

The Norwegian Care Coordination Reform was launched on 1 January 2012. How well has it worked, and where does it go from here?

The Norwegian Care Coordination Reform – what now?

The Care Coordination Reform is a reform for coordination and setting direction, in which financial, legal, organisational and professional instruments are to be used to promote goals for holistic patient pathways, more prevention, better user co-determination and sustainable development (1). The municipalities shall take a greater responsibility, services shall be provided closer to people's homes and the specialist and primary health services shall commit themselves to cooperation agreements. Evaluations of the Care Coordination Reform show that there is still some way to go before these goals can be said to have been achieved.

The initial period was marked by negotiations regarding the cooperation agreements. Equality in negotiations was emphasised in a guideline issued by the Ministry of Health and Care Services (2). Municipalities joined forces and mobilised their best experts in law, administration and finance. In the main negotiations, many therefore felt that the parties were on an equal footing. In terms of patients and healthcare provision, on the other hand, the relationship has been an asymmetrical one, in which the patients and health workers in the municipalities have been the weaker party. This is described in publications issued in the context of the Research Council of Norway's evaluation of the Care Coordination Reform (EVASAM), in a sub-project called «Interaction and patient pathways in the melting pot» (SPIS) (3).

Even during the initial six-month period, municipal medical officers and managers in the care services sector expressed grave concern (4). There was a marked increase in the number of patients who were reported as ready for discharge, and they were reported as ready for discharge at an earlier stage than before. Often, insufficient account would be taken of the poor condition of the patients or of any co-morbidity in the form of chronic diseases. Little flexibility was demonstrated with regard to the municipalities' need for time to plan ahead. The reform introduced day penalties if patients had to wait for a place in a municipal programme. Sweden and Denmark have done the same, but in contrast to our scheme, they take the patient's loss of function into account and require municipal involvement in planning *before* discharge. Norway has succeeded in reducing the number of patients waiting in hospitals, although at the cost of more frequent readmissions and more patients who are waiting longer for short stay beds and long term care in nursing homes (5).

Development of integrated patient pathways has been one of the key goals of the Care Coordination Reform. Many health enterprises have envisaged an expansion of their diagnosis-specific treatment pathways to include the time before as well as after the hospitalisation period. The municipalities have therefore experienced an increasing pressure for specialisation of services and personnel. The idea of diagnosis-specific patient pathways in the municipalities may stem from a lack of knowledge about the prevalence of disease. Nearly all patients who need municipal services suffer from multiple diseases, and the municipality needs to cater to the entire patient with all his or her diagnoses. Diagnosis groups that are prevalent in hospitals, such as COPD, heart failure and stroke, are less frequently represented among patients who receive muni-

cipal care services. Diagnosis-specific patient pathways and specialist training of personnel with regard to individual diagnoses are neither functional, nor sustainable in the primary health services.

A key topic for the Care Coordination Reform has involved the establishment of 24 hour municipal emergency beds programmes. A grant scheme was introduced, linked to beds in institutions. This spurred many municipalities to opt for the most profitable solution: to enter into inter-municipal collaboration on inpatient emergency services. In many locations, the scheme was co-located with the local out-of-hours service and often placed in a centrally located nursing home, frequently in the same municipalities that host a hospital. In this way, the funding scheme has resulted in a centralisation of emergency service provision to many frail, elderly and chronically ill patients, instead of providing them with help closer to their homes.

The article in this issue of the Journal of the Norwegian Medical Association on the establishment of emergency hospitalisation services in neighbouring municipalities is therefore interesting in several respects (6). These municipalities have developed emergency beds services in nursing homes located within the home municipalities. In their experience, this has helped strengthen the nursing home professionally, provided more flexibility in the utilisation of bed capacity and improved collaboration among the health personnel involved. They have also seen that provision of services close to the patient's home helps improve patient co-determination and cooperation with the next of kin. These qualities and the access to the patient records have boosted doctors' confidence in treating patients who are severely ill.

The most common pathway has been: home – hospital – home. For some patients, the organisation of inter-municipal emergency beds programmes and an intermediate ward for reception of patients who are ready for discharge have led to brief intermediate periods in an institution prior to, although most often after, a hospitalisation period. This may entail a more disjointed pathway for some patients, in contrast to the intentions behind the reform. The number of patients who are affected is unknown, but it most frequently applies to frail, elderly patients and those who are chronically ill. It is these who are least able to tolerate being transported and changes of environment.

The road ahead calls for a number of adjustments. In the Care Coordination Reform, the authorities have primarily relied on regulatory and financial instruments. They have worked, but without parallel professional development, unintended effects may readily occur, along with a risk that any positive effects may be of a transitory nature. Professional asymmetries between the health enterprises and the municipalities are part of the problem in achieving effective interaction. If the primary health services are to become an equal partner, they must be equal to the specialist health services in terms of research and professional development. The organisation of municipal health services in numerous small, independent units is also an obstacle to letting the municipalities assume a greater responsibility for patient treatment. The government's White Paper

on the primary health services of the future testifies to the authorities' intention to address the lack of cooperation within the primary health services (7).

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