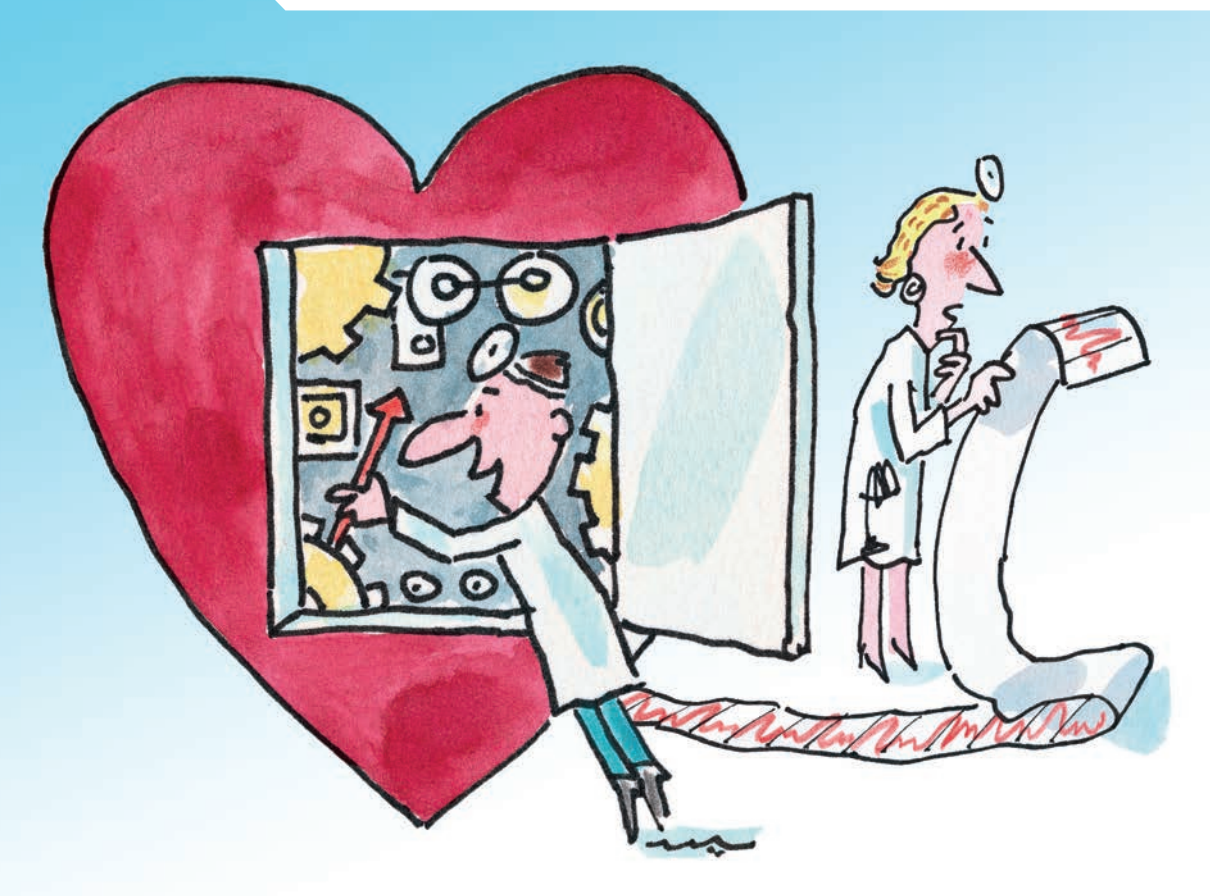
OECD Reviews of Health Care Quality

NORWAY

RAISING STANDARDS

EXECUTIVE SUMMARY,
ASSESSMENT AND RECOMMENDATIONS

21 May 2014



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OECD Reviews of Health Care Quality: Norway 2014

RAISING STANDARDS

Please cite this publication as:
OECD (2014), *OECD Reviews of Health Care Quality: Norway 2014: Raising Standards*, OECD Publishing.
http://dx.doi.org/10.1787/9789264208469-en

ISBN 978-92-64-20845-2 (print)
ISBN 978-92-64-20846-9 (PDF)

Series: OECD Reviews of Health Care Quality
ISSN 2227-0477 (print)
ISSN 2227-0485 (online)

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Foreword

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

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

ACKNOWLEDGEMENTS

This report was managed and co-ordinated by Emily Hewlett, Ian Forde and Francesca Colombo. The other authors of this report are Caroline Berchet and Niek Klazinga. The authors wish to thank Stefano Scarpetta and Mark Pearson from the OECD Secretariat for their comments and suggestions. Thanks also go to Marlène Mohier and Lucy Hulett for their tireless editing and to Judy Zinnemann for assistance.

The completion of this report would not have been possible without the generous support of Norwegian authorities. This report has benefited from the expertise and material received from many health officials, health professionals, and health experts that the OECD review team met during a mission to Norway in June 2013. These included officials from the Ministry of Health and Care Services and the Norwegian Association of Local and Regional Authorities, and officials from a number of local and regional authorities. Particular thanks go to the Norwegian Directorate of Health and the Norwegian Knowledge Centre. Many thanks also go to provider organisations and patient groups such as the Norwegian Nurses Organisation, the Norwegian Federation of Organisations of Disabled People, the Norwegian Diabetes Association and the Norwegian Medical Association, as well as to other institutions and experts such as the Institute of Health and Society at the University of Oslo.

The review team is especially thankful to Bjørn Inge Larsen and colleagues at the Ministry of Health and Care Services for their support of this review, to Jan Vegard Pettersen for his help with setting up the visit of OECD officials to Norway, and to Otto Christian Rø and colleagues at the Norwegian Directorate of Health for extensive assistance with the reviewing of chapters and co-ordination of responses to numerous queries and information requests. This report has benefited from the invaluable comments of Norwegian authorities and experts who reviewed earlier drafts.

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Acronyms and abbreviations

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

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

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

Executive summary

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

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

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

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

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

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

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

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

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

Assessment and recommendations

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

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

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

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

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

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

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

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

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

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

Complementing a quality improvement culture with quality assurance mechanisms

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

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

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

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

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

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

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

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

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

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

Broadening of the patient safety agenda to primary care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Co-ordination across health services and providers should be improved

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

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

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

Establishing workforce requirements and increasing mutual learning processes

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

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

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

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

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

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

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

Securing high-quality mental health care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Policies for improving quality of care in Norway

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

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

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

Supporting primary care physicians to improve health care quality

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

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

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

Make quality a priority for supplemented primary health care units

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

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

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

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

Work to secure high-quality mental health care

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

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

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