

# LTC COVID-19 Norway experiences

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# Plan for this talk:

- Brief outline of Norwegian LTC
  - Stress on nursing homes, for two reasons:
    - Most affected
    - Experiences from a government initiated project (The Norwegian Corona Commission)
- Impact of COVID-19 in Norway
- Lessons learned
  - Focusing on the Norwegian Corona Commission project

# Long-term care in Norway

- Norway's health expenditure 10,5 % of GDP (UK 10,3 %, Sweden 10,9 %, Denmark 10,0 %, Finland 9,1 %, Iceland 8,8 %, EU 8,3 %)
- Norway spend 3,3 % of GDP on LTC (United Kingdom 1,4 %, Sweden 3,2 %, Denmark 2,5 %, Finland 2,2 %, Iceland 1,7 %, OECD 1,7 %)
- Nearly three times as many as receive home nursing as NH care (Statistics Norway 2020, for 2019)
- LTC workers and education: 77,5 % formal health education (Statistics Norway 2020, for 2019). In 2017: 30 % RNs in NHs, statistics not available for later years.
- NH ownership: for-profit share from 6,6 % in 2015 to 4,7 % in 2019, non-profit relatively stable at 5,2 %, around 90 % public (local governance level) (Statistics Norway 2021)
- Interpretive rather than prescriptive regulatory environment

# Recent trends in Norwegian LTC

- Less cared for in nursing homes and other LTC facilities, more cared for in their own homes or in supportive housing
- Increased home-based care; care more geared towards health-related services, less practical assistance
- Stronger increase in municipal health and care services for people 67 years or less than for people 67+
- Since 2012: The Coordination Reform: shorter hospital stays, more acute and sub-acute care in the municipalities; municipalities fined for not immediately taking on patients discharged from hospital

# Nursing homes in Norway

- High coverage of NHs, mostly singular occupancies, smaller wards (8-12 residents common), averagely relatively good building standard.
- Health facilities subject to health and medical legislation (e.g. in contrast to Sweden and Denmark, where social and housing legislation play a major role)
- Relatively well staff and relatively high formal staff competence, in an international comparative perspective
- Relatively high level of absenteeism/sick leave, and related use of part time and temporary workforce
- Substantial variation in how individual nursing homes perform as to staffing, building standards and more

# COVID-19 in Norway

- No excess mortality reported (National Institute of Public Health, NIPH, 2021)
- Deaths to COVID-19 per 5<sup>th</sup> March 2021: 632 (tot.pop. appr. 5,4 mill), 11,7 deaths pr.100.000 (UK 183,3, Sweden 128,8, Denmark 41,1, Finland 13,8, Iceland 8,5)
- Around 85 % of death in pop. 70+
- Vaccination: 3,5 % fully vaccinated, 7 % at least one dosis (UK 32,1 %, Sweden 5,9 %, Denmark 8,9 %, Finland 8,7 %, Iceland 7,9 %, one dosis)

# COVID-19 in Norwegian NHs

- In Norway, a large share of COVID-related deaths took place in nursing homes (more than 50 %, in Sweden less than 50 %)
  - March to May 2020: 58 % of a total of 236 COVID-19 related were in nursing homes (NIPH 2020)
- Huge variation between NHs
  - Of around 1000 Norwegian NHs in total, relatively few have had outbreaks of COVID-19 (31 by end of April 2020, after the most severe surge of NH infections). A couple of them had a very high death toll.
  - Possible reasons discussed in mass media and in the academic community: 1. Use of parttime and temporary staff; 2. Older buildings with less opportunities for isolation and for infection control

# The Corona Commission report

- Asked to perform case studies in five NHs (spread geographically, varying exposure to COVID-19)
- Interviewing staff (leaders, nursing staff, physicians) and family
- Aim: to investigate experiences of COVID-19, including how the NHs were prepared for a pandemic, what challenges they encountered, and how they managed to deal with the pandemic.

# Some general findings:

- Reorganization and redistribution of resources
  - Also in wards with no COVID-19 but where one or two wards in the same NH was affected (e.g. drain on staff, in particular RNs)
  - Also in NHs that did not experience COVID-19, in order to be prepared (e.g. wards established for potential COVID-19 patients)
- Less activities for residents, in particular social activities
- Contact with family has been a huge challenge, not the least in ward with no COVID-19 in affected NHs
  - Examples of innovative solutions for meeting with family, e.g. large tents outside the NHs
  - Still: Several family members complained that the residents seemed to have lost hope after a while and decreasingly sought contact

# General findings, cont.

- Stronger cooperation among staff, in particular at the ward-level
- Increased use of internet platforms for planning and communication (online and offline)
- Relations with cleaning staff appeared to be important but precarious (cultural and language differences, misunderstandings etc.)
- Cooperation challenges with maintenance staff, food delivery companies etc.
- Investment in digital solutions for communication between residents and staff, but generally poor training and hence limited use of those solutions
- Ethical dilemmas as to infection control (forced isolation, forced sampling), in particular stressed by physicians

# Some lessons learned/recommendations

- There need to be a strengthening of the NHs in general regarding staffing, terms of employment and the built environment
- The fact that some staff work at more than one care home, and sometimes also in other sectors (e.g. restaurants) reveals the need for better paid staff with secure employment terms
- There needs to be increased efforts at strengthening cooperation and integration between care staff and cleaning staff
- Further development of IT-solutions based on experiences during the pandemic
- Preparing for future pandemics means first and foremost means improving conditions for care in general in NHs
- A nationwide mapping with regard to COVID-19 experiences in NHs is recommended.

Thank You  
For Your Attention

