NORWEGIAN MINISTRY
OF HEALTH AND CARE SERVICES

Meld. St. 29 (2012–2013) Report to the Storting (White Paper) Chapter 1–3

Future Care

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Recommendation from the Ministry of Health and Care Services of 19 April 2013, approved in the Council of State the same date.
(White paper from the Stoltenberg II Government)

CHAPTER 1

Figure 1.1

1 Introduction

"The care services crisis is not created by the elderly boom, but by the notion that care cannot be provided in a different way than it is today."

Kåre Hagen

This document is intended to be a report on the potential found within the care field. The main purpose is to provide users of the health and care services with new opportunities to manage better in their daily lives in spite of illness, problems or reduced functionality. At the same time, the white paper seeks to create a basis for further development of professional activities in the field, both for those with the greatest need for care and relief from their conditions and for those who will require daily assistance throughout their entire lives. It is also designed to provide safeguards to ensure that Norway can continue to focus on the community-based solutions it has developed over time through innovation and renewal. It is our job not only to defend, but also to develop, the welfare state.

1.1 The opportunities

Rather than allowing concerns over economic problems in Europe to get the upper hand, and the demographic challenges facing us to impede our capacity for action, this white paper explores opportunities and looks for new ways of performing caregiving tasks.

Against this background, the white paper has three main objectives:

- To obtain knowledge about, reveal, mobilise and utilise the totality of society's care resources in new ways.
- To develop new forms of care through new technology, new knowledge, new professional methods and changes in organisational and physical parameters.
- To support and strengthen research, innovation and develop activities in the care services at the municipal level.

1.1.1 The new elderly generation

It is true that the dramatic rise in the number of elderly in a few years' time will result in a greater number of more demanding tasks for the municipal care services in relation to today. It is also the case, however, that the new elderly generation is living longer because it is healthier and more able to meet old age with far better resources than previous generations. The new elderly have a higher level of education, a better financial situation, better living conditions and more functionality than any previous elderly generation. They are more accustomed to using technology and want to take more of their own decisions. This white paper will explore the significance of these resources for future care needs and the overall ability of society to provide this care.

1.1.2 The entire life course

In the past 20 years, the changes in the municipal care sector have largely been related to the rise in the number of recipients of care services under the age of 67. The care services are no longer for the elderly alone, but encompass the entire life course. New, younger user groups bring with them new resources, demands and coping strategies which gradually make an impact on and contribute to renewal in the health and care services.

1.1.3 A modern policy for informal care

A lack of volunteer care providers and recruitment of more health and social services workers in a competitive labour market may present major challenges to the care sector. A future shortage of workers and volunteers will therefore require solutions that make it easier to combine employment and caregiving by incorporating greater flexibility within both working life and the public services. This white paper looks closely at ways to organise the relationship between employment and caregiving in a more future-oriented manner as well as how to provide support for family members who perform demanding caregiving tasks,

either by means of professional support and guidance, the expansion of daytime activities or more comprehensive relief services. Official Norwegian Report 2011: 11 *Innovation in the Care Services* proposes a new, modern policy for informal care, and Official Norwegian Report 2011: 17 *Når sant skal sies om pårørendeomsorg* ("The Truth Be Told About Informal Care") presents specific recommendations for a new focus for economic benefits schemes. Proposals from both of these reports will be assessed in this white paper.

1.1.4 Responsible citizenry and solidarity between generations

A strong welfare society can only be created in cooperation with the citizenry. It must be based on faith in the people's capacity to assume responsibility and participate actively in the community at large, not only through public schemes but also by being willing to make a difference in the daily lives of others. This form of responsible citizenry is manifested in organised participation in volunteer organisations, cooperatives and user organisations, as well as in more informal efforts within the local community, the family and social networks. It is also built on trust and solidarity between generations. This white paper will examine the potential that lies in involving volunteer organisations, exploring new forms of volunteerism and creating a framework for informal caregiving in modern society.

Society's community-based solutions require that people also participate in the development and design of the public services and not merely approach them strictly as users and consumers of health and care services. Firstly, by doing so they will not only be part of the problem, but part of the solution as well. Secondly, active co-responsibility helps to ensure that expectations regarding the quality and scope of the services are more realistic. Thirdly, active participation strengthens the ability of individuals to take care of themselves and others so that all the caregiving tasks need not be entrusted to professional practitioners. Thus, greater user influence, responsible citizenry and more direct local democracy will be important factors in the caregiving community of the future.

An active, dynamic civil society and volunteer organisations are vital for establishing trust and networks, and will promote a stronger framework for collective action and effective community-based schemes.

1.1.5 Diversity and equality

Greater diversity will be a hallmark of the society of the future and will also be manifested within the many arenas of the care services: in activities, residential care homes, nursing homes and people's own homes.

Women comprise the majority of those involved in the care field, both as recipients and as providers of services. Men account for only 10 per cent of the person-hours within the sector. It appears that gender equality has come further within family care than within the public health and care services.

Gender equality and non-discrimination will comprise fundamental values in the efforts related to health and care services, and the Government views it as crucial to incorporate a gender equality perspective into the efforts to develop the health and care sector. This means that gender equality will be used as an assessment criterion in many of the proposed measures.

Some users will have special challenges related to e.g. language, cultural background or personal history. The care services of tomorrow must be based on an individual approach and adaptation of the care services to a person's background, whether this concerns their language, culture, faith, or worldview; their age, gender, and sexual orientation; or their diagnosis, reduced functionality or problem. Dealing with this will require leadership and good ethical practice at all levels, by means of legislation, regulations, and economic and professional priorities.

1.1.6 Life and health

Good health is one of the most important prerequisites for living life to the fullest. This is why the health and care services are so closely linked together. Affording people the opportunity to live a meaningful life will be central to the care services, as many people require services 24-hours a day over many months and years or need assistance throughout their entire lives. One of the key tasks of the care services is to ensure that people can live full lives within these parameters in spite of illness and reduced functionality.

The care services deal with matters of life and death. The objective is therefore not only good health, but life itself. Those who work in this sector must be acquainted with life's many facets, and will encounter the most basic human needs. They must be able to create a framework that addresses these needs in an integrated man-

ner, whether the needs are of a physical, social, cultural, psychological or existential nature. This requires knowledge and expertise across many professional areas.

There is a difference between receiving services in order to survive and receiving assistance in order to live one's life.

1.1.7 Close caregiving

Most – and the best – care is provided through "close caregiving", meaning that the public health and care services function as an integral part of a local community in close cooperation with the users themselves, their families and social networks, volunteer care providers, and local organisations and enterprises. This is one of the most prominent characteristics and distinctive features of the care services which is most clearly displayed in the activities of the home care services in thousands of homes around the country.

In a future perspective, it will be crucial that these services are not reorganised out of this context but that they remain decentralised as part of the local community and retain their strong municipal ties. This will enable the care services to continue to encourage co-responsibility and utilise the resources that the users themselves have and that are found within their environment.

Better adaptation of homes and the surrounding areas, new technology and new professional methods will help people to manage their daily lives for a longer period of time on their own. Therefore, this white paper targets the opportunities inherent in:

- using universal design to make existing homes and surroundings suitable for the elderly and people with reduced functionality;
- utilising new welfare technology that affords greater security, enhanced skills mastering and access to information and advice;
- putting more emphasis on skills mastering and rehabilitation for daily life.

The white paper confirms that the municipalities will continue to have responsibility for the municipal health and care services and that no changes will be made in the distribution of responsibility between the state and the municipalities. The state will work to ensure that good framework conditions are in place for local and regional research, innovation and development activities.

1.2 Innovation

Innovation and development activities in the care services are conducted primarily within the individual municipality and local community. This white paper is therefore intended to inspire and support municipal innovation activities in the care field. By the same token, it gives consideration to establishing state-level instruments that can enhance the innovative capacity of the care sector as part of the unified municipal innovation effort.

The care services constitute almost one-third of all municipal activities and must be viewed in connection with the needs across the entire municipal sector. The municipal health and care sector must work with innovation along two axes. Along the vertical axis, innovation activities take place across administrative levels between the specialist health care services and the municipal health and care services, as described in the Coordination Reform. Innovation activities along the horizontal axis take place in the areas of overlap between municipal spheres of activity, across the sectors, and between the municipality as part of the government administration and the municipality as a local community.

Innovation does not entail searching for best practice, but for what can be a better next practice. The concept of innovation implies change and assumes a willingness to take risks. One way to describe the concept of innovation may be to say that innovation is:

- known or new knowledge combined with a new method or use in a new context;
- ideas converted to better practice that creates added value;
- enterprising, daring and experimental in form;
- a way of approaching tasks – a culture;
- a process whose result is unknown in advance.

Innovation entails creating something new. It provides a means for opening up the future and expanding the latitude for action by identifying multiple options, highlighting alternatives and finding new paths and solutions.

There are powerful drivers for innovation within the municipal sector. In many contexts local democracy has in itself been the foundation of innovation and local societal development. Over the course of history the municipalities have established savings banks and power companies, built roads, operated ferry lines and secured the water supply. In the welfare sphere, the municipalities have in many cases taken the lead in developing new schemes, often in close cooperation with

local organisations and men and women who had ground-breaking ideas. Political elections and competition for political leadership positions, development-oriented leaders, skilled workers and a dynamic local community with active citizens, users, organisations and the private sector are still the driving forces behind innovation and development in the municipalities.

The care services of tomorrow will be dependent on cooperation between the state and the municipalities, cooperation between employees and managers, and cooperation between service providers, users and family members. To succeed in promoting new ways of thinking and innovation, employees must be viewed as teammates and resources. Change processes that are not in alignment with employees' views are seldom successful. Innovation that is propelled by publicly elected officials and employees may solve many of the future care challenges.

Future services must focus on innovation and expertise. The Government believes that this is the responsibility of the leadership and it recommends that the municipalities include innovation and expertise as specific items in their plans for the health and care sector as part of the overall municipal planning process.

There is a need to better equip the municipalities to conduct innovation activities in a systematic manner if we are to meet the challenges to come. This means increasing expertise in innovation, methodology and innovation management, and enhancing the ability and desire to work across traditional dividing lines, take political risks, give employees greater freedom to act, and involve citizens, users and organisations more actively and directly. Expanded cooperation with trade and industry and research institutions will also be crucial components of municipal innovation activities.

We cannot save our way out of the challenges facing the welfare society. We must develop our way out of them. This white paper will show another path to enhanced efficiency than through traditional savings policy and market-oriented thinking. It emphasises the development of a public administration that promotes diversity and mobilises the many resources found within the local community, that focuses on interaction based on trust rather than on bureaucratic control, that recognises and utilises professional knowledge and experience, and that cooperates across professional areas and administrative levels. A new public administration policy of this nature means that democratic governance must be enhanced both through political leadership at all levels and through direct user influence and participation of the citizenry, and that more focus must be placed on partnership solutions with civil society as well as with the private sector.

1.2.1 The Coordination Reform as the basis for thinking along new lines

The Government has introduced the Coordination Reform to ensure sustainable, integrated and coordinated health and care services that are of high quality and tailored to the individual user. Greater emphasis will be placed on measures to promote health and prevent disease, on habilitation and rehabilitation, on increased user influence, on courses of treatment and on binding agreements between municipalities and hospitals.

The Coordination Reform is designed to generate a change in course and forms the basis for a shift in the content and organisation of the municipal sector. The objectives of the reform are to ensure more coordinated health and care services and to put greater emphasis on measures that prevent and limit disease. The Government is focusing attention on renewal and innovation throughout the entire health and care services sector as a step in the effort to address the coming demographic, social and health-related challenges. In many ways the Coordination Reform also comprises a municipal reform.

One of the main action points of the Coordination Reform is to develop the role of the municipalities so that they are more capable than today of achieving the objectives related to prevention and early intervention to halt the development of disease. More support will be made available for the patient's own skills mastering, increased focus on preventive and health-promoting measures and the expansion of low-threshold services. This requires new forms of work and cooperation, new services and new ways of carrying out the tasks. Some of the current services will be moved closer to where the users live, and new municipal services are being developed for patients prior to, instead of or following admission to hospital. The established financial incentives are designed to achieve the desired solutions to the tasks and provide the basis for good patient services and cost-effective solutions. To ensure effective implementation of the reform, the Ministry of Health and Care Services and the Norwegian Association of Local and Regional Authorities have entered into a national framework agreement on coordination in the health and care services.

Experience from the first year of the reform shows that both the municipalities and the specialist health care services are well underway with these activities. Efforts related to cooperative agreements, adaptations to make immediate, 24-hour assistance available in the municipalities, and the municipalities' reception of more patients who are ready to be released from hospital show that both the municipalities and the specialist health care services have begun the process of achieving better coordination between the levels of the health and care services. It appears that the Coordination Reform has helped to chart out a new direction in the efforts to improve the health and care services.

In order to continue and further refine the Coordination Reform, there is a need to think along new, future-oriented lines about the substance, focus and resource utilisation of the municipal health and care services. The services must put more emphasis on active caregiving, prevention and rehabilitation and on encouraging the use of new technology and new work methods. This is in keeping with the recommendations in Official Norwegian Report 2011:11 *Innovation in the Care Services*, and this white paper will build further on the basis set out in the Coordination Reform.

1.2.2 Challenges for the care services

The few studies conducted on the activities of the care services indicate that their strength lies in the fundamental tasks they perform related to treatment and care. However, services often do not start until late in the game and are not equally effective with regard to preventive measures, training, rehabilitation, and physical, social and cultural activities. There is much evidence to suggest that this situation has been compounded in recent years.

This white paper has chosen to address some of the problems and weaknesses of the care services and to explore the possibility of finding new approaches and solutions that can turn this situation around.

The background for these challenges is described in St. Meld. nr. 25 (2005–2006) Report to the Storting, *Long-term care – Future challenges, Care Plan 2015* and in Official Norwegian Report 2011:11 *Innovation in the Care Services* as follows:

- the growth of new younger user groups;
- more elderly in need of assistance;
- the shortage of volunteer care providers;
- the shortage of health and social services personnel;
- the lack of coordination and medical follow-up;
- the lack of activities and coverage related to psycho-social needs;
- the internationalisation of the market for personnel, service providers, patients and users.

In this context, we cannot avoid addressing the considerable uncertainty in the global economy that has resulted in a high unemployment rate and major financial problems for many Europeans. In times like these, we must take care not to set all of the care services in stone, but ensure that the services we develop have the flexibility and restructuring capacity that may be needed.

As noted in Official Norwegian Report 2011: 11 *Innovation in the Care Services*, these challenges entail problems as well as opportunities. This white paper will focus on the opportunities.

1.3 Background and basis

In St. Meld. nr. 7 (2008–2009) Report to the Storting, *An innovative and sustainable Norway*, the Government selected the health and care services as a priority area for innovation and renewal, and appointed a public committee to explore new innovative solutions for meeting future challenges in the care services. The committee submitted its recommendations in Official Norwegian Report 2011: 11 *Innovation in the Care Services* in summer 2011. The report has generated a great deal of interest and gained broad support across most of the usual dividing lines. There is also considerable impatience in some quarters, especially with regard to issues related to restructuring of the care services with greater emphasis on welfare technology and rehabilitation and the need for new instruments in municipal innovation activities.

Official Norwegian Report 2011: 11

This white paper is based primarily on Official Norwegian Report 2011:11 *Innovation in the Care Services*, and the extensive input from stakeholders after the document was circulated for review. The white paper is intended to lay the foundation for a future-oriented policy for the municipal care services by establishing the perspectives and contributing to the design of new solutions for the care services as the major demographic challenges facing the care sector in the decades leading up to 2025 begin to intensify. The report identified an active ageing policy, a policy that removes

barriers for people with reduced functionality and a modern policy for informal care as the basis for its five recommendations:

- "Close caregiving" – the second Coordination Reform;
- "New rooms" – future housing solutions and neighbourhoods;
- "Technoplan 2015" – technological support for the care services;
- A national programme for municipal innovation in the care services;
- The care services as an industry.

Currently the care services cover the entire life course and have recipients of all ages with a need for a diversity of solutions related to housing options, services and professional approaches. The Coordination Reform reinforces this diversity, assigns the municipalities new tasks and affords them new opportunities.

Official Norwegian Report 2011: 17

This white paper emphasises the importance of enhancing community-based solutions by improving cooperation between the municipal services and civil society and by creating good, motivating framework conditions for the voluntary resources found within families and local communities. In formulating a modern policy for informal care, the white paper is in alignment with Official Norwegian Report 2011: 17 *Når sant skal sies om pårørendeomsorg* ("The Truth Be Told About Informal Care"), which recommends three main action points:

- an expanded benefit scheme for family caregivers;
- a new, enhanced municipal care benefit that replaces the current supplementary benefit and pay for family caregivers;
- legally established support for family members involving measures that give value to and include family members and ensure the quality of the services.

Welfare technology

In the efforts related to welfare technology, the Norwegian Directorate of Health submitted a report on the implementation of welfare technology in the municipal health and care services up until 2030 to the Ministry of Health and Care Services in 2012. That report has formed part of the basis for this white paper. In the report, the Norwegian Directorate of Health recommends the establishment of a national initiative on welfare technology through a Welfare Technology Innovation Programme (2013–2020).

The potential of information and communication technology (ICT) and welfare technology for the health and care services sector is also addressed in Meld. St. 23 (2012–2013) *Digital agenda for Norge – IKT for vekst og verdiskaping*, white paper on ICT for growth and value creation, Ministry of Government Administration, Reform and Church Affairs, and must be viewed in connection with Meld. St. 9 (2012–2013) *Én innbygger – én journal, Digital tjenester i helse- og omsorgssektoren*, white paper on digital services in the health and care services sector, Ministry of Health and Care Services.

Quality

The Government previously submitted Meld. St. 10 (2012–2013) *God kvalitet – trygge tjenester, Kvalitet og pasientsikkerhet i helse- og omsorgstjenesten*, white paper on quality and patient security in the health and care services, Ministry of Health and Care Services, in part with the aim of promoting more user-oriented health and care services, a more active patient and user role, more systematic testing of new treatment methods and higher quality through knowledge and innovation.

Agreement with the Norwegian Association of Local and Regional Authorities

The Government and the Norwegian Association of Local and Regional Authorities have entered into an agreement on further refining the quality in the municipal health and care services for 2012–2015. The parties have agreed to foster innovation and new ways of thinking in the municipal health and care services with a special focus on mobilising citizens' responsibility and participation, early intervention, prevention, rehabilitation and the use of new technology.

It has been noted that the municipalities are facing challenges with regard to changes in the age composition of the population, and new, younger user groups that have other needs and preferences. These challenges must be solved by achieving the most effective utilisation of the collective resources and through innovation:

> "The parties will ensure sustainable services in the future through research, innovation and solutions that enhance quality in all parts of the services. The parties agree that innovation

efforts in the health and care services must be incorporated as part of a cohesive set of municipal innovation activities.

The parties will work together to:

- promote innovation activities at the national, regional and local levels, across sectors and administrative levels, and in cooperation with trade and industry, organisations and civil society;
- cooperate on the development of infrastructure for municipal innovation cooperation;
- use the municipal planning system for innovative thinking, restructuring and implementation of new ways of working;
- work to implement solutions that allow users to live at home as long as possible, if they wish to;
- promote the development of new types of living arrangements and housing solutions, in part through new cooperative projects;
- encourage the use of welfare technology, in part through training, expertise and organisational development;
- promote a future-oriented policy for volunteer care providers;
- promote a policy that supports family members who provide care and make adaptations for volunteer caregiving.

Municipal innovation

Parallel with the activities of the Ministry of Health and Care Services related to the white paper, the Ministry of Local Government and Regional Development has drawn up a municipal innovation strategy designed to stimulate innovation activities throughout the entire municipal sector. This white paper must be viewed in connection with the strategy *Nye vegar til framtidas velferd* ("New roads to the welfare of the future"), and the general municipal policy instruments that are designed to promote municipal innovation.

The HelseOmsorg21 strategy

The Ministry of Health and Care Services will establish a forum for dialogue between the health and care services, academia, trade and industry, and professional organisations. In 2013, the forum will provide input and propose measures to be included in a broad-based, overall strategy for research and innovation in the health and care services, known as the HelseOmsorg21 strategy. The strategy will form the basis for a targeted, integrated and coordinated national initiative on research, development and innovation in the health and care services.

Innovation in health care

The white paper must also be viewed in connection with the 10-year (2007–2017) initiative from the Ministry of Health and Care Services and the Ministry of Trade and Industry on need- and research-driven innovation and commercialisation in the health and care services sector. The initiative involves innovation within ICT and technical medical equipment, innovation in public procurements, and innovation designed to address major societal challenges such as chronic illnesses, an increasingly ageing population, and better coordination between service levels.

Key participants in the initiative are the regional health authorities, InnoMed, Innovation Norway, the Research Council of Norway and the Norwegian Directorate of Health. The participants have entered into a national cooperative agreement and drawn up a plan outlining measures. The Norwegian Association of Local and Regional Authorities is also taking part in this cooperative effort. The initiative entails strengthening the scheme for public sector R&D contracts for health care purposes and measures designed to promote arenas and meeting places between the supply industry, the health care sector, and public funding and innovation agencies.

Innovation on the international agenda

Innovation in the public sector is now gaining a place on the agenda in international forums in the Nordic countries as well as in the rest of Europe in organisations such as the EU, OECD, UN and WHO. The demographic and economic challenges facing Norway constitute some of the key issues and driving forces behind this development.

"A society for all ages" and "active ageing and solidarity between generations" are two of the most important catch phrases in these efforts. A new picture of elderly inhabitants and their role in working, social and cultural life is emerging. Participation, inclusion, independence and self-sufficiency are key themes. Efforts to combat age discrimination and bridge-building that establishes trust between young and old are seen as vital instruments in a senior citizen's policy that encompasses all generations and that has significance for all areas of society.

Eight principles for high-quality care services

The Ministry of Health and Care Services established eight principles for good care services in cooperation with the Norwegian Pensioners Association, the Church City Mission, the Norwegian Association of Local and Regional Authorities, the Norwegian Nurses Organisation, Norwegian Union of Municipal and General Employees, and the Norwegian Union of Social Educators and Social Workers. These principles were presented in spring 2012.

The care services are to be:

- developed on the basis of a holistic view of the human being;
- based on user participation, respect and dignity;
- adapted to the users' individual needs;
- show respect and care for family members;
- comprised of competent managers and employees;
- focused on emphasising health-promoting activity and preventive measures;
- flexible, predictable and offer coordinated, integrated services;
- innovative, pioneering and engaged in promoting learning.

These eight principles also form part of the basis of this white paper.

CHAPTER 2

Figure 2.1

2 Summary – Care Plan 2020

"Everyone should be concerned about the future. That is where we will be spending the rest of our lives."

Norwegian proverb

The Care Plan 2020 is a plan for addressing the needs of today as well as the challenges of tomorrow. The efforts to develop and incorporate new, future-oriented solutions have been launched concurrently with the implementation of the Care Plan 2015. To ensure continuity and cohesiveness, the measures set out in this white paper will be included as new elements in the current care plan and will be overlapping features up through 2015. This will provide a foundation for coordinated activity and a common platform for progression. The current plan will gradually be replaced by the new measures, which will steer the plan in a more innovative direction:

- Caregiving of tomorrow – an innovation programme towards 2020;
- Future users of the care services – with a resource-oriented perspective;
- Caregiving community of tomorrow – with a programme for family members, a national volunteer strategy and policy for idealistic, cooperative-based and private service providers;
- The care services of tomorrow – with restructuring of professional activities and greater focus on early intervention, rehabilitation for daily life, and networking activities;
- The caregiving environment of tomorrow – with a programme for developing and introducing welfare technology and measures to promote renewal, construction and development of future nursing care facilities and residential care homes.

The Government will revert to the funding for various programmes and measures in the individual national budgets for the years to come, with implementation deferred until sufficient funding is made available in the budgets.

Activities relating to the implementation of the measures set out in the plan will be administered under the systems established in the Norwegian Directorate of Health, the Norwegian State Housing Bank and the regional government administration for execution of the current care plan. In its efforts to promote innovation, the Norwegian Directorate of Health is expected to focus on:

- strengthening the InnoMed national competence network and employing it actively in the efforts to promote innovation in the health and care services;
- contributing to and utilising the knowledge centre and the measures to be established in the Government's municipal innovation strategy.

In addition, there are plans to strengthen the regional centres for care research in order to assist the municipalities with follow-up research and make documentation from innovation projects available at the municipal level. The county development centres for nursing homes and home care service are to take part in disseminating results and information. At the same time, the funding instruments at the disposal of central research and innovation institutions will be targeted towards enhancing the municipalities' innovation capacity within the health and care services.

2.1 Caregiving of tomorrow

The health and care services will be facing major challenges in the years to come. The age composition of the population is changing, and the tasks that need solving are becoming increasingly complex. Rather than raising the requirements to qualify for assistance, more services that support prevention, early intervention and rehabilitation must be developed. In order to make the best use of resources across and outside of the municipal organisation, it will be important to take a fresh look at what a service should be and who should help to create it. The care services of tomorrow are to create a framework that enables users to become more of a resource in their own lives, that mobilises residents of local communities in new ways and allows them to become resources for

each other, that employs welfare technology as a resource for users who thus will become better equipped to manage their daily lives, and that develops and utilises the resources of idealistic and volunteer organisations in new ways. These resources in and of themselves are not new, but when we systematically include the various actors in the design and production of the services, new solutions will emerge.

2.1.1 Innovation programme 2020 – for the care services of the tomorrow

In recent decades the role of the municipalities in innovation efforts has been primarily to facilitate industrial development and innovation in the private sector. In the face of tomorrow's challenges, however, the innovation system will need to be targeted towards the municipalities themselves, with the design and production of the services as a focal point. But innovation processes do not launch themselves. Innovation always entails an element of uncertainty and thus presumes a willingness to take risks. While research institutions and trade and industry have their own public innovation and research funding agencies, there are few innovation instruments specifically designed for the care services sector and the municipalities. There is a need to establish a framework and funding instruments that legitimise innovation efforts in the municipal sector and that will better enable the municipalities to test new solutions for dealing with complex challenges.

This is a national task in which the most important efforts must take place in the individual municipality in cooperation between locally elected public officials, experts in the field, users, family members, organisations, and trade and industry. However, action must also be taken at the national level to coordinate, support and provide direction to local efforts, in addition to enhancing competence-building, research and knowledge development, dissemination, motivation, advisory services, documentation and the proliferation of new, tested solutions.

Caregiving of tomorrow is an innovation programme that will design new solutions for tomorrow's care services together with users, family members, municipalities, idealistic organisations, research institutions, and trade and industry. The innovation programme will promote the development and application of welfare technology, new work methods, new organisational solutions and living arrangements that are adapted for the future. At the same time, the activities will lay the foundation for state and municipal planning, including special instruments designed to support and facilitate municipal research, innovation and development activities in the health and care services for the period up to 2020, including the following components:

1. strengthening the regional research and development structure of the care services;
2. ensuring involvement of established innovation and research institutions at the national level;
3. enhancing the focus on research, innovation and development activities in the municipalities and relevant programmes under the Research Council of Norway.

Action point 1

At the regional level, the currently existing structure with five care research centres and a development centre for nursing homes and home care services in each county will be expanded. These centres are linked together in a network, and the Centre for Care Research at Gjøvik University College has been given responsibility for coordination and will play a leading role in terms of follow-up research and as a documentation centre. Together with the regional government administration and in cooperation with the Norwegian Association of Local and Regional Authorities (KS), the centres will serve as central, municipally-oriented partners for research, development and innovation activities in the health and care services sector.

Action point 2

At the national level, established innovation and research institutions will be involved, and some of the instruments at their disposal will be strengthened and targeted to stimulate innovation efforts in the municipal health and care services. In keeping with the Government's innovation strategy, a separate knowledge centre will be established to serve as a locomotive for the entire municipal sector. The Norwegian Directorate of Health has established the InnoMed national network for needs-driven innovation in the health care sector, which will be extended to encompass municipal health and care services in addition to the specialist health care services, and to support innovation activity across all levels of health care services administration as well.

Action point 3

The most critical need is to stimulate the municipalities' ability and power to innovate. The innovation programme will therefore strengthen municipal innovation efforts in the health and care services at the local level by:

- testing new solutions (professional methods, technology, housing arrangements, organisation, etc.) in cooperation between municipalities, the research community, and trade and industry or idealistic/volunteer organisations;
- ensuring documentation and research as the basis for dissemination and implementation;
- improving the knowledge base used for planning, development and innovation through relevant programmes under the Research Council of Norway.

Initially the structure at the regional and national levels will be expanded to assist the municipalities. The care services comprise almost one-third of the municipalities' overall activities and must be viewed in connection with the needs and resources in the entire municipal sector. Innovation efforts in the care services must therefore be carried out as part of an integrated innovation initiative in the municipal sector. The Government will develop and support the national and regional innovation groups.

2.2 Future users of the care services

Most development trends and projections indicate that there will be more users in all age groups with more complex care needs in the future.

The number of elderly users has not risen in the past 20 years. The greatest increase has taken place among people under 67 years old, especially those with long-term, chronic illnesses, reduced functionality and mental health and social problems.

The number of users in the 67–79 age group is expected to show the largest increase in the near future, while the dramatic growth in the age group over 80 years old will not occur for another 10 to 15 years. At that time the challenges related to dementia will show a corresponding increase.

While women currently comprise the vast majority of users, especially in nursing homes, this will even out over time since life expectancy for men is increasing faster than for women.

By the same token, future users will have other resources with which to face illness, reduced functionality and other problems. It is not enough just to predict the problems. It is also important to make predictions about the resources and determine how the users' own resources can be utilised. This applies in particular to the new generations of elderly who will live longer and enter old age with a better financial situation, higher level of education, better health and completely different material circumstances than the previous generation. Thus, an 80-year-old in 2000 will not be the same as an 80-year-old in 2030.

A holistic view of tomorrow's user lies at the core of all the measures and programmes set out in this white paper. These users have more than just illnesses and problems; they also have resources they can employ to master their own daily lives and participate in society at large. Each individual will have something valuable to contribute all the way up to the end of his or her life.

New organisational forms will encourage this. New forms of communication and work methods will lay the foundation for this. New technology and more universal design of housing and surroundings will create better opportunities for this.

This white paper incorporates terms such as responsible citizenry, co-creation, peer support and user control, and it invites users and their representatives to take active part in the caregiving community of tomorrow.

2.3 The caregiving community of tomorrow

When addressing future challenges in the care services, it will be necessary to mobilise all of society's care resources and examine how tasks are distributed among the actors in the care services sector. Public care services have undergone continual growth over the past several decades. In light of the demographic challenges that are expected to hit full force in 10–15 years, this growth must be organised so that it supports and stimulates the resources found among the users themselves, their families and social networks, neighbourhoods and local communities, idealistic organisations and trade and industry that assume their share of social responsibility. Professional activities will need to be restructured with a greater emphasis on networking, interdisciplinary cooperation, prevention, early intervention and rehabilitation. Furthermore, people will have to take responsibility for ensuring optimum adaptation of their own homes and we as a community must adapt the physical surroundings

to ensure they are accessible to everyone and to all generations.

If informal care is to continue at the current level, a new policy of informal care will be needed that makes it easier to combine work and caregiving duties, that is based on equality between the genders, that acknowledges and values the competency and effort of family members, and that is supported with professional training and guidance.

There are many possibilities for involving more people in volunteer caregiving. This will not happen by itself, however, but will require concentrated effort and systematic follow-up with recruitment, organisation, coordination, training, motivation and guidance. Dedicating professional workers or cooperating with idealistic and volunteer organisations on this is an investment that will yield enormous benefits.

There is also great potential within the care services sector to encourage the idealistic organisations to continue to take the lead and forge new paths, actively involve new generations of volunteers, and develop new forms of idealistic measures and cooperative solutions in which the users and their organisations are more active owners.

At the same time, companies in the private sector will subcontract with the municipalities for a number of services, such as in the areas of construction, technology and housing.

This will make it possible to distribute the care tasks to more actors in the future within the framework of the welfare state's community-based solutions.

2.3.1 Programme for an active, future-oriented informal care policy 2014–2020

In keeping with the recommendations in Official Norwegian Report 2011:11 *Innovation in the Care Services* and Official Norwegian Report 2011: 17 *Når sant skal sies om pårørendeomsorg* ("The Truth Be Told About Informal Care"), the Government will formulate a policy that helps to ensure that family members are valued and seen and that improves gender equality and affords greater flexibility. In this white paper the Government presents a programme for an active, future-oriented informal care policy that:

- draws attention to, acknowledges and supports family members who perform demanding caregiving tasks;
- improves coordination between the public care services and informal care, and enhances the quality of the overall services available;
- creates a framework to ensure that the current level of informal care is maintained and that makes it easier to combine work with caring for children and adolescents, adults and elderly with serious illness, reduced functionality or mental health and social problems.

The first phase of the programme will focus on measures that support family members and enhance cooperation between the health and care services and family members through:

- flexible schemes that provide relief to caregivers;
- support for family members, information, training and guidance;
- coordination and cooperation;
- improvement of the pay for family caregivers scheme;
- research and development.

The next phase will explore the issue of changes in financial compensation schemes and provisions on leave of absence in cooperation with the Ministry of Labour.

2.3.2 National strategy for volunteerism in the health and care services

The Government wishes to promote a dynamic civil society that generates a sense of belonging, solidarity and community, and will in this light develop a national strategy for volunteerism in the health and care services. The strategy will set out measures for recruiting and retaining volunteers in the care services, facilitate more volunteer activity and reduce loneliness by re-establishing or expanding the individual's social network. The strategy will take its point of departure in the following five components:

1. *Mobilisation, organisation and coordination*
   Enhancing expertise in recruiting, mobilising, coordinating, training, motivating, following up and guiding volunteers, with greater focus on training volunteer coordinators under the auspices of the Dignity Centre in Bergen.
2. *Networking activities*
   Developing networking and neighbourhood activities as a means of promoting volunteerism in the care services and creating nurturing, collaboration-oriented local communities.
3. *Arenas for volunteerism*
   Making use of the arenas for volunteerism in the care services sectors:
   - idealistic organisations in the health and care services

- volunteer organisations
- senior centres
- municipal volunteer coordination centres
- open nursing homes.

4. *"Joy of life" nursing homes*
   A national certification scheme for "joy of life" nursing homes under the auspices of the foundation *Livsglede for eldre* ("Joy of life for the elderly") that aims to enhance active caregiving and focuses on the social and cultural needs of users.
5. *Knowledge and research*
   Conducting research and knowledge development activity on volunteerism in the health and care services in order to create a framework for long-term planning and systematic cooperation.

The strategy will be finalised and specified in more detail in dialogue with the municipal sector and in cooperation with the Association of NGOs in Norway.

2.3.3 Idealistic service providers as innovators

Idealistic organisations have historically been the vanguard of the welfare state. They have expanded services for disadvantaged groups which have later been subsumed under public services, and they have developed new work methods, often with great emphasis on user influence and participation by the local community.

The need for such pioneers is just as great today. Idealistic organisations will continue to be important teammates in addressing the challenges and opportunities arising from an ageing population, increasing cultural diversity and rapid technological development.

For the Government, cooperation with the idealistic sector has been crucial for the development of the welfare state. The Government has high expectations of the idealistic actors' innovative approach to the health and care services sector, and it views this cooperation as one of several opportunities to mobilise volunteers and local communities.

EEA regulations set some parameters for procurement of services from idealistic organisations by public authorities. The Government is interested in taking advantage of the latitude for action that exists today for procurement of this type of service. Separate procurement processes for idealistic organisations, long-term agreements and cooperation on development and innovation prior to the procurement are constructive, potential alternatives for the municipalities that want to further develop cooperation of this kind.

In the future, the position of idealistic service providers and their high level of legitimacy in the health and social care sphere will depend on their ability to remain innovative, forge new paths, involve volunteers and step in when the welfare state falls short. They must be able to retain their value-based foundation and distinctive character, and find new forms of ownership and models of operation that involve users and their representatives in other ways than previously.

2.3.4 Cooperatives as a possibility

As a form of business organisation, the cooperative is well suited to the welfare sphere and in cooperation between the municipalities on the development of the care services. It is a form of business organisation that encourages more user influence, ownership and user control. It also invites the recipients of services and residents to be more than users and consumers by encouraging them to take responsibility and to participate in the design and production of the services.

The health and care services of the future must be designed and implemented in cooperation between municipal and non-municipal actors with a strong foothold in civil society. The distinctive features of cooperatives allow for local solutions that address local needs, and give individual residents the role of both consumer and producer through participation, user control and co-production of the services. Local democracy in the municipalities will be strengthened through stronger, more direct user democracy.

Cooperatives are widespread throughout the world. In Norway, the cooperative as a form of ownership and operation has generally been used very little in areas under the purview of the public sector, although it has played a dominant role in the private sector and other parts of society at large. In the care services sector there may be room for cooperatives comprised of users, personnel, tenderers and family members, or a combination of these.

The driving force behind social entrepreneurship is the desire to solve society's problems and safeguard social value creation. In order to promote entrepreneurship in the educational system, the Government is cooperating with *Ungt Entreprenørskap* ("Young Enterprise"), an idealistic organisation to encourage creativity, innovativeness and self-confidence among children and adolescents, in

which many of the companies established incorporate social entrepreneurship principles.

2.3.5 Cooperation with trade and industry

Expertise from Norwegian trade and industry will also be important in the development of the care services sector. By cooperating on the development of services and products, the public and private sectors can create new solutions. There is significant innovation potential inherent in public procurements. As a strategic instrument for innovation, procurements can be used not only to improve utilisation of society's resources, but also to generate new and better services that will benefit the users. An active private sector that participates in the design of solutions for municipal development needs will lead to better, safer and more effective services and create positive ripple effects within trade and industry.

The foundation will therefore be laid for a policy that:
- develops new services at the interface between the care services sector and trade and industry;
- enhances the role of the care services sector as a competent, demanding procurer;
- develops care services as an export item;
- meets a rapidly growing senior citizens' market.

The Government is concerned with ensuring that developments do not lead to greater inequality in the population's access to health and welfare services, but some of the practical, more service-oriented services will be produced by others and delivered via the municipalities and the individual senior citizens' market. This implies a policy in which the Government believes that the municipalities themselves, together with idealistic organisations, should operate long-term spaces in institutions and provide basic health and care services. At the same time, the private sector will subcontract for a number of services with the municipalities. This may apply to services related to construction, technology and housing.

2.4 The care services of tomorrow

The care services of tomorrow will create services together with the users, cooperate with family members, utilise welfare technology and mobilise local communities in new ways. The totality of new work methods and cooperation with family members and networks will require major changes in competencies and recruitment and entail new ways of organising the services. There is therefore a need for professional restructuring that refines the care services' nursing activities and utilises broader interdisciplinary expertise on rehabilitation and social networking activities.

The following three areas represent some of the most important challenges and opportunities within the care services:
- active caregiving
- rehabilitation for daily life
- caregiving and death.

2.4.1 Active caregiving

Culture, meals, activity and enjoyment are key aspects of integrated care services. In order to develop high-quality, future-oriented care services, there is a need to put more emphasis on activating users both socially and physically and to bring more attention to users' social, existential and cultural needs.

Daytime activity programmes are often referred to as the missing link in the care services. The Government has therefore launched a major expansion of daytime activity programmes for people with dementia and has proposed enacting legislation that requires municipalities to offer daytime activity programmes to people with dementia once this service has been made fully available. Daytime activity programmes give meaning to people's daily lives and provide a good experience for individual users. In many cases they can relieve some of the burden for family members and help to prevent or postpone admission to an institution.

Art and cultural activities may be used innovatively to develop new methods and professional approaches to the care services. Cultural activities and caregiving must be coordinated in a close interdisciplinary collaboration that stimulates the body and soul and that activates thought and feelings, such as through memory-enhancing groups and writing projects, dance evenings and music groups or through art and cultural projects based on the abilities, interests and life history of individuals. The Government wishes to further develop the cooperative effort which has been established between the cultural sector and the care services through the Cultural Walking Stick programme and which brings positive cultural experiences to people's daily lives.

Over time various activity measures have been developed that can be used therapeutically to

counteract the anxiety and depression associated with dementia or acting out behaviour when patients are being washed and dressed or carrying out their daily activities. Like the specialist health care services, the care services sector must also develop systems that ensure the application of new knowledge. To ensure that new methods are disseminated and used as a first choice in treatment and nursing, the Government plans to establish a resource centre that can take responsibility for developing and disseminating activity-based therapeutic treatment measures.

2.4.2 Rehabilitation for daily life

It is an objective for individuals and society at large to utilise the resources, abilities and potential of the users themselves as a basis for managing their daily lives. Consequently, habilitation and rehabilitation must be a natural and central part of all care and nursing activity. All effective treatment contains an element of rehabilitation.

A majority of the resources in the care services sector are targeted towards nursing the seriously ill and measures that compensate for reduced functionality. This must continue to be the case in the future as well. The care services must always be grounded in those with the greatest need for assistance and nursing. At the same time, we must remain open to new approaches that assess the potential of rehabilitation and provide the necessary expertise to utilise the resources found in the individual before traditional, compensatory measures are implemented. The Government will therefore facilitate the professional restructuring of the municipal health and care services through greater focus on rehabilitation, prevention and early intervention.

Rehabilitation for daily life is an example of how early intervention and rehabilitation in the care services promotes a better quality of life and greater functionality among users. Rehabilitation for daily life is a type of rehabilitation that can achieve a greater scope by involving the home care services. As a method and professional approach, rehabilitation for daily life takes its point of departure in uncovering the potential of the users themselves to actively assist with re-establishing or increasing their previous level of functionality. The users' own resources, desires and personal goals will serve as the basis for the services provided.

The method requires the employees to work together with, not for, the individual user. Early interdisciplinary mapping of the user's rehabilitation potential and corresponding early, intensive training increases the user's ability to cope and reduces the need for help from the public sector.

When rehabilitation for daily life is introduced in the home care services, it is usually in the form of an interdisciplinary team comprised of occupational therapists, physical therapists, social educators, social workers and nurses specialising in rehabilitation. The team goes in and assesses the individual's rehabilitation potential and cooperates on training and guiding employees of the home care services so they can be responsible for training in the user's natural arenas, in the home and in the local community.

The Government wishes to further develop initiatives regarding rehabilitation, activation and achievement of personal goals and to encourage the municipalities to test various models of early intervention and rehabilitation for daily life.

2.4.3 Caregiving and death

Some of the care services' users require treatment and nursing for shorter durations, while others need assistance and care throughout their entire lives. Seriously or terminally ill or dying patients and users with a great need for care and nursing must have access to safe, high-quality services. This means treating patients with dignity and respect and ensuring that their physical, psychological, social, spiritual and existential needs are met.

Norway is one of the countries in the world with the fewest deaths at home. Creating a framework that allows more people to die at home may better enable us to view death as a natural part of life. Dying at home can reinforce a sense of belonging to and cooperation with the family and civil society, make it easier to direct events according to the wishes of those involved than at the hospital, and help to ensure that death does not become the realm of the professions alone. The number of deaths in nursing homes has risen in recent years, which indicates a need for adequate resources and expertise in nursing homes in order to provide good treatment, nursing and care to patients in the final phase of life.

Caring for dying children is one of the most demanding tasks in the health and care services. There is a need to strengthen palliative treatment and care for children and their family members. National professional guidelines will be drawn up on palliative treatment related especially to children's needs. To enhance employees' expertise in

this area, several municipalities have been granted funding for competence-building projects in cooperation with volunteer organisations.

Meeting the needs of patients and their family members will require an interdisciplinary approach that utilises personnel and expertise in new and better ways, with more integrated services in the municipalities and health services that support the care services. To enhance quality, knowledge and expertise related to palliative treatment, the Government will establish a framework for greater involvement of family members and develop a training programme for care services employees that provides basic expertise in palliative treatment.

Family members will receive support and guidance through informal care schools and discussion groups. The regional centres for palliation in the specialist health care services will develop and disseminate expertise in palliative treatment within the region. Together with the palliative centres at hospitals, they are also responsible for interdisciplinary knowledge networks on palliative treatment and for ensuring the continuity of nursing and care services to palliative patients and bringing expertise to the municipalities.

2.4.4 Professional restructuring and broader expertise

To ensure sustainable, high-quality care services in the future, it will be necessary to restructure the professional activities of the care services. There will be a need for a higher level and different kinds of expertise, new work methods and new professional approaches. The professional restructuring will primarily be related to a greater emphasis on rehabilitation, early intervention, activation, networking, activity therapy, guidance for family members and volunteers, and the implementation of welfare technology. The further development of expertise in palliative treatment and care at the end of life will be encouraged as well. The Government's competency and recruitment plan, *Kompetanseløftet 2015* ("Competency Reform 2015"), will help to ensure adequate, stable and competent staffing of the care services sector.

To promote professional restructuring of the care services, the Government will focus on the following objectives in this white paper:

- raising the level of professional expertise in the care services, in part by increasing the proportion of personnel with a university college education and facilitating internal training;
- creating a broader professional base with more professional groups and increased focus on interdisciplinary activity;
- strengthening the care services' own knowledge base through research and dissemination of knowledge.

Professional restructuring will also have ramifications for how the services are organised, as well as for cooperative relationships and the interface with society at large. If the services are to develop new work methods and strengthen preventive and rehabilitative activities, they must team up with the overall resources of society. The care services must go out and meet the users and their networks. Thus, proximity and decentralised services are critical. The care services must be an integral part of the local community and not be removed from contexts in which professional and informal care can continue to work together.

New content and new professional approaches to the services will also mean that the municipalities must assess the focus and organisation of their services, both internally in the health and care services and in relation to other municipal services. Consideration must be given to new ways of organising and working that shift the current dividing lines between the professions and between the areas of activity in the municipalities.

The services must be organised in a closely coordinated manner to ensure that individual users experience them as being provided continuously and consistently. New work methods and redirection of municipal services will also require the specialist health care services to support and guide the municipalities. It is essential to establish contact channels and a system for competence development, task solving and interdisciplinary cooperation between the municipalities and the specialist health care services.

2.4.5 Men in the health and care services

Men represent perhaps the greatest unused resource in the care services. It is unrealistic to think that tomorrow's extensive caregiving tasks can be solved without recruiting more men to the health and care professions or involving them in the caregiving arena.

Trondheim municipality has made one of the most successful attempts to recruit men to the care services sector. Men there are lining up to try out health and care work in the home care services and nursing homes as a future workplace and vocation. The Government wishes to build on

the experience of Trondheim municipality and make "Men in the health and care sector" into a nationwide initiative. At the same time, municipalities, educational institutions and organisations are invited to place special focus on the recruitment of men and design measures that promote better gender balance at workplaces within the health and care services sector as part of their innovation activities.

2.5 The caregiving environment of tomorrow

The use of welfare technology and universal design principles will make it more possible for people to receive care services in their own homes. The design of future nursing homes and residential care homes will be crucial as a framework for service provision and cooperation with family members and local communities. The Government will therefore continue the current support scheme under the Norwegian State Housing Bank for nursing homes and residential care homes, and will explore whether the requirements of the scheme can be adapted to allow for the construction of assisted living residences. A scheme that sets aside funding for research, development and innovation with a view to designing and testing new models for future institutional and housing solutions will also be explored.

The Government is launching a national programme for the development and implementation of welfare technology that will promote the full integration of welfare technology into the services by 2020.

2.5.1 A new concept for nursing homes and residential care homes

There is an exciting development taking place in the municipalities in which the rooms in nursing homes are beginning to resemble actual homes and today's residential care homes are being built together and used both as a supplement and as an alternative to nursing homes. Soon it will not be possible to see the difference between small, modern nursing home units with a high living standard and local living and service centres with separate residences. The municipal care services also cover the entire life course from children's homes to nursing homes.

The Government wishes to take the best from the two different traditions and build tomorrow's solutions on the basis of several fundamental principles:

- "Small is good." Small shared flats and units instead of traditional institutional solutions.
- A clear distinction between the types of living arrangements and services in which the services and resources are tied to the individual's needs.
- A clear distinction between private, common, public and service areas in all buildings used for health and care purposes.
- Housing solutions that are adapted for use of new welfare technology and that have all the necessary amenities (bathroom, toilet, kitchenette, bedroom and living room) within the private area, adapted for both residents and family members.
- Care services with living arrangements and offices that are an integral part of the local community in towns and city neighbourhoods in which the public areas are shared with the population at large.

Based on these principles, a space in a nursing home can serve as a person's home and vice versa.

Very little research has been conducted on the developments in the care services, and there is a great need to document and systematise the experiences and to carry out knowledge development activities in this field. About 45 000 spaces in institutions and residential care homes have been built or renovated in the past 15–20 years. In order to assess which basic requirements should be applied to the design of future solutions, it is essential to evaluate the experience with existing buildings and learn more about how these function in relation to their purpose for the users, for employees, for cooperation with family members and for day-to-day operations. There is also a need to establish test housing for more systematic trials of new technology, fall-friendly materials and surroundings, bathroom solutions and interiors, as well as to establish pilot projects that are followed up by documentation and research. Against this background, the Government will look into the implementation of a scheme for research, development and innovation targeted at the design and testing of new models for future institutional and housing solutions.

Most of the homes and institutions where users will live and receive health and care services in the coming decades have already been built. This applies primarily to ordinary single-family homes, town homes and apartments which

in Norway are owned and used mainly by the people living in them. It also applies to the 40 000 spaces in old-age and nursing homes and some 50 000 homes used for nursing and care purposes, which are owned primarily by the municipalities and rented out to residents in need of assistance. An important focus in the next few years will be on renewal and rebuilding so that existing buildings are well adapted and can function optimally to address future needs.

Half of Norway's residential care homes and nursing homes were either newly constructed or completely renovated under the Action Plan for Elderly Care which ran from 1998–2007. The other half of the approximately 40 000 spaces in institutions and the roughly 50 000 homes used for nursing and care purposes will soon need to be renovated or replaced. The municipalities should concentrate on replacing the old, run-down spaces before the need for greater capacity manifests itself 10 years from now. To ensure an even pace of expansion, the renewal efforts should be completed before the need for greater capacity reaches a critical point in the years leading up to 2025. This will make it possible to distribute the rising costs that the municipalities will face in 10 years from now as a result of rapid demographic changes over a period of several years. Replacing the existing spaces will not necessarily lead to higher operational expenses and may in many cases also enhance the efficiency of operations. A long-term perspective and predictable investment parameters will be important for increasing capacity and renewal, and the rapid demographic changes will require planning and adaption at the national level. Thus, the Government wishes to continue the current scheme under the Norwegian State Housing Bank, after 2015 as well.

In addition, the question of whether the requirements for the scheme can be adapted to allow for expansion of assisted living residences will be explored. Assisted living residences are homes with Smart House technology, reception and hotel services which address the residents' various needs for practical services, such as housecleaning, laundry, home maintenance, meal service and other services that assist residents in their daily lives. Homes of this kind can preferably be built in connection with daytime activity centres, cultural centres, local community centres, welfare centres or the like with easy access to activities and opportunities to socialise with others.

2.5.2 Financing and user-payment schemes independent of type of living arrangements

The municipalities' total expenditures on nursing and care services came to approximately NOK 90 billion in 2012. Almost all of the expenses were financed through distributable municipal revenues, while revenues generated by user payments comprised about seven per cent.

The municipalities have the primary responsibility for financing most of the health and care services. However, the state contributes funding for medical services, physical therapy, pharmaceuticals, technical aids and housing allowances for users who live in their own homes. Today users of municipal health and care services pay for the services they receive according to two different sets of regulations depending on whether they receive services inside or outside an institution. People who live in their own homes pay for each service they receive, while people living in institutions pay a fixed percentage of their income for the entire set of services. Thus as a result of regulatory differences, users pay different amounts for the same services depending on whether the municipality provides them with a space in an institution or whether they live in a home that they own or rent.

It is becoming more and more difficult to see any difference between nursing homes and residential care homes other than in the way in which they are financed. Several municipalities are now referring to their residential care home facilities as nursing homes, while others are discontinuing their nursing homes spaces and calling them residential care homes, living and service centres and the like. Official Norwegian Report 2011: 11 *Innovation in the Care Services* therefore recommends introducing the use of the same financing and user-payment schemes and the same rights to pharmaceuticals, technical aids and housing allowances for everyone, regardless of the type of living arrangements. The same conclusion is presented in a research report that describes the tendency of the municipalities to place high-income groups in nursing homes and allot residential care homes to pensioners who receive the minimum state pension and who are eligible for housing allowances. The financing system can create economic incentives for the municipalities with unintentional effects that may change the development pattern.

The framework conditions for the municipalities and users must be designed to ensure that

services are primarily assessed on the basis of the needs of individuals and on the most effective course of action from a socioeconomic perspective.

The Government will launch a study of the financing and user-payment schemes used for various types of living arrangements. The purpose of the study will be to create a framework for a fair, predictable payment system for users and to clarify the spheres of responsibility between the state and the municipal sector.

2.5.3 Welfare technology programme

The use of welfare technology opens up many opportunities. Such technology can help people to cope with their daily lives and health issues, allow more people to live longer in their own homes despite reduced functionality, and help to prevent or postpone admission to an institution.

Technology can never replace human caregiving and physical proximity, but it can help to strengthen social networks and facilitate greater cooperation with the services, local communities, families and volunteers. Thus it can also free up resources in the care services that can then be used in direct user-oriented activities.

The development of welfare technology must be placed in a framework. It must be aimed at solving specific problems and addressing users' needs. Welfare technology should therefore be implemented in the health and care services alongside changes in the organisation and focus of the services.

In order to fully exploit the potential of welfare technology, a framework must be created that encourages the municipalities to make greater use of such solutions. To facilitate this, a national programme for the development and implementation of welfare technology in the municipal health and care services will be launched. The main objective of the programme will be to make welfare technology an integral part of the care services by 2020.

Greater implementation of welfare technology in the health and care services will:

- enhance the ability of users to manage their own daily lives;
- increase the sense of safety and security for users and their family members and relieve some of the concerns of family members;
- increase the participation of users and their family members in user networks and enhance the ability to maintain ongoing contact with each other and the support system.

The programme will be based on the objectives set out in the Coordination Reform regarding health-promoting activities, preventive services, early intervention and the delivery of services where people live. The programme will also build on the local conditions in the municipalities and address the need to view welfare technology solutions and service innovation in relation to each other. The programme will lay the foundation for new work methods and forms of cooperation between municipalities, users, family members, local communities, volunteers, the specialist health care services and the private sector.

The Norwegian Directorate of Health will have the primary responsibility for implementing the technology programme as part of the Care Plan 2020. The Norwegian Directorate of Health will be expected to implement the programme in cooperation with InnoMed and the knowledge centre to be established as part of the overall municipal innovation strategy.

The programme will consist of the following measures:

Introduction of open standards for welfare technology

Strong national steering of the development of ICT in the health and care services sector will be necessary. The standardisation efforts in the area of welfare technology will help to promote integrated welfare technology solutions independent of suppliers across the public and private sectors so that the users receive high-quality, coordinated, predictable services. The Norwegian Directorate of Health has been assigned responsibility for the overall standardisation efforts in this area. Close cooperation with the KommIT programme, a programme for ICT coordination in the municipal sector under the Norwegian Association of Local and Regional Authorities (KS), as well as with Standards Norway, suppliers and industry associations, and the Norwegian Health Network – Norsk Helsenett SF, will be critical. The efforts must be viewed in connection with the standardisation efforts on electronic coordination of the health and care services. Standardisation in the welfare technology area will be given priority in the national strategies for standardisation.

Development and testing of welfare technology solutions in the municipalities

The municipalities must participate in the development and testing of welfare technology solutions in a three-way cooperation with the private

sector and research, development and innovation circles. Top priority should be given to the development of safety packages, in keeping with the recommendation in Official Norwegian Report 2011: 11 *Innovation in the Care Services* and the Norwegian Board of Technology. A safety package is an expanded form of the safety alarm which may also include a self-triggering alarm, fall sensors, smoke detectors, electronic door openers, mobile phones, tracking solutions (GPS), etc.

Knowledge production and dissemination of welfare technology solutions

The programme will promote new research-based practice. To document the impact and benefits of employing various welfare technology solutions, priority will be given to knowledge production and dissemination of good welfare solutions to the municipalities. Top priority will be given to follow-up research and the establishment of knowledge-based practice. The regional centres for care research will be assigned a key role as documentation centres for innovation with follow-up research and dissemination.

Promote the development of good models for the implementation and use of welfare technology

The development of good models for the implementation and application of welfare technology will ensure that the technology becomes an integral part of the services and is not applied only as individual solutions. Therefore, the Government wishes to extend the InnoMed network beyond the specialist health care services to encompass the municipal health and care services as well, and to conduct innovation activities across administrative levels in the health care services. The scheme for public sector R&D contracts in Innovation Norway must be made more easily accessible and be adapted to the innovation needs within the health and care services sector, especially with an eye to welfare technology. In order to encourage a greater degree of municipal innovation, a separate knowledge centre will be established as part of the Government's municipal innovation strategy.

Competence-building

Training and competence-building for employees, users and family members must take place in advance of and alongside the implementation of welfare technology. Training must be carried out primarily in the form of internal training programmes in the municipalities, preferably in cooperation with and with the assistance of educational institutions, technical aid centres and other professional circles. Some of the practical training must be tied specifically to the implementation of welfare technology. Therefore, the Norwegian Directorate of Health, in cooperation with relevant professional circles, will develop a training package that provides basic expertise in welfare technology. Health and care services personnel must also be given knowledge about welfare technology through educational programmes, and changes in health and social care education should be assessed in light of the needs created by the implementation of welfare technology.

The programme will also help to ensure that the municipalities are supplied with the necessary expertise within innovation and innovation management, as well as with practical tools for mapping out needs. Knowledge about change processes, mapping of needs and implementation are critical for ensuring that the technology covers the intended needs and is in keeping with what is practically and organisationally possible in the municipalities. An educational programme on municipal innovation efforts for municipal managers and professionals in the sector will be developed as part of the Government's municipal innovation strategy. This programme will enable employees, managers and publicly elected official to learn about innovation processes and how to plan and implement an innovation project.

Legal framework

In order to ensure legal clarity and to lay a better foundation for new technology that will give the individual greater capacity for independence, safety and physical activity, the Government has presented Prop. 90 L (2012–2013), a bill on amendments to the Patients' Rights Act related to the use of notification and locating technology.

CHAPTER 3

Figure 3.1

3 History, development trends and the future

"Those who do not know the past do not understand the present, and are not well-suited to design the future."

Simone Weil

Planning for the future must be based on experience and grounded in history. By the same token, it is important to be open to new possibilities and let go of traditional ways of thinking. When addressing future challenges in the care services, it will be necessary to employ new methods and find new solutions rather than simply prolonging current trends and developments. It would be too naive a solution for the care services merely to increase the number of nursing home beds to keep pace with the rise in the number of elderly over 80 years of age. If there is as much change in the municipal health and care services in the next 40 years as has been the case in the past 40, the situation will look entirely different.

3.1 Forty years in the past and 40 years in the future

The public care services as we know them today have a brief history. In 40 years these services have expanded from some 20 000 person-years to more than 120 000 person-years. They have gone from focusing primarily on care for the elderly to providing services to users in all age groups with diverse diagnoses, disabilities and conditions. Some people receive services from birth and are dependent on the care services throughout their entire lives, while others receive just a few services for a limited period of time.

When planning for the future, there is good reason to place our efforts in the context of this relatively brief history. We should explore why the municipal care services were established, how conditions have changed through the years and what driving forces underlie developments characterised by strong, constant growth.

Official Norwegian Report 2011: 11 *Innovation in the Care Services* describes the development of care services in the past 40 years as one of the greatest social innovations of the post-war period. Public care services emerged in response to some of the most crucial challenges facing society:

> "Thus, the question was what was needed to ensure a higher birth rate, access to labour, women's liberation and care for the rising number of elderly, all at the same time. In light of this, the 40-year history of the municipal care services can be described as one of the truly significant innovations of Norwegian society in the post-war period. A large public welfare sector in the Nordic countries has helped to lay the foundation for economic growth and development and to create the security needed to bring children into the world. Against this backdrop, the Nordic model demonstrates greater economic and demographic sustainability than many other wealthy countries that do not have such as extensive care services sector."

Like other welfare schemes, the care services must be assessed in light of their significance for value creation in society and not merely be viewed as an ever-increasing public expenditure. Norway has consciously chosen to organise society in this way. This has proved to be successful both in economic and in demographic terms.

3.2 Recipients of care services – status and development trends

In the period from 1965 to 1980, the number of people receiving in-home nursing services more than tripled, from 24 000 to 75 000 recipients. Recipients of housekeeping services increased even more, from about 13 000 people in 1965 to roughly 98 000 recipients 15 years later. The number of people receiving in-home nursing services and housekeeping services continued to rise in the 1980s, although at a slower pace than during the previous decade. In the 2000s, home care services have become more focused on those in greatest need of assistance. The proportion of users receiving only practical assistance has

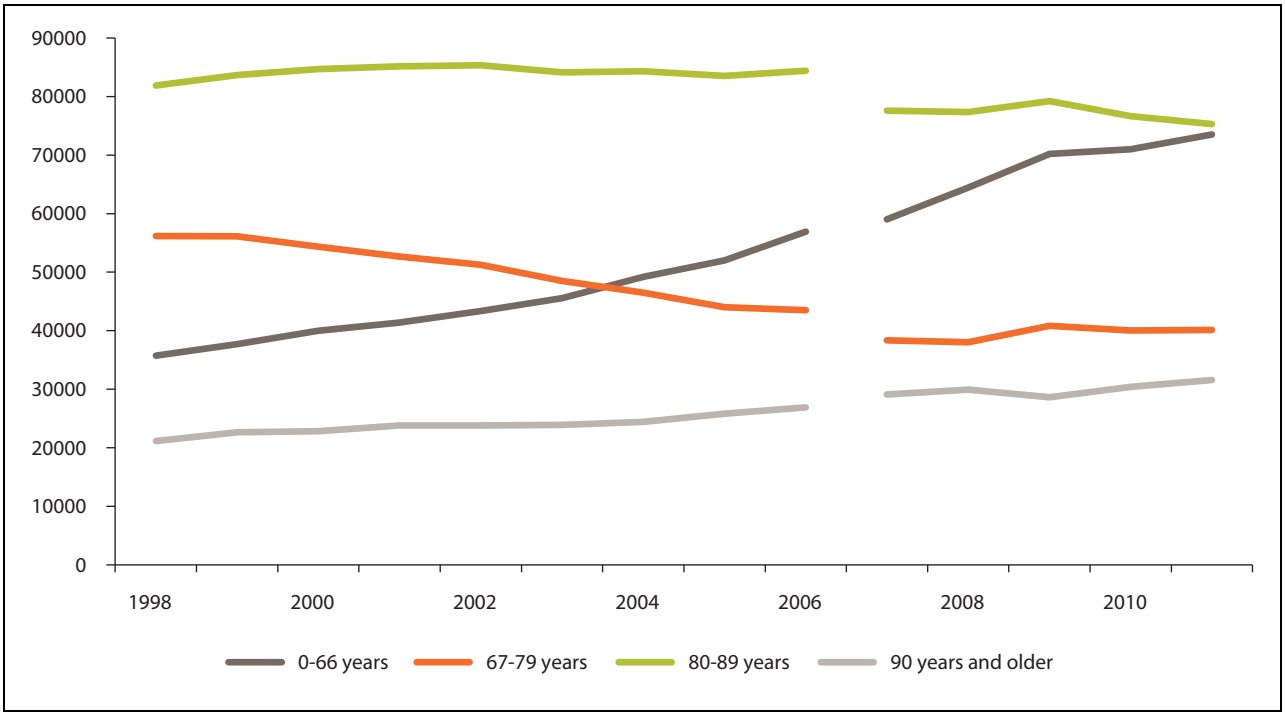

Figure 3.2 Number of recipients of care services by age 1998–2011

Source: Statistics Norway 2012. As from 2007 the data is taken from the IPLOS register and cannot be compared with previous years.

declined from almost half to one-fourth of all recipients. The number of residents in institutions increased up until about 1990, when responsibility for nursing homes was transferred from the counties to the municipalities and the institutions under the system of health care for individuals with cognitive impairments were closed down. Since then, the number of residents of various institutions has decreased, while the number of recipients of home care services and residential care homes has risen dramatically.

3.2.1 From care for the elderly to care for all

Despite substantial growth in the oldest age groups in recent decades, the number of elderly users of old-age and nursing homes and home care services has not risen. This demonstrates that not everything can be explained by demographics, and that developments are also affected by other changes in society. For instance, part of the explanation for this situation may lie in the redistribution of tasks between the specialist health care services, informal care provided by families and the municipal care services. Over time it has become less appropriate to use the term "elderly care" to describe the municipal care services.

Today the care services sector has recipients of all ages with highly divergent needs. At the end of 2011, more than 268 000 people had received care services in one form or another. Of these, about 43 500 people received services in an institution and some 177 000 were recipients of in-home nursing care and/or practical assistance. Roughly 50 000 people received other types of services such as relief from the caregiving burden, pay for family caregivers, individual support persons and user-driven personal assistance. These types of services are provided mainly to people under age 67. In 2011, more than 122 000 people over 80 years old received services in institutions or at home. Approximately two of three recipients of care services are women. This is partly because women live longer than men and have a longer period of serious illness and reduced functionality towards the end of their lives. Seventy-five per cent of recipients of in-home care services over the age of 90 live alone.

Almost 72 000 new recipients entered the care services system in 2009, 2010 and 2011, respectively, while some 69 000 recipients left the system in each of those years. This shows that roughly one-fourth of care services recipients are rotated out of the system each year. This in turns means that care services are provided to roughly 25 per

cent more recipients than the average figures shown above indicate.

Information about recipients' need for assistance is available from the IPLOS registry, the individual-based nursing and care statistics compiled by the Norwegian Directorate of Health. The need for assistance is a measure of the degree to which recipients are capable of helping themselves in most areas (need for some/limited assistance) or dependent on help in many areas (need for extensive assistance). Approximately 33 per cent of recipients over 90 years old have a need for extensive assistance. A total of 17 to 25 per cent of recipients in other age groups have a need for extensive assistance. The trend is towards a decline in the proportion of recipients with a need for limited assistance. Long-term residents of institutions generally have a need for more extensive assistance than recipients of home care services. Four of five long-term residents of institutions have a need for extensive assistance. The need for assistance is greater among younger rather than among elderly recipients of in-home nursing care and practical assistance. The reason is that many elderly people with a need for extensive assistance receive help in the form of a long-term space in an institution. Younger users with a need for extensive assistance receive more hours of in-home nursing care and practical assistance than elderly users with a comparable need for services.

3.2.2 The number of younger recipients of care services is increasing

Almost four of 10 recipients of nursing and care services are now under retirement age. In addition, practically all of the new resources allocated to the sector in the past 20 years have gone to covering the service needs of the rising number of younger user groups. Users of home care services under age 67 are distributed to some children and adolescents under age 18 (two per cent), a large proportion of younger adults age 18–49 (54 per cent) and a somewhat smaller proportion of middle-aged people age 50–66 (44 per cent). Of these groups, the most dramatic growth in the past decade has been in the number of younger adults. If recipients of relief from the caregiving burden, individual support persons and pay for family caregivers are included in the statistics, the number of children and adolescents is higher.

In terms of health, the group of recipients receiving home care services under age 67 is

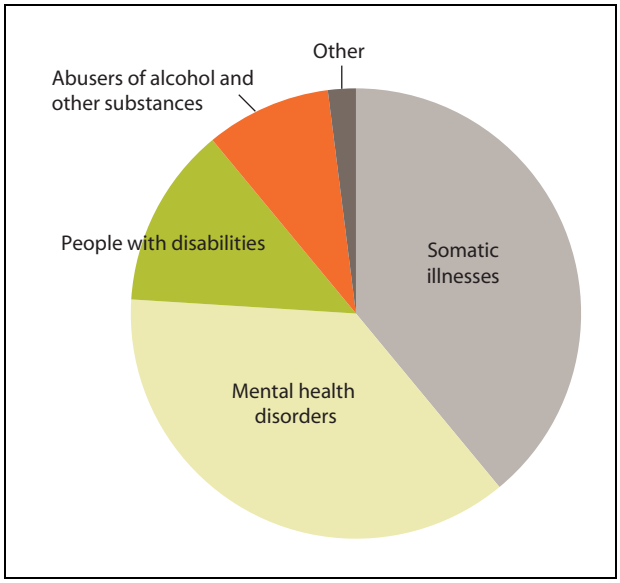

Figure 3.3 Causes of the need for assistance among recipients of home care services under 67 years old

Source: Romøren (2006)

comprised of two larger and two smaller groups. The largest group are people with a wide variety of somatic illnesses (39 per cent), comprised primarily of neurological conditions such as MS, stroke, and head and back injuries. Mental health disorders comprise a large group as well (37 per cent). The two smaller groups are people with disabilities (13 per cent) and abusers of alcohol and other substances (9 per cent). Those in the user group under 67 years old primarily receive home care services and very few live in institutions. Many of these recipients receive as many home

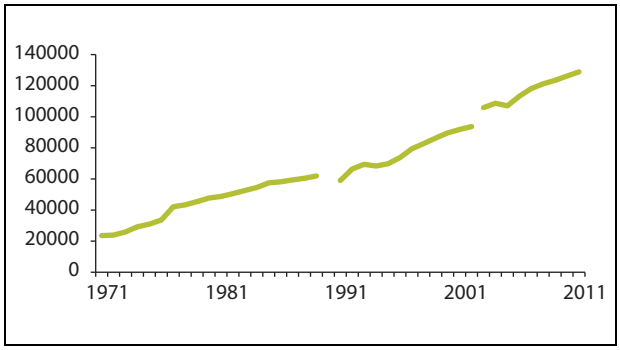

Figure 3.4 Person-years in the care services sector 1971–2011

Please note: Due to the gap in statistics, the figures from 2003 and onward cannot be compared to figures from 2002 and earlier. Statistics are not available for 1990. The figures also include the system of health care for individuals with cognitive impairments (HVPU) up until it was discontinued in 1991.

Source: Statistics Norway

care services and participate in as many daytime activity programmes as those living in nursing homes, measured in number of hours. Many of them attend school or work during the day. It is difficult to predict the extent to which the number of younger recipients of care services will continue to increase in the coming years. There is reason to believe that the growth will slow or stabilise, although there is no indication of when. It is crucial to acquire more research-based knowledge about this for planning purposes.

3.3 The care services – status and development trends

The greatest changes in the municipal health services in recent decade have occurred mainly in the home care services, where the in-home nursing services in particular have risen. This is a reflection of two major development trends, which show that there is a shift:

- from services provided in institutions to services provided in people's homes
- from practical assistance to health care services

3.3.1 From 20 000 to 130 000 person-years

Except for one year, the municipal care services have seen continual growth in the past 40 years. Measured in terms of the number of person-years, the care services sector has grown six-fold and increased from about 20 000 person-years in 1971 to almost 130 000 person-years in 2011.

The rate of growth has increased in the past 25 years after municipal responsibilities expanded with the nursing home reform and the reform relating to people with disabilities. The Action Plan for Elderly Care, the Care Plan 2015 and the Government's Escalation Plan for Mental Health have also led to an increase of resources and tasks, and the Coordination Reform is expected to reinforce this situation even further in the years to come. The dramatic growth must be viewed in connection with changes in the distribution of tasks with the specialist health care services and informal care. Both of these factors have contributed to the increase in the number of person-years. It is the in-home nursing services in particular that have increased, and these services are being directed more and more towards those with the greatest need.

Despite the significant rise in the proportion of elderly among the population, the largest growth

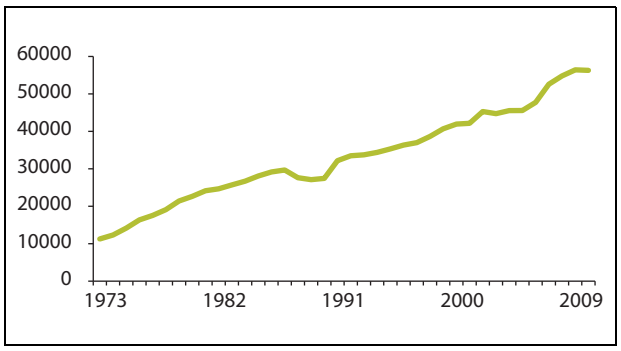

Figure 3.5 Gross operating expenses in fixed 2000 prices for nursing and care 1973–2010

Please note: The figures also include the system of care services for individuals with cognitive impairments people (HVPU) until it was discontinued in 1991.
Source: Statistics Norway

has occurred in the services provided to people under 67 years old. The municipal care services are intended primarily for people with long-term, complex conditions and substantially reduced functionality. This requires a high level of expertise and greater interdisciplinary cooperation. At the same time, there is reason to question whether it has become more difficult to qualify for help, so that the care services are pulled in too late, and to the detriment of early intervention, prevention and rehabilitation. This may prove to be an expensive and unsustainable solution in the long term.

It will be important for the municipalities to find the right balance between treatment and nursing on the one hand and prevention, habilitation and rehabilitation on the other.

With a few minor exceptions, gross operating expenses for the care services have shown a rela-

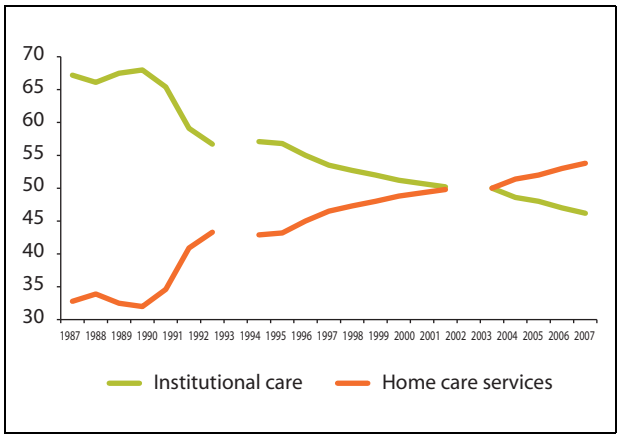

Figure 3.6 Proportion of person-years in the nursing and care services sector in percent, by institutional care and home care services 1987–2007

Source: Brevik 2010, Norwegian Institute for Urban and Regional Research

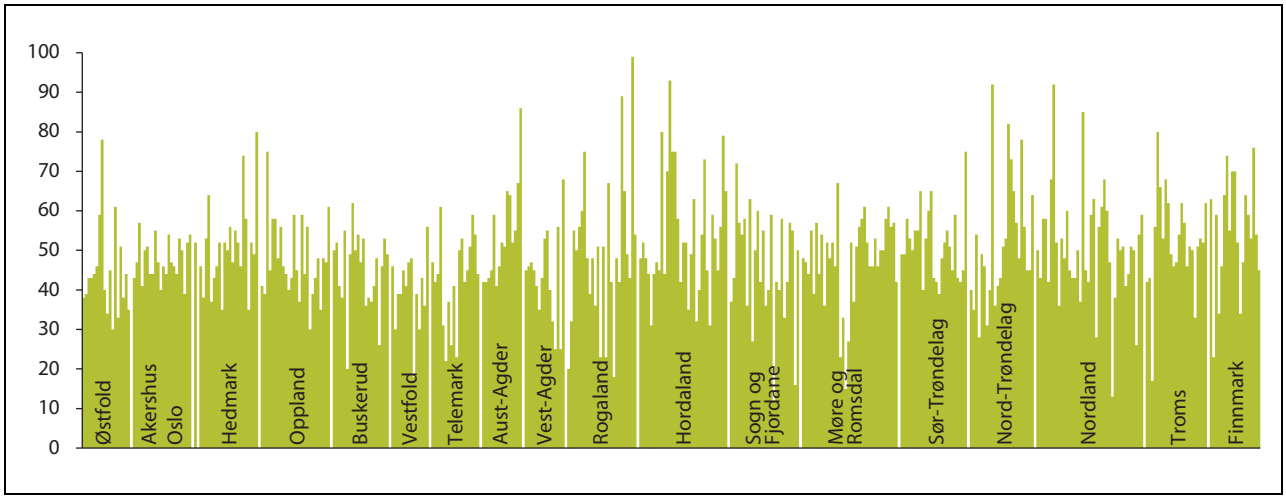

Figure 3.7 Proportion of the care services' net operating expenses used for institutional operations in 2011, per municipality by county. Per cent.

Source: Statistics Norway 2012

tively linear increase, measured in fixed NOK since the 1970s. Over a 40-year period, operating expenses have risen five-fold with average annual real growth of 4.5 per cent, except for the period around 1990 and 2002–2005.

3.3.2 From institution to home care services

Today the municipalities allocate more resources to home care services than to nursing homes and institutional care services. In contrast, 40 years ago over 80 per cent of operating expenses went to old-age and nursing homes, while only 20 per cent went to the operation of home care services, primarily professional homemaker and housekeeping services.

While 25 years ago as many as two-thirds of the person-years in the care services were associated with institutional care and only one-third with home care services, the ratio has now changed so that the proportion of person-years is largest in the home care services.

This development is due to reform efforts, professional and financial assessments in the municipalities, and greater involvement by the users in designing the services. The nursing home reform gave responsibility for home care services and nursing homes to the municipalities, which had to decide how they would organise the services to ensure the greatest overall impact. As a consequence, most of the growth in the care services occurred in home care services in the years following the reform. As long as the counties were responsible for nursing homes, the municipalities did not incur any costs.

Deinstitutionalisation was seen most clearly in the reform of services for individuals with cognitive impairments, where the system of care services in place (HVPU) and the HVPU institutions were closed down in the period from 1991 to 1995, and responsibility for these services transferred to the same agencies as for population at large. Integration, normalisation and participation comprised the key principles behind the measures to move people who previously lived in institutions into their own homes and provide them with health and care services adapted to their needs. At the same time, the services for those who had not previously been given a space in an institution were strengthened considerably. These users were given the right to the same services as the former residents of institutions. Other user groups were granted similar rights in the wake of the reform. This trend was further enhanced by *Unge ut av institusjon*, a project to move youth out of the institutions, and by the Escalation Plan for Mental Health. Some of this same development was incorporated into the Government's Dementia Plan 2015 and *Nevroplan 2015* ("Neuro Plan 2015") for people with neurological injuries and disorders.

The municipalities are responsible for providing necessary, safe services that meet the needs of individuals. Each municipality decides itself how these services will be organised based on local conditions and needs. As figure 3.7 shows, the way in which the municipalities have organised their health and care services varies widely. Twenty per cent of the municipalities use less than 40 per cent of the care services' net operating expenses for institutions and more than 60 per

cent on home care services. In 10 of these municipalities the share of expenses used for institutions is less than 20 per cent. In contrast, 15 per cent of the municipalities use more than 60 per cent of their expenses on institutions, and 11 of these use 80 per cent or more on institutions. However, almost two-thirds of the municipalities use 40–60 per cent on institutions, and the national average in 2011 was 46 per cent.

Some municipalities have still chosen to focus on nursing homes and institutional operations, while other municipalities emphasise home care services, daytime activity programmes and residential care homes. This is reflected partly in the variation in the cost of a space in a nursing home from NOK 500 000 to over NOK 2 million annually at the municipal level. However, it is the overall set of services that is most crucial for the residents of the individual municipality. All the same, studies indicate that municipalities which focus on home care services get more out of their resources than municipalities that put more emphasis on institutional services. One relevant report states:

> Therefore, an orientation towards home care services appears to be more effective in the sense that more people receive services that use fewer resources without a documented decline in the quality of the services.

3.3.3 From old-age homes to nursing homes and residential care homes

The days of the old-age home are past. Thus an era with its origins in the poorhouses of the past is over. Forty years ago there were more spaces in old-age homes than in nursing homes. While the old-age homes have been phased out since the municipalities assumed responsibility for nursing homes, the number of nursing home beds has increased from about 15 000 to 40 000 in the past 40 years.

Some old-age homes have been modernised and remodelled into nursing homes, but many old-age homes were so unsuitable or in such poor condition that they were replaced with new structures. In accordance with Report No. 50 (1996–1997) to the Storting, *Handlingsplan for eldreomsorgen* ("Action Plan for Elderly Care"), old-age homes were largely replaced with new, modern residential care homes. A large number of these have also been built in the municipalities for younger people with a need for adapted housing and services. More than one-third of people living in residential care homes are under the age

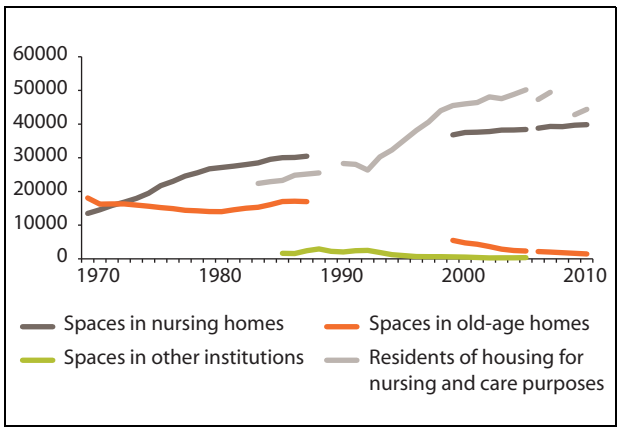

Figure 3.8 Number of spaces in institutions and residents of housing for care purposes 1970–2011

Please note: As from 2007 the data is taken from the IPLOS register and cannot be compared with previous years. Nor can figures for residents of housing for nursing and care purposes prior to 2009 be compared directly with figures after 2009.
Source: Statistics Norway

of 67. Of these, half have a cognitive disability and the other half either have mental health and social problems or long-term reduced functionality resulting from somatic illnesses, often neurological in nature. Over half of those living in homes for people in need of 24-hour services are under 67 years old.

The Action Plan for Elderly Care implemented the single-room reform, and half of Norway's nursing home spaces were either newly constructed or fully modernised. Nursing homes have therefore been expanded, renewed and renovated, both in terms of the buildings and to some extent with regard to the expertise needed to perform the tasks that the sector is now dealing with.

However, when addressing future challenges, there is a need for adaptation and restructuring in connection with the new, expanded tasks. As a result of the Coordination Reform, the pressure on 24-hour care spaces will continue to intensify, especially with regard to short-term spaces for relief from the caregiving burden, rehabilitation, training and emergency assistance. There will also be a need to modernise and renew old buildings that were not renovated under the Action Plan for Elderly Care. This should be done before the pace of expansion must be ramped up once again in 10 years due to the rise in the number of elderly over 80 years old.

The Dementia Plan 2015 also states that nursing homes with large wards and long corridors do not work well for people with dementia and other forms of cognitive decline. Since 80 per cent of nursing home patients today suffer from dementia,

the Norwegian State Housing Bank's support scheme has stipulated that all nursing homes and residential care homes must be built as small, adapted units, whether they are organised as small wards or as shared flats with several residents.

There is therefore much evidence to suggest that the more traditional institutions are on the way out and that new solutions will be created in the future that take the best from both the institution and the home care traditions. The question is what the new senior generation will want and prefer. Will they follow in the footsteps of the younger user groups or will they want to retain the institutions in their present form?

The kind of living arrangements that the municipalities offer to people with a need for 24-hour services varies widely. Figure 3.9 shows that the four northernmost counties have the highest overall coverage of 24-hour services (24-hour care spaces as a percentage of the elderly 80 years and older). However, while Finnmark county has the highest nursing home coverage, Nord-Trøndelag county has the highest coverage with regard to 24-hour spaces in residential care homes. The percentage of residential care homes coverage in Østfold, Buskerud and Telemark counties is high as well, while nursing home coverage is highest in Oslo and Sør-Trøndelag county, which so far have very few residential care homes. The level of coverage for the entire country is 28 24-hour care spaces as a percentage of the population 80 years and older, of which 18.5 spaces are in nursing homes.

3.3.4 From professional housekeeping and homemaker services to in-home nursing services

Three of four new positions in the care services in the past 15–20 years have been created within the home care services, with in-home nursing services representing much of the increase. Forty years ago, in-home nursing services comprised only 10 per cent of all the home care services, which at that time consisted mainly of professional homemaker and housekeeper services. Whereas professional homemaker services have disappeared and practical assistance has remained at roughly the same level in recent years, in-home nursing services have seen considerable growth and come to play a more prominent role in the municipal health and care services as a whole. This development reflects the fact that home care services have become more medically oriented and give priority to health over social services. At the same time, the process of phasing out old-age homes and expanding nursing homes has meant that medical treatment and nursing have been given a far more critical role in institutional care as well.

In addition, college-educated professional groups such as social educators, social workers,

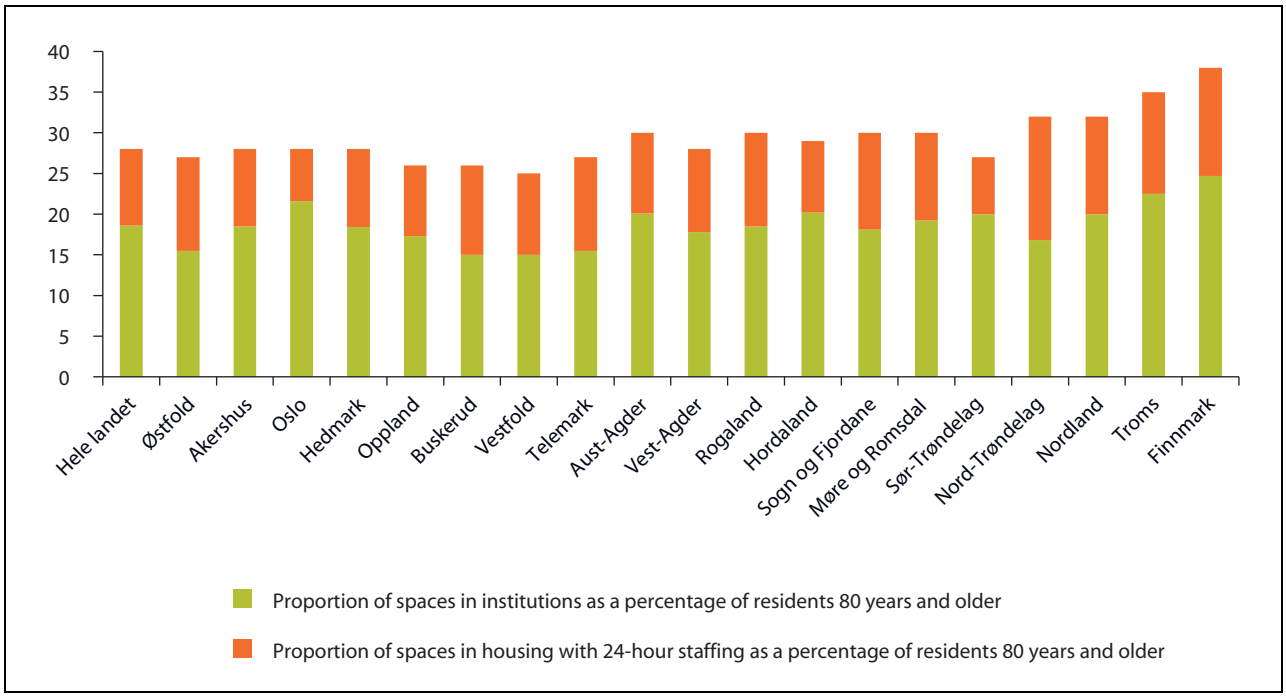

Figure 3.9 Spaces in institutions and housing with 24-hour staffing 2011 as a percentage of residents 80 years and older

Source: Statistics Norway 2012

child care workers and special education professionals have also become a part of the home care services, and the percentage of person-years from these groups has risen within the health and care services.

According to the Norwegian Directorate of Health:

> The changes in the nursing and care sector in recent years have been so far-reaching that the municipalities have had their hands full just handling the new younger groups of recipients and the elderly most in need of care. As a result, there have been too few resources to give adequate priority to practical, social and preventive services among the younger group of elderly as well.
>
> Despite strong growth in staffing and greater professional expertise in both nursing homes and home care services, there is much evidence to suggest that the direction taken by the services has been to the detriment of early intervention, prevention and rehabilitation. The Government wishes to help to improve the balance between treatment and prevention and between nursing and habilitation/rehabilitation.

The care services of the future must put more emphasis on active care and training through physical, social and cultural activities in order to meet the needs of new younger user groups who require personal assistance and the new generations of elderly. This will require a broader range of professional expertise with a different constellation of knowledge and skills as well as other professional approaches and work methods than is the case today.

3.4 Care Plan 2015

Several long-term, action-oriented strategies and measures underlie the development of the care services. The Care Plan 2015 is the Government's plan to enhance the capacity, expertise and quality of the municipal care services. The plan was presented in autumn 2006, and the measures and instruments have been implemented during the current and previous governments.

24-hour care spaces

The investment grant provides pledges for allocations for the construction or improvement/renovation of 12 000 24-hour care spaces in the period from 2008 to 2015.

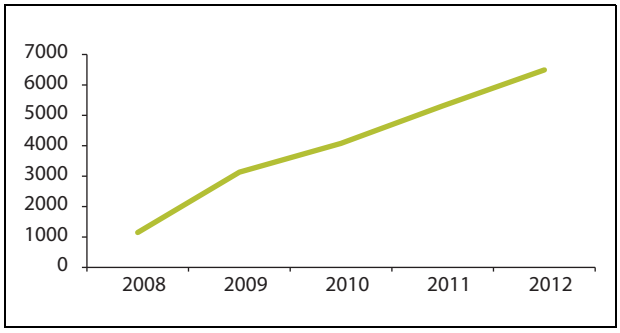

Figure 3.10 Number of pledges for allocations for 24-hour care spaces in nursing homes and residential care homes 2008–2012

Source: Norwegian State Housing Bank 2013

The municipalities are eligible for pledges from the Government for funding for a total of 9 500 units from 2008 through 2012. In the same period, the municipalities have submitted applications for about 6 500 units, and the Norwegian State Housing Bank has issued pledges for allocations for roughly 6 300 units. About half of these pledges have been issued for spaces in nursing homes (54 per cent) and the other half for spaces in residential care homes (46 per cent). Almost 60 per cent of the total number of units for which pledges have been issued involve the construction of new buildings. In the national budget for 2013 (Prop. 1 S (2012–2013)), the Government has approved pledges for allocations for 1 750 units in 2013. Developments indicate that the target of 12 000 spaces will likely be achieved by the end of 2015.

Increase in the number of person-years

In its first platform the Government established a target that increased the staffing in the municipal care services by 10 000 person-years by the end of 2009, based on 2004 levels. This target was exceeded with an increase of person-years of about 14 800. In its second platform the Government set a target to increase staffing in the municipal care services by 12 000 person-years in the period 2008–2015, measured at the end of the year.

The total increase in person-years to date in the current government term (2005–2011) has been about 22 000 person-years. Some 80 per cent of this growth has consisted of personnel with education in health and social care subjects. The proportion of personnel with an education in health and social care within the health and care services sector has

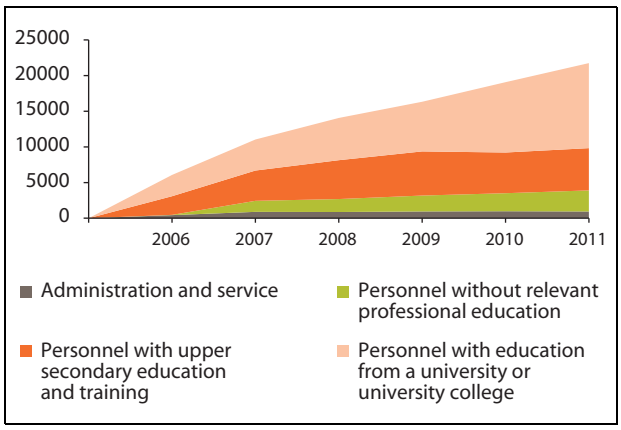

Figure 3.11 Increase in person-years within the nursing and care services sector 2005–2011

Source: Statistics Norway 2012. The increase in person-years is measured from the end of 2005 to the end of 2011.

thus risen from 66.4 per cent in 2005 to 69.1 per cent in 2011, helping to enhance both capacity and expertise within the services.

The proportion of personnel with a university or university college education has increased from 27.4 per cent to 32 per cent in the period from 2005 to 2011. The figures show that the increase in person-years has primarily involved nurses, which rose from 18.1 per cent in 2005 to 19.7 per cent in 2011 of the total number of person-years in the sector. There was a concurrent rise in the overall proportion of social educators, social workers, occupational therapists and child care workers from 5.9 per cent to 6.7 per cent. Here, social educators comprised the largest group by far. In 2011, the number of social educators corresponds to about 30 per cent of the number of nurses without an education in a specialisation.

The proportion of personnel with upper secondary education and training has shown a slight decline in the years since 2009. Most of this decline is due to a small decrease in health care workers, nursing assistants and care services workers, which this group primarily comprises. Taken together, these groups currently represent 35.3 per cent of the total number of person-years. The proportion of personnel without relevant professional education has declined in this period from 28.6 per cent in 2005 to 26.1 per cent in 2011, while the proportion of person-years that perform administrative and service tasks has remained stable.

Kompetanseløftet 2015 ("Competency Reform 2015")

Kompetanseløftet 2015 ("Competency Reform 2015") is the Government's competency and recruitment plan, and has as its primary objective to ensure that the municipal care services sector is adequate, competent and has stable staffing. A total of over NOK 300 million is used annually on competency and recruitment measures under the Competency Reform 2015.

The Competency Reform has five secondary objectives for the period 2011–2015: to increase staffing in the municipal health and care services by 12 000 person-years; to raise the level of education among care services personnel; to ensure an overall supply of about 4 500 health care workers per year; to broaden the sector's professional scope; and to enhance guidance, internal training and further education.

In the first six years of the plan period (2007–2012) roughly 21 000 people have completed basic, further or continuing education or another type of training with support from the Competency Reform 2015.

Development centres for nursing homes and home care services have been established in all counties throughout Norway. The centres are to serve as catalysts for knowledge and quality in the care services by conducting research, professional development and competency building activities, in addition to promoting the further development of practicum opportunities for pupils, apprentices and students. The municipalities with development centres are part of a common network and are linked to the regional centres for care research.

Dementia Plan 2015

The Dementia Plan 2015 was presented in autumn 2007. The objective of the plan is to strengthen services to people with dementia through three main measures: enhancing knowledge about and expertise on dementia, increasing daytime activity programmes, and creating more adapted housing.

A national overview of services for people with dementia has been compiled which shows that the municipalities have increased their activities for people with dementia and their close family members in the period 2007–2010 under the Dementia Plan 2015. The number of municipalities with training for family members has almost quadrupled during this period and comprised 246 municipalities at the last review. At the end of 2012, more than 14 000 employees in about 85 per cent of the country's municipalities had begun internal training programmes on how to care for people with dementia.

In 2011, the Dementia Plan was revised with a new four-year action programme (2012–2015). One of the main objectives of the revised plan is to legally require the municipalities to offer daytime activity programmes for people with dementia when they expand their services. Therefore, in 2012 an earmarked funding was allocated to encourage the municipalities to establish spaces in daytime activity programmes for people with dementia. To date, funding has been allocated for the establishment of almost 1 000 spaces.

Care services research

To strengthen the knowledge base in the care services sector, the Government has ensured an escalation of funding for care services research. In 2013, the allocation for care services research is NOK 37 million. This will help to expand the knowledge base for use in the planning, development and organisation of the care services. The funding is being channelled through the Research Council of Norway.

To strengthen practice-based research and development in the municipal care services sector, five regional care services research centres have been established. The centres are affiliated with educational institutions that provide training for health and social care personnel.

The Cultural Walking Stick programme

The Government has established the Cultural Walking Stick programme to enhance cultural activities for users of the care services. The programme was established in 2007. Approximately NOK 30 million has been allocated to cultural activities under the programme in 2013.

Neuro Plan 2015

Neuro Plan 2015 has been drawn up to highlight and draw attention to care services recipients with neurological disorders. The plan was presented in autumn 2012 and is intended to enhance expertise and quality in the municipal services with regard to people with neurological disorders. The plan has three main focus areas: information and new knowledge, rehabilitation in daily life through activities and training, and multidisciplinary development activity.

The agreement on quality and project on ethics

In December 2012, the Government and the Norwegian Association of Local and Regional Authorities (KS) entered into an agreement on quality development in the municipal health and care services. The agreement is based on the consultation scheme between the Government and KS. The agreement on quality sets out objectives and strategies for developing the quality of the municipal health and care services.

Under the project on cooperation on building competency in ethics, more than 200 municipalities have established various meeting places to strengthen expertise in ethics within the municipal health and care services. A handbook of methods and e-learning tools on ethical reflection have been developed as well. The project was launched in 2007 and will last until the expiry of the Care Plan 2015.

The Ministry of Health and Care Services has established eight principles for good care services in cooperation with the Norwegian Association of Local and Regional Authorities (KS), the Norwegian Nurses Organisation, the Norwegian Union of Municipal and General Employees, the Norwegian Union of Social Educators and Social Workers, the Church City Mission and the Norwegian Pensioners Association. The principles are intended to serve as a point of departure for reflection, culture building and local improvements within the services. As a follow up to these efforts, the Norwegian Directorate of Health is in the process of developing new quality indicators for the care services.

Regulations on dignified elderly care

To ensure that the elderly are not neglected with regard to the overall activities of the nursing and care services, the Government has drawn up regulations that specify the municipalities' obligations related to care for the elderly ("guarantee of dignity").

The regulations describe the values underlying elderly care and set out the measures to be implemented within the care services, such as appropriate and safe forms of housing, a varied and adequate diet, palliative treatment and a dignified death, professionally sound follow-up by doctors and other relevant personnel, conversations about existential questions, etc. The complaints and inspectorate authorities are responsible for ensuring that municipalities adhere to the "guarantee of dignity".

3.5 Projections

3.5.1 Changes in demographics

We are facing an unprecedented global demographic challenge caused by an ageing population that will continue to grow, and the far-reaching consequences of an economic, social, political and cultural nature that will follow as a result. This is the conclusion reached in the United Nations report World Population Ageing 1950–2050 from 2001.

In terms of demographics, Norway is one of the European countries that will experience the least dramatic changes in the age composition of the population. This is partly because Norway has already undergone such changes and partly because Norway has a higher birth rate.

The population of Norway has more than doubled in the past century, from 2.2 million in 1900 and 3.3 million in 1950 to 4.5 million in 2000. According to population projections from Statistics Norway, the population will continue to climb at an even pace to 6 million in 2030 and 6.7 million in 2050.

The number of people over age 67 will more than double in the period from 2000 to 2050. The number of people over 80 years old will increase from 190 000 in 2000 to almost 350 000 in 2030 and nearly 570 000 in 2050. The growth in the age group 80–89 years will begin in 10 years from now. There will be dramatic growth in the group of elderly 90 years and older in the next few years.

It was decided to use the median alternative in the population projections as the basis for the statistical analyses related to median fertility rate, median life expectancy, median net immigration and median mobility (MMMM).

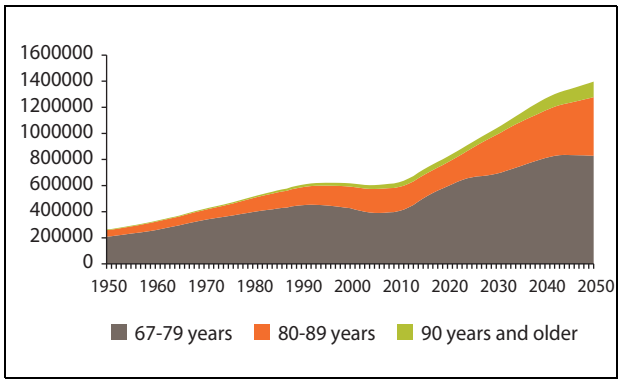

Figure 3.12 Number of persons in the age group 67 years and older 1950–2050

Source: Statistics Norway 2012. Median alternative (MMMM) for the population projections.

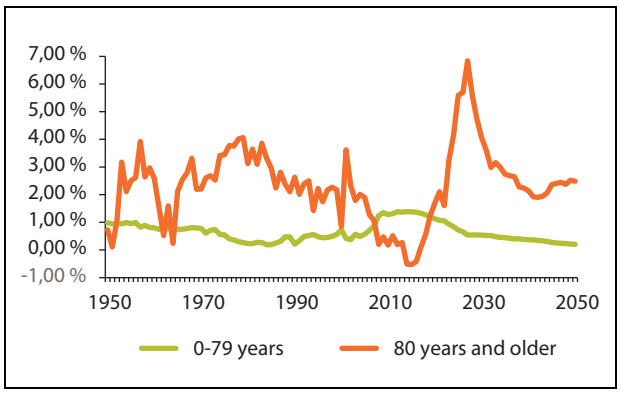

Figure 3.13 Annual percentage change in the number of persons over and under 80 years old 1950–2050

Source: Statistics Norway 2012. The median alternative (MMMM) for the population projections.

The upcoming demographic changes are often depicted as an uncontrolled elderly boom that will sweep the entire country. However, in the next few decades the number of elderly over age 80 will not increase; in fact it will decrease slightly. This presents an opportunity to plan and prepare for the changes that will occur in the age composition of the population further in the future.

The number of elderly, especially those over 80 years old, has been increasing substantially ever since 1950. The next 15 years there will be smaller growth and even a decline. Then the number of elderly over 80 years of age will rise dramatically in the period from 2020 to 2035 with up to seven per cent growth from one year to the next.

In the next few years, the growth will occur among the youngest elderly in the 67–79 age range, which will present a special challenge for the home care services. The number of people over 80 years old will remain stable in the next 10–15 years, except for the age group over 90 years. Due to the increase in the number of the most elderly, 24-hour services will need to be further expanded. It will also be crucial to take advantage of the relatively stable demographics in the next 10–15 years by gradually expanding the services and preparing for the rapid rise in the number of elderly over 80 years of age.

Special focus on dementia

Most elderly people are healthy, but most sick people are elderly. The incidence of illness and injuries rises with increasing age, and a significant proportion of elderly contract diseases or sustain injuries that result in varying degrees of reduced

functionality. This applies in particular to people who develop dementia. Today there are about 70 000 people with dementia in Norway, and it is estimated that some 250 000 people – both patients and their close family members – are affected by the disease. About 10 000 people per year are diagnosed with dementia. Since the number of elderly over 75 years old, especially those over 80 years, will increase in the coming decades, the number of people with dementia in Norway could double to about 140 000 over the next 25–30 years.

The large number of people affected by various types of dementia presents major challenges for the public administration, health care personnel and the service structure in terms of both planning and adapting services that are professionally sound and customised for individuals.

Recipients of services with an immigrant background

The number of elderly people with an immigrant background in Norway will rise in the near future. For the first time, Statistics Norway has prepared an estimate of the number of immigrants or those who were born in Norway to two immigrant parents living in all counties throughout the country as well as in some of the larger municipalities up until 2040. These groups will grow substantially in the future, especially in the major metropolitan areas. The care services must be adapted in a way that ensures these users receive sufficient services of high quality. The changing composition of the users' cultural and religious backgrounds will be a crucial factor in the design of the services and will pose new requirements for individual adaptation.

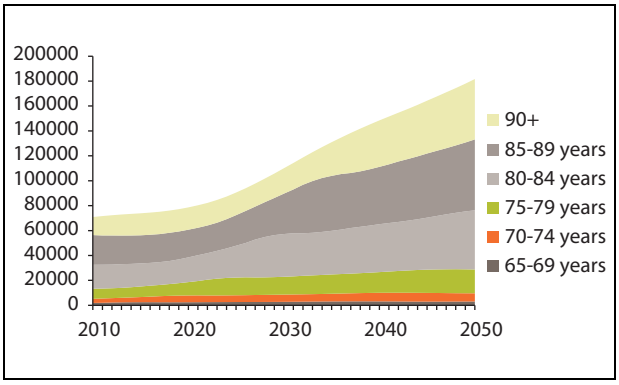

Figure 3.14 Number of persons with dementia projected for 2010–2050

Source: Ministry of Health and Care Services. Estimated on the basis of a given percentage of incidence of dementia per age group. Based on the median alternative (MMMM) for the population projections.

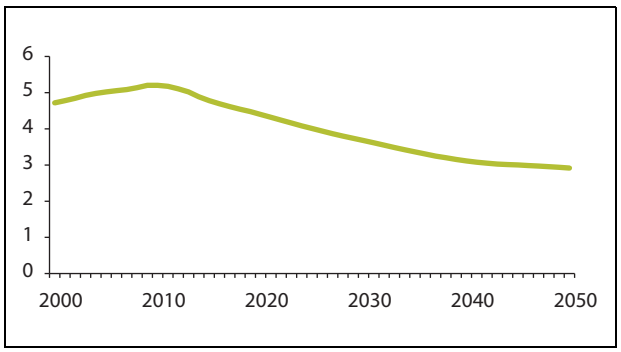

Figure 3.15 Number of persons of working age (16–66 years) per number of elderly 67 years and older (Potential Support Ratio) 2000–2050

Source: Statistics Norway 2012. The median alternative (MMMM) for the population projections.

Age composition and the Potential Support Ratio

The Potential Support Ratio shows the relationship between the working population (16–66 years) and the elderly population (67 years and older), and is of great relevance with regard to potential economic support, welfare benefits, and health and social services in the future. In 2000, there were 4.7 people of working age per elderly person, whereas the Potential Support Ratio will drop to 3.5 in 2030 and to 2.9 in 2050. The decline in the proportion of people of working age in relation to the elderly will likely present a challenge to the personnel situation within the health and care services sector as well as to value creation and the development of welfare.

Care providers within the family network

Changes in the age composition of the population have an impact on the number of informal care providers on whom the elderly can rely, and will affect informal care patterns in the future.

The UN's Parent Support Ratio, or the ratio of the number of people over age 85 to the number of people age 50–66, is a demographic expression of the potential ability to provide care to the elderly.

The Parent Support Ratio is highly relevant for Norway, but it can paint a rather simplified picture of future developments because trends other than age composition are significant for the potential of families to provide care and because cultural changes affect caregiving as well. In Norway, the volume of informal care has been stable in the past 20–30 years in areas for which statistics have been compiled. It appears that families and public

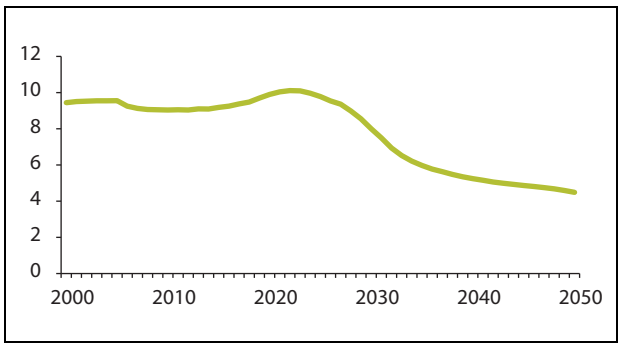

Figure 3.16 Number of persons in the 50–66 age group per person in the age group 85 years and older (Parent Support Ratio) 2000–2050

Source: Statistics Norway 2012. The median alternative (MMMM) for the population projections.

care providers complement each other under certain conditions. Families are able to participate in caregiving if they do not have to assume the entire responsibility.

3.5.2 Personnel needs

The projections on personnel needs up to 2050 have been developed by Statistics Norway. They are based on assumptions regarding some of the most critical driving forces underlying the demand for care services: demographics, morbidity, the volume of informal care, and the standard of the services.

Numerical projections of this type will always be surrounded by considerable uncertainty. There is little research on trends in the need for care services on which to base projections. In addition, it is important to emphasise that the projections do not take into account the impact of the strategies and measures designed by the Government to prevent or reduce the increase in the need for care services in the future. Thus, the projections are not intended as a prediction of the future, but as an illustration that can inform the debate on the kind of future Norway seeks to have.

Personnel needs up to 2050

The projection in figure 3.17 shows the personnel needs in the municipal care services sector up to 2050 under the following conditions: the size and composition of the population follow the median alternative in the latest projections from 2012 by Statistics Norway; the volume of age and gender-specific person-hours per user is continued at the 2010 level (constant standards); age-specific morbidity is reduced in keeping with increasing life expectancy so that the period when people are intensive users of care services towards the end of their lives remains roughly unchanged in the coming decades (postponed morbidity); the volume of informal care remains constant at about 100 000 person-years (unchanged informal care).

The projection shows that the number of person-years in the care services sector may increase

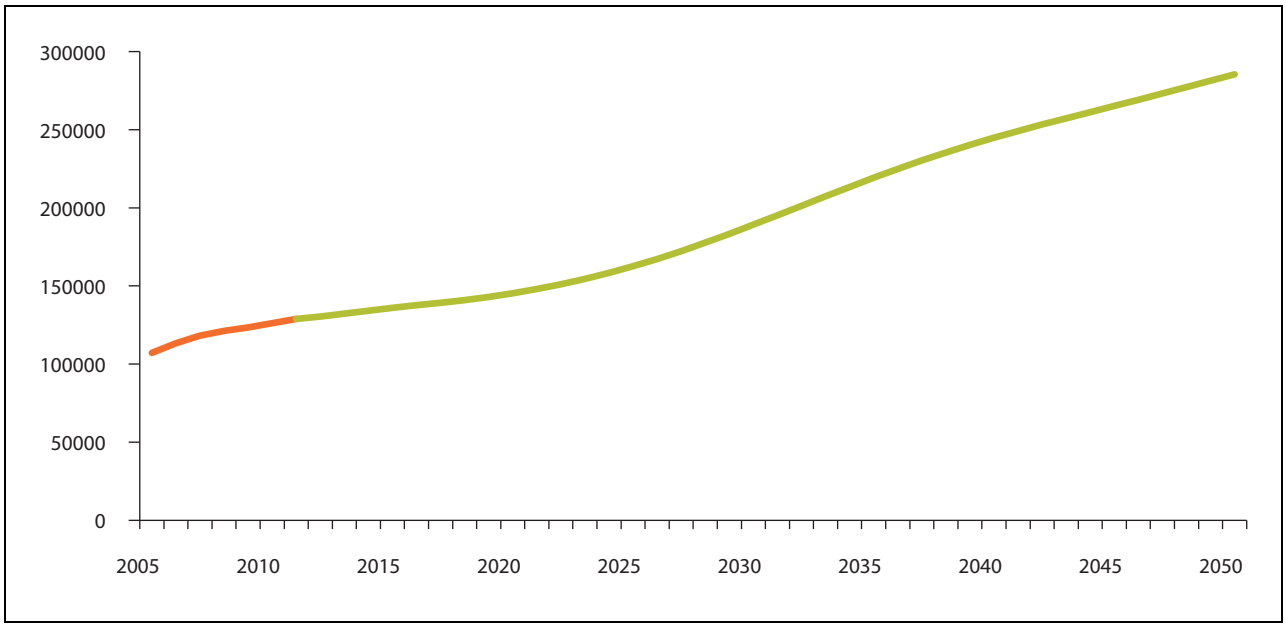

Figure 3.17 Projection on personnel needs in the care services sector 2012–2050 in number of person-years

Source: Statistics Norway

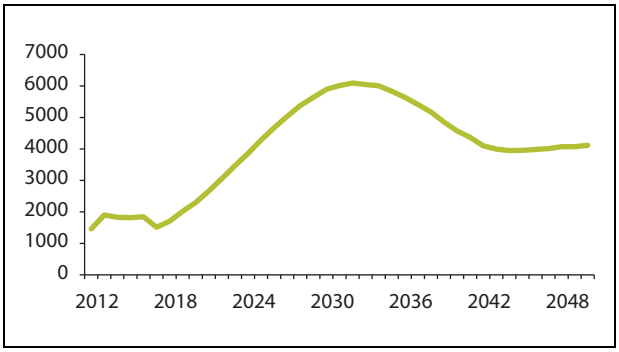

Figure 3.18 Annual increase in person-years within the care services sector 2012–2050

Source: Statistics Norway

by almost 50 per cent or about 60 000 person-years up to 2030 and be more than doubled up to 2050.

Figure 3.18 shows that the annual increase in person-years will be greatest from around 2025, peak just after 2030 with about 6 000 new person-years annually and then stabilise at a higher level just after 2040 with an increase in person-years of about 4 000 new person-years annually.

In addition, projections regarding the labour market for health and social care personnel show a cumulative shortage of the largest groups of educated workers in the care services sector amounting to about 55 000 person-years in 2030.

Due to a shortage of personnel with an education in health and social care combined with a growing need for recruitment, it will be necessary to recruit from a broader base and seek out personnel with a variety of backgrounds. At the same time, this highlights the need to invest more in welfare-related educational programmes in the future as described in Meld. St. 13 (2011–2012) *Utdanning for velferd – Samspill i praksis*, white paper on education for welfare, Ministry of Education and Research.

Informal care

The projection in figure 3.17 is based on the assumption that informal care will remain unchanged at about 100 000 person-years in the projection period.

On the basis of time-use and social conditions statistics compiled by Statistics Norway, it is estimated that the volume of informal care has remained relatively stable at about 100 000 person-years in recent decades, but with a slight decline from 1990 to 2000. This means that the number of person-years from families and informal social networks is not increasing in step with the care needs of the population and that it is probably unrealistic to assume that it will increase at the same pace as the need for care in the future. Demographic conditions do not support this either. The growth in care needs must therefore be addressed primarily in other ways. It will also be important to sustain, strengthen and maintain the resources that family members and volunteer care providers comprise for meeting future care challenges. A research report on this topic states:

> "Our finding that volunteer care declined from 1990 to 2000 shows that this form of care is threatened. Many factors are contributing to this. It is important to understand that the way in which public services are organised and the potential for cooperation established within these are significant for the scope and content of the care services. It appears that many of the organisational changes implemented in recent years have not taken this into account. In order to safeguard the volunteer care resources, the public actors must be supportive and cultivate and maintain these resources."

Figure 3.19 shows projections of the personnel needs under other assumptions about the development of informal care. In the alternative that assumes a reduction in informal care, the volume of informal care is reduced alongside the reduction in the Parent Support Ratio. In the alternative that assumes growth in the volume of informal care, the volume of informal care increases proportionally with the increase in formal care. These alternatives show that changes in the volume of informal care will have an enormous impact on the need for personnel in the care services sector.

Morbidity and functionality

Changes in the level of health and functionality are significant for the development of care needs in the future, and there is great uncertainty about how state of health and functionality will develop as life expectancy increases.

The Global Burden of Disease Study 2010 has compiled statistics on 235 causes of death, years of life for 291 illnesses or injuries adjusted for disability, life expectancy and 67 risk factors. Figures from 2010 have been compared with figures from the corresponding study in 1990. Results from the project show that an increase in life expectancy in Norway from 1990 to 2010 has primarily resulted in more healthy years of life. The longer life

Box 3.1 Personnel needs 2012–2050

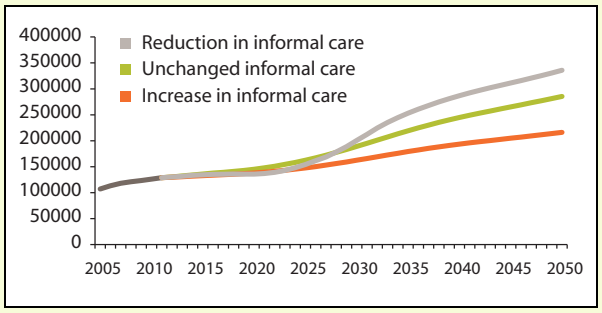

Figure 3.19 Personnel needs (2012–2050) under various assumptions about informal care

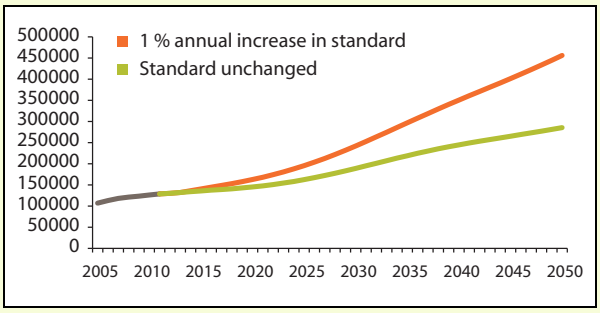

Figure 3.21 Personnel needs (2012–2050) assuming a one per cent increase in the standard of services

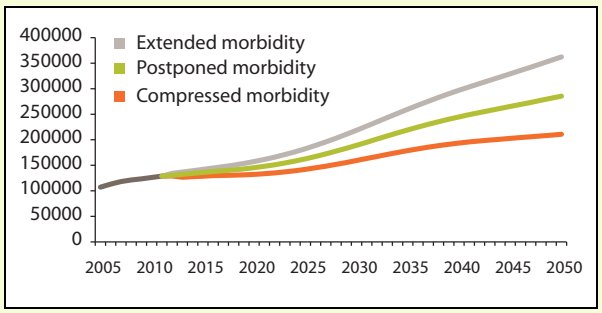

Figure 3.20 Personnel needs (2012–2050) under various assumptions about morbidity

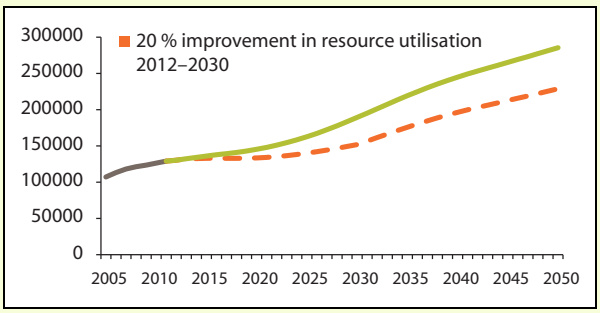

Figure 3.22 Personnel needs (2012–2050) assuming a 20 per cent improvement in resource utilisation 2014–2030 (Illustration)

Source: Statistics Norway

expectancy for men was 4.9 years, which consisted of 3.4 healthy years and 1.5 sick years, whereas the longer life expectancy for women was 3.1 years, which consisted of 2.3 healthy years and 0.8 sick years.

Figure 3.23 shows the remaining years of life of 65-year-olds in selected European countries in 2011, with an estimate of the remaining years of good and poor health. The figure shows that Norway is among the European countries whose residents have the longest life expectancy and the fewest years of poor health at the end of their lives.

A review of Swedish and international research shows that various studies draw different conclusions about the development of elderly people's health and functionality. Regardless of the differences in the methods used and the ages studied, the review of the research shows an improvement in the ability of the elderly to help themselves in daily life. By the same token, more elderly people report having specific health problems. These two development trends pull in opposite directions, and it is unclear the degree to which they balance each other out with regard to the need for care services.

The projection in figure 3.17 is based on one of many possible assumptions about the degree of postponed morbidity and an assumption that a lower mortality rate among the elderly is due to better health. This is seen in lower age-specific use of the care services, so that the amount of time with relatively serious illness and loss of functionality is about the same as before. This means that a 75-year-old in 2050 is expected to have better health and less need for care services than a 75-year-old in 2010. An assumption of postponed morbidity may be somewhat optimistic in light of the Global Burden of Disease Study 2010, but at the same time it takes into

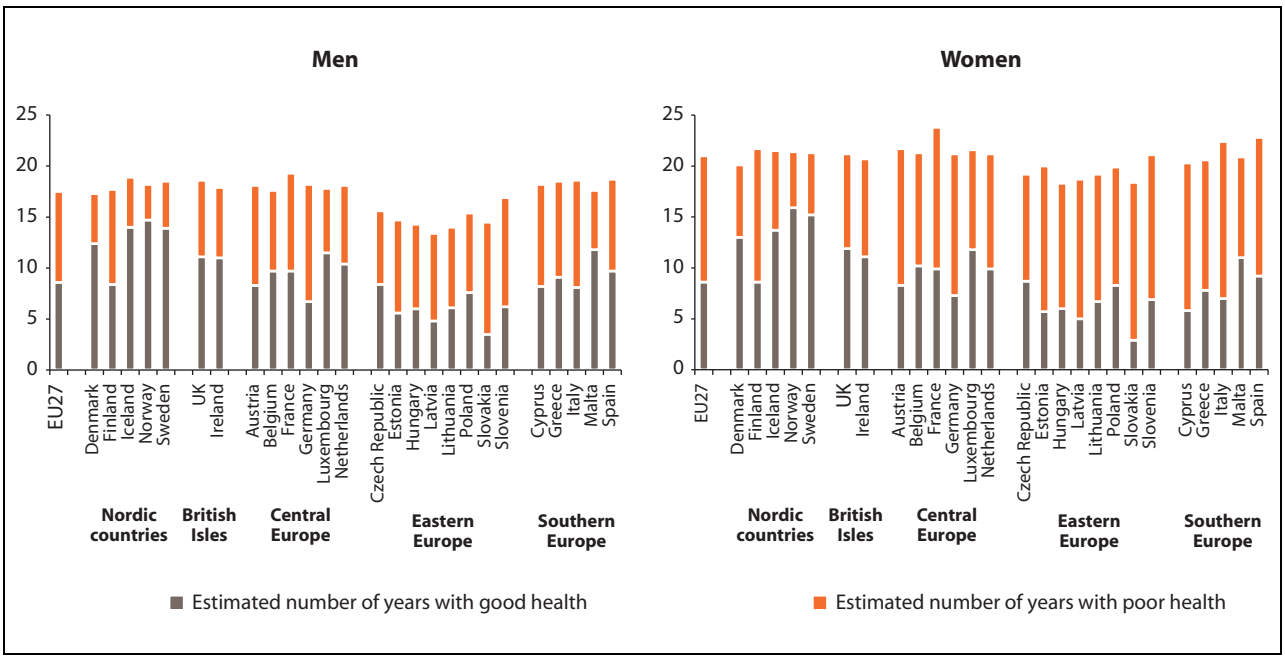

Figure 3.23 Anticipated remaining years of life and morbidity among 65-year-olds in Europe in 2011

Source: http://ec.europa.eu/health/indicators/healthy_life_years/

account the finding on an improvement in the ability of elderly people to take care of themselves better in daily life. For planning purposes it has been decided in general to assume postponed morbidity.

In figure 3.20 the personnel needs are projected on the basis of other assumptions about morbidity. In the case of prolonged morbidity, a longer life expectancy means that the number of years of illness and reduced functionality increases on average, and there will be more elderly people in all age groups that require intensive caregiving since more elderly are living longer. In the case of compressed morbidity, it is estimated that the number of healthy years will increase more rapidly than the higher life expectancy.

The projection does not take into account any breakthrough in dementia research, which would upset all of the projections regarding the need for care and personnel in the care services sector. About three-fourths of the residents in nursing homes have dementia as their main or sub-diagnosis. About 10 per cent of recipients of home care services receive assistance primarily because they have dementia. It must be emphasised that as of today there are no grounds to state a point in time or the potential for a breakthrough in treating various forms of dementia. All planning for the care services sector must therefore take its point of departure in the fact that dementia is a major, rapidly increasing cause of the need for care services.

Effect of changes in resource use

Several development trends point in the direction of a higher standard of services in the future. Future users of the care services will have different expectations and preferences than today's users, and a demand to raise this standard may come from several different quarters.

Figure 3.21 illustrates the effect of a one per cent annual increase in the standard of services and shows that the demands for and expectations about more resources over time will have a major impact on personnel needs in the care services sector.

Rather than increasing the standard of services, the opportunities inherent in the demographically stable period up to 2020 should be used primarily for improving the care services related to future care challenges. More emphasis on innovation and development, an effort to bolster and reorganise professional activities and physical structures in the services, increased use of welfare technology, and better realisation of society's care resources will improve resource utilisation and contribute to sustainable care services, also in the future. Figure 3.22 illustrates the development of personnel needs if the care services improve their resource utilisation by 20 per

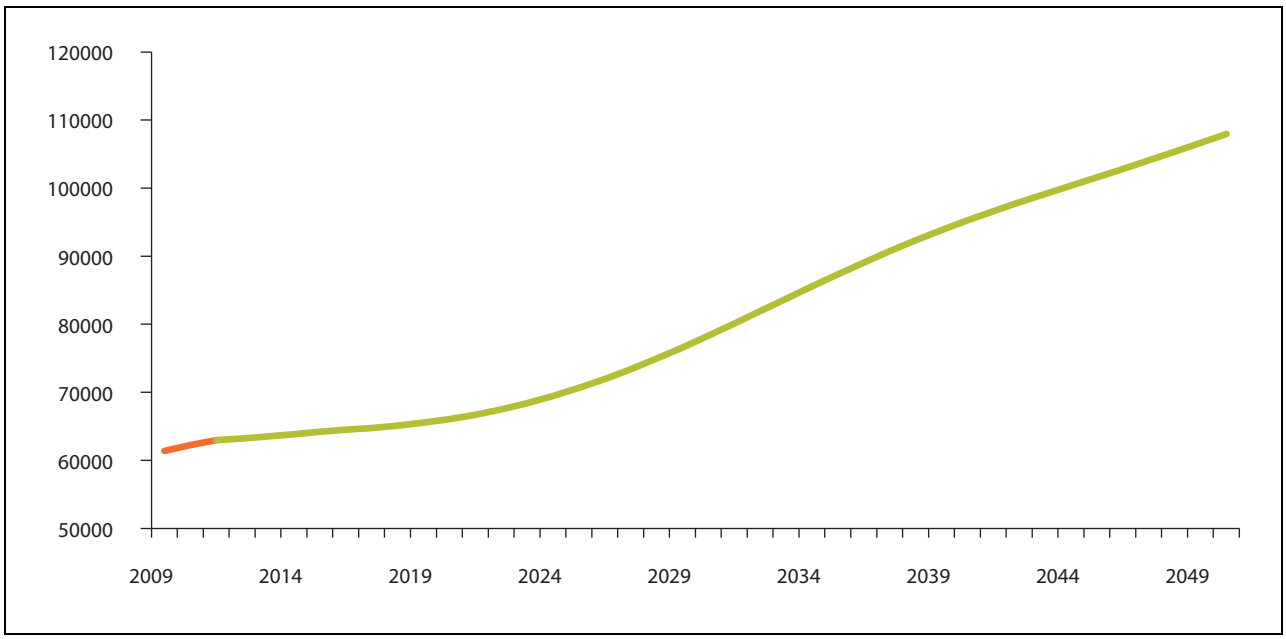

Figure 3.24 Projection of 24-hour care spaces 2012–2050

Source: Statistics Norway and the Ministry of Health and Care Services

cent from 2014 to 2030 with improvements evenly distributed in each year of the period.

3.5.3 24-hour care needs

A major challenge in the future will be to expand the capacity of all services related to 24-hour care spaces in nursing homes and residential care homes so that Norway does not lag behind when the need for care services increasing dramatically in 10–15 years.

In 2011, 24-hour care provided by the care services consisted of some 63 000 24-hour care spaces divided among about 41 000 spaces in institutions and 22 000 residents in housing with 24-hour staffing.

The projection below shows that the need for 24-hour care spaces could grow by almost 15 000 spaces up to 2030 and 45 000 spaces up to 2050. The trend is the same as that for personnel needs. It is especially beginning in 2025 that the need for 24-hour care spaces will increase substantially.
This projection is based on the assumption that tasks will be carried out in the same way with the same standard as today, that informal care will be maintained at its current level and that a longer life expectancy will postpone the period at the end of life with serious illness and reduced functionality.

Better adaptation of people's own homes, the use of welfare technology, daytime activity programmes, an expansion of assisted living residences and greater focus on home care services and rehabilitation may be an alternative to, or help to postpone the need for, 24-hour care spaces. The average cost of a 24-hour care space in a nursing home comes to almost NOK 1 million per year. It will be an innovation task for the municipalities to test out whether using such a large sum in a different way can result in other, better solutions for individuals.

3.6 Sustainable development

The successful development of public care services to the extent and at the professional level achieved in Norway suggests that future challenges must be addressed from two angles: continuing the best of what has been developed in the past 40 years and changing the course in some crucial areas.

Public care services have undergone continual growth over several decades. In light of the demographic challenges that are expected to hit full force in 10–15 years, this growth must be organised so that it supports and triggers the resources found among the users themselves, their families, social networks and neighbourhoods, organisations and local communities. It will require a restructuring of professional activities to put more emphasis on prevention, early intervention, social networking and rehabilitation and to make greater use of new technology and

work methods. At the same time, core nursing activities must be improved and medical follow-up strengthened.

The Norwegian care services model is characterised by a distribution of tasks and close cooperation between two major actors: the municipal health and care services and close family members. Future challenges raise the question of whether other actors should be given more room and more tasks and whether there should be a change in the ratio between public services, families, volunteers, the philanthropic sector, user-driven schemes, cooperative solutions, and trade and industry.

The uncertainty relating to economic trends, as seen in many countries in Europe, also suggests that the services should not be set in stone, but instead must have the necessary flexibility to address potential changes in the labour market. A focus on home care solutions and daytime activity programmes will offer the greatest flexibility with regard to family members' work situations and the needs of the labour market. It is the group of the youngest elderly that will experience the greatest increase in the near future. Thus, demographic changes also suggest that the initial growth should be addressed with home care services, rehabilitation and preventive measures.

Overall, this will create the most sustainable situation for addressing future care challenges.

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