Arthur J. has come home at last. After almost 30 years in institutional care, the 55-year-old mentally handicapped man has returned to his home village in a small municipality north of the Arctic Circle. Now he is working in the local grocery store. He lives in his own small flat and manages his own money. Arthur enjoys life in his own village and does not look back upon the many years of institutional life with any nostalgia.

Arthur’s return to his home village is the consequence of comprehensive reforms for the mentally handicapped whose aim is to make local municipalities fully responsible for mentally handicapped persons in their home environment.

This “reform” in the health care system for the mentally handicapped is an important link in a far-reaching process within the Norwegian health service. Nothing less than a small revolution is in progress. Time will show whether it will be a successful revolution. There is light at the end of the tunnel, but it may yet turn out to be a longer tunnel than expected.

This is not the first quiet revolution in the history of Norway. With the end of the 1940-45 war, a new chapter in national development opened. A new philosophy of social development, combined with economic optimism both nationally and generally in Scandinavia, led to rapid improvements in living standards in Norway. Massive resources were channelled into developing a public health service, and priority was given to building up central institutions and hospitals. The hospitals absorbed the vast majority of health personnel. Primary health care was starved of resources.

The system had its weaknesses. Decisions were taken above the heads of local communities. No unified plan for the delivery of primary health services existed. In 1975, in a parliamentary paper on hospital development in a decentralised health care system, the idea was launched that primary health services were to form the basis of all health services. The idea won universal support. Thus the primary health service team was to remain responsible for the patient even if she or he had to be “loaned” to higher levels of care for specialised treatment. An important task of the higher levels of the health service is to provide support and advice to the primary level.

A process of legal revision was embarked upon, and the Act on Municipal Health Services was ready for adoption in 1982. It entered into
Norway is putting increasing emphasis on rehabilitation for disabled persons and on assisting their families, in the context of the nation's strategy for Health for all.

Facing page: Care for the elderly is a special concern today throughout Europe.

force two years later. The purpose of the act was to ensure the development of comprehensive primary health services, operated as one continuous system of care. It would bring about a more equitable distribution of resources between municipalities and regions. Under the new system, state grants would be given according to need rather than in the form of reimbursements to existing services. The act also ensured a more efficient use of resources and laid the foundation for better cooperation between health and social services at the local level, and between ambulatory care and institutional care.

Subsequently the municipalities have taken over responsibility for running nursing homes which were previously regarded as institutions in the hospital system and were run by the countries. The emphasis in these homes will increasingly be on rehabilitation and on assistance to families faced with the burden of looking after disabled persons. The care and support of mentally handicapped persons will in future be the sole responsibility of the municipalities.

This far-reaching process of decentralisation is in keeping with the growing emphasis on district health systems within the strategy for Health for all. It is the primary health service which can reach people where they live and work, in municipalities and in the local communities. The Directorate of Health, in its book "Health for all in Norway?" states: "Primary health services must be easily accessible and acceptable to all, and be planned and operated with the full participation of the local community. Other levels of health services must have as their aim to provide support to, and increase the effectiveness of, local health services."

It has long been the expressed aim of Norwegian health policy to strengthen the ability of the primary health service to take care of the patient, and thus to ease the load on hospitals and specialists at the secondary and tertiary levels. Today, more than ten years after the first public statement of this principle, we have to accept the fact that the pressure on specialised health services has not eased noticeably. It is hoped that the legal reforms and reorganization of the last few years will provide the necessary basis for realising our aim.
In many European countries, primary care has for years been defined only as the contact with a physician whom people see initially in case of illness. In Norway, public health nurses have for years had a prominent place in primary health care and, since the 1970s, home nursing services have developed rapidly. Together with curative physician and physiotherapist services, nursing services now constitute the major elements of the primary level, while the role of midwives, dentists and pharmacists on the primary care level is currently less clearly defined. Conditions have become more favourable for the development of a comprehensive plan for health promotion and health services in each municipality. In order for primary health services to transmute into primary health care, the health sector needs cooperation with other sectors. We must succeed in creating a continuous chain of services through all sectors and all levels of service, if we are to provide adequate housing for persons with disabilities or chronic diseases.

In the meantime the target remains: “By 1990, the services provided by all sectors relating to health should be coordinated at the community level in a primary health care system.” Legislation exists to support this.

There have been conflicts. But the dividing line in this debate runs across party political boundaries. The Directorate of Health, which has the professional responsibility for the health services, has on several occasions voiced its scepticism about the decentralisation process. Responsibility for Norwegian health services is at risk of fragmentation, says the outspoken Director-General of Health, Torbjorn Mork. He is worried by some of the things he sees. And Patricia Melsom, a board member of the Norwegian organization for the disabled, considers that health care for members of her organization has deteriorated. Central authorities have no way of intervening in the case of unreasonable decisions at the local level, she says.

**Regional inequities**

The main concern of both Mork and Melsom is with the risk of regional inequities. If one local authority gives higher priority to a swimming pool or a new office block than to a nursing home, it is free to use its money any way it wants. There is a real risk that domicile may decide what kind of health services one can expect. Some foresee the development of a nation on the move: the young will prefer municipalities which have given priority to education and housing, while the elderly will pack their belongings and move to districts with renowned nursing homes and cultural facilities.

While the rest of Europe is experiencing reasonable economic growth, Norway has been suffering from an economic hangover since 1984-86. Local municipalities have had to take tough decisions in the course of budget processes. To all appearances the worst sufferers have been groups which were not so well-off before. The press has had juicy stories to tell of residents in nursing homes who - because of staff shortages - were put to bed at four o’clock on week-day afternoons, or who might not be able to get up at all on Sundays, or of disabled persons who have lost well-established services because the municipality could not afford the necessary personnel.

The period of prosperity which we hope Norway is now embarking upon will show whether the municipalities can indeed shoulder their responsibilities in keeping with the stated goals and in accordance with the Health for all strategy.

“We must succeed in creating a continuous chain of services through all sectors if we are to provide adequate housing for persons with disabilities.”

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