Norway

Long-term Care

18 May 2011

Key Facts

- About 14.8% (2009) of the Norwegian population is over the age of 65 while 4.6% population is over the age of 80.
- The population trends in Norway appear to differ slightly from that in many other OECD countries as the proportion of 65 and over population peaked at 16% in 1990 and has since decreased continuously to the current levels. Projections show that the population aged80 and over will double by 2040 (OECD Social and Labour Demographics, 2010).
- In 2008, approximately 5.5% of the population over the age of 65 received long-term care in an institution setting with 12.4% of this population receiving long-term care at home.
- Norway has a high percentage of formal LTC workers, 13% for the age 65 and over population compared to the OECD average of 6.1%.
- In 2008, Norway spent 2.2% GDP on long-term care with 2% GDP spent publicly for health related LTC (OECD Health Data, 2010)

Background

Norway has a tax-based, universal public long-term care (LTC) scheme. All LTC services are delivered in kind. The system is funded by national taxes but carried out at local level, and may require co-payments depending on the care required.

Benefits and Eligibility Criteria

Services cover home practical care, home medical care, institutional day and night care, daytime relief for informal carers, provision of assistive devices and technology, economical support to informal carers, social contact assistance, and personal assistance for disabled (user-organised).
Eligibility is assessed by municipalities (local government) agencies. Municipalities are free to organise the services as they find appropriate in order to fulfil their obligations according to medical and social rights determined by law. With funding tax-based, there is no clear “right” to care.

Furthermore, there is no absolute “criterion” that makes people eligible for care. However, there must be a need for “required health care” beyond immediate help, and health care should be “properly” secured by the municipality. In order to receive social services (personal and practical assistance at home, short-term stay in nursing homes, residence in elderly home or discretionary cash benefits), the client must have a special need for help due to factors such as sickness or disability. The client must be dependent on practical or personal help to manage ordinary activities of daily living (MISSOC tables, 2009). Normally, qualified staff will assess the need for care but variation exists.

Co-payments are required for home care and nursing homes. However for home nursing and medical care no co-payments are required. Maximal payment are regulated by secondary law. Most benefits are in kind, however some cash-benefits also exist.

Cash benefits

For the disabled: Basic benefit (grunnstønad) and Attendance benefit (hjelpestønad) from the general National Insurance Scheme (folketrygden) are paid directly to the person who is in need of care.

- Basic benefit to cover extra expenses due to permanent illness, injury or deformity. There are 6 different rates of benefit according to the level of extra expenses, in 2011 ranging from NOK 7 452 (EUR 930) to NOK 37 260 (EUR 4 660) per year (Ministry of Health, March 2011).
- Attendance benefit to cover the need for special attention or nursing. The standard rate is NOK 12,900 (EUR 1 331). For disabled children under 18, the benefit can be paid at 3 different higher

rates, up to NOK 80 136 (EUR 10 020). It is a condition for the Attendance benefit that the care is provided by an informal caregiver (Ministry of Health, March 2011).

- Discretionary cash benefit (omsorgslønn) paid by the municipality to an informal carer who has a particular burdensome care work. It is the municipality's discretionary power to decide whether, and what amount of cash benefit it will provide.

OECD (2005) adds that there are no clear policies regarding cash vs. care schemes. A clients' wish is not enough. It is up to the municipality to decide if cash is better than municipality-organised care. The municipality has the final say to whether a client can have either cash or care schemes.

Funding and Coverage

LTC is funded both by national and local taxation. National taxes are transferred to local government. Total LTC costs in 2009 were NOK 75 Billion (EUR 8.7 billion) of which about NOK 5 billion (EUR 0.6 billion) were covered by private sources/co-payments. There is no standardised means-testing system.

Municipalities are free to set co-payments for nursing home care and home help, within legal boundaries: For long-term nursing home care the patient must pay 75% of income above NOK 6 600 (EUR 850) and up to the Basic Amount (Grunnbeløpet) of NOK 75 641 (EUR 9 800), plus 85% of any exceeding income up to the full cost of a nursing home place (as calculated for the municipality in question). Property and capital assets are left untouched (Ministry of Health, March 2011.

Delivery

Most care-providing organisations are affiliated with the municipality. Quality regulations exist but do not provide legal requirements related to staff to patient ratios, neither do they specify the qualifications required for carers (workers). There are publically funded training programmes for unskilled and skilled workers on two different levels. Secondary vocational education, which provides a trade certificate Qualification for a healthcare worker, requires two years of schooling and two years of apprenticeship. Further vocational education requires higher education. A nursing qualification, for example, will require three years of theory and practice. Currently, there is a lack of adequately trained staff. As of 2009, the average monthly salary of a nurse was 33 300 NOK (EUR 4 200) (Ministry of Health, March 2011).

References

MISSOC tables, 2009

OECD 2009-2010 Questionnaire on Long-Term Care Workforce and Financing

OECD (2010), *Health Data 2010*, Paris

OECD Social and Labour Demographics Database 2010