Official Norwegian Reports NOU 2011: 11 Chapter 1, 2 and 3

Innovation in the Care Services

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Innovation in the Care Services

Report by the Committee appointed on 26. June 2009
Submitted to the Ministry Health and Care Services on 16. June 2011

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Chapter 1
Appointment, mandate and activities of the committee

1.1 Appointment

In Report No. 7 (2008-2009) to the Storting, *An innovative and sustainable Norway*, the Government recommended that a committee be appointed to explore new innovative solutions for meeting future challenges in the care services.

The committee was appointed in Council on 26 June 2009 and comprised the following members:
Kåre Hagen, Oslo (chair)
Siv Iren Stormo Andersson, Bjugn
Glenn Kenneth Bruun, Oslo
Siri Bjørvig, Tromsø
Annichen Hauan, Oslo
Karin Høyland, Trondheim
Shahzad Rana, Oslo
Bente Skansgård, Oslo
Per Gammelsæther, Fræna
Tove Johanna Fagertun, Bodø
Ivar Leveraas, Oslo

Committee member Shahzad Rana took part in the first meeting only.

The secretariat has consisted of the following members:
Steinar Barstad, Policy Director, Ministry of Health and Care Services (chair of secretariat)
Astri Myhrvang, Senior Adviser, from the secretariat for the National Council for Senior Citizens until 1 february 2010
Allis Granberg, Senior Executive Officer, Ministry of Health and Care Services from 1 february 2010
Åshild Willersrud, Strategic Adviser, Division for Innovation and Development of the Norwegian Association of Local and Regional Authorities (KS)
Espen H. Aspnes, Innovation Adviser, InnoMed
Geir Petterson, Adviser, Ministry of Trade and Industry, has followed the committee's activities.

In addition, Siv Svardal, Senior Adviser at the Ministry of Health and Care Services, and Une Tangen, Adviser at KS Konsulent, have assisted with the writing of this document.

1.2 Mandate

Presentation

«Society is facing demanding challenges in the care services in the coming decades related to an increasing number of elderly, new user groups and a shortage of health and social services personnel and volunteer care providers, cf. Report No. 25 (2005-2006) to the Storting, «Long-term care – Future challenges, Care Plan 2015.»

The municipal care services consist of extensive, round-the-clock activities that are carried out by a small number of managers, a large number of personnel, a high percentage of employees without professional training, many part-time workers, a very high percentage of women and often simple technical aids. Furthermore, care services involving daily life, meals, activities, and social and cultural factors are identified in most studies as among the weakest services today. There is therefore both a tremendous need and a vast potential to take innovative steps and find new solutions for meeting future challenges in the care services.

The municipal care services have gross operational expenses of roughly NOK 70 billion, divided more or less equally between about 40 000 nursing home residents and some 160 000 recipients of home care services. Despite its size, this sector has been the subject of very little systematic research and development activity.

Consequently, there is much to be gained by focusing attention and effort on a sector in which a great deal can be achieved with relatively limited resources. The municipal care services have great potential to implement innovative, creative measures in relation to:

– new technology in a conservative sector that has shown limited capacity to make use of new technical aids, new care services technology,

Smart House solutions and new communications technology;
- new architecture in a sector that is not adequately prepared to address the future preferences, demands and challenges of new user groups and new generations of elderly;
- organisational development in large enterprises that have broad-based cooperation with families, local communities and the specialist health care services and where the users should be challenged and given greater influence;
- research on a sector that has been the object of virtually no research activity and where hard-won research funding still comprises only a tiny proportion of the overall budget.

This is some of the background for why the Government chose to focus on the care services sector in its white paper on innovation policy (Report No. 7 (2008-2009) to the Storting, *An innovative and sustainable Norway*) when considering innovation in the public sector. The white paper recommended that a public committee be established to address these issues and laid down some guiding principles which are now more closely defined and specified in the attached mandate for the committee.

The mandate specifies in particular that the committee is to focus on the following:
- new technology
- architecture and new types of living arrangements
- user influence and skill mastery
- research and development activity

On this basis, the committee has been charged with the task of assessing new solutions and making recommendations for the design of future nursing homes, types of living arrangements and services to ensure that these will meet the needs of future users and make the most of their resources.

In its efforts, the committee is to emphasise that the services offered must, in keeping with the Care Plan 2015, have a more active profile that encourages greater user influence, user skill mastery and active participation by the individuals, their families and social networks. New types of living arrangements, forms of organisation and the use of new technology must first and foremost promote this objective. The committee is to assess the potential for developing new forms of ownership and operation and new types of cooperatives based on expanded collaboration with user organisations and idealistic enterprises.

The committee is also to assess the potential for developing care services products through cooperation between the public and private sectors, focusing in particular on the development of architecture and new technology.

Report No. 7 (2008-2009) to the Storting, *An innovative and sustainable Norway*, states:

> «The committee must be composed in a way that ensures it can view the care services sector with new eyes, with representatives of the business sector and professional circles as well as development-oriented representatives from the municipal sector, the care services and the users of the services.»

In keeping with the mandate, the committee comprised 11 members from the areas of business, technology, innovation, architecture, and health and social care as well as key representatives for the users. The chair of the committee has held positions as research director at the Institute for Labour and Social Research (Fafo), departmental head at BI Norwegian Business School and chair of the programme board of the Programme for Welfare Research. He has also participated in many future-oriented research and development projects.

There are six women and five men on the committee.

The committee is to submit its final evaluation and recommendation in the first half of 2011.

Mandate

On the basis of Report No. 7 (2008-2009) to the Storting, *An innovative and sustainable Norway,* and in cooperation between the public and private sectors, the committee is to assess the potential and make recommendations for new innovative measures and solutions designed to meet the future challenges of the care services, with special focus on:
- new technology
- architecture and new types of living arrangements
- user influence and skill mastery
- research and development activities

On this basis, the committee has been charged with the task of assessing new solutions and making recommendations for the design of future nursing homes, types of living arrangements and

services to ensure that they meet the needs of future users and make the most of their resources. The committee is to emphasise that the services offered must, in keeping with the Care Plan 2015, have a more active profile that encourages greater user influence, the users' own skill mastery and active participation by the individuals, their families and social networks. New types of living arrangements, forms of organisation and the use of new technology must first and foremost promote this objective. The committee is to assess the potential for developing new forms of ownership and operation as well as new types of cooperatives based on expanded cooperation with user organisations and idealistic enterprises.

The committee is to view its endeavours in a light of long-term thinking and development trends, and view its task in the context of prevention. At the same time, the committee's activities must be directed towards ensuring that the local care services are made capable of assuming new, professionally demanding tasks, as stipulated in the Coordination Reform. With a view to planning the care services of the future, the committee is to identify specific research needs and submit proposals that can strengthen research and development activities in the municipal care services. The committee may also take the initiative to raise questions and propose measures aimed at enhancing innovation and research in the care services sector.

The committee is to assess the potential for product development, business development and export activity arising from cooperation between the private and public sectors in the field of care services, focusing in particular on the development of architecture and new technology.

Smart House solutions and new technology for care services create new opportunities for the users to master their own daily lives, and can help to promote independence and autonomy. Telemedicine and new communications technology make it possible for the health and care services to improve, simplify and enhance the efficiency of their activities. The committee is to assess the ethical aspects of its proposals and the impact of these proposals on the individual's personal privacy, especially in relation to the use of new notification and monitoring technology.

Over the years, various institutional solutions and living arrangements featuring a wide array of names, designations and schemes have been developed in the municipal health and care services. The committee is therefore charged with reviewing and systematising the various institutional forms and living arrangements used for caregiving purposes with a view to standardising the terms used and simplifying the statistics and regulatory framework.

The committee's activities are to be based on the assumption that the care services of the future are rooted in publicly-funded schemes and a dynamic, humane civil society. Such community-oriented care services encompass the municipal care services, family-based caretaking, local communities, and user-driven and volunteer organisations working in close cooperation with the specialist health care services and other sectors. The committee's recommendations are to be formulated on the assumption that the collective resources of civil society and the public and private sectors are utilised in an economically beneficial way for society.

The committee is to submit its final report and recommendations within the first half of 2011. The ministry stipulates that the committee must employ an open work method and remain available to receive input and discuss key topics with various professional groups, government councils and special interest organisations, including identifying an effective means of coordinating its efforts with the activities of the technical aids committee (*Hjelpemiddelutvalget*).

1.3 The committee's activities

The activities of the committee are planned to be carried out in three phases:

1. Autumn 2009: Brainstorming
2. Spring/autumn 2010: Compilation and systematisation of knowledge
3. Winter/spring 2011: Writing and completion of the report

A total of 12 committee meetings were held: one three-day meeting, four two-day meetings and seven one-day meetings in Oslo, Drammen, Gardermoen, Drøbak, Trondheim and Arendal.

At the start of its work, the committee ordered three state-of-the-art overviews and reports from the Norwegian Knowledge Centre for the Health Services:

- Holte, Hilde H., Kirkehei, Ingvild and Gunn E Vist: *Omsorgsforskning i Norge* («Care Services Research in Norway»)
- Bakke, Toril and Hilde H. Holte: *Kartlegging av nye eier- og driftsformer i omsorgssektoren basert på samvirke, brukerstyring og kooperasjon* («Overview of new forms of ownership and

operation in the care services sector based on interaction, user control and cooperation»)
– Hofmann, Bjørn: *Etiske utfordringer med velferdsteknologi* («Ethical challenges related to welfare technology»)

In addition, researcher Ivar Brevik of the Norwegian Institute for Urban and Regional Research (NIBR) prepared an historical account of the development of various types of institutions and living arrangements used for caregiving purposes, which served as the basis for the committee's work with future types of living arrangements (Brevik 2011).

Research fellow Eline S. Lorentzen Ingstad submitted a memorandum to the committee which was used in the committee's discussion of social entrepreneurship.

In the phase of compilation and systematisation of knowledge, various presenters were invited to speak on relevant topics at all of the meetings held in 2010.

The committee received assistance from various departments in the Ministry of Health and Care Services and from the Research and Innovation Department in the Ministry of Trade and Industry.

A meeting was held with the chair of the technical aids committee, Arnt Holte, in which issues were discussed and boundaries for the work of the respective committees defined in relation to technical aids and welfare technology (see Norwegian Official Report 2010:5 *Aktiv deltakelse, likeverd og inkludering* («Active participation, equality and inclusion»).

A meeting was also held with the chair of the official committee on benefits for providers of informal care who replace municipal services, Karen Kaasa, in order to find an expedient means of coordinating and distributing the tasks related to issues of pay for family caretakers and the policy for informal care.

The committee's chair and secretariat held meetings with various players in Scotland, Sweden and Denmark for the purpose of gathering knowledge and learning from the experience of others.

In keeping with the committee's mandate, an open work method was employed which entailed contact and meetings with a number of companies, organisations and professional circles. The committee practiced an «open door policy», meaning that those who wished to communicate with the committee were given the opportunity to meet with the committee's chair and secretariat. The committee's chair held talks and presentations at several large conferences in Norway. At two of these, the committee was responsible for workshops in which the participants were invited to take part in the work on the future challenges in the care services.

In June 2010, the entire committee held a joint meeting with the members of the innovation alliance for the municipal sector under the Norwegian Association of Local and Regional Authorities (KS). During this meeting, work groups discussed the main issues set out in the committee's mandate.

In connection with the annual InnoMed conference in 2010, professional organisations, user organisations, municipalities, companies, etc. were invited to attend a seminar where information about the committee's activities was presented and participants were invited give their input and responses. The seminar was organised in cooperation between Innovation Norway and InnoMed.

The committee's chair gave 48 presentations and lectures at conferences, seminars, meetings and events at the national, regional and local levels. Together with the secretariat, the committee's chair held separate meetings with the Norwegian Association of Pensioners, the State Council of Equality for the Disabled, the Norwegian Association of Local and Regional Authorities (KS), the Confederation of Norwegian Enterprise (NHO), Innovation Norway, a number of professional organisations, associations, user organisations, municipalities, industries, companies, university colleges and professional circles. Input was also received from several organisations and enterprises.

During the committee's work, KS administered two questionnaires to its members about the use of welfare technology and local partnership agreements with NGOs in the municipalities. Statistics Norway participated in a Nordic study of innovation in public sector activities, and the committee had the opportunity to pose questions to Norwegian municipalities.

On its own initiative, Abelia, a trade and employers' association associated with NHO, conducted a survey of its members which provides an overview of the number of people involved in the production of services and products for the care services sector. Abelia has followed up these efforts by establishing an arena for safe care.

The committee also established a dialogue with the Data Inspectorate to achieve further clar-

ification and obtain advice related to personal privacy and tracking technology.

1.4 To the mandate

While carrying out its activities, the committee has seen a dramatic rise in interest in the issues that are central to the committee's mandate. The committee has therefore considered it a key task to encourage this interest and to generate a common movement by bringing together different professional circles and linking care services in the municipalities to knowledge circles that understand the significance of the care services sector for value creation in society.

In the course of its activities, the committee has determined that it is especially crucial to highlight the distinctive character of the care services and to strengthen their identity and pride by giving the care services the opportunity to develop their own knowledge base. Thus, the committee is pleased that the mandate has been so clearly defined and does not open the door for addressing larger medical and health-related issues and topics. A health services and treatment dimension will always be present. The care services probably often view themselves as a «second-rate health service» when they compare themselves with the specialist health care services. The committee has therefore focused on other key aspects of the care services and touches in particular on the interaction with families and civil society. These services find their own distinctiveness in their relation to and interaction with families and local communities, which no specialist health care services can match. This is «close caregiving».

The mandate given to the committee is quite broad and addresses future-oriented topics, each of which deserves an entire report. The committee has attempted to carry out its task primarily by restricting itself to the main themes and then selecting a few issues for more thorough assessment. By the same token, the committee has chosen to pass on and communicate some of the ideas it has discovered along the way, not least in its encounter with many committed users and professionals in the sector or players in research and business that have now turned their attention towards the care services. These are ideas that need further consideration and study.

Chapter 2
Perspective and summary

2.1 Innovation in the care services

The terms «innovation» and «care services» come from two different worlds. Many would think of these terms as complete antitheses, and be sceptical to using them together. However, the tension inherent in their pairing gives rise both to curiosity and to new ways of thinking. Innovation is a term that designates change and creation with relevance to all areas of life and society.

2.1.1 The care services sector as a historical innovation

From a historical perspective, the public care services sector, as developed in the Nordic countries, may be regarded as a major innovation in itself. It is just that the term «innovation» has not been applied to the strong growth of municipal homecare and institutional care services that occurred about 40 years ago. The expansion of these services was a response to some of the most crucial challenges that society faced at the time:

- the dramatic rise in the number of elderly;
- the lack of labour;
- the need for gender equality in the family and working life.

The innovative solution was to move part of the care arena out of the family and the private sphere by expanding the public welfare schemes. This means of transferring, or «outsourcing», caregiving tasks helped to enhance gender equality and freed up women to participate in the workforce. The proportion of women in the labour force in Norway is now one of the highest in the world. At the same time, this established the basis for a new distribution of caregiving tasks between the family and the public sector, making it possible to combine caregiving with employment and education. Thus, the new care services sector became a key component of the social value creation in society and the infrastructure for working life. Many were concerned about what this development would mean for birthrates and the family's ability to provide care. In retrospect, the Nordic welfare model has proven to have both economic and demographic sustainability. Birthrates in Norway are significantly higher than in countries where the women in the family are responsible for most of the caregiving tasks.

This does not mean that the solution developed 40 to 50 years ago will necessarily be robust enough to meet the challenges Norway will be facing in the coming decades. Most of the attempts to forecast trends by expanding on the current system with the same rate of growth experienced in recent years point to an impossible situation in a few decades. The successful innovation that the expansion of the care services represents from a historical perspective should provide inspiration for new ways of thinking in the future as well. If as many developments take place in the sector in the next 50 years as in the past 50 years, the situation may look entirely different.

On the other hand, the committee advises against entirely dismantling a model shown to be sustainable and capable of responding to the major societal changes that have occurred during this period. The committee has therefore chosen to retain the welfare model with local municipal responsibility for the caregiving tasks, and has been more concerned with identifying new adaptations and making changes to enable Norway to provide community-based solutions in the future as well, as stipulated in the mandate.

In the quest for areas of potential innovation, the committee wishes to point out that the most exciting renewal may occur in the interface between the public sector and civil society. Achieving such renewal may be contingent on proximity to the local administrative level. In this sense, the care services sector is strategically well-placed in the municipality. No major shifts are required. In most places it is an integral part of the local level and cooperates closely with users, families and the local community. In the coming years, the care services should better exploit the

potential right in front of them to achieve innovation across the municipality as a public administrative level and the municipality as a local community.

The care services constitute one-third of all municipal activities. Consequently, what occurs in the care services sector has a crucial impact on the municipality as a whole. Innovation efforts in the care services sector should therefore be conducted as part of an integrated innovation initiative in the municipal sector, where solutions are sought in the interface between the health and social services and the other municipal sectors and between the municipality, the local community and the private sector.

2.1.2 New solutions for six future challenges

In Report No. 25 (2005-2006) to the Storting, «Long-term care – Future challenges, Care Plan 2015»», the Government identified five future challenges. Two of these address problems that will increase in the future:

- the number of new younger user groups;
- the number of elderly in need of assistance.

Three of the challenges address areas in which there are deficiencies:

- the shortage of volunteer care providers and 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 committee has based its work on these five main challenges, and refers to the analyses presented in Report No. 25 (2005-2006) to the Storting. The Government has followed up efforts relating to these five challenges through the Care Plan 2015 and prepared a separate Coordination Reform on cooperation between the municipal health and care services and the specialist health care services. The committee has therefore decided to focus its efforts on those issues and needs that are not incorporated under the existing activities to the same degree. In keeping with the mandate and on this basis, the committee has put emphasis on investigating new action points and solutions for meeting the caregiving challenges in a time horizon that extends beyond the Government's Care Plan 2015, with special focus on technology, alternative housing and organisational solutions, research, innovation and business opportunities.

In its work, the committee has taken as its starting point three of the most common problems encountered by the care services:

- falls;
- loneliness;
- cognitive decline.

These three factors mutually affect one another and reach into most areas of the health and social services sector. The committee has chosen to use these as an illustration and practical point of departure for identifying and testing new solutions, work methods and approaches.

The sixth challenge

Additionally, the committee points to the challenges and opportunities inherent in these problems when viewed in an international context, where:

- the personnel market is becoming internationalised, and the care services workers are increasingly exported and imported;
- larger service providers operate in an international market, often in the form of multinational corporations;
- a growing number of patients and users are crossing national borders for treatment, recuperation and physical training.

The contours of the future must also be viewed in light of the vast changes occurring in the age composition of the population in both Europe and the world at large. There is reason to believe that this will affect all markets and social sectors throughout the world. In this context, Norway is more fortunate in that it is experiencing less dramatic changes in this regard than the other countries in Europe. However, Norway will be strongly affected by events elsewhere in the world, and should also be cognisant of the market-related opportunities this generates. Society will face major challenges relating to care services in the coming decades. These will be demanding enough without being made worse by dire predictions and worst-case scenarios. In the view of the committee, the future challenges for the care services cannot be dealt with by the health and social services sector alone. They must be addressed on the basis of a public responsibility involving most of the sectors in society and by supporting and developing new forms of involvement and participation by the families and local communities, organisations and enterprises. The issue at stake

has just as much to do with the kind of society Norway seeks to build for the future as with how the health and care services sector will develop.

2.2 New policy

Care services for all

Treatment for a wide variety of problems, diagnoses and disabilities relating to the entire life course from childhood and adolescence to adulthood and old age are now encompassed under the municipal care services. The care services sector has experienced significant growth, incorporated many new user groups and assumed a number of new tasks over the past 20 years. It has become a sector that provides services to everyone who has a need for assistance and care.

A future-oriented care services policy requires a broad societal approach to future user groups. Therefore, the committee's recommendation is based on the assumption that the policy of dismantling disabling barriers in society will be continued and strengthened. The committee also recommends the formulation of a new active ageing policy for all areas of society and a modern policy for informal care that is framed on equality between men and women and partnership between users, close relatives or friends and the care services.

2.2.1 A policy that removes barriers for people with reduced functionality

Dismantling of disabling barriers in society, equality and participation comprise the main elements of the struggle waged by people with impairments in recent decades. There is still a need to combat discrimination and prevent segregation to ensure that all segments of the population achieve full participation in working life and society and can live a normal life in community with others.

It is primarily younger people with reduced functionality who are at the vanguard in the development of the care services sector. They play, and will continue to play, a leading role in:

- the adoption of new technology and technical aids to cope with daily life on their own and to be as independent as possible;
- the demand for universal design of housing and the surrounding areas;
- user-driven ownership of service provision organisations and housing options;
- implementation of reforms involving the closure of institutions and the development of local services, independent housing and the opportunity to lead as normal a life as possible.

If the welfare society is to realise values such as participation, independence, autonomy, dignity and normalisation, the users must have a high degree of influence and control over their own life situations.

The committee believes that this policy will be resilient enough to address the future challenges in a wide range of areas. It is reasonable to assume that the new elderly generation will follow the lead of the younger users of municipal services. New generations of elderly will meet their old age with a completely different set of resources and will not accept being placed on the sidelines. Parts of what is referred to today as institution-based elderly care are therefore ripe for reform with the same goals as similar reforms implemented in the past 20 years for various groups with reduced functionality.

Many of the innovative solutions and action points that should be implemented in the municipal care services may simply be a matter of transferring the experience from the responsibility reform for mentally impaired persons carried out in the 1990s to the area of elderly care.

2.2.2 An active ageing policy

The committee also believes that Norway must develop a new policy for senior citizens that encompasses more than retirement pensions and elderly care. An active ageing policy for all areas of society must be developed.

The new generation of senior citizens will be large. Its members will enter old age with a higher level of education, better health, longer life span, better housing conditions and more resources. More than ever before in history, an elderly population with substantial resources and purchasing power will have an impact on all markets, all societal institutions, trade and the economy, demand and consumption – all over the world. On the one hand, they will have a better foundation for taking care of themselves than any other generation before them. On the other hand, they will place high demands on the global community.

An active ageing policy invites and expects participation in society and politics, in education and cultural life, in the family and volunteer work, and for those who have the opportunity: in business and working life.

An active ageing policy builds bridges between the generations and counteracts segregation and age discrimination.

An active ageing policy in the health and care services area puts emphasis on prevention and provides a framework so that people can take responsibility for their own lives as they wish by:

- making adaptations to their own housing conditions and nearby surroundings;
- taking part in physical, social and cultural activities;
- participating in education, physical training and rehabilitation.

An active ageing policy is based on the principles of autonomy, independence and influence over one's life, in spite of illness and reduced functionality.

The EU has decided that 2012 will be the European year of «Active Ageing and Solidarity between Generations», in which all of Europe will prepare and plan for the demographic changes that will affect all the countries in the coming decades.

The committee recommends that Norway take active part in this forward-looking work and formulate a senior citizen policy for all areas of society. Senior citizen policy will be so central to the development of society that the Government should consider giving it a higher profile and a more prominent role on the agenda.

2.2.3 A modern policy for informal care

Due to the future shortage of both volunteer care providers and care services workers, it will be necessary to combine work and caregiving in a different, more flexible way than today.

The new policy for informal care must first and foremost direct attention towards, and establish the value of, the contribution of family members, friends and neighbours. It must then ease the time crunch many experience by providing greater flexibility in working life, and integrate close cooperation with the municipal care services as a means of lightening caregiving burdens.

The committee therefore recommends a new policy for informal care incorporating six components:

- visibility;
- gender equality;
- flexibility;
- guidance;
- relief;
- value.

Box 2.1 Seven principles for active ageing

1. Active ageing entails all meaningful pursuits which contribute to the well-being of the individual concerned, his or her family, local community or society at large, and should not be concerned only with paid employment or production.
2. Active ageing must encompass all older people, even those who for various reasons are frail and dependent.
3. Active ageing is primarily a preventative concept and implies adopting a life course approach to understanding the ageing issue.
4. The centrality of intergenerational solidarity is a defining feature of active ageing.
5. Active ageing entails both rights and responsibilities.
6. A strategy for active ageing should be participative and empowering.
7. The concept of active ageing must respect cultural differences and promote diversity.

Alan Walker, the British professor of social policy who developed these seven principles for active ageing (Walker 1999 and 2002), says that:

> «Active ageing is intergenerational: it is about all of our futures and not just about older people. We are all stakeholders in this endeavour.»

Family-based caretaking activity does not show up anywhere. It remains essentially unregistered in case management files, statistics and public reports, despite its magnitude in terms of man-years, which equals that of the public care services sector.

The committee therefore recommends that the care provided by families is given greater emphasis in research and evaluation activities, that stronger political focus is directed toward family members and volunteers as a resource, and that an integrated policy is drawn up in this area.

The individual's efforts should be given much greater attention and recognition by the municipal authorities. Agreements made with family members and volunteers should be recorded in the case files and individual plans, both in order to

coordinate these efforts with the public care services and to assess relevant measures relating to training, guidance, relief from the caregiving burden and finances vis-á-vis the family members.

A modern policy for informal care must be framed on equality between men and women. It would not be desirable to have a care services policy that sets back gender equality efforts many years. It is therefore satisfying to see that according to the health and living conditions survey (Statistics Norway 2008), almost as many sons as daughters are providing help or supervision to their elderly parents on a regular basis. In this context, it is important to expand the focus on men's role as father to include focus on men's caregiving functions as sons and spouses.

An integrated, more cohesive policy for informal care will facilitate the introduction of new rights and welfare schemes that ensure:

- training, support and guidance for family members and volunteers;
- relief for those who have heavy caregiving burdens;
- financial security so that family members do not also find themselves in a difficult financial situation;
- necessary leaves of absence so that family members do not lose their right to work or have to take sick leave to care for their close relatives.

The committee believes that the future shortage of labour as well as volunteer care providers will require solutions that make it easier to combine employment with caregiving, and on this basis proposes that consideration be given to extending the leave of absence permissible in connection with caring for close relatives to one year.

The committee also proposes the establishment of more comprehensive, flexible schemes that provide relief to caregivers in their own homes, as a daytime activity programme and as short-term stays outside the home.

Furthermore, the committee takes note of the potential of measures using the new social media and new communications technology to reduce worry and provide security, guidance, establish contact and provide follow-up in relation to users, family members and the care services.

2.3 The committee's five proposals

2.3.1 «Close caregiving» – the second Coordination Reform

The first Coordination Reform has focused primarily on improving the utilisation of resources in the collaboration between the municipal health and care services and the specialist health services on health-related and medical issues. The «second Coordination Reform» revolves to an equal degree around mobilisation of resources, focusing on cooperation between the family, the social network and the local community.

Being a responsible citizen entails more than the consumption of public services. For community-oriented solutions to work, people must also take responsibility for the development and design of the services offered, and play a role as both producer and consumer. Caregiving should be an integral part of a thriving, dynamic society and this should be manifested in interpersonal relations in the family and local community, organisations and institutions, and in informal contexts where people meet, work and live together.

What is needed is to think along new lines regarding the interplay between the public schemes and civil society, to explore the new forms of volunteerism, and to put focus on alternative work methods, forms of operation and organisation that encourage participation of the citizenry. The committee has decided to call this project the «second Coordination Reform», which targets the family and local community. This reform will be based on close caregiving, responsible citizenship and co-production, and includes:

- a national agreement and local contracts for partnership between public and volunteer enterprises in the care services area;
- new forms of ownership and operation, such as cooperatives, user-driven schemes and social entrepreneurship;
- new work methods and professional approaches that give higher priority to active caregiving, ordinary rehabilitation, group methodology, culture and well-being;
- a new, modern policy for informal care;
- care services that are organised with the family and local community in mind and that emphasise homecare services, open institutions and networking activities.

The committee wishes to emphasise the importance of seeking new solutions and patterns of cooperation through dialogue and negotiations

between public and volunteer enterprises in the care services. It is in the interface between the public sector and civil society that new community solutions can be developed.

Idealistic measures and enterprises in the form of NGOs and user-driven cooperatives should be given a much larger role in the development of the future care services. The committee believes that this will strengthen innovation and development activities in the care services and encourage active participation and co-creation of the new forms of ownership and models of operation needed to meet the exponential growth in caregiving needs expected after 2025. Ambitious targets should be set. The committee proposes that one target should be to allow 25 per cent of all the activities in the care services sector to be organised and operated as idealistic enterprises by 2025.

2.3.2 «Technoplan 2015» – technological support for the care services

The care services have an enormous unexploited potential to utilise available technology and develop new technology. This applies to welfare technology that can give the users greater security and a better ability to take care of themselves in daily life, telemedicine solutions to help in treatment, supervision and care, and technical support for communication, administration and management that frees up care workers to spend more time on direct user contact.

The committee has submitted a three-phase plan for the expansion and practical application of welfare technology, and proposes its inclusion as part of the Government's Care Plan 2015:

Phase 1 further develops the security alarm concept into a security package which includes an adaptation for Smart House dwellings.

Phase 2 uses modern communications technology and social media to enable users to contact the health and social services, moderate loneliness, maintain contact with family and friends, and participate in user forums.

Phase 3 uses technology that stimulates, entertains, activates and structures daily life for the elderly.

The plan gives priority to training and competency measures, organisational development, and the establishment of cooperative arenas for innovative municipalities and professional circles.

The committee proposes that the specifications for new or renovated buildings financed through the Norwegian State Housing Bank's investment grant for nursing homes and residential care homes must include adaptation for the connection of alarms, sensors and Smart House technology. In this context, the committee also notes the need to develop a standardised communications platform in the home with services that can be adapted to the individual user's needs over time.

The committee also recommends more direct regulation of the use of tracking and warning devices (e.g. with GPS) in the statutory framework for health and social services. This will provide clearer rules, simplify case management and clarify which considerations must be weighed when employing technical aids that clearly will result in greater independence and freedom for many users.

At the committee's request, the Data Inspectorate has carried out a new assessment of personal privacy issues related to the use of welfare technology, which the committee finds clarifying. The Data Inspectorate's letter of 9 May 2011 is therefore attached to this report.

2.3.3 «New rooms» – future housing solutions and neighbourhoods

An important part of the planning of tomorrow's society will deal with making dwellings and surrounding areas good to grow old in. Most of the housing and institutions in which people will live and receive health and social services in the coming decades have already been built. This concerns primarily the ordinary building stock such as single-family homes, row houses and apartments, but also the more than 40 000 beds in retirement and nursing homes and the almost 50 000 dwellings built for caregiving purposes.

The large-scale renovation project

The committee is concerned that too much attention on new building may lead to neglect of renovation, and recommends strengthening the instruments used in housing policy to encourage renovation and renewal of the homes that already exist. Given the challenges that society is facing with regard to health and social services, it will be crucial to dismantle barriers and adapt homes and surrounding areas so they can function throughout the entire life of an individual. The committee seeks to promote a general line of thinking in which it is just as common to prepare a home for one's old age as it is to adapt it in other life phases. Thus the committee proposes that an advisory

service for housing adaptation be established as a cooperative effort between the Norwegian State Housing Bank, the municipalities and the technical aid centres of the Norwegian Labour and Welfare Administration. The committee also proposes a system for classifying various types of homes based on the specifications for universal design.

New concept

An exciting development is underway in the municipal care services, as two different traditions are in the process of merging into one. On the one hand, the rooms in nursing homes are becoming more and more similar to rooms in full-fledged residential care homes. On the other hand, today's residential care homes are being built together and used both as a supplement and alternative to nursing homes. The committee envisions a solution in which the best of each of the two different traditions is combined rapidly and constructively.

The new concept proposed by the committee entails a «fusion» in which a high standard of housing and services can be combined in various ways, prompting the development of a range of solutions based on six fundamental principles:

- a division between municipal housing policies and the municipal service policies in the area of health and social services so that the services and resources are linked to the individual's needs, regardless of type of living arrangements;
- a clear physical and legal division between private areas, common areas, public areas and service areas in all buildings used for health and social service purposes;
- a professional and organisational division between health services on the one hand and food service, cultural activities and other services on the other;
- housing solutions that provide access to all necessary living functions (bath/toilet, kitchen, sleeping area and general living area) within the private area, adapted for both residents and family members;
- the adaptation of the infrastructure of homes for the use of new welfare technology;
- a joint scheme for rent and self payment regardless of living arrangements, with an equal right to housing allowances from the Norwegian State Housing Bank, the same payment for services and same coverage of pharmaceuticals and technical aids under the Norwegian National Insurance Scheme.

The committee finds that the time of the large institutions has passed, and is of the opinion that the care services should include homes and premises that are an integrated part of the local community in towns and urban areas where the public common areas are shared by the rest of the population. A hub where a welfare centre and various types of housing are located must therefore be a component in the municipality's overall planning.

The committee wishes to incorporate these principles into the basis for the expansion of tomorrow's municipal housing solutions for people in need of health and social services. In this connection, the committee notes that the Care Plan 2015 estimates a need for the renovation and expansion of 12 000 24-hour care spaces in the period up to 2015.

The need for dramatically increased capacity will arise in 10 to 15 years. Therefore, importance should be attached to modernising, replacing and renovating existing nursing homes and residential care homes. Almost half of Norway's 90 000 spaces in institutions and residential care homes will soon be in need of renovation and replacement. The location and design of some of this building stock make it poorly suited to future user needs. The committee is concerned with ensuring that the renovation of the older building stock is completed well in advance of 2025, when the need for services hits the sector. It is also important to actively use this period to plan the expansion that will then take place.

Such renovation will pave the way for new structures and surrounding areas both for those who need services and for those who will provide care services in the future. This will generate opportunities for industrial development and a higher demand for construction and technology specialists. The committee recommends that municipalities, professional circles and companies view this as a call to innovate, in which the need is to find new solutions that both are adapted to the needs of future generations and the preferences of tomorrow's local communities.

2.3.4 A national programme for municipal innovation in the care services

Innovation in the care services will occur primarily at the local level in the individual municipality, close to the users and the publicly elected officials responsible for the services. The central government's role will be to establish an incentive structure that promotes innovation within the sector and to develop an infrastructure for research,

development and innovation in the care services that takes the initiative and responsibility for coordination, network-building and the dissemination of results at the national level.

Activities within the care services sector are also crucial to municipal development. In the view of the committee, it is therefore necessary to give the municipalities access to instruments designed to alleviate some of their risk and protected financial schemes that enhance their ability to innovate, test new work methods and find new ways of performing caregiving tasks. The development of the care services sector is closely linked to other segments of municipal activity, and would benefit from the allocation of similar contributions from other ministries to other municipal sectors in the municipality.

A municipal school for innovation

The committee proposes that, in cooperation with the Norwegian Association of Local and Regional Authorities (KS), a national training programme in innovation be established for high-level municipal administrators and others who carry out key functions in or for the care services, or if appropriate other parts of the municipal sector.

One per cent of the budget to research, development and innovation (RDI)

The committee believes it is irresponsible to operate a public care services sector with an annual operating budget of some NOK 80 billion while allocating less than .002 of this amount to knowledge development and research, innovation and development activities. The major challenges relating to care services that society faces will require:

- more research-based knowledge in order to plan future services at the local as well as the national level;
- the willingness to take risk and ability to innovate in order to test new professional approaches and find new ways of performing caregiving tasks;
- long-term development activities in order to prepare and implement the necessary changes and restructuring.

The committee recommends the allocation of additional funding from the central government through an escalation plan in the period up until 2020, so that one per cent of the total care services budget is used to develop the knowledge base for these services. The financing scheme should be used primarily to test and disseminate new ways of performing the caregiving tasks, i.e. through the use of technology, work methods or forms of organisation that help people to take care of themselves longer or that frees up care services workers so they can spend more time with the individual users. The allocation of additional funding assumes a three-way collaboration between a service provider, a municipality and a third party comprised of civil society, the business sector or the research community.

NISO – An overall national responsibility for knowledge dissemination and innovation in the care services

The committee proposes that the Ministry of Health and Care Services and the Ministry of Local Government and Regional Development, in cooperation with the Norwegian Association of Local and Regional Authorities (KS), establish a secretariat for municipal innovation, which will initially focus on the care services sector with links to the regional centres for care research for the health and care services and the county centres for development of institutional and home care services. The main task of the secretariat will be:

- advise the service providers regarding the testing and development of new solutions;
- allocate and manage innovation grants, including evaluation, documentation and dissemination of results;
- coordinate and further develop local and regional innovation networks.

NORAGE – An event-history study

The committee proposes the establishment of a national database (NORAGE) and an extensive research project that follows a large number of individuals through the last third of their lives to obtain knowledge for use in the planning of the care services and society's senior citizen policy in a wide range of different areas. A database of this type will provide a good framework for the design and investigation of questions for researchers with a background in the social sciences, medicine and other fields.

2.3.5 The care services as an industry

The committee sees great potential for developing a Norwegian-based industry for deliveries to the care services. The demand for appropriate housing solutions, activities and welfare technology

tools will increase from households and the municipal care services sector alike. This means that the care services will become increasingly more open, and like other industries, will be more exposed to import and export.

An overall knowledge and industrial development policy

In the care services today, cooperation with other industries occurs mainly through the municipal procurement of sub-contracted goods or services. With regard to housing, this comprises a crucial part of the service provision, with large investments in nursing homes and residential care homes. Growth in the procurement of welfare technology solutions is also anticipated. It is important that this procurement power is strengthened, developed and managed so that it promotes innovation among the suppliers of services. In this way, clearer signals will be given to players in the business sector and other suppliers about what the care services sector requires in order to carry out its responsibilities in a better way in the future.

To enhance the ability of the care services sector to perform its function as a visible, competent and demanding procurer of services, the committee recommends three types of measures:

- Systematic training of municipal players to improve the performance of their role as procurers of services with innovation potential and to increase their expertise in managing supplier development and innovation processes in cooperation with players outside of the care services sector.
- A financing scheme for innovation projects in the care services sector, organised through a national secretariat for innovation in the care services sector.
- A national programme for the spread of welfare technology that will both increase the municipal players' knowledge of and interest in welfare technology, and develop municipal expertise as procurers in this market.

Senior citizens' market

The committee notes in particular that the individual senior citizens' market will likely see strong growth in the future, both domestically and internationally. A large generation of senior citizens with considerable buying power will have an impact on demand. Many services and products that were previously channelled through needs-based public schemes will become available «off-the-shelf». The senior citizens' market is vast. Therefore, Norwegian care services companies should cultivate an interest in, and focus their efforts on, market segments other than just the domestic public sector. This applies especially to the individual senior citizens' market and to the potential for exports to other countries' public procurement of services. In order to highlight and increase demand from the individual senior citizens' market, the committee recommends measures to:

- raise the awareness of and strengthen the individual consumer in the markets for adapted housing solutions and welfare technology;
- increase demand for housing renovations to achieve more appropriate overall design and home interior elements.

In a business context, the committee also wishes to mention the advantages in renovating and upgrading today's homes and residential areas, and the need to replace or renovate up to half of Norway's 90 000 residential care homes and spaces in institutions in the next decade. The committee appeals to both the construction industry and the municipalities to find future-oriented solutions to this based on knowledge about the preferences and needs of new generations and user groups.

Cooperation among companies

Cooperation among private companies is critical to the development of products in demand within the care services. It is especially important that the housing industry and technology circles cooperate in viewing housing solutions and welfare technology as part of the same whole. Industrial cooperation with the involvement of research and development groups should be encouraged, regardless of the municipal dimension in the care services. In the view of the committee, three key conditions must be in place to promote such development:

- the need for industrial technical standards must be elucidated and clarified so that Norwegian products are developed according to standards that are future-oriented;
- the general system of public instruments must be used to boost interest in opportunities in the care services, and to encourage and finance development projects with relevance and commercial potential for individual senior citizens' markets and for export;

– Norwegian export of care services products and solutions must be promoted, and the committee proposes establishing a special foundation for this purpose.

«NORCARE» – care services as an export product

Many countries have shown an interest in the Nordic model with well-developed public welfare schemes, gender equality and a high level of employment. With this as a trademark, a 50-year tradition of care services as a professional field and a more favourable demographic trend than in the rest of Europe, it is reasonable to consider exporting Norwegian care services to a rapidly growing international market in close cooperation with other Nordic countries.

With this in mind, the committee recommends that the Ministry of Health and Care Services and the Ministry of Trade and Industry establish an export foundation for care services modelled after the Swedish foundation SWECARE, and in so doing lay the foundation for Nordic cooperation in this area.

INN scheme

The committee also sees the potential for great economic gains by involving other sectors of society as suppliers to the care services sector. This can both revitalise the content of these services and evolve into a new, alternative source of income for these enterprises.

«Inn på tunet» is an initiative under the Agricultural Agreement that uses farms for municipal daytime activities for people who need special resources. The committee recommends that the INN scheme not be limited to agriculture, but be expanded to include a variety of industries, workplaces and enterprises that can provide interesting environments for a daytime programme adapted for activity, learning and skills mastering.

In this way, individuals can find activities suited to their own histories, backgrounds and interests, and companies and enterprises can make use of their particular surroundings and expertise to develop a supplementary product that is lacking in the health and social services.

Chapter 3
Myths about care services and themes for the future

«We did not come to fear the future.
We can here to shape it.»
Barack Obama

3.1 Future challenges for the care services

In Report No. 25 (2005-2006) to the Storting, «Long-term care – Future challenges, Care Plan 2015»», the Government identifies five future challenges for the care services:

> Society is facing demanding challenges in the care services in the coming decades. These cannot be dealt with by the health and social services sector alone, but must be addressed on the basis of a public responsibility involving most of the sectors in society and by supporting and developing new forms of involvement and participation by the families and local communities, organisations and enterprises. As far as we can see today, the challenges will be related primarily to:

New user groups

> Due to the dramatic rise in the number of younger users with reduced functionality and a wider array of health and social problems, the care services will need to incorporate a different type of professional expertise and an integrated life course perspective.

Ageing

> The growing needs of a larger number of elderly will require an expansion in capacity and greater expertise on ageing, especially related to dementia and complex medical conditions. The scope of the challenges must nonetheless be viewed in light of the fact that the new elderly generation is better equipped to meet and cope with old age owing to its improved state of health and greater resources in the form of higher education and better financial situation.

Shortage of care providers

> Due to changes in the age composition of the population, there will be no substantial increase in access to labour and potential volunteer care providers. A lack of growth in informal care means that the public sector must assume responsibility for the entire increase in needs that is anticipated, and will be dependent on locally based care services that cooperate more closely with families, volunteer care providers and local communities.

Medical follow-up

> There is a need for better medical and interdisciplinary follow-up of recipients of public home care services and residents of nursing homes and residential care homes. This applies especially to people with chronic and complex medical conditions, dementia, mental health problems and others who have a need for coordinated services from both the specialist health care services and the municipal health and social services.

Active caregiving

> Care services involving daily life, meals, activities, and social and cultural factors are identified in most studies as comprising the weakest services today. Improving these areas will require a greater breadth of professional expertise that includes a wider variety of professional groups so that the care services are able to meet users' psychosocial needs and can be given a more active profile.

The committee has used these five main challenges as the basis for its activities, and refers to the analyses performed in connection with the Government's Care Plan 2015 (Report No. 25 (2005-2006) to the Storting). The Government has also followed up the efforts related to these five challenges in its Care Plan 2015, which lays out a main strategy that utilises the upcoming period of relative demographic stability to:

- plan and prepare for the rapid growth in the need for care services that is expected to occur in 10 to 15 years from now, and
- gradually expand the care services by investing in preventive measures, education and competency building, new technology, housing and facilities.

In addition, the Government has drawn up the Coordination Reform to improve cooperation between the municipal health and care services and the specialist health care services. The committee has decided to explore those issues and needs not covered in the reform. In keeping with the mandate and on this basis, the committee has focused its efforts on assessing new approaches and solutions for meeting the caregiving challenges in a time horizon that extends beyond the Government's Care Plan 2015, putting special emphasis on technology, alternative living arrangements and forms of organisation, and research and innovation.

Moreover, the committee points to the challenges and opportunities inherent in these problems when viewed in an international context, where:

- the personnel market is becoming internationalised, and the care services workers are increasingly exported and imported,
- larger service providers operate in an international market,
- growing numbers of patients and users are crossing national borders for treatment, recuperation and physical training.

The future outlook must also be viewed in light of the vast changes occurring in the age composition of the population in both Europe and the world at large. There is reason to believe that this will affect all markets and social sectors throughout the world. In this context, Norway is more fortunate in that it is experiencing less dramatic changes in this regard than the other countries in Europe. Society will face major challenges relating to care services in the coming decades. These will be demanding enough without being made worse by dire predictions and worst-case scenarios.

In the view of the committee, the future challenges for the care services cannot be dealt with by the health and social services sector alone by employing more professional staff, building more institutions and implementing new, formal assistance schemes. On the basis of a public responsibility, most sectors of society must help to further develop community-oriented solutions that are adapted to the new needs and available resources. It will be essential to support and develop new forms of involvement by volunteers from families and local communities, user-driven organisations and enterprises, based on interaction between the public sector and civil society. The issue at stake has just as much to do with the kind of society Norway seeks to build for the future as with how the health and care services sector will develop.

3.2 Five myths about care services

In order to address the future challenges of the care services, it has been crucial for the committee to obtain a clear picture of the current caregiving situation. Many ideas about this have been formed, partly from descriptions in the media and partly as a result of the particular focus in the public debate at the national level. It has been important for the committee to clear away some of the misconceptions that have long been associated with the care services sector and to obtain an up-to-date picture by using relevant data and research in the field.

3.2.1 The myth about elderly care

The municipal care services are no longer for the elderly only. They cover the entire life course and offer services to families with children, adults with reduced functionality and elderly with serious illnesses and loss of functionality. Services are provided in all types of dwellings, from homes for disabled children with a great need for assistance to residential care homes and nursing homes, although most of the people receiving care services are living in their own homes.

In the public debate, however, the care services are often discussed as if they were synonymous with elderly care. The media and participants in the public debate often measure the success of these services in terms of the number of nursing home beds. The actual situation is far more nuanced. While only about 40 000 people

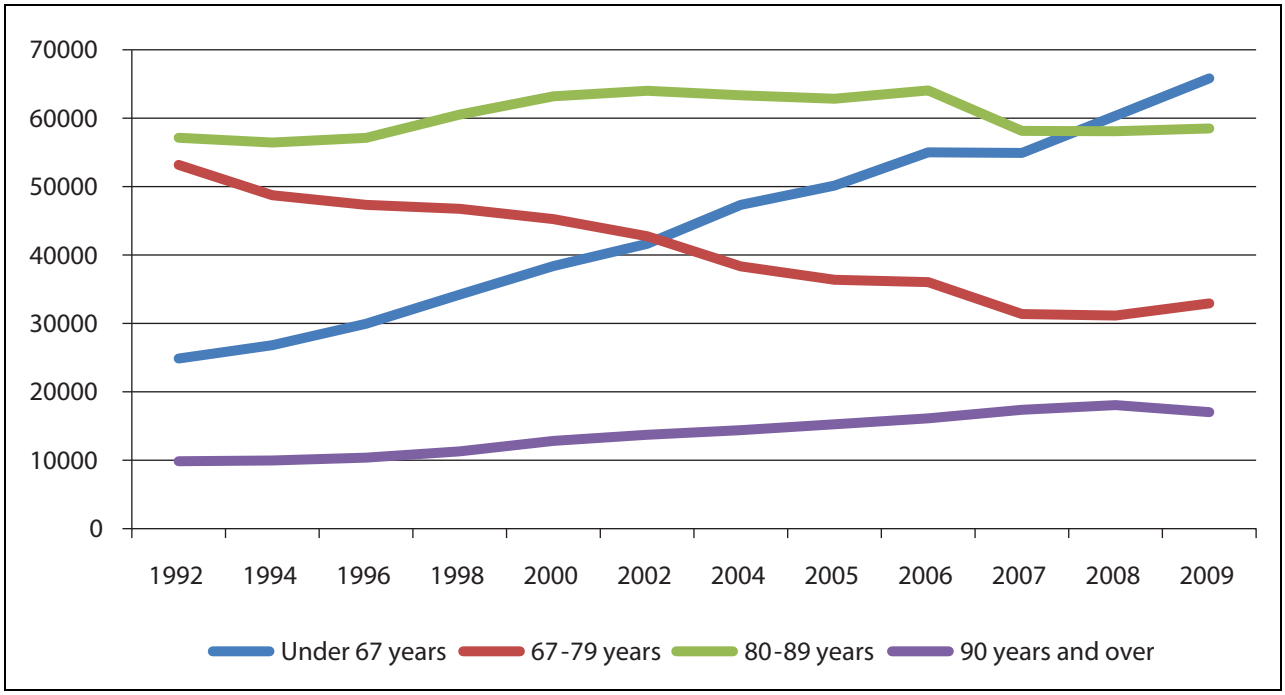

Figure 3.1 Number of recipients of home care services by age. 1992-2009

Source: Statistics Norway. See http://www.ssb.no/pleie/ (in Norwegian only)

receive care services in nursing homes, 225 000 people receive care services in their own homes or in residential care homes. One-third of these are under the age of 67.

Twenty years ago, two-thirds of the care services resources were used in homes for the aged and nursing homes, while only one-third was used on home care services. Today more than half of the resources in the sector go to home care services and measures outside of institutions (Brevik 2010).

The fact that the municipal care services have recipients of all ages with a variety of needs, both with regard to the type of living arrangements and the services offered, is often left out in discussions of nursing homes versus residential care homes and institution-based services versus home care services.

This is why the concept of «elderly care» does not figure in health and social services legislation or in the national or municipal budgets. The statutory framework and access to resources are primarily based on the principle that age must not be used in a discriminatory fashion. The care services therefore encompass everyone who has a need for them, regardless of age, gender, diagnosis, level of functionality or problem.

The idea that the municipal care services are synonymous with elderly care has become less and less correct over time. In fact, in the past 20 years the number of elderly users of these services has not grown, while the number of users under the age of 67 has tripled in the same period. Almost all of the new resources invested in the sector in recent years have gone to covering the growth in the younger user groups.

Despite the strong growth in the oldest age groups in recent decades, the number of elderly users of homes for the aged and nursing homes has not increased. Thus developments are not only being driven by ageing, but are also influenced by other changes in society and the shift in the distribution of tasks which has occurred over time between the specialist health care services, informal care providers and the municipal care services. In this context, the municipal care services fall right in the middle between the special health care services and informal care providers, and have a broad scope of interaction with both areas.

The committee sees the importance of continuing to ensure that care services are provided to everyone regardless of age. More than ever before, it is crucial to build a foundation for the welfare schemes that is based on support from young and old alike and that encourages solidarity between the generations. Equal rights to services for everyone with a need, regardless of age, is a basic principle underlying mutual understanding and joint responsibility.

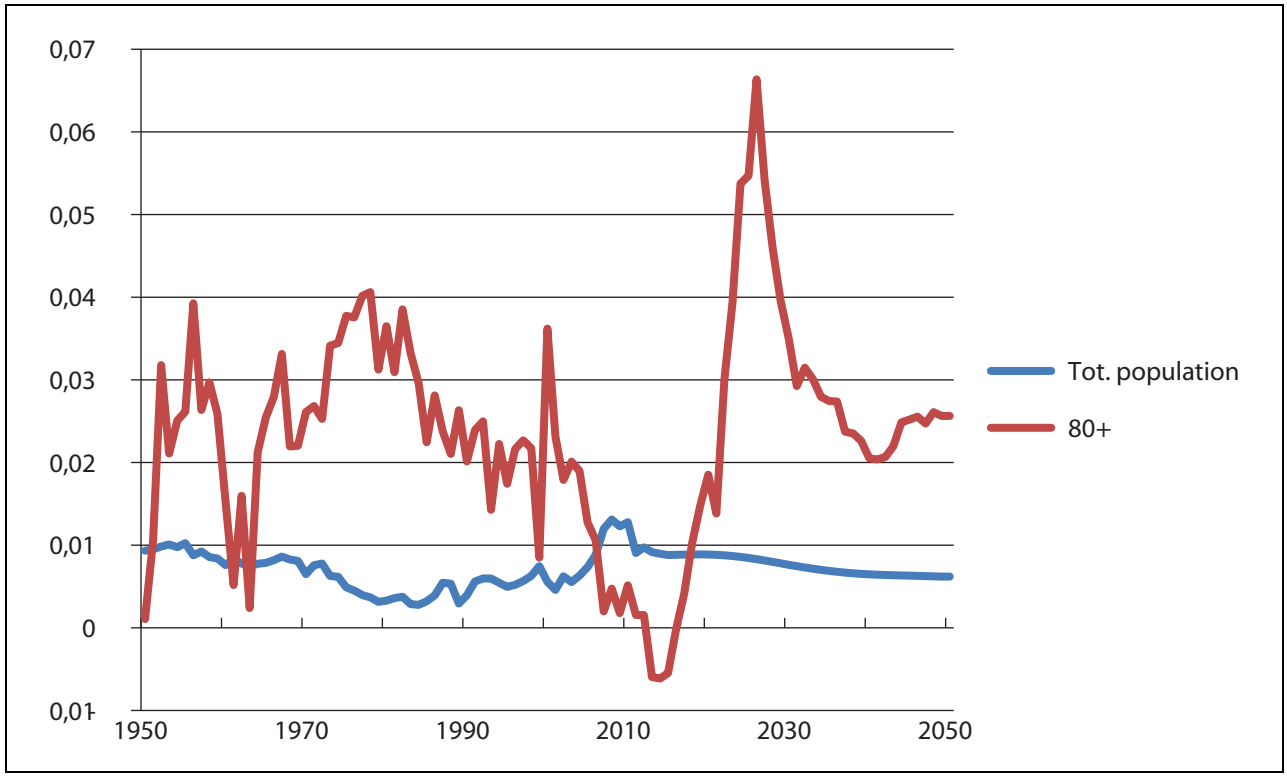

Figure 3.2 Percentage change from the previous year in the number of persons 80 years or older and for the population as a whole. 1950-2050

Source: Statistics Norway 2010 Population projections, median alternative

The services must nonetheless be adapted to various phases of life and to the individual's particular resources and needs. The services provided to a younger user with reduced functionality who requires assistance to complete an education or to gain employment may therefore be different than the services provided to an elderly couple where one of them has developed severe dementia. In one instance, the main focus will be the person's potential to live an independent life, relying as little as possible on others. In the second instance, the need for safety and protection will be more important, even if it comes at the expense of independence.

With regard to the use of new technology and advanced technical aids, younger people with reduced functionality are at the vanguard in the development of this sector precisely because these advanced technical aids help individuals to cope better with daily life on their own and be independent of others. There is reason to believe that the new generation of senior citizens will follow suit, given their attitudes towards independence and control over their own lives. Since the care services sector has limited historical experience with applying new technology, it is the users themselves who will more often be the driving force behind innovations and the implementation of such technology. Demand from a much larger user group with greater buying power will also probably create a basis for more market-based services.

Given how care services evolve, there is great potential for new solutions for the traditional care services to elderly users to be found in transferring the experience gained from reforms implemented for other user groups. For example, the reform for people with disabilities showed that it was possible to establish effective 24-hour services outside of the institutional framework. The reform also encouraged other sectors to take responsibility for people with disabilities on par with the rest of the population with regard to everything from education, employment, activities and transport to participation in cultural events and sport. In the view of the committee, these should be key objectives for the development of care services in the future.

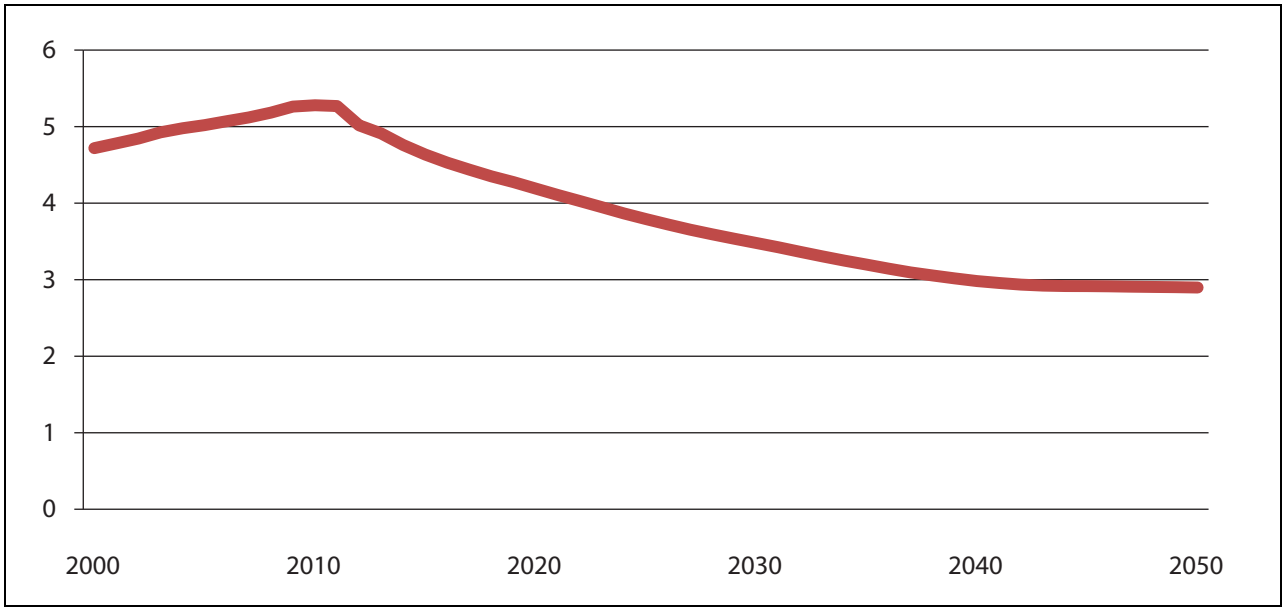

Figure 3.3 Number of persons of working age (16-66 years) per person 67 years and older. 2000-2050

Source: Statistics Norway 2010 Population projections, median alternative

3.2.2 Myth about the «elderly boom»

The demographic changes facing society are often depicted as an unchecked «elderly boom» about to inundate the world. Crisis scenarios are being applied to pension systems, the labour force and the lack of health and social services workers, and dramatic projections are being made about the extent of illness and caregiving needs among the population.

However, the «elderly boom» will be demanding enough without painting the blackest picture. The committee takes a more moderate view of the impact of the changes that will occur in the age composition of the population, and identifies certain factors that will mitigate the challenges facing Norway, especially in the area of care services:

- The number of elderly over 80 years of age will not increase in the next 10 to 15 years. Since a substantial share of the resources in the care services sector are dedicated to the 80+ age group, Norway now has a «demographic moratorium» or «breathing room» (Barstad 2006). This period should be used to prepare and plan for the dramatic increase in this age group that will occur from 2025 onward (Fig. 3.2).
- In terms of demographics, Norway is the country in Europe that will experience the fewest dramatic changes in the age composition of the population, in part because Norway has already undergone such changes and in part because Norway has a higher birthrate, so that ageing is combined with continued population growth. 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 interest with regard to the financing of pensions, welfare services, and health and social services. Figure 3.3 shows that while there were 4.7 persons of working age per elderly person in 2000, the Potential Support Ratio will decline to 3.5 in 2030 and 2.9 in 2050.
- The new generation of senior citizens will meet their old age with more resources. The «new elderly» will have a better financial situation, better living conditions, a higher level of education and better health than any previous generation of elderly (ÆldreSagen 2001, Barstad 2006). Studies also show that in the future more elderly will have someone to live together with (Keilman 2010). Thus, an 80-year-old in 2030 will not be the same as an 80-year-old in 2010. On this basis, long-term planning should not only project the scenario involving problems and illnesses, but should also take into account the elderly population's resources and ensure that these are used.
- It is uncertain what the relationship between a longer life span and the needs for health services will be in the future. Three different hypotheses are possible:
  a. A longer life will mean more good years of life because the period of serious loss of

functionality will be about the same length as for today's elderly.
b. A longer life also will entail overall better health so that the period of serious loss of functionality will be shorter than today.
c. The period of serious loss of functionality will be longer.

Another relevant factor is that although the elderly of the future will have more health problems, they will also meet reduced functionality with more resources (Thorslund and Parker 2005).

3.2.3 The 25 per cent myth

It is claimed in many connections in the public debate that there is a need for 25 per cent coverage of nursing home beds as a percentage of the elderly 80 years of age and older, and that this is a government norm for nursing home coverage. This is a myth that is used in political exchanges, by special interest organisations and in local planning.

In fact, no such government norm exists. The figure of 25 per cent coverage also lacks any scientific basis and becomes particularly problematic when applied to individual municipalities.

The government has never established a norm or a minimum degree of coverage for 24-hour care spaces in nursing homes or residential care homes. It is the needs of the population in the individual municipality at any given point in time that determine how many people will be given 24-hour services in a nursing home, in a residential care home or in their own homes. There is a relatively wide variation in needs among the municipalities due to differences in the composition of the population and various local conditions. Contrary to claims, Report No. 31 (2001-2002) to the Storting, *Avslutning av handlingsplan for eldreomsorgen* («Conclusion of the Action Plan for Elderly Care») warned against applying such norms:

> «The Government wishes to emphasise that the degrees of coverage should not be regarded as norms or minimum standards and that in this connection they should only be used as target figures for the action plan.»

The figure of 25 per cent is taken from Report No. 50 (1996-1997) to the Storting, *Handlingsplan for eldreomsorgen* («Action Plan for Elderly Care»), which states that «for the plan period 1998-2001, it is assumed that there will be a need for 24-hour care services provided in suitable dwellings corresponding to approximately 25 per cent of the population 80 years and older.»

The report emphasises that this is an estimate of the need for coverage on a nationwide basis provided that well-developed home care services and reasonable access to adapted dwellings are available. This applies to all age groups regardless of whether 24-hour care is provided in nursing homes, in residential care homes or in people's own homes.

In other words, this figure is a 15-year-old estimate that was never meant to serve as a norm for the degree of coverage in the individual municipality, but which was used at the time as a basis for calculating the costs of the Action Plan for Elderly Care. This estimate, however, has begun to live a life of its own and gained status as a government norm in the public debate.

In recent years, it is primarily the number of recipients of municipal care services under the age of 67 that has risen. As a consequence, the degree of coverage viewed only in relation to the number of elderly over 80 years of age becomes less and less relevant. According to Statistics Norway, 24-hour coverage in nursing homes and residential care homes comprises 28 spaces per percentage of the population over 80 years of age, and is higher than anticipated when the Action Plan for Elderly Care was implemented.

3.2.4 The myth about informal care

The perception that public sector care displaces informal care and that the family withdraws if the public sector assumes responsibility remains widespread.

However, there is little evidence to suggest that families are failing in their caregiving duties. On the contrary, it appears that public sector care providers and volunteer informal caregivers cooperate with and complement each other. Informal care has proven to be dynamic and strong, and is more independent of public care services policy than presumed (Lingsom 1997). The level of stability in the extent of informal caregiving during the 20 to 30 years when this trend has been followed is striking (Daatland and Solem 2000, Rønning 2009). Nor is there evidence to suggest that the family withdraws when the public care system becomes involved by providing home care services. Although the welfare state has assumed the family's previous obligations related to ageing, illness and disability, it does not appear that this has diminished family solidarity, as is often claimed (Langsether and Hellevik 2002).

The elderly who receive municipal home care services actually receive more help from their daughters and sons than the elderly who do not receive such services. The relationship between public and informal care is more cooperative than competitive in nature. A study of cooperation between public services and informal caregivers in the period from 1965 to 1995 shows that the amount of care provided to the elderly by family members remained stable rather than declined. Even though family members who provide care do so slightly less than before, there is much evidence to suggest that a larger number of people participate in this type of care provision (Lingsom 1997). More men participate, and the caregiving tasks are divided among several generations. Although the overall amount of informal care has remained at roughly the same level, the tasks are now divided among more recipients due to the major changes that have occurred in the age composition of the population.

However, families have less contact and provide less practical help when their elderly relatives live in nursing homes. It is easier for families and the public sector to share responsibility for caregiving tasks when the person in need of care lives at home or in a residential care home rather than in a nursing home (Lingsom 1997; Bogen and Høyland 2006). As a result, the expansion of home care services has ensured that the welfare state can continue to rely on, and cooperate with, the family in the provision of care services. The public home care services allow the family to provide assistance without having to assume the entire responsibility, leading to a kind of partnership with an informal distribution of tasks and responsibilities. This strengthens what the committee's refers to as the «complementary hypothesis», meaning that under certain circumstances the public sector services and informal care can complement and strengthen each other. In contrast, some argue that the public care services replace, and in part compete with, informal caregiving, a situation described in the «substitution hypothesis» (Lingsom 1997; Daatland and Solem 2000; Daatland 1994).

The public care services have not expanded because families, friends and volunteers have failed their loved ones, but because there has been a need to move some of the caregiving arena out of the family and private sphere and to organise some of the caregiving tasks in a different way. The impetus for this was mainly to facilitate the inclusion of more women in working life in a period with a high demand for labour. This occurred simultaneously with a situation in which the needs of a rapidly increasing elderly population exceeded what families and volunteers could provide.

There used to be a widespread belief that the participation by women in working life would cause them to fail to perform their caregiving tasks in the family. In reality, there appears to be a positive correlation between participation in working life and caregiving. Working men and women provide as much care to their parents as those who are not employed.

In addition, the middle-aged women and men of the 60s generation have been shaped by the traditions and values of the society in which they grew up, and it seems unlikely that they will turn their backs on their parents. There appear to be small differences between the people who have made modern, individualistic choices regarding the family and working life and those who have made more traditional choices (Gautun 2003). However, there is reason to monitor whether the new generations will provide less care to the elderly due to their focus on self-realisation and individualisation or whether the amount of care they provide will remain stable or increase because it assumes new forms.

Next to the children of the elderly, it is primarily the grandchildren who provide practical help to their older relatives. A reciprocal relationship exists between the younger and older generations, whereby the assistance provided by younger adults to the elderly is counterbalanced by the financial and practical assistance younger adults in the establishment phase of their lives receive from their parents and grandparents. The potential for assistance inherent in family relationships remains great and must be viewed as a sign that the family ties are strong. Geographic proximity appears to be significant for the amount of help children provide to their parents. The closer children live to their parents, the more help the children provide to their parents (Gautun 1999).

Friends of the family also serve as important care providers throughout a person's lifetime. In fact, friends often provide more assistance than siblings, including to the oldest age groups. Of people 80 years and older, three-fourths received practical help from their children in the past year, almost 40 per cent received help from their grandchildren and about one-fourth received help from friends (Langsether and Hellevik 2002).

While people have longer life spans they are also having fewer children. More and more people have both grandparents and great-grandparents

who are still living, and many live to see both their grandchildren and great-grandchildren in their old age. Since practical help and contact are exchanged primarily through direct ascending and descending generations, it may be that more help from grandchildren will compensate for the lower number of siblings, nieces and nephews.

The «generation squeeze» experienced by the «sandwich generation» — that is, people with responsibility for providing care to their older parents as well as to their children — is limited in scope. If such a «generation squeeze» exists, it relates instead to people who care for their older parents and who themselves are grandparents providing care to their grandchildren (Hagestad 2003).

There are indications that formal and moral obligations are met through mutual commitments spawned through cooperation and the development of good mutual relations throughout one's life (Gautun 1999 and 2003). More than before, people need to form their own networks and not just maintain the ones into which they were born. Perhaps close personal relationships and agreements between family members and friends can in the future compensate for and replace what is lost, should it turn out that the highly normative caregiving obligation vis-á-vis family and friends breaks down in modern society.

Close, strong personal relationships may therefore play a more important role in future care provision than pure moral obligation. This paves the way for more care providers both inside and outside the family circle and puts focus on people's ability to build social relations. From this perspective, the opportunity for people to obtain informal support and care will depend more than before on solid social networks and the amount of «social capital» people bring with them into old age (Barstad 2006).

3.2.5 The illness myth

The municipal care services are developing a stronger health orientation, emphasising medication-based treatment, medical follow-up and nursing care. A report by the Norwegian Directorate of Health on care services in the past 20 years states that «Medical services are given priority over social services» (Norwegian Directorate of Health 2010a). The report points out that in-home nursing services account for most of the growth in the sector, while the number of recipients of practical assistance and housekeeping services has declined. Researchers note that in this way home care services have become more medically oriented (Romøren 2007):

> «And it could be asked to what extent the home care services for the elderly have become medicalised at the expense of prevention and social and practical assistance» (Brevik 2010).

In addition, as homes for the aged have been phased out, medical care has taken on greater importance in institution-based care. This is a key feature in the development of the municipal care services in recent years, and is reflected in the professional groups that manage the sector and the expertise that is sought.

The committee is concerned about this trend as it relates to finding solutions to the future caregiving challenges.

People with reduced functionality are not necessarily patients nor are they sick. Ageing is not an illness either. It entails completely normal loss of functionality, greater practical obstacles, social factors and living conditions. The response must be to remove disabling barriers and to provide practical and personal help, assistance, activities, healthy meals, a satisfactory daily life, active prevention and early intervention.

Anxiety and grief may be an appropriate reaction to one's own loss of functionality or to the loss of a loved one, but this need not manifest itself in illness. As a general rule, problems in human relationships or in a person's relationship to their social and physical environment should also be solved before they result in illness.

A system which requires that people first have status as a patient before they are eligible to receive help with simple, basic tasks in daily life risks becoming involved too late. This implies a trend away from early intervention and prevention and towards the treatment of those patients with the greatest needs. This trend is probably an adaptation to a health service comprised of professional health personnel whose level of expertise in medical treatment is constantly being enhanced.

The field of «anti-ageing medicine» is growing rapidly throughout the world. The World Anti-Aging Academy of Medicine (WAAAM) was established in 1995 and states the following about its activities:

> «Anti-aging and regenerative medicine are among the fastest-growing medical specialties throughout the world and are founded on the application of advanced scientific and medical technologies for the early detection, preven-

tion, treatment, and reversal of age-related dysfunction, disorders, and diseases. It is a healthcare model promoting innovative science and research to prolong the healthy life span in humans (WAAAM 2011).»

It is no longer just about wrinkle creams and liposuction, but also about plastic cosmetic surgery, hormone therapy, gene therapy, biotechnology, stem cell therapy and nanotechnology.

The committee cautions against turning age into an illness. It is true that the elderly fall ill more often than others and will need treatment. But ageing must also be allowed to be a natural part of life, both for the individual and in a societal context. Ageing is a biological, social and psychological process, and there is good reason to review and assess the cultural and social aspects of ageing, not least in relation to the role that the elderly should be assigned in the society of the future.

Similarly, one should avoid viewing people with reduced functionality as ill and instead help to dismantle physical, social and cultural barriers to their participation in working life and society at large.

3.3 Falls, loneliness and cognitive decline

Many people will experience accidental falls, loneliness and cognitive decline in the course of their lives. This may be because they are afflicted themselves or because someone they know is affected. The result is often a poorer general condition and reduced functionality. Much evidence suggests that these three factors are closely related and have a reciprocal impact on each other. A poorer general condition in one area often has consequences for the other areas, which in turn has ripple effects in other areas of life:

- Unpleasant experiences with falls often result in a fear of falling again, leading to withdrawal, social isolation and inactivity.
- A lack of social contact and stimulation can lead to more rapid cognitive decline.
- Cognitive decline can lead to forgetfulness, reduced coordination and less attention to risk. This can in turn increase the likelihood of falling.

This «vicious circle» can be turned into a «circle of opportunity» with the help of preventive measures, innovative actions and appropriate, sensible use of technology.

The Irish Centre for Technology Research for Independent Living (TRIL) (see www.trilcentre.org) has shown how a poorer general condition in individuals, both physically and mentally, can result in:

- Instability or a tendency to fall
- Social isolation
- Cognitive decline

The committee has chosen to use these three factors as a point of departure and illustration in its efforts to find new solutions and test them out. This applies to various types of living arrangements, technology, new work methods and ways of approaching the future caregiving challenges. In many ways, these factors also represent the various professional traditions in the health and social services sector, and show that interdisciplinary activities will be essential for developing new lines of thinking and innovative solutions in the care services.

3.3.1 Falls

Falls have many causes. They may be a pure accident or coincidence or they may be a sign of illness and a poor general condition. Falls and injuries from falls is one of the most common single reasons that the elderly are admitted to hospital. Each year about 30 per cent of all people over the age of 65 and 50 per cent of people over the age of 80 experience a fall. Roughly 10 000 people over the age of 65 break a hip due to a fall. Of these, eight of 10 are women. A broken hip causes excessive pain and a deterioration in quality of life, and the consequences are often so severe that they may lead to a long-term reduction in functionality, complications, accompanying diseases and death. Many never return to the same level of functionality they had prior to the break, becoming reliant on housekeeping services, in-home nursing care and stays in a nursing home (Skadeforebyggende Forum 2011; Sletvold 2010).

The risk factors for falls among the elderly are complex, but they can be classified into three categories: internal, external and risk exposure (Todd & Skelton, 2004). Internal factors include age, gender, whether a person lives alone, the use of medication, overall medical condition, reduced mobility/ability to walk, deficiency diseases, cognitive decline and diseases of the foot. External factors include poor lighting, slippery floors, uneven surfaces, footwear, clothing, inappropriate walking aids or other technical aids. Risk exposure involves the level of activity. Internal factors

appear to be the most common among people over 80 years old, while external factors are most common among younger people.

A project in Nord-Trøndelag county analysed the more than 1 200 incidents of falls that occurred in the course of a year (Kjølstad, Pettersen, and Tvete, 2009). The data was taken from five municipalities and pertained to people over the age of 65. The findings showed that almost half of all falls occurred in the bedroom. In one-third of the cases the falls were caused by illness or dizziness, and in another third of the cases the person had tripped. Fifteen per cent had fallen from a chair or out of bed, and 13 per cent had fallen due to a slippery floor. Breaks and head injuries are among the most serious injuries from a fall.

Falls and injuries from falls are a health problem as well as a socioeconomic problem with a major negative impact on those affected. The consequences of a fall include not only the injury itself, but also the fear of falling again, leading to inactivity with accompanying decline in functionality, social isolation, reduced quality of life and, in the most serious cases, death. Many fall without injuring themselves physically, but they experience the same insecurity and fear of falling again and injuring themselves. In many cases, this leads to a reduction in physical activity and social withdrawal.

The risk of falling can be prevented and reduced through various forms of physical activity, physical training, rehabilitation and medical treatment. One example of a prevention measure is the «Fall Project» in Trondheim. The project is a cooperative effort between several players who work in an active, targeted way to prevent falls among the elderly (Sletvold 2010).

3.3.2 Loneliness

Loneliness is the feeling of a lack of desired contact with others. The person who is lonely has less contact with others or the contact is less meaningful than he or she would like. Thus the person's desire for contact, and not only the contact itself, is of significance. Being lonely is therefore not the same as being alone or isolated, living alone, having few friends or have little social interaction. Loneliness and «aloneness» are two different conditions. Nonetheless, people with only a few contacts say more often that they are lonely than people with many contacts (Thorsen & Clausen 2009).

Only about one per cent of the population says that they do not have any good friends. The elderly lack good friends to a somewhat greater degree than younger people, but the number of people between 60 and 79 years of age who say they lack good friends has declined, from seven per cent in 1980 to three per cent in 2007 (Barstad A. 2009). About one in 10 states that they do not have any good friends in the place where they live. This figure remained stable from 1987 to 2007. Elderly, single men comprise the largest group with a relatively unsatisfactory friendship situation. They have a low level of education and are often without jobs. They may receive a disability pension or work at home, and they tend to be in poor health and have financial difficulties.

Women state more often than men that they feel lonely (Barstad A 2000). Men have fewer close friends than women have, and they often say that their spouse is their only close relationship. Loneliness is most widespread among the oldest age groups, among those 80 years and older and in the 70-79 year age group, and the difference in perceived loneliness between women and men increases with age. Women are usually married to older men, they experience the loss of a spouse more often, they live alone more often, they live longer and they have more health concerns. All of these factors may play a role in why women tend to feel lonely more often than men.

Young people often blame their loneliness on their own personal qualities, and this affects their self-esteem to a greater extent than the elderly, who are more likely to attribute their loneliness to external factors such as the death of their spouse or closest friends. The group that feels the least lonely is young adults, people in the establishment phase of life and established adults.

Feelings of loneliness are also associated with poor health. Poor health may lead to loneliness, and feelings of loneliness may lead to poor health. It is known that loneliness can cause depression, insomnia, tension, anxiety and despair (Luanaigh and Lawlor 2008). Three times as many people who say they are in poor health have feelings of loneliness as compared with people who say they are in excellent or very good health (Tornstam 1988, Lunaigh and Lawlor 2008). There appears to be a stronger correlation between loneliness and mental health than between loneliness and physical health (Thorsen and Solem 2005).

3.3.3 Cognitive decline

It is generally understood that cognitive functioning refers to the ability to comprehend and obtain information from the world around us, store it,

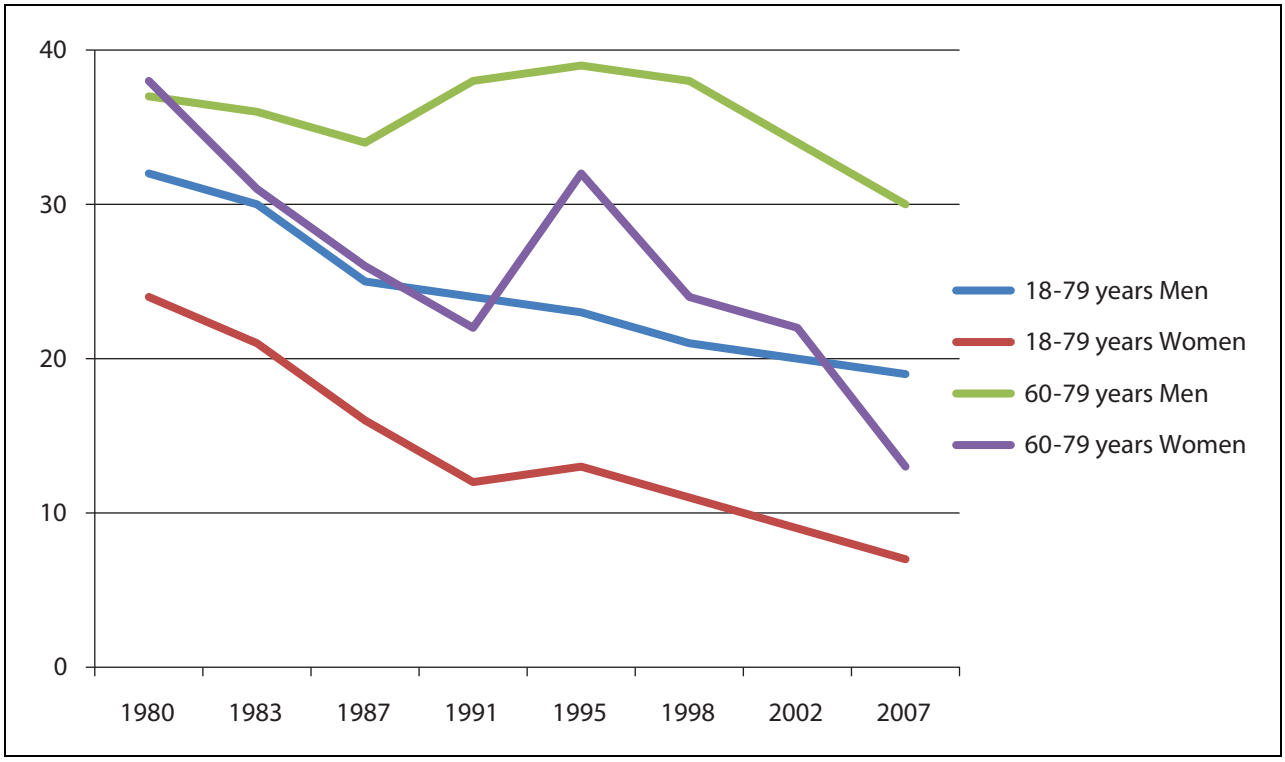

Figure 3.4 Percentage who state that they do not have anyone outside of their own family in whom they can confide. 1980-2007

Source: Statistics Norway, A. Barstad. Living conditions survey and LOGG 2007, Statistics Norway and Norwegian Social Research (NOVA)

and plan and act on the basis of this information. Even ordinary tasks, such as engaging in conversation, require complex interaction between many different thought processes. Although there are individual differences in people's natural cognitive abilities, there is good reference data to indicate what may be considered normal cognitive functioning. In order to apply the term «cognitive decline», the deficiency must be significant enough as to have a negative impact on the person's ability to tackle daily challenges and demands. Thus, cognitive decline is a concept viewed in relation to the individual person's life situation (Follesø 2010).

Mild cognitive decline may be described as a gradual reduction in cognitive performance, and commonly occurs with increasing age. In some cases, a slightly more pronounced cognitive decline occurs than is expected with age, even though this does not fulfil the criteria for a diagnosis of dementia. This may often be manifested in an experienced or proven memory problem, and it may have many different causes.

Neurological diseases caused by pathological changes in the central nervous system are often classified according to the physical symptoms they produce. However, many feel that their illness is not limited to the physical aspect, but that a decline in cognition is a crucial aspect of their overall condition.

Dementia is an umbrella term for several different brain diseases that often occur in old age and result in cognitive decline. The most important symptom or defining feature of dementia is memory loss. People afflicted with dementia have difficulties maintaining learned skills and mastering daily tasks. Some people develop changes in their personality such as a lack of insight and poor judgment. Other frequent symptoms are anxiety, depression, suspicion, delusions and obsessive-compulsive behaviour.

Currently in Norway about 70 000 people have some form of dementia, and it is estimated that 10 000 people are stricken with the disease each year. Studies show that only half of them are examined and diagnosed (Ministry of Health and Care Services 2007). Activity and social contact may enhance the quality of life for people with dementia and cognitive decline, and to some extent delay the development of the disease and reduce the need for treatment with medication.

Conclusion

Falls, loneliness and cognitive decline constitute a «vicious circle» which has major ramifications for the people afflicted and for society at large. Preventive measures that help to remove the risk factors or reduce the consequences of falls, loneliness and cognitive decline will therefore be a good investment in the future.

The committee has chosen to use these three factors as the point of departure and illustration for its efforts to find new solutions and test them out. Falls involve a person's relationship to the physical environment. Loneliness involves the person as a social being and the relationship between people. Cognitive decline involves the brain and the person as a biological being. Together they represent crucial challenges that call for interdisciplinary cooperation between the medical, social and technical fields in order to find new solutions in which the use of new technology and new housing solutions, combined with activity and treatment, can prevent falls from occurring and loneliness from arising or reduce the consequences of increasing cognitive decline. The committee refers to the discussion of this in chapter 5 and onward of this report.

3.4 Borderless care services

The committee has chosen to refer to the internationalisation of care services as the «seventh challenge». In the future people will cross municipal boundaries and national borders more often to obtain health and care services, and health and social care workers and companies that provide such services will operate in several different countries.

3.4.1 Patients and users without borders

Today more and more patients and users are crossing national borders to obtain treatment and participate in recreational activity and physical training. Some combine their holidays with dental treatment or an eye operation in Asia; others travel to the Mediterranean coast for parts of the year for recreation and for health-related reasons. Norway is not the only country where this is happening. Throughout the world, patient and user flows are becoming internationalised across regions and national borders. It is easy to obtain information from the Internet, and the new generation of senior citizens has more resources than before and appears to be more mobile. Certain countries address some of their caregiving challenges by sending people in need of care services to other countries where labour is less costly and access to care workers is simpler (Isaksen 2005).

3.4.2 International labour market

The labour market, including health and social care personnel, is becoming internationalised, and care workers are crossing national borders to provide care to other people's families abroad.

«The global care chain»

An increasing proportion of the world's population is migrating from one country to another. A large part of the labour migration that occurs among women is related to what could be called the «care deficit» in the rich part of the world. The export of care workers has therefore already become a major growth industry for poor countries.

On the one hand, women are employed as au pairs or maids by families caught in a time crunch between employed work and caring for their children and elderly relatives. Many of these women support their own children and families in their home country by taking care of other people's children and families abroad. This situation has been termed the «global care chain» (Hochschild 2001, Isaksen 2001, Yeates 2005). Some also get married in another country, and after some time they bring their mothers with them to take care of their children. These «transnational grannies» expand the global care chain even further. Part of this picture includes illegal immigrants who are exploited as undocumented maids and home assistants, some of whom are forced into prostitution (Isaksen 2001).

«Care drain»

On the other hand, there are health and social care professionals who have the opportunity to emigrate to Western countries in order to help meet the demand for health and care personnel in hospitals and elderly care facilities. They come from India, Thailand and the Philippines to the US, Europe and the Middle East, or they come from countries in Eastern Europe to Western Europe (Isaksen 2005). In this way, the «care drain» becomes one aspect of the «brain drain», a situation in which expertise moves from the areas

Box 3.1 Sunrise Senior Living

Sunrise Senior Living operates 365 «senior living communities» with almost 40 000 residents in most US states as well as in Canada, England and Germany. The company offers:

Independent Living Assisted Living Alzheimer's Care
Nursing & Rehabilitative Care
Hospice Care
Short-term Stays

Source: http://www.sunriseseniorliving.com/

where the need is greatest to areas where demand and the ability to pay are greatest.

3.4.3 International providers

At the same time, service providers are crossing national borders. Norwegian municipalities are establishing nursing homes, physical rehabilitation services and residential care homes in the Mediterranean countries, or entering into agreements with others that provide these services. And the thousands of Norwegians who have become residents or long-term tourists of Spain are working to expand Norwegian involvement in social measures and care services along the Spanish coast.

The relationship between health and climate is given as a main motivation factor for the rather extensive emigration to and long-term tourism in Spain. Individuals suffering from rheumatism and asthma experience especially positive health effects, such as less pain, a simpler daily life, better training opportunities and less use of medication. Although only scarcely one-fourth of Norwegians in Spain say they would travel home to Norway if they were to become severely ill or injured, they nonetheless harbour worries about finding themselves in such a situation and are working actively for the establishment of good care services with assistance from their home country. The question then becomes whether it is easier, less expensive and better, not only for the users but also for their home municipalities in Norway, to finance or establish care services in Spain, as many would like (Helset et al. 2004, Sørbye et al. 2004).

Box 3.2 Two small projects on the Norwegian-Swedish border

Gränsprojekt

The EU-funded INTERREG project *Midt-Skandinavisk Regionprosjekt* encompasses the Frostviken region in Strömsunds municipality and the Hotagen region in Krokoms municipality in Jämtland county, both in Sweden, and Lierne and Røyrvik municipalities in Nord-Trøndelag county in Norway. The project promotes industrial development, cooperation on and development of public service production, and the removal of border-related barriers as a means of reversing the negative population trend in the region. The cooperative project also entails health and care services. See http://www.gransprojekt.eu/

Gränslös omsorg («Borderless care»)

Gränslös omsorg is a cooperative project between Inari municipality in Sweden and Sør-Varanger municipality in Norway which aims to develop new, innovative business models for cooperation on elderly care and home care services that extend across national borders.

Source: See www.interregnord.com/

A growing number of service providers offer recreational activities, physical training services and care services in this international market. Both major international humanitarian organisations and more commercial players offer everything from short-term, traditional spa stays to long-term stays in institutions or permanent relocation to senior living communities. These communities are targeted at people 55 years and older and offer activities, daytime programmes, practical and personal assistance, separate nursing home facilities and special services for people with dementia (Barstad 2007).

In Norway, Nordic companies such as Norlandia Care and Alleris provide home care services and institution-based services to various user groups, and Adecco, the world's largest staffing agency, has been involved in the operation of several nursing homes.

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