Active Ageing and the Norwegian Health Care System

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Contents

Foreword

Demographic ageing is a key challenge European policy-makers will face in the coming decades. An ageing society will strain European labour markets, pension systems and health care systems. This publication comes out of the Active Age project, financed by the European Union. The project aims at identifying and analysing the socio-institutional, economic, and political realities facing the implementation of active ageing policies in 10 European countries. This implies the following: 1. Chart and analyse the existing active ageing policy landscape in Europe, 2. Identify and outline barriers to and opportunities for implementing active ageing policies in Europe, 3. Highlight and explore means of overcoming barriers and seizing opportunities for active ageing policies in Europe.

Rune Ervik
Projectleader for the Norwegian Partner

Summary

This paper provides results from the fourth work package (WP4) of the Active Ageing project dealing with how the ongoing health policy in Norway has given rise to an Active Ageing agenda. The aim is to identify the institutional, political and socio-economic barriers and opportunities for implementing active ageing policies in the health care sector in Norway. To which extent have recent health care reforms contributed to national active ageing policy objectives? Active age does not exist as a publicly-expressed aim in the health care policy. Nevertheless, active ageing policies seem implicit in the recent health care reforms. The most important change is the redirection of housing policy for the elderly and the trend toward live at home as long as possible and receiving individually adapted services. However, some challenges still remain. The focus on health care might neglect the social needs of the elderly. Thus, an important precondition for being active is ignored in the policy. Another policy challenge is how the elderly make use of their good health and the possibilities to live an active old age. The trend for the elderly to segregate and live outside the productive sphere is perceived as a problem in the Norwegian policy debate, as politicians want the healthy elderly to make use of their resources in a more 'productive' term.

Generally, the health care policy has resulted in a good health condition for the population and the preconditions for an active age have never been better. However, due to demographic ageing, authorities are dependent on activity for the healthy elderly to be used in working life in order to lighten the demographic burden. Increased exit from labour market for those aged 60+ gives rise to questions about the health conditions of this group. When it comes to self-reported health, a large percentage of the population live with chronic health problems, somatic pain and psychiatric disorders. This could be part of the explanation for increased exit from the labour market. For retirees within the voluntary scheme, the barriers are not necessarily health conditions nor working place conditions, but economic incentives. Thus, barriers to active ageing in this group seem to be attitudes towards work and leisure, in addition to the overall cultural understanding of old age.

Relying on text analysis of academic literature and policy documents, expert interviews and a statistical analysis of quantitative data, this report is structured as follows: First, the health status of the population is outlined followed by health risk statistics. The health care system and policies accommodated toward active aging are then described. How are the challenges met and policies set? In this section, the formal administrative system and policies are presented in addition to the results of interviews with key actors. This presents the actors experiences, knowledge, and apprehensions of the system and policies. Lastly, the findings are reviewed and the policies assessed by analysing the identified barriers and possible opportunities for implementing health policies for active ageing in Norway.

Sammendrag

Notatet er utarbeidet innenfor det EU finansierte prosjektet Active Ageing Policy in Europe. Utgangspunktet er de demografiske endringene som innebærer flere passive eldre og færre yrkesaktive i fremtiden. Prosjektet som helhet har som målsetning å identifisere og analysere de institusjonelle, økonomiske og politiske realitetene som møter implementeringen av en aktiv aldringspolitikk i 10 europeiske land. I dette notatet rettes fokuset mot den norske helsepolitikken og hvordan de senere reformer har bidratt til målsetninger om Active Ageing i Norge. Active ageing eksisterer ikke som en uttalt målsetning i norsk helsepolitikk men kan likevel sies å ligge implisitt i de senere reformer i helsesektoren. Et eksempel på det er avinstitusjonaliseringen i den kommunale eldreomsorgen som gjenspeiler trenden til å bo hjemme og motta individuelt tilpasset hjelp. På den annen side er det et hovedfokus på helse i eldreomsorgen noe som kan gå på bekostning av sosiale aktiviteter. En annen utfordring er hvordan eldres bedrede helse kan bidra til mer "produktiv" aktivitet. I den norske politiske debatten blir det oppfattet som et problem at eldre viser tendenser til segregering på utsiden av den produktive sfæren. Myndighetene peker på at den generelle helsetilstanden er kraftig forbedret og at vi trenger å bruke den fordelen til å lette på den demografiske byrden. På den annen side kan vi stille spørsmål ved helsetilstanden til den økende gruppen av personer på 60 + som slutter i arbeidslivet og blir uføretrygdet. I tillegg oppgir en økende del av befolkningen at de lever med kroniske helseproblemer, fysisk smerte og psykiske problemer, noe som kan være forklaringen til økning i uføretrygden. For personer som går av på grunnlag av AFP virker de økonomiske incentivene sterk i tillegg til innholdet i arbeidsoppgavene. Derfor ligger barrierene mot active ageing for denne gruppen i holdningene til arbeid og fritid i tillegg til vår kulturelle forståelse av alderdom. Notatet baserer seg på tekst analyser av forskningsrapporter og offentlige dokumenter, ekspert intervjuer og statistiske analyser. I første delen presenteres analysen av helsestatus og helserisiko. Så følger en beskrivelse av helse- og omsorgssystemet. I siste delen, basert hovedsakelig på eksperteintervjuene, presenteres de tiltak som kan sies å være rette mot active ageing i Norge, hvilke utfordringer som finnes og hvordan de søkes løst. Notatet slutter av med en identifisering av barrierer og muligheter for å iverksette helsepolitikk rettet mot active ageing.

Introduction

This report deals with how the ongoing health policy in Norway has given rise to an Active Ageing agenda. There are two leading definitions of active ageing. The first one, according to OECD (2000), emphasises the productive dimension of ageing. OECD defines active ageing as '..the capacity of people, as they grow older, to lead productive lives in the society and the economy. This means that they can make flexible choices in the way they spend time over life – in learning, in work, in leisure and in care-giving' (p.126). The other definition, provided by WHO (2001), concerns the 'quality of life' dimension: 'Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age' (p.12). Thus, the link between health policy and active ageing depends on which of these definitions is in force. In accordance with the former, productive, definition health policy is important as an indirect measure to enhance good health in order to enable older people to participate in the productive sphere of society. Concerning the latter definition, the link is more obvious: health policy designed to improve health is directly tied to the process supposedly leading to quality of life in old age – the meaning of active ageing.

The World Health Organization defines health as 'a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity'. As described in the Report to the Storting, "Prescriptions for a Healthier Norway", this definition forms the basis of/grounds Norwegian public health policy, suggesting that good health equals a good life (Report No. 16 (2002–2003) to the Storting). Accordingly, on the one hand, public health policy is about promoting physical health by influencing living habits and living conditions. On the other hand, public health is about promoting mental health 'by helping people to feel that they can cope, giving them self-esteem, human dignity, security, respect and visibility' (Report No 16 ibid). The WHO has shown that a third of the total burden of disease in industrialized countries is caused by five risk factors: tobacco, alcohol, high blood pressure, cholesterol and being overweight. Against this background and due to new social trends, the Norwegian Government wishes to revitalize public health work. Two contributions are outlined as current objectives in health policy: 1.More years of healthy life for the population as a whole; and 2. A reduction in health disparities between social classes, ethnic groups and the sexes. In these objectives, we find a link to policies which bring about a healthier and more active old age.

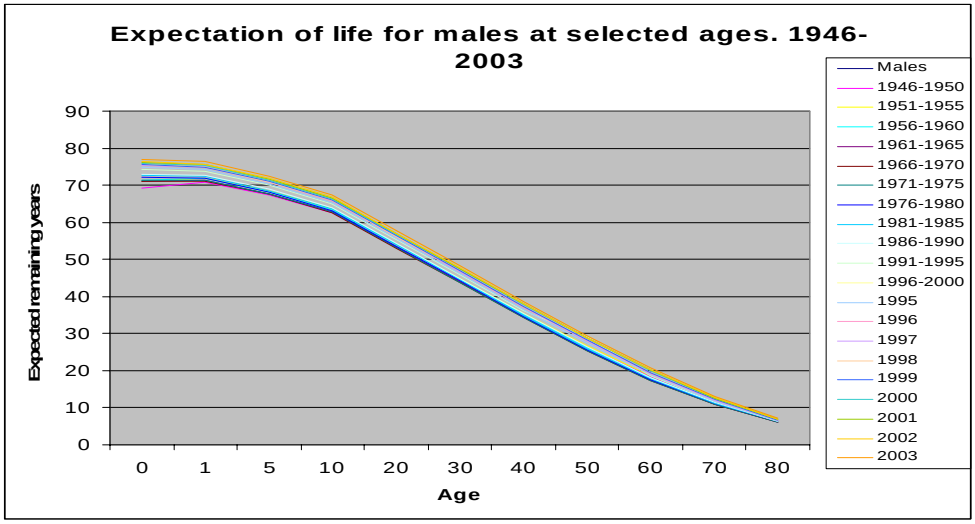
This report deals with active aging policies in the health care sector. By identifying the institutional, political, and socio-economic barriers and opportunities for implementing active ageing policies in the health care sector in Norway, the aim is to assess the extent to which recent and current health care reforms have contributed to national active ageing policy objectives.

Relying on text analysis of academic literature and policy documents, expert interviews and a statistical analysis of quantitative data, this report is structured as follows: First, the health status of the population is outlined followed by health risk statistics. The health care system and policies accommodated toward active aging are then described. How are the challenges met and policies set? In this section, the formal

administrative system and policies are presented in addition to the results of interviews with key actors. This presents the actors experiences, knowledge, and apprehensions of the system and policies. Lastly, the findings are reviewed and the policies assessed by analysing the identified barriers and possible opportunities for implementing health policies for active ageing in Norway.

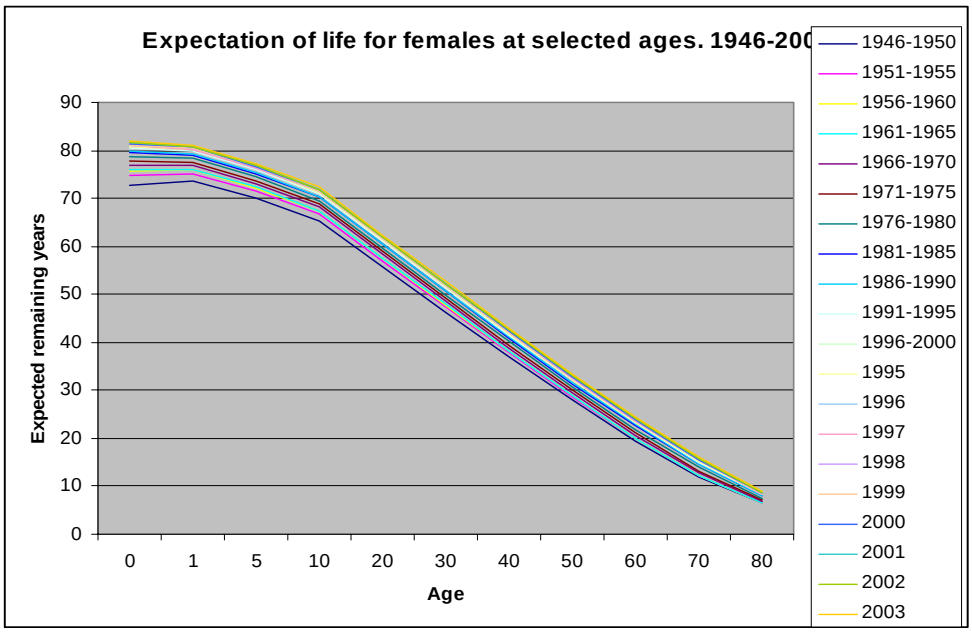
Demographic characteristics

During the twentieth century we have seen a radical and incomparable improvement in health in the Norwegian population, indicated, among other factors, by a more than thirty year rise in life expectancy. From 1946 to 2003, life expectancy has risen by almost 8 years for males and 9 years for females, as illustrated by the following figures:



Source: Statistics Norway

Figure 1 Life expectancy for males at selected ages, 1946–2003



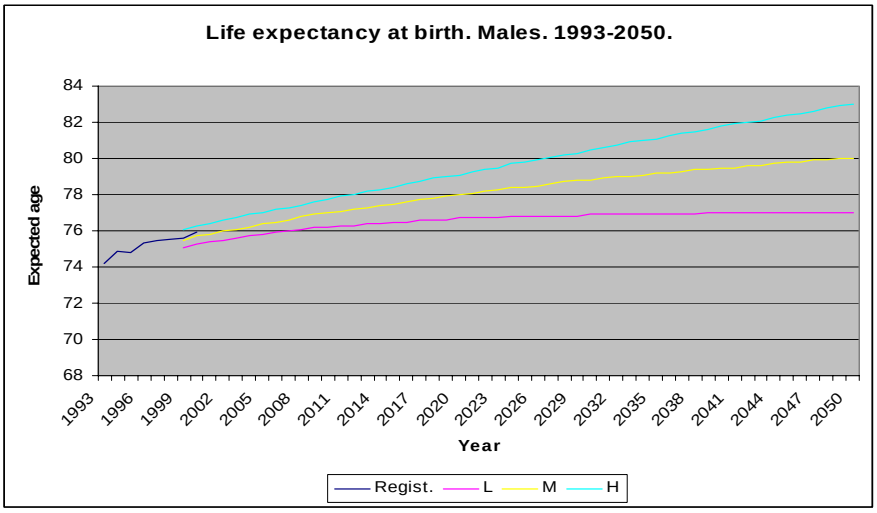
Source: Statistics Norway

Figure 2 Life expectancy for females at selected ages, 1946–2003

Between 2002–2003, life expectancy increased by 0.59 for newborn boys and 0.41 years for newborn girls, which represents one of the highest increases in life expectancy over the past fifty years. Life expectancy reached 77.04 years for men and 81.93 years for women. The last five years, life expectancy has increased more for males than for females, producing a decrease in life expectancy between the sexes. The last five years, there have been more women than men who died. This trend is opposite of prior years and is due to changes in the age composition of the population. Fifty-five percent of those who died in 2003 were 80 years and older. That year, 55 percent of those who died were women, while 45 percent were men.

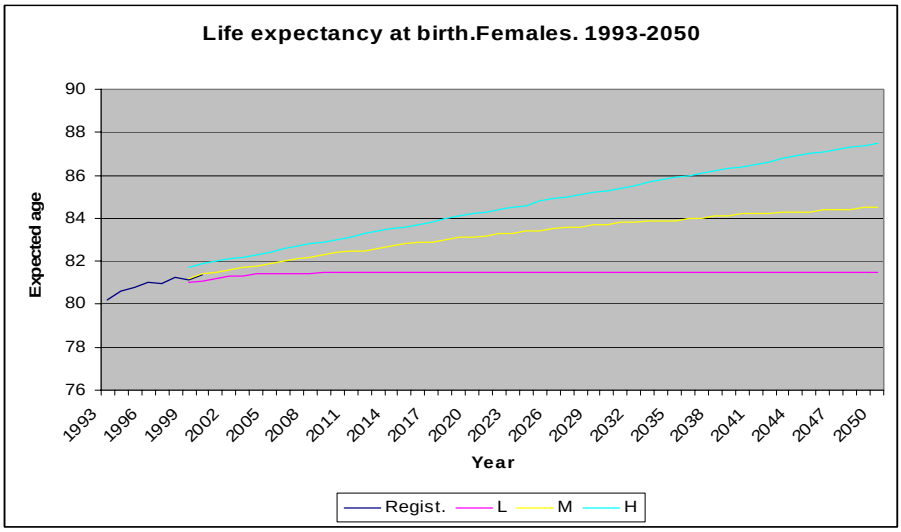
Compared to other European countries, men from Iceland, Sweden, Austria, Switzerland, and Italy can expect to live longer than Norwegian men. Japanese men still have the longest lifespan but Icelandic men now have the same longevity of 78,4 years. European women who may expect to live longer than Norwegian women are from Iceland, Sweden, France, Switzerland, Italy, and Austria. Japanese women lead with 85,3 years.

Life expectancy projections indicate a continued increase in longevity. Even though there are uncertainties and different alternatives in the projections, all the alternatives expect both males and females to live longer in the future as well. The following figures illustrate three different projection alternatives. Alternative Low (L) indicates high fertility but a lower increase in life expectancy. The middle range (M) alternative indicates middle fertility and a middle increase in life expectancy, whereas the high (H) alternative indicates lower fertility but higher life expectancy than in alternative M.



Source: Statistics Norway

Figure 3.

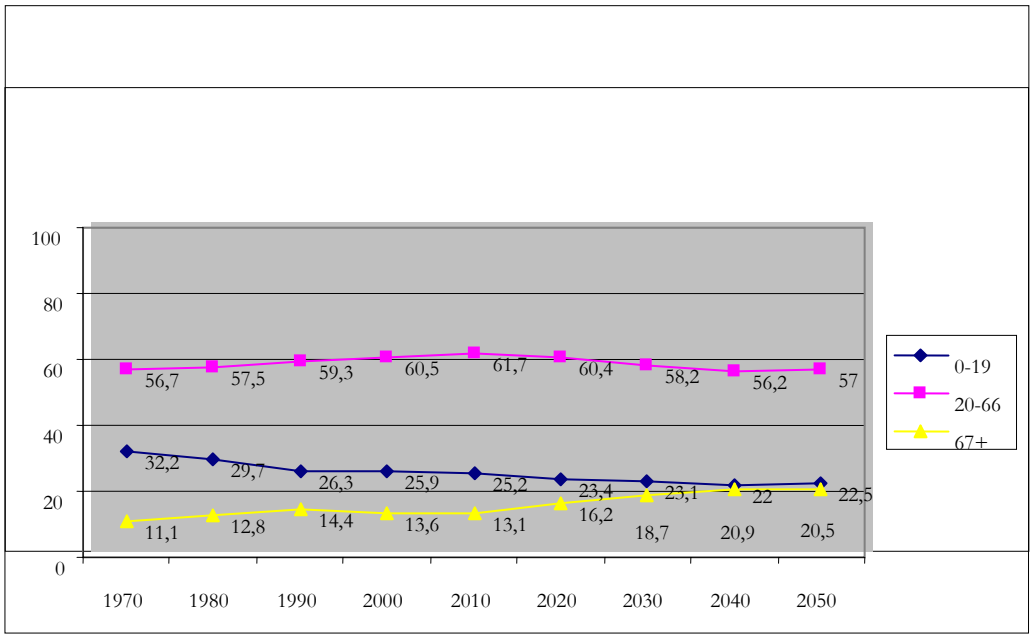


Source: Statistics Norway

Figure 4.

The projected life expectancy is strengthened by developments over the last ten years in which both males and females have increased their life expectancy to a high degree. In this period, the increases have been stronger than the average increase expected in any of the three projected alternatives (Report No. 8 (2004–2005) to the Storting).

With a higher life expectancy, the share of the elderly in the population has, and will continue to increase, as illustrated in figure 3.

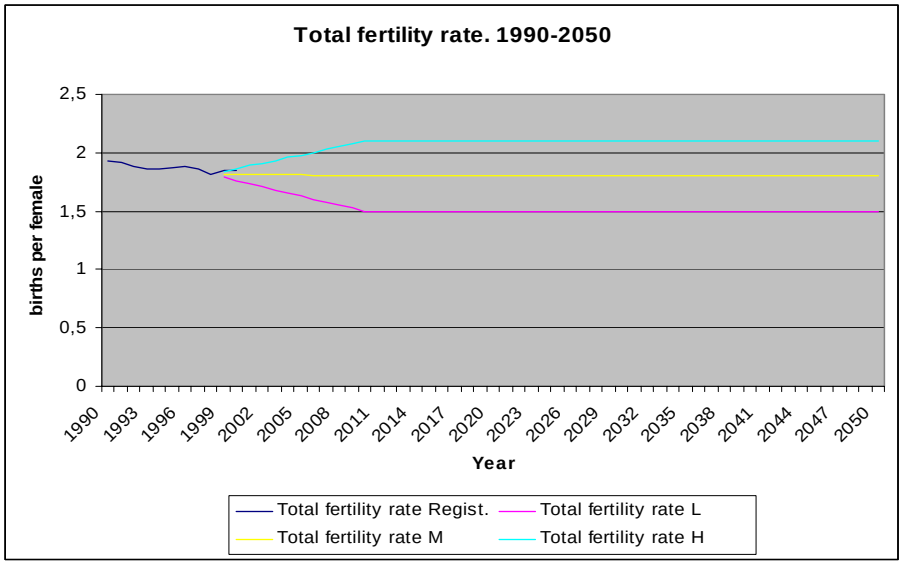


Source: NOU 2000:27, p.34.

Figure 5 Population projections among different age groups, 1970–2050. Percent

Figure 5 illustrates that the share of persons aged 67 and over will increase from 11,1 per cent in 1970 to 22,5 per cent in 2050.

Over the last decades, the fertility rate has fallen in most of the western world. This trend is due to changes in the structure of the society and familial patterns. Currently, the fertility rate in Norway is high compared to the other OECD countries; some decades ago the opposite was the case, however. The explanation for this is two-fold. Norway integrated women in the labour market early on, and this is one of the reasons for the decline in the fertility rate (from 4,4 in 1900 to 2,5 in 1950 to 1,8 in 2003). The reason why Norwegian females still have a high birth rate, compared to other OECD countries is due to the generous welfare states benefits that make it possible to combine family life with participation in the labour market for females/parents. In the projected fertility rates illustrated in figure 6, the middle alternative expects a constant fertility rate at 1,8, which is the same average as in the 1980 period.



Source: Statistics Norway

Figure 6 Total fertility rate. 1990–2050

In alternative H, the fertility rate is projected more optimistically and increases to 2,2 per female in 2050. This rate is higher than the rate necessary to keep the population constant in the future, which is 2,1 per female (when immigration and emigration are ignored). The lowest fertility alternative is 1, 5 in 1950 (not included here; 1,3 in 2060, according to the Report No. 8 (2004–2005) to the Storting, p. 43). This would be close to the level in the OECD countries with the lowest fertility rates.

Health Status

The Norwegian population has good health and its health status is improving. However, the improvement is slower than before and many comparable countries have passed Norway since 1970. While Norway was ranked first for women and third for men in life expectancy among OECD countries in 1970, in 1999 men was ranked eight and women ninth. Today, a woman in Norway can expect live until the age of 81.4; a man until the age of 76 (Report No. 16 (2002–2003) to the Storting).

In the beginning of the century, every tenth child died before one year of age and every second death was due to infectious disease or epidemics, hunger or poverty. Due to a rise in prosperity, lifestyle diseases like cancer, cardiovascular diseases, pulmonary diseases and type II diabetes have increased. The new millennium is characterized by disorders caused by obesity, physical passivity and discontent. Currently, health problems like heart disease are gradually challenged by depression and chronic pain.

As the following tables illustrate, the overall population reports their health as good or very good. Only a small minority reports very bad or bad health condition.

Table 1 Reported Health by age. Males. Percent

Age	Total	16–24	25–44	45–66	67–79	80+
Very good/good	83	94	87	79	72	64
Very bad/bad	5	1	3	7	7	13
Long duration sickness	55	38	47	60	76	87
Sickness strongly influencing daily life	9	5	8	12	10	15
Sickness to some degree influencing daily life	17	10	16	17	24	28

Source: Statistics Norway

Males report good health in all age groups but the proportion decreases by age; the variation is from 94 percent in very good or good health in the 16–24 age groups to 64 percent among those aged 80 and above. The youngest age group, 16–24, reports almost a complete absence of bad health. The same is the case in the 25–44 age group, where 3 percent report bad health. Only 7 percent in the 45–79 age group reports bad health, and 13 percent report the same among the 80+ age group . The share of chronic diseases is remarkably higher among the oldest age groups: 87 percent of those aged 80+ report chronic diseases, but only 15 percent report that the disease influences their daily life to a great extent. Thirty-eight percent of the youngest age group reports chronic diseases, and 5 percent are influenced by diseases in their daily life.

Table 2 Reported health by age. Females. Percent

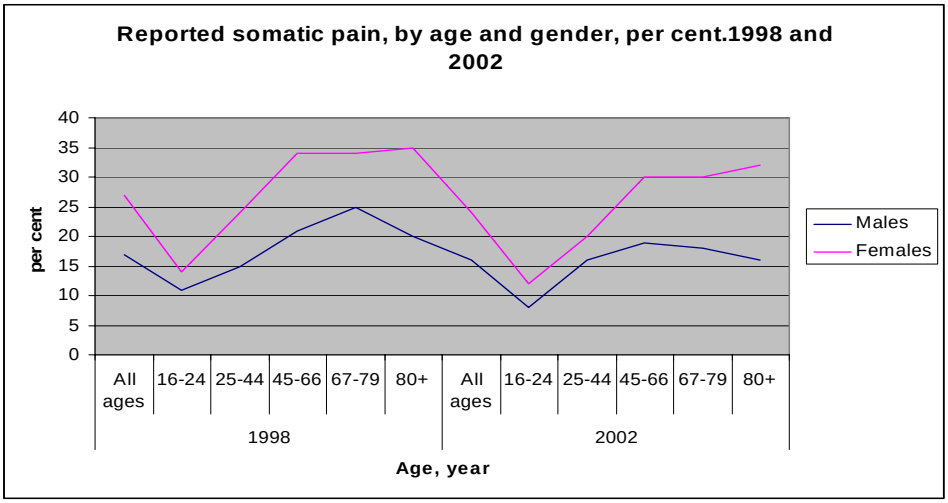
Age	Total	16–24	25–44	45–66	67–79	80+
Very good/good	77	90	88	72	62	49
Very bad/bad	8	1	4	10	13	26
Long duration sickness	62	44	50	72	78	81
Sickness strongly influencing daily life	13	6	9	17	18	23
Sickness to some degree influencing daily life	21	15	18	24	26	

Source: Statistics Norway

There are obviously differences among the sexes when it comes to reported health. Females report worse health than males. There are differences between the sexes in all age groups but is clearest in the 80+ age group, where 64 percent of males report very good or good health compared to 49 percent of females. Females also report sickness strongly affecting their daily life to a greater degree than do males. However, when it comes to chronic diseases, old aged males have the highest score with 87percent compared to 81 percent among females.

The tables accordingly illustrates that despite the fact that four out of five people report good or very good health, more people live with chronic health problems. One out of three says they have illnesses or are affected by conditions that affect their everyday lives. One out of eight has problems that seriously affect their lives.

Increasing by age, many people live with somatic pain. Thirty percent of females reports somatic pain by the age of 45, compared to 20 percent of males. For both sexes, the rates of somatic pain decreased between 1998–2002, as illustrated in figure 7.



Source: The National Institute for Public Health.

Figure 7 Reported somatic pain by age and gender, percent. 1998 and 2002

Not included in the above tables, there has also been an increase in both physical and mental problems. One in every fifth or sixth young person complains of life problems that affect their ability to function, and every tenth person has such serious problems that they need professional help and assistance. Fifteen percent of males aged 80 and above reports health problems affecting their ability to function compared to 5 percent of younger males. Among females, the difference is 23 percent and 6 percent respectively (Report No. 16 (2002–2003) to the Storting).

Research *on Analysis of Age Specific Level of Functions* in Norway concurs with the international trend in a decreased function shortage among the elderly. The following table illustrates the share of elderly persons characterised by shortages in managing daily functions (ADL) such as personal hygiene, dressing], eating, getting up and going to bed, taking a bath and going to the toilet and IADL functions as cooking, shopping, personal economy, telephone calling, easy housework and cleaning.

Table 3 Share of elderly by (I)ADL shortage, per cent

Age	1985	1987	1991	1995	1998	2002
67–79	28,1	26,7	25,3	23,9	23,2	18,2
80+	58,1	60	57,6	55,0	48,8	52,8
67+	35,5	34,6	33,9	33,0	29,0	28,7

Source: Botten and Hagen (2004).

Functioning ability has considerably increased since 1985, especially for persons between 67 and 79 years where the share of function shortage has been reduced by 10 percent. This analysis does not tell us anything about cognitive function (dementia), however. An evaluation from 2003 concluded that dementia was the reason for the demand for services among 20.9 percent of the elderly. Among elderly people living in institutions 42,2 percent have a diagnosis of dementia (Romøren 2003).

Health inequalities

Although on average the health status in Norway is improving, the differences among social groups are growing. The established principle of equal accessibility to health care and services independent of geography, economy, and gender and the like is still not a reality. Instead of erasing the social differences, the differences are stronger than ever before. Education, gender, civil status and income are of importance for life expectancy. A study covering the periods 1970–77, 1980–87 and 1990–97 concludes that the health differences among social groups, as measured by death rates, have increased during the 30 years periods (Zahl et al 2003). Most of the groups have improved health but the strength of the improvement varies between social groups. Thus, the differences have increased between groups. Despite the fact that differences among the sexes has have been reduced, the differences between males and females are still obvious in that males have death rate 2.5 times higher than females. Income is important in influencing the death rate: high income means lower death rates. The difference between the low- and the high-income groups has increased during this period. While there has been a clear reduction in the death rate among the high-income groups, this is not the case for the low-income groups. Education is also important for affecting the death rate. Since the 1990s, income is becoming a more important factor. Education and income are far more important for males' health than for females.

The variable of strongest importance is civil status. The change in family patterns means an increase in single persons. This development explains much of the inequality in health status. Males with low education and females with high education are overrepresented in the singles group. The importance of income in the 1990s could be explained by an increased movement of groups with high death rates, like single people, into the low-income group.

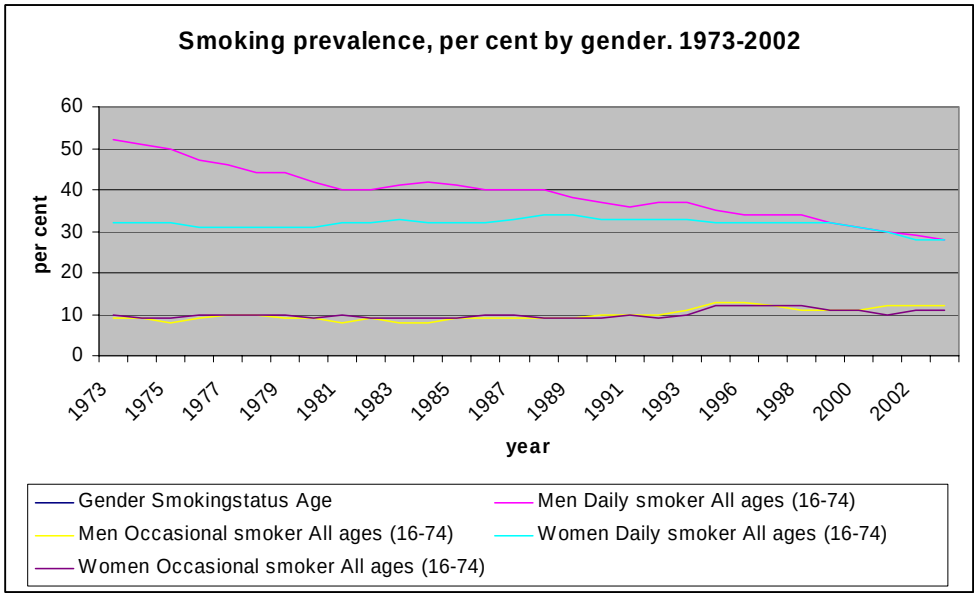
Following this, well-educated women with high-incomes who are married or living in partnerships have the best chances for longevity. The socio-economic disparities in

health have also grown, which may be explained by a less favourable health trend among people living alone. An increasing proportion of the population lives alone: in 1980, 12 percent lived alone; in 1995, 18 percent and in 2002, 22 percent. Moreover, single status increases by age, with 46 percent of those aged 67 and above living alone. Women are most likely to live alone due to the fact that women live longer than men.

Health Risks

Health risk factors are connected to health trends in the Norwegian population. The authorities point to lifestyle diseases as the greatest current health risks. The World Health Report 2002 identifies five risk factors that cause one-third of all the disease burden in industrialised countries: *tobacco, alcohol, blood pressure, cholesterol and obesity*. The Norwegian challenges are in line with these findings.

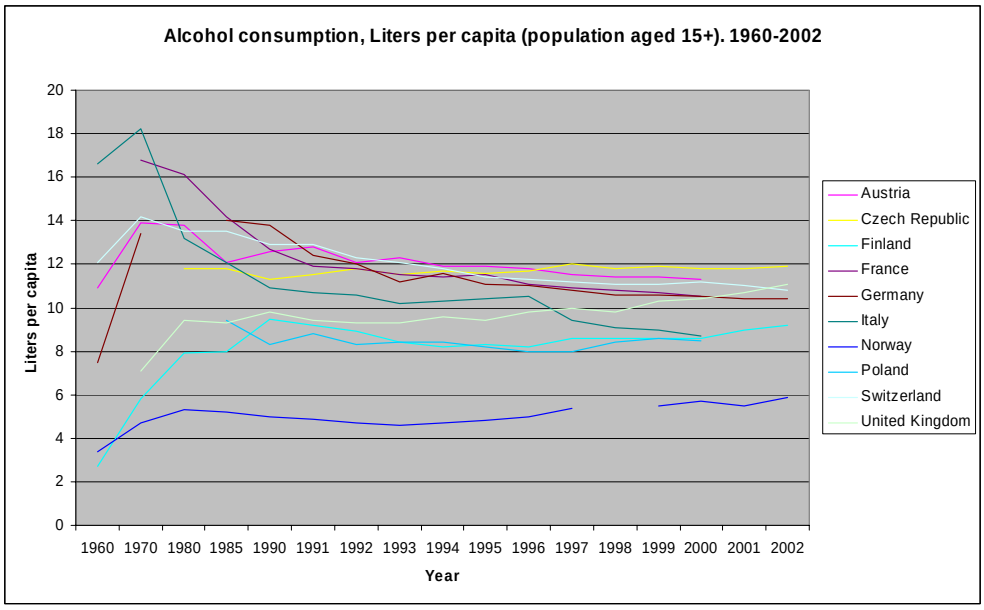
Physical inactivity has lead to increased weight, i.e., the weight of 40-year-old men has increased by 9.1 kg over the past thirty years. At the same time, surveys show that more than half of the population suffers from day-to-day physical activity that is too low. Level of activity is connected to education and income. Persons with high education/income exercise far more than persons with low education/income. When it comes to age, surveys show that children and young people are less active than before. Moreover, the average weight of children and young people is increasing. In addition, surveys conclude that elderly people are physically active. In the 55–75 age group, 86 percent are physically active regularly; in the 70–75 age group, 81 percent are regularly active. Another risk factor is Norwegians' *eating habits*. Even though the diet has become leaner and the consumption of fruit and vegetables has increased, the eating habits of a large part of the population has not changed. They still consume too much fat, sugar, salt and alcohol instead of fruit, vegetables and fish. The third risk factor is *smoking*. About 1, 1 million persons smoke daily, constituting about 30 percent of the adult population in Norway. In addition, about 400.000 people smoke occasionally. Smokers are divided similarly between men and women, but percentage of men who smoke daily has fallen steeply since the 1970s while the percentage of women has remained stable.



Source: The National Institute of Public Health.

Figure 8 Smoking prevalence by gender. Percent. 1973–2002

Lastly, risks factors such as alcohol and drugs are consumed less in Norway than in other European countries. Table 9 illustrates alcohol consumption in selected OECD countries.



Source: OECD Health Data 2004

Figure 9 Alcohol consumption 1960–2002 in selected OECD countries

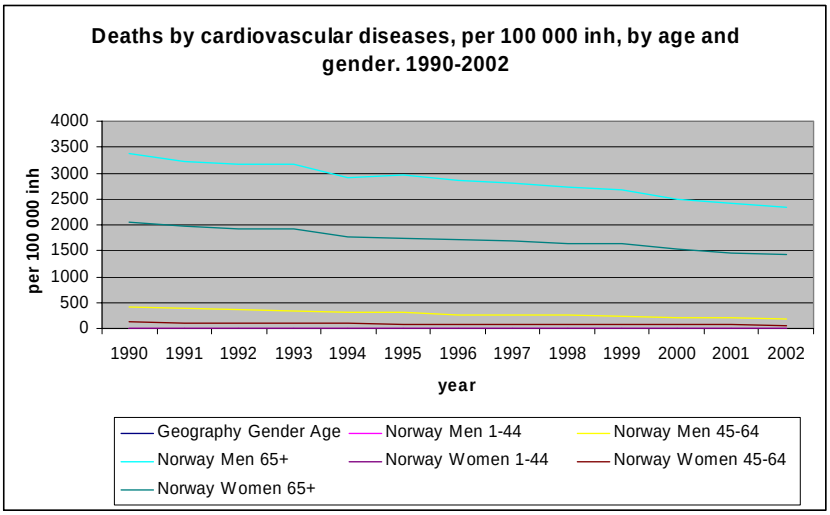
The Norwegian consumption of alcohol is the lowest among the represented countries in the figure with a rate of 5,8 litres, which is only half of the consumption in Czeck Republic, which tops the list in this figure. Also, the other Nordic country in this figure, Finland, consumes remarkably more alcohol than Norway, averaging 9,2 litres. Despite relatively low alcohol consumption, the Norwegian drinking culture results in accidents and violence due to high alcohol intake and drinking patterns. From the 1980s – the end of the 1990s, total consumption has risen, as well as the use of narcotics. Over the last ten years, there has been an increase in the use of drugs and alcohol among young people and several campaigns to change this behaviour have not been successful.

During the period of 1993–2000, alcohol consumption increased by 20 percent (Strand 2003). Males consumed] double the amount of alcohol compared to females. Males and females with high income consumed more alcohol than others. Among females aged 60 and above, 30 percent did not use alcohol at all, whereas 17 percent of men in the same age bracket are total abstainers. Comparatively, total abstainers constitute only one-third of other age groups.

Lifestyle and physical health are not the only challenges and risks in health care. In Norway, as in the rest of the world, mental health represents a great new challenge. In 2001, WHO reported that mental and neurological disorders was responsible for twelve percent of all lost years of full functional capacity and will represent 15 percent of the disease burden by 2020.

Causes of death

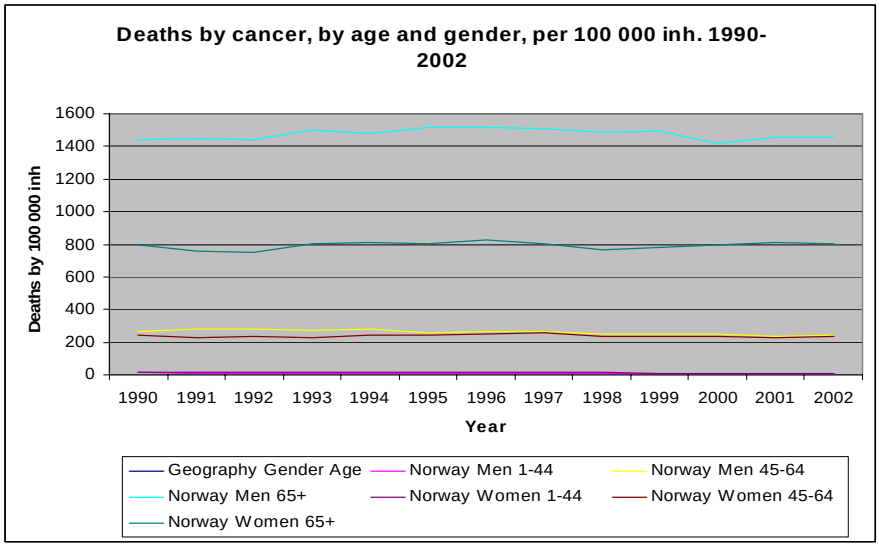
Cardiovascular disease is the leading cause of death for both men and women, followed secondly by cancer.



Source: The National Institute of Public Health.

Figure 10 Deaths by cardiovascular diseases, per 100 000 inhabitants, by age and gender. 1990–2002

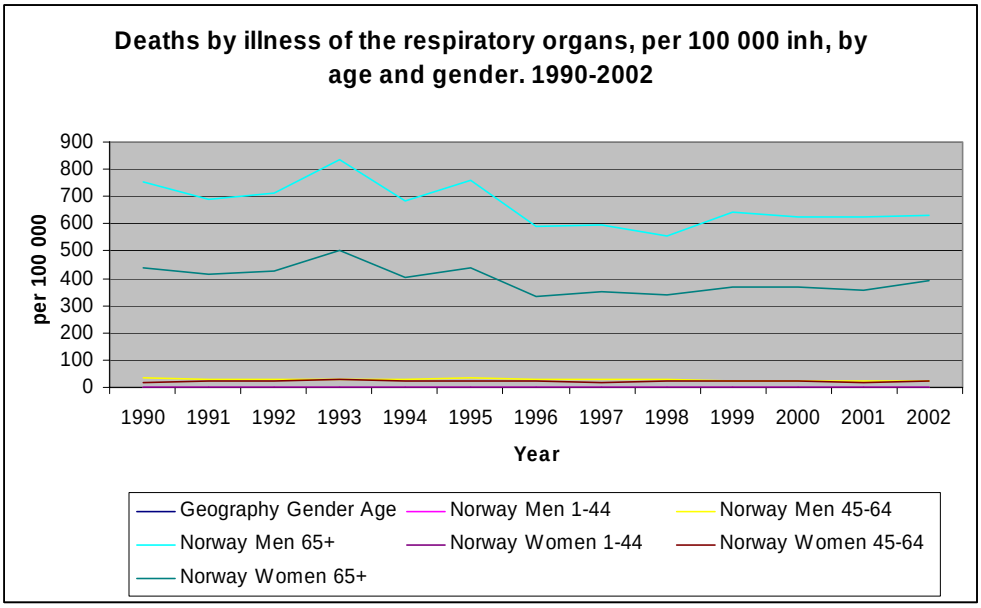
While the mortality rate for cardiovascular disease has fallen, the mortality rate for cancer remained stable in the 1990s. In 1955, 7,500 cases of cancer were registered, compared to more than 21, 000 yearly in the 1990s.This increase can be explained by the increasing elderly population.



Source: The National Institute for Public Health.

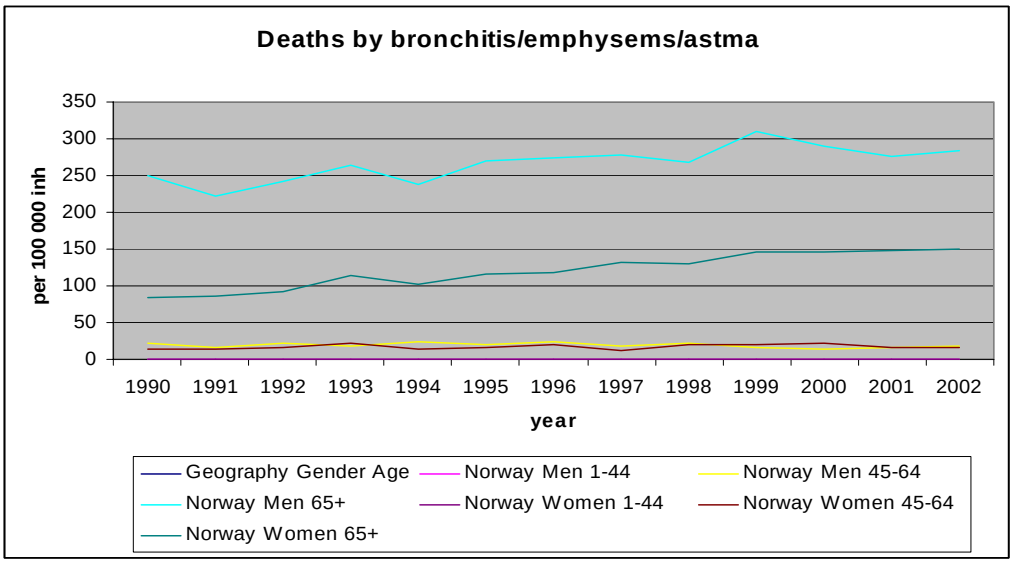
Figure 11 Deaths by cancer, per 100 000 inhabitants, by age and gender. 1990–2002

The third most common cause of death is chronic respiratory diseases, which strike 6 percent of the population.



Source: The National Insitute of Public Health.

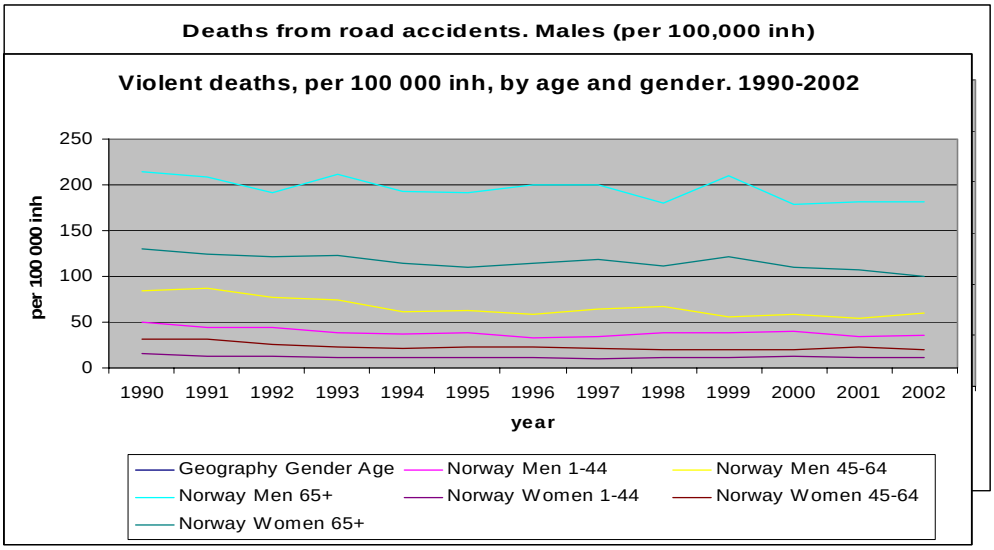
Figure 12 Deaths by illness of the respiratory organs by gender and age, per 100 000 inhabitants. 1990–2002



Source: The National Institute of Public Health.

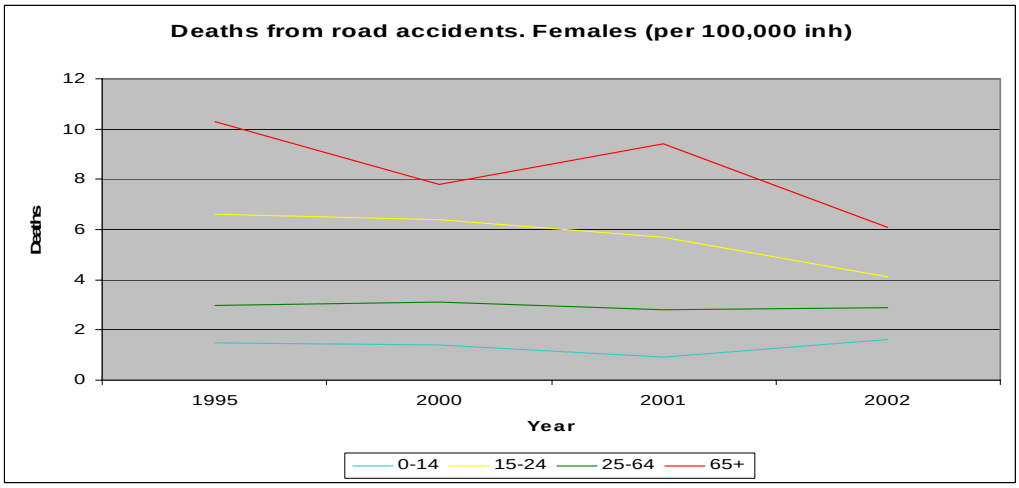
Figure 13 Deaths by bronchitis/emphysema]/asthma, by age and gender per 100 00 inhabitants. 1990–2002

Accidents and injuries are the fourth most common cause of death. Even though the number of people losing their lives in accidents has decreased, persons admitted to hospital with accidental injuries increased.



Source: Statistics Norway

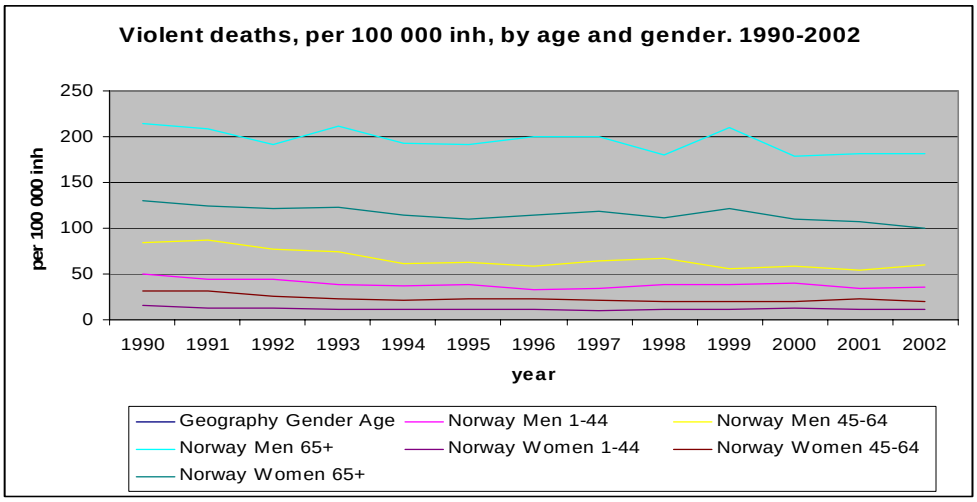
Figure 14 Deaths from road accidents, Males per 100 000 inhabitants. 1995–2002



Source: Statistics Norway

Figure 15 Deaths by road accidents. Females per 100 00 inhabitants. 1995–2002

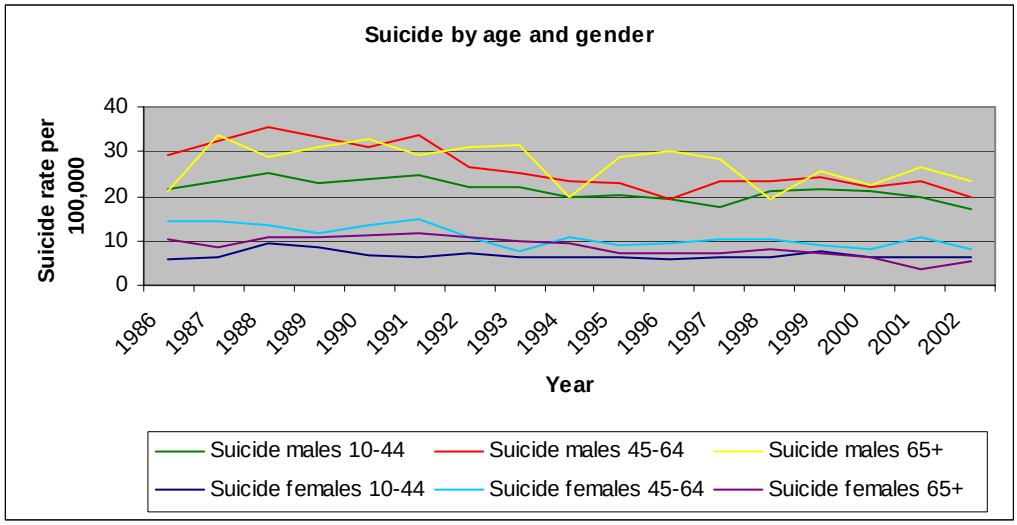
Since 1990, violent deaths (deaths by accidents/suicide/murder) show a small decrease. Males above the age of 65 have the highest rate of violent deaths, followed by females of the same age. In addition, males aged 45 to 64 have scores between 50 to 80 per 100 000 inhabitants. Other groups are impacted to a much lesser extent by violent death.



Source: The National Institute of Public Health.

Figure 16 Deaths by violence, by age and gender, per 100 000 inhabitants. 1990–2002

As illustrated in figure 15, deaths by suicide have decreased somewhat.



Source: Statistics Norway

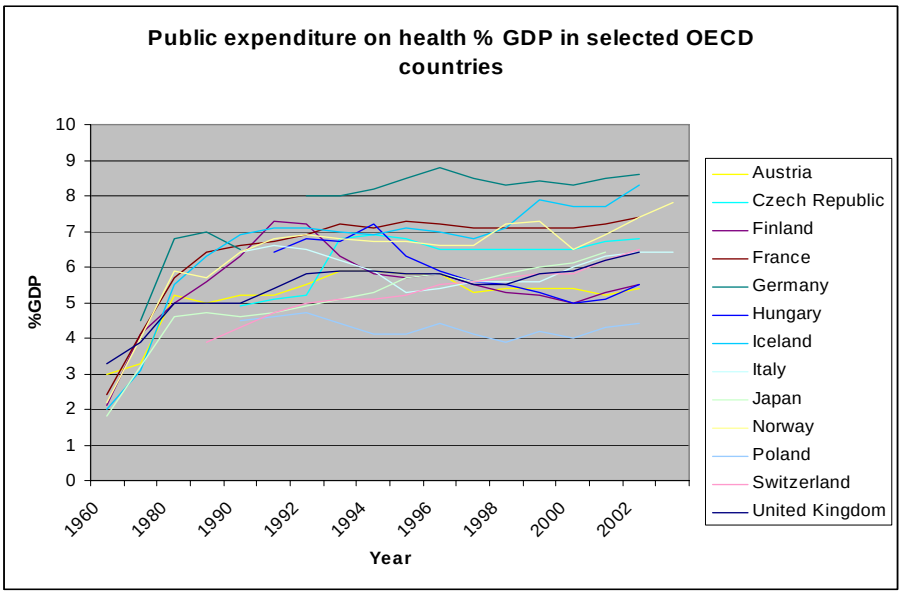
Figure 17 Deaths by suicide by age and gender, per 100 000 inhabitants. 1986–2002

From 1970 to the end of 1980, the suicide rate increased, whereas the rate decreased through the mid-1990s. Since 1996, the suicide rate again increased, especially among men aged 15–19 and 40–49. Males score radically higher in all age groups, and, at present, those aged 65 and older are the most inclined to commit suicide.

Health care organisation and expenditure

In line with the Norwegian welfare state model, the health care system is extensive and universal, based on social rights. The leading principle is equality and distribution of health care services independent of habitation and financial circumstances. The health service is divided into a primary and a specialist health service. The state finances and is responsible for the specialist health care, which includes, among other services, hospitals. The funding of the primary health services is divided between the state, municipalities and patients. The primary health services are organised as private practises but are regulated by municipalities and the National Insurance legal framework. Eighty-five percent of the total expenditures on health services are public, which is considerably higher than the EU average. Most of the hospitals and other kinds of institutions, like medical care institutions for the elderly, are owned and managed by public authorities bound to the legal framework of public services.

Norwegian health expenditures are among the highest in the OECD countries, but they do not top the list. Both Iceland and Germany spend more on health – 8,6 and 8,3 % GDP respectively – compared to Norway's 7,4 % GDP (this figure increased to 7,8 in 2003). For each of the countries, the increase was greatest from 1960 to the 1990s, but during the 1990s, expenditures stabilise or even decreased. Since 2000, expenditures again increased in most of the countries.



Source: OECD Health Data

Figure 18 Public expenditure on health in selected OECD countries

Compared to the EU's average expenditures (% GDP), public expenditures on health, education and care for the elderly are relatively high in Norway and Sweden. Whereas Norway and Sweden spend about 17 % GDP, the average in EU is between 12 and 13% GDP. The difference is even higher when it comes to public expenditures on care for the elderly, where education, gender, civil status and income are important factors affecting life expectancy. Norway and Sweden spend about 5 and 6 % GDP respectively, compared to the EU average of 1–2 % GDP (Report No. 8 (2004–2005) to the Storting, pp 65–66).

The health and care services represent 55 percent of the total public consumption in Norway, while kindergartens and primary schools account for 17 percent.

The Ministry of Health and Care Services holds the superior responsibility concerning health policy, public health, health care services and health legislation in Norway.

The Ministry of Health consists of six different departments lead by a Director General:

- The Department of Public Health
- The Department of Health Services
- The Department of Hospital Ownership
- The Department of Health Legislation
- The Department of Administration
- The Department of Financial Affairs

The Ministry of Health and Care Services has the ultimate responsibility for providing the population with adequate health care services, including health promotion. First and foremost, the Ministry directs the health care services through a comprehensive legislation, annual budgetary allocations (approaching 90 billion N.Kr. in 2004), and through governmental institutions, enterprises and establishments.

The ministry's website presents its' central tasks areas as follows:

'The public health endeavours aspire to contribute to the promotion of prolonged healthy lives of the population with reduced risk for contracting disease, and reduced social inequality as health is concerned. The prevention of the use of tobacco and enhanced physical activity are vital fields of endeavour in order to improve the general health status of the population. Furthermore, the Ministry of Health and Care Services is responsible for contributing to the realisation of a healthy and wholesome nutrition and to secure safe food.

The Primary Health Care System in the municipalities has the task to secure adequate and efficient medical treatment where people live and stay. Together with Emergency Clinics

and Mother and Child Clinics the Regular General Practitioners constitute a vital component in this service.

The Specialist Services, including hospitals, out patient clinics, ambulance services etc., primarily offer the population specialised medical treatment. The specialised health care services are organised through five Regional Health Authorities owned by the State through the Ministry of Health. The Regional Health Authorities are responsible for providing specialised health care to the population either through health care enterprises owned by the Regional Health Authority or through a contract with private service providers.

The Public Dental Service is a public service for certain groups of the population, whereas the majority of the population is obliged to pay for these services themselves. The Public Dental Service is, however, responsible for securing an equal accessibility to dental services to all age groups and within all parts of the country.

Support to Persons suffering from Psychiatric Disorders is given partly through the primary- and partly through the specialist health care services; and also through municipal and voluntary services not included in the health care system. Since the end of the 1990s psychiatric health has been a field of endeavour, and it is being followed up by the so-called "Escalation Plan for Psychiatric Health".

Health Care Services to Drug Addicts have during the last years been built up as a supplement to the ordinary health care service. This comprises e.g. health services with a high accessibility and medical treatment supported by medication. On January 1st 2004 the responsibility for the specialised treatment service was handed over to the state owned Health Authorities.

Alternative Medical Treatment, such as Acupuncture and Homeopathy, is not part of the public health care service. There exists, however, an endeavour to promote the establishment of a public framework for this activity. A new act concerning alternative medical treatment and the establishment of a register of alternative practitioners are concrete manifestations of this endeavour.
Medicines must be easily accessible to the population. Through the so-called "Blue Prescription" arrangement, the National Insurance System grants financial support to patients with special needs.

The Pharmaceutical Service is private in Norway. The public health care system secures, however, a reliable and safe accessibility to medicines.

The use of *Biotechnology* is regulated through the Biotechnology Act and a number of supplementary acts. Legislation and ethical questions related to biotechnology are important components of the fields of responsibility of the Ministry of Health and Care Services'. (http://www.odin.no/hod/engelsk/ministry/about_ministry/bn.html).

The regional and local government are to a large extent responsible for health services. All citizens have the right to satisfactory health care that is accessible in their local communities. The table below presents a chronology of major health legislation since the 1980s.

Table 4 Major health legislation since 1984

1984	The Local Authority Health Care Act
1986	The Block Grant Act
1991	Increased Local Responsibility for the Mentally Disabled, Alcoholics and Drug Addicts
2001	The Family Doctor Act
2002	The Specialist Care Act: The State takes over the responsibility for specialist care from the counties
2002	The Hospital Reform Act: The State take[s] over the hospitals from the counties

Since the 1980s, the purpose of enabling counties and municipalities to take over service provision has been intensified. In 1986, a Block Grant financing system was introduced, giving municipalities the possibility of prioritising different types of services. Through this decentralized model, giving the municipalities autonomy to decide the level of service provision and the economic means to provide the services, the aim was to provide a more efficient service provision serving local needs better than a centralized model. In 1984, the Local Authority Health Care Act was passed which made local municipalities responsible for all primary health care. It defines the responsibilities of the primary health care and patient rights. Municipalities must organize and finance services for disease prevention and health promotion, diagnosis and treatment of illness, and rehabilitation. In 1991, the responsibility of local health care authorities was further strengthened, when care of the mentally disabled, alcoholics and drug addicts was added to their charge. Municipalities are obliged to allocate sufficient services to persons living or stay in the municipality. Municipalities play an important role in the provision and coordination of services for those with psychiatric problems.

To improve the situation characterised by a scarcity of resources, insufficient knowledge of needs and a lack of solutions, municipalities have been mandates to implement the legal rights of patients to make individual plans coordinating necessary services. Concerning primary care, a reform came into effect in 2001 that secured the rights of all patients to have a family doctor. Municipalities are also responsible for social services, including the provision of care for the elderly and the disabled, continuous care residences and nursing homes, social support and leisure activities, day-care centres, and social security benefits. Specialized care and hospitals had been the responsibility of the counties, but on 1 January 2002, the state took over the responsibility, and this part of health care is now organised in five health regions.

Health and working life

The overview of health status in Norway gives the impression of a healthy population at all ages. Thus, important preconditions to live an active life are fulfilled. However, there is still a mismatch between health and participation in the labour market. What worries the authorities is that despite better preconditions to continue working, the trend is to leave work earlier than before. Similarly, there has been a continuous increase in sick leave since the beginning of the 1990s. This trend is strongest among men aged 60–66 (Helgøy 2004). In addition, there is a clear correlation between age and days of sick leave so, with older persons up to the age of 67 absent more often than younger persons.

After decades in which the trend increased, sickness absences showed a marked decline from 8,1 percent in autumn 2003 to 6,5 percent in autumn 2004. Among men, the oldest age groups had the greatest decrease in sickness absences, and among the 60–64 year-olds, the decline was recorded at 2.1 percentage points. This pattern is also evident among women (http://www.ssb.no/english/subjects/06/02/sykefratot_en/main.html). The results are interesting, i.e., the almost 60 percent increase in sick leave between 1994 to 2001, which was a major drain on the budget (Wallin 2002). However, the reasons for the reversed trend – if it really is reversed – future developments and the long-term effects are highly uncertain.

Empirical findings point to at least three factors leading to early exit from the workforce: economic incentives, individual factors and contextual factors connected to the work place. There seems to be agreement on the connection between early retirement and economic factors even though experts emphasise different aspects of incentives. Furthermore, the type of connection to the labour market is important to the question of exiting the labour market. If the person has been a full time worker and has experienced unemployment, there is a stronger chance of using their right to exit by AFP (The Contractual Early Retirement Scheme). A survey of persons aged 62–66 asked why they still participated in the labour market. One in three respondents provided economic reasons, while one in five underscored the importance of interesting work tasks or the wish to be engaged in activity (Vaage 2003). The fact that well-educated persons, to a greater degree, prolong their working careers is in line with these findings. A study done by the research institute FAFO found that educational level has the largest impact on the decision to exit the workforce, and, moreover, it seems to reduce the chance of being worn out or hit by bad health, as characterises service providers and workers. On the other side, the jump factor, such as the wish for more leisure time, is more typical for the group of service providers and workers. Further, economic factors were not as important as expected and another finding was that firms challenged by working stock reduction contributed to early retirement (Midtsundstad 2002).

From the authorities' point of view, however, the most recognised conclusion seems to be the results stressing the importance of factors such as learning and receiving support and recognition from the employer. Accordingly, the main measure established

to prolong working careers, The Agreement on an Inclusive Working Life, is based on the employer's increased responsibility to accommodate and support employees to stay longer, to decrease sick leave and to include handicapped persons in the labour market. Table 9 illustrates new retirees in the 60–66 age group by branch of industry.

Table 5. New retirees in the 60–66 year age group within different early retirement schemes by the branch of industry they belonged to the year before retiring, numbers in %

Type of early pension scheme:	Disability	Special age limit/restructuring state	Special age limit municipality	AFP retirees
Branch:				
Agriculture, forestry, fishing and hunting	1,5	0,8	.	0,7
Oil and gas production	0,3	0	0,3	0,3
Industry and mining	10,2	1,7	0	22,9
Power and water supply	0,5	0,8	0	1,8
Building and construction	4,8	4	0,3	5,4
Trade, hotel and restaurants	12,4	0,4	2,1	10
Transport and Communications	5,5	9,8	0	6,8
Financial services	1,1	0,6	0,6	2,8
Business[-] based service provision and property	4,2	2,6	0	3,9
Public administration	5,9	44,6	1,2	9,2
Educational services	8,6	2,8	2,7	14,1
Healthcare- and social services	14,4	3,6	47	14,9
Other social- and personal services	2,6	2,6	1,8	2,9
Unknown	27,8	25,7	33,5	4,4
Total number of new retirees	7281	529	328	8239

Source: NOU 2004:1, Table 9.3., p. 175.

The table shows a remarkable difference between the branches. The health care and social services lead the disability pension trend with a 14,4 percent exit rate before the age of 67, followed by trade, hotel and restaurants (12,4 per cent) and industry and mining (10,2 per cent). The industry and mining branch is on the top of AFP retirees (22,9 per cent), as are the two main public services; health care and social services and educational services frequently use the voluntary AFP scheme at a rate of 14,9 and 14,1

percent respectively. It is also in these branches (namely industry and public services) where the AFP is strongly established. The special age limit in public administration is also reflected in/reflective of the high number of retirees in this branch (44, 6 per cent), and the low number of disability and AFP pensions.

Earlier reports on active ageing policies have pointed to the complex pattern of factors that determine retirement decisions of older workers. This implies measures encompassing economic incentives, work environment and health conditions. Even though the health status has improved for all ages it is still relevant to discussions of health and working life. Tables 1 and 2 (pp. 7 and 8), point to the fact that a large amount of the population lives with chronic health problems. Females are hit harder than males, and, moreover, the 45–66 and 67–79 age groups are almost similar when it comes to reported sickness that influences their daily life strongly or to some degree. The same pattern emerges when it comes to reported somatic pain affecting women over the age of 45. Lastly, the reported lack of functioning caused by mental problems affects every fifth or sixth young person. Such life problems, striking persons more or less over longer periods of their lives, might play an important role in people's ability to stay in the workforce. At the same time, these findings question the official picture of a healthy population.

As outlined in the reports on *Active Ageing and the Labour Market* (Helgøy 2004) and Active *Ageing and the European Pension System* (Ervik 2004), the authorities' answer to increased early exits and increased sick leave has been to tighten eligibility rules in the disability pension scheme during the 1990s. In addition, new rules governing sickness absenteeism came into force on the 1st of July 2004. As part of the Agreement on an Inclusive Working Life, the new rules require that the person on sick leave is to be in a work-related activity and that the employer has the responsibility to set up an action plan adapted to the employee in order to get him back to work as soon as possible. That means that if the doctor finds that sick leave is required, partial sick leave shall be the first option before active sick leave is considered. Both cases provide the opportunity for the employee to engage in work-related activities.

The current measures set up to prevent sick absence and exiting the workforce are designed to make both the employer and employees more responsible. Thus, the main arena for improvement is the working place. The Working Environment Act regulates Health, Environmental and Safety Activities (HES) in Enterprises. The Act puts an obligation on a different set of actors. First, *the employer* is responsible for ensuring that the working environment is in accordance with the Act (§ 14). Second, the employee is obligated to cooperate in implementing HES measures and to participate in the Safety work (§ 16). Third, *the Safety Representative* and the *Work Environment Committee,* regulated in Chapter III, § 25–27 and §23–25, is focused on all aspects of the working environment. Fourth, the *Occupational Health Service,* founded in The Working Environmental Act § 30, and in special instructions, is obliged in branches characterised by a working environment prone to develop diseases, damage and psychic strain. Individual treatment is not mandated in the Instruction, even though some enterprises still offer individual health care services. The Occupational Health Service should first and foremost be preventative by focusing on the system-wide level. Passed in 1991, and revised in 1996, Norway established regulations relating to Systematic Health, Environ-

mental and Safety Activities in Enterprises, and Internal Control Regulations (FOR 1996-12-06 nr 1127: Forskrift om systematisk helse-, miljø- og sikkerhetsarbeid i virksomheter, (Internkontrollforskriften)). The regulations require that all enterprises establish systems for the follow-up of HES in accordance with the legislation. The purpose of the regulation is the promotion of continuous improvements of and safety in working environments, protection of the environment from pollution and prevention of health damage or environmental disturbances. Lastly, the *Norwegian Labour Inspection Authority*, a governmental agency under the Ministry of Labour and Social Affairs, has administrative, supervisory and information responsibilities in accordance with the regulations.

The Occupational Health Care is an important implementer of the Agreement on an Inclusive Working Life, that was signed in October 2001. The agreement is in effect for four years, from 3 October until 31 December 2005. The aim was originally two-fold: First, to reduce sickness absences by 20 percent by the end of 2005 through an increased focus on rehabilitation and retraining. The second aim was to entice disability pensioners and older workers to participate in the labour market.

The main focus is on the company level and is based on the assumption that employers and employees in workplaces will cooperate closely to probe the reasons and find solutions for sick leave and absenteeism. Employers can make special arrangements with the National Insurance offices, including: a) easier access to activation during sickness leave; b) better guidance by the national insurance authorities; c) special reimbursement for occupational health care services; and d) extended possibilities for self-reported sickness absences.

In a study of firms‘ role in the active age policies, we asked about the Health Services offered in within various enterprises (see the outline of firm interviews in the WP 3 report, Ervik 2004) The interviews uncovered that seven of the eight firms included in the study had an Occupational Health Service as an important preventive measure. Depending on the character of the work, monitoring is made of high risk groups like painters and surface treatment workers, offshore workers, shift workers, parks workers and employees working with solvents. Some firms also have professionals that assess and improve special working situations. Another finding was the emphasis of health and training campaigns in the firms, including sponsored training during leisure time or physical training during working time. Anti-smoking campaigns were also taking place in the firms. The statement that it is a challenge to keep workers with reduced work capacity at work was valid in all of the firms, as reduced work capacity increased the danger of dropping out of work. Private firms identified the competitive of the firm as a main reason for dropping out, in addition to a lack of positions in which to place workers with reduced work capacity. The demands for productivity increases steadily and some firms' tradition of taking care of and integrating employees with different disabilities is increasingly difficult. Even though public firms are not competitive in markets, they realised 'you are not longer as safe as before'. Thus, all firms, including public organisations, etc. seem to be driven by economic cost considerations in their personnel policies towards the elderly and disabled. For some firms, this represents a shift in basic norms, from being a firm proud of taking care of workers with reduced capacity to realising barriers to continuing this. However, some firms were more open

to finding solutions than others, such as a public firm that hired a handicapped social therapist and a blind physiotherapist. As this firm described, 'disability is not a topic if you can perform the work tasks'. The question was how the working place could be adapted. Thus, some firms seem to look more at solutions than at barriers for the disabled. Nevertheless, due to efficiency demands adaptation of the work place must still secure a 100 percent work performance also for this group of workers.

Within a work-centred active ageing perspective, the working place is seen as crucial. How people fit into working life determines whether they are characterised as 'active' or 'passive'. The Occupational Health Care Service seems important as a preventive measure. However, measures at the firm level also have to encompass the wide spectrum of factors which are at play in decisions to exit or prolong the working career including incentives, the work environment and health measures both inside and outside of firms. In implementing a policy for seniors, the centrally determined intentions and cooperation between the partners, i.e. The Agreement on an Inclusive Working Life, have to be integrated at different levels and be reflected in the firms overall personnel policy. According to the firms, their established and permanent personnel policy before experiencing the increasing challenges facing senior workers is of great significance. A long-term strategy based on a value orientation and tradition of social responsibility for their employees and for societal development seems to be a precondition for implementing a successful policy for seniors.

Health care provisions and the elderly

Health seems to be occupying an increasingly important place in people's awareness and a more predominant place in the mass media. People react to illness different than before, lowering the threshold for seeking professional help. Growing old is recognised as a natural part of life to a lesser degree. There is an ever-increasing pressure on the use of health services and authorities link this trend to the fact that we define and handle diseases and disorders differently than the way we used to. Furthermore, authorities link this development to the breakdown of informal and social networks (Report No. 45 (2002–2003) to the Storting).

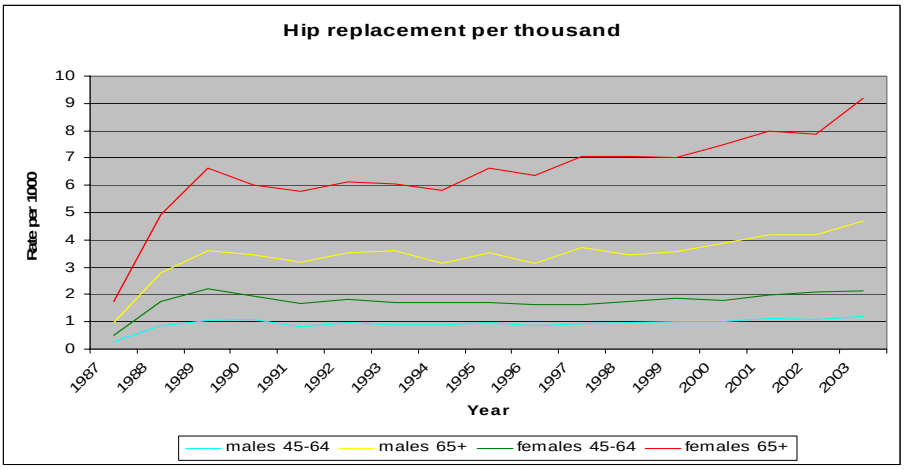
The trend of visiting a doctor has increased during the last few years. In 2002, respectively 71 percent of males and 78 percent of females contacted a doctor, which represents an increase of 3 percent for both sexes. The share of persons with more than five visits to their doctor increased from 9 percent to 13 percent for males and from 14 percent to 19 percent for females. 'Contact' includes both contact by telephone or in-person visit, even though the trend is toward in-person visits rather than telephone contact. In addition, the trend is to visit the doctor more often, paralleled by increasing age. From 1998 to 2002, the share of males visiting their doctor more than five times increased from 9 to 13 percent, and for females the number increased from 14 to 19 percent. After the 2001 reform in which every person in Norway is contracted to a family doctor, 98 percent of the population made such a contract in 2002 (Statistic Norway).

Table 6 Use of health services by age and sex, per cent. Source: Statistics Norway

	Total Males	Total Females	M 16–24	F 16–24	M 25–44	F 25–44	M 45–66	F 45–66	M 67–79	F 67–79	M 80+	F 80+
No family doctor	3	1	5	2	5	2	2	0	-	1	-	4
Easily access to their family doctor	77	83	73	72	73	83	81	85	83	84	81	94
Contact Primary doctor	71	78	65	75	67	73	74	82	83	84	80	78
Cont. Specialist (inside/out-side h)	35	45	25	30	29	38	40	50	47	62	54	46
Contact primary doctor/f.d. (last 14 days per 100 pers)	16,3	21,7	11,6	16,0	15,9	23,3	17,5	24,2	19,5	17,7	15,9	20,5
Contact specialist inside/out-side h (last 12 m per 100)	73,7	88,5	45,2	58,4	59,4	78,4	87,7	100,4	101,7	118,6	111,6	82,5
Five or more contact primary doct. last 12 months	13	19	7	13	10	15	16	22	16	21	23	29
Cont. psychologist or psychiatrist last 12 months	3	4	5	7	4	5	2	4	1	1	1	-
Cont. phy.[therapy /chiropracti cs last 12 m	19	25	12	15	20	24	21	31	19	24	12	25
Alternative treatm. Last 12 months	6	12	5	8	6	14	6	15	4	5	5	1
In hosp. last 12 m	11	14	7	11	8	16	12	11	15	14	21	25
In psych. H. l 12 m	0,5	0,5	0,8	0,4	0,7	0,5	0,3	0,3	-	1,4	1,1	0,8
Waiting for hospital/ pol.hosp	5	6	3	3	5	4	6	6	6	12	5	4
Waiting 30 days+	3	4	2	3	3	3	4	4	4	7	2	3

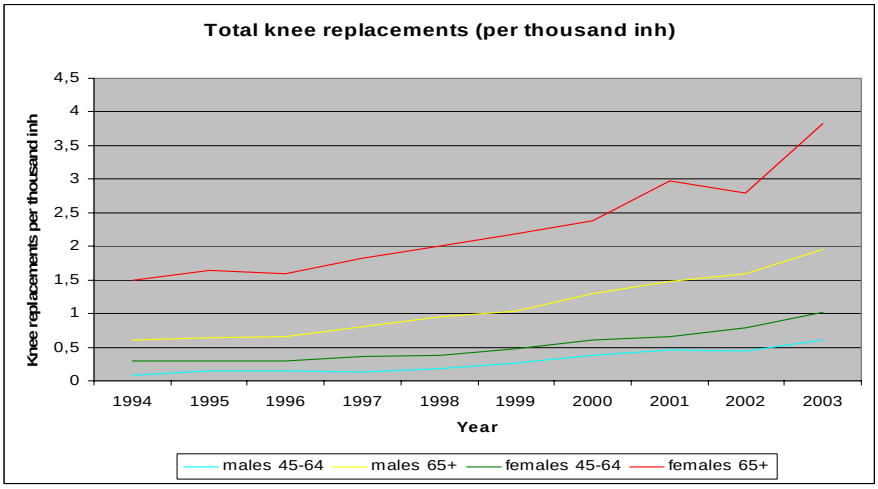
According to table 4, approximately 40 percent of the population has contact with the specialist medical service, compared to about 75 percent that has contact with primary doctors. There are some gender differences in these figures, as more females seem to contact the medical services, including both the primary and specialist health care. Females also tend to visit their doctor more often than males, a trend in accordance with findings from the expert interviews.

Health care capacity has increased radically. According to the expert interviews, waiting lists have largely decreased for procedures such as hip replacements, knee operations and cataract operations, which are of great importance for the daily functions of the elderly and the possibilities for them to live an active life.



Source: The national Register for Joint Prosthesis, The Region Vest Health Authority.

Figure 19 Hip replacements by age and gender per thousand inhabitants



Source: The National Register for Joint Prosthesis, The Region Vest Health Authority.

Figure 20 Total knee replacements. By age and gender per thousand inhabitants

The care service for the elderly and disabled in the municipalities makes up almost half of the total health care services in Norway. Concerning the elderly, the nurse and care services focus on citizens' right to diagnosis and treatment of diseases, injury and default, medical habilitation and rehabilitation, and nursing care. General practitioner services, physiotherapist services, nursing and home nurse services and institutions or 24-hour nursing and care are allocated by the municipalities. A 1990 court decision held that municipalities' economic situations can not be used to justify services that do not satisfy vital needs for nursing and care. The Social Service Act (§ 4–3) instructs municipalities to grant practical or personal services to those who cannot manage daily life or care for themselves or are totally dependent on practical help. The Act also provides for assistance for those who need other forms of assistance (circular 1-1-93, page 104). These services include practical assistance and training, relief measures, support personnel, placement in facilities with 24-hour service and wages provided to those who have strong burdens of private care for others (§ 4–2, a to e).

The care service in the municipalities is more extensive than the hospital sector, employing 95 000 employees compared to 63 000 employees in somatic hospitals. Twenty-five percent of users are less than age 67 but receive about 50 percent of the total provided. Even though private care exists, public care for the elderly is manifested as an established responsibility. Almost every old person is in contact with municipal care services: 9 of 10 persons over the age of 90 live in institutions or receive home services while 2 of 3 persons between the ages of 85–89 do the same (Breivik 2004).

Policies affecting older people and 'active ageing'

In the last decade, the aspiration of health care policy in Norway has been to include all groups in a general service model. This means we do not find special services reserved for the elderly due to the ideal of equal treatment of all patient groups.
Health policy has, in the last years, focused on efficiency, quality of services and a strengthening of patients' rights. The Patients Right Act, the Psychiatrist Care Act and the Specialised Health Care Act, all implemented on 1 Jan. 2001, highlight the value of placing patients first. This was also reiterated through the passage of the Primary Care Act of 2001, which provided for a family doctor for all citizens.

Lately, the focus in public health care policy is connected to three main areas: mental health, chronic diseases and a preventative focus on improving our lifestyle. Authorities have implemented the *Escalation Plan for Mental Health* (1999–2006) to promote mental health as a priority area, both in the health sector and in other social sectors. Relying on the understanding that mental problems are caused by a complex interaction of biological, psychological and social factors, the focus is on follow-up services and treatment and not only on preventing mental problems and disorders. As will be outlined below, implementation has failed, which also affects the service for the elderly.

Prioritising chronic diseases has so far been insufficient when it comes to implementation of the intentions in the public health care. As illustrated previously, the

number of patients with chronic pain is decreasing. However, according to the expert interviews, acute medicine will always displace patients with chronic pain.

The White Paper, *Prescriptions for a Healthier Norway* (Report No. 16 (2002–2003) to the Storting), presents what is called "*A broad policy for public health"*. The main recommendation of the policy is to make the individual more responsible for his/her health and to prevent diseases through lifestyle changes. The four prescriptions for a healthier Norway in the White Paper are to: 1. Make it easier for people to take responsibility for their own health; 2. Build alliances to promote public health; 3. Encourage more prevention and fewer cures in the health service; 4. Build up new knowledge.

From the perspective of active ageing, the main policy for the elderly has been labelled as *"The Action Plan for Elderly Care",* implemented from 1998 to 2001. The aim has been to improve service capacity and to offer new ways of living for the elderly. According to a White Paper (Report No. 50 (1996–1997) to the Storting), the aims can be identified as follows:

- Securing satisfactory nurse and care services adapted to individual needs
- Strengthening the capacity and quality of services
- Developing more complete and flexible services
- Ensuring equality independent of geography, income and resources
- Increase [Increasing] user-participation and individual choices in the daily care

The capacity improved by 12 000 employees between 1998 to 2001. Whereas the staff increase was 2 600 per year before implementation of the Action Plan, the increase during the plan period was 3 200 per year (Romøren 2003). Another purpose has been to change the housing policy by offering different forms of housing for the elderly. Since 1950, the only possibility for the elderly not able to live alone at home had been institutions for the elderly (aldershjem). The new direction has been to offer medical treatment in institutions by establishing nursing homes for the elderly (sykehjem). The other direction in elder care has been to build smaller flats on behalf of the elderly institutions for persons not in need of medical treatment. Thus, institutions for the elderly have declined from 10 741 places in 1994 to 5240 in 2001 (the prognosis for 2005 is 3 100 places). Instead, care residents have increased radically, from 5 350 places in 1997 to 16 150 places in 2001 (the prognosis for 2005 is 26 000 places) (White Paper, St. meld. nr. 45 (2002–2003)). Accordingly, the trend has been to reduce institutions but to secure institution places for those elderly in need of medical treatment, especially in cases of dementia. Part of the action plan has includes securing the right of the elderly to live in single rooms at institutions. The other trend is to build adapted, homelike care residences for the elderly. The following tables illustrates the development in recipients of home care compared to the number of elderly living in medical and elderly institutions.

Table 7 Recipients of home services 1992–2002. Number per year by age

Age/year	1992	1996	1997	2000	2002
Below 67	24 870	29 945	31 442	38 393	41 615
67–74	24 413	20 700	20 347	18 888	17 926
75–79	28 758	26 625	26 966	26 358	24 782
80–84	34 613	32 621	33 342	35 524	35 623
85–89	22 530	24 498	25 024	27 677	28 342
90+	9 854	10 376	10 533	12 829	13 710
Total	146 272	144 765	149 026	159 669	161 998

Source Statistics Norway

The most evident increase in home care recipients is among persons below the age of 67. The explanation is a 1991 reform that made municipalities responsible for the care of the mentally disabled. Other disabled people below the age of 67 also fall within this category. Persons between 67 and 80 have decreased their reliance on home services, whereas persons above 80, and especially those above 85, have increased their use of home services.

Table 8 Persons in institutions for the elderly and handicapped. Share per year by age

Age/year	1992	1996	1997	2000	2002
Below 67	1 804	1 576	1 586	1 598	1 722
67–74	4 202	3 617	3 566	3 194	2 973
75–79	6 377	6 172	6 199	5 896	5 534
80–84	10 749	9 998	10 096	10 001	9 938
85–89	12 058	11 268	11 351	11 469	11 398
90+	10 381	9 794	9 644	10 007	10 128
Total	45 571	45 075	42 236	42 236	41 693

Source: Statistic Norway

Parallel to the increase in home services, the share of the elderly living in institutions has decreased. This tendency is similar across all age groups. The explanation seems to lie in the medicalisation and professionalisation of help in institutions on the one hand and the reorientation toward home services for other groups on the other. Still, the question remains whether the expansion in employed persons is enough to cover the expansion of housing places. The policy for nursing and care for the elderly seems to turn to issues of securing the efficiency and quality of services. This aim was the reason for the first

national evaluation of the nursing and care service carried out by the Norwegian Board of Health and the research institute NOVA (Helsetilsynet 2003).

The evaluation showed that there seems to be a sharp division between those living in institutions and those living in their own houses or in different kinds of subsidised housing owned by municipalities. Elderly persons living in institutions have greatly reduced physical and mental capacities and are placed in institutions permanently, while elderly people living outside institutions are in need of help to a lesser degree. Of those living in institutions, 42,2 per cent have the diagnosis of dementia, which is the primary reason for being placed in institutions. The need for services for those receiving help at home has several causes, even though their need for help is more limited. Psychiatric diseases are a common reason for services, impacting 14,3 of those living in adjusted houses, 18,3 of those living in municipality-owned houses and 12,9 of those living in their own houses.

Understanding the Active Ageing concept

The Norwegian health care policy for older people has so far not promoted the concept of active ageing directly. Nevertheless, the ideal seems to be implicit in the general health care policy. The health system has a capacity to treat all age groups, thereby promoting the precondition of activity for older people as well. The experts concur that active ageing is not an individual health problem in Norway. The challenges lie with the other levels.

The concept of active aging is not unknown to the experts. All the informants perceive the concept as more than a productive term, but rather one that points towards the ideal of "living as long as we are alive". Active age is conceptualised as the participation of older people to a greater extent in all of society's arenas. The idea is to integrate and prevent segregation among both the weakest and the strongest of the elderly. Active age is described as a cross-generational way of thinking, compared to the traditional pensioners' concept of the industrial society. Active age represents a way of thinking of older people as more than just recipients of pensions and health care services. Being an active older person prevents the development of a narrow senior identity.

The experts worry quite a bit about the tendency to segregate healthy and wealthy seniors while the weakest groups' lack possibilities to fit into the active ageing concept. Thus, the active ageing concept contains tensions because it aims to empower and integrate the weakest people on the one hand yet, on the other hand, it aims to decrease the strongest groups' tendency toward luxury-segregation. A typical apprehension is illustrated in the quotation below:

> 'I think the Norwegian concept of Active Ageing is linked to the European senior policy which emphasises several societal areas, expressing values and aims of elderly not resting in their own old age but to a stronger degree participating in all parts of the society. It is important to resist segregation! At least the luxury based segregation represented by those drawing back in their own wealth in ghettoes, senior cities, of older rich people' (Expert interview 2).

Further on, the experts expound active ageing for promoting policies focusing on individual mastery, whatever individuals' level of functioning. The effect of the opposite strategy, which includes taking over responsibility for a lot of individuals' daily functioning, leads to passivity and to further reliance on services. Belief in activity is connected to beliefs of its' positive effects on health, both mentally and physically, and on a more meaningful social life. Activity and individual responsibility become the medicine for the future.

Yet some find the concept problematic. The ideal of active ageing connected to health is not without tensions and internal opposition, according to some experts. What does it mean to be active? There are several possibilities; for example, to be an active grandfather, to take care of oneself without public service, to be productive in labour market or to be active in the voluntary sector.

The most critical informant points to the fact that active ageing is just another parallel to the ideal of youth far away from the reality of the elderly. The ideal of active age may lead to a feeling of double failure for those not able to fulfil the tenets of active ageing.

Sufficient services for the elderly to live an active life?

Concerning health care services, the expert interviews emphasise the increased capacity of the health care system. According to the experts, concerns about age and accessibility to health care services, such as different kinds of operations and the availability of primary health care, are not the most relevant questions to ask in connection with active ageing. The waiting lists for operations have to a great extent, been removed, i.e., for hip replacement and knee operations:

> 'I don't think that the problem lies in the health care system or in lack of capacities in health care. The queues for operations like hip and knee replacement are almost removed. Moreover, my opinion is that we carry out too many cataract operations! The health is not the barrier for active ageing, elderly are becoming healthier and healthier'. Instead we have to look at cultural and social factors as barriers in active ageing' (Expert interview 6)

However, the experts hold that a problem is the medical professions' lack of interest in dementia and geriatrics, in addition to chronic diseases. These cases are handed over from the specialists' service to municipalities, which suffer from a lack of competence:

> 'When it comes to the treatment of chronic diseases the health care is insufficient. The system is uncoordinated which means a lot of instances to handle one person. Instead of doing a deeper diagnostic assessment of the chronic and complex diseases, one condition is treated after the other one without seeing the person's diseases in connection. Some financial mechanisms are at play here, in addition to a lack of interest and competence in the geriatric specialisation' (Expert interview 6).

According to the experts, two areas of service are important for the elderly to live an active life. *Firstly*, to need to receive practical help in their daily life, wherever they live.

Secondly, the service should, to a greater extent, concentrate on measures to cover the need for a social life for older people, which is an important finding of the evaluation.
In the interviews, the experts focused on the fact that The Action Plan was an attempt to comply with the demographic changes and the differentiated needs among older people. The intent was to remove the typical big institutions of the 1950s and replace them with home-like buildings or 24-hour home services in order to enable the elderly to live at home as long as possible.

The evaluation concerns the quality of services and whether the elderly get the services they are supposed to in accordance with their rights and needs. On average, recipients receive 4,5 hours of practical assistance per week and 10 home care visits each. The duration of the visits is typically less than 15 minutes. Age, sex and functional level are of no importance to the amount of help received. Types of health problem and lifestyle are of importance, however. The mentally retarded get the most help, whereas those with psychiatric diseases are the most underserved. This group receives less help in all areas than other groups. Specifically, they have difficulties of orientation and problem solving in their daily lives, and they need help to perform social functions and with personal care (Romøren 2003).

Variation was also uncovered depending on where the elderly live. Those living outside institutions have similar needs for assistance. Despite this, it seems easier to access help if you live in subsidised municipality houses rather than in one's own house. The National Board of Health is doubtful that those living in their own houses are actually receiving the help they are entitled to. This group systematically receives less help than they need despite the fact that they should receive the same help independent of where they live. Based on this, we can ask iwhether the possibility to continue to live in one's own house is weakened.

In addition, the evaluation questions the need for more spots in institutions, especially short-time places to make services more flexible and to relieve the burden on caregivers and family members.

The experts question the availability of sufficient medical practitioners in nursing institutions, pointing to under-staffing in relation to the numbers of elderly in institutions who are in need of medical services.

Another evaluation asked the elderly about their views on public care services (Næss 2003). Elderly people ages 70 and older were asked to assess accommodations, their health condition, health care, social activities and contacts, security, quality of life, self-determination and overall satisfaction with a wide range of aspects connected to public welfare services. They were interviewed by nursing students at two points in time: in 1997 before the Action Plan was enacted and again in 2001 after it was implemented.

The costs of the Action Plan's provision to allocate 24-hour service has been huge: 24-hour service in one year demands 5,2 employees, compared to the former day and evening shifts, which demanded two employees each year. The question raised was whether the costs reflected better quality services. The findings were quite depressing: despite the huge costs, there is a clear indication that recipients' experiences were worse during the period after implementation of the programme. In addition, satisfaction with the services varied. Recipients were most satisfied by the level of self-determination and least satisfied by their ability to participate in activities in order to meet their social

needs. The negative experiences were expressed most strongly among groups with several or special needs. Thus, the aims of taking care of the weakest and strengthening equality among groups have not been achieved. The evaluation concludes that from the elderly's point of view, the Action Plan has failed when it comes to quality of the services. An important findings from this evaluation is that reforms in the public health care services can cannot be justified by arguments of security for the weakest, the ability to satisfy the majority or the principle of equality.

A consequence of the focus on nursing and care in services for older people is that the doctors' services are placed in the background. According to one of the informants, there is a shortage of doctors in nursing institutions, averaging one doctor per 125 patients. Thus, follow-up services for patients are thereby limited.

The focus on nursing and care could also be one of the reasons why the social aspects of the policy are absent. The evaluation finds that only 40 percent of recipients were offered sufficient social contact and activities. The experts also referred to this problem but point to the inadequate staffing and resource shortages to satisfy this need. Instead, they suggest cooperation with other sectors like the voluntary sector, the cultural sector, the transport sector and so on. We used to believe that the private network for the elderly plays a more incidental role than previously. This is not true, according to our informants. The volume of contact has remained steady but has changed in character. Family members have contact across the generations, but intimate services are provided by professionals. The elderly are not taken care of by their families but by professionals. The new form of living after the Action Plan might have promoted more contact. The expert informants point to the fact that more normalised homes are a better precondition to visit our elderly parents or grandparents.

The focus of the services

According to the experts' interviews, there is no doubt that the main focus in health care services for older people is on nursing and caring, at the expense of other service areas like basic medical treatment, social activities or practical help.

The evaluation of the 'Action Plan' concludes that there seems to be a tendency to prioritize medical and health problems instead of more practical problems. For instance, the evaluation indicates that those living in subsidised house that are most dependent on help receive less practical help than those with a lesser need for assistance. Instead, the most dependent recipients get nursing rather than practical help. The profile of help in these houses points in the direction of small institutions. The starting point for these houses was more autonomy for the elderly and the possibility to make decisions affecting their daily lives. Not all elderly are capable of taking responsibility for themselves or influencing and participating in decisions about their daily lives. Accordingly, both the profile of medical help and the lack of possibilities to be an active partner in decisions reduces the ability for active contributions from the elderly. In addition, the focus on basic care might overshadow the social aspect in public services.

Other research findings support this conclusion. The trend to organise public activity in accordance with New Public Management ideology has brought about important

changes in the relationship between the professionals and the recipients. The professionals are becoming more efficient and task-oriented, meaning that the personal relations between professionals and recipients are becoming less important (Dahle og Thorsen 2004). The new organisation currently being implemented is based on the model of ordering-executer, which means that the office of ordering assesses the needs and makes decisions about which services the elderly are supposed to get. Earlier it was the practioners who made decisions based on their professional judgment and experience. The distance between those who make the decisions and those who implementing them is growing, and it could be difficult to adapt and adjust services in accordance with recipients' changing needs and conditions. The focus is on bureaucratisation through reporting, registering, and controlling by tasks- and time-registration. The tasks' instructions are becoming more and more specific, which is paradoxical since practitioners are becoming more and more competent in this field of service. One of the conclusions of this research is that this model will serve the resource-rich elderly but not the weakest, who are not in a position to speak for themselves or behave as customers in a market. Another conclusion of importance is that the new service model is based on rhetoric intended to activate the elderly. For instance, are daily activities like taking a walk categorised as "activation and mobilisation"? Dahle and Thorsen conclude that daily activities are dressed in a rehabilitation style of language (ibid).

The rehabilitation ideology

The dominant idea in health care is to activate individually-based levels of mastery. The message of the Report to the Storting 'Prescriptions for a healthier Norway' (Report No. 16 (2002–2003) to the Storting) has been interpreted to mean (that) 'everybody should be their own health minister' (Neumann and Sending 2003). The report underlines everybody's responsibility to live a healthy life and/or to rehabilitate oneself back into normal life after sickness. It is easy to link this to the idea of active ageing.

According to some of the experts interviewed, the idea of active ageing challenges our conceptions of different levels of activity. For instance, does it make sense to talk about active ageing for the increasing group of elderly who have dementia? Our experts point out that even this group has experienced positive changes in treatment and care by having been given more physical challenges and freedom.

> 'Increased life expectancy leads to an increase in the group of dementia. The trend in some municipalities is therefore to try to rehabilitate this group by activating them physically. The result is less medicine and less agitating behaviour. Physical activity is a fruitful strategy. Everybody has some capasity to rehabilitate' (Interview 5)

The Action Plan was designed and implemented in line with the rehabilitation idea that is asserted in the general health care system. Independence is the key word. The current norm is to be independent of the total institution and to manage daily life at home. Individual responsibility is highly-valued and is implicit in the action plan. Our informants hold that this norm also reflects another view on the elderly as a group. The

intention of the reorientation has been to encourage independence, including living in one's own flat, and this reorientation has influenced the whole society's thinking of older people as a valuable group. The reform has also made the elderly conscious of own needs and demands; for instance, in their demand for high-quality services in their summer residents and the like.

Among the experts interviewed, there is strong agreement about the strengths of the elderly as future consumers. The experts' tips are that the service will be managed by the elderly themselves who will be instructed neither by the state nor the market. The care services for the elderly could learn something from the care services for the handicapped, which are based on self-managed, non-profit agencies and cooperatives.

The work force situation in health care services for elderly

When it comes to the workforce situation, this evaluation shows that municipalities have problems in staffing their own shift-work plans, especially during the day time. Of the total positions in the home nurse service, 9.2 percent were without personnel during the daytime, which means that several people did not receive the services they were promised. A lack of professional staff, especially psychiatric professionals at the municipality level, is also an important finding of this evaluation. The current situation is characterised by earlier and earlier discharges from the specialised care service, which accordingly demands professional follow-up services in the municipalities. Several of these patients need comprehensive and intensive care, i.e., persons who want to die at home and patients in need of a respirator. It is problematic that municipalities could not manage to secure professional staff for medical treatment in all cases. The problem might be a symptom of an unclear task division between the first- and the second-level services. With shorter periods of care and treatment by specialists at the second-level service, municipalities are also expected to take care of specialised treatment.

Findings of a lack of personnel are in accordance with the sick leave situation and also reflect the trend of exiting the workforce due to disability pensions in the health care field, as illustrated in table 9. In the health care field, 10 percent of the staff are continuously on sick leave, which means that this field has the highest share of sick leave absences. Its' share of disability pensions are also the highest in the country (NOU 2004:1). The Board of Labour Market has uncovered strong work pressure in the home service system. In addition, compared to the increase in home care facilities, the increase in the total amount of staff in the health care service is limited. The main problem lies in the lack of competent personnel in the municipalities.

According to one of the experts interviewed who works as a researcher on care for the elderly, the problem in the health care system today is that the state tries to delimit its responsibility:

> 'The state stresses the lack of personnel as an organisational problem as opposed to the employees claiming that the effectiveness potential is already spent. What is happening is that whereas doctors define themselves out of the field the nurses and employees downward in the hierarchy intensify their efforts. The result is a

> moral overload on these employees who feels a moral obligation to hang on. We find this trend in the whole area of health care for elderly' (Expert interview 1)

A research report points to the fact that the working situation and increasing sick leave are the reasons why 50 percent of all employees are considering leaving their jobs (Næss 2003). Moreover, efficiency in health care has taken away the most important element in their professional work, namely the focus on the human relations between professionals and recipients. Thus, the original and most important dimension of meaning in their work has been lost.

Barriers and opportunities

Based on the exploration of the health status and projected life expectancy among older people in Norway, the future looks bright. By overcoming barriers and seizing opportunities, the general health conditions can not be seen as a strong barrier to an active ageing. On the other hand, there is a mismatch between the presentation of the population' general health status and participation in the labour market. This report has pointed to some nuances in the positive pattern of health conditions. We believe it is important to relate the discussion of sickness absenteeism and exiting the labour market to different kinds of factors. Both special diagnoses and special branches seem to be of importance in understanding sickness absences and exits from the labour market. Persons living with chronic diseases and pain in addition to psychiatric diagnoses constitute an increasing population group and might affect the preconditions to staying in the workforce. Table 5 (page 22) illustrates a particular difference between branches when it comes to early retirees, with industry and mining and health care and social services on the top. To make this picture even more complicated, only about half of the retirees exit within the disability pension scheme; exits for the other half in the voluntary AFP scheme are not based on medical diagnoses. This indicates the need to differentiate between measures to keep persons active in labour market. We also need to differentiate between measures designed to promote active ageing depending on whether they are inside or outside the labour market.

Concerning those outside the labour market, the overall health policy and health status of the majority of the population could be an opportunity to achieve active age. On the other hand, 66 percent of the older population – those aged 80 and more – consists of older women living alone who need to be taken care of. Women have weaker health than men and need an average of 3 years of intensive care before they die. Men need less care (from 1 to 2 years), and are healthier but have shorter life spans (Romøren ibid). The discrepancy between the healthier and longer-living majority on the one hand, and the minority in greater need of intensive care and treatment on the other hand has to be taken into consideration in the assessment of barriers and opportunities.

At the rhetorical level, we clearly observe a change from a policy focusing on 'taking care of' the elderly to a policy stressing self responsibility, participation and an obligation for the elderly to use their resources. However, according to our informants, the rhetoric has so far not succeeded in changing behaviour among the healthy and

wealthy majority of the elderly who, to a great extent, exit the productivity sphere as well as the cultural and political spheres. Thus, the policy challenges in the future will be to combine the 'taking care of' perspective and the 'obligation to participate' perspective in policies for the elderly. Efforts to change society's opinions about older people's capacity, accepting the improved health of the elderly and their abilities to participate in different arenas of society are currently the Norwegian health care policy, in line with the ideas of active age. Nevertheless, the ideal of high quality care and nursing of the weakest still has a strong role in driving policy towards the elderly. Both the activation line and the care perspective are important because of their impact on confidence in the health care services.

Following this, a main barrier to active ageing is the cultural understanding of ageing. The experts hold that because patients' health conditions are of minor importance in active ageing, cultural interpretations are all the more significant. Age discrimination through legislation is not the issue; instead, the issue is how the elderly are in a position of power to define their own old age. An increasing group of elderly has a lot of intellectual and economical resources. Thus, there is need for a strategy in the policy arena directed at those aged 60 + who have left the labour market but are still able to be active in several arenas. The problem with this group, from an active age perspective, is that they use their resources on themselves and not on the collective group. Thus, the opinion among the experts, as well as among the authorities in general, is that this group gives too little back to the society. A lot of resources are spent on private projects like "playing golf on the Spanish coastline". The informants point to the danger of segregation areas consisting of populations 60+, whether localised in Spain or in parts of the biggest towns in Norway. The challenge is to prevent segregation and to prepare for older people to integrate in society. This could be done either by encouraging and adapting so that people can stay longer in the workforce or to engage the voluntary sector so that society can still enjoy their resources and competence. The authorities recognise that older people could not expect to live healthy lives for thirty years on pensions without giving something back to the society. The policy has to be redirected in line with the demographic challenges and the resources represented by the well-functioning elderly have to be used for the collective benefit, according to our informants.

According to the authorities, attitudes need to change in the different sectors of society, in the different population generations, and, not least of all, among the elderly themselves. This barrier, however, is not easy to overcome. Compared to barriers of physical environments, which could be removed after decision have been made, the effort to change attitudes is harder, and is not only a political issue. The political challenge is to oversee the situation and to balance the tension between the weak minority and the stronger majority. It will still be crucial to take care of the most needy in order to secure the legitimacy of the health care system.

From this, a second barrier to active ageing is marketization in health care and the threats commercialization makes against using health policy as a policy tool for active ageing. Crucial issues seem to lie outside the control of politicians. In the future, public services must offer services both in accordance with the ideas of active age and in line with the demands of self-conscious and wealthy customers. The health care system is

dependent on the increasing middle class who possess resources and capital. This group will decide how to spend their old age and which type of services they need. Thus, the challenge for future policy will be to satisfy this group with good quality services. The mix of future advances in medical technology, an increased demand for high quality services and an increased willingness among the elderly to pay leads to continuously higher demands for health care services. In the future, politicians will have difficulties in controlling driving forces like these. In addition, there is a question of where to set the border of the responsibility of the state. The rising wealth among the elderly actualises discussions of the responsibility between the public and the private in health care for the elderly, according to the experts.

Based on the statements of our informants, a barrier to the active ageing project is the element of paternalism that could be a consequence from implementing the idea. Active ageing relies upon the opinion that an active life is healthier than a passive life. This is in accordance with public health policy that focuses on a healthier way of living. Thus, implicit in this policy is a tendency toward fundamentalism. Everyone should eat healthier, drink less, not smoke, exercise more and so on. The prescription for a happy life is decided by the authorities. This breaks with the new liberalistic, individualistic ideas which are present at the same time in the welfare services. Whether the focus on prevention represents a barrier or an opportunity is dependent on how this contradiction is handled by politicians and the implementers of public health.

Another barrier to overcome is connected to the issues of gender and class in the active ageing project. The group that fits into the ideal of active aging is healthy middle class males aged 60+. The consequences of not fitting into the concept might stigmatise other groups and in the long run strengthen the class and gender gap. There is a rising divide of A and B groups of the elderly. Those who fall outside the normal and active ideal in the B category have a greater distance than before.

In overcoming barriers and seizing opportunities, collaboration is a crucial issue, both inside the health care sector and between the different public sectors and the voluntary sector. There seems to be too little coordination and dialogue between the doctors and those involved in providing daily care for elderly. The lack of collaboration between the primary health care providers and the specialist care is a recurring issue. In addition, the variety of elderly needs can not be met by the health care system alone. The expert hold that collaboration with cultural agencies and with the voluntary sector is highly relevant. There is a need for competence in coordination and network building in order to bring the different areas together. The expert suggestion that the municipalities employ a coordinator might be an opportunity for extension of social activity.

Concerning the tendency of the elderly to segregate, the process of area planning and the idea of universalism have to be taken into consideration. This would also be in line with the idea of living at home as long as possible in order to uphold an active and integrated life style. Concerning this point, accessibility of public spaces is important. Increased mobilisation among the elderly, in addition to the services offered by several actors, also represents a challenge because people have the right to receive services where they stay. The system has to ensure that people receive services in different municipalities, or in different countries by different actors.

Professional engagement and interest in health care services for elderly are crucial to eradicating the barriers and realising opportunities. The issue of care for the elderly is said to be of greater importance for politicians than for the professions. Neither the geriatric specialist area nor other areas of importance for older people (like chronic diseases) are on the top of the list among the medical professions. This is reflected in the public administration, where bureaucrats working with the hospital sector are far more plentiful than bureaucrats working with primary health care services for the elderly.

Conclusion

In identifying institutional, political and socio-economic barriers and opportunities for active ageing in the health care sector, several conclusions can be made. The strongest opportunity for active age might be the general health status of the older population and the extensive and universal public health care services open to all. Limited to people above the age of pensioning, the current health policy is not a barrier to active age in Norway. However, including the 60+ group, increased exit from labour market gives rise to questions about the health conditions of this group. When it comes to self-reported health, a large percentage of the population live with chronic health problems, somatic pain and psychiatric disorders. This could be part of the explanation for increased exit from the labour market. Even though there are several reasons to exit, a large proportion of the exits that occur before the formal pension age are based on medical diagnoses within the disability pension scheme. Policies intended to limit exiting are currently geared toward cooperation between employers and employees in finding solutions at the firm level to stay in the workplace despite sickness. After three years, the Inclusive Working Life program might reap the fruits from the decline in sickness absenteeism for the first time since the late 1980s. For retirees within the voluntary scheme, the barriers are not necessarily health conditions nor working place conditions, but economic incentives. Thus, barriers to active ageing in this group seem to be attitudes towards work and leisure, in addition to the overall cultural understanding of old age.

Active age does not exist as a publicly-expressed aim in the health care policy. Nevertheless, active ageing policies seem implicit in the recent health care reforms. The most important change is the redirection of housing policy for the elderly and the trend toward live at home as long as possible and receiving individually adapted services. In addition, health care policy for the elderly relies on a combination of the ideology of responsibility and the rehabilitation ideology. Thus, taken together, this might strengthen the policy enabling the elderly to live as normalised and integrated as possible in line with active ageing ideas. However, two main challenges still remain. The focus on health care might neglect the social needs of the elderly. Thus, an important precondition for being active is ignored in the policy. Another policy challenge is how the elderly make use of their good health and the possibilities to live an active old age. The trend for the elderly to segregate and live outside the productive sphere is perceived

as a problem in the Norwegian policy debate, as politicians want the healthy elderly to make use of their resources towards the collective.

In conclusion the health care policy has resulted in a good health condition for the population and the accessibility of health care is sufficient. The preconditions for an active age have never been better. However, due to demographic ageing, authorities are dependent on activity for the healthy elderly to be used in working life, to take care of themselves and to give something back to the community in order to lighten the demographic burden. This challenge is even stronger because of the manifested cultural norms of self-realisation among the older population. Accordingly, political tools encouraging health are only part of the means to overcome this barrier.

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