. The public sector specialist health services are organised as 32 health enterprises in five health regions.

The regional health authorities have experienced a real growth in funding (corrected for new tasks) of an average of NOK 1 300 million or 1.6% per annum from 2002 to 2006. In real terms the costs for the specialist health services increased by 5.1% per annum during the period 1997 to 2001. In the period 2002 to 2004 this growth in costs has fallen off to 3.2% per annum; in line with the general economic growth. Costs have increased more rapidly in Norway that in comparable countries since 1995, in 2005 health care spending accounted for 10% of the gross national product. This has largely been a deliberate development aimed at increasing activity, reducing waiting lists, and increasing provision within mental health services.

Since 1990, the number of health personnel in specialist health services has increased strongly and is now at 93,000 man-years. The number of physicians increased by 80% in

the period 1990-2004 and more than 10,000 physicians now work in the specialist health services, the number of nurses increased by 60% to 31,000 in the same period. These figures amount to around 65% of the country's physicians and 50% of nurses.

In 2005, there were 4.8 million outpatient consultations and just over 6 million inpatient days in Norwegian hospitals. The number of provided treatments increased strongly during the period 2002-2005. The greatest increase was seen in outpatient treatments. From 2002-2005, the number of inpatient stays in somatic institutions increased by 9%, while the number of outpatient treatments increased by around 42%. Mental health services saw an increase of 82% from 1998-2005 in the number of outpatient consultations for adults, in the case of children and young people the number of treated patients increased by 110% during the same period.

The increase in activity has resulted in reduced waiting times. During the first tertiary of the year 2006 the average waiting time was 68 days versus 96 days in 2001 which corresponds to a reduction of almost 30%. The number of patients having to wait more than 1 year has in the same period been reduced from 47 000 to 4 500.

In international comparisons, the Norwegian specialist health services are considered to be among the best in the world. In 2004, the World Health Organisation (WHO) conducted a review of the health systems in many countries and ranked Norway third. In Norwegian surveys, 4/5 patients who have received general treatment and 2/3 patients who have received mental health services say they are satisfied with the services they have received.

Specialist health services are now contributing to better results and greater health benefits than before. A child born in Norway today can expect to live nine years longer than a child born in 1960. We have made major breakthroughs in the prevention and treatment of heart disease, cancer, strokes and premature birth. New medicines and modern, less invasive surgery are resulting in faster and less painful treatment and rehabilitation. We can operate and treat far more disorders now than before for both senior citizens and people with chronic diseases.

Emergency medical provision has been improved. The ambulance service has got personnel with better training and equipment, the ambulances are operated by crews of two, and new communications technology makes it possible for specialists in the hospitals to start treatment before patients arrive at a hospital. The use of air ambulances has doubled in the last ten years. A major new improvement will take place with the introduction of the new digital emergency network in Norway.

Organisation and governance

The state ownership and the enterprise structure of the specialist health services are based on a combination of national policy formulation, political governance and delegating of authority to hospitals. The enterprise model shall be continued and will remain the foundation for the organisation and governance of Norwegian specialist health services. Further development and appropriate modifications will take place within the enterprise

model. The model shall be developed further such that specialist health services are politically governed, professionally managed, and characterised by transparency and participation.

The health enterprise model in general
The background for the hospital reform, with the state assuming ownership and the restructuring of specialist health services into enterprises from and including 2002, included organisational, managerial and coordination related challenges. The reform was firmly anchored in the core values of the welfare state with the aim of both producing good and equal specialist health services for the general public and achieving a better utilisation of resources. It involved the comprehensive reform of both structures and responsibilities with a clear allocation of responsibilities and roles which allows continued political governance while simultaneously providing a better basis for the service providers' autonomy.

The model is based on a combination of political governance, to ensure that provision develops in line with national health policy and within the given resource limits, and the simultaneous delegation of relatively wide-ranging autonomy to the health enterprises. The Ministry's governance is addressed through the communication of general health policy orders, funding means, and ownership governance. The annual mission statements for the regional health authorities communicate the health policy guidelines, grants, and conditions for receiving funding. The financial and organisational governance requirements and framework conditions for the regional health authorities are set through the ministry's owner position (eierstyringen). The enterprises' activities are otherwise subject to the legislative guidelines (act, regulations, etc) and other applicable legal framework. During the health plan period, the National Health Plan for Norway shall be followed up, including the planning and reporting by the regional health authorities, in the annual national budgets.

Management at all levels have a comprehensive responsibility to ensure that the activities and results concur within the official regulations, including the requirement concerning justifiability (forsvarlighet). Managers are also responsible for ensuring that the professional work is performed according to the goals and limits stipulated by the authorities and the hospital owners. Managers are responsible for the professional content, quality and distribution of services and the financial results.

The five regional health authorities and local health enterprises have all been established as independent legal entities with their own boards. The boards have a comprehensive, overall responsibility as control, strategic and decision-making bodies. The enterprise model has not been a static structure. It has over a relatively short period of time undergone development in several areas. The appointment of politicians to the enterprises' boards and the opening of board meetings are examples of this. A majority of the owner appointed board members have been appointed from among proposed candidates at a county and municipality level after a round of nominations among the country's county councils and the Sámi Parliament. The boards' gender compositions

comply with applicable requirements. Similar changes have taken place in the local health enterprise boards.

Funding
Specialist health services are funded through both block grants and activity based grants. The funding system is not a goal in itself, but rather a means of supporting the health policy goals. The funding system shall support the regional health authorities' comprehensive responsibilities. Therefore as a rule the regional health authorities are the recipients of the government grants for specialist health services. Within the responsibilities the regional health authorities have to address that they have a large amount of freedom to design income models and contracts with the enterprises that carry out the work.

The block grants to the five regional health authorities are distributed according to historical factors and the income distribution system that started in 2005 cf. White paper St.meld.nr 5 (2003-2004) and Recommendation Innst.S.nr 82 (2003-2004). In general the restructuring involves Western Norway Regional Health Authority and Central Norway Regional Health Authority receiving a larger proportion of block grants, while the three other regional health authorities will receive reduced proportions. In the government's proposed national budget for 2007 the transition period for the redistribution will be concluded in 2007. A committee will be appointed to assess the current system for income distribution between the regional health authorities.

The Diagnosis Related Groups (DRG) system's classification of patients according to their diagnoses and treatment measures does not accord with the prioritisation regulations' requirements concerning seriousness, expected benefit of treatment and the effect of treatment in relation to costs. The confidence in and legitimacy of the funding system however depends on there not being any direct inconsistencies between financial considerations and the rules and regulations for prioritisation. Activity-based funding is an average value system, which in some cases means that there will be deviations between the actual utilisation of resources and the activity-based funding refunds. The goal to get an up dated activity-based funding system may conflict with the need for stable and predictable framework conditions for the regional health authorities and the hospitals.

New medical methods affect how treatment is given and thus also the cost levels and relative cost ratios between various forms of treatment and patient groups. Changes in relative cost ratios are set by updating and maintenance of the system of codes, classification systems and cost weightings. An increase in the general costs level is set by the unit price, which is adjusted upwards annually. Activity-based funding does not regulate the introduction of new methods, but rather is intended to absorb new methods at an ongoing process through the updating of the system of codes, classification systems and cost weightings.

In line with St.meld nr 5 (2003-2004) *Inntektssystem for spesialisthelsetjenesten* (Income system for specialist health services) the Ministry will include the funding of somatic

activities in public sector outpatient clinics (today funded by a fee for service system) to the activity-based funded DRG-system. Work is also being done on developing the system of codes and patient classification system for mental health services, rehabilitation, habilitation and interdisciplinary treatment for substance abuse. This will make it easier to compare hospitals' patient groups, activities and use of resources. The development of code and classification systems is vital in order to achieve good governance systems regardless of whether these are subsequently used as a funding system.

Evaluation of the enterprise structure

At the end of 2006 a threefold evaluation will be concluded aimed at illuminating and evaluating the effects, suitability and results of the hospital reform. The evaluation report that assesses the model's suitability (Agenda & Muusmann, December 2005) states, among other things: "It is a clear assessment that the hospital reform and introduction of health enterprises at a regional level – and the establishment of health enterprises as a framework for the public part of the provision system – has been of benefit to Norwegian specialist health services and their development." At the same time, the evaluation highlights several areas in which it is recommended that changes or modifications be made, for example:

- better interaction between municipal health services and specialist health services and within specialist health services – with a view to what is best for the patients
- measures that can ensure better national political cooperation
- measures that can ensure better regional political cooperation
- inadequate focus and knowledge vis-à-vis prioritisations between main areas
- clarification of roles vis-à-vis the Ministry of Health and Care Services, the Directorate for Health and Social Affairs and the regional health authorities

The evaluation of the results, which is being conducted under the auspices of the Research Council of Norway, will be finalised at the end of 2006/beginning of 2007. This evaluation has not come far enough for the main results to be presented here.

In 2007, the Ministry will come back with a total presentation of the evaluations. The evaluation results will be used actively as part of the development work in the coming four-year period.

Key challenges

Sustainability

The types of disease change over time. Death and disability resulting from heart disease have been reduced, while the incidence rates for cancer, type 2 diabetes, excess weight that is harmful to health, COPD, and mental health disorders are increasing. WHO forecasts that by 2020 the most important cause of health problems after cardiovascular diseases will be mental health disorders. An increasing number of people with cancer and chronic diseases are living with their diseases for many years and are learning to cope with their disease(s). There will be an increasing proportion of very old patients in the specialist health services. Many senior citizens and people with chronic disorders need

long-term help – from a health service that has to cooperate far better in order for the patient to receive comprehensive and reliable health provision. An action plan is being drawn up to strengthen the specialist health services for senior citizens. This will focus on the following six areas:

- the patients' coping of their disease and functional impairment
- preventive and health promoting measures in connection with hospital stays
- provision in hospitals, including good interaction initiatives with municipalities
- the recruitment of key personnel
- increased interdisciplinary competence and improved research into senior citizens' health and provision
- a review of the funding systems to ensure these are suitable for good clinical practice

Besides changes in diseases and more senior citizens, increased patient mobility between health regions and between countries in the EU/EEA area might challenge the health service's organisation and financial models. The Norwegian model is based on joint solutions and solidarity, including funding. The model's long-term sustainability with respect to trends characterised by individual solutions instead of solidarity, and mobility instead of national solutions will, among other things, depend on healthy financial management and financial balance within the framework stipulated by democratically elected bodies.

New treatment methods, technologies and specialisation

New treatment methods, advanced electronic equipment, and new, expensive medicines are continuously being developed. In Norway we want to be at the forefront and offer the best new treatments, once their effect has been documented as efficacious and reasonable in relation to costs. Much of what patients want access to can still be untested or alternative treatments that not have yet been documented as being effective. In an open international health market, individuals can track down treatment offers that may appear more advanced or different to what is provided in Norway and which patients want to have paid for by the Norwegian health service. Achieving the correct balance between the treatment the patient wants and what is medically justifiable and sensible from a socio-economic perspective is an increasing dilemma. The Ministry wants to establish a system that results in a better dialogue and greater acceptance vis-à-vis decisions to introduce new medical technology, cf. discussion in chapter 6.4.1.

More advanced treatments can result in specialisation in the medical fields that are necessary to ensure good quality, but this specialisation can at the same time have the effect of developing the service in a more fracturing and centralising manner. In the future training of health personnel, there will be a need to encourage the development of training courses that result in wide-ranging professional competence such that the most common diseases and health problems can be dealt with safely at local hospitals and through other decentralised health service provision, cf. discussion in chapter 6.4.2.

Equality of access

Good access to equal health services is a fundamental tenet. People should have equal access to services regardless of place of residence, income, gender, age and ethic

background. Achieving this requires a combination of means: well-developed services, low consultation fees, and financial protection schemes targeting those who need a lot of health services. Health legislation has acquired steadily greater importance as a means of ensuring equal services, good distribution and correct prioritisation. The patients have been given robust and extensive rights through the Patients Rights Act in which the right to an assessment and the right to the necessary health care are key rights. Nonetheless there are differences in the consumption of health services that cannot be explained by differences in sickliness. Social and geographical differences in access to health services may contribute to sustaining social disparities in health. Specialist health services face a major challenge with respect to contributing to a reduction in social disparities in health.

Quality and patient safety

Norwegian health services generally achieve a level of high quality. Nonetheless, information comes to light in many countries – including in Norway – about mistakes, deficiencies and variations in quality. Patients have a right to safe services. Specialist health services must develop even better quality development and management systems. The services must also be able to document how mistakes are handled in order to prevent future accidents, cf. discussion in chapter 6.4.1.

The specialist health services shall be developed in close consultation with other parts of the health service. The specialist health services will thus be integrated into the development measures discussed in chapter 6.4 concerning general strategic areas such as quality, patient safety and prioritisation, personnel and competence, research, pre-hospital services, etc.

National government and coordination

The enterprise model has established the conditions for better resource utilisation, opportunities to equalise inappropriate differences – and national control in some areas. In order to realise more of the reform's intentions, the Ministry will place more emphasis on interregional national government and coordination in selected areas. In those cases where the government stands in the direct line of ownership vis-à-vis the specialist health services' activities, there is a basis for direct administrative follow-up aimed at taking advantage of this potential to develop uniform and equal provision. The Ministry is preparing to increase its alertness with respect to the principal of equal provision. As part of the government dialogue concerning the National Health Plan for Norway a thorough analysis will be conducted of the factors associated with equal health services, including which national measures have to be introduced.

Regional health authorities have substantial of autonomy regarding which strategies and solutions they choose – and shall continue to do so. However, an equally important aspect of the model is that this shall take place within nationally established goals and long-term limits. During the coming period there will be a stronger focus on identifying and following up areas with the potential for interregional harmonisation and joint solutions. The focus will especially be on stronger national government and coordination in the areas of investment and ICT (Information and communication technology). The development of rational specialist health services also means that this may also be a good

idea for administrative and support functions that do not impinge on the enterprises' core activities. The Ministry will give emphasize to preserving the main features of the enterprise model's decentralised decision-making structure, but believes that clearer national limits will result in a better basis for the administration of the decentralised responsibilities. After all, one of the main aims of the enterprise structure was to maintain decentralised provision and decentralise authority and responsibility for the activities.

Framework conditions for the health enterprises' management of capital (buildings and equipment) and personnel

Personnel, buildings and equipment constitute the key input factors in the specialist health services. The specialist health services accounts for around 93,000 man-years and these constitute the foundation of the provision. The competence, knowledge and experience of the employees constitute the basis of the provision's value creation. The purpose of the health service is in every way served by its personnel's perceptions of prestige and work satisfaction. Through its 2005 "Good shift!" (God vakt!) campaign, the Norwegian Labour Inspection Authority uncovered deficiencies in the systematic HSE work carried out in the health enterprises. Health, safety and the environment are not being adequately followed up in the day-to-day work of the hospitals, and sufficient attention is not being paid to the reasons why working environments become strained. Health, safety and environment work must therefore be afforded status and priority, and attention must be paid to finding out which conditions are causing working environments to become strained. It is vital that work have good medical content in order to motivate people. Skilful management and a better understanding of competence development are therefore important. Personnel and competence are discussed in chapter 6.4.2.

Buildings and equipment

Buildings and equipment are an important foundation for good health provision. Investments in new buildings and new equipment, and maintaining existing buildings such that they maintain their standard, provide opportunities to maintain and develop services. This applies to all parts of the health service. Building hospitals involves making investments that make great demands on society's resources and place constraints on health provision for the general public for many decades ahead. The enterprise reform involves a substantial restructuring of the system in that the costs of capital expenditure are included in operating budgets and operating accounts.

Regional health authorities have the authority to take decisions concerning the evaluation and initiation of investment projects, as well as responsibility for ensuring that the projects are carried out in accordance with the reasons why the decision was taken – and within the limits of the region. On the one hand this has resulted in better coordination and distribution of tasks between the health enterprises in the individual regions, while on the other it may appear that there is too little interregional coordination, with the accompanying risk that this may result in overcapacity and the development of parallel provision in some areas.

The issue within the area of investment will be how one can improve national coordination of the investments being planned.

Development traits up to 2002

The period from 1990 until the time of the reform was characterised by a relatively low level of investment in specialist health services by the county councils. The only large hospital that was built was the new Rikshospitalet, which was completed in 2000. This is a state-owned hospital and the new building was directly funded through the national budget. Some hospitals were expanded in smaller phases, e.g. the hospitals in Arendal and Tønsberg.

In the last half of the 1990s, investment funds were earmarked for the county councils through the Escalation Plan for Mental Health (1999-2008), the Equipment Plan (1998-2002), and the National Strategic Plan for Cancer (1999-2003). The fact that there was a need for such investment plans may indicate that the level of county council investment in the specialist health services had been low. However, county council plans for hospital expansions were not lacking.

Development traits after the hospital reform (2002 – present)

An analysis of current and planned investment projects at the start of the reform showed a total investment volume of almost NOK 50 000 million, cf. White paper St.meld.nr 59 (2001-2002). The Storting has assumed the implementation of the new Akershus University Hospital, New St Olav's Hospital and the research building at the Radiumhospitalet. The Storting has also decided that the regional health authorities shall complete the investment projects in the National Strategic Plan for Cancer and the Escalation Plan for Mental Health. These projects correspond to an investment/liquidity need of around NOK 27 000 million.

The period after 2002 has thus been characterised by a high level of investment activity in the specialist health services, as the table below shows:

Table 6.1 Annual investments in buildings, technical medical equipment and other equipment

	2002	2003	2004	2005	Total
Total	3 191	5 735	7 164	7 469	23 559

Source: BUS. Million NOK. Current prices 2002–2005.

During the course of 2006, more than NOK 30 000 million will have been invested since the reform came into effect.

National management in the area of investment

In this national budget the government is putting in place the framework conditions for the health enterprises' management of real capital (buildings and equipment) by announcing an increase in the funding until 2010 totalling NOK 1 000 million. This corresponds to, seen on its own, the health enterprises being able to reacquire around 80% of the real capital they took over in 2002, this makes high expectations for the health enterprises vis-à-vis being able to increase the efficiency of existing buildings, however the scope of the investment and the scope of the current plans also necessitate the increased use of national coordination measures.

The Ministry will ensure that clear processes will be carried out that ensure the Ministry, government and Storting can draw up general limits for the investment activity and also general limits for the individual regional health authorities. Such central administration will result in a higher level of certainty that the investment measures are well coordinated nationally, such that capacity is not expanded beyond total national needs. This does not mean that a general system with central approval of individual projects is being planned. Emphasis shall be placed on the individual regional health authorities having the flexibility to carry out investment projects within their total financial constraints.

One shall seek to embed the political administration in processes in which the enterprises, municipalities, county councils, patients' organisations and professional organisations are given an opportunity to participate. At the same time it is important that the interregional national management and coordination takes place in forms that correspond with the governance model for the specialist health services.

The Ministry will emphasise that the analyses of investment needs shall be evaluated in connection with the review of the specialist health services' capacity needs and structural analyses. The regional health authorities have through the letter of instructions (oppdragsdokumentet/ bestillerdokumentet) for 2006 been assigned the task of undertaking a capacity analysis. Preliminary feedback from the regional health authorities indicates that overall there are no capacity problems (in the sense of available space), but there are major challenges associated with maintenance investments and that the current hospital structure is nearly optimal. Nor do forecasts of the need for space based on population and disease trends, technological developments and the development of forms of treatment indicate that there will be an overall need for space in the years ahead. This does however require far better utilisation of the space and equipment than today, e.g. expanded opening times and more rational patient pathways.

The regional health authorities also point out that the provision must be developed as a well-functioning, cohesive system in which the tasks are appropriately distributed and the capacities within the various parts are well-balanced and utilised. The Ministry will come back to this in the follow-up of the National Health Plan for Norway.

The regional health authorities have a comprehensive responsibility for investments and operations in their own regions. This means that they shall evaluate and be responsible for ensuring that investment projects are carried out in accordance with the reasons why decisions were taken and within the constraints of the region's total resources.

The management system for investments is based on a combination of the fact that the enterprises have been given extensive autonomy in the area of investments, at the same time the follow-up and management of investments must take place at a general level such that investments are made in accordance with the general health policy goals and within accepted resource constraints. In the case of major investments projects it is important to avoid extensive processes and planning work being initiated which will later prove to be unrealistic or undesirable to implement for financial or medical reasons. All

planning at a health enterprise level shall therefore be embedded in a general strategic investment plan at a regional level.

In the case of projects that exceed NOK 1 000 million, the results and the regional health enterprise's evaluations after the end of the concept phase shall be submitted to the Ministry. Key elements of these evaluations will include:

- relevant project ideas being quickly assessed against realistic financial constraints and the projects' total finances being evaluated in relation to the region's financial capacity
- projects one decides to continue having to be incorporated into the general plans and budgets in order to, in this way, confirm that projects are assessed and prioritised within comprehensive professional and financial constraints
- all projects having to be subjected to satisfactory quality assurance and management with special requirements for major projects with cost limits that exceed NOK 500 million
- the project supporting general future capacity and rational national solution goals

The following improvement measures are suggested during the health plan period:

- development and improvement of the common data set and the methodology used to document and describe activity and capacity
- developing better methods for forecasting needs and developing models that link data concerning needs, capacity and space that makes it possible to calculate the consequences of expected changes in needs and technology
- developing corresponding models for the calculation of business-economic and socio-economic consequences
- common and uniform descriptions of functions and resources (rooms, space, etc) that make it possible to calculate the efficiency of the space and capacity utilisation, and compare these across health enterprises and regional health authorities

Better coordination of national governance vis-à-vis regional health authorities

The Ministry will emphasise clear corporate governance vis-à-vis the regional health authorities. Furthermore the health enterprises will be evaluated in relation to the stipulated governance requirements; this will also require a need for uniform management information.

From and including 2006, the Directorate for Health and Social Affairs will prepare an annual report that provides a presentation and evaluation of the health service's situation (monitoring report). This report shall provide the Ministry with a basis for evaluating measures of a management-related nature and are a supplement to the information and contributions the Ministry obtains through its direct governance dialogue with the regional health authorities. In some areas it is useful that the regional health authorities present general viewpoints to the directorate and Ministry. Examples of these are the requirements that regional health authorities conduct a capacity analysis and draw up a comprehensive plan for the future organisation of highly specialised services, these will provide a better basis for the Ministry's governance.

A clear dividing line shall be developed between directorate functions that are of an authority exercising nature and measures that are of a management or advisory nature. Chapter 6.4 discusses the system for ensuring that in the future there is a clear dividing line between professional guidelines and measures that are advisory in nature. In this work the Directorate for Health and Social Affairs will emphasise tempo and processes that include the participation of relevant clinical environments in order to ensure the necessary embedding.

Roles and management models in regional health authorities

Regional health authorities have an opportunity to have a managerially close relationship with their subordinate health enterprises. It is precisely the enterprises' autonomy with respect to the management and administration of their own resources that was one of the motives for the reform, and a central management challenge for the regional health authorities has been – and is – to balance and reconcile the regional management and coordination needs with the individual health enterprise's independence. The greatest challenge in the future lies precisely in the management relationship between regional health authorities and health enterprises.

One key organisational challenge for regional health authorities has been the importance of managing the roles of both ensuring provision is provided and being the owner of the health enterprises in an orderly manner. A requirement was stipulated from and including 2005 concerning the establishment of greater organisational differentiation between the roles assigned to the regional health authorities. At the same time, it is precisely this combination of roles that is considered to be a core property of the integrated enterprise model, which enables comprehensive management and a regional perspective vis-à-vis the overall provision.

The regional health authorities have chosen slightly different management models for their subordinate health enterprises. One problem has been to do with the extent to which managers in the regional health authorities can participate in the boards of subordinate health enterprises – which was a widespread practice in the first years after the reform. In 2005, limitations were stipulated concerning how this can be done. The issue was last brought up in enterprise meetings in January 2006 in which it was stipulated that employees who directly ensure the provision of health services couldn't participate in the boards of health enterprises. During the health plan period the Ministry will base its work on no further changes or restrictions being introduced into the regional health authorities' management models in this area. This means that it will still be possible for regional health authorities to have so-called internal board members, assuming that this is done in accordance with the applicable requirements.

It is in the health enterprises that the services are carried out and costs arise. In order for the health enterprises to be able to carry out skilful management and the other follow-up of the requirements stipulated in the enterprise meetings and statements in the letter of instructions (oppdragsdokumentet/ bestillerdokumentet), they have to establish workable general monitoring systems vis-à-vis subordinate health enterprises.

Conducting professional audits of their health enterprises could be an important means for the regional health authorities of achieving the specialist health services' general goals of good, equal health provision. In the Ministry's opinion it is possible to conduct such professional audits without contravening the regulations concerning confidentiality. The Ministry will however consider whether or not there is a need to establish a clearer legal framework that provides regional health authorities with access to confidential information in connection with quality work and internal audits, and present any necessary proposals.

In the coming period more attention will be paid to systematic improvement work with respect to management, internal organisation and coordination within the health enterprises. Pilot hospitals (Modellsykehus) will be developed by using available knowledge about what ensures good operational systems, including skilful management, and in which the focus will be on achieving good interaction in particular. Work will be done to come up with pilot projects in which understanding, embedding and obligations are created vis-à-vis new forms of operation and skilful management.

Staff initiated restructuring

Employees at all levels possess invaluable knowledge about how the health service works. The Ministry has pointed this out in mission statements (letter of instructions) and at the enterprise meetings. There are many examples of good results resulting from this competence being drawn more actively into the restructuring and renewal work. This is not just about using resources more efficiently; it is also about how patients can be met better and experience higher quality services. The Ministry will work to ensure that good models for cooperation with the employees and their organisations are developed.

Transparency, trust and legitimacy

During this period of reform, both the Ministry and the health enterprises have paid attention to the need for trust and legitimacy, and transparency vis-à-vis the enterprises' activities. The enterprises administer critically important welfare tasks of great importance and interest to both the general public and the public sector. The public profiles of the enterprises have developed positively and a number of transparency measures and contact points have been established. However, there is still reason to note that this is an important area with a continuing need for alertness and systematic efforts during the health plan period. The Ministry of Health and Care Services would especially like to highlight the importance of skilful management and cooperation with various interested parties, including contact with local and regional democratically elected bodies. Emphasis will be placed on systemising the work on cooperation agreements between health enterprises and municipalities. Equally important is the systematic work on transparency and publishing information about the enterprises' activities, including the boards' work and ongoing processes.

Development of the position of patients/patient organisations in health enterprises

Pursuant to health legislation patients are entitled to participate and to information, including when it comes to choosing forms of treatment. However, patient participation should take place at all levels: through participation in the shaping of policy, influence at a system level, and participation at an individual level. The organisation of the health enterprises has systematised and improved the position of patients in relation to the specialist health services. The Ministry has through its guideline requirements ordered that health enterprises and regional health authorities establish patient committees, and guidelines have been drawn up concerning the role the committees shall play in the enterprises' work. Some enterprises have also chosen to grant observer status on their boards to patient organisations NGOs. A central contact forum has been established for cooperation between the Ministry of Health and Care Services and the patient organisations NGOs. The Ministry assumes that this use of patient committees and cooperation bodies will form the foundation for cooperation during the health plan period, and that there will be a greater focus on producing results from these forms of patient participation. The emphasis will be on the Ministry, patient organisations , and health enterprises reviewing experiences with a view to identifying weaknesses and implementing improvement measures.

The participation of private agents in public health policy

The overall provision in the specialist health services is generally provided by the public sector. Almost 96% of all assessments and treatments that trigger activity-based funding refunds are carried out under the auspices of the public sector. Contracted specialists meanwhile constitute an essential and important part of the specialist health services. Together the specialist physicians with practice contracts account for 17% of total national outpatient activities and 9% of all specialist health services.

Private, contracted specialists are a valuable resource in the specialist health services. The general goal is that specialists with practice contracts with regional health authorities (private, contracted specialist) shall help to fulfil the responsibility to ensure that provision is provided. These must also be organised in such a way that they can be better integrated with a view to achieving a good distribution of tasks in relation to other specialist health services. Few new contract practice licences are being established. It may appear as though the current framework conditions do not provide sufficient incentive to establish new contract practice licences and advertise expired practice licences. The Ministry will initiate a project aimed at changing the framework conditions in order to achieve better interaction vis-à-vis contracted specialists in the health enterprises' responsibility to ensure provision is provided and to continue the private contracted specialist physicians' scheme. The regional health authorities, the Directorate for Health and Social Affairs and the professional associations will be drawn into this work. The work could touch on the legal interests associated with established contractual relationships. The Ministry will consider implementing a corresponding review of funding and contract schemes for other private agents. The aim must be to consider the extent to which the current system supports good, professional, comprehensive provision.

The need for specialist health services shall primarily be met through good utilisation of the public sector provision. Spare capacity in the enterprises shall be utilised as well as

possible, among other things through good distribution of the work in and between hospitals. Private agents are an important supplement to the public health service and shall continue to contribute to the total provision. The following factors will play a key role in the Ministry's work during the health plan period:

- hospitals and health institutions owned and run by non-governmental organisations shall be ensured good, stable framework conditions in their contracts with the public sector – cooperation and the signing of contracts between regional health authorities and other private service providers shall also be managed in a organised and orderly manner
- one will aim to amend the regulations concerning public procurements in order to permit the procurement of specialist health services from private commercial rehabilitation institutions as well, without having to comply with the detailed requirements in the regulations. The applicable legal requirements regarding transparency, equal treatment and competition will still apply
- pursuant to the Soria Moria Declaration it is assumed that the scope of contracts between regional health authorities and private commercial hospitals will be limited
- the Ministry will initiate a project aimed at changing the framework conditions in order to achieve better interaction of contracted specialists into the regional health authorities' fulfilment of their responsibility to ensure that provision is provided and to continue the private, contracted specialists scheme

Comprehensive treatment provision in specialist health services

A comprehensive hospital structure with tasks and functions appropriately distributed between hospitals, supplemented by rural medical centres/wards, rural psychiatric centres and contracted specialists shall provide patients with comprehensive specialist health services. The hospitals shall deliver generally good quality services in accordance with documented medical practice. University hospitals perform special tasks within research and highly specialised treatment.

The Ministry wants to improve the governance of highly specialised services and has asked the regional health authorities to draw up proposals concerning a comprehensive plan for the future organisation of this area. The plan must be dynamic and take as its starting point the fact that the provision is constantly changing due to developments in the fields of medicine and medical technology, changes in patient volumes, and skills upgrading. The Directorate for Health and Social Affairs will review the material and provide its recommendations before the Ministry makes its decision.

Ante/post-natal services

The quality of ante/post-natal provision is key to the confidence women experience in one of life's most vulnerable situations, and it is vital with respect to giving a child a good start in life. Proximity to ante/post-natal provision shall be assured. A decentralised model for ante/post-natal provision has been adopted in Norway. When considering St.meld.nr. 43 (1999-2000) *Om akuttmedisinsk beredskap* (About Emergency Medical Preparedness), the Storting adopted decentralised and differentiated ante/post-natal provision, with criteria concerning delivery rooms, maternity wards and women's clinics.

As part of the development of ante/post-natal provision one now differentiates between normal and complicated pregnancies and births. The ante/post-natal provision for low risk births/delivery rooms should be accessible, decentralised at most local hospitals and be part of the local hospital functions at the larger hospitals. In addition to this there should be delivery rooms located outside hospitals in those areas with large distances. Continuity and safety for the women are characteristic of high quality ante/post-natal provision, therefore the emphasis must be cohesive ante/post-natal provision. An important part of the future development of good ante/post-natal provision will therefore be to develop this comprehensiveness in cooperation with the municipal health services.

Emergency functions

Access to emergency functions is fundamental to the safety of the general public. People shall know that help is at hand when emergency injuries occur or illnesses arise. The emergency functions of local hospitals must be seen in the context of the other parts of the emergency medical chain and it is the comprehensiveness of the entire treatment chain that is decisive for good content-related provision. The emergency medical chain includes the emergency telephone service, municipal health services' casualty clinics, the ambulance services (air, land and sea) and also the emergency preparedness at hospitals. The pre-hospital services shall bring patients to the correct treatment centres based on their condition and assumed diagnosis. This will very often be the nearest hospital, but the allocation of tasks and differences in competence profiles between hospitals in the enterprise's area or across enterprise areas, and the need for specialised competence for different illness and injury cases will also dictate direct transport to other hospitals. In the event of rare emergency surgical conditions especially, it is critically important to arrive at the correct treatment centre within a short space of time, and in these cases the airborne ambulance service will often be appropriate. In some cases which require advanced treatment involving several specialists, time may be lost if a patient is admitted to a hospital that cannot provide this, this dictates that the comprehensive emergency preparedness in many medical specialities should be stationed at larger more specialised hospitals. It is not always medically appropriate, and nor would it result in good medical quality, to have 24-hour emergency preparedness in many medical specialities at small hospitals.

There is a need for cohesive treatment chains in emergency medicine based on good professional practice in which the various links have specific tasks. There is a need to coordinate municipal health services' casualty clinics, pre-hospital preparedness and emergency preparedness at other hospitals. The development of good systems to ensure a good, comprehensive emergency service should be a central theme in the future.

Local hospitals in particular

Both the general public's need for health services and medical developments provide a good basis for developing vigorous local hospitals. Local hospitals and local hospital functions are characterised by the fact that they provide specialist health services to the general public in a specific catchments area. Local hospitals are thus different to, for example, specialist hospitals whose main task is to address niche functions for elective

activities within defined fields. Local hospitals shall be genuine hospitals that provide services based on the needs of the general public, and based on an allocation of tasks in which the local hospitals' provision is justifiable and good from a quality-related perspective. Most of the people admitted to hospitals can receive their treatment at a local hospital level. The plan is to maintain decentralised hospital provision. No local hospitals are going to be closed down. The work of improving the distribution of tasks between hospitals shall be continued.

The future development of local hospitals shall focus on patient services, in a wider perspective than the institutions/buildings, and should contain organisational models, forms of work and responsibilities that are adapted to the needs of the general public and current knowledge, technology and the competence of the personnel.

It is often suggested that there is a contrast between professional considerations and considerations concerning the efficient use of resources. In many cases this contrast does not exist and the challenge lies in taking advantage of the professional opportunities, including from a decentralisation perspective. It is important that local hospitals, with their proximity to the patients and municipal health services, represent a safety net for the general public. This is also true for the general public in the major cities who shall have local hospital services available to them when they need them.

Local hospitals' services
The specialist health services face a major challenge in the future with respect to providing patients with chronic diseases and sick senior citizens with compound disorders provision with good accessibility/capacity and of good quality. The local hospital services must be centred around the needs of the major groups of diseases, on patients who need close monitoring, and cases where the treatment requires a general approach and not marked specialist competence. These are tasks that together ensure the local hospitals are genuine hospitals. Moreover, the Ministry will follow up the National Health Plan for Norway with a project aimed at clarifying the tasks of local hospitals with respect to emergency functions and the overall treatment chain. The Ministry believes that it is important that central agents participate in the project and will invite representatives of the health enterprises, patients' organisations, affected municipalities, business and industry, and professional organisations to participate. The group's recommendations shall be made available early in 2007 in order to ensure the health enterprises' strategy processes move ahead.

The large hospitals should also focus more on local hospital functions. The organisation of the large hospitals to a large extent reflects the various medical specialities and these hospitals' highly specialised provision. The local hospital functions, which often account for the greatest volume of treatment, should to a greater degree be arranged so as to provide patients with comprehensive provision. The organisation and composition of the personnel in the local hospital services, both at large and small hospitals, should reflect the patients' need for a general and comprehensive approach. This is especially important for patient groups with compound conditions.

Local hospitals should also be able to offer patients assessments and diagnosis, and refer those who need more specialised examinations and treatment. Good methods for setting precise diagnoses, including clarifying whether or not patients should be referred, are key topics in this context cf. the chapters on quality, chapter 6.4.1, and the chapter on pre-hospital emergency services, chapter 6.4.8 as well.

Local hospitals – part of the treatment chain

A local hospital's services will form part of the comprehensive treatment chain. Many patients will need follow-up from both municipal health services and specialist health services. Many patients will also have a need for services at several levels in specialist health services, cf. cancer patients who have surgery at a specialist hospital, while the follow-up takes place at a local hospital/outpatient department.

Well-functioning interaction systems are important for modern, professional health provision, cf. chapter 6.3.4. Local hospital services will act as the specialist health services' link to the municipal health services and will together with the municipal health services be in charge of the practical interaction vis-à-vis patient groups and individual patients.

Seen from a patient's perspective, the proximity to the provision can be a very important dimension, especially for patients who are dependent on very close follow-up, e.g. dialysis patients or those with cancer in their final phase of life. This is the reason for decentralising local hospital services further to wards and rural medical centres, and also offering hospital services in patients' homes. For example, mobile teams were developed within services for sick senior citizens, for the mentally ill and for cancer patients. These types of decentralised services are examples of the fact that the boundaries between the treatments systems are suppressed to the benefit of a cohesive treatment chain in which the patients' needs are central.

In a comprehensive treatment chain, medical innovations will take place that will result in a need for changes to the distribution of tasks, both between levels within the specialist health services, and between the primary and specialist health services. These are reasons that dictate that one should not put in place a specific organisational model that determines the content of the treatment provision at all local hospitals. Instead room should be allowed for flexibility in the organisation and distribution of tasks between the various parts of the health service. The work on improving the distribution of work between the hospitals in order to improve the quality of the provision shall continue.

6.3.4 Comprehensiveness and interaction

The lack of interaction within and between municipal health and care services and specialist health services perhaps represents the greatest challenge the health service is facing, highlighted in the evaluation report from Agenda and Muusmann (*Belyse helseforetaksmodellens funksjonalitet – en evaluering av utvalgte sider ved helseforetaksmodellens virkemåte og effekter, begrensninger og potensialer*, November 2005. [Illuminate the functionality of the health enterprises model – an evaluation of

selected aspects of the health enterprises model's mode of operation and effects, limitations and potential,]) and is supported by patients, service providers and administrative bodies who have contributed to the National Health Plan for Norway. The Wisløff Committee (NOU 2005: 3 From Piecemeal to Complete – A Continuous Chain in the Health Service) points out that there are great differences in how interaction functions in different parts of the health service. The committee refers to several good examples of well-embedded interaction, and also to the fact that interaction is failing in a number of areas, both in individual cases and at systems level, reports from the Norwegian Board of Health confirm this situation.

Creating comprehensiveness and cohesion in the provision is an important health policy goal, especially for patient groups who need compound provision over a long period of time. In the National Strategy for Quality Improvement in Health and Social Services published by the Directorate for Health and Social Affairs in 2005, interaction is regarded as a fundamental prerequisite for quality in the health service.

In Request No. 528 of 16th June 2005 the Storting asked the government to present a report to the Storting concerning the interaction between municipal health services and specialist health services based on the goal that increased access to specialist health services in the case of large geographical distances to hospitals can help to equalise differences in access to specialist provision in the population. The National Health Plan for Norway shall follow this up by stipulating primary goals and guidelines aimed at creating comprehensiveness and cohesion in the provision for individual patients and patient groups. The challenges are associated with the fact that the number of people with long-term, compound disorders is increasing, that the health service is divided into several organisational levels, it consists of many medical specialities and has a large number of services providers with varying qualifications and methods of working. From a patient's perspective such division is successful only when the agents cooperate and the conditions are put in place for good interaction.

Another important challenge is that a steadily increasing number of people also need help from other services in connection with, for example, training, work and housing. All of the services must be professionally coordinated and be provided at the correct time. Cooperation with employers and strategies for facilitating work will therefore be important in securing comprehensive and coordinated provision for the individual.

In order to meet these challenges, the Ministry will pay special attention to measures that support better interaction in the health sector and between the health service and other sectors.

Status and challenges

A number of schemes have been established to support interaction across services and levels. Examples of these include cooperation agreements, cooperation forums, the physician practice consultation scheme, mobile teams, IT-based communication, and the systematic work on the general patient pathways. Chief administrative officers also have responsibilities with respect to interaction. Examples of organisational changes that can

promote interaction include developing local hospital functions, decentralising specialist health services, collocating municipal health and care services and specialist health services, common arenas for professional in related fields (geriatric outpatient clinics with psycho geriatricians, geriatricians, etc) and placement schemes. Statutory and regulatory schemes that can contribute to securing comprehensiveness and cohesion in the provision for the individual patient include, for example, regular general practitioners, physicians in charge of patients, patient journals with treatment plans, referrals and an epicrisis, as well as personalised plans for patients who need long-term, coordinated provision. Specific requirements are stipulated vis-à-vis planning and cooperation for patients who need rehabilitation and habilitation services. The Wisløff Committee stresses that the potential for interaction is not utilised well enough in several of these schemes.

Work and health

The goals of specialist health services and municipal health and social services coincide with those of the Norwegian Labour and Welfare Organisation (NAV) in some important areas for a large number of their patient groups. New opportunities afforded by the establishment of NAV must be taken advantage of to develop quality and more comprehensive provision in cooperation with the health and social services and NAV. The goal of getting more people into work and having fewer on (passive) benefits cannot be achieved without ongoing cooperation between NAV and the work that is carried out by employers and employees, the parties involved in employment, and other authorities. There will be a strong correlation between the responsibilities and tasks of municipal health social services, NAV and other agents in the areas of working environments, health/rehabilitation and training especially, and thus an extensive need for cooperation and coordination.

What can be done to improve comprehensiveness and interaction?

The breadth of the issue shows that there is no single measure that can be implemented to develop a comprehensive health service with good interaction. The Wisløff Committee believes that many of the interaction challenges will have to be resolved locally and in the providing service. The committee points out that in some places cooperation agreements have been signed between municipalities and enterprises and that systematic interaction procedures have been established for some patient groups. At the same time the committee stresses that development measures to improve interaction must be embedded in a overall organisational structure to ensure the necessary framework conditions and managerial embedding, this issue has been followed up by a working group that has looked at the organisational conditions for better interaction in more detail. The working group believes that one should focus on measures that are both rooted in the field of practice and that are of an overall organisational character. The idea is that the overall organisational measures should provide good framework conditions for interaction and thus contribute to a stronger overall effect of the individual measures that are close to practices. This will form the basis for the Ministry’s future work in this area.

During the health plan period the issue of interaction will be widely worked on. Interaction must be incorporated as a natural part of the services’ work and a culture must

be established in which interaction activities are valued and demanded. Equal partnership and mutual respect between the cooperating agents is vital to success. All elements in the big picture are important, as is the establishment and maintenance of a good culture of cooperation. Addressing this requires clear and deliberate management at all levels. In the same way as crisis teams in acute medicine draw up routines for interaction, exercises and evaluations, other parts of the service must develop activities on the basis of a corresponding understanding. In order to support this development there will also be a need for research into different ways of organising health services and interaction models through health service research, cf. chapter 6.4.3 concerning research. Moreover, the issues associated with interaction will form an essential part of the work on quality and prioritisation. Particular attention will be paid to this work through the National Health Plan for Norway, see, among other things, the discussion about a new national board for quality and prioritisation in chapter 6.4.1.

The Ministry will emphasise these strategies in the work on interaction:

Strategies closely associated with patients

As mentioned earlier, the potential for interaction is not being utilised well enough in several statutory and authority embedded initiatives such as, for example, physicians in charge of patients, interaction for patients who need habilitation and rehabilitation services, cooperation agreements between district psychiatry centres and municipalities, etc, the work on personalised plans (individuell plan) is of importance in this context.

A number of forums have been established in which interaction has a natural place. Regular general practitioners have been assigned an important gate keeping role in the overall health service and the local cooperation committees that have been established in 70% of municipalities are regarded as being a very suitable forum for dialogue and interaction between regular general practitioners and municipalities. At the same time the Research Council of Norway’s evaluation of the RGP scheme shows that there is potential for better interaction between regular general practitioners, the municipal care sector and specialist health services. This applies to, among others, older patients, people with a need for follow-up after treatment in the specialist health services and people with mental health disorders, cf. chapter 6.3.2 Municipal health and social services.

Ensuring that statutory measures and those adopted by the authorities are followed up is one of the responsibilities of managers at all levels, and individual managers are responsible for identifying areas where this is not done. Patients’ experiences will be key to improving practice here. The Ministry wants intensified follow-up of such measures. Please also refer to the work on expanding the patient advocate scheme and the new common Act relating to Municipal Health and Social Services, cf. chapter 6.3.2 Municipal health and social services.

As part of the work on improving interaction between municipal health and care services and specialist health services, the Ministry will follow-up with a view to ensuring that the level of professionalism vis-à-vis treatment in nursing homes is raised.

Treatment chains

Patient pathways or treatment chains are a way of seeing patients in a comprehensive patient pathway independent of service level. Even though there are major individual differences between patients, many patients' problems can be resolved in a relatively similar way, from a patient pathway perspective, in and between the individual units. This applies to both planned patient pathways and emergency patient pathways. This does not mean that patients receive the same treatment, rather that the organisation of the services for the individual may have common pathways.

One challenge when it comes to analysing patient pathways is the lack of base data. This makes it difficult to describe the entire treatment chain across administrative boundaries. A working group consisting of the Ministry of Health and Care Services, the Norwegian Association of Local and Regional Authorities and the Directorate for Health and Social Affairs have analysed the distribution of tasks between the municipal health and social services and the specialist health services (Analysis of the Distribution of Tasks Between the Municipal Health and Social Services and the Specialist Health Services, February 2006). The group points out that the base data will be strengthened by IPLOS (individual-based care statistics), but that this is not sufficient to meet the need to achieve comprehensive analyses of patient pathways. In the future work on IPLOS, the Ministry will assess the possibilities of undertaking such comparisons.

One consequence of utilising patient pathways in order to ensure patients receive comprehensive and cohesive health services is that the pathways can achieve a more important role as a structuring element in the design of the provision, while the division into wards, clinics, institutions, etc, may end up as somewhat less significant. In other words, more attention will be paid to how the services can put together qualitatively good and effective treatment chains within the existing organisation's structure, rather than attention being paid to the organisation itself. At the same time it is stressed that the organisational units will continue to be of decisive importance vis-à-vis the delineation of responsibilities, management, financial management, working environment, etc, and perform the same important function for that part of the provision that is carried out within an area of responsibility.

The use of treatment chains as a structuring element in the work on creating comprehensiveness and cohesion in the provision of treatment for the individual is regarded as a useful tool. The Ministry will support this work during the health plan period. The emphasis during the drawing up of national professional guidelines will be on, among other things, interaction challenges and comprehensive patient pathways.

Cooperation at a national level

The Ministry of Local Government and Regional Development and the Ministry of Health and Care Services shall continue the work, and include other agents, on defining measures that can improve cooperation between municipally embedded health and care services and specialist health services.

Increased use of agreements to bind responsible agents

The Ministry and the Norwegian Association of Local and Regional Authorities have agreed to start a project aimed at signing a general agreement concerning cooperating to improve interaction. As part of the work on the project, patient organisations will in a systematic manner have an opportunity to submit their experiences of how the interaction functions. The agreement is rooted in the consultation scheme and shall apply to specialist health services and municipal health and care services. Other municipal services can be incorporated into the agreement should this prove appropriate. The national agreement will form the basis for local agreements between health enterprises and municipalities. One important aim of such agreements is to produce common analyses of the interaction challenges and agree strategies and measures. The Ministry assumes that the agreement project will be able to help clarify the frameworks and prerequisites for various interaction measures.

Information and communications technology (ICT)

Technical solutions that provide agents involved in the provision with access to up-to-date information in the meeting with users/patients are vital with respect to good interaction. In recent years, a number of initiatives that have had a positive effect have been initiated to improve ICT coordination. For further information about the Ministry's future work during the health plan period in the area of ICT, see chapter 6.4.4.

Further revision of regulations

As part of the work on achieving better framework conditions for interaction, the Ministry, through dialogue with involved parties, will consider how the regulations concerning municipality payments for patients ready for discharge function. It shall also consider whether and possibly how the regulations should be amended with respect to mental health provision.

Systematic use of feedback from patients

The Ministry will discuss the detailed arrangements with patient organisations in order to develop a good system for participation in the initiative areas discussed above.

6.4 General strategic areas

In the preceding chapter, the health service's main areas were presented together with a description of the mutual interdependence between the areas and the need for systematic interaction. This chapter presents key strategic areas for the entire health service. In order to develop the Norwegian health service, it is important to establish a common understanding of the status of and challenges faced by agents in these strategic areas and then illustrate the development initiatives and who is responsible for their implementation. In some areas there is a need to take responsibility for development, coordination and governance at a national level. These are areas that are important with

respect to achieving the primary goals of the health service and where responsibility for the implementation of the measures depends on a coordinated effort.

6.4.1 Strategy for quality, patient safety and prioritisation

Principals and framework

The strategy takes two key health policy goals as its starting point:

- The health service shall offer the general public good quality health care
- The health care shall be equally accessible to all

Quality is understood to mean the degree to which activities and measures carried out under the auspices of the health service increase the likelihood of an individual or groups of the population obtaining a desired health benefit given current knowledge and resource constraints. A health benefit can mean remaining healthy, becoming healthy, coping life with a disease and the end of life. Quality is created in the many daily encounters between the patients and providers in the health service. A series of processes have to be coordinated in order to achieve good quality provision. The improvement of quality in the health service therefore requires a comprehensive effort in many areas and throughout the entire treatment chain.

The National Strategy for Quality Improvement in Health and Social Services, which the Directorate for Health and Social Affairs published in 2005, provides an overall framework aimed at supporting health and social services in the work of providing good quality health provision. The strategy states that good quality provision is characterised by the provision:

- being effective (resulting in a health benefit)
- being safe and secure (avoiding unintentional incidents)
- involving the patients and giving them influence
- being coordinated and characterised by cohesiveness
- utilising resources in a proper manner
- being accessible and fairly distributed

The fact that the National Health Plan for Norway discusses quality and prioritisation in the same strategy shows that the Ministry believes that the prioritisations that are made are of significance vis-à-vis quality. By prioritisation we mean giving something precedence. Prioritising something involves distributing and redistributing resources and services, which at the same time means something else has to be given a lower priority. The need to prioritise arises when needs or demands are greater than the provision it is possible to provide given the existing resources framework. Despite the fact that Norway is among those countries that spend most resources on health, there is a gap between the general public's demand for health services, medical possibilities and the resources that are available. Driving forces that contribute to this include the increased demands and expectations of "the users", stronger patient rights, a greater focus on the risk of disease and more older inhabitants. In addition new and often expensive provision, e.g. medicines

with preventive, life extending and alleviating effects, is being developed. This means that Norway will also have to prioritise in the future in order to ensure that health resources are utilised in the best possible manner for the entire population. Due to the fact that activities that are aimed at promoting quality in one area may mean costs that require savings in other areas, it is necessary to balance and prioritise between the six characteristics of good quality provision. Quality in the health service must be assessed on the basis of the degree to which the health service as a whole, given resource constraints and other framework conditions, provides the individual patient with the best possible health care, at the same time as the health care shall be equally and fairly distributed across patient groups, social status, genders, ethnicity and place of residence.

Status and challenges

Quality

The Norwegian health service maintains a high level of quality from an international perspective. Nonetheless, the services have to be continually developed and improved. The work on quality has traditionally had to do with clinical quality, and much of it has been aimed at ensuring a high degree of professional competence in the providers through good fundamental, further and continued training. Service providers have to a large degree themselves taken the initiative regarding, and responsibility for, improving quality through professional networks and work in their professional organisations. Medical quality registers are one example of a more recent measure being driven forward by professional circles themselves. In 1995, the first national strategy for quality in the health service was published. The primary goal of the National Strategy for Quality in the Health Service 1995-2000 was that “everyone who provides health services shall establish comprehensive and effective quality systems by the year 2000”. The incorporation into law of requirements concerning internal control and the establishment of quality committees formed part of this. The strategy for 1995 shows that achieving quality in a service also has to do with improving the quality of the processes and structures that surround clinicians. In recent years the establishment of national quality indicators, drawing up of national professional guidelines, and the establishment of national medical quality registers have been central to the national work on quality. These are pedagogic means that are intended to contribute to good practice by strengthening the knowledge base for the health service and countering unwanted variations in provision.

One key challenge the quality work faces in the health service is that technological and medical developments are taking place quickly. Improving quality is therefore a continuous process that has to be embedded culturally and organisationally in the management at all levels of the provision, as well as be seen in close correlation with research and education. We currently possess knowledge about the status of some aspects of the six characteristics of good quality in the National Strategy for Quality Improvement, but lack a systematic overview. In those areas where we have quality indicators, there are considerable variations in the results. The variations are greater than the variations in patient composition and geographical factors should dictate.

Prioritisation

Health policy priorities in Norway have traditionally been associated with securing the goal of equal access to health services regardless of diagnosis, geography, socio-economic status, gender and age, in a situation where demand exceeds provision. Stronger national governance and more transparency about prioritisation in the health service were placed on the international agenda in the 1980s, and Norway was a pioneer in systemising its work on prioritisation. The principles on which prioritisation is based, i.e. the condition's seriousness and the benefit, which was launched by the two Norwegian prioritisation committees, Lønning I and II, and in the measure's benefit and cost-effectiveness and scientific documentation, which was emphasised in Lønning II, have subsequently faced little challenge on fundamental grounds. The prioritisation regulations are an example of how the principles were put into operation when individual patients within specialist health services were awarded the right to receive the health care they need. The criteria are also incorporated into the Norwegian Medicines Agency's criteria for the approval of refunds pursuant to the regulations concerning pharmaceuticals.

Today, few people believe it is possible to establish detailed national prioritisation criteria in order to resolve the challenges associated with prioritisation. The health service is too complicated for simple criteria to cover all situations. Judgement must therefore always be exercised. This acknowledgement has contributed to more emphasize being placed on facilitating legitimate prioritisation through transparent processes. The establishment of a national council for prioritisation in the health service (*Nasjonalt råd for prioritering i helsetjenesten*) in 2000 must be understood in this context. This acknowledgement has also resulted in a greater focus on prioritisation through knowledge-based medicine and during the formulation of professional guidelines that provide guidelines regarding which assessments and treatment provision should be offered to various patient groups. Measures have also been initiated to produce a more uniform interpretation of, and practice in relation to, the regulations concerning prioritisation.

There will be several major challenges associated with the prioritisation work in the health service in the years ahead. One of the greatest challenges is a lack of acceptance in the general public, and in some agents in the health service, that prioritisation is necessary. A common understanding of the challenges associated with prioritisation is needed in order to get agents to take comprehensive responsibility for priorities at their level in accordance with the national guidelines and constraints. One important prerequisite for the prioritisation work is knowledge about both the costs and benefits of measures in the health service and about actual prioritisations. A continued focus on health service research, including health economics research, is therefore needed, cf. chapter 6.4.3.

Another prerequisite for the prioritisation work is better coordination between the levels. Better coordination and comprehensive thinking will facilitate a better distribution of work between the municipal and specialist health services, and is necessary to ensure that prioritisation is based on the patients' needs for provision. One area in which initiatives have been initiated in order to improve coordination is within the area of pharmaceuticals

in which a contact point has been established between various agents who work with information about pharmaceuticals. The Norwegian Medicines Agency bases its prioritisation decisions concerning admission to the pre-approved refund scheme blue prescriptions (for pharmaceutical etc) on cost-benefit analyses. One of the goals of the contact point is to ensure that such prioritisations are reflected in the national guidelines for affected therapy areas drawn up by the Directorate for Health and Social Affairs.

A further challenge for the prioritisation work is the relatively large, and probably increasing, social disparities in the general public's health that have been uncovered. The goal is to counter social disparities in health by becoming aware of the needs of groups in the population that need special measures, e.g. refugees, asylum seekers, prisoners, and people addicted to drugs, alcohol, other intoxicants and gambling. It appears as though some patient groups are more easily assigned a lower priority than others, and there is a suspicion that there is a correlation between the field's status and the patients' socio-economic status. There is therefore a need for a targeted effort to ensure better distribution of the resources between diagnoses and professional areas. At the moment there is a great deal of variation in how the regulations concerning prioritisation are understood and practised. For this reason a cooperation project has been commenced between the Directorate for Health and Social Affairs and the regional health authorities, *Riktigere Prioritering* (more correct prioritisation), which is intended to contribute to more uniform practice. It is also important to uncover the degree to which other health policy means, such as funding schemes and other patient rights, can contribute to producing and maintaining social disparities in health.

Yet another challenge during the health plan period will be the fact that the prioritisation debate has largely been about the municipal and specialist health services separately. This is despite the fact that many decisions of great importance vis-à-vis the municipal health services are made in the specialist health services, and vice versa. One example is the regular general practitioners' referral behaviour, which in line with their role as gatekeepers determines the demand for specialist health services. At the same time more outpatient and day surgery treatment of patients with compound needs means that municipalities' responsibilities are growing. The municipalities must thus reprioritise their resources.

Several factors represent a challenge when it comes to a comprehensive approach in the work on quality and prioritisation in the health service. First of all, different management models are used for the specialist health services and municipal health and social services (including regular general practitioner). The municipalities are an independent administrative level that has freedom and responsibility vis-à-vis designing their services while specialist health services are to a greater degree subject to national governance. Secondly, there are many factors that affect prioritisation in the municipalities and specialist health services, such as patient rights, funding schemes, national and professional guidelines, etc. A third dilemma is that managers at all levels are expected to assume a comprehensive responsibility for resources and content, while at the same time the goal is to provide equal provision across regions and levels of service. A fourth factor is that the health service is a knowledge sector in which the professional qualifications

and engagement of each provider are necessary to achieve high quality provision with the correct prioritisation. At the same time, professional engagement tends to result in people upgrading in their own field at the expense of others, and the professional judgement that is exercised by providers leaves room for variations in practice. This, plus the fact that the quality of the provision and the actual prioritisations depend on cooperation between providers in several departments and at several levels, dictate that quality and prioritisation have to be managerial responsibilities. When working on quality and prioritisation one continually faces challenges associated with the balance between local autonomy and regional and national governance, and between professional embedding and management administration. This balance is demanding and can result in unclear responsibilities and in some cases "passing the buck" in order to move the responsibility and costs to others.

Goals of the health service's work on quality and prioritisation

Given the principal goal of ensuring the general public equal, good quality health provision, the framework for good quality health services, and the challenges described, a collective effort is required in several areas in order to improve quality and prioritisation in the health service. We would like to stress the following goals for the four-year period:

- more uniform and coordinated prioritisation in primary and specialist health services, including a more uniform interpretation of the regulations concerning prioritisation in specialist health services
- professional practice that accords with up-to-date knowledge concerning good and cost-effective practice
- equal distribution of the provision across fields and diagnosis groups within and between the various parts of the health service
- ensuring that improvements in quality and prioritisation become an integrated part of the provision and management at all levels of the health service, with solid cultural and organisational embedding
- establishment of the systematic reporting of central key data that illustrates the trends in relation to prioritisation and quality
- ensuring that expensive methods and investments are subject to a process of professional and overall assessment
- greater transparency regarding mistakes and unintentional incidents in the health service, such that the incidents can be used in teaching and prevention

National board for quality and prioritisation

A comprehensive approach to the work on quality and prioritisation requires clear positions of responsibility and good interaction in the health service, to which the National Health Plan for Norway aims to contribute. Work on quality and prioritisation should not take the individual department, activity or level of treatment as its starting point. Meanwhile, there are few organisational meeting points for the agents who bear responsibilities in the health service. Several bodies have spoken of the need for a new, overall body with tasks within quality and prioritisation. Agenda and Muusmann also spoke of the need for this in their evaluation of the hospital reform. The *Nasjonal Strategigruppe for Prioriteringer* (national strategy group for prioritisations) headed by

the managing director of the Northern Norway Regional Health Authority did the same. The Directorate for Health and Social Affairs and the Norwegian Knowledge Centre for the Health Services have also spoken in favour of such a body. The various agents have meanwhile been in favour of various organisational models.

In order to clarify the roles and responsibilities of those agents who bear responsibilities in the work on quality and prioritisation, and in order to improve interaction between the levels and produce more comprehensiveness in and transparency about the work on quality and prioritisation in the health service, the Ministry will establish a national board for quality and prioritisation. The board shall help to ensure a coordinated effort is made within themes of a general nature where there is a need for discussions across positions of responsibility. The board will not hand down follow-up instructions; its task is to create transparency and legitimacy around difficult quality and prioritisation issues. Agents with responsibilities shall meet in the board so they can get to grips with key issues associated with quality and prioritisation together. The agents shall initiate professional analyses and together assess the various aspects of an issue's complexity by, among other things, taking the National Health Plan for Norway's quality and prioritisation goals as their starting point. Assessments of patient benefit, cost-effectiveness and total costs will provide a key basis for the board's evaluations.

The result of the board's work will be an assessment and recommendation concerning the follow-up of the individual topic being drawn up. The board will handle complex and demanding issues, and the assessments must illustrate the dilemmas and elements of uncertainty. The board's members will on the basis of their positions of responsibility and independently take those initiatives they believe necessary vis-à-vis follow-up. The Directorate for Health and Social Affairs will, in line with its role as a national actor, have a special responsibility to follow-up those recommendations of the board that require coordinating activities.

As part of the work of ensuring a comprehensive approach to the work on quality and prioritisation, the Ministry will appoint a national board and draw up its mandate.

Relevant topics:

- identifying areas in which there are, or are developing, unacceptable disparities in provision across fields or geographical areas
- considering issues associated with the introduction of new and expensive technologies/medicines
- assessing the distribution and use of national competence centres and national functions
- assessing the need to develop national guidelines
- assessing the distribution of work between the various levels of the health service

The formal participants on the board shall be those agents in the health service with responsibilities, i.e. the Directorate for Health and Social Affairs, the regional health authorities, municipalities (including the regular general practitioners)/the Norwegian Association of Local and Regional Authorities and universities/university colleges.

Equality vis-à-vis representation must be strived for between the agents. The patient organisations shall be represented. The agents in the health service with responsibilities must ensure adequate professional participation and embedding through local processes, and use the necessary expertise when presenting issues. The board shall be chaired by the Directorate for Health and Social Affairs' director general. The board will be supported by a secretariat which shall ensure the assessments and documentation necessary to shed light on the topics that are going to be considered by the board are obtained. The secretariat shall support the preparation of issues initiated by the various agents and be attached to the Norwegian Knowledge Centre for the Health Services. The existing boards attached to the Directorate for Health and Social Affairs, will be assessed due to the establishment of the *Nasjonalt Råd for Kvalitet og Prioritering* (national board for quality and prioritisation). The board will be subject to evaluation during the health plan period.

Focus areas during the health plan period

Today's health service is very complex and it is difficult to change professional practices, there is therefore a need regarding quality and prioritisation to integrate a number of elements and work according to several models simultaneously. The Ministry of Health and Care Services stresses that one has to develop and continue the strategies and systems that have proved useful, while at the same time one has to develop new strategies where these are needed. The Directorate for Health and Social Affairs work on the national quality strategy and the follow-up of this is important, in addition the Ministry will during the health plan period work on six areas, most of which accord with the focus areas in the directorate's work on the national quality strategy.

Development of base data and key data/indicators

Useful base and key data is important for maintaining an overview of status in relation to quality and prioritisation, changes over time, and differences between local, regional and national levels. National indicators have been developed in the care sector and specialist health services that should be used by the population in order to compare provision, by owners and politicians at various levels as a basis for management, and by providers and managers as a basis for improving quality. The goal during the health plan period is to develop the national indicator system further. In that way, the system could becomes a universal key data set that tells you something about practice in the Norwegian health service based on the six measurements of good quality. The data should illustrate changes over time and disparities across fields and geographical areas. The experience of using the current national indicators shows that it is difficult to find good indicators that cover all purposes and target groups. There is therefore a need for the indicators to differentiate between goals and target groups more clearly. The directorate will, as part of its monitoring role, perform the central role in developing the national indicators. The Norwegian Knowledge Centre for the Health Services, with its methodological competence, will be an important partner. As well as the national indicators system, the aim is also that the managers could develop indicators as part of their own quality work, in line with the Norwegian Internal Control Regulations.

The development of the key data/indicators will be based on existing data sources, for the municipality sector this will be KOSTRA, the introduction of IPLOS in the municipalities from 2007 will provide an opportunity to develop indicators that provide information about the scope and priorities of care services in the municipalities. As far as general medical/practitioner services are concerned, the follow-up of the SEDA (central data from general medical/practitioner services) project could form a basis for key data/indicators vis-à-vis this provision. The Norwegian Patient Register and the national medical quality registers are important and suitable sources for the specialist health services, despite the challenges associated with data quality and methodology. Other data sources are the national health registers and the national health surveys. One special challenge will be the differences between the base data, reporting arrangements and key data from primary and specialist health services.

Good practice

a) National guidelines
   National guidelines are an important means of ensuring high quality and proper prioritisation, and of reducing unwanted variation. The Directorate for Health and Social Affairs has within a legal framework a role to play across health regions and service levels with respect to standardisations in the health service. The directorate is the only agent that has a mandate to produce national guidelines. Producing and, not least, updating national guidelines/guides and facilitating their implementation is a time and resource consuming task. At the same time it is important that there are national guidelines in some areas in order to preserve equal, high quality provision. There is a difference between national guidelines and locally developed routines and guidelines. Health service managers have a responsibility to implement national guidelines in their own organisations.

   In order to clarify the content and processes associated with the drawing up of guidelines, there is a need to review the routines for developing national guidelines. One has to clarify which processes and criteria should form the basis for selecting areas that need guidelines. Relevant criteria are major disease groups, high levels of resource consumption, areas in which there is a danger of failure in patient safety, large variations in practice, the need to clarify tasks and responsibilities, and better interaction between municipal and specialist health services. One also has to specify what should be included in the work on guidelines. The groups that are put together to draw up the guidelines must be ensured adequate professional legitimacy and there must be routines for how they are appointed. Furthermore, multiple patient pathways should be drawn up to illustrate the need for several types of documents that can define standard procedures, etc (e.g. checklists). Professional guidelines may need to be produced fast, in these cases there must be clear procedures that ensure quicker progress than in the case of ordinary guidelines.

   Guidelines must be knowledge-based and they must preserve the established prioritisation criteria and other ethical and social considerations. Cost and effect considerations must be included in all guidelines/guides, as must an assessment of the total costs of the introduction of the recommendations. Pursuant to the instructions

concerning assessments, government authorities have a special responsibility to assess the administrative and financial consequences of recommendations that are being drawn up. Therefore, the routines for drawing up guidelines must clearly state the guidelines' financial, organisational and administrative consequences. It is important that those who will bear the costs are involved in the process. The prioritisation, ethical and social considerations, and the implementation and follow-up must take place in a dialogue with the responsible agents, and patient participation must be ensured.

As well as developing national professional guidelines there is a need, at a national level, to maintain an overview of international guidelines in order to make these available to the health care service. International guidelines will have to be assessed in relation to Norwegian conditions. Facilitating the application of international guidelines will be a joint task for the Directorate for Health and Social Affairs and the Norwegian Knowledge Centre for the Health Services. *Helsebiblioteket* (the health library) is an important tool for communicating up-to-date knowledge, including guidelines from Norway and other countries.

b) Good practice and good routines
Professional, capable providers supported by national professional guidelines in selected areas form the basis for good practice, but this is not enough. Managers at all levels, from senior managers in the regional health authorities and in the municipalities to the individual department, are responsible for ensuring that the provision accords with good practice so that professional justifiability is preserved. Internal control is a statutory management tool in such a process. Even though the purpose of internal control is to help ensure professionally justifiable health and social services, and ensure compliance with health and social legislation, it is suitable as a framework for all quality work. Compared with many other countries, Norway's health and social legislation sets the bar regarding proper practice high. Good practice is therefore at the heart of statutory requirements concerning professional justifiability.

One important part of the management responsibility, cf. the Internal Control Regulations, is to monitor activities and select areas in which there is a need for improvements. Such processes require close interaction between managers and staff. When providers participate in the work of evaluating and improving their own practices, competence is developed, and the quality work becomes professionally embedded. In those cases where health services are delivered by private providers, who have an independent responsibility to carry out internal control, the managers in the public sector have a responsibility to ensure that quality is maintained and that the provision is targeted at prioritised areas through the contracts that are signed.

The Norwegian Knowledge Centre for the Health Services can support the health service's quality improvement work by assisting knowledge summaries and methodological support. Furthermore the Knowledge Centre via *Helsebiblioteket* (the health library) has books regarding routines and methodology that could be of help

and provide inspiration vis-à-vis the development of professional fields. Nonetheless, it is still the agents themselves who are responsible for the professional quality of the documents and follow-up in the work on improving professionalism and quality carried out under the auspices of the health service.

There will often be necessary for the health service's work on quality and prioritisation to cooperate with other departments, municipalities, enterprises and service levels. The cooperation forums that is established, the proposed national board, the proposed agreement system (see chapter 6.3.4 Comprehensiveness and interaction), the internship schemes and physician practice coordination schemes (praksiskonsulentordning) will be important arenas for the work on quality and prioritisation. The quality improvement work that is currently taking place in municipal health services is also important, including NOKLUS (Norwegian Quality Improvement of Primary Care Laboratories) NOKLUS Clinic and the SEDA project (central data from general medical/practitioner services).

c) Medical quality registers

During the health plan period, the Ministry will focus on the work of developing medical quality registers. The medical quality registers main purpose is quality improvement and research. Medical quality registers shall help to ensure that the health service utilises the best and most effective methods. It is therefore a goal to establish good national medical quality registers for important fields. The Directorate for Health and Social Affairs has published a report with proposals concerning the future prioritisation of quality registers, organisation, common technical solutions, as well as proposals concerning the statutory basis and regulations for consent-based quality registers. The proposals have been the subject of consultation. The responses to the consultation process support the work on quality registers, but also reveal a need to look more closely at issues associated with the scope and prioritisation of quality registers that will be "upgraded" to become national medical quality registers, as well as the relationship between national medical quality registers and other national health registers. Today, just over 60 registers can be described as medical quality registers.

The main purpose of the quality registers will be quality improvement and research. This requires good embedding in the service providers who are going to register data and use them in the work on quality improvement and research. This is the reason the Ministry of Health and Care Services is placing the responsibility for data processing in the regional health authorities, including the associated responsibility for operation and funding. In those cases where a national medical quality register may be authorised by existing central/national registers (e.g. cancer) it may be relevant to have someone else be responsible for the data processing.

As the entities responsible for data processing, it is the regional health authorities that are responsible for assessing and determining who should carry out the data processing tasks (operation). This should be decided in a close consultation with the providers. Considerations vis-à-vis safety, protection of personal data, finances,

operational efficiency and competence indicate the need to have a limited number of people responsible for operations that are based on common technical solutions, as well as solutions that ensure a short distance between researchers, specialist physicians, IT experts and statisticians.

The existing quality registers are different in several areas such as basis in law, technical solutions, data quality and scope. The Ministry believes that the methodological, technical and legal solutions for national medical quality registers should be seen in connection with corresponding solutions for other national registers. As far as possible common technical solutions should be chosen that make it possible to link different quality registers and quality registers and central registers such as, for example, the Cancer Registry of Norway, the Medical Birth Registry of Norway (MFR), the Norwegian Surveillance System for Communicable Diseases (MSIS), and the Norwegian Patient Register (NPR). In connection with this, one will have to assess technical solutions that can be based on data extracted from a possible Norwegian Patient Register in which individuals can be identified, national disease registers and, in the long-term, also obtain data from electronic patient records (EPR). The regional health authorities will, based on the general guidelines from the Ministry of Health and Care Services, be assigned responsibility for ensuring that common technical solutions are developed.

National medical quality registers are health registers that have to be established and run pursuant to the Personal Health Data Filing System Act and other regulations. The principal rule is that health registers shall be based on consent from those registered. Work is being done on drawing up regulations that can provide a legal basis for more consent-based quality registers. The design of key parts of these regulations will depend on the content of the future health research act (cf. proposal in NOU 2005: 1 Good Research – Better Health). The draft regulations concerning consent-based quality registers will therefore be circulated for consultations after the proposal concerning a new health research act is submitted to the Storting.

In order to strengthen and support the national work on medical quality registers, a national service environment will be established containing database competence and regulations competence. The main task of the service environment will be to provide technical register advice to the regional health authorities and shall be able to assist with legal, IT technical, research-related and quality-related competence.

Patient safety

Several schemes have been established to promote patient safety in the Norwegian health service. The Norwegian Board of Health carries out supervision in order to ensure that the services are run in a professionally justifiable manner and administers the notification schemes pursuant to section 3-3 of the Specialist Health Services Act and section 17 of the Health Personnel Act which oblige health institutions and health personnel respectively to report incidents that have had or could have had serious consequences for the patient. The boards of health in the counties deal with complaints from patients who believe they have not received satisfactory provision. Patient advocates can assist patients

with the submission of such complaints, and *Norsk Pasientskadeerstatning* (NPE) (the Norwegian system of compensation to patients) can award compensation to patients in the event of shortcomings in treatment, without assigning responsibility. The Internal Control Regulations instruct the health service to maintain an overview of areas in activities in which there is a risk of shortcomings occurring.

The recommendations concerning patient safety from WHO, the EU and the Council of Europe favour notification systems intended to promote learning and characterised by "No shame, no blame, no name". Furthermore, the notification systems are not connected to the supervisory authorities. In addition, the significance of analysing the reasons for the incidents based on a system perspective rather than a person perspective is stressed.

The Ministry wants a cultural change to take place in the health service during the health plan period. There is a need for greater acknowledgment of mistakes, as well as greater transparency concerning adverse events. In order to support the health service's work on this, the Ministry proposes the establishment of a national unit for patient safety from 1st February 2007. Funding for the initiative is proposed and discussed in chapter 725, item 01. The unit shall be independent of all authority bodies in the health service and its purpose is to support the health service's work on registering, analysing, learning from and preventing mistakes and adverse events. The unit shall produce training materials and present proposals concerning measures that support the health service's efforts to learn from mistakes in such a way that practices are changed. The unit will also be able to address measures for the national authorities. Central to the development of the unit will be analysing and ensuring that information collection and reporting to the unit provides an adequate basis for uncovering risk areas and the reasons for these. The aim is for the unit to primarily collect information from existing notification schemes locally, regionally and nationally, including the statutory notification schemes in section 3-3 of the Specialist Health Services Act and section 17 of the Health Personnel Act, as well as the regional notification systems being established in several region health enterprises. However, it is important that the supplementary reports that are necessary in order to realise the unit's purposes are implemented. During its start-up phase, the unit will focus on the specialist health service. However, the aim is to develop it to cover municipal health services. The unit will be established as part of the Norwegian Knowledge Centre for the Health Services.

System for assessing medical technologies/medicines

New medical knowledge and new technologies are important with respect to improvements in the health service. The Norwegian health service shall contribute to the development of medical knowledge and technologies by, among other things, focusing on medical research and making research results available, cf. chapter 6.4.3. New medicines and new methods are often more expensive than the established ones and will often act as supplements to existing treatments. Costs will therefore increase as a whole. Many of the medicines will affect the quality of life, but not necessarily the length of life. From a prioritisation perspective it is important that comprehensive assessments of effects and costs be carried out. Internationally, a great deal of attention is being paid to catching new technologies early on so that one can implement cost-effective measures as quickly

as possible, while at the same time one cannot subject patients to treatments that are ineffective or have harmful results. It is important to ensure that technologies that find their way into the Norwegian health service through research studies do not become established practice before the method's usefulness, harmful effects, and costs have been analysed. Given such knowledge, the questions concerning the implementation of new and expensive methods will form an important part of the prioritisation decisions that managers in the health service shall take. Such decisions must take account of the goal of equal provision across health regions. In the case of decisions concerning the extent to which medicines shall be able to be prescribed via the blue prescriptions scheme (the pre-approved refund scheme for pharmaceuticals etc) and entitle social insurance refunds, there have been established procedures for assessing cost-effectiveness. There are no corresponding routines for assessing needs, costs and the cost-effectiveness of new major investments in the specialist health services, but such routines will also be developed.

Projects are already underway in this area in, among other places, the Knowledge Centre and regional health authorities. During the health plan period the Ministry will develop systems that ensure that new medical technologies/medicines are identified and assessed before they become established practice. Because new technologies are introduced at the same time into many countries, it is important to draw on knowledge and experiences from international networks.

The Ministry will establish processes and methods that ensure:

- that new and expensive technologies/medicines are identified
- that a quick assessment of the medical effects and costs specified by patient groups, total costs upon introduction, organisational effects, etc, takes place
- assessments are made of costs and usefulness in the event of new technology investments

The basis on which decisions are made (effect, cost-effectiveness/total costs, etc) may be a topic for the national board for quality and prioritisation.

Strengthening competence and leadership associated with quality and prioritisation

Providers with a high level of competence and skilful leadership at all levels of the health service are important prerequisites for achieving the goals for good quality and correct prioritisation. Quality development in the health service must also be seen in the context of working environments and the health status of the personnel in the health sector. One measure for achieving good quality in the sector is to emphasise good working environments because this also prevents sick leave related to employment conditions. The Internal Control Regulations impose a responsibility on managers at all levels to identify areas in which there is a need for quality improvements and to initiate, coordinate and implement processes aimed at improving practice. They also have a responsibility to ensure that employees possess sufficient knowledge and skills, and to ensure that they participate such that the total knowledge and experience is utilised. The latter are important prerequisites in the work on quality and prioritisation, because good quality and correct prioritisation require professional embedding through the participation and engagement of service providers. In this way one creates a culture of continuous

improvement in quality and an understanding, and willingness to work to ensure that the prioritisation takes place in accordance with national goals and regulations. The hospital reform has facilitated better management through a clear management structure in the specialist health services. However, work on supporting this structural change must be continued. Among other things, there is a need to strengthen the competence in improving quality and prioritisation, including with respect to the purpose and content of the Internal Control Regulations, both among the health service's managers and service providers. Such skills upgrading must take place both through the providers' fundamental, further and continued training, and through the management training provision that has been established as part of or independent of the professional training courses. For example, the Norwegian Association of Local and Regional Authorities and the Ministry of Health and Care Services have for many years reaped benefits from the *Flink med Folk* (Good with People) management development project for managers at all levels in the care services. The recommendations from the working groups in the two focus areas in the National Strategy for Quality Improvement in Health and Social Services, improving management and organisation and strengthening improvement competence in the training courses, are important.

Accreditation and certification

Accreditation schemes and certification are tools that provide opportunities for more comprehensive assessments of systems. Accreditation means authorisation and takes place through an external body certifying that an enterprise is competent to carry out certain tasks pursuant to stipulated standards. Certification is understood as meaning that the enterprise has established a quality management system that has been approved pursuant to stipulated framework requirements. In Norway we have so far primarily used pedagogic means (guidelines) and stipulated standards for selected quality indicators, however several regional health authorities have introduced or are working on introducing systems for accreditation/certification at a regional level. Managing according to quality indicators may be experienced as fragmentary. Most of the countries that are systematically working on quality indicators utilise various forms of accreditation systems to achieve a more comprehensive approach to the work on quality and follow-up. There is little information about the relationship between costs and usefulness/effect of accreditation. The Ministry is in the process of assessing the use of accreditation and certification in order to evaluate these as national means for following up quality. Such an assessment must be viewed in the context of existing legal requirements and legally defined management principles for the health service (internal control).

6.4.2 Personnel and competence

The health service is a knowledge body – and its personnel are the most important input factor. The (formal and genuine) competence and suitability of personnel form the basis for all value in the service. At the same time the health service has important personnel training tasks; both in relation to fundamental training, compulsory practice periods, further training and continued training. Training is one of four statutory main tasks of the specialist health services (sections 3-5, 3-8 and 3-10 of the Specialist Health Services Act) and the funding of the training tasks is included in the basic grants for the regional

health authorities. Municipal health services also obliged to participate in the training of personnel (sections 6-1 and 6-2 Act relating to the Municipal Health Services) and must address the training tasks within its framework grants.

Provision of health personnel: capacity and content

The authorities have an overall responsibility to dimension some of the training courses to help ensure adequate and competent personnel in the health service. The individual enterprise must however meet the need for competence with a broad spectrum of initiatives. The enterprises' ability to realise goals will depend on the degree to which an enterprise is able to recruit, gain access to, administer and develop competence through further and continued training. Below, the terms personnel and health personnel are used as interchangeable terms denoting health and social services personnel, and the terms provision, services and health service as interchangeable terms for health and care services.

Fundamental training

The dimensioning and content of fundamental training courses are of key significance with respect to the supply of personnel within the various groups of personnel and with respect to formal competence.

Fundamental training courses are expected to meet competence needs in the health service. This requires, among other things, knowledge about the conditions inside and outside the health services that could influence the competence needs. These could be factors such as economic, international and demographic factors, the demand for health services, the disease picture, medical and technological developments, as well as political prioritisations with respect to both the content and structure of the health service. These are complex relationships and there are many things that have to be weighed in order to dimension training courses and formulate their professional content. Such changes can, in addition to influencing the needs regarding competence in the provision, also make new and different demands vis-à-vis forms of working, the composition between personnel groups, and the organisation of the provision.

The dimensioning of the fundamental training courses at university colleges and universities will remain within the framework of the Storting's funding decisions laid down by the Ministry of Training and Research following consultation with the Ministry of Health and Care Services. The regional health authorities are instructed to arrange the correct number of qualitatively good training places for the pupils/apprentices/students, and this is communicated as a management requirement in the annual mission statements. Municipalities have a corresponding responsibility associated with training places, but specific governance demands are not communicated to the individual municipality.

The quality reform is a reform of higher training in Norway. At the centre of the reform are new degree structures, a common grade system, and increased internationalisation. In 2003, an independent state body (NOKUT – the Norwegian Agency for Quality Assurance in Training) was established to monitor that training courses at the various institutions achieve the necessary quality and that internal quality management systems

have been established. The training institutions have a significant degree of autonomy with respect to defining the academic content of the training themselves. Pursuant to the Act relating to Universities and Colleges, national frameworks for training courses can still be stipulated. The national frameworks for several of the university college training courses that result in authorisation have to a large extent to be continued and maintained. The training courses shall also fulfil the requirements stipulated in relevant acts relating to the execution of professions, special directives from the EU, and international conventions.

Further and continued education

Further education is formalised additional education at vocational training schools, university colleges or universities. The term continued education is used to denote another type of training that contributes to work-related skills upgrading. Specialist training courses for physicians, dentists and opticians are to varying degrees practice-based further training which lead to official specialist authorisations. In addition, several professional organisations have established their own specialist training courses and authorisation schemes. Both further education and continued education form part of the skills upgrading of personnel and are as a rule implemented as a measure in an employer/employee relationship. Participation in further or continued education will to a large extent be decided and determined through an interaction between employer and employee, in which the local/local authority or regional need for competence is an important element.

Several of the competence-providing further education courses have been restructured into masters' degree courses. This applies to, for example, the further education in manual therapy for physiotherapists.

Specialist physician training in particular

As far as physicians' specialist training is concerned the Ministry of Health and Care Services bears overall responsibility and stipulates both the structures and rules for specialities. The structure for a speciality influences how the health services are organised. As per today there are 30 main specialities and 13 branch specialities (internal medicine (8) and general surgery (5)). The training that turns someone into a qualified specialist takes around six to eight years. The Norwegian Medical Association plays a central role in specialist physician training. The National Council for Specialist Training and Distribution of Medical Practitioners was established in 1999 as part of the work on strengthening government management of specialist training and physician distribution. The National Council provides advice both to the Directorate for Health and Social Affairs and the Ministry of Health and Care Services on questions linked to specialist training and physician distribution. The Ministry annually stipulates the number of new physician positions in specialist health services (including training positions) distributed between the health regions and possibly between the various specialities. The regional health enterprises distribute the positions in the health regions and between the specialities. This system is intended to help ensure good training capacity and support good local, regional and national distribution of physicians and specialities. The regional

health enterprises shall help to ensure efficient training courses and implement recruitment measures if some training positions prove difficult to fill.

The theoretical part of specialist training, which is arranged as a partnership between the Norwegian Medical Association and universities, has been assigned a steadily more important role in the training. Nonetheless, specialist physician training is training that is still provided close to the place of practices, in which the genuine content of the training is largely formulated in an interaction between the physician being trained and the specialist health services. A quality management system has been established to ensure the quality of this part of the training, which, among other things, means that departments that participate in specialist training must be certified as educational institutions.

Challenges

Access to health personnel, dimensioning of training

Key factors associated with the dimensioning of fundamental training at universities and university colleges are the estimated national need for the various health personnel groups, as well as the capacity at the educational institutions and the health service as the practice arena. The dimensioning of further education and continued education is to a large degree steered by the health service's need for competence, and means both the health enterprises and local authorities, as employers, have an importance influence. Specialist physician training holds a special position within the hospital-based specialities. This training is carried out by the physicians being appointed to training positions in specialist health services and the dimensioning of the training positions takes place through a combination between national governance (the awarding of new physician positions) and regional management (the distribution of physician positions).

The dimensioning of the training requires a good basis for making decisions and good analyses. Key elements in the assessment of the national need for the various health personnel groups are the training capacity in Norway, supply from abroad, departures from the professions and the personnel's occupational activity. Statistics Norway has, on behalf of the ministries, developed a statistical model for the fundamental training courses with forecasts of the supply and demand vis-à-vis health personnel (*Helsemod*). *Helsemod* is based on a range of assumptions that have historically been shown to have the greatest influence on the demand for personnel. As a basis for dimensioning decisions, *Helsemod* must be supplemented with assessments of the assumptions on which the model is based, as well as factors that lie outside the model, for example political focus areas.

As far as specialist physician training in the hospital-based specialities is concerned, the distribution of the training positions is based on the needs reported by each of the regional health enterprises. The National Council also monitors the positions in specialist health services through a database system, the NR database, and advises the Ministry on the distribution of new physician positions on the basis of this.

Follow-up during the health plan period

The Ministry will assess how the current basis for making decisions concerning the dimensioning of training courses can be developed. As far as information about the physician positions in specialist health services is concerned, the current database system (the NR database) shall be developed. This shall be done in manner that addresses the authorities' need to monitor physician positions and the system simultaneously having to function as a management tool for the health enterprises.

Competence and qualifications – content in the training

The training of health personnel holds a somewhat special position in that theoretical learning at educational institutions is combined with practical teaching in the health service. The health service therefore has important responsibilities as a practice arena in the training courses, and as a current or future employer or party to contracts with fully qualified health personnel. The health service is undergoing rapid development with respect to organisation and task distribution, technological innovations and the development of medical knowledge. At the same time, changes are taking place in the incidence rates of diseases and living conditions that necessitate the continuous maintenance and upgrading of the personnel's skills. In addition to this, the patients' own mastering of their every day lives and the need for interaction are being emphasised, and this requires an increased focus on patient participation and interaction. It is therefore vital that the content of the training courses changes in line with these developments.

The training of health personnel consists of a combination of theoretical teaching and practical teaching. For this reason, cooperation between the educational institutions and the health service will constitute an important arena for picking up on and communicating the need to change the content of training courses. The universities, including the university colleges, are to a great extent autonomous, and are delegated academic, financial and administrative responsibilities vis-à-vis training courses. This means that the universities themselves stipulate the academic content of the training courses. In the university college sector, this academic freedom is limited in the case of training subject to national framework plans. Given the general level at which the framework plans steer, these institutions nonetheless have substantial room for manoeuvre. However, it is assumed that the institutions will be attentive and adequately respond to the needs for competence that are expressed. Contracts have been signed and cooperation bodies established between the training institutions and the regional health enterprises in the specialist health services. These are arenas that must be used to continuously discuss the relationship between the content of training courses and the services' need for competence. Corresponding cooperation bodies have not been established for the municipal sector, but it is important that any need for changes in municipal health services are also picked up on. Should the necessary changes require changes to the nationally stipulated framework plans, these must be assessed and stipulated by the Ministry of Education and Research after consultation with the Ministry of Health and Care Services. When it comes to specialist physician training, the Ministry of Health and Care Services bears, as mentioned, overall responsibility and stipulates both the structures and rules for specialities. An increasing degree of specialisation on the one hand and a trend towards a need for more general competence in local hospitals on

the other, indicates that there is a need to look at specialist physician training in light of this.

Follow-up during the health plan period

The Ministry will, in cooperation with the Ministry of Education and Research, consider how the current systems and process can be improved such that the content of the training courses always, and to the greatest extent possible, corresponds to the health service's tasks and challenges.

As far as the university college training courses are concerned, the Ministry will consider how the nationally stipulated framework plans, with respect to both processes and content, can be changed and improved.

During the coming health plan period, a material and technical review of the regulations that regulate specialist physician training shall be conducted. At the same time the Ministry will assess other measures that can help to ensure that the content of specialist training corresponds to the health service's tasks and challenges, as well as taking account of the need for efficient training courses. This will be done through a close dialogue with the actors.

Distribution of personnel

One expressed goal of the health services' activities is to ensure the equal provision of health services regardless of, for example, place of residence. One important prerequisite for realising this goal is that the health service must have a sufficient number of competent personnel – in all parts of the country. Overall Norway has a good level of personnel coverage in an international perspective. Nonetheless we face challenges associated with achieving a distribution of the personnel that can ensure the equal provision of health services across the entire country. The issue of distribution is particularly associated with three factors: geographical distribution (north/south national/local), the distribution between fields, and the distribution between specialist health services and the municipal sector.

In the case of some groups of professionals, and particularly physicians and dentists, it has been difficult to both recruit and stabilise physician/dentist coverage in some parts of the country. This applies to regular general practitioner positions in some counties, especially Finnmark, Nordland and Sogn og Fjordane, but also within specialist health services, for example for local hospitals and community mental health centres. There have been recruitment problems in some fields such as substance abuse care, mental health care, and municipal care services, even though on a nationwide basis there is a good supply of personnel.

The Norwegian health service has for longer periods been characterised by a greater demand than supply of physicians. This was one of the reasons behind the establishment and maintenance of distribution systems for physicians. The current distribution system for physicians was established in 1999 and was established by law (section 4-2 of the Specialist Health Services Act). This system permits the Ministry to annually stipulate

the number of new physician positions divided between the health regions and possibly between the various specialities. This is communicated in the annual mission statements for the regional health enterprises, together with the other management requirements. It is up to the regional health enterprises to distribute the physician positions within the health region and ensure compliance with the distribution system.

In addition to the physician distribution system, several other incentive measures are of current interest. Examples of such measures include various personnel measures in the Escalation Plan for Mental Health, especially the measure within general medical/practitioner services in some counties, and the recruitment of dentists from Germany. As far as the municipal care services are concerned, funds have been granted every year since 1998 via the competence plan.

Getting sufficient and competent health personnel represents, and will do so in the years ahead, one of the greatest challenges for the health service. It is assumed that the health enterprises and the local authorities, as employers and parties to contracts, will plan and perhaps establish competence strategies to ensure that the provision's total competence is commensurate with its tasks and the future challenges it faces. At the same time the health enterprises and local authorities have training duties, both as practice arenas and as the employers of personnel. The authorities' training policy and the local authorities and the services' competence strategies may involve conflicting interests. Good handling of the links between the authorities' training policy on the one hand and the services' competence strategies on the other is a prerequisite for us being able to achieve a good distribution of personnel and realise the health policy goals on a national level.

Follow-up during the health plan period

During the health plan period, the Ministry will assess the roles, responsibilities and tasks of the various actors in order to achieve more targeted and effective initiative means that can help to ensure a good distribution of personnel. In connection with this, the physician distribution system and distribution of responsibilities between the Ministry of Health and Care Services, the Directorate for Health and Social Affairs and the National Council for Specialist Training and Distribution of Medical Practitioners will be reviewed and the necessary changes implemented.

Special competence challenges – language and culture

Equal health provision requires that patients and their relatives can communicate with and understand the health personnel who are providing the health care. Patient participation and, not least a patient's right to informed consent (to examinations and treatment) cannot be preserved unless the patient and health personnel understand each other. Being able to understand each other requires knowledge about languages and cultures, and multicultural understanding.

As an indigenous people, the Sámi population has special rights regulated by Norwegian law and international conventions. The legislation contains provisions concerning communication and information in one's own language. Pursuant to the language provisions of the Sámi Act, patients in the Sámi language administrative district shall be

able to be served in the Sámi language when in contact with the health services, and the health service shall ensure that the information that is provided is received and understood. This is primarily the responsibility of the administrative level (such as health enterprises and local authorities) and the enterprises. Health personnel in the Sámi language administrative district are also obliged to facilitate good communication with the Sámi population. This means that interpreters shall be used if the personnel do not themselves speak the Sámi language.

Norway is experiencing an increase in immigration. The immigrant population amounts 7-8% of the population. In parts of Oslo, the immigrant population amounts to more than 30-40%. This indicates that the need for language and cultural knowledge in the health service is increasing. The government's action plan for the integration and inclusion of the immigrant population includes a number of measures that are intended to ensure better Norwegian language skills and qualifications for occupational activities. One of the measures in the action plan is to improve interpreter training. An increasing immigrant population constitutes an important labour resource, including in the health service. Both the municipal care services and the hospitals in major cities are enterprises in which staff from many countries work. Multilingual and multicultural factors are therefore gaining greater and greater importance when it comes to equal provision and the patient perspective. This applies to ethnic minorities as patients and relatives, and ethnic minorities as health personnel serving the ethnically Norwegian population.

Follow-up during the health plan period

During the health plan period, the Ministry will increase its focus on measures that are intended to help ensure equal health provision and address the patient perspective with respect to ethnic minorities.

6.4.3 Research for better health

Medical and professional health and social research provides new knowledge that is fundamental to the development of the health service and ensures a high level of quality in prevention, diagnostics, treatment, rehabilitation and care. The results from long-term research lead to new or improved treatment methods and procedures, and contribute to patient safety. The research thus provides a basis for ensuring that the treatment that is provided is safe, up-to-date and provides a health benefit. In addition to this, research contributes to the increased competence of health personnel, a knowledge-based health policy and the efficient utilisation of health resources.

Research into health is one of the four thematic focus areas highlighted in the research report (White paper St.meld.nr 20 (2004-2005) Commitment to Research). Strengthening research in the health service is highlighted as an important goal in the Soria Moria Declaration.

One prerequisite for all research aimed at improving health is that it is of a high professional quality. Various types of research from multiple fields and disciplines are necessary. This includes fundamental research, translation research (bridge building

between fundamental research and clinical practice) and studies of patients in various phases of treatment and follow-up (clinical studies), epidemiological research (distribution and causes of diseases) and health service research.

The Ministry of Health and Care Services and the health service have a special responsibility regarding medical and professional health and social research that is carried out in proximity to patients and practices, and for targeted skills upgrading in the sector. This includes research into preventive measures and treatment in municipal and specialist health services. Public funds for medical and professional health and social research are primarily provided by the Ministry of Education and Research and the Ministry of Health and Care Services. The Ministry of Education and Research funds, among other things, fundamental research through the Research Council of Norway, universities and university colleges. The Ministry of Health and Care Services grants funds to the regional health enterprises, the Research Council of Norway and subordinate units that carry out research activities and/or commission research. The Ministry also funds research units linked to alternative treatments, health services for the Sámi population, general medicine, casualty clinic medicine, etc. In addition there are also many private sources of research funding. Research in the health service is dependent on a good partnership with universities and university colleges that have research as one of their primary tasks.

Research in the health sector

Norway currently does less research measured by the number of scientific publications, input of resources, and doctoral theses submitted in medical and health subjects than other Nordic countries. At the same time an analysis of research into clinical subjects in 2000-2005 (NIFO 2006) shows that there is a positive trend with increased research activities within clinical subjects and health subjects in recent years. An evaluation of medical and professional health research from 2004 (the Research Council of Norway) showed that several research environments maintain high international standards. At the same time, the evaluation pointed out that there was too little interdisciplinary research, many small research environments and a lack of cooperation, too little translation research, little international cooperation, and inadequate access to expert support and technical equipment.

Increased knowledge about distribution, casual relationships and disease mechanisms with respect to the major public diseases and small and rare diseases are a prerequisite for the development of effective prevention measures, early diagnoses and good forms of treatment. Such knowledge requires a multidisciplinary approach. Health registers and biobanks are especially important with respect to shedding light on causal relationships. It is necessary in order to strengthen public health work to acquire more knowledge about disease prevention, the correlation between behaviour and health, and effective health promotion measures (diet, physical activity, smoking, etc). It is also important to uncover the background for social disparities in health such that effective measures can be implemented to equalise disparities. Long-term and interdisciplinary research efforts are needed, cf. chapter 6.3.

Research is one of the hospitals' four primary tasks. University hospitals have been given a special responsibility for research. Research has been a focus area in the health enterprises. A partially incentive-based funding system has been established for research in the enterprises that is intended to address the need for both strategic prioritisation and research initiated studies. Following the hospital reform, the number of published scientific papers and doctoral theses that have been submitted in the health enterprises has increased. The health enterprises currently contribute around one quarter of all scientific papers produced by Norwegian research in international scientific publications. In those health enterprises without university functions, the amount of research activities nonetheless remains modest. There is a need to strengthen research at local hospitals in a close partnership with the university hospitals. Unlike the specialist health services, neither local authorities, county councils nor individual practices are obliged to carry out research. The large number of local authorities and the fact that health personnel in municipal health services are organised into small practices means that it is difficult to establish an overarching institutional structure in order to organise research of a certain scope and quality. Knowledge from other levels of treatment is not necessarily directly transferable to general medical/practitioner services. In addition to this, the research activity is relatively low. The municipal health and social services have also been paid little attention from a research point of view. This applies both to the efficiency and quality of the services and the effectiveness of provision and measures aimed at society and the individual patient. This means that these services currently face some particular challenges associated with the organisation and strengthening of the research carried out in proximity to practices. Research activity in care services is currently disproportionately low in relation to this field of practice's needs and the scope of provision, cf. discussion in chapter 6.4.2.

More and better health research

Increasing research activity is a national goal as is ensuring a high level of quality and relevance in the research such that the available research resources are utilised in the best interests of the patient. Norwegian health research should aim to be on a par with that of the other Nordic countries. This means that research and researcher training in the health service must be prioritised and strongly embedded, managerially speaking, at all levels in the years to come. We must ensure that we utilise and preserve the national advantages we have both from internationally competitive research environments and from our national health registers, biobanks and major population surveys. At the same time, research activities should be strengthened in areas in which a gap in knowledge is demonstrated.

Nationally speaking a good partnership concerning research, researcher training, research guidance and research-based innovation must be established between the health service and the university and university college sector. In line with this there are now plans to establish general medicine research centres in universities. Six teaching nursing homes have been established in municipal health services. The activities are based on partnership agreements between local authorities/nursing homes, university colleges and universities and contribute to increased quality in the care services through research, development of the professional knowledge base, and skills upgrading. In the area of

research into social services, trials have been initiated with university social services offices involving new forms of cooperation between research, training and practice in the social services. Formal partnership bodies involving universities and university colleges have been established in the specialist health services and processes started to coordinate national systems for measuring research.

The focus on research in the health service also creates a need to establish new types of positions, for example positions that combine research and clinical practice. Research and researcher competence should also have a positive impact in the form of pay and recognition. There is also a need to increase the research competence of specialists in the health service. The experiences gained from pilot projects in psychology combined with training programmes for researchers and specialist training will also be important in this context.

Exploiting our national advantages

Exploiting our national advantages with respect to clinical and epidemiological research in Norway is a challenge. We have several competitive research environments within, for example, cancer, cardiovascular disorders, neuro subjects, and epidemiology that need to be sustained and strengthened. These environments will be important driving forces when it comes to strengthening research activity on a national basis, and many will be key to the strengthening of translation research. These environments must also assume a special responsibility for establishing professional researcher networks, cf. chapter 6.4.7.

It is important to exploit the potential inherent in various population, disease and quality registers, biobanks, large population surveys, any patient registers in which individuals can be identified, and, in the long-term, electronic patient records. For example, many small studies are carried out that are not large enough for their results to be extrapolated to the population as a whole. In addition to this, access to the data material in national registers and biobanks has not been god enough, and there have been some challenges associated with comparing various data materials. Good organisation and better access to data for research will be important measures in the work of strengthening research in the health service.

Special skills upgrading

A high quality health service requires the development of research activities and knowledge within most medical and professional health fields and with respect to the various patients and/or disease groups.

Low levels of research activities in relation to the need for knowledge in some fields or for some patient groups have been demonstrated, and measures have to be implemented to strengthen research. This includes, for example, fields such as mental health and substance abuse, in which a number of areas in which the research is either inadequate or absent have been pointed out, prevention (cf. chapter 6.3.1), rehabilitation, chronic diseases, musculoskeletal disorders, dental health and general medicine (cf. chapter 6.4.2) and patient groups such as children/adolescents, women, ethnic minorities and senior citizens. Important means of strengthening research efforts in selected areas include

national research programmes, strategic efforts under the auspices of the Research Council of Norway or subordinate departments, and the establishment of national competence centres. A focus on research can also form part of a more comprehensive, strategic focus on a field or a patient group.

The government wants to strengthen the research and development associated with care services and geriatric care. Research and development centres will be established for the municipal health and social services sector in existing research environments at university colleges and the conditions put in place for a gradual escalation of funds for care research and research into the living conditions and health of senior citizens, with a particular emphasis on dementia disorders. This will be done by strengthening the Research Council of Norway's health and care research programme. A national competence centre for women's health has been established to strengthen research into women's health. Similarly a national competence for ethnic minorities' health has been established to strengthen linguistic and cultural competence in the health service. The National Centre for Sámi Health Research has, together with the Norwegian Institute of Public Health, conducted an extensive health and living conditions survey. The results from the survey shall help to produce a basis for making decisions about and increased research into health and social conditions among the Sámi population. Research into the diseases and health status of senior citizens and how society can help to facilitate an active old age and good services for this group will be important in order to handle the increasing number of old people. Norwegian Social Research (NOVA) has established a database in which they monitor 5 000 people over the age of 40 years every five years and which will be an important means of strengthening research into senior citizens, cf. White paper St.meld.nr. 25 (2005-2006) *Mestring, muligheter og mening* (Long term care - future challenges – Care plan 2015)

Research for the benefit of patients

Sometimes, effective treatment is introduced too late, treatment without documented effect is used, and there are variations in the treatment methods used in the health service. One important measure for ensuring the quick and equal implementation of new treatments with documented effect is the establishment of systems for comparing, making available and communicating scientific information quickly and systematically. Making research available and comparing research results also provides a good knowledge base for the future prioritisation of research and prevention of unnecessary duplicated research.

Research taking place in proximity to patients/practices and knowledge-based summaries of this – provide a basis for general knowledge about the use of various prevention and treatment methods. In medical practice, general knowledge must be tailored to local needs. This is part of the quality development work. There is a need for the effects of changes in medical practice through quality development projects to be documented pursuant to accepted scientific methods.

It is important that the general public perceives research as useful. Patients, patient organisations and health personnel (professional organisations) should contribute their

opinions to ensure the prioritisation of relevant research themes and play an important role in the carrying out of studies in proximity to patients. This will ensure that the research – and the end points for the research – appear relevant to the patient and care the treatment providers. For example, experienced suffering, life quality and coping will be important end points for many people with chronic disorders.

Ethically justifiable research

Society must be able to trust that the research carried out in the health service is ethically justifiable. Good ethical research practice must therefore be facilitated. Good routines and guidelines for designing, carrying out and publishing research are also vital for the trust relationship between patients/research participants and the health service/research institutions. Given the focus on the need for good ethical research practice, the Ministry has stated that a review and strengthening of the quality management systems that have been established for research in the health enterprises shall be conducted. It is also important to establish systems that ensure qualification, transparency and quality in the awarding of resources for research.

National and regional research ethics committees, the establishment of a new national committee to examine integrity in research and a good set of regulations are important measures for ensuring the legitimacy of research. The Ministry of Health and Care Services is carrying out work with the aim of presenting a proposal for a new act concerning health research that follows up the proposals in NOU 2005: 1 Good Research – Better Health (God forskning – bedre helse). The aim is to draw up an act that protects research participants and addresses privacy protection, while at the same time clarifying, simplifying and creating a comprehensive set of regulations. The goal is for the act to promote good research while at the same time taking account of research freedom and the need for less bureaucracy.

Research collaboration and researcher networks

Strengthened national and international collaboration on research is an effective and necessary means of achieving the goals of increased quality and productivity in the research in the health service. There is a need to develop strategies that place Norway in an even better position to compete for international research funding in general and for the EU's 7th Framework Programme in particular. The programme includes, among other things, health funding of NOK 48,000 million. This area includes biotechnology, generic tools and medical technology, translation research, vis-à-vis among other things biodata, brain research and infectious diseases. Research in the European health services is new in relation to the 6th Framework Programme.

Many actors in the public sector, voluntary sector and the pharmaceutical industry carry out and/or fund research in the health service that takes place in proximity to patients without this being adequately coordinated. Increased national cooperation will ensure that the various means are coordinated. The national research collaboration that has been established between central actors in medical and professional health research should still be strengthened. A good coordination of funding shall be ensured by funds earmarked for

research in the health enterprises being distributed by cooperation bodies, in which the Research Council of Norway acts as observers.

One important measure for strengthening national cooperation will be establishing formal research networks across institutions, service levels and professional disciplines for the various fields. In this way, local hospitals and more specialised hospitals will gain a stronger role in the research collaboration, and research into treatment pathways and treatment chains across service levels will be addressed.

Needs-driven research

Scientific studies of patients in various phases of treatment and follow-up are important with respect to ensuring the documentation of effects and possible side effects when new methods are introduced or for comparing various treatment alternatives and effects over a long period of time. In order to secure statistically tenable data (for example gender specific analyses), controlled studies of large patient populations often have to be conducted. These types of studies are demanding from a resource, technical and competence perspective, and are often initiated and carried out in cooperation with the pharmaceutical industry. However, there is a need to increase the scope of free researcher initiated clinical studies in Norway, cf. White paper St.meld.nr 20 (2004-2005) Commitment to Research. Such research will address research into issues (e.g. diet, physical activity, alternative treatments) and patient groups that the pharmaceutical industry does not prioritise. For example, studies of adults will not necessarily provide good information concerning the correct treatment of children or the oldest senior citizens. Such a focus will also increase access to untested treatment for patients. Patients, especially those with serious and often incurable diseases, are becoming increasingly interested in participating in untested treatments even if there is insufficient documentation concerning the effect of the treatment.

Health and care services research

We have a limited amount of research-based knowledge about organisation, management, resource utilisation, interaction, ICT (Information and communications technology) and patient flows in the health service. For example, we currently lack good information about interdisciplinary and intersectoral cooperation within the field of rehabilitation. Research into correlations between patient flows and how this influences the use of resources over time, organisation and hospital buildings and infrastructure will help to ensure a better and more knowledge-based basis for making decisions concerning the planning and management of the provision. There is also a need to conduct individual-based selective surveys that follow patients through the treatment system, and that shed light on possible gender differences in the practice of diagnostics, assessments, referrals and treatment, cf. NOU 1999:13 Women's Health in Norway. Two specialist environments have been built up through an earmarked focus on research into health economics. There is a corresponding need for a focus on skills upgrading within health service research. One important prerequisite for strengthening health and care services research will be national health service data and the linking of data from the health service with health register data.

Research aimed at value creation

Cooperating with business provides the health sector with an opportunity to develop products and solutions that result in increased efficiency and quality. Innovation is important both for the fields and business, but must not be done at the expense of the health service's primary tasks. A focus on innovation and commercialisation in the health sector will be important in order to achieve the goal of increasing research activity to 3% of GNP by 2010, cf. White paper St.meld.nr 20 (2004-2005) Commitment to Research.

The Ministry of Health and Care Services together with the Ministry of Trade and Industry wants to strengthen innovation and commercialisation in the health sector through a joint five-year focus on needs driven innovation with a focus on ICT and technical medical equipment. Important actors will be the regional health enterprises, InnoMed, Innovation Norway and the Research Council of Norway. The focus will include a strengthening of the scheme for public research and development contracts (PRD) for health purposes, and measures aimed at encouraging arenas and meeting places between the supplier industry, the health sector and the funding system.

6.4.4 Information and communications technology (ICT)

Information and communications technology (ICT) is a key tool in preventive work and service provision in the health sector. The correct use of ICT combined with organisational development and a stronger focus on cooperation and interaction can help to achieve health policy goals, improve the quality of the health services and make the work more efficient.

Organisational measures have been implemented and development measures are being implemented that in differing ways facilitate electronic cooperation within the health service and between various actors. The consulted bodies point out that the sum of these measures has not resulted in enough electronic interaction between the health service's actors and that the number of services and information exchange is too low. The Ministry agrees with these viewpoints and will during the health plan period work on improving electronic interaction between the sectors and actors. This will partly involve joint solutions and partly standards that provide an opportunity for communication across systems. This will include the specialist health services' health enterprises, regular general practitioners and other enterprises within municipal health and care services, chemists and parts of the new, Norwegian Labour and Welfare Organisation (NAV). Many conditions have to be fulfilled before the goal of nationwide electronic interaction across the health network for all actors in the health and care sector is achieved and this will take time. The Ministry's perception is nonetheless that things have developed so far that the necessary institutional measures should be implemented to achieve the goal. This will be a significant step on the road towards the goal of achieving equal health services regardless of the patient's place of residence. Taking this as the starting point, the following elements will be central during this health plan period:

Norsk Helsenett

Norsk Helsenett AS (Norwegian Health Network) is an operating organisation that is intended to facilitate secure communication and deliver basic services that support interaction. The services in and utilisation of the health network have until now been far lower than expected. Only 29 local authorities are connected up to the health network. The reason for so few local authorities being connected include, among other things, the fact that no price model has been developed for connection, operating expenses and support, the fact that few services have been developed for local authorities, and the fact that the standards for information exchange have not been implemented in the record systems. Taking the Directorate for Health and Social Affairs' strategy document *S@mspill 2007* (Inter@ction 2007) as its starting point, a lighthouse project has been initiated in five local authorities. The lighthouses shall identify needs, potential benefits, and possible solutions for electronic cooperation within the municipal health and social services and between social services and specialist health services. The lighthouse projects have contributed to increased interest in the local authorities' vis-à-vis connection to the health network and use of electronic message exchange.

The content in the health network shall be developed and increased. The Ministry will stipulate requirements for the health enterprises that they facilitate electronic services and force the phasing out of old technology and electronic patient records (EPR systems) that do not meet current needs. The Ministry will also consider whether the requirements for the electronic processing of patient information, including the requirements concerning the electronic transfer of referrals, epicrises, doctors' certificates, and the use of the EPR standard should be stipulated in regulations.

Norsk Helsenett's bylaws largely deal with the goal of a common national ICT system. During the organisation's start-up phase, solutions have been chosen that do not fully reflect this ambition. Today five regional health enterprises own Norsk Helsenett and hold a dominant position on its board. The Ministry believes that Norsk Helsenett's national role dictates that the organisation, board composition, bylaws and strategy should reflect this function and will commence a dialogue with the Norwegian Association of Local and Regional Authorities and other relevant actors in order to initiate the necessary changes.

ICT in the local authority sector

Municipal care services are responsible for the largest groups with a need for compound and coordinated services. The care sector is responsible for the majority of the communication with the enterprises in connection with admissions and discharges from hospital. Electronic message exchange has not been adopted much. A lack of access to the health network is one reason why it has not been adopted. In order to be able to interact electronically across administrative levels, regions and internally one requires reliable and well-developed infrastructure that is dimensioned for large quantities of data. Experience shows that technological development varies from local authority to local authority. Many local authorities will face major challenges with respect to both infrastructure and the security the health network requires.

The specialist health services are strengthening the regional and national cooperation on ICT solutions through the establishment of regional ICT units and strategic ICT cooperation. The regional health enterprises have established the National ICT cooperation forum, which works on ICT coordination between the enterprises and can represent the enterprises in issues relating to systems, etc, with respect to other parts of the health and care services. The cooperation forum operates within the framework stipulated by the regional health enterprises at any given time. National ICT is a powerful driving force behind increasing the efficiency and coordination of the specialist health services' ICT solutions. At the same time, it creates guiding rules for the interaction between the local authorities. There is a risk that the local authorities will have too little influence in the development of the ICT cooperation with the health enterprises such that the solution will be based too much on the processes in the specialist health services. The specialist health services lack an equivalent counterpart in the local government sector.

The future development work will entail making decisions about systems that will also be of major importance vis-à-vis the local government sector. If the development work is to succeed, it is important that the national and local government sectors are equals. The local government sector shall itself choose which organisational solutions it includes in this cooperation. The Ministry will, in consultation with the Norwegian Association of Local and Regional Authorities, define methods of cooperation that can support the goal of equality in the development work.

Use of standards

The use of standards vis-à-vis electronic message exchange is an important prerequisite for achieving large-scale interaction between the sectors, within the health sector and within the individual health enterprises. The standardisation work is of absolutely vital importance with respect to the development of services in the health network. The use of standards is currently based on the suppliers of ICT systems voluntarily choosing to implement them. The Ministry will consider introducing a scheme regarding the national certification of standards for message exchange and electronic patient records (EPR) that suppliers will be obliged to implement in their systems and which shall oblige the actors to adopt the standards. The work on standardisation in the health sector shall take place in close partnership with the standardisation committee for the public sector under the Ministry of Government Administration and Reform.

Electronic patient records

Electronic patient records (EPR) include all patient information, i.e. documentation pursuant to the regulations concerning patient records including x-rays, laboratory results and other patient documentation. Current EPR systems cover, in varying degrees, the data content that pursuant to the regulations concerning patient records are regarded as patient records. In addition to the information in the actual EPR system, there will often be information in multiple specialised systems and in paper documents that pursuant to the regulations concerning patient records are regarded as part of a patient's record. One key challenge with respect to the introduction of EPR is to ensure the necessary access while at the same time addressing the requirements concerning confidentiality and secrecy.

Most general practitioners have held EPR for many years. All of the country's hospitals have now installed EPR systems and a gradual transition from paper records to electronically stored records is taking place. A lack of confidence regarding operational stability is one hindrance to the transition to fully digital production in the health enterprises. The consequence of this is expensive duplicate functions based on both paper records and EPR.

The current EPR systems are largely a continuation of the chronological, documentation-oriented and paper-based patient records. The current records are however not very comprehensible and do not facilitate information exchange or the registration of patient-related information for use in the administration of the health care of patients. EPR in hospitals also provide little support for the clinician with respect to processes and making decisions and scattered management information vis-à-vis the enterprises' and the authorities.

The Ministry believes that electronic patient records are vital to achieving electronic interaction in the health service. Further development of EPR must be based on patient pathways and the content of the health provision/health care given to the patient. In order to achieve the necessary interaction between the various actors in the health service, one must ensure that the necessary patient information can be exchanged electronically, reused and imported into the EPR systems operated by the various actors/health personnel. The development work should be integrated and coordinated with the other work on quality improvement that is taking place in the health service and must ensure that privacy protection is well addressed.

The introduction of EPR into the hospital sector enables better and more secure communication/interaction with regular general practitioners and the municipal health services (nursing homes and home care services) when connected up to the health network. It opens up opportunities for electronic communication/interaction and the use of health information, and thus gives rise to a number of challenges as well. This is particularly true in the area of information security.

The Ministry has therefore started work on a project to assess EPR in the specialist health services and the access to, exchange and sharing of patient-oriented information between health enterprises and internally in enterprises. This project shall assess what measures have to be introduced to give care providing health personnel access to the patient information they need in the simplest and most flexible manner possible. The primary principles of confidentiality and the patient's right to protection against the dissemination of information shall remain in place. If it is impossible within the current law to provide health personnel with electronic access to the health information they need, the Ministry will assess any required amendments to the law and/or regulations.

Information security

A great deal of attention will be paid to the issue of information security during the work on improving electronic interaction. The term information security refers to the information's confidentiality, integrity, quality and accessibility. Considerations

concerning the health service's overall functionality dictate that the necessary health information must be accessible to health personnel that are going to provide health care to the patient. Considerations concerning the patient's right to confidentiality dictate that one should be reticent with respect to sharing particularly sensitive information without the patient's consent. The relationship between the need for access and confidentiality shall be looked at in more detail in a dialogue involving the Ministry, patient organisations , regional health enterprises, the Data Inspectorate, the Directorate for Health and Social Affairs and other involved actors. The Ministry will return to this issue in its follow-up to the National Health Plan for Norway in 2007. This shall include recommendations concerning further follow-up.

The sector has developed a standard for information security that shall help to ensure good security during communication via Norsk Helsenett. Issues associated with critical social functions will also be dealt with in the coordinating committee for preventive information security.

Patients have a right to see their records. Today, a paper printout of the information is normally provided when electronic records are used. Due to a lack of security solutions, patients are not given access to their patient record via electronic means of communication. The Ministry will return to this issue in its follow-up to the National Health Plan for Norway in 2007. This shall include recommendations concerning further follow-up.

6.4.5 Biotechnology

Developments in the medical use of biotechnology have illustrated the value and potential biotechnology may have vis-à-vis medical examinations, treatment, research and business development. The Ministry wishes to encourage the development of modern biotechnology for the benefit of the individual and society as a whole. This shall be done within a justifiable framework of ethics and safety vis-à-vis health and the environment.

Biotechnology is an interesting field that presents exciting ethical, technical, medical and legal challenges, different considerations and interests may in connection with these conflicts with each other. It is therefore extremely important to be open about the questions and issues that the medical use of biotechnology raise. It is vital to have public debates about questions associated with values and good information about the developments and potential in order to create trust and credibility vis-à-vis the field.

The Biotechnology Act

The medical use of biotechnology is regulated by the Act of 5th December 2003 no. 100 relating to the Application of Biotechnology in Human Medicine, Etc. The act covers assisted fertilisation, prohibitions against research on embryos and cloning, prenatal diagnosis, postnatal genetic testing, gene therapy, etc. Compared with a number of other countries, Norway has restrictive regulations in this area. As the technology develops and new knowledge is generated, new opportunities for research and treatment also open up. The Ministry wishes to take advantage of the opportunities that modern biotechnology

presents within an ethically justifiable framework. The Ministry will therefore review the current regulation of biotechnology. This shall be done according to the principles of respect for human dignity, human rights and personal integrity, and without any discrimination on the basis of genetic constitution, in line with the act's objects clause.

Preimplantation diagnostics and embryo research (stem cell research)

The Ministry wishes to permit the limited use of preimplantation diagnostics (PGD) and to allow research on surplus embryos under certain conditions. In the spring of 2006 the Ministry carried out a wide-ranging consultation process concerning these proposals. It aims to present a proposal concerning amendments to the law to the Storting at the turn of the year.

Preimplantation diagnostics (PGD)

Preimplantation diagnostics involves a genetic examination of embryos outside the body prior to implantation in the womb. Its purpose is to help couples with genetic traits that may result in a future child being born with serious, genetically inherited diseases. By examining the embryos, one can choose an embryo that does not have the relevant diseases. The Ministry also wishes to permit, in connection with PGD aimed at excluding serious, genetically inherited diseases, the examination of the embryos' tissue type with a view to sibling donations for sick siblings with the same tissue type. Given strict conditions and limited use, the Ministry believes that it is justifiable to offer this treatment.

Stem cell research

Stem cell research is an exciting field with great potential. The Ministry wants to help ensure that the potential inherent in this area can be utilised to the benefit of people and wishes to support stem cell research with a view to finding new treatment opportunities for serious diseases. Several diseases could be cured by taking advantage of the medical progress that biotechnology and gene technology will bring about. The Ministry wants an increased focus on research on so-called adult stem cells (from born individuals).

In connection with the proposals concerning permitting the use of surplus embryos in research under certain conditions, the Ministry also wants to permit embryonic stem cell research. Embryos are a source of embryonic stem cells. These stem cells can develop into almost every cell in the body and are therefore assumed to be of great value with regard to knowledge about the development processes of cells, and the development of treatment methods for serious diseases for which we currently do not have satisfactory treatment options.

Further follow-up

Due to developments in the field of biotechnology, the Ministry also wants to look more closely at the other sections of the Biotechnology Act. The Ministry aims to start work on a major revision of the act when the proposition concerning amendments in connection with research on surplus embryos and PGD is presented to the Storting.

6.4.6 Preparedness in the health and social services sector

The health and social services sector constitute a comprehensive preparedness organisation. The purpose of the sector's preparedness is to help ensure that the population can be offered the necessary health care and social services in the event of crises, catastrophes and war. The preparedness requirements follow from the Act on Health and Social Preparedness and other health and social services legislation. The Act on Health and Social Preparedness obliges local authorities, county councils, regional health enterprises and the national government to have preparedness plans. Hospitals, waterworks and food authorities have an independent duty to have plans. The measures are followed up in line with responsibilities, proximity and the principle of equality. In order to achieve comprehensiveness and cohesion in the services, every part coordinates its own preparedness with cooperating parts.

Hospitals and emergency medical services outside hospitals constitute the main basis of the health service's day-to-day preparedness. In the event of accidents and catastrophes the health service is involved at the site during crises steering through the presence of the emergency services (police, fire service and health service). Outbreaks of infectious diseases are handled as part of the general infection control preparedness. Outbreaks of infectious diseases are normally discovered by sick people visiting municipal casualty clinics or their regular general practitioners. When a crisis requires more resources than those which are available locally, resources are mobilised upon receipt of a request for assistance from other local authorities and health enterprises, and at the national level. The nature of the crises and its scope determine the need to activate the crisis steering system at a central authority level.

The Ministry of Health and Care Services bears overall responsibility for the sector and for coordinating measures and information in relation to other ministries. The Ministry is a permanent member of the government's crisis council and in the event of major health-related crisis situations the Ministry can be assigned the task of heading the crisis management.

The Directorate for Health and Social Affairs shall in all preparedness activities vis-à-vis the overall health and social services and administration contribute to comprehensiveness, interaction and cohesion – both during preparedness planning and in crisis situations. Pursuant to the established distribution of tasks between the Ministry and the Directorate for Health and Social Affairs, the directorate shall, pursuant to delegation from the Ministry, ensure the overall coordination of the health and social services sector's efforts, and if necessary implement measures when a crisis situation threatens or has occurred. The Norwegian Institute of Public Health is the state's infection control institution and is, among other things, responsible for monitoring infectious diseases and is at the centre of the infection tracking work. The Norwegian Board of Health ensures that the health service fulfils its statutory preparedness responsibilities and the Norwegian Medicines Agency is responsible for approving medicines and the supervision of the pharmaceutical industry. The Norwegian Food Safety Authority supervises preparedness plans associated with food safety and drinking

water. The Norwegian Radiation Protection Authority is responsible for the intersectoral coordination of nuclear preparedness and heads the crisis committee for nuclear preparedness. The national nuclear preparedness is stipulated by a Royal Decree dated 17th February 2006. The preparedness is built around the Crisis Committee for Nuclear Accidents, which consists of representatives from the national authorities who have special responsibilities vis-à-vis nuclear preparedness. The chief administrative officers of counties are responsible for the regional coordination of civil protection, preparedness and regional nuclear preparedness.

A number of health-related preparedness challenges are international in character. Norway therefore participates in WHO's, FAO's and the International Atomic Energy Agency's (IAEA) global partnership on monitoring, analysis, warning and reaction forms in the event of outbreaks of infections diseases and radiation-related incidents. Norway also works with NATO and the EU in this area by, among other things, participating in the EU's new European Centre for Disease Prevention and Control (ECDC) and the EU's Health Security Committee. Norway also participates in the EU's notification systems in the area of food. A health-related preparedness agreement has been signed in the Nordic Region which, among other things, includes assistance and information sharing in the event of crises and catastrophes.

The Act on Health and Social Preparedness has, together with the reform of the national health administration and hospital reform in 2002, helped to improve the sector's ability to manage crises. Figures from the Norwegian Board of Health show that all of the regional health enterprises, the health enterprises, and most local authorities have preparedness plans pursuant to the Act on Health and Social Preparedness. Moreover, all regional health enterprises and local authorities, with one exception, have infection control plans. The Norwegian Board of Health and the Directorate for Health and Social Affairs nonetheless see a need to improve the quality of the existing plans by, among other things, producing risk and vulnerability analyses, procedures for resource allocation, plans to ensure the certainty of supplies of medicines and materials, and plans for the municipal social services.

Challenges and focus areas up to 2010

Ensuring robust preparedness and the ability to manage crises

The development of good routines for interaction and coordinated efforts internally in the sector and with respect to other sectors are permanent challenges. In the event of accidents, the emergency services at the scene, the ambulance service, and the emergency ward at the hospital must operate in a coordinated manner. For those affected the experience of a cohesive chain of provision will be of great importance – both during the acute phase and during the follow-up where they live after treatment in the specialist health services.

An increased focus on terrorist activities and the risk of an outbreak of infectious diseases are helping to ensure that the attention being paid to the work on preparedness is strengthened. A great deal of media coverage of crises and catastrophes can result in a stronger general feeling of insecurity. The fact that crises situations have arisen abroad or

that Norway is threatened by incidents abroad, outside the authorities' control, can further increase this feeling of insecurity. This increases the importance of the right information being given at the right time.

Further follow-up

- Competence measures: exercises, training and supervision of the services and their administration.
- The Directorate for Health and Social Affairs and the Norwegian Board of Health monitor the preparedness work in local authorities through advice and supervision. The directorate especially monitors airports, local authorities' with ports with international traffic – the planning of reception centres.
- Strengthening information preparedness vis-à-vis the general public, relatives and the media.
- Further developing information systems for resource steering and decision making support.

Ensuring robust supply systems

The health service is a complex organisation that relies on supplies of a large number of input factors. The trend is in the direction of increasingly greater demands vis-à-vis efficiency and the increased internationalisation of supply chains. This involves the reduction of stores of supplies and the fact that important input factors have to be imported into the country. Strengthening the robustness of supply chains in normal as well as extraordinary situations will be of key importance in the future work.

Further follow-up

- The regional health enterprises are incorporating preparedness considerations into their logistics systems and delivery agreements so that the health enterprises can together address the total national responsibility for the supply of medicines and materials, and other important input factors for the specialist health services.
- The Directorate for Health and Social Affairs is reviewing the national security of supply chains and assessing whether or not there is a need for new measures to ensure the necessary robustness.

Strengthening ABC preparedness, including infection control preparedness

Achieving coordinated intersectoral measures in the preparedness for atomic, biological and chemical incidents (ABC preparedness) is a challenge because a very large number of actors involved. The Crisis Committee for Nuclear Accidents, which coordinates nuclear preparedness, has come a long way in the work of drawing up coordinated plans. The Ministry will conduct a review of the sector's preparedness vis-à-vis biological and chemical incidents.

Outbreaks of infectious diseases have placed infection control preparedness high on the agenda. Good infection control preparedness requires good cooperation on disease monitoring and reporting, adequate analysis capacity and the ability to manage crises, including medicines to treat outbreaks of infectious diseases. The organisation that is

going to follow up the measures from a local to a national level must be well drilled and ensure good interaction within the health service and with the other sectors that will be involved.

Further follow-up

- Developing plans and measures for managing a possible epidemic.
- Considering a partnership vis-à-vis the Nordic production of vaccines against an influenza pandemic for the domestic market that can also make a positive contribution on a worldwide basis, including also considering an increased national focus on research into and the development of vaccines.
- Considering measures with respect to hospital infections, laboratory and isolation capacity.

Strengthening participation in international partnerships in the area of health preparedness

A number of health-related preparedness challenges are international in nature. The risk of terrorist-caused outbreaks of infectious diseases and radioactive or chemical discharges do not stop at our borders. Norwegians travel abroad more (work and leisure related travel) and have expectations regarding the health authorities' crisis steering and expect health care and social services to be available quickly, regardless of where the crisis occurs. International cooperation is therefore important and Norway is increasingly cooperating with other countries and international organisations in order to strengthen its ability to manage major crises.

Further follow-up

- Develop the Nordic partnership: measures against pandemics and crises abroad.
- Follow up WHO's international health regulations (IHR 2005) in the national regulations and plans.
- Participate in the work on developing the ability of the EU to manage crises.

6.4.7 International partnerships within the area of health and social services

A number of health challenges are international in nature. The purpose of Norway's international health cooperation is to meet these challenges by developing systems for effective prevention and combating diseases, and helping to improve the health situation in Norway's neighbourhood and other parts of the world. Norway's international involvement primarily takes place through the EU, EEA, WHO, Nordic Council of Ministers, IAEA, the EU's Northern Dimension and the Barents Health and Social Programme.

Main features of the EU/EEA cooperation

The Ministry of Health and Care Services, the Norwegian Food Safety Authority, the Norwegian Medicines Agency, the Directorate for Health and Social Affairs and the Norwegian Institute of Public Health are extensively involved in the ongoing work with the EU/EEA on issues to do with the administration of health and food safety.

Norway participates in the EU's inner market (cf. the EEA Agreement) and every year an extensive set of EU regulations are implemented in Norwegian law in the following areas: food, drinking water, tobacco, medicines, cosmetics, medical equipment, and blood/cells/tissue. The four freedoms also entail a right to have health care expenses paid and the mutual recognition of occupational qualifications for health personnel. Norwegian experts from the health and food safety authorities have through the EEA Agreement the right to participate in the working groups that draw up proposals for new or revised regulations.

The Treaty on EU's public health article (article 152) stipulates that health policy (including the levels of provision, organisation and funding) is the responsibility of each member state. The article also stipulates that member states can enter into voluntary partnerships vis-à-vis common challenges in the area of health policy. In EU circles, there is a growing acknowledgement of the correlation between public health and economic growth, and there is increased EU cooperation in this area.

The EU member states emphasise cooperation on preventive measures that are intended to raise the awareness of citizens concerning consumption and lifestyle, and involve business and special interests organisations.

Important areas for cooperation in which the Norwegian health authorities participate primarily via EFTA's established groups for public health are:

- The Public Health Programme 2003-2008 (continued in 2007-2013 with reservations concerning the consent of the Storting). Norway participates in projects within the areas of health information, health threats and the prevention of risk factors.
- Health preparedness: the EU member states have established an extensive partnership that ensures they are well equipped to handle outbreaks of infectious diseases across borders and any terrorist actions involving the use of biological and chemical weapons.

Norway also participates in a cooperation concerning patient mobility. A high level group has been established with several working groups in order to, among other things, assess various aspects of cooperation between the countries' health services and the practical effects of the European Court of Justice's judgements concerning entitlement to have health service expenses incurred abroad paid. The principle of the free movement of services includes patients as provision recipients.

Radiation control: EURATOM under the EU's 6th Framework Programme for Research (is continued in the 7th Framework Programme from 1st January 2007).

The EU has expert bodies for several key cooperation areas. Within the Ministry's area of responsibilities, Norway participates in the European Agency for the Evaluation of Medicinal Products (EMEA) in London, the European Centre for Disease Prevention and Control (ECDC) in Stockholm, the European Monitoring Centre for Drugs and Drug

Addiction (EMCDDA) in Lisbon and the European Food Safety Authority (EFSA) in Parma (Norwegian participation will be formalised from 2007).

Trends and challenges up to 2010

Factors that contribute to the development of the EU: new member states with their own challenges, judgements in cases that involve the four freedoms, the growth of common challenges in which the individual countries believe they will benefit from a collaboration also in areas outside the EU's inner market create challenges for Norway.

Challenges in the relationship between Norwegian health and food safety authorities and the EU

The EU member states are increasingly developing health cooperation in areas that fall outside the EEA Agreement. It is therefore important for Norway to supplement the work within the EU with an active Nordic cooperation and bilateral partnerships. Norway has a health cooperation agreement with France and a partnership with Poland and other new EU member states through the EEA funding schemes. Norway will contribute NOK 10,000 million through the EEA funding schemes to the new EU member states during the period 2004-2009. The purpose is to contribute to the countries' economic and social integration. Health is a prioritised sector (projects: health system development and prevention, eHealth, health registers, alcohol, narcotics, tobacco and health promoting measures). The scheme shall contribute to strengthening bilateral connections and partnerships in projects.

Challenges for the Norwegian health and food safety authorities

Participating actively in the formulation and follow-up of new regulations in the area of food safety and on patient mobility, etc, is a challenge. Since health services were exempted from the scope of the Service Directive, the introduction of separate regulations has been announced for this area. It is also important to involve special interests organisations, business and other involved parties from Norway's side – from start to finish.

Challenges for the Norwegian health service

Trends in the EU with respect to patient mobility may result in the future in an increasing number of Norwegians crossing borders to receive health care abroad. Over time, this could entail a challenge for the Norwegian health service (quality, capacity, patient base) because the service will experience competition from the services in other European countries. This may also lead to increased pressure on Norwegian hospitals in the form of demand from patients from other countries.

Further follow-up

With reference to the White paper St.meld.nr. 23 (2005-2006) Action Plan for the Implementation of Norway's European Policy, the Ministry will draw up a strategy for the EU/EEA work. Central measures will be:

- developing inter-ministerial cooperation and cooperation within national health and food safety authorities

- assessing measures in order to address national interests
- strengthening quality and tailoring in the Norwegian health service to compete with other European countries' services

Cooperation with the World Health Organisation (WHO and other UN Forums)

Globally speaking the WHO partnership is our most important health policy arena. The cooperation is politically important and of great significance in a development perspective. WHO are a key standard setting organisation and the most important global health policy actor. WHO and the organisation's regional offices play an active role as a contributor to and driving force behind developments in global health issues. The development of national health systems, combating infectious diseases, and preventive tobacco work have in particular been central elements of the European region's work in recent years. In 2005, WHO adopted a resolution concerning the problems caused by the harmful consumption of alcohol.

In cooperation with the UN's organisation for food and agriculture (FAO), WHO is responsible for the development of international standards for food quality and food safety via Codex Alimentarius. These standards also provide a basis for international trade through the Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) under the World Trade Organisation (WTO).

Regarding narcotics the UN's drugs commission (of which Norway is a member) is of importance.

Challenges up to 2010

WHO's unique role as the world's arena for health policy cooperation is required by specific challenges particularly associated with the third world. GAVI focuses on vaccines, UNAIDS on the fight against HIV/AIDS, the global health fund GFATM's mandate is concerning HIV/AIDS, tuberculosis and malaria. A number of public/private partnerships work on, among other things, research into diseases and health problems that impact developing countries. Private foundations such as the Gates Foundation have more than three times WHO's resources at their disposal. This fragmentation requires effective cooperation and a rational distribution of tasks based on the actors' competence. WHO also plays an important role in focusing on lifestyle and on non-infectious diseases, which are increasing problems in developing countries as well. It is important that WHO's role as a setter of standards and health advisor for all the countries of the world is preserved. The demand for WHO's neutral and knowledge-based advice is increasing.

Health systems

The development of comprehensive national health systems, including prevention, is perhaps WHO's greatest challenge in a development perspective. Today most developing countries lack both adequate capacity and competent health personnel. WHO's role is required due to the fact that the World Bank is trying to move away from funding disease-based programmes towards health sector development. It is becoming important to ensure that WHO's systems knowledge is linked to the World Bank's financial resources.

Infectious diseases/preparedness

WHO's role and importance for countries is most evident in connection with outbreaks of global health threats such as SARS and pandemic influenza. The international health regulations that come into force in June 2007 formalise WHO's right to implement the measures it regards as necessary in the case of outbreaks that may threaten global health. It is important to protect and develop this role.

UN reforms

The UN organisations are characterised by relatively cumbersome administrative and financial systems, decision-making mechanisms and work methods. These do not always ensure optimum functionality. Result-based budget and programme steering is an important challenge for the UN. WHO's result-based programme budget is a model for the entire UN system. WHO shall place greater emphasize on advice and specialist support vis-à-vis countries' own health plans and coordinating its efforts with other international and bilateral actors.

Global mobility and health workers

Globalisation entails the increased mobility of health labour. The world is currently experiencing a deficit of 4 million health workers. The situation is particularly acute in developing countries in which qualified health personnel are being recruited to better paid positions in industrialised countries. Norway is playing an important role in a new global alliance on human resources based in WHO in which the issue of migration is included as a key area. One fundamental criterion for developing countries to be able to succeed better in keeping its own quality labour within the health sector is rich countries implementing a policy of not emptying poor countries of their few qualified health workers. Norway aims to implement such a policy. The Ministry of Health and Care Services will ask the Directorate for Health and Social Affairs to assess the elements this policy should be based on. The Ministry will also ask the Directorate for Health and Social Affairs to examine, in cooperation with NORAD, how Norway can otherwise help to improve the health worker situation in developing countries.

Food quality and food safety

As time passes, the market for food is developing from being local or regional to increasingly being global. The food trade across national borders is increasing, this means that it is becoming steadily more important for Norwegian consumers that food quality and food safety maintain high levels in all parts of the world.

Nordic cooperation

Nordic health and social services cooperation is based on a cooperation programme. The cooperation programme builds on the values of the Nordic welfare model and covers a wide spectrum from research and training to sharing information and experiences, and intercourse between the countries through conventions and agreements. The most important arenas are the Nordic Council of Ministers and the Nordic Social Policy

Committee. In addition to these, diet and food safety are part of the Nordic cooperation within fisheries and fish farming, agriculture, food and forestry.

Trends and challenges up to 2010
Dismantling of border barriers between the Nordic countries
The Nordic countries have decided to establish incentive schemes in the expert ministerial committees in which the problems associated with border barriers are most prominent. In the initial phase the schemes shall run until the Nordic Council's session in 2008. Thereafter, one will decide whether to make any changes or continue them.

Regional cooperation arenas for European and global cooperation
The Nordic network is a good starting point for formal and informal discussions about sharing information on relevant issues in an EU/EEA and WHO context. One example is the issue of narcotics and alcohol policy cf. the Nordic ministers' initiative from 2004 concerning strengthening measures to reduce alcohol-related problems. WHO's European region adopted a new framework for alcohol policy in 2005. The EU Commission has announced the presentation of an alcohol policy strategy in the autumn of 2006. Annual reporting in the health and social services minister meetings until 2009 will form a basis for the discussions the health and social services ministers will have on the further follow-up of the policy.

Health and social preparedness
The Nordic health preparedness agreement was signed in June 2002 and came into force on 20th November 2003. The purpose of the agreement is to increase the Nordic countries' overall ability to manage crises and catastrophes. It emphasises measures to counter pandemic influenza. Analyses are currently underway to develop Nordic cooperation in the event of major crises situations abroad.

The EU's European Centre for Disease Prevention and Control (ECDC) in Stockholm has strengthened infection control cooperation between the EU's member states and Norway participates in the centre's activities.

Barents health cooperation and bilateral cooperation with Russia

Health is an area where cooperation with the authorities in Russia and the Baltic states has come a long way. Projects are underway at regional and local authority levels with an emphasis on initiatives to combat infectious diseases, lifestyle diseases and social problems. The most important overarching structures for the work are the Partnership in Public Health and Social Wellbeing under the EU's Northern Dimension and the Barents Committee's working group for health and social issues.

Trends and challenges up to 2010
The border between Norway and Russia is a marked dividing line: economically, health-wise and socially. Figures from WHO show that infant mortality in Russia is 15.5 per 1,000 live births. In Norway it is 3.8. Life expectancy for men in Russia is 58 years and in Norway 77 years. For women the figures are 77 and 82 years. Many Russian men are

hit by disease and die at an age when they could be occupationally active and family fathers.

Alcohol abuse and malnutrition are the causes of many diseases. Accidents and violence cost more lives than in Norway. The incidence rate of infectious diseases is generally high. The situations vis-à-vis HIV/AIDS, tuberculosis and multi-resistant tuberculosis are worrying. Improving public health and living conditions is important with respect to preventing the spread of infectious diseases and for economic and social development in Russia. The involvement is currently very diffuse. There is a need for oversight and cohesion in the involvement.

Further follow-up

The focus on tuberculosis in the Barents region is continuing with the aim of achieving the goal of bringing the disease under control by 2013. An action plan has been drawn up to combat HIV/AIDS, which is being implemented in north-western Russia under Norwegian steering and in close cooperation with Russian experts. Improving health conditions in prisons is of great importance with respect to limiting infectious diseases. Norway bears a special responsibility for this area in the Partnership in Public Health and Social Wellbeing under the EU's Northern Dimension.

Other bilateral cooperation

In 2003, Norway and France signed a bilateral health agreement that covers, among other things, cooperation on a regional level and hospital cooperation. Other areas of cooperation include alcohol and meningitis. The agreement with France will be renewed in the autumn of 2006.

Norway and China have cooperated on health issues since 1999. China is, as one of the world's most populous countries with a strongly growing economy, an important country from a health perspective. The cooperation will continue during the period 2006-2009 with a new action plan with the following primary priorities: health system and services, public health and prevention, care and organisation, local health provision, the prevention and control of infectious diseases, and mother/child health.

6.4.8 Pre-hospital emergency provision

The public's confidence that they will receive help in the event of acute somatic and mental illness and injury is an important welfare benefit. Such confidence is based on the certainty and experience of receiving rapid, qualified help and transport in the event of acute injuries or illnesses. Most acute cases are dealt with by the municipal general medical/practitioner services. In the event of serious accidents or serious acute illnesses, treatment starts on-site/in the place where the acute illness situation occurred, and is continued during transport to a hospital. Measures and services that represent necessary medical aid in the event of acute injuries of illnesses requiring medical treatment are referred to as the emergency medical chain. That part of the emergency medical chain that lies outside the hospital is called pre-hospital services. The pre-hospital services

include the medical emergency reporting service, municipal casualty clinic systems and the ambulance service.

Around 90% of acute cases are treated by municipal health services, while around 10% are referred to or sent directly to hospitals. For 1 out of 100 patients the treatment will be time critical and, in these circumstances, it is absolutely vital that the emergency medical chain functions satisfactorily in order to save lives and reduce subsequent medical consequences.

Medical emergency reporting service

The medical emergency reporting service's system consists of a medical emergency number, medical emergency call centres (AMK call centres) in the specialist health services, casualty clinic call centres (LV call centres) in municipal health services and a shared, closed, uniform and nationwide communications network for on-call health personnel to which both AMK call centres and LV call centres shall be connected.

The first link in the emergency medical chain is often the patient himself or herself, relatives or the general public, and is vital with respect to reporting to LV call centres or the emergency number 113 in the event of serious illnesses or injuries. The health enterprises' AMK call centres receive reports via this emergency number. The health personnel in the AMK call centres acquire information about the condition of the person in cooperation with the caller and ensure that the necessary resources are sent to the site where the injury occurred or illness arose. AMK call centres shall also assess the need for assistance from the municipal casualty clinic such that local doctors can reach the patient(s) before an ambulance arrives, and notify and communicate calls to other emergency services and possibly the joint rescue coordination centres, and other involved AMK call centres. When necessary the health personnel in AMK call centres shall be able to provide expert medical advice, including on lifesaving first aid.

In the event of less serious cases, the municipal casualty clinic will as a rule is contacted. Local authorities shall ensure they organise a casualty clinic number and, possibly in cooperation with other local authorities, run an LV call centre that accepts and handles reports concerning emergency medical assistance, including the prioritisation, implementation and follow-up of enquiries to on-call physicians, district nurses, midwives, crisis teams and other relevant services.

The medical emergency reporting service has undergone both organisational and technical changes in recent years. We have achieved a reduction in the number of LV call centres by getting more local authorities connected to a common call centre, and the number of AMK call centres has been reduced. The aim was to achieve call centres that were better staffed with increased competence and better equipment. AMK call centres have been equipped with electronic maps and so-called fleet steering for ambulances such that the staff on-call at AMK call centres can at any given time "see" the resources (e.g. ambulances) that are closest to the patient. A new, digital emergency network will further strengthen the AMK call centres.

New emergency network

Effective, lifesaving efforts in all situations require a predictable, modern communications system with appropriate functionality and coverage, and adequate capacity. In connection with its handling of the national budget for 2005 the Storting decided to invite bids for the establishment of a common digital radio network (emergency network) for the emergency and preparedness services (fire, police, health) and that a contract can be signed for the first development area. In the initial phase this will include large portions of the Eastern Norway Regional Health Authority (Follo, Romerike, Oslo, Østfold, Asker and Bærum) and parts of the Southern Norway Regional Health Authority (southern Buskerud): 54 local authorities will be included in the first building phase.

The collation of all organisations with preparedness-related duties into a single network will help to make the emergency services' work in their day-to-day work and in the event of major incidents more efficient, and will thus result in an increased feeling of confidence depending on where one lives. The new emergency network will, among other things, enable the electronic transmission of patient information from the incident site/ambulance to the hospital and enable patients to be monitored during transport. One prerequisite for fully achieving the potential of such an extensive social investment is that the relevant health personnel, both in the ambulance service and the physicians on-call, are easily accessible via the network.

The municipal casualty clinic system

Around nine out of ten cases of acute illnesses are diagnosed and treated outside hospitals in the municipal casualty clinic system. The municipal casualty clinic system can, together with the ambulance service, also play a key role in the diagnosis and stabilisation of acutely ill people prior to transport to a hospital, especially outside the largest cities.

During the daytime, the municipal casualty clinic preparedness in most local authorities is addressed by general practitioners in their own practices. In larger local authorities, the emergency help provision is often organised as daytime-open casualty clinics with their own casualty clinic premises. In the evening, at night and during the weekend/public holidays the local authorities have, in various ways, organised casualty clinics. In large cities the casualty clinics have their own premises. 30% of local authorities have their own municipal casualty clinic. Of these around 1/3 have plans concerning inter-municipal cooperation. 70% of local authorities cooperate with other local authorities in some form or other in an inter-municipal system. There are great variations in this. On a nationwide basis, no less than 30 forms of inter-municipal casualty clinic cooperation with joint casualty clinics have been established. The majority of these are collocated at a local hospital in the area. There are many advantages in having joint casualty clinic centres instead of casualty clinic based on physicians running the casualty clinic. One is that the casualty clinic centre is, as a general rule, staffed by both nurses and doctors around the clock. Many calls can be resolved on the telephone and people can be encouraged to contact the regular general practitioner the next day. Alternatively the patient/relative can call back later if the situation deteriorates. If the situation requires examination and

treatment, the nurses and doctors have a better range of the necessary equipment available to them than that which can fit into a physician's medical bag, as would be the case with a home visit. The disadvantage can be longer travel distances for parts of the population. If the inter-municipal casualty clinic district is large, then it may be necessary to have support services available in the outskirts of the district. Such a structure often entails greater costs for local authorities due to a considerable increase in the quality of emergency preparedness. On the other hand it has been shown that the organisation of municipal casualty clinics into inter-municipal casualty clinic centres is important with respect to being able to recruit recently qualified physicians to the rural areas, especially female physicians. This also entails a considerably less burden vis-à-vis duties for the established physicians. General medical practitioners over the age of 55 years old can ask to be exempted from casualty clinic work. Nonetheless, in those areas with such inter-municipal casualty clinic partnerships many physicians over the age of 55 years old participate since the burden of being on-call is low for the individual.

Good access to one's regular general practitioner and well-organised municipal casualty clinics result in confidence and ensure rapid treatment, and if necessary rapid admission to hospitals for those who need it.

In every county at least one of the inter-municipal casualty clinic centres shall function as a reception centre for victims of violence and rape. This shall be low threshold provision for everyone who has been the victim of violence and/or attacks, regardless of gender, age, ethnicity, etc.

The Ministry of Health and Care Services has established the National Centre for Emergency Primary Health Care at the University of Bergen. The centre shall carry out research and development, in cooperation with other research environments, in order to help build up and disseminate expert knowledge within municipal casualty clinic health care.

The ambulance service

In NOU 1998: 9 *Hvis det haster*…(If it is urgent…), the vehicle ambulance service was assessed as being the weakest link in the emergency medical chain. Better training and better organisation have since this significantly boosted the service in terms of professionalism. All ambulances now have two person crews, better equipment and personnel with more competence in both diagnostics and treatment prior to arrival at hospital. New communication solutions make it possible for specialists at the hospital to make precise diagnoses (for example in the case of acute heart conditions) and start treatment long before the patient arrives at the hospital. Pre-hospital services are expected to be pioneers in the health service with respect to the application and utilisation of ICT.

For many island communities ambulance boats are just as important as vehicle ambulances. Even though the use of air ambulances has increased access, it is often only ambulance boats that can go out when the weather is poor. There will therefore continue to be a need for ambulance boats in several places along the coast, and in most health enterprises the professional standard is now on a par with the vehicle ambulance service.

The air ambulance services is organised as a state-owned company, Luftambulansetjenesten ANS, and operates from eleven helicopter bases and seven aeroplane ambulance bases. The use of air ambulances has doubled in the last ten years, for as number of reasons:

- changes in medical treatment, with a greater requirement for the centralisation of services, e.g. the treatment of acute heart attacks and complicated injuries
- an increased degree of the distribution of functions between hospitals entails an increased need for transfers between hospitals, and of seriously ill patients
- pressure in the intensive care wards of the major hospitals entails an increased need for transport back to local hospitals once treatment has been completed.

In this way, the air ambulance service helps to ensure that the public is ensured access to equal treatment provision regardless of where one lives.

The health authorities have stipulated specific requirements concerning the competence of personnel who operate ambulances. The current training of ambulance personnel takes place in upper secondary schools and results in a trade certificate as an ambulance worker. A project has been started to assess the need for the further education of ambulance personnel.

Cohesion between the pre-hospital services and hospital structure

The way in which the pre-hospital services are organised and dimensioned will be affected when the structure of hospitals is changed. Structural changes in and between hospitals involve changes to patient pathways within specialist health services and it is vital that the cohesion in the professional provision is quality assured by, for example, distributing functions between hospitals. The quality of emergency medical provision depends on the competence and capacity of the entire emergency medical chain. Changes to the structure will have consequences for the rest of the treatment chain, and it is therefore necessary to clarify which measures are needed to ensure that emergency preparedness is maintained.

The pre-hospital services are of vital importance in cohesive emergency preparedness, both between hospitals, and between home care services and specialist health services. The dimensioning of pre-hospital services is therefore a consequence of medical developments and the distribution of functions between hospitals.

6.5 Key development measures during the health plan period

In chapter 6.3, the health service’s primary areas were presented together with a description of the mutual interdependence between the areas and the need for systematic interaction.

Chapter 6.4 discusses the key strategic areas for the entire health service in which there is often a need for joint national efforts to achieve the overall goals of the health policy. The

overall measures in these areas are intended to help ensure the equal distribution of health provision and good utilisation of resources by supporting the six cornerstones of the National Health Plan for Norway:

- cohesion and interaction
- democracy and legitimacy
- proximity and security
- stronger patient role
- professionalism and quality
- work and health

An overview of the key development measures associated with each of the cornerstones is provided below.

Cohesion and interaction

The health service does not involve enough comprehensive thinking and interaction vis-à-vis the individual patient. It is a paradox that the individual enterprises may at the same time appear successful based on their assigned tasks and the applicable allocation of responsibilities. The Ministry wants to change this through the National Health Plan for Norway such that interaction becomes an integral part of the tasks of and content in the individual enterprises.

During the health plan period, the Ministry will work on several strategies and initiatives:

- The principal strategies in public health policy are designed to ensure both the municipal health services and the specialist health services place more emphasis on preventive work in their activities.
- Where the total treatment and follow-up provision is important for the patient, the health care cannot take place in isolation within the municipally-embedded health and social services and the enterprise-organised specialist health services. A national board for quality and prioritisation shall therefore be established. All those actors with responsibilities shall participate in the board and shall help to ensure comprehensive and coordinated transfers of responsibilities and costs between actors.
- Work shall be done in the area of ICT to ensure local authorities a stronger role in the work on a national health network such that the use of ICT between the specialist health services, the municipal health and social services and the Norwegian Labour and Welfare Organisation is facilitated.
- Training shall continue to be rooted in the individual health fields, but stricter requirements shall be stipulated concerning the training including the challenges posed by interaction.
- The development of the research areas shall include the challenges posed by interaction by, among other things, the establishment of a formal research network across institutions, service levels and disciplines in the various fields.
- The follow-up of interaction measures in proximity to patients such as personalised plans and the physicians' practice consultation scheme shall be strengthened.

- The work on improving interaction between the municipal health and care services shall be followed up with a view to greater medical professionalism in nursing homes.
- The Ministry and the Norwegian Association of Local and Regional Authorities have agreed to start a project aimed at signing a universal agreement that shall focus on interaction in the area of health and care.

Democracy and legitimacy

A good health service must have legitimacy amongst and the trust of the general public. Evaluations show that most people are satisfied with and have confidence in the provision. At the same time expectations of the health service are increasing more than that which one will be able, from a resource perspective, to provide in the future. The Ministry will continue to base its work on the health service being politically steered and professionally run and being characterised by transparency and participation. The National Health Plan for Norway was drawn up following an extensive dialogue with many actors during the consultation process. It is important in the follow-up of the plan to work for a shared understanding of status, goals and relevant strategies, and means.

During the health plan period, the Ministry will work on several strategies and initiatives:

- A presentation shall be made to the Storting in connection with the national budget and as follow-up to the National Health Plan for Norway concerning the health service's situation. This shall provide a good basis for the national political steering of the health service.
- Patient organisations and the various actors in the health service must to a greater degree discuss and seek a common understanding of the key challenges and solution strategies for a better health service. Every spring, processes aimed at doing this shall be conducted. Information from the processes will be included in the follow-up presentation to the Storting of the National Health Plan for Norway.
- Transparency is a necessary foundation for the health service and enterprises' legitimacy. The new unit for patient safety shall provide a basis for greater transparency concerning mistakes in the health service. Greater transparency shall also form a general basis for development work, including by informing patients and society about differences in the results of the various parts of the health service.
- Good quality health provision shall be delivered. The fact that the results are presented in a fragmented and not particularly systematic way is a challenge vis-à-vis democracy and legitimacy with respect to the health service. One of the goals during the health plan period will be to develop a national indicator system that, linked to the six internationally recognised indicators of quality, provides a systematic illustration of the quality situation.
- People with ethnic minority backgrounds shall be given a more central role as both patients and colleagues in the health service. Inclusive processes shall be conducted so that everyone feels a sense of ownership vis-à-vis the health service.

- Emphasize shall be placed on systemising the work on cooperation agreements between the health enterprises and local authorities. Emphasize shall be given to ensuring that the agreements manifest equality between the parties to the agreements.
- Emphasize shall be placed on ensuring that the use of resources in the specialist health services is in line with the Storting's grants and is under financial control.

Proximity and security

The government's goal is for the entire population to have equal access to health services. Treatment and follow-up shall continue to be organised according to the lowest, effective level of care principle (known in Norway as the LEON principle). The organisation of the provision evident from the chapter on municipal health and social services and in the discussion of local hospitals and pre-hospital emergency services will be key to developing proximity to the patients. Having good access to services when you need them the most is the key to feeling secure. The efficient sharing of information is necessary for a safe, efficient health service in the event of acute illness and for good crisis steering. In the area of pre-hospital services, preparedness, ICT and patient safety, there is a need for universal strategies and coordinated national efforts in order to address the public's need for proximity and security.

During the health plan period, the Ministry will work on several strategies and initiatives:

- The evaluation of the RGP reform showed that access to regular general practitioners was the area that patients were least satisfied with. Nine out of ten patients with acute conditions are treated by municipal health services and good access to regular general practitioners is therefore important in order to achieve confidence in the provision. During the health plan period, the Ministry will assess various measures to increase access to regular general practitioners.
- The casualty clinic system works well in many places. In some local authorities it has been difficult to achieve stable solutions in place that address the needs of the population for immediate provision outside ordinary working hours. The Ministry will in cooperation with the Norwegian Association of Local and Regional Authorities and the Norwegian Medical Association conduct an assessment of how means can be developed that help to ensure that more local authorities can establish inter-municipal casualty clinic partnerships.
- Local hospitals shall be developed further in order to address the need for general provision and form a link between the municipal services and centralised/specialist hospital functions. The Ministry will follow up the National Health Plan for Norway with work on clarifying the tasks of local hospitals associated with emergency functions and the overall treatment chain.
- Community mental health centres shall provide local and specialised provision for patients with mental disorders.
- Encouraging the development of the mobile teams in the specialist health services such that these can assist the municipal systems and ensuring the transfer of competence.

- Developing the new emergency network into a predictable and modern communications system.
- Developing robust crisis steering and preparedness. Key to this work will be conducting exercises and training, as well as strengthening information preparedness vis-à-vis the general public.
- Ensuring robust supply chains for medicines, materials and other input factors to which access may be limited in a crisis situation.
- Strengthening international cooperation in the area of health preparedness, both with WHO and the EU.
- Efficient electronic interaction between local authorities and health enterprises requires development work to define common system solutions. During the health plan period, the Ministry will develop good processes for this work through a dialogue with the Norwegian Association of Local and Regional Authorities.
- Developing and expanding the content of the Norwegian health network.
- Considering the introduction of a system for the national certification of standards for message exchange and electronic patient records.
- Establishing a new, independent unit for patient safety, this will be tasked with preventing unwanted incidents in the health service.

A more active role for the patient

Many of today's patients are active users who want to receive good information so that they can make good decisions themselves with respect to improving their own health. Good information, freedom of choice and participation in one's own treatment and the design of the provision are areas that will be emphasised during the health plan period.

During the health plan period, the Ministry will work on several strategies and initiatives:

- Increasing the utilisation of patient experiences as part of the improvement of quality. Users of the health service possess unique knowledge concerning how the provision is organised and experienced. This is a resource that has not been exploited to any great extent to improve the quality of the provision. Patients will be represented on the national board for quality and prioritisation. Patients will be systematically drawn into the work on developing national guidelines.
- Patients' experiences will be systematically used to improve interaction in the provision. Feedback systems with respect to the issue of interaction will be developed in cooperation with patient organisations .
- Transparency and easier access to information about the services. It is vital that patients and users are given good information about their illnesses, provision and rights in order to ensure that they have an opportunity to participate in the development of their own treatment and provision. Possessing good information generates confidence in the general public; one knows how the provision is organised and what services are provided.

- Developing options associated with the free choice of hospitals and the RGP scheme such that patients receive the information they think is relevant in order to be able to make a choice.
- Increased knowledge about the population and the patients' wishes and preferences. As part of the follow-up of the National Health Plan for Norway, patient organisations will play a central role in annual reviews of the status of the area.
- Further development of the patients/patient organisations ' position in relation to enterprises and local authorities.

Professionalism and quality

The Norwegian health service maintains a high level of quality from an international perspective. New knowledge is being acquired rapidly and new methods for diagnosis, treatment and rehabilitation are being developed. These developments provide opportunities for better treatment and quality of life for patients. At the same time, many innovations will be very expensive and it is necessary to consider the implementation of new measures in light of the alternative use of resources. Personnel are the most important input factor in the health and social services sector and are, together with capital, the key input factors. The knowledge, competence, experience and skills the care providers possess generate the value created in the provision. The rapid development the health service is undergoing is also a challenge vis-à-vis the composition of personnel and competence strategies. On the one hand there is a trend towards more specialised medicine, while at the same time one wants to preserve a safe, locally-based and comprehensive health service. Research is important from a quality and competence perspective. Research generates new knowledge that is of direct benefit in patient care and will also form part of the knowledge base for health policy. The health sector plays an important role as a professional contributor to and driving force behind local public health work.

During the health plan period, the Ministry will work on several strategies and initiatives:

- Establishing a national board for quality and prioritisation that shall help to ensure a coordinated and comprehensive approach to quality and prioritisation.
- The role of the Directorate for Health and Social Affairs in the work on national guidelines and indicators will be clarified in order to help ensure equal provision. Professional circles will play a central role in the drawing up of guidelines.
- Establishing a new unit for patient safety tasked with preventing unwanted incidents in the health service.
- The Directorate for Health and Social Affairs' quality strategy "And it's going to get better!" and the work on following up this will be central during the health plan period.
- Easy access to information/knowledge is important with respect to providing good quality services. The Ministry will develop the national health library as a knowledge base for the health service's employees.

- Better routines shall be established with respect to assessing the effects and costs of major and new investments, technologies and the introduction of expensive treatment methods.
- More emphasize will be placed on national governance and interregional coordination through corporate governance of the health enterprises in, among other places, the areas of investment, ICT and within staff/support functions.
- Further developing the quality in municipal health and social services through agreements with the Norwegian Association of Local and Regional Authorities.
- The National Health Plan for Norway stipulates that one must establish a culture of quality development and improvement; professional development must be facilitated through work on quality registers and easy access to up-to-date knowledge.
- Assessing the need to develop the base data and basis for making decisions for forecasting the need for health personnel. The Ministry will review the current use of means for distributing health personnel between the fields, geographical areas, and specialist health services and the local authorities with a view to implementing measures to counter biased distribution.
- Reviewing current routines and processes to ensure that the content of the training corresponds to needs.
- The tasks and responsibilities associated with the distribution of physicians will be reviewed and the necessary changes made. During the health plan period, the Ministry will also, in close consultation with the actors, review specialist training for physicians.
- Norway has several competitive research environments. Norway also has several large health registers and population surveys, and it will be important to use these advantages in the development of research policy.
- In some areas there is a need to strengthen specific areas in which there is too little research activity such as the care sector, general medical services, rehabilitation, etc.
- The amount of knowledge generated in medicine and medical research is vast internationally speaking, and the Ministry will help to make new knowledge available so that it can be used by service providers.

Work and health

The health and social services sector shall help to ensure that the users of services can master their own lives and that they can through participation in work and leisure activities experience meaningful every day lives. For some, this will involve preventing absences from work by developing good working environments and active health promoting strategies in the workplace, for others it will involve rehabilitation and a return to work.

- Working for a public health policy in which work is an important arena for preventing absences due to illness and improving public health.

- Initiating strategies for particularly vulnerable groups such as, for example, people with mental disorders in order to reduce absence due to illness and contribute to increased employment. The strategies shall be supported by the Norwegian Labour and Welfare Organisation (NAV) and the agreement concerning inclusive workplaces (IW Agreement).
- Drawing up a national strategy for habilitation and rehabilitation in the health and social services. Through rehabilitation with work as the goal, one can help to ensure that more people return to work. The health and social services shall cooperate with the new Norwegian Labour and Welfare Organisation to achieve the goal of more people in work.
- Work on health, safety and the environment shall be emphasised and special attention shall be paid to the reasons why working environments become strained.

6.6 The national coordination of some specialist fields

Chapter 6.6 discusses the development work aimed at ensuring the health service's treatment and follow-up of the individual is better coordinated. The challenges vis-à-vis coordination also apply at a general level in relation to the various fields, such as mental health, substance abuse, rehabilitation, etc. At a general level, this is about ensuring that the efforts of the many subsections of the health service are well tailored to each other. This applies to prevention, health and social services embedded in the local authorities, the specialist health services, training, research, etc. One of the central goals of the National Health Plan for Norway is to contribute to this coordination. As the ministry responsible for the sector, the Ministry of Health and Care Services has a specific responsibility to ensure that the management of the health service's various units incorporates the concept of comprehensiveness in the best possible manner. Forms of cooperation will be facilitated with the local authorities and the municipally-embedded health and care services that support this. The Directorate for Health and Social Affairs will also play a central role in the follow-up work through implementing coordination measures and by establishing processes and arenas that can help to ensure that the various fields in health service function in an as coordinated a manner as possible. Patient organisations will be key partners in this work.

In some cases, it will be appropriate for specific strategies or plans to be drawn up for some fields, in order to support both correct prioritisation and good coordination. The Escalation Plan for Mental Health is one example of an area in which a need was acknowledged for resource and medical management. The National Strategic Plan for Cancer from 1999 to 2003 is an example of an implemented plan. Such plans will partly be rooted in special deliberations and resolutions on the part of the Storting and partly in the Ministry and authorities within the framework of health policy stipulated by the Storting and government. Overall these are characterised by great breadth with respect to topics, scope, duration, and the use of means. In order to successfully implement them it is important that the various strategies are seen in context and are coordinated.

This chapter provides a general discussion of the plans and strategies for the individual fields. It includes both plans that have been adopted and are being implemented, as well as plans that are being drawn up.

6.6.1 Escalation Plan for Mental Health (1999-2008)

Basic provision has been built up through the Escalation Plan for Mental Health which allows Norway to assert that it is well on its way to modern, locally-based provision in line with WHO's recommendations. Around 6,000 new person-years of work have been added to the mental health work in local authorities and health enterprises, around 3,400 residential care places have been established for people with mental disorders, around 70 community mental health centres have been established, and the number of people receiving treatment has increased significantly. The goal of 5% coverage for children and young people is expected to be achieved before the expiry of the plan. Measures have been implemented associated with work and ensuring people with serious mental disorders social contact and a sense of belonging in their own local community. Strategies for increasing knowledge about and changing attitudes to mental health and mental illness have been established. The traditional hospital wards are being restructured and shall carry out advanced functions.

The specialist health services are characterised by "bottlenecks". Patient counts from SINTEF (November 2003) show that 40% of all patients admitted to 24-hour wards would be better served by care in the community in the opinion of the care provider. Surveys also show that many acute wards are characterised by over-occupancy and premature discharges. One of the main reasons for this appears to be a lack of interaction both within specialist health services and between primary and specialist health services, though it also has to do with a lack of capacity and competence in other parts of the provision. During the first three months of 2006 the Directorate for Health and Social Affairs carried out a project in cooperation with the regional health enterprises and SINTEF Health involving analysing and assessing capacity, through flow, cooperation and staffing at hospitals and in rural medical centres in relation to acute psychiatric services for adults. The results of the survey show that they are major and inexplicable variations between the health enterprises when it comes to occupancy rates, coverage and the proportion of patients ready for discharge. The analysis provides no systematic correlation between the number of acute beds per 100,000 inhabitants and the other quantitative measures. This means that the areas with the highest established number of acute beds in relation to population size do not necessarily have lower occupancy rates and longer occupancy periods than areas with a low number of acute beds in relation to population size. This indicates that the capacity problems within the acute psychiatric services are not necessarily due to a lack of beds in the acute wards.

The substance abuse reform in 2004 assigned responsibility for the treatment of people with drug, alcohol and other intoxicant problems to the specialist health services as well. One of the main goals of this reform was to bundle the services for people addicted to drugs, alcohol, and other intoxicants together with the other parts of the specialist health services. Coordinated and simultaneous initiatives for people with both substance abuse

problems and mental disorders represent a particular challenge, cf. discussion of the Escalation Plan for the Field of Substance Abuse in chapter 6.6.2.

There is however some substantial challenges associated with the qualitative content of the provision. This is expressed through, among other things, the lack of competence in parts of the provision, continued poor access, inadequate coordination of provision, etc. The municipal provision is characterised by large variations from local authority to local authority.

Areas for special follow-up during the health plan period

Even though the escalation plan has contributed both to building up and restructuring the provision, several issues will remain that the national authorities will have to continue to focus on after the plan is phased out in 2008.

During the health plan period, the Ministry will focus on the quality of and content in all parts of the treatment system. Furthermore, emphasize will be placed on strategies and measures that strengthen preventive work, contribute to social inclusion in the local community and work, and measures aimed at the general public's knowledge and attitudes. The development of the municipal services is a central focus area, cf. chapter 6.3.2. Besides this the following areas, among others, will be followed up:

Greater focus on preventive work

The prevention of mental disorders has so far been among the poorest developed aspects of the escalation plan and is poorly developed in the local authorities. There is therefore a need to ensure more effective implementation of preventive measures while at the same time focusing more strongly on documentation, knowledge development and research, cf. discussion in chapter 6.3.1 about prevention.

Attitudes in society – stigmatisation

The fight against stigmatisation is considered to be central to succeeding with respect to establishing meaningful lives for people with mental disorders. Within the framework of the Escalation Plan for Mental Health, an extensive communication strategy has been initiated with the aim of increasing knowledge about mental health and mental illness among the population.

Patient perspective

Integrating the patient perspective into professional thinking represents a special professional challenge for the services. The patient perspective requires the development of a cooperative relationship in which the user/patient and provider each contribute their knowledge. This does not mean that professional knowledge is less important than before, but it must be put in a different context. As a rule relatives are a key party in cooperation processes at the same time as it is necessary for relatives themselves to assess their own situations and receive adequate support and relief. The patients and relatives perspective will be focused on during the health plan period in a partnership between the services and the patient organisations.

Quality of the provision
Increasing the quality of the total provision is regarded as the greatest challenge with respect to how the health service provision for people with mental disorders is manifested. As part of the work on the National Strategy for Quality Improvement in Health and Social Services, "And it's going to get better!", cf. discussion in chapter 6.4.1, the Ministry has started work on defining clearer goals that better define what quality of provision entails, and developing indicators that can shed light on trends. The purpose of this is first and foremost to contribute to better quality locally, but is also intended to enable monitoring of how the provision develops at all levels in the system. This will involve, for example, access, opening hours, waiting times, the goal of good acute provision, patient satisfaction, goals concerning the use of personalised plans, the efficient use of resources, etc.

Strategy for implementation and follow-up
Key means in the escalation plan are the earmarking of funding with accompanying conditions, the management of investment funds, professional advisors, conferences, the establishment of competence centres, direct guideline instructions for the regional health enterprises and the establishment of advisory systems in the offices of the chief administrative officer of counties to monitor local authorities. When experience tells you that these means have not after 7 years achieved a sufficient level of quality, there is a need to consider closer follow-up of the local authorities and service points that do not adequately restructure or achieve sufficiently good results. The Ministry will together with the Norwegian Association of Local and Regional Authorities and the regional health enterprises discuss how closer follow-up should take place in such cases.

Children and adolescents
The need of children, adolescents and families for specialist health services must be viewed in the context of the establishment of good and effective primary health services because the demand for specialist health services largely depends on the provision available to children and adolescents in the municipal health services, and the degree to which the municipal health services choose to refer them to specialist health services.

In 2006, it was indicated to the regional health enterprises that provision for children and adolescents with mental disorders and young addicts are a particular priority. Children with mental illnesses and/or substance abusing parents shall be ensured follow-up. Furthermore, measures shall be implemented that provide better access through mobile teams and extended opening hours at outpatient clinics. The Ministry will strengthen the right to health care from specialist health services for these groups by introducing a special waiting time guarantee. The report from one working group that assessed how such a waiting time guarantee could be formulated and established has been circulated for comments with a deadline of 1st November 2006.

Prevention of dangerous acts
It is rare for people with mental disorders to carry out dangerous acts against another person, and there are no documented facts to support the idea that mental illness in itself results in dangerous acts. People with mental disorders are however vulnerable and at risk

with respect to committing inappropriate acts in relation to long-term rejection or exclusion from society, and in relation to acute, pressured situations that they do not master. The combination of traumatic experiences and long-term rejection by society appear to be critical factors. A lack of housing, work, social network and safer framework, discriminatory attitudes, etc, are important exclusion mechanisms. With respect to the services, the lack of provision, inadequate follow-up and cohesion will be critical factors. This means that the general measures in the escalation plan are of great significance when it comes to preventing dangerous acts. In addition, a series of measures have been implemented or are planned under the auspices of the involved ministries associated with services and provision to immigrants and asylum seekers, and within the area of violence and traumatic stress generally. Professional developments within psychiatry in a secure ward, the security perspective and the need for follow-up after discharge shall be emphasised. Assessments of suicide risk and dangerous acts in relation to others will be assigned greater significance. A number of people with behavioural deviations have considerable problems living normal lives in their local communities, both due to their behaviour and repeated criminality. Many of these people will be too sick to serve prison sentences, while at the same time they do not satisfy the criteria for involuntary mental health care. The Ministry of Health and Care Services and the Ministry of Justice and the Police will carry out a review of the regulations and an assessment of which type of measures are best suited for this group.

Training and recruitment
There must be a correlation between a medical focus in fundamental training courses and specialist training courses and social challenges, including the political signals in the escalation plan. Among other things, it is important to balance between focusing on individual diseases and a comprehensive and social perspective in the training courses. The patient perspective forms part of this. These issues will be followed up in a dialogue with the training authorities. Otherwise when it comes to recruitment and training capacity please refer to the discussion in chapter 6.4.2.

Substance abuse and mental health
Surveys have shown that a significant proportion of patients admitted to acute units in mental health care also have somewhat extensive substance abuse problems besides their mental disorders. Other parts of the mental health services also report patients who besides their mental disorders have substance abuse problems. Most of these patients do not receive satisfactory provision for their compound conditions. Research shows that the best treatment results for this patient group are achieved by personalised, coordinated and comprehensive treatment provision in which the treatment of the compound disorders takes place at the same time. The development of competence and work methods will be focused on during the health plan period.

Work and mental health
Part of the escalation plan includes a strategy for work and mental health, which is currently being drawn up. The purpose of the strategy is to ensure that people with mental disorders have a better opportunity to exploit their own ability to work. The strategy shall encompass the entire spectrum of people with mental disorders and be reinforced by the

Norwegian Labour and Welfare Organisation (NAV) and the agreement concerning inclusive workplaces (IW Agreement).

Research
There is a lack of knowledge about the causes, scope and incidence of mental disorders in the population. A substantial escalation of the efforts in this area has been implemented through the Norwegian Institute of Public Health. Furthermore, the Research Council of Norway's Programme for Mental Health (2006-2010) shall contribute to the development of relevant knowledge about mental health with a view to promoting mental health and reducing substance abuse problems in society. During the health plan period, a position will be arrived at concerning possible continuation of the programme.

6.6.2 Escalation Plan for the Field of Substance Abuse

The specific budget proposals and plans for the strengthened efforts within the field of substance abuse in 2007 are discussed above in the budget chapters. An overall presentation of the efforts in 2007 is provided in chapter 718.

During the autumn of 2006 the Ministry will finalise an Escalation Plan for the Field of Substance Abuse, cf. the Soria Moria Declaration. This is the planning work that is discussed below.

People addicted to drugs, alcohol or other intoxicants have the highest rate of illness and mortality in our country, the Norwegian Institute for Alcohol and Drug Research (SIRUS) estimates that 30,000 people may have alcohol problems that require treatment and that 11,000-15,000 are intravenous drug addicts (new estimates will be available in the autumn of 2006). Waiting times for assessments, rehabilitation and treatment are too long. There are about 500 people on the waiting list for medicine-assisted rehabilitation following long-term drug abuse, despite the fact that the capacity for this type of treatment has increased substantially in recent years. A large group of people, around 20,000, have both mental disorders and substance abuse problems. People addicted to drugs, alcohol or other intoxicants have a difficult time in the housing market. There are calculations that estimate that 5,500 people were homeless in 2005, many of these have substance abuse problems.

The challenges in the field of substance abuse are significant and increasing. The consumption of alcohol among the population of Norway is increasing even though the Norwegians' consumption is still far lower than that of our European neighbours. Research shows that there is a strong correlation between the total consumption of alcohol and the extent of diseases, injuries and accidents. The World Health Organisation has reported that there is a correlation between alcohol consumption and more than 60 different diagnoses, including several types of cancer.

There has been a political majority in favour of a restrictive drugs and alcohol policy in Norway for a long time. This has been expressed through, among other things, the deliberate utilisation of means such as pricing and availability in alcohol policy. Research shows a correlation between pricing and total consumption. The Norwegian policy has

been crucial with respect to the lower average consumption in our country and thus the fewer alcohol-related injuries and diseases. A report commissioned by the EU Commission emphasises that the types of measures implemented in Norway are among the most successful. A good drugs and alcohol policy will involve both continuing measures that we know work and promoting new measures within prevention, treatment and follow-up.

The Ministry is concerned about both the status and trends within this area and will meet the challenges through an escalation of activity and means in several areas during the health plan period.

The RGP reform, hospital reform, substance abuse reform and the new Norwegian Labour and Welfare Organisation have put in place the organisational framework for the provision for people addicted to drugs, alcohol or other intoxicants. The Ministry wants through its work in the local authority sector and in the specialist health services to emphasise that the question of substance abuse is part of the integrated work of the health and social services. One important purpose of the substance abuse reform was to ensure that all parts of the health and social services could address their responsibilities regarding people with substance abuse problems better – both with respect to treatment associated with the problem of substance abuse and measures associated with mental health and somatic care. The starting point is that people with substance abuse problems shall also access to the ordinary services. Separate care services should not be established for addicts. The reform shall be followed up. The provision for this group shall form part of the ordinary provision regardless of whether it involves health services, housing, or work or activity related measures. Addicts will also be an important target group for the Ministry's special efforts in the area of poverty, work through the *På vei mot egen bolig* (On the pathway to your own home) strategy and work through the Escalation Plan for Mental Health.

Nonetheless, the Ministry believes that in some areas it will be necessary to meet the needs of the prevention aspects and addicts' needs with special measures, cf. the Soria Moria Declaration. Given this, the Ministry will in the autumn of 2006 finalise an escalation plan that will create the professional foundation for a project aimed at increasing efforts.

The escalation plan shall take as its starting point the fact that the Ministry will base its drug and alcohol policy on equality for the individual addict and solidarity with relatives and children who experience the negative consequences of substance abuse. It shall focus on prevention, treatment and follow-up. Care services shall be facilitated for addicts who need these. Everyone shall be given an opportunity to dignity in a difficult life. It is important to the Ministry that alcohol is not and does not become an ordinary commodity even though alcohol is a legal product consumed by the vast majority of the adult population. Measures aimed at limiting total consumption will continue to be prioritised in order to reduce the negative consequences of alcohol consumption. This represents a challenge because effective means simultaneously encroach upon the freedom of individuals.

All drugs are, and shall remain, illegal. Combating the production, import and sale of drugs shall therefore represent a key part of the Ministry's drug and alcohol policy. Emphasize shall also be given to measures that reduce the demand for drugs. There will be a special focus on children and adolescents. The provision for people with substance abuse problems shall be characterised by respect, dignity and solidarity. There is no place for moralism in drugs and alcohol policy.

The principal goal of the escalation plan will be to reduce the negative consequences of substance abuse for individuals and society as a whole. In order to address this goal in the best possible manner, the Ministry shall during the health plan period follow a policy that focuses on five goals. These will form the basis for the Ministry's Escalation Plan for the Field of Substance Abuse.

Give drugs and alcohol policy a clearer public health perspective

The increased consumption of drugs, alcohol and other intoxicants means that the people most vulnerable to the negative consequences of substance abuse become even more vulnerable. The Ministry wants a two-sided focus. On the one hand measures directed at the entire population, and on the other measures targeted at especially vulnerable groups. Factors that contribute to better health shall be strengthened, and work will be actively done to reduce factors that entail a risk to health.

Increase quality and competence in the field of substance abuse

There is a need to strengthen the quality of the provision and increase the competence of employees in the field of substance abuse. The provision for people with substance abuse problems shall be knowledge-based and of good quality. There is a need to systemise the work on prevention, assessments, diagnosis, treatment and follow-up for addicts. Treatment and follow-up must to a far greater extent be viewed in connection with other fields. The organisation of the provision within interdisciplinary specialised treatment must be more tailored to the organisation and structure of the other specialist health services. Mental health work in the local authorities bears many similarities to the work with addicts, and facilitation and close follow-up in relation to work, activities, housing, ability to live independently and social functioning are equally important elements in the work with addicts as they are for people with mental disorders.

The available knowledge shall be utilised better and new knowledge shall be acquired through skills upgrading and research through, among other things, the establishment of a new substance abuse research programme in the Research Council of Norway.

Contribute to social inclusion and better access to provision

People with substance abuse problems must receive faster help at all levels of the treatment and rehabilitation chain. It is particularly important that local authorities and the specialist health services prioritise early intervention measures targeted at children and adolescents. Measures that ensure better access to provision and that address the need for social inclusion shall be prioritised. People with substance abuse problems must receive the provision they need and are entitled to a good place to live and personalised

help and rehabilitation measures. Good, safe routines must be developed for discharge from specialist health services and upon release from prison. There should always be measures in place upon discharge or release for those who need them. Waiting times for assessments, rehabilitation and treatment, including medicine-assisted rehabilitation, must be reduced.

Facilitate the interaction and coordination of providers

Many addicts need various providers to interact vis-à-vis comprehensive provision. Greater emphasize shall therefore be placed on measures that are aimed at more mandatory interaction, both at a system level and at an individual level. The best possible interaction and coordination of providers shall be better facilitated to the benefit of the individual patient by, among other things, encouraging the adoption of personalised plans pursuant to the legalisation, drawing up action plans for local authorities' drugs and alcohol policy, facilitating the use of formal agreements between health enterprises and local authorities.

Ensure patients influence over the provision they receive and better attention for relatives

The right to participate plays a central role in the health and social services. There is still some way to go before the patients' and relatives' perspective is fully implemented. The relatives of addicts shall be paid more attention to and have a higher profile in the municipal health and social services and within specialist health services. Measures shall be implemented to increase patient influence in the sector and to ensure that the provision is put together in a way that is tailored to the individual's individual needs. The Ministry shall with respect to this continue and follow-up the work in the field of substance abuse through the ongoing budget processes, including through a comprehensive focus and prioritisation in the local authorities and specialist health services.

6.6.3 National Strategy for Habilitation and Rehabilitation in Health and Social Services

The Soria Moria declaration states that the government will ensure rehabilitation and training for all who need it. The Ministry of Health and Care Services shall help to achieve these goals through a national strategy to strengthen the health and social services' habilitation and rehabilitation services, which will be finalised in the autumn of 2006.

Habilitation and rehabilitation are statutory focus areas in the local authorities and in the specialist health services. The goals of the regulations concerning habilitation and rehabilitation authorised by the Act relating to Municipal Health and Social Services and the Specialist Health Services Act is to ensure that people with a need for habilitation and rehabilitation are offered and provided with services that can help to stimulate their own learning, motivation, and increased functional and mastering abilities, equality, and participation. Habilitation and rehabilitation provision can also include services from other sectors such as social services, work, school, leisure time, etc. The provision shall be designed and provided in cooperation with the patients. This is followed up by, among

other things, a statutory right to a universal personalised plan and regulations that clarify the local authorities' and specialist health services' responsibilities within this area.

Habilitation and rehabilitation do not appear to have been given adequate priority either in local authorities or within the specialist health services. Both patient organisations and professional circles have pointed to the need to strengthen the health service's rehabilitation provision. This is especially true with respect to habilitation for children, the strengthening of adult habilitation provision, provision for people with serious head injuries, and improving rehabilitation provision for adults with impaired sight.

Training institutions, health sports centre, etc, and more lung hospitals provide rehabilitation-oriented provision within the specialist health services. From 2006, the responsibility for commissioning and funding has been transferred to the regional health enterprises.

One principal goal of the health services and large portions of the care services is to help ensure that individuals lead independent lives and are not socially excluded. The roles of both municipal social services and care services in rehabilitation will be covered by a strategy document.

The health and social services shall cooperate with the new Norwegian Labour and Welfare Organisation on achieving the goals of getting more people into work. The health and social services measures within the field of rehabilitation must therefore be viewed in the context of government work-oriented measures. This is assessed separately together with the Ministry of Labour and Social Inclusion and is discussed in the White paper on work, welfare and inclusion. One can help more people return to work through rehabilitation with work as its goal. This is an important goal for the health and social services.

The content of the national strategy

The strategy will discuss habilitation and rehabilitation activities within local authorities and the specialist health services. Goals, challenges and measures will be key themes in the document.

The strategy will focus on, among other things:

- the need for habilitation and rehabilitation provision
- interaction
- quality of the provision
- research
- knowledge and skills upgrading

Some of the areas that will be discussed in the strategy are:

- training institutions, health sports centres, etc, and the future position of lung hospitals in the specialist health services

- adult habilitation provision. Based on a review of adult habilitation provision in 2005, the strategy will outline the main features of the future development and organisation of this provision
- child habilitation, including 30 different projects that have been started in the regional health enterprises in order to develop competence and improve the provision, among other things
- rehabilitation provision for people with serious head injuries
- rehabilitation provision for adults with impaired sight

Taking the patient perspective as its starting point, the strategy will stipulate expectations regarding the provision and the patients' participation, both at an individual and system level. The strategy's primary target group will be the services.

6.6.4 National Cancer Strategy (2006-2009)

The National Cancer Strategy is a continuation of the efforts in the National Cancer Plan (1999-2003) and a follow-up to the National Strategy for Work within Cancer Care – Quality, Competence and Capacity (June 2004) report. The Ministry has through the National Cancer Strategy provided an overall frame of reference for the Directorate for Health and Social Affairs, regional health enterprises, local authorities and other relevant authorities and services. The National Cancer Strategy (2006-2009) contains national goals and measures within prevention, diagnostics, treatment, rehabilitation and research.

In order to ensure the comprehensive follow-up of the National Cancer Strategy, the Directorate for Health and Social Affairs has been assigned the role of national coordinator. A strategy director for cancer has been appointed to ensure that the focus on the area is maintained and that the goals of the strategies are being followed up with concrete measures in the services. Even though the cancer strategy primarily covers the area of health, the coordinating role of the Directorate for Health and Social Affairs will ensure comprehensive follow-up between the health and social services as well. The directorate is also responsible for establishing forums for contact with relevant actors, including the voluntary sector.

The prevention of cancer includes a series of general public health measures such as better diet, more physical activity and not smoking. The primary focus will be on making the healthier options easier to choose, facilitating low threshold measures in local communities and strengthening the preventive work in the health service.

Strengthening the Norwegian Radiation Protection Authority has been suggested as part of the work on the prevention of cancer such that it can work on assisting local authorities and the construction industry with information and skills upgrading with respect to radon, cf. discussion in chapter 715, item 01. More work will be done on implementing cost-effective radon protection measures.

Screening programmes for cervical cancer (mass screening programme for cervical cancer) and breast cancer (the mammography programme) have been established. The

Ministry wishes to continue the focus on these screening programmes, including evaluating whether they are functioning as intended.

The goal is equal cancer treatment regardless of gender, finances and place of residence. One of the most important measures in the cancer strategy to counter disparities and differences in assessment and treatment is its focus on national action programmes for cancer treatment. The action programmes shall help to ensure equal public provision throughout the country and will contain guidelines for the entire treatment pathways for the various forms of cancer: from suspicion of cancer to assessments, diagnostics, treatment and medical rehabilitation. A proposal concerning a system for continuously updating the action programmes will also is drawn up, which will include the timely reporting of new technology and methods.

Good interaction between the services and administrative levels will help to ensure increased quality in the area of cancer. The cancer strategy stresses that good cooperation, communication and cohesion is important with respect to creating comprehensive treatment chains, both in the encounter between the provider and patient and also between the various sectors in the health service. Interaction also includes cooperation with the voluntary sector in which organisations function as a supplement to the public provision. The Ministry therefore wants the voluntary sector to continue to have good framework conditions for providing non-profit services.

Two important measures for improving knowledge about any disparities in treatment and treatment results vis-à-vis cancer are the focus on cancer research and the establishment of national medical quality registers within the area of cancer. National medical quality registers will, together with the available data from the Cancer Registry of Norway, be able to tell us something about the variations in medical practice and not least the results and side effects of treatment.

Another goal is to improve palliative provision. Rehabilitation and pain alleviation shall be decentralised such that the provision can be provided closer to the patients. Work is being done on establishing/developing palliative teams.

Correct, neutral information materials shall be produced about alternative medicine for cancer patients.

Another important goal in the national cancer strategy is to provide cancer patients with better help to analyse their own non-medical needs, and information about and help with addressing their rights in non-medical areas as well.

6.6.5 National Diabetes Strategy (2006-2010)

In order to meet the challenges in the area of diabetes in a systematic and aggressive manner, the Ministry has drawn up a National Diabetes Strategy (published in July 2006) that contains a description of the status, as well as national goals and measures within

primary prevention, diagnostics, care and secondary prevention, rehabilitation, training and research.

The Directorate for Health and Social Affairs has been assigned a national coordinating role in the future follow-up of the diabetes strategy. A strategy director has been appointed in the directorate who will be responsible for this function. This role shall not alter the responsibilities of the various actors, but shall ensure constant systematic and comprehensive oversight of the implementation of the diabetes strategy.

Type 1 diabetes can currently not be prevented because we do not know the factors that are involved in triggering the disease. Changes in lifestyle can reduce the incidence rate of type 2 diabetes and prevent and postpone subsequent complications from both type 1 and type 2 diabetes.

The challenges in the primary preventive health care in the area of diabetes correspond to a large extent with the prevention of other lifestyle-related diseases. The prevention of type 2 diabetes shall be viewed in the context of White paper St.meld.nr 16 (2002-2003) Prescriptions for a Healthier Norway, and the action plan for physical activity, Working Together for Physical Activity.

It is important to identify people at a high risk of developing type 2 diabetes. Municipal health services, hereunder including regular general practitioners, are important vis-à-vis the identification of people at a high risk of developing type 2 diabetes since the people concerned will often be detected by them. The green prescriptions scheme will often be able to be used for this target group. A reduction in weight will often be a key goal.

One of the most important tasks for the Directorate for Health and Social Affairs' new coordination function will be to draw up a strategy for those at a high risk that includes both general measures and measures directed at individuals.

Early diagnosis, good treatment and secondary prevention will result in people with diabetes having a better quality of life, a longer life and fewer subsequent complications. The most important elements of treatments are patient education, self-examinations and medicines. In order to ensure that equal treatment is provided regardless of finances and place of residence, the Directorate for Health and Social Affairs shall draw up professional guidelines for the diagnosis, treatment and follow-up of the patient group in the specialist health services. As far as the municipal health services are concerned, the Ministry wants to reinforce the further implementation of the Norwegian College of General Practitioners' action programme for diabetes in general practice.

The Ministry wants to expand the knowledge base vis-à-vis incidence rates, prevention, diagnosis and treatment of diabetes. The incidence rates of diabetes must especially be analysed such that the number of people with diabetes can be estimated precisely.

6.6.6 National COPD Strategy

Chronic obstructive pulmonary disease (COPD) is one of the new major public diseases. In the 1950s-1960s, COPD or an equivalent condition was almost unknown in the health service. Today, an estimated 200,000 people in Norway have COPD. This is a chronic disease involving significant illness, disability and mortality, and the cause of COPD in most cases is tobacco smoking. Exposure to hazardous substances at work and genetic factors are also of significance vis-à-vis the development of the disease. A new survey of the population in Western Norway indicates that around half of all those with COPD have not been diagnosed. This reduced the opportunities for prevention and illness-limiting measures.

In order to meet these challenges, a national strategy for the area of COPD is being finalised which covers prevention, follow-up/rehabilitation, training and research. The Directorate for Health and Social Affairs and patient organisations have made expert contributions during this process. This strategy is in line with the signals given by the Storting vis-à-vis an interpellation on 11th April 2005. The issue is also discussed in the National budget proposal St.prp.nr 1 (2005-2006). Three important areas of focus for the COPD strategy are:

- the prevention of COPD
- the tracking down and diagnosis of COPD patients
- the follow-up and rehabilitation of people living with COPD

The Directorate for Health and Social Affairs is responsible for the national follow-up and coordination of the strategy. In order to ensure good follow-up of the strategy, a national COPD council shall be established consisting of representatives of patients and the professional circles. The council's most important tasks will be to provide advice concerning the further definition of the strategy and ensuring comprehensive oversight of the COPD area.

The prevention of new cases of COPD through measures directed at the reduced consumption of tobacco is a stated goal. Furthermore, the COPD preventive work shall contribute to reducing social disparities in health. The challenges within the preventive work on COPD largely correspond with the prevention of other lifestyle-related diseases, and the same means should be used. It is therefore important to view the various action plans and strategies in this area in the same context.

People with COPD need to be met by a health service that offers a cohesive treatment chain within the provision and between the levels of service, and the treatment that is provided must be personalised to suit the individual. Early diagnosis and correct treatment help to reduce complications and the worsening of the disease.

These patients need good education in order to be able to live with their chronic disease in the best manner possible, and information, education and guidance will therefore be key elements of the care. The establishment of learning and mastering centres (LMC) in all of the health enterprises is one important element of addressing this responsibility. There are currently around 40 LMCs and more are being planned, however the provision

the individual LMCs can provide varies greatly. It will therefore be a challenge to develop education and rehabilitation provision that ensures adequate education for this group.

The primary purpose of medicine-assisted treatment for COPD is to minimise the symptoms, reduce the number and seriousness of acute exacerbations, improve general health status, and increase stamina. COPD is a disease with a wide range of symptoms and involves great individual differences. It is therefore important that the medicine-assisted treatment provision is tailored to the individual patient.

Rehabilitation can have a favourable effect in relation to quality of life, physical fitness and mastering of the disease, and must be personalised. The goal is to achieve the highest possible level of functional ability and independence. Patient organisations and peer work are important elements of the rehabilitation provision.

The Ministry wants to strengthen the research into chronic diseases, including COPD. This will primarily be done under the auspices of the Research Council of Norway and the regional health enterprises. For further information concerning the focus on research, see chapter 6.4.3.

6.6.7 Strategy for Women's Health (2003-2013)

A strategy plan for women's health was presented in White paper St.meld.nr 16 (2002-2003) Prescriptions for a Healthier Norway. The strategy primarily builds on knowledge and recommendations presented in NOU 1999: 13 Women's Health in Norway. The assessment showed that we need more knowledge about women's health and diseases. At the same time, there is a lot of important knowledge that has not been incorporated into or used to influence health policy decisions and practices in the health service.

Two trends within the field of health and social services are well documented. One trend is that women and men are being treated equally despite the fact that problems, resources and needs can vary. The knowledge base is often based on studies of men such that "equal treatment" is often more poorly tailored to suit women. Another trend is that women and men are being treated differently – not as a response to varying needs but as an expression of the providers' lack of knowledge about the significance of gender. Firstly, this means that the public are not receiving optimum provision, and secondly it contravenes the goals of gender equality and legal requirements. In some cases, one will have to use differing means for men and women to achieve the same effect because men and women are different.

A lack of gender-tailored treatment within the field of health has had particularly poor results for women. Questions have been asked both nationally and internationally about the extent to which variations in health, illness and living conditions have gender-based biases. There also seems to be a lack of knowledge and understanding with respect to the casual relationships and treatment for a number of disease and disorders that principally effect women.

The follow-up of the Strategy for Women's Health concentrates around two axes. The first is to include a gender perspective in all activities where this is relevant. The second is to particularly focus on diseases that women exclusively suffer from, or diseases in which women form the majority or experience particular difficulties.

The Ministry has asked the regional health enterprises and the Directorate for Health and Social Affairs to emphasise that the health enterprises shall be developed in a gender perspective and that special challenges associated with men's health and women's health must be met with adequate knowledge and resources. The need to address the gender perspective and raise awareness of gender-related differences in all clinical research is addressed through specified requirements vis-à-vis regional health enterprises and the Research Council of Norway. The requirement is also laid down in the Research Council of Norway's new programme plans for clinical practice and health and care services respectively. Research into women's health is highlighted in the Ministry of Health and Care Service's research strategy for 2006-2012. The National Committee for Research Ethics for medicine has been assigned a special responsibility to administer guidelines concerning the inclusion of women in medical research.

In 2005, the Research Council of Norway produced a status report concerning research into women's health in which a need for further research in a number of areas was pointed out. Research into women's health has been strengthened in recent years. The funds have gone to osteoporosis research, serious eating disorders, and social disparities in women's health (HUNT) in the Research Council of Norway, as well as mental health and the conduct of the Norwegian Mother and Child survey under the auspices of the Norwegian Institute of Public Health.

In 2006, the Southern Norway Regional Health Authority established a national competence centre for women's health at the Rikshospitalet-Radiumhospitalet Medical Center. The centre will carry out special tasks within research, skills upgrading, advice and the dissemination of knowledge vis-à-vis women's health

Other measures for improving women's health are presented through the strategies for cancer and diabetes respectively, the action plan for the prevention of unwanted pregnancies (2004-2008), professional guidelines for the prevention and treatment of osteoporosis and osteoporotic fractures, and the Escalation Plan for Mental Health.